

# Fast Track Underwriting: Customer Medical Questionnaire

## Kidney and urinary abnormalities

Name of customer applying for cover

Date of birth

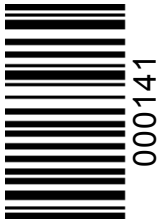
Application number

Financial Adviser

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### 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.



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### 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. 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.

## Kidney and urinary abnormalities

- 1 Please give the diagnosis, or the nature of the condition you are suffering from (for example kidney stones, haematuria, blood in the urine, protein in the urine, nephritis, kidney infection, urinary tract infection, nephrotic syndrome or other).

Diagnosis

- 2 When did you first experience symptoms and why did you get medical advice at that time?

Date

- 3 When was this condition diagnosed? Date

- 4 Please describe your symptoms when you were diagnosed. For example, how severe they were, how long they lasted and how often you got them?

- 5 About any current symptoms

- What are they
- Are these ongoing?
- Are they getting worse more severe stable or considerably improving
- When did you last experience symptoms?
- If ongoing, how often do you have symptoms and how long do they last?
- If your condition is kidney stones (renal calculi), please confirm:

Have one or both kidneys been affected (now or in the past)? Yes No Date

Details

- 6 Do you currently take medication or other treatments for this condition? Yes No

If 'Yes', please give details including names, doses and how often.

Details

- 7 Have you taken medication or other treatments in the past for this condition? Yes No

If 'Yes', please give details including names, dose and how often.

Details

- 8 Have you ever had any tests or investigations carried out for this condition? (Examples include blood tests, IVP, cystoscopy, ultrasound scan, CT scan or MRI scan, biopsy or other).

Yes No If 'Yes', please give details.

Date Details of investigations

Results

- 9 Have you ever had surgery for this condition or has the possibility of surgery been discussed with you?

Yes No If 'Yes', please give details.

Details

- 10 Have you ever been treated in hospital for this condition? Yes No If 'Yes', was it:

Inpatient (overnight or longer)? Yes No Date

Details and length of stay

Outpatients? Yes No Date

Details

Accident and emergency? Yes No Date

Details

- 11 Are you currently going for follow-up reviews for your condition?
- |     |    |  |
|-----|----|--|
| Yes | No | If 'Yes', please give full details, including names of doctors seen and dates including the most recent visit. |
|     |    | Dates  |
|     |    | Details  |
- 12 Are you currently waiting for or considering any investigations or to see a specialist about this condition?
- |     |    |                                |
|-----|----|--------------------------------|
| Yes | No | If 'Yes', please give details. |
|-----|----|--------------------------------|
- 13 Has your condition meant you couldn't carry out everyday activities or were off work sick?
- |     |    |   |
|-----|----|---|
| Yes | No | If 'Yes', please give details of absences from work or incapacity and the reason. |
|-----|----|---|
- 14 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.
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## Doctors and specialists you have seen

Please fill in the name and address of doctors and specialists you have seen.

### Names

- 1.
- 2.
- 3.

### Addresses

- 1.
- 2.
- 3.

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## Further medical information

Please use this space if you need more space to fill in your answers.

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## 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.**