

Fast Track Underwriting - Customer Medical Questionnaire

Arthritis and other joint disorders

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS
If any item is blank or illegible, this will cause a delay in processing your application.

Name of customer applying for cover	
Date of Birth	dd/mm/yyyy
Application Number	
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 material facts.
- Please complete the questionnaire, providing as much details as possible 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 material facts

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

- You must tell us everything relevant when filling in this questionnaire. If you do not, or if any of the answers to these questions are not true and complete, we could treat the plan as void. If this happens there will be no cover under the plan and we will not refund the payments. In these circumstances we will not pay a claim. A relevant fact (material fact) includes anything that a reputable insurer would treat as likely to influence their decision to provide insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the "further medical information" section.
- 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 any genetic test (that is, analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. However, you must 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 personal medical circumstances or family history or dangerous pursuits you take part in between the time you apply for cover and the time your application is accepted.

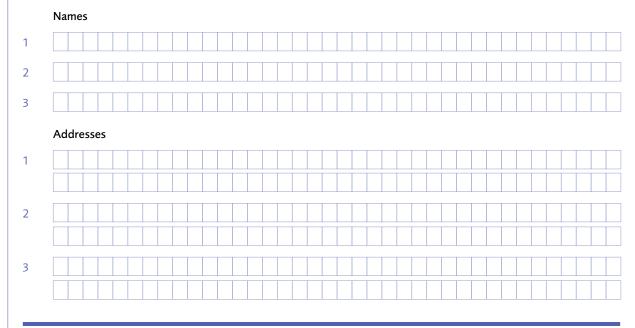
Diagnosis

Q1.	What is the condition	or symptoms that you suffer from?		
		osteoarthritis rh	eumatoid arthritis 🔵	psoriatic arthritis (
		gout anky	losing spondylitis	joint replacement
Othe	er (please name)			
Q2.	When was the condit	ion diagnosed?		d d / mm / y y y
	And please describe	your symptoms at the time of diagnosis		
-	mptoms			
Q3.	What joints are affect	\sim		. (
		ankles knees	hips (spine (
Othe	er (please name)			
Q4.	Do you have any curr			Yes 🕖 No 🤇
	If Yes, please describe	e your symptoms and how frequently they	occur?	
05	When did you last ex	perience major symptoms?		
QJ.	-	A&E referral, inpatient treatment or an in-	crease in medication.	
	Please confirm the da	tes, symptoms and treatment required for	r any major episodes in t	he last 5 years
~ -				
Q6.	What has your G.P. o	r specialist told you about the current con	trol of your condition?	
Q7.	Is your mobility impai	red in any way?		Yes No
	If Yes, please describe	e how. e.g use of a walking stick or walking	g frame	
Q8.	Have you experience	d any associated complications or sympto	ms affecting the bowel,	skin, eye, lungs or heart?
				Yes No
		and the second	work?	Yes No
Q9.	Have your symptoms	meant you can't carry out daily duties or v	WORK.	ies ino (

li tes,	please provide full details including name and dosage. e.g. Met	hatrovata Uumira ata	
	please provide fuil details including fiame and dosage. e.g. Met	nonexale, numira etc.	
Q11. Please	confirm the date and results of your latest investigations or revie	ew carried out regarding your condition	,
	oods, scans, consultant reviews etc	dd/mm/v	vv
c.g bit			77
L			
	any treatment changes been discussed or are you currently awai	ting any further	/
investi	gations, specialist review or surgery?	Yes	No (
lf Yes	please give details		
11 105,			
O13 Is ther	e any other information that you would like to include to assist o	ur assessment?	
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Doctors and specialists you have seen

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



Further medical information

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

Declaration

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

I agree that this questionnaire will form part of my application for cover to Irish Life Assurance plc.

I have read and understood the note on the first page of this form about telling Irish Life about material facts and I understand that if I do not reveal all these facts, Irish Life could treat the plan as void and in these circumstances Irish Life will not pay a claim or refund my payments.

I have read over the answers to all the questions on this form and declare that all statements (including any statements written down for me) are true and complete. I understand a copy of this form is available to me if I ask.

I understand that this cover will not start until you have accepted me for cover and I have paid the first premium. I understand that I must tell you in writing about any changes in my personal medical circumstances, family history or taking part in dangerous pursuits before this application is accepted.

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Please sign and date	

d d / mm / y y y y

X

Signature

Date

