

Pension  
**Annuity** for  
Enhanced and Impaired Terms

Client Information Form including Medical Evidence Questionnaire

## Completing this form

It is important to know that around 40% of the retiring population qualify for 'enhanced terms' on their annuity but very few actually apply for them. By taking some time to complete this form you can be sure that you are getting the best possible deal - remember we can look at getting you on average 22% more income in retirement based on the information you provide.

So, to enable us to search the annuity market to get you the best deal for your circumstances we need you to:

- Complete section 1 (Client Information Form) and sign page 3.
- Complete section 2 (Medical Evidence Questionnaire). This section includes the smoking questions as well as the medical information we require. If you are applying for a joint annuity, your spouse/partner will also need to complete their details on page 5.
- If you are declaring any medical conditions you (and your spouse/partner if applicable) must then complete pages 6 and 7 plus any appropriate supplementary questionnaires.
- Then, ensure you (and your spouse/partner if applicable) complete, sign and date the declaration and consent on page 15. This section must be completed in **all** cases.

Return the completed form to us at:

**Bank of Scotland Annuity Service**  
**Freepost SCE8362**  
**Aylesbury HP21 7BR**

If you need any help completing the form please call **0845 6006651** or email **information@bosas.co.uk**

If, once you have read the guidance notes, you are still unsure about any question(s) please call our helpline on 0845 600 6651 or email: [information@bosas.co.uk](mailto:information@bosas.co.uk)

Please use block capitals and tick where applicable

## Section 1 - Client Information Form

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### Your details

Title Mr/Mrs/Miss/Ms/other (please state) \_\_\_\_\_

Sex: Male  Female

First name(s) \_\_\_\_\_

Surname \_\_\_\_\_

Date of birth \_\_\_\_\_

National Insurance Number \_\_\_\_\_

### Marital status

Single  Separated  Married  Divorced

Widowed  Civil partnership  Dissolved civil partnership

Residential address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Town \_\_\_\_\_

County \_\_\_\_\_

Postcode \_\_\_\_\_

Occupation \_\_\_\_\_

Country of residence \_\_\_\_\_

Nationality \_\_\_\_\_

### Phone numbers (including dialling code)

Home \_\_\_\_\_

Mobile \_\_\_\_\_

Work \_\_\_\_\_

Fax \_\_\_\_\_

Email address \_\_\_\_\_

If we need to contact you, how do you prefer to be contacted?

Email  Home  Work  Mobile

When is it most suitable for us to contact you? \_\_\_\_\_

Has Power of Attorney been vested in another party?  Yes  No  
(if yes please enclose the appropriate documentation)

If so - which type? \_\_\_\_\_

### Dependant e.g. spouse or partner (if applicable)

Title Mr/Mrs/Miss/Ms/other (please state) \_\_\_\_\_

Sex: Male  Female

First name(s) \_\_\_\_\_

Surname \_\_\_\_\_

Date of birth \_\_\_\_\_

National Insurance Number \_\_\_\_\_

### Marital status

Single  Separated  Married  Divorced

Widowed  Civil partnership  Dissolved civil partnership

Residential address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Town \_\_\_\_\_

County \_\_\_\_\_

Postcode \_\_\_\_\_

Occupation \_\_\_\_\_

Country of residence \_\_\_\_\_

Nationality \_\_\_\_\_

### Phone numbers (including dialling code)

Home \_\_\_\_\_

Mobile \_\_\_\_\_

Work \_\_\_\_\_

Fax \_\_\_\_\_

Email address \_\_\_\_\_

If we need to contact you, how do you prefer to be contacted?

Email  Home  Work  Mobile

When is it most suitable for us to contact you? \_\_\_\_\_

Has Power of Attorney been vested in another party?  Yes  No  
(if yes please enclose the appropriate documentation)

If so - which type? \_\_\_\_\_

Please complete the following, so we know what type of annuity to look for, using the guidance notes overleaf

Do you want your income to be fixed or increasing? *See Note 1*  Fixed  Increasing

If you want an increasing annuity, by how much would you like your income to increase? *See Note 2*  In line with RPI  Fixed at 3%  Fixed at 5% Fixed percentage of  %

Do you want a pension for your spouse/partner? *See Note 3*  No  Yes 50%  Yes 65%  Yes 100%

