



Health questionnaire

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

About this form

Please use BLOCK CAPITALS and tick or complete answers as appropriate. Please help us by filling in the application form honestly and in full. If you miss any information out, or give us misleading information, it may mean that we do not pay your claim. In addition, this could also delay the processing of your application. If you are uncertain about whether any particular fact would influence our decision, you should include it. If you do not, it may mean that a claim in the future will not be paid. Please disclose all relevant information as we may not contact or obtain a report from your doctor.

If someone else fills this form in for you (for example, your financial adviser), please check that all the details are correct before you sign the declaration. You are responsible for the written answers. If you make a mistake please cross it out, put in the correct word or words and initial next to the correction.

If you would prefer, you may complete the medical questions in private and return the Health Details section direct to our Chief Medical Officer. Please indicate on this form if you have done so.

It is very important that you tell us if there is a change to any of the following:

- › your personal health
- › your family history
- › your occupation
- › your participation in any hazardous leisure activities
- › your travel or residence
- › your lifestyle (smoking/alcohol consumption/etc)

between completion of this form and your plan starting. If you do not, your plan may be cancelled and your claim will not be paid.

Genetic testing

If this application, taken together with any other insurance policies you already have, is for life insurance up to a sum of £500,000 you need not disclose any genetic test you may have had. You need not disclose the result of any genetic test undertaken in the context of research. Genetic test results need only be disclosed where the sum for life insurance exceeds £500,000 and its use by insurers has been independently approved. You may, of course, disclose any genetic test result which is in your favour. If you either have a family history of, are receiving treatment or experiencing symptoms of a genetic condition, you must tell us.

Further information is available on request which fully explains this policy and details those genetic tests approved for use by insurers.

Part A – Your details

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

1. Scheme name

Title Mr Mrs Miss Ms Other

Full forename(s)

Surname

Address

Postcode

Date of birth

D	D	M	M	Y	Y	Y	Y
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Daytime telephone number

Marital status

2. Occupation

Business or industry

Does your occupation involve:

- | | | |
|--|------------------------------|-----------------------------|
| (i) any form of manual or physical activity – includes, but not limited to, lifting/carrying or standing for long periods? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ii) working with any form of machinery or tools? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iii) any work at heights over 40 feet? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iv) driving more than 18,000 miles per annum? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If Yes, please provide specific information below :

Manual/physical tasks

Task	% of day
	%
	%
	%
	%

Machinery/tools

% of day

Machine/tool:	%
Machine/tool:	%
Machine/tool:	%
Machine/tool:	%

Working at heights

Max height	ft/m
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Driving

Avg miles per year

Part A – Your details – continued

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

3. Have you in the last five years, or do you intend to:

- (i) Participate in any sport or pastime which involves any additional risk of accident such as motor sports, mountaineering or underwater activities? Yes No
- (ii) Travel or reside abroad (apart from holiday visits)? Yes No
- (iii) Fly except as a fare-paying passenger on an established public service or take part in aviation-related sports? Yes No

If Yes, please provide full details

4. Have you ever been declined (refused cover), deferred, or offered non-standard terms for life cover, critical illness or any disability benefit?

Yes No

If Yes, please provide full details

5. Have you smoked or used any tobacco products in the past 12 months? Includes cigarettes, cigars, pipe, loose tobacco and any nicotine replacement therapy.

Yes No

If Yes, please provide details of daily amounts:

Cigarettes	<input type="text"/>
Cigars	<input type="text"/>
Pipe	<input type="text"/>
Tobacco	<input type="text"/>
Nicotine replacement products	<input type="text"/>

6. Name of doctor

Doctor's telephone number

Doctor's address

Postcode

How long has he/she been your doctor? years

You should not assume that we will obtain a report from your doctor.

