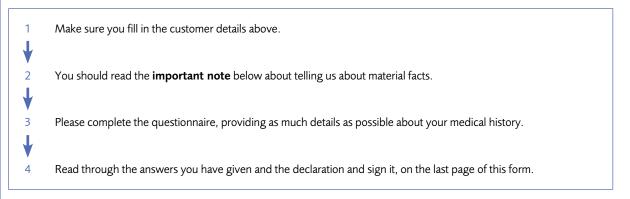


# FAST TRACK UNDERWRITING

# CUSTOMER MEDICAL QUESTIONNAIRE - HIGH BLOOD PRESSURE (HYPERTENSION)

46	Application Number:										
0000	Name of customer applying for cover										
	Date of Birth (dd/mm/yyyy)	/	/								
	Financial Adviser										

## Guide to filling in this questionnaire



# 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 date cover is accepted.

### Diagnosis

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



- 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:
d d / m m / y y y y		
d d / m m / y y y y		
d d / m m / y y y y		

Do any of your immediate family (mother, father, brothers, sisters) suffer from or had any of the following before age 60 -4. 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.

Nature of problem:

Da	te:								
d	d	/	m	m	/	y	y	y	y
d	d	/	m	m	/	y	y	y	y
d	d	/	m	m	/	y	y	y	y

d / m m / y y y y	
d / m m / y y y y	

Do you have any related medical conditions? 6.

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

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

No

Yes

tobacco you smoke each day. Year you started smoking:



Yea	ır y	ou	sto	ppe	ed s	smo	okir	ıg (	if tł	nis ap	olies	;).
d	d	/	m	m	/	У	У	у	y			

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

1	number	of cigarettes,	cigars	٥r	ounces	٥f	tohacco	12
	number	or cigarettes,	cigars	or	ounces	0I	lobacco	):

cigarettes	per day
cigars	per day
ounces of tobacco	per day

### Treatment

Do you currently take medication (for example, Adalat, Atenolol, C				athar)2			
If 'Yes', please give name(s) and			II, Offiesar of	otrier):			
Name(s):	ausage caen da	ty.	Dosa	ge each o	lav:		
				50 00001			
Have you ever stopped taking yo	our medication(	s)? If 'Yes', why?			Ye	s 🔘	No
Has the type of medication or do	-		gan treatment	2	Ye	s 🔘	Nc
If 'Yes', please give dates and det	ails of the chan	iges.					
Date:	Changes ma	ide:	Rea	ison:			
d d / m m / y y y y							
d d / m m / y y y y							
Have any future treatments or inv					Ye	$\frown$	
(such as changing your medication	on referral to a	specialist doctor s	urgen or oth	or thoron	12		
If 'Yes', please give details.							
Have you ever been treated in ho	ospital for this o	or any other heart o	ondition?		Ye	5	Nc
Have you ever been treated in ho	ospital for this o Yes	or any other heart o	ondition?	Date	Ye:	s ()	Nc
Have you ever been treated in ho If 'Yes', was it:	Yes		ondition?	Date	Ye:	s () m m /	Nc
Have you ever been treated in ho If 'Yes', was it: Inpatient?	Yes		ondition?	Date	Ye:	s ()	Nc
Have you ever been treated in ho If 'Yes', was it: Inpatient? Details and how long you stayed	Yes		ondition?	Date	Ye	s ()	Nc
Have you ever been treated in ho If 'Yes', was it: Inpatient? Details and how long you stayed Outpatient?	Yes	No	ondition?		Ye:	s () m m /	Nc
Have you ever been treated in ho If 'Yes', was it: Inpatient? Details and how long you stayed	Yes	No	ondition?		Ye:	s () m m /	
Have you ever been treated in ho If 'Yes', was it: Inpatient? Details and how long you stayed Outpatient? Details and why	Yes	No	ondition?	Date	Ye:	s () m m / () m m / ()	Nc
Have you ever been treated in ho If 'Yes', was it: Inpatient? Details and how long you stayed Outpatient?	Yes	No	ondition?		Ye:	s () m m / m m /	Nc

	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 d d f m f y y y
		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.	Please provide any other information on this subject which you feel may be beneficial in assessing your application.
		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).
		yoursen have implemented as a result of your condition (for example, weight reduction, low-sait diet of other).
		Declaration
		lease review the answers given in this questionnaire and then read, sign and date this declaration.
		agree that this questionnaire will form part of my application for cover to Irish Life Assurance plc.
	tŀ	have read and understood the note on the first page of this form about telling Irish Life about material facts and I understand nat 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 aim or refund my payments.
		have read over the answers to all the questions on this form and declare that all statements (including any statements written own for me) are true and complete. I understand a copy of this form is available to me if I ask.
	L	understand that this cover will not start until you have accepted me for cover and I have paid the first premium.
		understand that I must tell you in writing about any changes in my personal medical circumstances, family history or taking art in dangerous pursuits before this cover is accepted.
	Si	ignature X
Please sign and date	D	d d 7 m m 7 y y y
	In t	he interest of customer service we will record and monitor calls.
		h Life Assurance plc is registered in Ireland number 152576, VAT number 9F55923G.

Irish Life Assurance plc is regulated by the Central Bank of Ireland.

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🚺 Irish Life