Do you want a guarantee period? *See Note 4*  No  Yes 5 years  Yes 10 years

Would you like Value Protection? (Please note Value Protection is only available in certain cases and you cannot select it if you have chosen a Guarantee Period) *See Note 5*  No  Yes 50%  Yes 100%

How often do you want to receive your income? *See Note 6*  Monthly  Quarterly  Half yearly  Annually

Do you want your income to be paid in advance or in arrears? *See Note 6*  In advance  In arrears

Do you want to receive your income 'with proportion'? *See Note 6*  Yes  No

How much tax-free cash do you want? *See Note 7*  None  Maximum Amount Fixed amount of £ \_\_\_\_\_

Please give details of your existing policies.

Provider name

Policy number

Policy type *See Note 8*

Total maturity value (before deduction of tax free cash) *See Note 9*

Amount of maturity value relating to protected rights benefits *See Note 10*

Do you want to transfer via an Open Market Option or transfer for Immediate Benefit? *See note 11*  Open Market Option  Transfer for Immediate Benefit

Please add any additional notes or information that you feel will help us deal with your enquiry

\_\_\_\_\_

\_\_\_\_\_

**Your declaration** I confirm that the information provided on this form is correct and I have received and read the 'key facts' document. Any information I provide to Bank of Scotland Annuity Service will be treated with the strictest confidence and it places me under no obligation to complete annuity business.

**Data Protection Notice:** Any information you provide may be held by BoSAS and Bank of Scotland plc which is a member of the HBOS group of companies. BoSAS will pass your details to product providers to obtain quotations for annuities on your behalf. If you take out a product after completing our financial planning process, your details will be held by the product provider. Some of the information may be passed to the financial adviser or other persons acting on your behalf. Relevant information may also be passed to our agents and service providers. Where you have given information about another person, you are acting for them and with their knowledge and approval. You also have their authority to agree to the processing of their personal details. BoSAS and the HBOS group of companies will use your information to contact you by mail, telephone, e-mail, SMS or otherwise about other products and services that may be of interest to you. If you do not wish to receive this information, please contact BoSAS by any convenient means. Please find our Freepost address for your convenience. BoSAS, FREEPOST SCE8362, AYLESBURY HP21 7BR.

You have a right of access to your personal information held on our records. If you request a copy of your personal information, we may charge you a fee. If anything is inaccurate, please let us know and we will correct it. By signing this form, you agree that we can use your information in the ways described.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Please use these notes to complete Section 1.

It is important that you fully understand the highlighted words as your choices will impact on the income you receive in retirement. These notes provide clear explanations so you can make the right choice for your individual needs.

### Note 1

A **fixed income** will give you a higher starting income than an increasing income but because the amount is fixed, its value can be eroded by inflation. You may want to consider an increasing income - see note 2.

### Note 2

An **increasing income** will give you a lower starting income than a fixed income. You can choose to increase your income in line with the Retail Price Index (RPI) if you are concerned about inflation. Or you can choose for it to increase by a fixed percentage each year so you know how much income you will get every year.

### Note 3

If you want to provide for your spouse or partner, you should take out a **joint life annuity**. This means that your spouse or partner will get an income for the rest of their life, if you die first. You can arrange for them to get the full amount of your income or a smaller proportion. The greater the proportion, the lower your starting income will be.

### Note 4\*

A **guarantee period** will ensure that any income is paid for five or ten years from the date the annuity is set up if you die before the end of the period. If you die during the guarantee period, then the income will continue to be paid to your dependants or estate to the end of the selected period.

If you have a joint life annuity, a guarantee period is likely to be less important to you. However, for example, if you opted for a 50% spouse's pension and a five year guarantee and died in year 2, your spouse would receive the full amount of your income until the end of year 5, when it would reduce to 50%. The cost of a guarantee period is usually small.

### Note 5\*

**Value protection** is an alternative to choosing a guarantee period if you qualify for an enhanced rate due to your health or lifestyle. If you die before you are 75 and have the value protection option, a lump sum will be paid to your estate. This amount is equal to the amount you used to buy your annuity, less the gross annuity payments already made to you, less a 35% income tax charge. It can be quite expensive to take this option, although you can opt to protect 50% of your fund instead of 100%.

