The Retirement Health Form

Enhanced pension annuity quotation request form

Providers participating in the Retirement Health Form:













You/Your dependant to complete sections 1 & 2
Please ensure you complete and sign the Declaration and Consent
page at the end of Section 2.

Financial Adviser to complete sections 3, 4 & 5



Section 1Personal Details



Section 2Medical Assessment



Section 3 Financial Adviser's Details



Section 4Pension Details



Section 5
Next Steps

For more information visit www.retirementhealthform.co.uk

(this includes details on how to complete this form).

IMPORTANT NOTES

Please describe in as much information about your health as possible before signing this form. All questions asked are relevant, and by providing full and accurate information you will allow an insurer to provide as accurate a quotation as possible. The amount of your annuity income will be based on the medical information supplied. However, an insurer may also seek to obtain independent verification of this information from your doctor. If it is subsequently found that the questions were not answered accurately and with reasonable care, then that could result in your income being reduced or your policy being cancelled.

Participating providers can't guarantee that they will receive any form that you send by email to them (or anyone else), or that it won't be intercepted by someone else. For these reasons, you should always protect the information in this form when sending it by email.

Section 1: **Personal Details**

	Your details	Your dependant's details
Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other	☐Mr ☐Mrs ☐Miss ☐Ms ☐Other
If 'other' please specify		
Gender Forename(s)	Male Female	Male Female
Surname		
Date of birth	$_{\rm D}$ $_{\rm D}$ $/_{\rm M}$ $_{\rm M}$ $/_{\rm Y}$ $_{\rm Y}$ $_{\rm Y}$ $_{\rm Y}$	$\frac{1}{D} \frac{1}{D} \frac{1}{M} \frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y}$
Marital Status	Single Married/Civil Partnership	Single Married/Civil Partnership
Relationship to the dependant	Separated Divorced Widowed	Separated Divorced Widowed
Present occupation		
If no longer working, previous occupation	Full-time Part-time	Full-time Part-time
Date ceased	$_{\overline{M}}$ $_{\overline{M}}$ $'_{\overline{Y}}$ $_{\overline{Y}}$	<u>/</u>
Are you living	In own home – alone In own home – with someone else With relatives In a residential home In a care home	In own home – alone In own home – with someone else With relatives In a residential home In a care home
House name/number		
Address		
Postcode		
Email address		

NOW PLEASE COMPLETE THE MEDICAL ASSESSMENT FORM IN SECTION 2 AND ANY OTHER QUESTIONNAIRE AS DIRECTED.

Section 2: **Medical Assessment**

	Your details	Your dependant's details
1. Height	ft ins or cms	ft ins or cms
2. Weight	st lbs or kgs	st lbs or kgs
3. Waist measurement	ins or cms	ins or cms
4. Do you currently smoke?	☐ Yes ☐ No	☐ Yes ☐ No
 a) If yes, please advise month/year started 	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
b) Have you been a regular daily smoker for the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
c) If you are a regular smoker, please indicate the average daily level	Manufactured cigarettes Cigars	Manufactured cigarettes Cigars
d) If you are a regular smoker, please indicate the average weekly level	Rolling tobacco (Gms) Pipe tobacco (Gms)	Rolling tobacco (Gms) Pipe tobacco (Gms)
If you previously smoked, please advise of the months/years you started and stopped	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
 a) If you were a regular cigarette and/or cigar smoker, please indicate the average daily level 	Manufactured cigarettes Cigars	Manufactured cigarettes Cigars
 b) If you were a regular rolling tobacco/or pipe smoker, please indicate the average weekly level 	Rolling tobacco (Gms) Pipe tobacco (Gms)	Rolling tobacco (Gms) Pipe tobacco (Gms)
6. How many units of alcohol do you drink weekly ?		

中

Guidance Note: A unit of alcohol is equivalent to half a pint of normal strength beer, lager, or cider, one small (125ml) glass of wine, or a single measure of spirit.

Have you been diagnosed with high blood pressure (hypertension)?	Yes No	☐ Yes ☐ No	
a) If yes, specify date of diagnosis	/	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	-
b) If yes, specify last readings(s)			
Guidance Note: Blood testing kits.	pressure readings required are tho	ose taken by your GP/Clinician	rather than home self-
c) Date of reading(s)	/	/	/
d) Your current medication	Dosage Frequency	Dependant's current medication	Dosage Frequency
1		1	
2		2	
3		3	
4		4	
5		5	
 8. Have you been diagnosed with high cholesterol? a) If yes, specify date of diagnosis b) If yes, specify last reading(s) Guidance Note: Choles kits. 	Yes \square No $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$ Intercolling required are those to	Yes No M M / Y Y taken by your GP/Clinician rath	
c) Date of reading(s)	$\frac{1}{M} \frac{1}{M} \frac{1}$	/	
d) Your current medication	Dosage Frequency	Dependant's current medication	Dosage Frequency
1	- Fosage Trequency	1	- 15000 Frequency
2		2	
3	- - !	3	
		4	
4			
5		5	

IMPORTANT NOTES

The amount of your annuity income will be based on the medical information supplied. An insurer may also seek to obtain independent verification of this information from your doctor. If it is subsequently found that the questions were not answered accurately and with reasonable care, then that could result in your income being reduced or your policy being cancelled. All questions asked are relevant, and by providing full and accurate information you will allow an insurer to provide as accurate a quotation as possible.

