



## Medical questionnaire

Please use black ink and **write clearly in CAPITAL LETTERS** or tick  as appropriate.

Any corrections must be initialled.

Please do not use correction fluid as this will invalidate your questionnaire.

### About this form

If you have any questions about this form, you can call us free on **0800 000 000** between 8am and 6pm Monday to Friday.

Calls may be monitored or recorded for quality and security purposes. Please return all 24 pages of this form in the enclosed reply paid envelope to: **Prudential, Stirling FK9 4UE.**

Alternatively, you can return your completed form to us by email. Please scan all 24 pages and email to: **enhanced.annuities@prudential.co.uk**

We offer enhanced annuity terms for individuals who suffer from certain medical conditions. Medical conditions that may qualify are those such as stroke, some cancers, diabetes, or diseases of the kidneys, heart or lungs. This list is intended as a guide and is not comprehensive.

We offer a full range of **single** and **joint-life underwriting options**. We're happy to offer enhanced rates to:

- An unhealthy applicant with no dependants.
- An unhealthy applicant with a healthy financial dependant.
- An unhealthy applicant with an unhealthy spouse or civil partner, or an adult who is financially dependent.
- A healthy applicant with an unhealthy spouse or civil partner, or an adult who is financially dependent.

Our Enhanced Annuity option is available with our Guaranteed Pension Annuity and our Income Choice Annuity if you have a pension fund worth at least £10,000 after taking any tax-free cash.

In most cases we will provide a quote within **24 hours** using the information gathered in our questionnaire. However, for more serious conditions we may obtain detailed medical evidence by writing to your GP. This process will take longer, but will enable us to offer the best possible terms for all individuals.

### For internal use only

PRUDIRECT	
Consultant's name	
Aqua reference	
Fund value (after tax-free cash)	
Policyholder's surname	
Postcode	
Table numbers	
INTERNAL	
Policy number	
Table number	



## Part 1 – Personal details – continued

Has Power of Attorney been vested in another party?

Yes  No

Has Power of Attorney been vested in another party?

Yes  No

If **Yes**, please enclose the appropriate documentation.

## Part 2 – Medical details

**An annuity may start on the basis of the medical information you supply. Failure to disclose material facts may result in your annuity being reduced. Material facts are those that an insurer would regard as likely to influence the assessment and acceptance of a proposal.**

**If you are unsure whether certain facts for your case are material, they should be disclosed.**

### Applicant

### Spouse or civil partner, or an adult who is financially dependent (if applicable)

1. What is your exact height and weight? (either/or)

ft	ins	st	lbs
cm		kg	

ft	ins	st	lbs
cm		kg	

2. Do you smoke? Yes  No

Yes  No

What do you smoke? (tick as appropriate)

Cigarettes or hand made cigarettes

Pipe

Cigar

Cigarettes or hand made cigarettes

Pipe

Cigar

Number smoked per day:

3. Do you drink alcohol? Yes  No

Yes  No

If **yes**, please state weekly consumption of beer, wine and spirits. (A unit of alcohol is equivalent to half a pint of normal strength beer, lager or cider, one standard glass of wine or a single measure of spirit.)

## Part 2 – Medical details – continued

4. If you have suffered from/are suffering from a serious medical condition (such as any of the following conditions) please indicate by ticking the appropriate box and follow the guidance given for each condition detailed below.

Please tick the appropriate box

	<b>Applicant</b>	<b>Spouse or civil partner, or an adult who is financially dependent</b>	
Heart attack, angina or any other heart condition			Complete questionnaire on pages 9 & 10
Diabetes			Complete questionnaire on pages 11 & 12
Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour			Complete questionnaire on pages 13 & 14
Stroke			Complete questionnaire on page 15 and also ADL* questionnaire on page 20
High blood pressure			Provide details overleaf
High cholesterol			Provide details overleaf
Chronic respiratory disease (e.g. bronchitis, emphysema, COPD)			Complete questionnaire on pages 17 & 18
Kidney disease			Provide details overleaf
Liver disease			Provide details overleaf
Multiple Sclerosis			Complete questionnaire on page 16 and also ADL* questionnaire on page 20
Motor Neurone disease			Complete questionnaire on page 19 and also ADL* questionnaire on page 20
Alzheimer's disease, dementia or Parkinson's disease			Complete questionnaire on page 19 and also ADL* questionnaire on page 20
Any other serious illness or condition			Provide details overleaf

If you have suffered from/are suffering from any other condition, or conditions, not mentioned in the list above, please also provide us with details overleaf.

