

# Personal information form

Please fill in this form and return it to us. The information you give us may mean you get a higher income in retirement.

If you're not ready to take your benefits yet, you don't need to fill in this form, however it's important that you call us to let us know.

## **Make sure you complete and return this personal information form**

Please fill in this form and return it to us. If you have any questions just call us on the number provided in your covering letter.

Make sure you answer all the questions as fully as you can. The more we know about your personal circumstances, the better we can tailor your retirement income to suit you.

If any sections or questions are returned blank, we'll make certain assumptions about your health and lifestyle. These assumptions may give you a lower income than if you tell us the answers.

If you're unable to answer all of these questions, please speak to your GP or medical specialist.

Please note, this form is confidential once it's filled in.

### **Why does it matter?**

We can only give you a personalised quote for an annuity if you give us the information we ask for.

This is important because we calculate how much income you'll get from your annuity using the information you give us.

If you don't complete and return this form, you could get a lower income as we'll have to assume things about you that may not be true.

Please be as accurate as you can when you fill in this form. Every bit of information makes a difference. You must answer every question that's relevant to you as we can only offer you a quote if you've fully completed the form. Make sure you tell us about any illnesses you've had as it may mean you get a higher income from your annuity.

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## About you

Plan number(s)

Do you want to provide an income for a spouse, civil partner or financial dependant upon your death?

Yes  No

If Yes, you will also need to complete the dependant's information in the right hand column and any of the medical forms that are applicable.

### Your personal details

	You	Your dependant
Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other (Please specify) <input type="text"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other (Please specify) <input type="text"/>
Forename	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
National insurance number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Home address	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Postcode	<input type="text"/>	<input type="text"/>

Please give us some details in case we need to contact you about anything you've told us on this form.

Daytime telephone number

Mobile number

Email address

### Your personal circumstances

Please tick one box that best describes your personal circumstances

You	
Single	<input type="checkbox"/>
Married	<input type="checkbox"/>
Civil Partnership	<input type="checkbox"/>
Cohabiting	<input type="checkbox"/>
Intend to Marry	<input type="checkbox"/>
Intend to form Civil Partnership	<input type="checkbox"/>
Separated	<input type="checkbox"/>
Separated Civil Partnership	<input type="checkbox"/>
Divorced	<input type="checkbox"/>
Dissolved Civil Partnership	<input type="checkbox"/>
Widowed	<input type="checkbox"/>
Surviving Civil Partnership	<input type="checkbox"/>

## About you - continued

### Your health & lifestyle

We'll use the information you give us in this form to provide you with an annuity quote tailored to your personal circumstances.

#### Height and weight

Please tell us your height  
(in feet and inches or  
centimetres)

ft  in  
 cm

Please tell us your weight  
(in stones and lbs or kilograms)

st  lb  
 kg

Please tell us your waist  
measurement  
(in inches or centimetres)

in or  cm

#### Your dependant

ft  in  
 cm

st  lb  
 kg

in or  cm

#### Smoking

##### You

##### Your dependant

We need to know whether you or your dependant smoke tobacco, and if you do, how often. If you do not complete this section we will assume you are a non-smoker.

I have never smoked



I am a regular smoker



I used to smoke



Have you been a regular daily  
smoker for the last 10 years?

Yes  No

Yes  No

#### If you are a smoker or used to smoke please answer the following questions

Date started

MM  YYYY

MM  YYYY

Date stopped (complete this  
only if you no longer smoke)

MM  YYYY

MM  YYYY

Amount smoked daily

Cigarettes

Cigarettes

Cigars

Cigars

Amount smoked weekly

g or  oz Rolling Tobacco

g or  oz Rolling Tobacco

g or  oz Pipe Tobacco

g or  oz Pipe Tobacco

#### Alcohol consumption

##### You

##### Your dependant

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).

Units

Units

## About you - continued

### Blood pressure

Have you been diagnosed with high blood pressure (hypertension)?

You  
Yes  No

Your dependant  
Yes  No

When was this diagnosed?

Please specify your last 2 blood pressure readings and the dates

over

over

over

over

Do you currently take any medication for this condition?

Yes  No

Yes  No

Please list all medication you currently take for high blood pressure, and how often you take each of them

Medication	Dose (eg 3mg)	How often (eg twice daily)

Medication	Dose (eg 3mg)	How often (eg twice daily)

### High cholesterol

Have you been diagnosed with high cholesterol?