Medical Conditions If you have ever been diagnosed Heart condition Diabetes Cancer, leukaemia, lymphoma, g Stroke – please also complete th Respiratory/lung disease Multiple sclerosis – please also conditions Neurological disease – please also	rowth, or tumo e Activities of D omplete the Act	uraily Living ques	stionnaire	naire		page 5 page 7 page 8 pages 11 & 16 page 12 pages 14 & 16
Other Medical Conditions For any other conditions, please on page 16). If you or your depo	complete the q					
	Your details			Your depen	dant's details	
Condition 1						
Condition 2						
Condition 3						
	Condition 1	Condition 2	Condition 3	Condition 1	Condition 2	Condition 3
When were you first diagnosed with this condition?	$\frac{1}{M} \frac{M}{M} \frac{M}{Y} \frac{M}{Y} \frac{M}{Y}$	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	$\frac{1}{M} \frac{1}{M} \frac{1}$	$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	$\frac{1}{M} \frac{1}{M} \frac{1}$
b. When did you last experience symptoms for this condition?	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$	$\frac{1}{MM}$	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$
c. When did you last receive medication/treatment for this condition?	$\frac{M}{M} \frac{M}{M} \frac{Y}{Y} \frac{Y}{Y}$	$\frac{MM}{MM} \frac{Y}{Y} \frac{Y}{Y}$	$\frac{M M Y Y}{M M M Y Y}$	$\frac{MM}{MM} \frac{Y}{Y} \frac{Y}{Y}$	$\frac{MM}{MM} \frac{Y}{Y} \frac{Y}{Y}$	$\frac{M M Y Y}{M M \sqrt{Y Y}}$
d. When were you last admitted to hospital for this condition?	$_{\overline{M}}\overline{M}/_{\overline{Y}}\overline{Y}$	$_{\overline{M}}/_{\overline{Y}}$	$_{\overline{M}}$ $_{\overline{M}}$ $_{\overline{Y}}$ $_{\overline{Y}}$	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$	$_{\overline{M}}_{\overline{M}}/_{\overline{Y}}_{\overline{Y}}$	$\frac{1}{M}\frac{1}{M}\frac{1}{Y}\frac{1}{Y}$
e. How many times have you b	een hospitalis	ed for this cor	ndition? Please	put a figure in	the relevant l	box.
f. Have you received any of the	following trea	atments for th	nis condition w	ithin the PAST	5 YEARS? Pleas	se tick box.
None Renal dialysis Surgery Please specify						
Your current medication 1 2 3 4	Dosage	Frequency	Dependant's of 1 2 3 4	current medication	on Dosage	Frequency

Heart attack, angina and other heart conditions questionnaire

You Your dependant	Nam	0.				
Please complete a separate heart condition Please refer to any available hospital letter You may also include copies of any reports	rs or reports abo	ut your hear		-	-	
Have you ever been diagnosed with any of	the following?					
Diagnosis	Date of diagnos	is (MM/YY)	No. of occurre	nces	Condition ong (yes/no)	oing?
Heart attack (Myocardial Infarction)					Not Applicable	<u> </u>
Angina						
Heart failure						
Aortic aneurysm						
Cardiomyopathy						
Heart valve disorders						
Atrial fibrillation (AF)						
Other irregular heart rhythm						
Other: please specify (e.g. blocked artery)						
Symptoms at rest						Alway
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness						
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts	ate type of proce	dure and da	ite of MOST RE	CENT	surgery.	
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please sta			i te of MOST RE teries treated	CENT		
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please sta		Number of a		CENT	Date	
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please state Coronary artery bypass graft (CABG) Coronary angioplasty/stents		Number of a	teries treated	CENT	Date Date	$\frac{1}{M}\frac{1}{M}$
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please state Coronary artery bypass graft (CABG) Coronary angioplasty/stents Aortic valve replacement		Number of an Number of an Successful?	teries treated	CENT	Date Date Date	$\frac{1}{M}\frac{M}{M}\frac{M}{M}$
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please sta Coronary artery bypass graft (CABG) Coronary angioplasty/stents Aortic valve replacement Mitral valve replacement		Number of an Number of an Successful?	teries treated teries treated	CENT	Date Date Date Date	$\frac{1}{M} \frac{1}{M} \frac{1}$
Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please state Coronary artery bypass graft (CABG) Coronary angioplasty/stents Aortic valve replacement Mitral valve replacement Tricuspid valve replacement		Number of an Number of an Successful? Successful? Successful? Successful?	teries treated teries treated Yes No	CENT	Date Date Date Date Date	MM/Y MM/Y MM/Y MM/Y MM/Y MM/Y
Breathlessness walking from room to room Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts If surgery has been carried out, please state Coronary artery bypass graft (CABG) Coronary angioplasty/stents Aortic valve replacement Mitral valve replacement Tricuspid valve replacement Pacemaker Cardioversion/ablation		Number of an Number of an Successful? Esuccessful? Esuccessful? Esuccessful?	teries treated teries treated Yes No Yes No	CENT	Date Date Date Date Date Date	$\frac{1}{M} \frac{1}{M} \frac{1}{Y}$ $\frac{1}{M} \frac{1}{M} \frac{1}{Y}$ $\frac{1}{M} \frac{1}{M} \frac{1}{Y}$

What medication are you CURRENTLY taking? Please list all medication prescribed for your heart condition:

Medication name	condition(s)	Dosage	Frequency	(MM/YY)
1				
2				
3				
4				
5				
Are you currently under the ca	re of a cardiologist? \Box Y	es 🗌 No 🏻 Last co	nsultation date:	-/ _{\overline{\gamma}\overline{\gamma}}}
How many times have you been	n admitted to hospital du	ie to your heart co	ndition WITHIN THE	10 PAST YEARS?
Number of hospital admissions	Date of last admis	sion $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$		
Is any future treatment planned?				
Please advise date and result of	-	G testing e.g. using	a bicycle or treadmi	ill.
Please advise date and result of (Do not include resting ECG tests.) Date	-	G testing e.g. using	a bicycle or treadmi	ill.
Please advise date and result of (Do not include resting ECG tests.)		G testing e.g. using	a bicycle or treadmi	ill.
Please advise date and result of (Do not include resting ECG tests.)	Result rmation you think may be			