\* ADL – Activities of Daily Living

**Part 2 – Medical details – continued**

**Applicant**

**Spouse or civil partner, or an adult who is financially dependent (if applicable)**

**Condition 1**

**Condition 1**



Month/year.

1. Date of diagnosis?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

2. When did you last attend your GP/ consultant in relation to this condition?

M M Y Y Y Y

M M Y Y Y Y

3. How often do you attend check ups?



4. Is treatment still required?

Yes  No

Yes  No

If **yes**, how many prescribed medications are currently required for this condition?



Date and details.

5. Please provide details of any special investigations for this condition (e.g. surgery, renal dialysis, endoscope, CT scan, MRI, etc). Please include dates.

6. Have you been admitted to hospital for this condition?

Yes  No

Yes  No

If **yes**, when were you last admitted?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

7. Do you still suffer from symptoms?

Yes  No

Yes  No

If **yes**, date of last symptoms

M M Y Y Y Y

M M Y Y Y Y

Month/year.

**Part 2 – Medical details – continued**

**Applicant**

**Spouse or civil partner, or an adult who is financially dependent (if applicable)**

**Condition 2**

**Condition 2**



Month/year.

1. Date of diagnosis?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

2. When did you last attend your GP/ consultant in relation to this condition?

M M Y Y Y Y

M M Y Y Y Y

3. How often do you attend check ups?



4. Is treatment still required?

Yes  No

Yes  No

If **yes**, how many prescribed medications are currently required for this condition?



Date and details.

5. Please provide details of any special investigations for this condition (e.g. surgery, renal dialysis, endoscope, CT scan, MRI, etc). Please include dates.



6. Have you been admitted to hospital for this condition?

Yes  No

Yes  No

If **yes**, when were you last admitted?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

7. Do you still suffer from symptoms?

Yes  No

Yes  No

If **yes**, date of last symptoms

M M Y Y Y Y

M M Y Y Y Y

Month/year.

**Part 2 – Medical details – continued**

**Applicant**

**Spouse or civil partner, or an adult who is financially dependent (if applicable)**

**Condition 3**

**Condition 3**



Month/year.

1. Date of diagnosis?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

2. When did you last attend your GP/consultant in relation to this condition?

M M Y Y Y Y

M M Y Y Y Y

3. How often do you attend check ups?



4. Is treatment still required?

Yes  No

Yes  No

If **yes**, how many prescribed medications are currently required for this condition?



Date and details.

5. Please provide details of any special investigations for this condition (e.g. surgery, renal dialysis, endoscope, CT scan, MRI, etc). Please include dates.



6. Have you been admitted to hospital for this condition?

Yes  No

Yes  No

If **yes**, when were you last admitted?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

7. Do you still suffer from symptoms?

Yes  No

Yes  No

If **yes**, date of last symptoms

M M Y Y Y Y

M M Y Y Y Y

Month/year.

**Part 2 – Medical details – continued**

**Applicant**

**Spouse or civil partner, or an adult who is financially dependent (if applicable)**

**Condition 4**

**Condition 4**



Month/year.

1. Date of diagnosis?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

2. When did you last attend your GP/consultant in relation to this condition?

M M Y Y Y Y

M M Y Y Y Y

3. How often do you attend check ups?



4. Is treatment still required?

Yes  No

Yes  No

If **yes**, how many prescribed medications are currently required for this condition?



Date and details.

5. Please provide details of any special investigations for this condition (e.g. surgery, renal dialysis, endoscope, CT scan, MRI, etc). Please include dates.



6. Have you been admitted to hospital for this condition?

Yes  No

Yes  No

If **yes**, when were you last admitted?

M M Y Y Y Y

M M Y Y Y Y

Month/year.

7. Do you still suffer from symptoms?

Yes  No

Yes  No

If **yes**, date of last symptoms

M M Y Y Y Y

M M Y Y Y Y

Month/year.

## Part 3 – Supplementary questionnaire – Heart attack, Angina or any other heart conditions

Please photocopy this supplementary questionnaire **if** one is required for both the annuitant and the dependant.

Annuitant	<input type="checkbox"/>	Dependant	<input type="checkbox"/>
Name	<input type="text"/>		

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Heart valve disorders Please give more details, including exact diagnosis
<input type="checkbox"/> Angina	<input type="text"/>
<input type="checkbox"/> Heart failure	<input type="checkbox"/> Irregular heart beat/ arrhythmia Please give more details, including exact diagnosis
<input type="checkbox"/> Aortic aneurysm	<input type="text"/>
<input type="checkbox"/> Enlarged heart	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Cardiomyopathy	<input type="text"/>
<input type="checkbox"/> Atrial Fibrillation (AF)	
<input type="checkbox"/> Recurrent chest pain	

Please provide date of diagnosis for each symptom, that you ticked from the previous question.

Condition 1	Condition 2	Condition 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Date of diagnosis</b>	<b>Date of diagnosis</b>	<b>Date of diagnosis</b>
M M Y Y Y Y <input type="text"/>	M M Y Y Y Y <input type="text"/>	M M Y Y Y Y <input type="text"/>

Please photocopy this page **if** you've been diagnosed with more than three of the listed conditions.

Month/year.

If you ticked the box for "Angina", do you continue to suffer from this? Yes  No

If **yes**, please give full details:

**If surgery has been carried out, (please state type of procedure)**

Coronary artery bypass graft (CABG): <input type="checkbox"/>	How many arteries: <input type="text"/>	Date(s): <input type="text"/>
Angioplasty/stents: <input type="checkbox"/>	Number of arteries treated: <input type="text"/>	Date(s): <input type="text"/>

Other surgery, please give details and date of procedure:

**Part 3 – Supplementary questionnaire – Heart attack, Angina or any other heart conditions – continued**

How often have you been admitted to hospital due to this condition within the last 10 years?

**Condition 1**

Never <input type="checkbox"/>	Once <input type="checkbox"/>	Twice <input type="checkbox"/>	Three times <input type="checkbox"/>	More than three times <input type="checkbox"/>	Date of last admission <input type="text"/>
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**Condition 2**

Never <input type="checkbox"/>	Once <input type="checkbox"/>	Twice <input type="checkbox"/>	Three times <input type="checkbox"/>	More than three times <input type="checkbox"/>	Date of last admission <input type="text"/>
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**Condition 3**

Never <input type="checkbox"/>	Once <input type="checkbox"/>	Twice <input type="checkbox"/>	Three times <input type="checkbox"/>	More than three times <input type="checkbox"/>	Date of last admission <input type="text"/>
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1. Did you under go any stress (exercise) ECG testing (bicycle or treadmill)? Yes  No

If **yes**, when?

M M Y Y Y Y

2. Did you consult a heart specialist (cardiologist) due to your condition? Yes  No

If **yes**, when did you last consult a specialist?

M M Y Y Y Y

**Does your heart condition affect you in any of the following ways?**

	Never	Occasionally	Always
Breathlessness walking from room to room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent chest pains requiring tablets or spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of dizziness or blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is treatment still required? Yes  No

If yes, what medication are you currently taking? Please list all medication prescribed for your heart condition:

Medication	Dose prescribed
1	
2	
3	
4	
5	

## Part 4 – Supplementary questionnaire – Diabetes

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

Annuitant	<input type="checkbox"/>	Dependant	<input type="checkbox"/>
Name	<input type="text"/>		

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

When was your diabetes diagnosed? Date

D	D	M	M	Y	Y	Y	Y

How is your diabetes controlled?