You  
Yes  No

Your dependant  
Yes  No

When was this diagnosed?

Please specify your last 2 cholesterol readings and the dates

#### Reading 1

HDL  LDL

HDL  LDL

Total  mmol/l

Total  mmol/l

Date

Date

#### Reading 2

HDL  LDL

HDL  LDL

Total  mmol/l

Total  mmol/l

Date

Date

Do you currently take any medication for this condition?

Yes  No

Yes  No

Please list all medication you currently take for high cholesterol, and how often you take each of them

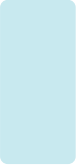








Medication	Dose (eg 3mg)	How often (eg twice daily)

Medication	Dose (eg 3mg)	How often (eg twice daily)

## About you - continued

### Medical conditions

Please complete a separate questionnaire for each medical condition. One is required for both you and your dependant, so if you need extra questionnaires, please contact us using the details on the cover letter. These forms appear over the following pages:

	You		Your dependant		Form page no.		
Please tick the box if you have or have ever had any of the following conditions	I have no other medical conditions	<input type="checkbox"/>	I have no other medical conditions	<input type="checkbox"/>		Please ensure you complete the pension details section on page 18.	
	Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>	8		
	Diabetes	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	9		
	Respiratory	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	10		
	Stroke	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	11		
	Multiple Sclerosis	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	12		
	Neurological	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	13		
	Cancer	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	14		
	Other medical conditions	<input type="checkbox"/>	Other medical conditions	<input type="checkbox"/>	16		

# Heart attack, angina and other heart conditions questionnaire

You  Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your heart condition.

Have you ever been diagnosed with any of the following? Please tick all that apply

Diagnosis	Date of diagnosis	No. of occurrences	Ongoing?	
			Yes	No
<input type="checkbox"/> Heart Attack (myocardial infarction)	MM/YYYY			
<input type="checkbox"/> Angina	MM/YYYY			
<input type="checkbox"/> Heart failure	MM/YYYY			
<input type="checkbox"/> Aortic aneurysm	MM/YYYY			
<input type="checkbox"/> Cardiomyopathy	MM/YYYY			
<input type="checkbox"/> Heart valve disorders	MM/YYYY			
<input type="checkbox"/> Atrial fibrillation (AF)	MM/YYYY			
<input type="checkbox"/> Other irregular heart rhythm	MM/YYYY			
<input type="checkbox"/> Other (please specify):	MM/YYYY			

How often does your heart condition(s) currently affect you in any of the following ways?

	Never	Some of the time	Most of the time	Always
Symptoms at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness walking from room to room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness climbing stairs	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Chest pains on severe exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

			Date of most recent procedure
Coronary artery bypass graft (CABG)	<input type="checkbox"/> Number of arteries	<input type="checkbox"/> Date	MM/YYYY
Coronary angioplasty/stents	<input type="checkbox"/> Number of arteries treated	<input type="checkbox"/> Date	MM/YYYY
Aortic valve replacement	<input type="checkbox"/> Successful? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date	MM/YYYY
Mitral valve replacement	<input type="checkbox"/> Successful? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date	MM/YYYY
Tricuspid valve replacement	<input type="checkbox"/> Successful? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date	MM/YYYY
Pacemaker	<input type="checkbox"/> Successful? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date	MM/YYYY
Cardioversion/ablation	<input type="checkbox"/> Successful? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date	MM/YYYY
Aortic aneurysm repair	<input type="checkbox"/> Successful? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date	MM/YYYY

## Heart attack, angina and other heart conditions questionnaire - continued

What medication(s) are you currently taking for your heart condition(s)?

Medication	Name of heart condition	Dose (eg 3mg)	How often (eg twice daily)	Start date
				MM/YYYY
				MM/YYYY
				MM/YYYY
				MM/YYYY
				MM/YYYY

Are you currently under the care of a cardiologist?

Yes  No

Last consultation date

If yes, name of cardiologist

Name of hospital

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

Last admission date

Is any future treatment planned?

Please tick all that apply

- Coronary artery bypass graft (CABG)
- Coronary angioplasty/stents
- Aortic valve replacement
- Mitral valve replacement
- Tricuspid valve replacement
- Pacemaker
- Cardioversion/ablation
- Aortic aneurysm repair

Please advise date and result of any stress (exercise) ECG testing eg using a bicycle or treadmill

Normal  Abnormal  Other



Please ensure you complete the pension details section on **page 18**.

# Diabetes

You  Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your diabetes.