Diabetes questionnaire

ls your diabetes?	Π		
	☐ Type 1	☐ Type 2	
How is your diabetes c	ontrolled? Diet only	Non-insulin (tablet/inje	ection) Insulin
Please list all the medi	cation you CURRENTLY take for	your diabetes?	
Medication name	Dosage	Frequency	Date commenced (MM/YY
2			
3			
4			
5			
Neuropathy Kidney disease (prote			
Neuropathy Kidney disease (prote Peripheral vascular d Amputation	ein in urine) isease (with ulceration)		
Neuropathy Kidney disease (prote Peripheral vascular damputation Please give the last two usually higher for lower figures be	ein in urine) isease (with ulceration) o readings for HbA1c: (Please receive: HbA1c readings can be reported figures between 40 mmol/mol and	d as mmol/mol or as a perce 1 140+ mmol/mol; whereas	entage. Mmol/mol readings are
Neuropathy Kidney disease (prote Peripheral vascular d Amputation Please give the last two usually higher f lower figures be tests or random	ein in urine) isease (with ulceration) o readings for HbA1c: (Please receive: HbA1c readings can be reported figures between 40 mmol/mol and etween 3.0% and 16.0%. (Please do	d as mmol/mol or as a perce 1 140+ mmol/mol; whereas o not advise results of glucos	entage. Mmol/mol readings are percentage readings are usually
Neuropathy Kidney disease (protection of the peripheral vascular description of the last two services of the last two se	ein in urine) isease (with ulceration) o readings for HbA1c: (Please receive: HbA1c readings can be reported figures between 40 mmol/mol and etween 3.0% and 16.0%. (Please do blood sugar tests here.) mmol/mol or mmol/mol or	d as mmol/mol or as a perce 1 140+ mmol/mol; whereas o not advise results of glucos % Da	entage. Mmol/mol readings are percentage readings are usually se finger prick tests, fasting blood subte: $\frac{M}{M} = \frac{M}{M} \frac{1}{M} $
Neuropathy Kidney disease (protection of the peripheral vascular description of the last two services of the last two se	ein in urine) isease (with ulceration) o readings for HbA1c: (Please receive: HbA1c readings can be reported figures between 40 mmol/mol and etween 3.0% and 16.0%. (Please do blood sugar tests here.) mmol/mol or mmol/mol or	d as mmol/mol or as a perce 1 140+ mmol/mol; whereas o not advise results of glucos % Da	entage. Mmol/mol readings are percentage readings are usually se finger prick tests, fasting blood subte: $\frac{M}{M} = \frac{M}{M} \frac{1}{M} $
Neuropathy Kidney disease (prote Peripheral vascular d Amputation Please give the last two usually higher f lower figures be tests or random HbA1c Reading 1 HbA1c Reading 2	ein in urine) isease (with ulceration) o readings for HbA1c: (Please receive: HbA1c readings can be reported figures between 40 mmol/mol and etween 3.0% and 16.0%. (Please do blood sugar tests here.) mmol/mol or mmol/mol or	d as mmol/mol or as a percell 140+ mmol/mol; whereas o not advise results of glucos M Da M Da T OF YOUR DIABETES?	entage. Mmol/mol readings are percentage readings are usually se finger prick tests, fasting blood subte: $\frac{M}{M} = \frac{M}{M} \frac{1}{M} $
Neuropathy Kidney disease (prote Peripheral vascular d Amputation Please give the last two usually higher f lower figures be tests or random HbA1c Reading 1 HbA1c Reading 2 Have you ever been ad	ein in urine) isease (with ulceration) o readings for HbA1c: (Please receive: HbA1c readings can be reported figures between 40 mmol/mol and etween 3.0% and 16.0%. (Please do blood sugar tests here.) mmol/mol or mmol/mol or mitted into hospital AS A RESUL	d as mmol/mol or as a percell 140+ mmol/mol; whereas o not advise results of glucos M Da M Da T OF YOUR DIABETES?	entage. Mmol/mol readings are percentage readings are usually se finger prick tests, fasting blood subsets: $ \frac{M}{M} = \frac{M}{M} \frac{1}{Y} = \frac{1}{Y} $ ate: $ \frac{M}{M} = \frac{M}{M} \frac{1}{Y} = \frac{1}{Y} $ Yes No If yes, when? $ \frac{M}{M} = \frac{M}{M} \frac{1}{Y} $

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please refer to and/or include any available hospital letters or reports about your cancer, stage, grade and treatment received to complete this section.

You Your dependant Name:	
Please complete a separate questionnaire if one is required for both you and If you have a history of more than one type of cancer please complete a sepa	
What is the name or type of the tumour/malignant condition and its locati	on?
When was the tumour/malignant condition first diagnosed? $\frac{\sqrt{\sqrt{\gamma}}}{\sqrt{\gamma}}$	
Was the tumour: Benign Pre-cancerous Mali	ignant
If you know the clinically confirmed staging of the tumour, please tick and classification below:	provide details against the relevant
General Classification (used for all cancers e.g. Stage 1B):	
Stage: $\square 0 \square 1 \square 2 \square 3 \square 4$ Su	b-stage (1-4 only)
TNM (commonly used for most cancers e.g. T1aN0M0)	
T Stage ☐ Ta ☐ Tis ☐ TX ☐ T0 ☐ T1 ☐ T2 ☐ T3 ☐ T4 Su	b-stage (T1-T4 only) a b c
N Stage \square NX \square N0 \square N1 \square N2 \square N3 Su	b-stage (N1-N3 only) a b c
M Stage ☐ MX ☐ M0 ☐ M1	
Dukes classification (used for colorectal cancers)	
Stage: A B C D	
Modified Astler-Coller (MAC) (used for colorectal cancers):	
Stage \square A \square B1 \square B2 \square B3 \square C1 \square C2 \square C3 \square D	
Figo classification (used for gynaecological cancers)	
Stage: \square 1 \square 2 \square 3 \square 4	
Clark level (used for skin cancers, specifically malignant melanomas)	
Stage: \square 1 \square 2 \square 3 \square 4 \square 5	
Breslow thickness (used for skin cancers, specifically malignant melanomas)	
Details:mm	
Details.	
Ann Arbor classification (used for lymphomas)	
Stage: \square 1 \square 2 \square 3 \square 4	
Do you know the clinically confirmed grade of the tumour? \square Yes \square N	0
If yes, please tick appropriate option Grade 1 (Low) Grade 2 (Intermediate Section 1)	ediate) Grade 3 (High)

Please tick the box that most closel	ly describes the nature of th	e tumour.	
Carcinoma-in-situ (stage O, Tis, Ta)			
Only local tumour growth			
Tumour invaded adjacent lymph n If ticked, please advise number of noc			
Tumour invaded distant lymph noo			
Tumour spread to distant organs (If so, where?	distant metastases)		
Guidance Note: The removal	l of lymph nodes for biopsy do	es not necessarily mean tl	ne cancer has spread there.
In the case of PROSTATE CANCER, p	lease advise where known		
Current Prostate Specific Antigen (PSA	A) level		Date: $\frac{1}{MM} \frac{1}{M} \frac{1}{M}$
Pre-treatment PSA level			Date: $\frac{M}{M} \frac{M}{M} \frac{Y}{Y} \frac{Y}{Y}$
Gleason Score			Date: $\frac{M}{M} \frac{M}{M} \frac{Y}{Y} \frac{Y}{Y}$
In the case of BREAST CANCER, plea	se advise where known		M M Y Y
Breast Cancer Hormone Receptor State	tus		
Did you have, or are you due to have. Surgery Type of surgery:	re, any of the following as a	result of your tumour o	r malignant condition: Date: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
Chemotherapy	Date comme	nced: MM/YYY	Date ended: $\frac{M M Y Y}{M M M Y Y}$
Radiotherapy (including brachythe	rapy) Date comme	nced: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	Date ended: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
Bone marrow/stem cell transplant	Date comme	nced: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	Date ended: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
Hormone therapy	Date comme	nced: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	Date ended: $\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
Other (Please give full details) (e.g. BCG, HIFU, Immunotherapy)			Date: $\frac{1}{M} \frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$
What medication are you CURRENT	LY taking for this condition?	•	
Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
4			
5			
Has there been any recurrence in the	he same location?	No If yes, please ad	vise date, staging, treatment:

When was your last tumour follow-up appointment with your treating doctor/hospital consultant? $\frac{1}{N}$	$\frac{1}{\sqrt{M}} \frac{1}{\sqrt{N}} \frac{1}{\sqrt{N}}$
Have you now been discharged?	
Please provide any further information you think may be important.	

