

BBT ASSET MANAGEMENT

Your Medical Details

(If this questionnaire is not completed an enhanced annuity cannot apply)

The amount of pension paid from a pension annuity policy can be increased for individuals who have certain medical or lifestyle conditions. The following sections should be completed by the Annuitant and Dependant (if a Dependant's pension is to be provided) and should take only a few minutes to complete, to determine whether an enhanced annuity is available. Information marked with an asterisk (*) must be completed.

A) Personal Details:

Details About You

About your dependant

Name:

Address:

Postcode:*

Date of Birth (DD/MM/YY):*

Are you Male or Female: *

Height (ft/ins or cms):*

	cms	Ft	Ins
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	cms	Ft	Ins
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Weight (st/lbs or kgs):*

	Kg	St	Lbs
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	Kg	St	Lbs
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What was your main occupation during your working life?*

Are you currently living in your own home or a residential nursing home?

B) Lifestyle Conditions

1. If you drink alcohol please state approximate intake per week

(1 pint of beer = 2 units 1 glass of wine = 1 unit 1 measure of spirits = 1 unit)

 units

 units

2. Are you currently a smoker and have been for the last 10 years?*

 Yes No

 Yes No

3. Please advise the average number of:*

a) Manufactured cigarettes you smoke per day

b) Cigars OR ounces/grams of pipe tobacco you smoke per day

c) Ounces/grams of cigarette tobacco you smoke per day

4. If you suffer from high blood pressure please advise:

a) BP readings POST medication (systolic/diastolic) if known

b) Number of prescribed medications taken for high blood pressure per day

5. If you suffer from high Cholesterol please advise:

a) Cholesterol level POST medication (mmol/l) if known

b) Number of prescribed medications taken for high cholesterol per day

6. Have you suffered from any of the following?

Details About You

About your dependant

a) Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Heart Bypass or Angioplasty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) Asthma or Chronic Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Impaired Kidney or Ongoing Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) Bladder or Liver complaint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j) Digestive or Bowel complaint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k) Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l) Alzheimer's or Parkinson's disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m) Are you on the waiting list for treatment or awaiting test results?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
n) Any other serious illness or condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

- Date of diagnosis
- Treatment received (with dates)
- Dates of hospitalisation
- Current medication

Please include a separate sheet if required. The more fully you answer the questions, the more accurate the assessment we can make of your eligibility for enhanced rates.

Details About You

About your dependant

C) Medical History

Please give full name of medical conditions and answer all applicable questions 1 – 8.

	Details About You	About your dependant
Condition 1	<input type="text"/>	<input type="text"/>
Condition 2	<input type="text"/>	<input type="text"/>
Condition 3	<input type="text"/>	<input type="text"/>

	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
1. When did you last suffer symptoms or receive treatment for this condition?						
a) 0-6 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 7-24 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 25-60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) More than 60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. How long have you suffered from this condition?						
a) 0-12 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 13-60 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 61-120 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) More than 120 months	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. When were you last hospitalised for this condition?						
a) Never	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 0-12 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 13-60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) More than 60 months ago	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. What treatment have you received in the last 2 years for this condition?						
a) Nothing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) 1 - 2 prescribed medications daily	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) 3 + prescribed medications daily	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Special treatment e.g. Surgery Radiotherapy, Chemotherapy or Renal Dialysis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Concerning your mobility, in respect of this condition are you?						
a) Fully independent	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Able to walk only with assistance, e.g. stick, frame	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Permanently and irreversibly Wheelchair bound	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Permanently and irreversibly in need of daily nursing care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Permanently and irreversibly bedridden	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D) If you have diabetes, please also answer the following questions

6. What type of diabetes do you have?		
a) Controlled by diet only	<input type="text"/>	<input type="text"/>
b) Non insulin dependent diabetes	<input type="text"/>	<input type="text"/>
c) Insulin dependent diabetes	<input type="text"/>	<input type="text"/>
7. Do you have any of the following related conditions due to your diabetes?		
a) Kidney disease	<input type="text"/>	<input type="text"/>
b) Eye disease	<input type="text"/>	<input type="text"/>
c) Heart disease	<input type="text"/>	<input type="text"/>
d) Poor circulation	<input type="text"/>	<input type="text"/>
8. If you have insulin dependent diabetes, how many times do you take insulin per day?		
a) One	<input type="text"/>	<input type="text"/>
b) Two	<input type="text"/>	<input type="text"/>
c) Three	<input type="text"/>	<input type="text"/>
d) Four or more	<input type="text"/>	<input type="text"/>
9. When were you first diagnosed with diabetes? (Please give date)	<input type="text"/>	<input type="text"/>

E) Declaration – PLEASE ENSURE THIS SECTION IS COMPLETED

Your Rights under the Access to Medical Reports Act 1988

Before we obtain a report from your doctor we are required to inform you of your rights under the Access to Medical Reports Act 1988, under which you may wish to exercise your rights as follows:

- a) you have the right to see the report from your doctor before it is sent, or during the six months after that
- b) you have the right to withhold your consent to your doctor sending a report to any or all of the companies, and
- c) you have the right to ask your doctor to change any parts of the report you consider to be inaccurate or misleading (if your doctor is not in agreement with the changes you may add your own comments to the report).

If you tell us you wish to see the report before it is sent, your doctor must show it to you first, unless you fail to make arrangements to see it within 21 days of the day the company, or companies, made the request for the report. You should be aware that your doctor could withhold the report or part of it from you if he thinks you would be harmed by seeing it.

We have been informed of my rights under the Access to Medical Reports Act 1988 and consent to:

- ✓ Just Retirement Limited
- ✓ GE Life Limited
- ✓ Prudential (which is the trading name of Prudential Assurance Company Limited & Prudential Retirement Income Limited)
- ✓ The Pension Annuity Friendly Society Limited

seeking medical information concerning my physical or mental health from any doctor who has attended me at any time. I agree that a copy of this consent shall have the validity of the original.

I/We confirm that to the best of my/our knowledge and belief the above details are true and complete and this questionnaire shall form part of my application for a pension annuity. I confirm that all facts that might be important in assessing the policies under this application have been provided. I understand that if I have failed to give all relevant facts, you may cancel the policies under this application. If I have any doubts as to whether a fact is relevant I will disclose it.

DATA PROTECTION ACT 1998

I understand that any information provided in this application, including medical details, will be held by you and used to set up and administer the policy.

Details About You

Doctor's Name:

Doctor's Address:

Postcode:

Doctor's Telephone Number:

I do not wish to see the doctors report before it is sent (I am aware that I may approach my doctor with a request to see a copy of the report within 6 months of it's completion).

I wish to see the report before it is sent

Print Name:

Signature Annuitant:

Date:

About your dependant

Doctor's Name:

Doctor's Address:

Postcode:

Doctor's Telephone Number:

I do not wish to see the doctors report before it is sent (I am aware that I may approach my doctor with a request to see a copy of the report within 6 months of it's completion).

I wish to see the report before it is sent

Print Name:

Signature Dependant:

Date: