



LIFE & CRITICAL ILLNESS QUESTIONNAIRE

APPLICATION FORM - PART A

It's very important you answer every question truthfully and accurately to ensure all valid claims are paid to protect you and your dependants. If you don't, it could mean a claim may not be paid and your policy may be cancelled.

Please confirm you have read the above statement

Customer Details

	Applicant 1	Applicant 2 (if applicable)
Title	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Forename(s)	<input type="text"/>	<input type="text"/>
Gender	<input type="text"/>	<input type="text"/>
Date of Birth	<input type="text"/>	<input type="text"/>

Employment

	Applicant 1	Applicant 2 (if applicable)
Occupation	<input type="text"/>	<input type="text"/>
How many business miles do you drive on average each year?	<input type="text"/> Miles	<input type="text"/> Miles
Do you work in any of the occupations or environments?		
Outside at heights over 15 metres (50ft) for more than 5 hours during a typical week?	<input type="checkbox"/>	<input type="checkbox"/>
The armed forces or as a member of the army reserve?	<input type="checkbox"/>	<input type="checkbox"/>
Offshore fishing industry	<input type="checkbox"/>	<input type="checkbox"/>
Offshore oil or gas industry	<input type="checkbox"/>	<input type="checkbox"/>
As a full time barman, barmaid or landlord in a public house <small>(Full time means working an average of 30 or more hours per week)</small>	<input type="checkbox"/>	<input type="checkbox"/>
Under water	<input type="checkbox"/>	<input type="checkbox"/>
Underground, e.g., mining or tunnelling	<input type="checkbox"/>	<input type="checkbox"/>
With explosives	<input type="checkbox"/>	<input type="checkbox"/>
None or the above	<input type="checkbox"/>	<input type="checkbox"/>

Travel

Applicant 1

Applicant 2 (if applicable)

During the last 5 years have you spent more the 90 consecutive days in the following?

Africa

The Caribbean

Russia

Thailand

Ukraine

None of the above

During the next 2 years, do you intend to spend more than 30 consecutive days outside the UK?

Yes

No

Yes

No

If yes, will you be staying within the following?

European Union

United States

Canada

Australia

New Zealand

None of the above

Do you plan to leave the UK permanently?

Yes

No

Yes

No

If yes, when do you intend to leave?

If no, how long do you plan to be outside the UK during the next 2 years?

Which counties or Islands outside the European Union, United States, Canada, Australia or New Zealand are you going to?

Hazardous Activities

Applicant 1

Applicant 2 (if applicable)

Do you regularly take part in any of the following activities or do you intend to do so within the next 6 months?

Caving or Potholing

Flying (other than as a fare-paying passenger or cabin crew)

Hang gliding or paragliding

Motor car sport

Motorcycle sport

Mountaineering or Rock climbing	<input type="checkbox"/>	<input type="checkbox"/>
Parachuting, Sky diving or BASE jumping	<input type="checkbox"/>	<input type="checkbox"/>
Powerboat racing	<input type="checkbox"/>	<input type="checkbox"/>
Sailing other than island	<input type="checkbox"/>	<input type="checkbox"/>
Underwater diving	<input type="checkbox"/>	<input type="checkbox"/>
Any Extreme Sport, for example bungee jumping, Cannoning, white water rafting	<input type="checkbox"/>	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	<input type="checkbox"/>