Stroke questionnaire

	iy reports with your	request form.	to complete this secti	ion.
ease advise which of the follow	wing you have been	diagnosed with and g	ive details of all episo	des below:
CVA (Cerebrovascular Accident	– major stroke)			
SAH (Subarachnoid Haemorrha	ige)			
Cerebral haemorrhage/bleed				
TIA (Transient Ischaemic Attack	– mini stroke)			
pisode/type t.g.CVA, TIA)	Date	Part of body affected	Duration of initial symptoms (i.e. number of hours or days)	Duration until full recovery
Paralysis leg				
Short-term memory loss				
Short-term memory loss				
Short-term memory loss	ENTLY taking for this Dosage	condition?	y Date cor	mmenced (MM/Y
Short-term memory loss			y Date cor	mmenced (MM/Y
Short-term memory loss			y Date cor	mmenced (MM/Y
Short-term memory loss			y Date cor	mmenced (MM/Y
Short-term memory loss			y Date cor	mmenced (MM/Y

Respiratory/lung disease questionnaire

You Your dependant Name:				
Please complete a separate respiratory/lung disease questionnaire if o Please refer to/include any available hospital letters or reports as no	-	d for both you	ս and the dep	endant.
Please advise which of the following respiratory conditions you have	e been diagn	osed with:	Date of di	agnosis:
Chronic obstructive airways/pulmonary disease (COAD/COPD)			$\frac{1}{M}\frac{1}{M}\frac{1}{M}$,
☐ Emphysema			$\frac{1}{M} \frac{M}{M} \frac{1}{Y} \frac{1}{Y}$	
Bronchiectasis			$\frac{M}{M}$ $\frac{M}{Y}$	
\square Pneumoconiosis (a type of lung disease related to occupation)			$\frac{M}{M}$ $\frac{M}{Y}$	
Asbestosis			$\frac{M}{M}$ $\frac{M}{Y}$ $\frac{1}{Y}$	
Asthma			$\frac{M}{M}$ $\frac{M}{Y}$ $\frac{M}{Y}$	
Pleural plaques			$\frac{1}{M}\frac{M}{M}\frac{M}{Y}\frac{M}{Y}$	
Sleep apnoea			$\frac{M}{M}$ $\frac{M}{M}$ $\frac{M}{Y}$ $\frac{M}{Y}$	
Other Please specify			$\frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$	
How has your lung function been graded according to FEV1? (This do	es not refer	to Peak Flow):	
Unaffected	Yes	□No		
Minimally impaired (FEV1 greater than 70%)	Yes	□No		
Moderately impaired (FEV1 50-70%)	Yes	No		
Severely impaired (FEV1 less than 50%)	Yes	□No		
Do any of the following apply due to your respiratory lung condition?	? Never	Some of the time	Most of the time	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 (in tablet form only e.g. Prednisolone)				
If you have been admitted to hospital for your respiratory/lung diseand please indicate date of last admission?	ase, how ma	ny times hav	e you been a	dmitted
Number of hospital admissions Date of last admission $\frac{1}{M} \frac{1}{M} \frac{1}{M}$,			

What medication are you currently taking for your respiratory/lung disease?

Medication name	Dosage	Frequency	Date commenced (MM/YY)
1			
2			
3			
4			
5			

3			
4			
5			
Please provide any further informati	on you think may be impo	rtant	
	on you tillik may be impo	i carre.	

Multiple sclerosis questionnaire

		12				
When was your multi		nosea? N	$\sqrt{\frac{1}{N}}$			
Please advise subtype						
Relapsing remitting						
Secondary progress						
☐ Primary progressive						
Progressive relapsing						
Please advise number	r of attacks in the	last 5 years:				
What medication are	you CURRENTLY t	aking?				
Medication name		Dosage		Frequency		Date commenced (MM/YY
2						
3						
5						
	_	-	ultiple scle	rosis, please ind	icate h	ow many times you have
been admitted and th	missions	at admission? Pate of last adm	nission	/ _{Y Y}		
been admitted and the Number of hospital add	missions D	at admission? Date of last admine following in	nission	$-\frac{1}{\sqrt{\frac{1}}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}{\sqrt{\frac{1}}}}}}}}}}$	scleros	is?
been admitted and the Number of hospital adm Do you have, or have Bladder incontinence/s	missions D you had, any of the self-catheterisation	at admission? Date of last admine following in	nission	$\sqrt{\frac{1}{Y}}$ So your multiple so Yes	scleros	is? No
Number of hospital add Do you have, or have Bladder incontinence/s	missions D you had, any of the self-catheterisation g. pneumonia)	at admission? Date of last admine following in	nission	$\sqrt{\frac{1}{Y} \frac{1}{Y}}$ D your multiple : \sqrt{Y} Yes	scleros	is? No
Number of hospital add Number of hospital add Do you have, or have a Bladder incontinence/s Secondary infection (e.go	missions D you had, any of the self-catheterisation g. pneumonia)	at admission? Date of last admine following in	nission	your multiple s Yes Yes Yes	sclerosi	is? No No
been admitted and the Number of hospital admitted and the Number of hospital admitted progressive mental det Vision impairment	missions D you had, any of the self-catheterisation g. pneumonia)	at admission? Date of last admine following in	nission	your multiple s Yes Yes Yes Yes Yes	sclerosi	is? No No
Number of hospital add Number of hospital add Do you have, or have a Bladder incontinence/s Secondary infection (e.go Progressive mental det Vision impairment Speech impairment	missions D you had, any of the self-catheterisation g. pneumonia)	at admission? Date of last admine following in	nission	your multiple s Yes Yes Yes Yes Yes Yes		is? No No No
Number of hospital add Number of hospital add Do you have, or have a Bladder incontinence/s Secondary infection (e.go Progressive mental det Vision impairment	missions D you had, any of the self-catheterisation g. pneumonia) terioration	et admission? Date of last admine following in	nission M N	your multiple s Yes Yes Yes Yes Yes	scleros	is? No No No