When was your diabetes diagnosed?

Diabetes type Type 1  Type 2

How is your diabetes controlled? Diet only  Tablets (no insulin injections)  Insulin

What medication are you currently taking for your diabetes?

Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY
			MM/YYYY

If this has changed please advise previous treatment regime

Medication	Dose (eg 3mg)	How often (eg twice daily)	End date
			MM/YYYY
			MM/YYYY
			MM/YYYY
			MM/YYYY

Do you have any of the following?  
Please tick all that apply

Heart disease  Kidney disease (protein in urine)   
 Retinopathy (diabetic eye disease)  Peripheral vascular disease   
 Neuropathy  Amputation

Please tell us your last two readings and dates for HbA1c

**Reading 1**  
 DCCT% or  IFFC (mmol/mol)  
 Date

**Reading 2**  
 DCCT% or  IFFC (mmol/mol)  
 Date

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

If yes, when was your last hospital admission date?

 Please ensure you complete the pension details section on page 18.

## Respiratory/lung disease questionnaire

You  Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your respiratory/lung disease.

Please advise which of the following you have been diagnosed with and when your condition was diagnosed. Please tick all that apply

Name of condition		Date of diagnosis
<input type="checkbox"/>	Chronic obstructive airways/pulmonary disease (COAD/COPD)	MM/YYYY
<input type="checkbox"/>	Bronchiectasis	MM/YYYY
<input type="checkbox"/>	Asbestosis	MM/YYYY
<input type="checkbox"/>	Pleural plaques	MM/YYYY
<input type="checkbox"/>	Emphysema	MM/YYYY
<input type="checkbox"/>	Pneumoconiosis (type of lung disease related to occupation)	MM/YYYY
<input type="checkbox"/>	Asthma	MM/YYYY
<input type="checkbox"/>	Sleep apnoea	MM/YYYY
<input type="checkbox"/>	Other (please specify):	MM/YYYY

How often do any of the following apply?

	Never	Some of the time	Most of the time	Always
Chest infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need for home oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need for continuous positive airway pressure (CPAP) breathing machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness walking from room to room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness when lying flat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral steroids (tablet form only e.g. prednisolone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many times have you been admitted to hospital with this condition?

When was your last admission?  MM  YYYY

What medication are you currently taking for your respiratory/lung condition(s)?

Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY



Please ensure you complete the pension details section on page 18.

## Stroke questionnaire

You  Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your stroke(s).

Please advise which of the following you have been diagnosed with

CVA (Cerebrovascular Accident - major stroke)  SAH (Subarachnoid Haemorrhage)   
 Cerebral haemorrhage/bleed  TIA (Transient Ischaemic Attack - mini-stroke)   
 Don't know

Episode/ type (eg CVA, TIA)	Date	Part of body affected (e.g. arm, leg, speech, vision, memory loss)	Fully recovered (yes/no)	If yes, how long it took for you to fully recover
	MM/YYYY			
	MM/YYYY			
	MM/YYYY			

Please advise of any of the following current and ongoing problems due to your stroke(s). Please tick all that apply

Speech difficulties  Vision impairment   
 Paralysis arm  Paralysis leg   
 Memory loss

What medication are you currently taking for this condition(s)?

Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY

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

Follow-up  Discharged

Name of your consultant

Name of your hospital



If you have completed the 'Stroke questionnaire' you must complete the Activities of Daily Living questions on page 17.

## Multiple sclerosis questionnaire

You  Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your multiple sclerosis.

When was your multiple sclerosis diagnosed?

Please advise subtype if known

Relapsing remitting	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
Primary progressive	<input type="checkbox"/>	Progressive relapsing	<input type="checkbox"/>
Secondary progressive	<input type="checkbox"/>		

Please advise the number of relapses or flare-ups you have had in the last 5 years

What medication are you currently taking for your multiple sclerosis?

Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY

How many times have you been admitted to hospital due to your multiple sclerosis?  Last admission date

Do you have or have you had any of the following in relation to your multiple sclerosis? Please tick all that apply

Bladder incontinence/self-catheterisation	<input type="checkbox"/>
Secondary infection (eg pneumonia)	<input type="checkbox"/>
Mental deterioration	<input type="checkbox"/>
Impairment of vision	<input type="checkbox"/>
Impairment of speech	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>



If you have completed the 'Multiple sclerosis questionnaire' you must complete the Activities of Daily Living questions on page 17.