<input type="checkbox"/> Diet	<input type="checkbox"/> Non-Insulin (tablet)	<input type="checkbox"/> Insulin
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Please list all the medication you currently take, and how often you take each of them	If this has changed, please advise your previous treatment regime	Date altered

**Do you suffer from any of the following diabetic complications?**

- |                                                                  |                                                           |
|------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Problem with your eyes                  | <input type="checkbox"/> Renal Disease (protein in urine) |
| <input type="checkbox"/> Diabetic Neuropathy (loss of sensation) | <input type="checkbox"/> Elevated blood pressure          |

If **yes**, please give details:

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**How often do you monitor your blood glucose level yourself?**

- |                                                     |                                                    |
|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Do not monitor             | <input type="checkbox"/> Once a day                |
| <input type="checkbox"/> Once a week or longer      | <input type="checkbox"/> Two – three times per day |
| <input type="checkbox"/> Two – three times per week | <input type="checkbox"/> More than 3 times per day |

**Part 4 – Supplementary questionnaire – Diabetes**

Blood glucose result:	<input type="text"/> fasting/non-fasting <i>Please delete as appropriate</i>	Date: <input type="text"/>
HbA1c:	<input type="text"/>	Date: <input type="text"/>
Cholesterol level:	<input type="text"/>	Date: <input type="text"/>
Blood pressure (BP) reading:	<input type="text"/>	Date: <input type="text"/>

Have you ever been admitted into hospital as a result of your diabetes?

Yes  No

If **yes**, when?

**According to your treating doctor, how was the level of control of your diabetes over the last year?**

My doctor told me that my overall diabetes control during the last year was:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Satisfactory	<input type="checkbox"/> Poor
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Please give details:

Please provide any further information you think may be important.

**Part 5 – Supplementary questionnaire – Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour**

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

**If you have a history of more than one different type of cancer please complete a separate questionnaire for each.**

Annuitant       Dependant   
 Name

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

What is the name or type of the tumour/malignant condition?

Where is the tumour located?

When was the tumour/condition first diagnosed?		<input type="text"/>	
Was the tumour:	<input type="checkbox"/> Benign	<input type="checkbox"/> Pre-cancerous	<input type="checkbox"/> Malignant
Has there been any spread of the tumour?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not known
If <b>yes</b> , please describe where (e.g. lymph nodes, liver, lung, etc):			
<input type="text"/>			

Has there been any recurrence?

Yes  No

If **yes**, please give details, including date of recurrence:

Did you have, or are you due to have, any of the following:

<input type="checkbox"/> Surgery	Type of surgery: <input type="text"/>	Date: <input type="text"/>
<input type="checkbox"/> Chemotherapy	Date commenced: <input type="text"/>	Date ended: <input type="text"/>
<input type="checkbox"/> Radiotherapy	Date commenced: <input type="text"/>	Date ended: <input type="text"/>
<input type="checkbox"/> Bone Marrow Transplant	Date commenced: <input type="text"/>	Date ended: <input type="text"/>
<input type="checkbox"/> Medication	Type: <input type="text"/>	Date ended: <input type="text"/>
<input type="checkbox"/> Other	<input type="text"/>	

Please give full details.

**Part 5 – Supplementary questionnaire – Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour – continued**

Do you know the staging and/or grading of the tumour?

Yes  No

If **yes**, please give details:

If you do not know the exact staging and/or grading of the tumour please tick the box that most closely described the nature of the tumour:

