

Fast Track Underwriting - Customer Medical Questionnaire

Crohn's disease, ulcerative colitis and gastro intestinal inflammatory 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

- 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.
- A 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.

-
£
v
10
-
+
b
. =
~
6
,~
$\overline{}$
U
\geq
ú
-
œ
_
\sim
00
23
-
⋖
_

Di	agnosis					
Q1.	What is the exact cond	lition that you suffer from?				
	Crohn's disease	ulcerative colitis	colitis	proctitis	inflammatory bowel d	isease
Oth	er (please name)					
Q2.	Do you know what par	t of your bowel is affected	by this condition	?		
		rectum only	small bov	vel only	left sided d	lisease (
	large l	powel involvement or	outside the int	estines or	total involvement of the	colon
Oth	er (please name)					
Q3.	When was the condition	on diagnosed?			dd/mm/)	у у у
	And please describe yo	our symptoms at the time o	of diagnosis			
Sy	mptoms					
Q4.	Do you have any curre				Yes	No 🤇
	If Yes, please describe	your symptoms				
Q5.	When did you last exp	erience major symptoms?			dd/mm/)	/ y y y
	= :	eroid treatment, A&E refer				
	Please confirm the date	es, symptoms and treatmer	nt required for an	y major episodes v	within the last five years	
06.	What does your G.P. o	r specialist tell you about tl	ne current contro	l of vour condition	1?	
		7		, , , , , , , , , , , , , , , , , , ,		
Q7.	Please confirm the date	e, type and results of the la	test investigation	s carried out in co	nnection with the condition	on?
	e.g. colonoscopy				d d / m m /)	/ у у у
			livi 2			
Q8.		ed symptoms or medical cover problems	onditions? skin problems	mouth ι	ulcers eye pro	blome
ماء		ver problems	skin problems	moutrit	licers eye pro	bilems
	er (please name)					
Q9.		neant you can't carry out d	-		Yes	No (
	Please provide dates th	nat you have been absent f	rom work within	the past five years		

	а	
	t	
	1	
	-	
		>
	Y	
	\	
		١
į	s	
	ď	

Treatment		
Q10. Do you currently take any medication or other treatments for this condition?	Yes	No 🤇
If Yes, please provide full details including name and dosage		
Q11. Have you ever been treated in hospital?	Yes	No (
If Yes, please confirm dates and details	103	110
Q12. Have you ever had surgery for this condition?	Yes	No (
If Yes, please confirm dates and details		
Q13. Have any treatment changes been discussed, are you currently awaiting any further		
investigations, specialist review or surgery?	Yes	No (
If Yes, please give details		
Q14. Is there any other information that you would like to include to assist our assessment?		

Doctors and specialists you have seen

ther medical information												en.							
ther medical information	Nam	es																	
ther medical information																			
ther medical information																			
ther medical information																			
ther medical information use this space if you need more space to fill in your answers.																			
	Addr	ess	es																
			T																
		+																	

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.

Please sign and date

Signature	X
Date	dd/mm/yyyy