General Health and Lifestyle

	Applicant 1	Applicant 2 (if applicable)
What is your height? <small>(Without shoes)</small>	<input type="text"/>	<input type="text"/>
What is your weight in st & lbs? <small>(In indoor clothes)</small>	<input type="text"/>	<input type="text"/>
What is your Trouser/dress/skirt size? <small>(UK sizes)</small>	<input type="text"/>	<input type="text"/>
If you're pregnant, please give your weight immediately prior to this pregnancy.	<input type="text"/>	<input type="text"/>
How many cigarettes do you smoke on average each day?	<input type="text"/>	<input type="text"/>
During the last 5 years have you used any of the following?		
Recreational drugs other than cannabis, for example, cocaine, ecstasy, heroin	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic steroids not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	<input type="checkbox"/>
How often do you drink alcohol?		
Never	<input type="checkbox"/>	<input type="checkbox"/>
On special occasions only	<input type="checkbox"/>	<input type="checkbox"/>
Monthly or less frequently	<input type="checkbox"/>	<input type="checkbox"/>
Two or three times a month	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been seen by an alcoholic specialist or attended an alcoholic support group or been told that you have liver damage?		
Seen by an alcoholic specialist or attended a support group	<input type="checkbox"/>	<input type="checkbox"/>
Told about liver damage	<input type="checkbox"/>	<input type="checkbox"/>
Neither	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been told by a health professional that you should reduce the amount of alcohol you have because you were drinking too much?

Yes

No

Yes

No

If yes, when was this?

Health – Ever

Have you ever:

Had diabetes or a heart condition, for example angina, heart attack, heart valve problem, heart surgery?

Yes

No

Yes

No

Had a stroke, mini stroke, transient ischaemic attack (TIA), brain haemorrhage or surgery to your blood vessels?

Yes

No

Yes

No

Please ignore varicose veins unless there's ulceration presents.

Had cancer, Hodgkin lymphoma, Non-Hodgkin lymphoma, leukaemia or a melanoma?

Yes

No

Yes

No

Had a cyst, growth or tumour in either your brain or spine?

Yes

No

Yes

No

Had any neurological condition or visual disturbance, for example epilepsy, multiple sclerosis, muscular dystrophy, cerebral palsy, motor neurone disease, Parkinson's disease, optic neuritis?

Yes

No

Yes

No

Please ignore long or short sightedness that's been corrected.

Been admitted overnight to hospital or referred to a psychiatrist for mental illness, anorexia or bulimia?

Yes

No

Yes

No

Tested positive for HIV, or are you waiting for the result of an HIV test?

Yes

No

Yes

No

A negative HIV test result wont by itself, have any effect on your acceptance terms of insurance.

Health – Last 5 Years

Apart from anything you've already told us about in this application, during the last 5 years have you seen a doctor, nurse or other health professional for?

Yes

No

Yes

No

Raised blood pressure, raised cholesterol or condition affecting blood or blood vessels, for example anaemia, excess sugar in the blood, blood clot, deep vein thrombosis?

Yes

No

Yes

No

Any condition affecting your kidneys or bladder, for example blood or protein in the urine, kidney or bladder stones?

Yes

No

Yes

No

Any condition affecting your stomach, oesophagus or bowel, for example Crohn's disease, ulcerative colitis?

Please ignore diarrhoea, food poisoning, sickness or vomiting, stomach bug or upset, provided no hospital investigation was advised or completed.

Yes

No

Yes

No

Any condition affecting your gall bladder, liver or pancreas, for example hepatitis, fatty liver?

Yes

No

Yes

No

Any condition affecting your lungs or breathing, for example asthma, emphysema, sleep apnoea, sarcoidosis?

Please ignore hay fever and one off chest infections from which you've fully recovered.

Yes No Yes No

Lupus, fibromyalgia, gout or any type of arthritis, neck, back, spine or joint trouble, for example rheumatoid arthritis, sciatica?

Yes No Yes No

Anxiety, depression or stress that's required treatment or counselling, or chronic fatigue syndrome?

Yes No Yes No

A growth, lump, polyp or tumour of any kind?

Yes No Yes No

Any condition affecting your thyroid?

Yes No Yes No

Any condition affecting your ears or hearing, for example Meniere's disease, deafness?

Please ignore simple earache and ear infections that have resolved leaving no continuing hearing loss.

Yes No Yes No

Any condition affecting your eyes or vision, not wholly corrected by spectacles, lensor laser treatment, for example cataract, blindness?