<input type="checkbox"/> Only tiny tumour growth (carcinoma in-situ)	<input type="checkbox"/> Only local tumour growth																
<input type="checkbox"/> Tumour invaded adjacent lymph nodes	<input type="checkbox"/> Tumour invaded distant lymph nodes																
<input type="checkbox"/> Tumour spread to distant organs (distant metastases). If so, where: <input style="width: 150px;" type="text"/>																	
In the case of prostate cancer, please advise where known:																	
Prostate Specific Antigen (PSA) level: <input style="width: 150px;" type="text"/>	Date recorded <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="text-align: center; font-size: small;">D</td><td style="text-align: center; font-size: small;">D</td><td style="text-align: center; font-size: small;">M</td><td style="text-align: center; font-size: small;">M</td><td style="text-align: center; font-size: small;">Y</td><td style="text-align: center; font-size: small;">Y</td><td style="text-align: center; font-size: small;">Y</td><td style="text-align: center; font-size: small;">Y</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>	D	D	M	M	Y	Y	Y	Y								
D	D	M	M	Y	Y	Y	Y										
Gleason Score <input style="width: 150px;" type="text"/>	Date recorded <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="text-align: center; font-size: small;">D</td><td style="text-align: center; font-size: small;">D</td><td style="text-align: center; font-size: small;">M</td><td style="text-align: center; font-size: small;">M</td><td style="text-align: center; font-size: small;">Y</td><td style="text-align: center; font-size: small;">Y</td><td style="text-align: center; font-size: small;">Y</td><td style="text-align: center; font-size: small;">Y</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>	D	D	M	M	Y	Y	Y	Y								
D	D	M	M	Y	Y	Y	Y										
When was your last tumour follow-up appointment with your treating doctor/hospital consultant: <input style="width: 150px;" type="text"/>																	

Please provide any further information you think may be important.

**Part 6 – Supplementary questionnaire – Stroke**

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

Annuitant       Dependant   
 Name

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

Please advise which of the following you have suffered from:

- CVA (Cerebrovascular Accident – major stroke)
- TIA (Transient Ischaemic Attack – mini-stroke)
- Subarachnoid Haemorrhage (SAH)

Episode/Type e.g. stroke/TIA	Date	Part of body affected	Duration of symptoms	Duration until full recovery

Please advise of any of the following ongoing problems:

- Speech impairment
- Vision impairment
- Paralysis – arm
- Paralysis – leg
- Short-term memory loss

Are you under follow-up or have you now been discharged?

Name of consultant

Name of hospital

Please provide any further information you think may be important.

**Please also complete the Activities of Daily Living questionnaire on page 20.**

## Part 7 – Supplementary questionnaire – Multiple Sclerosis

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

Annuitant                       Dependant

Name

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

Month/year.

1. When was this condition diagnosed ?

M M Y Y Y Y

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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2. Please give a description of the symptoms in the box provided below, including:

- What part(s) of the body is/are affected?
- Frequency and severity of symptoms, to date.
- The date of the last episode, if not ongoing.

3. Over the past 2 years, would you describe your condition as

- |                                               |                                                   |
|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Stable               | <input type="checkbox"/> Deteriorating moderately |
| <input type="checkbox"/> Deteriorating mildly | <input type="checkbox"/> Deteriorating rapidly    |

4. Do you have any of the following?

- |                     |                              |                             |
|---------------------|------------------------------|-----------------------------|
| Visual impairment   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Speech impairment   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Paralysis of a limb | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

5. Please list the medication you currently take for this condition.

6. Have you been admitted to hospital for this condition?

Yes  No

Month/year.

If **yes**, what was the date of your last admission?

M M Y Y Y Y

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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7. Please provide any additional information which you feel may be beneficial in assessing your application including any correspondence from your consultant/hospital.

**Please also complete the Activities of Daily Living questionnaire on page 20.**

## Part 8 – Supplementary questionnaire – Respiratory/Lung disease

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

Annuitant	<input type="checkbox"/>	Dependant	<input type="checkbox"/>
Name	<input style="width: 100%;" type="text"/>		

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

Have you ever been diagnosed with any of the following?

Chronic obstructive airways/ pulmonary disease (COAD/COPD)	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Pleural plaques	<input type="checkbox"/>
Bronchiectasis	<input type="checkbox"/>	Sleep apnoea	<input type="checkbox"/>
Pneumoconiosis	<input type="checkbox"/>	Other Please specify:	
Asbestosis	<input type="checkbox"/>	<input style="width: 100%;" type="text"/>	

When was your condition diagnosed?