Part B – Health details

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

1. If we require a medical examination to complete our underwriting, please indicate if you want to attend one of our selected examiners or your own GP. Selected examiner Own GP

2. What is your height and weight? Height Weight

In questions 3 – 9, for Yes answers please give full details including dates, treatment and periods off work

3. What is your average consumption of alcohol units per week?
- (i) 1 unit = 1 single pub measure spirits/small (125ml) glass of wine or 1/2 pint standard strength beer, lager or cider
- (ii) Have you ever been advised to reduce or cut down your alcohol intake or has your alcohol intake ever been significantly higher? Yes No
- (iii) Have you ever used recreational drugs including (but not limited to) cannabis, ecstasy, cocaine, heroin or similar substances? Yes No

If Yes, please provide full details

4. (i) Have you **ever tested positive** for HIV, Hepatitis B or C, or are you awaiting the results of such a test? Note: If the result is negative, the fact of having an HIV test will not, in itself, have any effect on your acceptance terms for insurance. Yes No
- (ii) Within the **last five years** have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU) Yes No
- (iii) Within the **last five years** have you tested positive or been treated for any disease, which was transmitted sexually? Yes No

If Yes, please give full details, including nature and date of test, reason for exposure, country involved (if applicable) and/or nature of sexually transmitted disease.

This information may be sent in confidence direct to our Chief Medical Officer, Prudential, Stirling FK9 4UE.

Part B – Health details – continued

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

5. Do you **currently have** or have you **ever had** any of the following:

- | | | |
|--|------------------------------|-----------------------------|
| (i) cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ii) heart disease or disorder – including heart attack, angina, heart murmur, cardiomyopathy, heart valve defect or heart surgery? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iii) stroke or transient ischaemic attacks (mini-stroke); brain haemorrhage or permanent brain injury through accident? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iv) multiple sclerosis, epilepsy, paralysis, muscular dystrophy, Parkinson's disease (or other movement disorders), motor neurone disease, or cerebral palsy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (v) disease or disorder of the arteries – including disease in the legs, deep vein thrombosis or the aorta? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vi) diabetes or sugar in the urine? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vii) mental illness that has required hospital treatment or referral to a psychiatrist or other specialist? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered Yes to any of question 5, please give details below.

Disease/disorders:

Date of disease/disorders:

Treatment:

Results of investigations:

Time off work and when:

Please continue on a separate sheet if necessary.

Part B – Health details – continued

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

6. In the last five years have you had any of the following:–

- | | | | |
|--------|---|------------------------------|-----------------------------|
| (i) | a lump or growth of any kind; or any mole or freckle that has bled, become painful, changed colour or increased in size? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ii) | chest pain, irregular heart beat, raised blood pressure or raised cholesterol? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iii) | optic neuritis, numbness, tingling, facial pain, visual disturbance including blurred or double vision, dizziness, chronic fatigue or tiredness? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iv) | seizure, fits, fainting or blackouts? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (v) | any disorder of the digestive system, liver, stomach, pancreas or bowel – including gastric or duodenal ulcer, hepatitis, colitis or Crohn's disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vi) | any disorder of the kidneys, bladder or prostate – including blood or protein in the urine; or urinary tract infections? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vii) | blood disorder or anaemia? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (viii) | any disorder of the adrenal, pituitary or thyroid glands? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ix) | asthma, bronchitis or any other disorder of the lungs or respiratory system? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (x) | any pain or other disease, disorder or problem relating to your back, neck, joints, bones or muscles including arthritis, slipped disc, rheumatism or gout? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xi) | any form of mental illness including anxiety, depression, stress, nervous breakdown or eating disorders? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xii) | disorder of the eyes including blindness or problems with sight – you can ignore sight problems fully corrected by glasses or contact lenses? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xiii) | disorder of the ears including difficulty hearing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xiv) | any gynaecological disorder (including cervical smears) or breast condition for which you have been referred to a specialist or required investigations or treatment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xv) | undergone or been advised to have any investigation, x-ray, scan or blood test for any condition not already mentioned? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xvi) | received any form of medical attention at a hospital, as an inpatient or outpatient, for any condition not already mentioned? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xvii) | a surgical operation for any condition not already mentioned? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If you have answered Yes to any of question 6, please give details below.