## Neurological conditions questionnaire

You  Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your neurological condition.

Have you ever been diagnosed with any of the following?  
Please tick all that apply

Condition type	Date of diagnosis
<input type="checkbox"/> Dementia	MM/YYYY
<input type="checkbox"/> Vascular dementia	MM/YYYY
<input type="checkbox"/> Alzheimer's disease	MM/YYYY
<input type="checkbox"/> Parkinson's disease	MM/YYYY
<input type="checkbox"/> Motor neurone disease	MM/YYYY
<input type="checkbox"/> Other (please specify):	MM/YYYY

How many times have you been admitted to hospital with your neurological condition(s)?

Last admission date

Have you had any of the following in relation to your neurological condition(s)?  
Please tick all that apply

Pressure sores   
 Falls   
 Tremors   
 Seizures

What medication are you currently taking for your neurological condition(s)?

Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY

Please advise last MMSE score  /30 if known



If you have completed the 'Neurological conditions questionnaire' you must complete the Activities of Daily Living questions on page 17.

# Cancer, leukaemia, lymphoma, growth or tumour questionnaire

You  Your dependant

**If you have a history of more than one different type of cancer please contact us for a separate questionnaire for each.**

**Please tick the box if you have enclosed 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 of the tumour, for example TNM or Duke classification? Yes  No

If yes, please enter the letter or number or a combination of both in the relevant box:

Dukes	<input type="text"/>	TNM	<input type="text"/>
MAC	<input type="text"/>	FIGO	<input type="text"/>
Clark	<input type="text"/>	Breslow Thickness	<input type="text"/>
Ann Arbor	<input type="text"/>	Other (eg stage 1)	<input type="text"/>

Do you know the grading of the tumour? Yes  No

If yes, what was the grading of the tumour? Grade 1 (low)  Grade 2 (intermediate)  Grade 3 (high)

Please tick the box that most closely describes the nature of the tumour

Carcinoma in situ (stage 0, Tis, Ta)	<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)	<input type="checkbox"/>		

Please advise the number of lymph nodes affected and location

<input type="text"/>	Head, face and neck	<input type="checkbox"/>	Chest	<input type="checkbox"/>
	Abdomen	<input type="checkbox"/>	Armpit or arm	<input type="checkbox"/>
	Groin or leg	<input type="checkbox"/>	Pelvic	<input type="checkbox"/>
	Other	<input type="checkbox"/>		

If your tumour has spread to distant organs (distant metastases), please state where

Brain and central nervous system	<input type="checkbox"/>	Reproductive eg prostate, uterus	<input type="checkbox"/>
Urinary eg kidney	<input type="checkbox"/>	Respiratory eg lungs	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Digestive eg stomach, pancreas	<input type="checkbox"/>
Liver	<input type="checkbox"/>	Heart	<input type="checkbox"/>
Bones	<input type="checkbox"/>	Other	<input type="checkbox"/>

## Cancer, leukaemia, lymphoma, growth or tumour questionnaire - continued

Did you have, or are you due to have, any of the following as a result of your tumour:

Surgery

Type of surgery	Date of surgery
	MM/YYYY
	MM/YYYY
	MM/YYYY

Chemotherapy

Start date:

End date:

Radiotherapy  
(inc Brachytherapy)

Start date:

End date:

Bone marrow/stem  
cell transplant

Start date:

End date:

Hormone therapy

Start date:

End date:

Other  
eg BCG, HIFU,  
Immunotherapy

Name of therapy	Start date	End date
	MM/YYYY	MM/YYYY
	MM/YYYY	MM/YYYY
	MM/YYYY	MM/YYYY

Has there been any recurrence in the same location?

Yes  No

If yes, please advise date

What medication are you currently taking for this condition?

Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY

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

Have you now been discharged?

Yes  No

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:



Please ensure you complete the pension details section on page 18.

## Other medical conditions

You

Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your other medical conditions.

Please tell us about any other medical conditions you have

Condition	Date of diagnosis	Date you last experienced symptoms
1:	MM/YYYY	MM/YYYY
2:	MM/YYYY	MM/YYYY
3:	MM/YYYY	MM/YYYY

What medication are you currently taking?

	Medication	Dose (eg 3mg)	How often (eg twice daily)
1			
2			
3			



Please ensure you complete the pension details section on page 18.

# Activities of daily living questionnaire

You  Your dependant

Please tick one box from each of the following that most closely reflects your current condition(s).