Yes No Yes No

A mole or freckle?

Please ignore birthmarks where no treatment or specialist referral has been advised.

Yes No Yes No

Chest pain, palpitations or irregular heartbeat, paralysis, numbness, persistent tingling or pins and needles, tremor or facial pain other than dental pain, memory loss, dizziness or balance problems?

Yes No Yes No

THIS QUESTION IS APPLICABLE FOR FEMALES ONLY:

Any gynaecological condition for which you've not yet been discharged from follow up, or a cervical smear requiring further investigations?

Please ignore routine cervical smears if the result have been normal.

Yes No Yes No

ONLY ANSWER THIS QUESTION IF YOU'RE APPLYING FOR INCOME PROTECTION BENEFIT:

Any other illness or injury or disability that's kept you off work for a continuous period of 2 weeks or more, for example stress, headaches, trapped nerve?

Please ignore colds and flu from which you've fully recovered and pregnancy where no complications were present.

Yes No Yes No

Health – Last 12 Months

Applicant 1

Applicant 2 (if applicable)

Apart from anything you've already told us about in this application, during the last 12 months have you:

Had any medical condition, illness or injury that you've received treatment for over a continuous period of 4 weeks or more?

Please ignore oral contraception pill, pregnancy and minor accidents and injuries, for example pulled or strained muscle, torn ligament, or tendon, sprained joint, provided they've not kept you off work for 2 weeks or more.

Yes No Yes No

Been referred to or had any investigations in hospital, for example biopsy, scan, ECG?

Please ignore investigations related to pregnancy or infertility where the results have been confirmed as normal.

Yes

No

Yes

No

Health – Continued

Applicant 1

Applicant 2 (if applicable)

Apart from anything you've already told us about in this application, do you have any medical condition or symptoms that:

Your doctor or nurse told you to see them about during the next 3 weeks?

Please ignore consultations for repeat prescriptions and pregnancy.

Yes

No

Yes

No

During the last 3 months have you had any of the following?

- Unexplained bleeding, weight loss, lump or growth
- Mole or freckle that's bled or changed in appearance
- A cough that's lasted for 3 weeks or more
- Any other symptom that you may see a health professional about for the first time during the next 4 weeks

Yes

No

Yes

No

Family History

Applicant 1

Applicant 2 (if applicable)

Have any of your natural parents, brothers or sisters, before the age of 60, had any of the following?

Heart attack, Angina, Stroke or Type 2 Diabetes

Yes

No

Yes

No

Cancer

Yes

No

Yes

No

Cardiomyopathy (Primary disorder of the heart muscle)

Yes

No

Yes

No

Multiple Sclerosis

Yes

No

Yes

No

Myotonic Dystrophy

Yes

No

Yes

No

Polyposis coli (Familial adenomatous)

Yes

No

Yes

No

Polycystic Kidney Disease

Yes

No

Yes

No

Motor Neurone Disease

Yes

No

Yes

No

Motor Neurone Disease

Yes

No

Yes

No

Huntington's disease

Yes

No

Yes

No

Parkinson's disease

Yes

No

Yes

No

Alzheimer's disease

Yes

No

Yes

No

Any other condition that runs in your family and that you're receiving regular follow up or screening for

Yes

No

Yes

No

Doctors Details

	Applicant 1	Applicant 2 (if applicable)
Please provide your GP name and Doctors surgery below:		
Doctor's name	<input type="text"/>	<input type="text"/>
Surgery name	<input type="text"/>	<input type="text"/>
Address line 1	<input type="text"/>	<input type="text"/>
Address line 2	<input type="text"/>	<input type="text"/>
Town	<input type="text"/>	<input type="text"/>
County	<input type="text"/>	<input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>
Surgery contact number	<input type="text"/>	<input type="text"/>

Thank you for taking the time to complete this document. Please return at your earliest convenience and we can move on to printing the necessary documentation to ensure you are fully projected in your home.