Disease/disorders:

Date of disease/disorders:

Part B – Health details – continued

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

If you have answered Yes to any of question 6, please give details below – continued

Treatment:

Results of investigations:

Time off work and when:

Please continue on a separate sheet if necessary.

7. i) Are you aware of any other medical condition or symptoms where you intend to seek medical advice or are you waiting for the results of any medical investigation? Yes No

If Yes, please provide full details

- ii) Are you currently taking prescribed drugs, medicines, tablets or any other form of treatment for any condition not already mentioned? Yes No

If Yes, please provide full details

8. In the last five years have you been **off work for 2 weeks or more** for any medical condition, illness or injury? Yes No

If Yes, please provide full details

Part B – Health details – continued

Failure to disclose relevant information may result in non payment of a claim

Please do not assume that we will contact or obtain a report from your doctor.

9. Before the age of 65, did either of your parents or any brothers or sisters, suffer or die from:

- (i) cancer? Yes No
- (ii) heart disease, stroke or diabetes? Yes No
- (iii) multiple sclerosis or Alzheimers disease? Yes No
- (iv) muscular dystrophy, Parkinson's disease, motor neurone disease or haemochromatosis? Yes No
- (v) Huntington's disease, polycystic kidney disease, polyposis of the colon? Yes No
- (vi) Any other potentially hereditary disease or disorder? Yes No

If Yes, please complete this table.

Relationship			
Illness (if cancer, which part of the body was affected?)			
Age at onset			
Current age			
Age at death (if applicable)			

It is very important that you tell us if there is a change to your answers to any of the questions on this application form between completion of this form and your plan starting. Your plan will not start until we have assessed and accepted your application and the first premium has been paid.

Declaration

- › I understand that this Application is subject to written acceptance by Prudential.
- › I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my proposal. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for. I authorise those asked to provide medical information when they see a copy of this consent form. This form allows you to gather medical reports within six months of the start of the plan, or after my death, to support any claim made on the plan proceeds.
- › I declare that nothing material has been withheld and that the information given on this form is true. I understand that failure to disclose a material fact, that is a fact that may influence the assessment and acceptance of this Declaration, may result in the contract being declared void and that a claim for the proceeds may not be paid. Any doubt as to whether a fact is material must be disclosed.
- › To the best of my knowledge and belief all the statements made, which includes anything I may have said, have been recorded accurately in this Application and are true and complete. This disclosure will form the basis of the contract and benefits may be lost if material facts are not disclosed.
- › I will inform you immediately of any changes that occur before the plan starts.
- › I agree to Prudential accepting medical reports faxed directly to Prudential from my doctor's surgery. I do not* object to copies of the report being faxed to any other company that I have applied to at their request. (*Delete the word "not" if you do not want us to fax information.)
- › This information can also be used to maintain management information for business analysis.

Important notes

The plan will not start until we have assessed and accepted your application, and the first premium has been paid. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.

In most instances your payments will be as originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms.

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

If we ask you to come for a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.

We may need to send your application and relevant medical reports to our reassurers for their opinion or agreement of the terms offered. Or, we may need to send them at a later stage for purposes relating to managing the policy. You can get details of general reinsurance principles and details of any company we use to assess your application, from our head office.

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.

You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

Access to medical reports

We may need to get 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, urinalysis (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 have asked 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:

- refusing to provide insurance;
- increasing premiums above standard rates; or
- setting premiums at 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

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.

This is our standard client agreement upon which we intend to rely. For your own benefit and protection you should read these terms carefully before signing them. If you do not understand any point please ask for further information.

I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.

Signature

X

Date

D	D	M	M	Y	Y	Y	Y
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I do not want to see the report before it is sent to the company.

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

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.

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www.pru.co.uk

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