\* There may be inheritance tax to pay if you choose the options outlined in notes 4 and 5 above so you should seek advice.

### Note 6

Your annuity payments can be made monthly, quarterly, half yearly or once a year, so choose the **frequency** that suits you best. The payment frequency cannot be changed in the future. The longer you wait for your money, the higher your income will be. You can opt for the first payment to be made on the date the annuity is set up - this means it will be paid in **advance**.

Alternatively you can opt to have your first payment made one month, one quarter, one half year or one year after the date the annuity is set up - this means it will be paid in **arrears**. You will receive the highest income if you opt to have your payments once a year in arrears.

You can add a 'with proportion' option. This means that when you die, a payment is made for the last part year of your life. If you would like this option included, please say so on the form.

### Note 7

You can normally choose to receive a **tax-free lump sum** from your pension plan when you buy an annuity. If you have a retirement annuity contract, your tax-free lump sum entitlement will always be up to 25% of the fund. If you have a personal pension plan, your entitlement will also be up to 25% of your fund. You

may be entitled to a higher tax-free amount if you previously transferred benefits from a former employer's pension scheme into the plan. If you hold benefits directly under a current or former employer's scheme (known as an occupational scheme), then your entitlement will always be at least 25% of your fund (assuming their scheme rules changed on 6 April 2006). It could also be more. If you are unsure of your entitlement, please contact your scheme administrator.

If you do not select a box, we shall assume you wish to take 25% of your fund as a tax-free lump sum. If you do not wish to take your full entitlement as a tax-free lump sum, please confirm the amount you need on the form. If your funds are held under an Unsecured Pension (also known as Income Drawdown Plan) then you will not be entitled to any tax-free lump sum.

### Note 8

The **type of policies** we deal with are:

- Money Purchase Occupational Scheme
- Personal Pension Plan
- Stakeholder Pension Plan
- Retirement Annuity Contract
- Freestanding AVC arrangement
- AVC Scheme
- Section 32 Buy Out Policy
- Unsecured Pension (also known as Income Drawdown Plan)

It is vital that you tell us the type of policy you have, as this could affect any tax-free lump sum you take and also the way that benefits are paid out. If you are unsure about the type of policy you have, please contact your existing pension plan provider.

### Note 9

The **total maturity value** is the amount you have available to buy your annuity. This is sometimes different from the actual fund value. If you have a 'with profits' policy, the provider will sometimes make a reduction known as a market value adjustment (MVA) if you take your benefits on a different date to that originally chosen. If you want an explanation of any MVA that applies to you, your pension plan provider will be able to give you more information. When stating the amount of your total maturity value on the form, include any protected rights benefits - see note 10.

### Note 10

You may have **protected rights benefits** if you have used your pension plan to contract out of a state earnings related pension scheme (SERPS) and/or the State Second Pension (S2P). You must tell us if you have protected rights benefits because restrictions apply to how this money can be used. For example, if you have a spouse you must provide a 50% pension for them. The maximum guarantee period allowed is five years. So if, for example, you tell us that you would like a ten year guarantee period, we will use a five year guarantee period for your protected rights benefits but use a ten year period for the rest of your pension.

### Note 11

If you have just one plan the Open Market Option ensures that your existing pension provider pays your tax free lump sum direct to you and sends the rest of your money to your annuity provider. We will prepare our report on this basis in the majority of cases as this is the quickest way to get your tax free lump sum. However if you have more than one private pension plan it is normally better to have your funds amalgamated in which case your annuity provider will send you your tax free cash from your combined funds. This is known as a transfer for immediate benefit.

If you need assistance, please call our helpline on 0845 600 6651 (lines open 9am - 5pm, Monday to Friday) or e-mail [information@bosas.co.uk](mailto:information@bosas.co.uk)

**To be completed by the Applicant**

**Section 2 - Medical Evidence Questionnaire**

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Please disclose as much information about your health and lifestyle as possible before signing this form. An annuity may commence on the basis of the medical information supplied. Failure to answer questions about your health fully, accurately and truthfully may result in any annuity enhancement being reduced or removed in full which means you will receive standard annuity rates. If you are unsure about details of any material facts or dates, check the details to ensure they are accurate to the best of your knowledge and belief. A report from your doctor may be obtained subsequently but it remains your responsibility to complete the application form accurately.