Other neurological condition questionnaire

Please refer	to any available hospi	tal letters or report		th you and the dependant. logical conditions to complete
Please advis	e which of the followir	ng you have been di	agnosed with:	
Vascular c	dementia			Date of diagnosis: ${M} {M} {Y}$
Alzheimer	r's disease	Date of diagnosis: $\frac{M}{M} \frac{M}{M} \frac{M}{Y}$		
Dementia	(not otherwise specified	d above)		Date of diagnosis: $\frac{M}{M} \frac{M}{M}$
Parkinson	ı's disease			Date of diagnosis: $\frac{M}{M} \frac{M}{M} \frac{M}{Y}$
Motor neu	urone disease			Date of diagnosis: $\frac{M}{M} \frac{M}{M} \frac{M}{Y}$
Other	Please specify			Date of diagnosis: $\frac{M}{M} \frac{M}{M} \frac{M}{Y}$
Pressure sore		or the following sy.	inproms in relation to you	r neurological condition?
Pressure sore Falls Tremors Seizures What medica	es Yes No Yes No Yes No Yes No		n to your neurological co	
Falls Tremors Seizures	es Yes No Yes No Yes No Yes No Yes No			
Falls Tremors Seizures What medica Medication I	es Yes No Yes No Yes No Yes No Yes No	TLY taking in relatio	n to your neurological co	ndition?
Falls Tremors Seizures What medic a Medication i	es Yes No Yes No Yes No Yes No Yes No	TLY taking in relatio	n to your neurological co	ndition?
Falls Tremors Seizures What medication is 1 2 3 4	es Yes No Yes No Yes No Yes No Yes No	TLY taking in relatio	n to your neurological co	ndition?
Falls Tremors Seizures What medication in the service of the servi	es Yes No Yes No Yes No Yes No Yes No	TLY taking in relatio	n to your neurological co	ndition?

Activities of Daily Living (ADL) questionnaire

You Your dependant Nam	ne:
Please complete a separate ADL questionnaire if one is re	equired for both you and the dependant.
Please advise relevant diagnosis in relation to	
which you are completing this questionnaire:	
Please tick one box from each of the following that most	closely reflects your current condition.
Dressing: How is your ability to dress yourself?	Bowel Control: How would you describe your current
I am able to fully dress myself (including buttons,	bowel control?
zips, laces etc.)	l am in full control of my bowel movements
I am able to dress myself but require some assistance	☐ I have occasional accidents
with buttons, zips and laces etc.	I have no control of my bowel movements
☐ I require full assistance to dress myself	
Mobility Indoors: How easily you can move from one place to another?	Bathing and Showering: How easy is it for you to bathe and get in and out of the bath or shower?
\square I can independently move from one place to another	I can independently wash and bathe myself
I walk with assistance (frame/stick/rolling walker)	I can wash independently but require assistance in
I use a wheelchair some of the time	and out of the bath or shower
I use a wheelchair always	☐ I require full assistance to bathe or shower
☐ I require full assistance of one or two people	Feeding: What is your current ability to feed yourself
☐ I am bedridden	once food has been prepared and made available?
	I can independently feed myself
Transferring: How well are you able to move from one position to another, e.g. from a chair to a bed?	I require assistance to cut up the food on my plate but I am able to feed myself
\square I am able to get into a chair or bed independently	I am unable to feed myself or require a naso-gastric/
I require the assistance or supervision of one person to get into a chair or bed	PEG tube
☐ I require the assistance of two people to get into a chair or bed	How has your ability to perform your ADL changed over the last 5 years?
I am unable to transfer and require a hoist to transfer	☐ I have experienced no change; or deterioration in only one activity
Bladder Control: How would you describe your current bladder control?	I have experienced deterioration in two or more activities
I am in full control of my bladder	I have experienced deterioration in two or more
☐ I have occasional accidents	activities within the last 12 months
I am unable to control my bladder or I am catheterised	

Current Data Protection Laws and Future Legislation

The information provided on this form, together with medical and other information about you provided in connection with this application, will be used for the operation of insurance which covers you. You can understand how we use and share your personal data by reading and retaining the generic Privacy Notice accompanying this application (page 24) or reviewing each Provider's full Privacy/ Data Protection Notice from their website. Their web addresses are on the first page of the accompanying Privacy Notice.

Your data will be processed fairly and securely in accordance with current Data Protection laws and future legislation and may be passed to organisations outside of the Provider for the provision of underwriting, administration, claims management, rehabilitation and customer concern handling services and may also be shared with group companies and third party insurers, re-insurers, insurance intermediaries and service providers.

Furthermore, your sensitive data, such as medical records, will be used for the purposes of underwriting or claim management and rehabilitation and will be seen only by the people authorised by the Provider's Medical Officer or equivalent.

Your personal data will only be available to those who need that information and you have the right to receive a copy of all your personal data held by contacting either your Financial Adviser, the Provider or by writing to the Provider's Data Protection Officer.

Please note that during the processing of any proposals and administration, information may be transferred outside the European Economic Area.

Notice of Statutory Rights

Under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Access to Health Records and Reports (Isle of Man) Act 1993, the Provider reserves the right to apply for a medical report from any doctor who has at any time attended you. The declaration gives us your consent to apply for such a report if we need to.

Your rights:

- You do not have to give your consent but, without it, the Provider will not be prepared to accept your request.
- If you do give your consent, you can indicate whether or not you wish to see any report before it is sent to us.

If you indicate that you do not wish to see any report:

- The doctor can forward it to us immediately and we should be able to process your proposal without delay.
- You can, however, still change your mind at any time
 within six months and notify the doctor that you wish to
 see the report. If the doctor has already forwarded the
 report to us, he/she will send you a copy and, if not, he/she
 will give you 21 days to arrange to see it.

If you indicated that you do wish to see any report:

- This may delay the processing of your proposal.
- The doctor is allowed to charge you a fee to cover the cost of supplying you with the report.
- You should follow the procedures outlined below.

Procedures for Access to Reports

- 1. If you indicate that you do wish to see any report we will notify you if we apply for one, and will inform the doctor of your wishes. You will then have 21 days to contact the doctor to arrange to see the report.
- 2. If you do see the report, the doctor must obtain your consent before sending it to us.
- You have the right to request that the doctor amends any part of a report you consider incorrect or misleading, and can attach your written views on any part the doctor refuses to amend.
- 4. The doctor does not have to let you see any part of a report that he/she considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his/her intentions towards you. He/she also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report he/she must notify you of that fact.