M	M	Y	Y	Y	Y

Is your lung function?:

Minimally impaired (FEV1 >70%)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Moderately impaired (FEV1 50-70%)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Severely impaired (FEV1 <50%)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Do any of the following also apply:

	Never	Occasionally	Always
Chest infections			
Need for home oxygen			
Need for a continuous positive airway pressure (CPAP) breathing machine			
Signs of cor pulmonale (right heart failure due to lung disease)			
Breathlessness walking from room to room			
Breathlessness climbing stairs			
Breathlessness when lying flat			
Oral steroids			
Swollen legs			

Please tick the following

Have you been admitted to hospital?      Never       Once       More than once

Last admission

D	D	M	M	Y	Y	Y	Y

**Part 8 – Supplementary questionnaire – Respiratory/Lung disease – continued**

What medication are you currently taking?

<b>Medication</b>	<b>Dose/frequency</b>	<b>Date commenced</b>	<b>Date ended</b>

Please provide any further information you think may be important.

**Part 9 – Supplementary questionnaire – Other Neurological condition**

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

Annuitant       Dependant   
 Name

Only complete if you have indicated that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

Have you ever been diagnosed with any of the following?

Senile dementia       Parkinson's disease   
 Vascular dementia       Motor neurone disease   
 Alzheimer's disease       Other Please specify:

When was your condition diagnosed?  
 D D M M Y Y Y Y

Have you been admitted to hospital?      Never       Once       More than once

Last admission  
 D D M M Y Y Y Y

Have you had any of the following symptoms?

Pressure sores      Yes       No   
 Falls      Yes       No   
 Tremors      Yes       No   
 Seizures      Yes       No

What medication are you currently taking?

Medication	Dose/frequency	Date commenced	Date ended

Please advise last MMSE score if known  /30

Please provide any further information you think may be important.

**Please also complete the Activities of Daily Living questionnaire on page 20.**

## Part 10 – Supplementary questionnaire – Activities of Daily Living (ADL)

Please photocopy this supplementary questionnaire if one is required for both the annuitant and the dependant.

Annuitant	<input type="checkbox"/>	Dependant	<input type="checkbox"/>
Name	<input type="text"/>		

Only complete if you have been asked to do so in a previous section of this form. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway – it may be helpful to us.

Please advise relevant diagnosis:

Please tick one box from each of the following that most closely reflects your current condition

### Dressing

- Dependent, requires full assistance
- Needs help, but can do about half unaided
- Independent (including buttons, zips, laces etc.)

### Bowels

- Incontinent (or requires enema)
- Occasional accident (once a week)
- Continent

### Mobility

- Bedridden
- In need of daily nursing care
- Wheelchair – permanent
- Wheelchair – non-permanent
- Walks with assistance (frame/stick etc.)
- Independent (needs no assistance)

### Bathing

- Dependent
- Needs some assistance
- Independent

### Feeding

- Unable (nasogastric tube/PEG tube in place)
- Needs some help cutting, spreading butter etc.
- Independent

### Transferring

- Unable, no sitting balance
- Major help
- Minor help, can sit unaided
- Independent

### Bladder

- Incontinent/catheterised/ unable to manage alone
- Occasional accident (once a week)
- Continent

### Please advise any progression in the last 5 years:

- Stable (no/minimal change)
- Deteriorating (impact to 2 or more ADLs above/acute episodes)
- Rapid deterioration

We may need to get access to medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows.

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

### Your current health

- Any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.

### Your past health

- Details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
  - musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
  - suicidal thoughts or attempts at suicide; or conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We ask your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health; or
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

The information you and your doctor provide about your health may result in us:

- increasing your annuity above our standard rates; or
- keeping your annuity at our standard rates

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to:

Chief Medical Officer  
Prudential  
Stirling  
FK9 4UE

## Part 11 – Access to medical reports – continued

### Important notes

- ▶ The annuity will not start until we have assessed and accepted your application, and all the money has been paid. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.
- ▶ It is our policy to obtain a random sample of medical reports shortly after acceptance of an enhanced annuity to monitor the accuracy and completeness of information given. By signing the declaration you will be giving us the right to request a medical report. Your rights under the Access to Medical Reports Act remain the same. In the event that the medical report highlights a material fact that you have knowingly disclosed incorrectly, we reserve the right to reconsider the terms offered to you which may result in your income reducing and significant tax consequences.
- ▶ We are not able to offer an enhanced annuity rate to your spouse or civil partner, or an adult who is financially dependent for any Guaranteed Annuity Rates within your pension fund.
- ▶ We do not offer an enhanced annuity rate on a purchased life annuity.
- ▶ We may ask you to contact your doctor if we are waiting for reports which we have asked for.
- ▶ We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.
- ▶ A copy of your completed application is available on request.