**Please enclose copies of any available hospital letters and a copy of your latest repeat prescription form, if possible.**

**Your details**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex: Male  Female  Height  Weight  Waist measurement  Dress size  Trouser size

Do you currently smoke? Yes  No  Never

If you are a regular cigarette smoker and have been for the last 10 years, please indicate the average daily level.

Smokers:  Cigarettes per day  Cigars per day  Hand-rolled (ozs per week)  Pipe tobacco (ozs per week)

If previously smoked, please advise of the years you started and stopped:

Started  Stopped

How much did you smoke?  Cigarettes per day  Cigars per day  Hand-rolled (ozs per week)  Pipe tobacco (ozs per week)

How many units of alcohol do you drink weekly?

*(a unit of alcohol is equivalent to half a pint of normal strength beer, lager or cider, one standard glass of wine or a single measure of spirit)*

Are you currently living: in own home  in care home  living alone in own home  with someone else

**Please now complete the section below and the tick box section on pages 6 and 7.**

**Please do not forget to complete a supplementary questionnaire if applicable.**

- Heart attack, angina or any other heart condition** - please complete the questionnaire on page 8
- Diabetes** - please complete the questionnaire on page 10
- Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour** - please complete the questionnaire on page 11
- Stroke** - please complete the questionnaire on page 13
- High blood pressure or high cholesterol** - please specify, provide latest reading if possible and treatment received
- Chronic respiratory disease** - name of condition, treatment required, impact on daily living
- Kidney or liver disease** - specify type of disease, list investigations, whether dialysis required
- Multiple sclerosis** - specify any mobility restrictions (e.g. wheelchair bound), severity of condition, investigations and treatment required
- Alzheimer's disease, dementia or Parkinson's disease** - specify symptoms, treatment, assistance required and any complications e.g. pressure sores
- Any other serious illness or condition** - please give full details below

**Please do not forget to complete the additional questionnaire for your relevant medical condition/s.**

Please state exact condition, date of diagnosis, treatment/medication and dosage required. Please give full details of any hospitalisation and whether you are suffering symptoms, their frequency and severity. Include any relevant family history. (Please note, the more information you provide us with the better the enhancement we may be able to offer you.)

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To be completed by the Dependant, only if a joint life annuity is required.

## Medical Evidence Questionnaire

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Please disclose as much information about your health and lifestyle as possible before signing this form. An annuity may commence on the basis of the medical information supplied. Failure to answer questions about your health fully, accurately and truthfully may result in any annuity enhancement being reduced or removed in full which means you will receive standard annuity rates. If you are unsure about details of any material facts or dates, check the details to ensure they are accurate to the best of your knowledge and belief. A report from your doctor may be obtained subsequently but it remains your responsibility to complete the application form accurately.

Please enclose copies of any available hospital letters and a copy of your latest repeat prescription form, if possible.

### Your details

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex: Male  Female  Height  Weight  Waist measurement  Dress size  Trouser size

Do you currently smoke? Yes  No  Never

If you are a regular cigarette smoker and have been for the last 10 years, please indicate the average daily level.

Smokers:  Cigarettes per day  Cigars per day  Hand-rolled (ozs per week)  Pipe tobacco (ozs per week)

If previously smoked, please advise of the years you started and stopped:

Started  Stopped

How much did you smoke?  Cigarettes per day  Cigars per day  Hand-rolled (ozs per week)  Pipe tobacco (ozs per week)

How many units of alcohol do you drink weekly?

*(a unit of alcohol is equivalent to half a pint of normal strength beer, lager or cider, one standard glass of wine or a single measure of spirit)*

Are you currently living: in own home  in care home  living alone in own home  with someone else

Please now complete the section below and the tick box section on pages 6 and 7.

Please do not forget to complete a supplementary questionnaire if applicable.