Declaration and Consent

Please read, complete and sign this section

Has Power of Attorney been vested in another party?	I/We accept the Provider will use the information I/we give for administration, underwriting, claims, research and statistical				
Yes No If yes, please enclose the appropriate documentation	purposes. I/We agree the Provider may pass information about my/our physical or mental health or condition to medical				
If so, which type?	practitioners and reinsurers.				
I/We declare that the information and statements provided above are true and I/we have taken reasonable care to ensure that my/our answers to the questions asked are correct. I/We understand that if any information provided by me/us is subsequently found to be inaccurate the policy may be amended or cancelled in accordance with the Consumer Insurance (Disclosure and Representations) Act 2012. I understand that this may mean the benefits payable to me/ us are reduced and in some instances the policy may be cancelled. I/We agree that the Provider may obtain medical information from any doctor who, at any time, has attended me/us, about anything that affects my/our physical or mental health and/or any insurance office to which a proposal has been made on my/our life and I/we authorise the giving of such information. This consent shall remain valid throughout the duration of the insurance and after my/our death unless I/we advise the Provider otherwise. I/We agree that the Provider may apply for medical evidence. I/We authorise the Provider to pass medical information to any medical officer on the Provider's behalf.	I/We agree that a copy of this declaration and consent can be treated as the original. I/We agree to the Provider processing my/our medical data in accordance with the Privacy Notice, a copy of which has been provided to me/us. I/We understand that I/we must inform the Provider without delay if there is a change to my/our health or circumstances before the commencement of the policy. I/We understand that failure to do so may result in amendment or cancellation of the policy in accordance with the Consumer Insurance (Disclosure and Representations) Act 2012. I/We have been duly notified of my/our rights under the Access to Medical Information legislation as detailed overleaf governing access to medical records. I/We understand that the Provider may pass the information to third parties for the prevention or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.				
YOU I do o not wish to see the report	t before it is sent to the Provider				
YOUR DEPENDANT I do do not wish to see the repor	t before it is sent to the Provider				
The information provided in this form will be shared with Aviva, C Life to allow them to provide you with an Annuity quotation. These if applicable, your dependant's personal and medical information market leading comparison quote (in accordance with Financial C annuity income with another Provider. YOU - I do do not consent for my/our personal and medic purpose of obtaining a market leading comparison quote (in accordance).	e Providers will share your personal and medical information and, n contained in this form with other companies to obtain a Conduct Authority regulations) to see if you could receive more cal information to be shared with other companies for the				
The Provider reserves the right to decline any requests. The Prov I/We have read and understood the Privacy Notice regarding the	, ,				
YOU	YOUR DEPENDANT				
Doctor's Name	TOOK DEFENDANT				
Surgery Address					
Telephone number					
Fax number					
YOU	YOUR DEPENDANT				
Name (BLOCK CAPITALS)					
Signature					
Date of Signature $\frac{1}{D} \frac{1}{D} \frac{1}{M} \frac{1}{M} \frac{1}{M} \frac{1}{Y} \frac{1}{Y}$					
/	, ,				



Section 3: **Financial Adviser's Details**

What was the basis of sale? (please tick)	Advised – Independent
	Advised – Restricted
	Non-Advised
Name of Firm	
Contact Name	
RI/Adviser Name	
Company Address	
Postcode	
Email	
PRA and /or FCA Reference Number	
Telephone Number	
Remuneration	
Please note that a copy of the Service Agr	reement will need to be provided at the point of application.
a) Adviser Charge	Not to be facilitated by the annuity provider
Initial Adviser Charge facilitated	£ (Monetary Amount)
by the annuity provider	% (Percentage)
Where should the Initial Adviser Charge be deducted from <i>(please tick)</i> ?	Total purchase money*
	Purchase money after the payment of any Pension Commencement Lump Sum (tax free cash)*
	Pension Commencement Lump Sum (tax free cash)**
	* Please note this is only available from providers who support these options.
	** Please note that if Adviser Charge is deducted from Pension Commencement Lump Sum this will reduce the amount paid to the client. This is only available from providers who support this option.
b) Commission (only available on Non-Advised Sales)	£ (Monetary Amount) or (Percentage) or Nil Commission

Section 4: **Pension Details**

Quote Reference No. (if a	applicable)							
Source of quote	ірріісцыіс)							
·					and DDI and latin			
	s. You will need	to conta			•	may only be available se photocopy this page		
Only complete one bo	Х							
Total purchase price	£	Before payment of pension commencement lump sum (tax free cash)						
Fund value	£	Net amo	ount after paym	ent of p	ension commencement	lump sum (or GAR value)		
The quote will calculate the purchase price required to secure the specified income amount.								
Product required								
Open market option								
Immediate vesting pers	sonal pension							
Source of funds								
Name of ceding pensio	n provider/s							
Protected Pension Com	nmencement Lun	np Sum (T	ax Free Cash) a	bove 259	%? Yes No			
Pension Commenceme	ent Lump Sum (Ta	ıx Free Ca	sh) required?		Yes No (tax)	free cash already paid)		
If yes, please give amou	unt, if less than 2	5% £						
Registered pension sch	ieme 🗌 Yes 🗌	No						
Death in service	☐ Yes ☐	No						
Pensions credit	☐ Yes ☐	No						
Assumed annuity comr	mencement date		<u> </u>	<u>Y</u> <u>Y</u> -	<u>Y</u> <u>Y</u>			
Pension benefits		£						
Is a GMP or GAR quot	e required? If so	, please c	complete the f	ollowing	.			
Benefit type	Income (per ar	nnum)	From (date or	age)	Escalation rate	Revaluation rate		
GAR	£				%	%		
GMP (pre 06/04/1988)	£				%	%		
GMP (post 05/04/1988	£				%	%		
Benefit type			Income		From (date or age)	Escalation rate		
Section 9(2B) rights (06	5/04/1997 to 05/0	4/2005)	£			%		
Section 9(2B) rights (fro	om 06/04/2005)		£			%		
Excess (non-GMP) ben	efit		£					
If GMP start date is ea	arlier or later th	an GMP a	age (65 male, 6	0 female	e)			
GMP at GMP age (pre 0	06/04/1988)	£						
GMP at GMP age (post	05/04/1988)	£						

Has the GMP been equalised	d?	Yes				
If yes, has the GMP been cor	nverted to non-GMP	benefit? Yes	∐N	0		
If yes, tell us how you wan	t each benefit type	to escalate and	depend	lant's ben	efit percenta	ge on death
Benefit type		Income p.a		Escalation	n rate	% dependants
		£			%	%
		£			%	%
		£			%	%
Step up						
Type of scheme						
Defined benefit						
Defined contribution						
Hybrid						
Annuity options						
Payable	Yearly In advance With proportion With overlap	Half Yearly	☐ In a	arterly arrears hout propo hout overla		(maximums will vary by provider)
Escalation	3%	5%	RPI		LPI	% Other
Guarantee	□ None [5 years	10 ³	Years	Other	
Payable as lump sum, if possible	Yes	No				
Value Protection	%	olease specify the	e percen	tage of the	purchase pri	ce to be protected
Value Protection (Joint Lives)	Payment on spo	use death	Pay	ment on a	nnuitant's dea	ath
With dependant's benefit	☐ Yes [No				
% dependants benefit on death	33.3%	50%	☐ 66.°	7%	100%	% Other
Ceasing on remarriage	Yes [No				
Single life and joint life	☐ Yes [No				
Number of illustrations expe	ected					
Lump Sum Allowance and	Lump Sum and Dea	ith Benefit Allov	vance			
Please state the percentage place if any.	of each allowance th	at the annuitant	has alre	ady used, a	and the type a	and level of protection in
		Percentage alr	ready	Type of p	rotection	Level of protection
Lump sum allowance						
Lump sum and death bene	fit allowanace					