## Data protection notice

### How we use your personal data

The Prudential Assurance Company Limited, its group companies \* and its business partners will use your information together with other information for administration, credit decisions, customer services, marketing and profiling your purchasing preferences. We will pass your information to them (including our service providers and agents) for these purposes. If you are a joint applicant, we will also pass your information to the other joint applicant(s).

For certain products, we may search the files of credit reference agencies that will record any credit searches on your file. This is to help us make credit decisions about you, to prevent fraud, to check your identity and to prevent money laundering. We may disclose details of how you conduct your account to such agencies. The information will be used by other credit grantors for making credit decisions about you and the people with whom you are financially associated, for fraud prevention, money-laundering prevention and occasionally for tracing debtors. This information may be used to recheck these purposes. We will pass your information to any legal or regulatory body if required to do so.

For certain products, we will need to process sensitive personal data such as health data. It may also be necessary, for the above purposes, to transfer your information to countries that provide a different level of data protection from the UK. In such circumstances, we will put a contract in place to ensure your information is protected. By completing and submitting this form, you consent to us processing your sensitive data and to the processing mentioned above.

You have a right to obtain a copy of your personal information (for which we may charge a fee) and to have any inaccuracies corrected by writing to: The Information Risk & Privacy Team, The Prudential Assurance Company Ltd, 3 Sheldon Square, London, W2 6PR. To make sure we follow your instructions correctly and to improve our service to you through training of our staff, we may monitor or record communications.

### Acting on someone's behalf?

When giving us information about another person, you confirm that they have appointed you to act on their behalf. This includes providing consent to:

- ▶ the processing of their personal and sensitive data
- ▶ receive any data protection notices on their behalf
- ▶ receive marketing information as indicated.

### Marketing choice

We would like to keep you updated with information on our products and services. To do this we would like to contact you by telephone, email or text. If you would not like to be contacted, please tick this box.

\* Prudential Assurance Company Limited is part of the Prudential group of companies which at the time of printing includes Prudential UK & Europe, the M&G Investments Group, Prudential Corporation Asia, Jackson National Life, and PPM America Inc (indirect wholly owned subsidiary).

## Declaration

- › I/We agree to you asking any doctor I/we have consulted about my/our physical or mental health to provide medical information so you may assess my/our proposal.
- › This information can also be used to maintain management information for business analysis.
- › I/We agree that a copy of this consent shall have the validity of the original.
- › I/We have read the declaration, important notes and information relating to my/our rights under the Access to Medical Reports Act.
- › I/We understand that Prudential reserves the right to offer revised policy terms should they issue the policy and subsequently find that I/we have failed to disclose or misdisclosed material facts.

### Applicant

Signed

Full name (in block capitals)

Date 

D	D	M	M	Y	Y	Y	Y

Please indicate if you want to see the medical report before it is sent to the Prudential.

I do not want to see the report before it is sent to Prudential.

I do want to see the report before it is sent to Prudential.

It would be helpful if a contact telephone number could be provided for the **main applicant, partner** (if applicable) and **financial adviser** (if applicable), in case we have any queries regarding the form.

### Main applicant

Telephone number (Daytime)

Mobile telephone number

Telephone number (Evening)

E-mail address

### Partner (if applicable)

Telephone number (Daytime)

Mobile telephone number

Telephone number (Evening)

E-mail address

Is a **financial adviser** helping you with this application?

Yes  No

If **yes**, please provide contact details below.

### Financial adviser (if applicable)

Name

E-mail address

Telephone number

Please only provide contact details here if a financial adviser is helping you with this application



[www.pru.co.uk](http://www.pru.co.uk)

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ANF6382 10/2011