- Heart attack, angina or any other heart condition** - please complete the questionnaire on page 8
- Diabetes** - please complete the questionnaire on page 10
- Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour** - please complete the questionnaire on page 11
- Stroke** - please complete the questionnaire on page 13
- High blood pressure or high cholesterol** - please specify, provide latest reading if possible and treatment received
- Chronic respiratory disease** - name of condition, treatment required, impact on daily living
- Kidney or liver disease** - specify type of disease, list investigations, whether dialysis required
- Multiple sclerosis** - specify any mobility restrictions (e.g. wheelchair bound), severity of condition, investigations and treatment required
- Alzheimer's disease, dementia or Parkinson's disease** - specify symptoms, treatment, assistance required and any complications e.g. pressure sores
- Any other serious illness or condition** - please give full details below

Please do not forget to complete the additional questionnaire for your relevant medical condition/s.

Please state exact condition, date of diagnosis, treatment/medication and dosage required. Please give full details of any hospitalisation and whether you are suffering symptoms, their frequency and severity. Include any relevant family history. (Please note, the more information you provide us with the better the enhancement we may be able to offer you.)

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**For all conditions please complete the questions below. Please use block capitals and tick where applicable.**

**Your details**

Condition 1 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Condition 2 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Condition 3 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

If you have more than 3 conditions, please photocopy and provide full details.

1. When did you last receive treatment for this condition?

0-6 months	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
6 months - 1 year	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
1 - 2 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
2 - 3 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
3 - 5 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
5 -7 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
7 - 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
More than 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>

2. When did you suffer symptoms for this condition?

0-6 months	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
6 months - 1 year	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
1 - 2 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
2 - 3 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
3 - 5 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
5 -7 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
7 - 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
More than 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>

3. How long ago were you last hospitalised for this condition?

0-6 months	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
6 months - 1 year	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
1 - 2 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
2 - 3 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
3 - 5 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
5 -7 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
7 - 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
More than 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>

Your current medication

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

Dose prescribed

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

Frequency

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

**Your dependant's details**

Condition 1 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Condition 2 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Condition 3 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

If you have more than 3 conditions, please photocopy and provide full details.

1. When did you last receive treatment for this condition?

0-6 months	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
6 months - 1 year	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
1 - 2 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
2 - 3 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
3 - 5 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
5 -7 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
7 - 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
More than 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>

2. When did you suffer symptoms for this condition?

0-6 months	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
6 months - 1 year	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
1 - 2 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
2 - 3 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
3 - 5 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
5 -7 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
7 - 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
More than 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>

3. How long ago were you last hospitalised for this condition?

0-6 months	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
6 months - 1 year	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
1 - 2 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
2 - 3 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
3 - 5 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
5 -7 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
7 - 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>
More than 9 years	Cond 1 <input type="checkbox"/>	Cond 2 <input type="checkbox"/>	Cond 3 <input type="checkbox"/>

Your current medication

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

Dose prescribed

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

Frequency

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_



Please complete a separate questionnaire if one is required for both the applicant and the dependant.

Applicant  Dependant

Name \_\_\_\_\_

### Supplementary Questionnaire - Heart attack, angina or any other heart condition

Only complete if you have indicated on pages 4 and/or 5 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your heart condition.

**Have you ever been diagnosed with any of the following?**

- Heart attack       Aortic aneurysm       Atrial fibrillation (AF)       Angina       Enlarged heart  
 Heart valve disorders       Heart failure       Cardiomyopathy

Other (please specify) \_\_\_\_\_

Please provide full details including date(s) of diagnosis, all subsequent hospital treatments and current symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

If 'yes', please give full details: \_\_\_\_\_

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

- Coronary artery bypass graft (CABG)       How many arteries \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Angioplasty/stents       Number of arteries treated \_\_\_\_\_ Date(s) \_\_\_\_\_

Other surgery (please give details and date of procedure):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your heart condition affect you in any of the following ways?	Never	Occasionally	Always
Breathlessness walking from room to room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains on minor to moderate activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains on severe exertion only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of dizziness or blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please give, if known, your latest:**

Blood pressure reading: \_\_\_\_\_ Date: \_\_\_\_\_

Cholesterol reading: \_\_\_\_\_ Date: \_\_\_\_\_

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

Name of medication	Name of heart condition	Dose prescribed
1		
2		
3		
4		
5		

Are you currently under the care of a cardiologist? Yes  No  Last consultation date

Name of cardiologist \_\_\_\_\_

Name of hospital \_\_\_\_\_

How many times have you been admitted to hospital due to your heart condition within the past 10 years?