Privacy Notice

All the Product Providers; Aviva, Canada Life, Just, Legal & General, Scottish Widows and Standard Life, that take part in the Retirement Health Form Service (referred to as "Product Providers" or "we" in this Privacy Notice (PN)) take their privacy obligations very seriously. Any personal information provided to them, as Data Controllers, by a policyholder, joint policyholder, employer policyholder, trustee, insured person, beneficiary, claimant or member (referred to as 'you' or 'your' in this PN), will be treated in accordance with current Data Protection legislation, and any successor legislation. This is a generic PN which explains how the Product Providers may use your personal information. Full details of how each Provider will use your data can be found on their websites:

Aviva

www.aviva.co.uk/legal/privacy-policy.html

Canada Life

www.canadalife.co.uk/data-protection-notice

lust.

www.wearejust.co.uk/privacy-policy

Legal & General

www.legalandgeneral.com/privacy-notice

Scottish Widows

https://www.scottishwidows.co.uk/legal-information/privacy

Standard Life

www.phoenixlife.co.uk/legal-and-policies/privacy-notice

What is personal information?

Personal information means any information about you which is personally identifiable, including your name, age, address, telephone number, email address, financial details, and any other information from which you can be identified. It will also include genetic and biometric data, location data and online identifiers which may identify you, such as your internet protocol (IP) address (the unique personal address which identifies your device on the internet) and mobile device IDs.

What do we collect?

The Product Providers will collect the following information about you and your dependants (this includes your authorised Power of Attorney) when you use their services or they may collect it indirectly from their business partners, such as financial intermediaries:

- Personal data: your name, date of birth, telephone number, address, email address, dependants, marital status, IP address and media access control (MAC) address.
- Sensitive/special categories of personal data: gender and other sensitive information such as information about your physical and mental health. They recognise that information about health is particularly sensitive information. Should consent be the legal basis of processing special categories of personal data, they will ask for consent to collect and use this information.
- Financial information: information that may relate to your financial circumstances (for example your pension values,

- income and existing investments), bank account details and details of product options you may consider.
- Technical Information: such as details on the devices and technology you use.
- Public Records: This includes open data such as the Electoral register, Land register or information that is openly available on the internet.
- Documentary data and national identifiers: Information that is stored on your passport, driving license, birth certificate, and National Insurance number.

As well as collecting personal information about you, they may also use personal information about other people, for example family members you wish to insure on a policy. If you are providing information about another person, the Product Providers expect you to ensure the other person knows you are doing so and are content with their information being provided to them. You might find it helpful to show them this PN and if they have any concerns to contact the relevant Product Provider(s) directly. If personal information is submitted about another person (for example spouse/partner), then by signing this form, you confirm that they have consented to providing their information for the information to be used and shared as set out in this notice.

How we use the information we collect

Product Providers on this form will use personal information collected from you and personal information about you obtained from other sources such as your financial intermediary in the following ways:

- · To provide you with your required policy;
- · To decide what terms, they can offer;
- · To administer your policy;
- To support legitimate interests that they have as a business;
- · To prevent, detect or investigate financial crime;
- To help them better understand their customers and improve customer engagement. This may include research; statistical analysis, profiling and customer analytics which allows them to make certain predictions and assumptions about your interests, and make correlations about their customers to improve their products;
- To meet any applicable legal or regulatory obligations: they need this to meet compliance requirements with their regulators (e.g. Financial Conduct Authority), to comply with law enforcement and to manage legal claims; and
- To carry out other activities that are in the public interest: for example, they may need to use personal information to carry out anti-money laundering checks.

Some of the information they collect as part of an application for a policy may be provided to them by a third party. This may include information Product Providers and their subsidiaries already hold about you and your dependant, including details from previous quotes and claims, information they obtain

from publicly available records, their trusted third parties and from industry databases, including fraud prevention agencies and databases.

Legal basis for processing Personal Data

Where processing of data is necessary for entering into a contract with a Product Provider or for the performance of a contract which you (the data subject) are aware of the legal processing of Personal Data, this is based on Article 6.1(b) of the General Data Protection Regulation (GDPR).

Processing of Special Categories of Personal Data (for example health or medical data) is based on Article 9.2(g) of the GDPR in that processing is necessary for reasons of substantial public interest and conducted on the basis of applicable law where the only data processed will be that necessary for the aim specified in order to respect the Data Subject's rights and interests.

Who your Personal Information may be shared with

The personal information a Product Provider holds about you may be shared with the following recipients subject to security, contractual and transfer adequacy safeguards as appropriate:

- (a) their group affiliates (where they exist);
- (b) their agents;
- (c) their business partners/service providers who assist them in providing the services they offer;
- (d) doctors or any relevant medical professional; and
- (e) credit agencies (for the purpose of identification verification).

The following categories of agents, business partners and close affiliations assist them in the provision of ancillary services and they only use your personal information to the extent necessary to perform their functions:

- Providers for pricing/underwriting purposes: these Providers may share your personal information with their group companies for the same purpose;
- Service providers: for the provision of support services such as reinsurance, product administration, receiving and sending marketing communications, data analysis and validation, IT support services, archiving, auditing, business administration and other support services and tasks, from to time;
- Business partners who may have referred you to us: to provide them with relevant management information;
- Other companies in the event we undergo a re-organisation or are sold to a third party;
- Regulators and public authorities who have a legal right to request and process your personal information e.g. the FCA, HMRC and the DWP;
- Other subsidiary companies, where relevant, for management information purposes;
- In addition, a Product Provider may disclose your personal information if legally entitled or required to do so, for example, if required by law or by a court order or if they believe that such action is necessary to prevent fraud or cybercrime or to protect their website or the rights of individuals or their property or the personal safety of any person.

How long Product Providers will keep your Personal Information for

Product Providers maintain a retention policy to ensure they only keep personal information for as long as they reasonably need it for the purposes explained in this notice. They need to keep information for the period necessary to administer your insurance and deal with claims and queries on your policy. They may also need to keep information after their relationship with you has ended, for example, to ensure they have an accurate record in the event of any complaints or challenges, carry out relevant fraud checks, or where they are required to do so for legal, regulatory or tax purposes.