If you complete any of the sections on this page please ensure you tell us which medical condition(s) your answer relates to.

### Dressing:

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

### Condition:

### Mobility:

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

### Condition:

### Transferring:

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

### Condition:

### Bladder:

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

### Condition:

### Bowels:

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

### Condition:

### Bathing:

- Dependent
- Needs some assistance
- Independent

### Condition:

### Feeding:

- Unable (nasogastric tube/PEG tube in place)
- Needs help (cutting, spreading butter, transferring food to mouth etc)
- Independent

### Condition:

### Please advise any progression in the last 5 years:

- Stable (no/minimal change)
- Deteriorating (impact 2 or more ADLs above/acute episodes)
- Rapid deterioration

### Condition:



Please ensure you complete the pension details section on page 18.

## Pension details

### Total pension fund

(only complete one box)

£	before payment of tax-free cash
	net amount after payment of tax-free cash

### Source of funds

Tax free cash required?

Yes  No (tax-free cash already paid)

If yes, please give amount,  
if less than 25%

£

Registered pension scheme

Yes  No

Death in service

Yes  No

Pensions credit

Yes  No

Assumed annuity commencement date

MM YYYY

### Non-protected rights benefits

Pre 06/04/1997

£ Value

Post 05/04/1997

£ Value

### GMP/related benefit

Pre 06/04/1988

£ Value % Escalation rate

Post 05/04/1988

£ Value % Escalation rate

% Revaluation rate

### Annuity options

Payable

Yearly  Half Yearly  Quarterly  Monthly

In advance  In arrears

With proportion  Without proportion

With overlap  Without overlap

Escalation

3%  5%  RPI  LPI  Other

Guarantee

None  5 years  10 years (max)  Other

Payable as lump sum, if possible

Yes  No

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 expected

## Pension details - continued

**This assumes that the annuitant has enough unused Lump Sum Allowance and Lump Sum & Death Benefit Allowance (the 'allowances') to cover the payment of the tax-free cash sum.**

If any of the following applies please provide details:

- the annuitant does not have enough allowances available to cover the tax-free cash sum
- the annuitant has any form of protection or an enhancement factor from HM Revenue and Customs (HMRC)
- the annuitant has a transitional tax-free amount certificate.

## Financial adviser's details

### To be completed by the financial adviser (if applicable)

Name of firm

Contact name

Company address

Postcode

E-mail

Financial Conduct Authority (FCA) reference number

Telephone number

Fax number

On what basis is the quote required?  
 Adviser charge facilitated by Aviva i.e. charge is taken from the fund after tax-free cash. (complete details below)  
 Adviser fee not facilitated by Aviva i.e. a cheque.  
 Full commission\*  
 100% commission rebated\*  
 other commission (please specify)\*

\*With effect from 31st December 2012 these options are only available for non-advised sales.

Adviser Charge details - only complete if this is to be paid out of the pension fund

£  OR  %  
If %,  £ minimum and/or  % maximum

We only facilitate the payment of an adviser charge where you can confirm that advice has been given.

How would you prefer to receive the quote:  
 Post  Fax  E-mail



Next you need to read and sign the declaration on page **21-23**.

## Important information

### Privacy Notice

Aviva Life & Pensions UK Limited is the main company responsible for your Personal Information (known as the controller).

We collect and use Personal Information about you in relation to our retirement and investments products and services. Personal Information means any information relating to you or another living individual who is identifiable by us. The type of Personal Information we collect and use will depend on our relationship with you and may include more general information (e.g. your name, date of birth, contact details) or more sensitive information (e.g. details of your health).

Some of the Personal Information we use may be provided to us by a third party. This may include information already held about you within the Aviva group, information we obtain from publicly available records, third parties and from industry databases, including fraud prevention agencies and databases. Where you are a member of an occupational or workplace pension scheme, or if you join a savings product through your employer, we may obtain information from, and share information with, the employer who set up your pension or savings product, the trustees of the pension and any third parties who are providing services to you or them.

This notice explains the most important aspects of how we use your Personal Information, but you can get more information by viewing our full privacy policy at [aviva.co.uk/privacypolicy](https://aviva.co.uk/privacypolicy) or requesting a copy by writing to us at: **The Data Protection Team, Aviva, PO Box 7684, Pitheavlis, Perth PH2 1JR**. If you are providing Personal Information about another person you should show them this notice.

We use your Personal Information for a number of purposes including providing our products and services and for fraud prevention.

