PENSIONS
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LIFE INSURANCE

Irish Life

FAST TRACK UNDERWRITING

CUSTOMER MEDICAL QUESTIONNAIRE - HIGH BLOOD PRESSURE (HYPERTENSION)

000046

Application Number:

Name of customer applying for cover

Date of Birth (dd/mm/yyyy)

Financial Adviser

Guide to filling in this questionnaire

1. Make sure you fill in the customer details above.
2. You should read the **Important note** below about telling us about relevant information
3. Please complete the questionnaire, providing as much details as possible in response to the questions about your medical history.
4. Read through the answers you have given and the declaration and sign it, on the last page of this form.

Important note - Telling us about relevant information

Please read the information below carefully – ask your financial adviser if you have any questions.

- When deciding whether to insure you and when setting the terms and premium, we will rely on the information you have given us. You must answer all questions that we ask honestly and with reasonable care. Where we ask you to answer a specific question, the subject matter of the question is material to the risk we are undertaking or the calculation of the premium or both.
- If your answers are not true and complete, we may be entitled to void the policy without return of premium, repudiate liability, treat the policy as if it had been entered on different terms, or limit the amount paid on foot of the contract of insurance. You must tell us all relevant information when answering all of the questions. This includes disclosing tobacco consumption or use of nicotine replacement products including e-cigarettes. If you are not sure whether something is relevant, you should tell us anyway. We may also contact you if we need to ask you for further information on your answers or as part of any subsequent claim.
- We will rely on what you tell us and you must not assume that we will automatically confirm with your GP or any other doctor any information that you provide. If relevant, you can consult your GP about the questions on this form, but we cannot cover the cost of your doctors' time. You can provide any highly confidential information direct to our Chief Medical Officer in a sealed envelope and give this to your financial adviser. In these circumstances you must refer to this information when answering your health questions.
- You do not need to tell us about and genetic test (that is, analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. However, you must, where required by our questions, tell us if you are having treatment for or experiencing symptoms of a genetic condition. We may also ask you to give us full information about your family history, including all genetic conditions.
- You must tell us in writing about any change in your answers to any of the questions in this form (for example, in relation to personal medical circumstances or family history or dangerous pursuits you take part in) between the time you apply for cover and the date your application is accepted. Failure to do this may result in a claim being refused.

Diagnosis

1. When was your high blood pressure (hypertension) diagnosed?

2. Why was your blood pressure measured at that time? (for example, routine exam, due to symptoms, pregnancy, executive health check, check due to family history, life assurance medical or other)?

3. Have you ever had any tests or investigations carried out in connection with this condition? Yes ◯ No ◯

   (examples include blood tests, ECG, echocardiogram, 24-hour blood-pressure monitor, urine tests, exercise or treadmill stress test, coronary angiogram). If 'Yes', please give dates and results.

Date:	Test:	Result:

4. Do any of your immediate family (mother, father, brothers, sisters) suffer from or had any of the following before age 60 – raised blood pressure, raised cholesterol, angina, heart attack, heart disease, bypass surgery, angioplasty, stroke or diabetes?

   Yes ◯ No ◯

   If 'Yes', please list all those affected, the condition suffered and their age at diagnosis.

Relative	Condition	Age when diagnosed

Symptoms

5. Have you had any symptoms (for example dizziness, headache, chest pain, other)? Yes ◯ No ◯

   If 'Yes', please give full details including dates.

Date:	Nature of problem:

6. Do you have any related medical conditions? Yes ◯ No ◯

   (for example, raised cholesterol, raised blood-sugar levels, diabetes, kidney problems, chest pain, problems with your eyes etc)? If 'Yes', please give details.

7. Do you smoke tobacco or have you ever smoked? Yes ◯ No ◯

   If 'Yes', please give full details including the year you started smoking, the year you stopped (if this applies) and how much tobacco you smoke each day.

Year you started smoking:

Year you stopped smoking *(if this applies)*.

How much tobacco do you currently smoke or used to smoke if you have now stopped?

(number of cigarettes, cigars or ounces of tobacco)?

Cigarettes ◯ ____ per day

Cigars ◯ ____ per day

Pipe ◯ ____ per day

Treatment

8. Do you currently take medication or other treatment for this condition? Yes ◯ No ◯

(for example, Adalat, Atenolol, Capoten, Centyl K, Innovace, Zestril, Omesar or other)?

If 'Yes', please give name(s) and dosage each day.

Name(s):	Dosage each day:

Have you ever stopped taking your medication(s)? If 'Yes', why? Yes ◯ No ◯

9. Has the type of medication or dosage been changed since you began treatment? Yes ◯ No ◯

If 'Yes', please give dates and details of the changes.

Date:	Changes made:	Reason:

10. Have any future treatments or investigations been discussed? Yes ◯ No ◯

(such as changing your medication, referral to a specialist doctor, surgery or other therapy)?

If 'Yes', please give details.

11. Have you ever been treated in hospital for this or any other heart condition? Yes ◯ No ◯

If 'Yes', was it:

Inpatient? Yes ◯ No ◯ Date

Details and how long you stayed

Outpatient? Yes ◯ No ◯ Date

Details and why

Accident and emergency? Yes ◯ No ◯ Date

Details and why

12. **About monitoring your condition**

Who do you see to review your condition?

How often do you go for a review?

What has your doctor (and specialist, if you have one), told you about your current blood-pressure control?

When was your last consultation? Date

Please provide details of your last blood-pressure reading if you know.

Do not know ○ (tick if appropriate)

Date: Reading:

If you were told that your blood pressure was completely normal at that time, please say this

13. If there is any other information in relation to this condition which you feel may help us assess your application for cover, you can provide it here.

Please, outline details of any regular exercise you undertake or lifestyle changes your doctor has recommended, or you yourself have implemented as a result of your condition (for example, weight reduction, low-salt diet or other).

Declaration

Please review the answers given in this questionnaire and then read, sign and date this declaration.

I understand and agree that the information I have provided in this questionnaire is material to the decision of Irish Life Assurance plc (Irish Life) to enter into the contract, on the terms and for the calculation of premium and that Irish Life has relied on this information in so doing. My contract with Irish Life comprises the plan schedule, the terms and conditions booklet and any extra rules which Irish Life head office staff may add in writing. I understand that this questionnaire will form part of my application for cover.

I have read and understood the important information about my obligation to answer all questions asked by Irish Life in this questionnaire and in connection with the application and I understand that if I do not answer these questions honestly and with reasonable care, Irish Life will be entitled (depending on the breach) to declare the plan void, refuse my claim, treat my insurance as if it was entered on different terms, or reduce my claim. If this happens, I understand and acknowledge there may be no cover under the plan, Irish Life may not refund my premiums and Irish Life may not pay a claim.

I have read over the answers to all the questions on this form and declare that all answers (including any answers written down for me) are true and complete. I declare that I have answered all of the questions in this form honestly and with reasonable care. I understand that a copy of this completed form is available to me, on request from Irish Life.

I understand that I must tell you in writing about any changes in my answers to any of the specific questions in this form (for example, in relation to personal medical circumstances, family history or taking part in dangerous pursuits) between the time I applied for cover and the date my application is accepted.

I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment.

Please sign and date

Your Signature ✗

Date

Please be aware for all signatures typed herein, you are electronically certifying this document, just as if you were physically signing on paper.

In the interest of customer service we will record and monitor calls.

Irish Life Assurance plc is registered in Ireland number 152576, VAT number 9F55923G.