Never  Once  Twice  Three times  More than three times

Is any future treatment planned? Yes  No

If 'yes', please give full details: \_\_\_\_\_  
\_\_\_\_\_

Are you awaiting the results of any investigations? Yes  No

If yes, please advise for what \_\_\_\_\_

Date \_\_\_\_\_

Please provide any further information you think may be important, including any family history of cardiovascular (heart) disease or the date of any stress (exercise) ECG testing, e.g. using a bicycle or treadmill.

\_\_\_\_\_  
\_\_\_\_\_

Please complete a separate questionnaire if one is required for both the applicant and the dependant.

Applicant  Dependant

Name \_\_\_\_\_

## Supplementary Questionnaire - Diabetes

Only complete if you have indicated on pages 4 and/or 5 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your diabetes.

**When was your diabetes diagnosed? Date** \_\_\_\_\_

**How is your diabetes controlled?**

Diet

Non-Insulin (tablet)

Insulin

Please list all the medication you currently take, and how often you take each of them

If this has changed, please advise your previous treatment regime:

Date altered:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Coronary Heart Disease

Problem with your eyes (retinopathy)

Elevated blood pressure

Diabetic Neuropathy (loss of sensation)

Renal Disease (protein in urine)

Poor circulation

If 'yes', please give full details:

How often do you monitor your own blood glucose levels? \_\_\_\_\_

Blood glucose result: \_\_\_\_\_ fasting/non-fasting (Please delete as appropriate) Date: \_\_\_\_\_

HbA1c: \_\_\_\_\_ Date: \_\_\_\_\_

Cholesterol level: \_\_\_\_\_ Date: \_\_\_\_\_

Blood pressure (BP) reading: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been admitted into hospital as a result of your diabetes? Yes  No

If yes, when? \_\_\_\_\_

Please provide any further information you think may be important, including any family history of diabetes if known.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please complete a separate questionnaire if one is required for both the applicant and the dependant. If you have a history of more than one different type of cancer please complete a separate questionnaire for each.

Applicant  Dependant

Name \_\_\_\_\_

### Supplementary Questionnaire - Cancer, leukaemia, Hodgkin's disease, lymphoma, growth or tumour

Only complete if you have indicated on pages 4 and/or 5 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any hospital letters or reports about your cancer to confirm the type of cancer, stage, grade and treatment received.

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

Where was the tumour located? \_\_\_\_\_

When was the tumour/condition first diagnosed? \_\_\_\_\_

Was the tumour:  Benign  Pre-cancerous  Malignant

Do you know the staging and/or grading of the tumour, for example TNM or Duke classification? Yes  No

If yes, please give details: \_\_\_\_\_

#### Please tick the box which most closely describes the nature of the tumour:

- |   |   |
|---|---|
| <input type="checkbox"/> Only tiny tumour growth (carcinoma in-situ)          | <input type="checkbox"/> Only local tumour growth           |
| <input type="checkbox"/> Tumour invaded adjacent lymph nodes                  | <input type="checkbox"/> Tumour invaded distant lymph nodes |
| <input type="checkbox"/> Tumour spread to distant organs (distant metastases) |   |

If so, where? \_\_\_\_\_

In the case of prostate cancer, please advise where known:

Current Prostate Specific Antigen (PSA) level: \_\_\_\_\_ Date recorded: \_\_\_\_\_

Pre-treatment PSA level: \_\_\_\_\_ Date: \_\_\_\_\_

Gleason Score: \_\_\_\_\_ Date recorded: \_\_\_\_\_

Has there been any spread of the tumour? Yes  No  Not known

If yes, please describe where: \_\_\_\_\_

Has there been any recurrence? Yes  No

If yes, please give details: \_\_\_\_\_

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

Surgery Type of surgery \_\_\_\_\_

Chemotherapy Date commenced: \_\_\_\_\_ Date ended: \_\_\_\_\_

Radiotherapy Date commenced: \_\_\_\_\_ Date ended: \_\_\_\_\_

Bone Marrow Transplant Date commenced: \_\_\_\_\_ Date ended: \_\_\_\_\_

Medication	Dose/frequency	Date commenced	Date ended

Other (please give full details)

When was your last tumour follow-up appointment with your treating doctor/hospital consultant:

Have you now been discharged? Yes  No

If yes, when?

