Fast Track Underwriting - Customer Medical Questionnaire

Stomach and bowel disorders (not crohn's disease or ulcerative colitis)

Name of customer applying for cover

Date of birth dd / mm / yyyy

Application number

Financial adviser

14432

000145

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.

3 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 cover begins.

Irish Life

Stomach and bowel disorders (not crohn's disease or ulcerative colitis)

1 What is the nature of the condition you suffer from (for example, reflux oesophagitis, coeliac disease, irritable bowel syndrome, spastic colon, ulcer, Barrett's Oesophagus, indigestion, heartburn, or other)?

Diagnosis

2 When was the condition diagnosed or when did you first experience symptoms? dd / mm / yyyy

3 Please describe your symptoms when you were diagnosed.

4 About your current symptoms.

- What are they?
- Are these ongoing?
- Are they getting worse, more severe, stable or considerably improving?
- When did you last have symptoms?
- What is the typical length of time between episodes or significant symptoms?

5 Have you ever had any tests or investigations carried out in connection with this condition (examples include blood tests, endoscopy, ultrasound, colonoscopy, gastroscopy, barium meal or enema, biopsy or other)?

Yes ◯ No ◯ If 'Yes', please give details including dates and results.

Dates dd / mm / yyyy Results

Details of test done

6 Do you currently take medication or other treatments for this condition (for example, Colofac, gluten-free diet, Fybogel, Zantac, Motilium, Tagamet, triple therapy, Proton pump inhibitor, Nexium, Losec or other)?

Yes ◯ No ◯ If 'Yes', please give details including names, doses and how often

Names of medication

Dose How often?

7 Have you taken any other medication or treatments in the past for this condition?

Yes ◯ No ◯ If 'Yes', please give details including names, doses and how often.

Names

Dose How often?

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

- inpatient (overnight or longer)? Yes ◯ No ◯ Dates dd / mm / yyyy

  Details and length of stay
- outpatients? Yes ◯ No ◯ Dates dd / mm / yyyy

  Details
- accident and emergency? Yes ◯ No ◯ Dates dd / mm / yyyy

  Details

9 Have you ever had surgery for the condition?

Yes ◯ No ◯ If 'Yes' give dates, details and procedure carried out.

Dates dd / mm / yyyy Details

10 What has your GP or specialist told you about whether your condition is fully controlled or not?

Please give details .

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11 Are you waiting for or considering any future investigations or to see a specialist about this condition?

If 'Yes', please give details.

12 Have you ever taken time off work or had difficulty carrying out your normal activites with this condition?

Yes ◯ No ◯

If 'Yes' give the dates and reasons.

Dates	Reasons
dd / mm / yyyy	
dd / mm / yyyy	
dd / mm / yyyy	
dd / mm / yyyy	

13 Were you given any specific health advice or suggested lifestyle changes by any health professional about this condition ?

Yes ◯ No ◯ If 'Yes', please give details.

14 Please provide any other information on this condition which you feel may help us assess your application for cover.

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

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 cover starts.

Your signature X

Date dd / mm / yyyy

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Irish Life