We also use profiling and other data analysis to understand our customers better (e.g. what kind of content or products would be of most interest) and to predict the likelihood of certain events arising (e.g. to assess risk or the likelihood of fraud).

We may sometimes make decisions using automated decision making. More information about this, including your right to request that certain automated decisions we make have human involvement, can be found in the “Automated Decision Making” section of our full privacy policy.

We may use Personal Information we hold about you across the Aviva group for marketing purposes, including sending marketing communications in accordance with your preferences. If you wish to amend your marketing preferences please contact us at [contactus@aviva.com](mailto:contactus@aviva.com) or by writing to us at: **The Data Protection Team, Aviva, PO Box 7684, Pitheavlis, Perth PH2 1JR**. More information about this can be found in the “Marketing” section of our full privacy policy.

Your Personal Information may be shared with other Aviva group companies and third parties (including service providers and regulatory and law enforcement bodies). We may transfer your Personal Information to countries outside of the UK but will always ensure appropriate safeguards are in place when doing so.

You have certain data rights in relation to your Personal Information, including a right to access Personal Information, a right to correct inaccurate Personal Information and a right to erase or suspend our use of your Personal Information. These rights may also include a right to transfer your Personal Information to another organisation, a right to object to our use of your Personal Information, a right to withdraw consent and a right to complain to the data protection regulator. These rights may only apply in certain circumstances and are subject to certain exemptions. You can find out more about these rights in the “Data Rights” section of our full privacy policy or by contacting us at [dataprt@aviva.com](mailto:dataprt@aviva.com)

The Aviva group and its agents would like to contact you from time to time to provide you with updates and offers for Aviva’s products and services tailored to you by direct marketing, by post, phone, email or text.

### Tell us if you do not want to hear from us

#### How we keep you informed

You can tell us below if you would prefer not to hear about Aviva products, services, and promotions. You can always tell us if you change your mind.

- Post
- Email
- Telephone
- SMS/Text

## Declaration and consent

### 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.
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.

**Please read, complete and sign this section.**

I am completing this declaration to allow Aviva to prepare a quotation for an Aviva Pension Annuity/Enhanced Pension Annuity.

If I choose to accept a quotation prepared on the basis of the information given in this form, this declaration will form part of my application for an Aviva Annuity.

I declare that, to the best of my knowledge and belief, the statements above are true and complete and if I have not provided full information this may result in amendment of the plan. The information I give during this application process will be used to assess the terms and extent of the benefits provided within the plan.

If I apply for an Aviva annuity, I agree that Aviva may obtain medical information from any doctor who, at any time, has attended me, about anything that affects my physical or mental health and/or any insurance office to which a proposal has been made on my life and I authorise the giving of such information. This consent shall remain valid throughout the duration of the insurance and after my death.

If I apply for an Aviva annuity, I agree that Aviva may apply for medical evidence. I authorise Aviva to pass medical information to any medical officer on Aviva's behalf.

I understand that Aviva reserves the right to offer revised policy terms should they issue the policy and subsequently find that I have provided incorrect information.

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

I agree to Aviva processing my medical data. I understand that I must inform Aviva without delay if there is a change to my health or circumstances before the commencement of the policy. I understand that failure to do so may result in amendment of the policy.

I understand that the Aviva Pension Annuity plan conditions will apply to my plan.

	You	Your dependant
Doctor's Name	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Telephone number	<input type="text"/>	<input type="text"/>
Fax number	<input type="text"/>	<input type="text"/>

**Aviva 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.**

I do/do not wish to see the medical report before it is sent to Aviva I do  I do not  I do  I do not

Aviva reserves the right to decline any requests.

**I have read the notice regarding Use of personal information.**

Name (BLOCK CAPITALS)	<input type="text"/>	<input type="text"/>
Signature	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="D D M M Y Y Y Y"/>	<input type="text" value="D D M M Y Y Y Y"/>

# Get in touch

If you have any questions you can call us on the number provided in your covering letter.

you can also:

 Email us at [contactus@aviva.com](mailto:contactus@aviva.com)

 Write to us at **Aviva, PO Box 582,  
Bristol BS34 9FX, United Kingdom**

## Need this in a different format?

Please get in touch if you'd prefer this form (**AN15095**) in large print, braille, audio or in a different colour.

**Aviva Life & Pensions UK Limited.**

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[aviva.co.uk](http://aviva.co.uk)

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 **AVIVA**