**Please provide any further information you think may be important, including any family history of cancer, if known :**

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Please complete a separate questionnaire if one is required for both the applicant and the dependant.

Applicant  Dependant

Name \_\_\_\_\_

## Supplementary Questionnaire - Stroke

Only complete if you have indicated on pages 4 and/or 5 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your stroke/s.

Please advise which of the following you have suffered from:

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

Episode/type (e.g. stroke, TIA)	Date	Part of body affected	Duration of symptoms	Duration until full recovery
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please tick one box from each of the following that most closely reflects your current condition as a result of your stroke:

**Dressing:**

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

**Mobility:**

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

**Transferring:**

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

**Bladder:**

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

**Bowels:**

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

**Bathing:**

- Dependent
- Independent

**Feeding:**

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

**Other residual problems:**

- Speech difficulties
- Vision impairment
- Paralysis arm
- Paralysis leg

Please give your last blood pressure (BP) reading, if known: \_\_\_\_\_ Date: \_\_\_\_\_

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

Name of your consultant \_\_\_\_\_

Name of hospital \_\_\_\_\_

Please provide any further information you think may be important, including any family history of cerebrovascular disease if known.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Data Protection Act 1998

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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.

This includes the process of underwriting, administration, claims management, rehabilitation and customer concern handling. In order to do this the information may be shared with group companies and third party insurers, re-insurers, insurance intermediaries and service providers.

Your data will be processed fairly and securely in accordance with the Data Protection Act 1998. Details of your rights under the Act, the data which the Provider holds, the data which may be passed to organisations outside of the Provider and the organisations which might be involved, can be obtained by writing to the Providers' Data Protection Officer.

Your personal data will be available to only those who need to see it. For example, 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 Providers' Chief Medical Officer or equivalent.

**Please note** that you are explicitly consenting to the processing of your medical data by signing and returning this document.

You are entitled to receive a copy of all your personal data held by contacting either your Financial Adviser or the Provider.

**Please note** that during the processing of any proposals and administration, information may be transferred outside the European Economic Area. You are consenting to this transfer by signing and returning this document.

## Notice of Statutory Rights

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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

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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.
3. 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.

I/we declare that, to the best of my/our knowledge and belief, the statements above are true and complete and that I/we have not withheld any material information. I/we understand that failure to do so may result in amendment of the policy.

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.

I/we agree that this form together with any statements made to the medical officer form the basis of the contract between me/us and the Provider.

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 Providers behalf.

I/we understand that the Provider reserves the right to offer revised policy terms should they issue the policy and subsequently find that I/we have failed to disclose material facts or misdisclosed material facts.

I/we accept the Provider will use the information I/we give for administration, underwriting, claims, research and statistical purposes. I/we agree the Provider may pass information about my/our physical or mental health or condition to medical practitioners and reinsurers.

I/we agree 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.

I/we agree that a copy of this consent can be treated as the original.

I/we agree to the Provider processing my/our medical data

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 of the policy.

I/we have read and understood my rights under the relevant legislation as detailed overleaf governing access to medical records.

**Please indicate which Provider/s you require annuity quotation terms from:**

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Canada Life   | <input type="checkbox"/> Just Retirement | <input type="checkbox"/> Legal & General | <input type="checkbox"/> LV=             | <input type="checkbox"/> MGM advantage |
| <input type="checkbox"/> Norwich Union | <input type="checkbox"/> Partnership     | <input type="checkbox"/> Prudential      | <input type="checkbox"/> Scottish Widows |  |

The Provider/s who receive this completed form, may use some of the information to advise you by post or telephone of other products and services offered by themselves or by their business partners.

If you do not wish to receive this material please tick this box.  Applicant  Dependant

### Applicant

- I do wish to see the report before it is sent to the Provider  
 I do not wish to see the report before it is sent to the Provider

### Dependant

- I do wish to see the report before it is sent to the Provider  
 I do not wish to see the report before it is sent to the Provider

The Provider reserves the right to decline any requests.

The Provider is not on risk until a policy is issued by the provider.

I / we have read and understood the notice regarding the Data Protection Act 1998.

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

### Applicant

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Dependant

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



The information contained in this booklet is based on our understanding of current legislation.

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LOOK AT THINGS DIFFERENTLY  
 **BANK OF SCOTLAND**