Anonymised personal information will not be considered as personal since no individual can be identified by that information. Product Providers may use anonymised personal information for further actuarial and business analysis, business research and reporting to help develop their products and services.

Transmission and Security of Personal Information

Product Providers have security measures in place to protect against the loss, misuse and alteration of personal information under their control as required by current Data Protection laws and, as of May 2018, the EU GDPR.

For example, Product Providers' security and privacy policies are periodically reviewed and enhanced as necessary and only authorised personnel have access to personal information. Whilst they cannot ensure or guarantee that loss, misuse or alteration of information will never occur, they will use all reasonable efforts to prevent it.

Data Transfer outside of the European Economic Area (EEA)

Given the global nature of some Product Providers' businesses, some will use third party suppliers and outsourced services (including Cloud-based services), which can require transfers of personal information outside of the EEA. In doing so, Product Providers will ensure that there are appropriate contractual arrangements in place and will choose only those organisations with strict controls via appropriate organisational and technical measures to protect your personal information.

Notification of Changes to Privacy Policy

Product Providers will reserve the right to amend or modify the Privacy Policy at any time and in response to any changes in applicable Data Protection and privacy legislation.

If Product Providers decide to change their Privacy Policy, they will post these changes on their websites so that you are aware of the information they collect and use it at all times.

If at any point Product Providers decide to use or disclose information they have collected, in a manner different from that stated at the time it was collected, they will notify you.

Individual rights under the General Data Protection Regulation

From 25th May 2018 individuals (Data Subjects) are provided with various rights including the right to be told what Personal Data is held by Product Providers and the right to request that any inaccuracies in respect of your Personal Data are corrected. Details of all individual rights are shown below:

- The right to be informed you have the right to be informed how your Personal Data will be used. For example, this may be set out in a company's Privacy Notice.
- 2. The right of access you have the right to access your Personal Data and supplementary information. For example, you may wish to access your data to become aware of and verify the lawfulness of the processing.
- **3. The right to rectification** you have the right to have your Personal Data rectified. For example, if you feel it is inaccurate or incomplete.
- **4. The right to erasure** you have the right in specific circumstances to request the deletion or removal of Personal Data where there is no compelling reason for its continued processing. For example, your Personal Data was unlawfully processed.
- **5. The right to restrict processing** you have the right to restrict the processing of your Personal Data in certain circumstances. For example, you wish to contest the accuracy of your Personal Data.
- 6. The right to data portability you have the right to obtain and reuse your Personal Data for your own purposes. For example, you may wish to move, copy or transfer Personal Data from one information technology environment to another in a safe and secure manner.
- 7. The right to object you have the right to object to your Personal Data being used for processing based on legitimate interests or for a task in the public interest. For example, you no longer want your Personal Data used for direct marketing.
- 8. Rights in relation to automated decision making and profiling you have the right to challenge decisions that are made using an automated approach including profiling. For example, you may want to request human intervention where you do not agree with an automated decision.

Contact Details:

Any enquiries relating to Data Protection issues should be sent to a Provider at the Data Protection address which can be found on pages 22-23 of this form or from their website.

You also have the right to talk to the Information Commissioner's Office whose main role is to uphold information rights in the public interest.

Website:

ico.org.uk/for-the-public

Email:

casework@ico.org.uk

Phone:

0303 123 1113

Address:

Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF



How to get a quote

Once you have completed the form with your client, you can use this information to obtain a bespoke annuity quote using one of the third-party portal providers below.

Alternatively, you can capture the information directly on one of the portals. Each portal will search the whole of market to ensure your client receives the best rate available at that time from all participating providers. By using one of the portals detailed below, once you have input all the client details, you could receive a fully underwritten and guaranteed quote in as little as 15 seconds.

AMS

Web: https://amsretirement.co.uk

Free to use



IPIPELINE

Web: https://uk.ipipeline.com/products/assureweb-annuities/

Free to use



Iress: The Exchange

Web: https://exweb.exchange.uk.com/public/login/logdefault.aspx

Charge to use



Synaptic

Web: https://synaptic.co.uk/solutions/webline

Charge to use



Alternatively you can email the completed form to the participating providers but it may take longer to receive your annuity quotes. Please note that not all providers can provide quoes via email and we cannot guarantee that we will receive any email you send us, or that it will not be intercepted by someone else. For those reasons, you should always protect any personal information you share with an insurer by email.

Participating providers

Aviva Email: enquote@aviva.com

For Data Protection enquiries, you may contact: dataprt@aviva.com

Aviva Life Services UK Limited. Registered in England No 2403746. 2 Rougier Street, York, YO90 1UU. Authorised and regulated by the Financial Conduct Authority. Firm Reference Number 145452.



Canada Life Email: AnnuityQuotes@canadalife.co.uk

For Data Protection enquiries, you may contact: dpo@canadalife.co.uk

Canada Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Canada Life International Limited and CLI Institutional Limited are Isle of Man registered companies authorised and regulated by the Isle of Man Insurance and Pensions Authority. Canada Life International Assurance Limited is authorised and regulated by the Central Bank of Ireland.



Just. Email: support@wearejust.co.uk

For Data Protection enquiries, you may contact: dataprotection@wearejust.co.uk

Just is a trading name of Just Retirement Limited. Registered Office: Enterprise House, Bancroft Road, Reigate, Surrey, RH2 7RP. Registered in England and Wales Number 05017193. Just Retirement Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Please note your call may be monitored and recorded and call charges may apply.



Legal & General Email: <u>Broker.AnnuityQuotes@landg.com</u>

For Data Protection enquiries, you may contact: Data.Protection@landg.com

Legal & General Assurance Society Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Registered in England and Wales No. 00166055. Registered Office: One Coleman Street. London EC2R 5AA.



Scottish Widows Email: annuities@scottishwidows.co.uk

Please get a quotation directly through one of our associated portals. Email quotations are by exception only. **Please include your Scottish Widows Agency Number.**



For Data Protection enquiries, please visit:

https://www.scottishwidows.co.uk/legal-information/privacy

Scottish Widows Limited is registered in England and Wales No. 3196171. Registered office in the United Kingdom at 25 Gresham Street, London EC2V 7HN. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register number 181655.

Standard Life Email: AdviserAnnuitySupport@standardlife.com

For Data Protection enquiries you may contact: <u>DataProtection@thephoenixgroup.com</u>



Phoenix Life Limited, trading as Standard Life, is registered in England and Wales (1016269) at 10 Brindleyplace, Birmingham, B1 2JB. Phoenix Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.