

# The Impaired Life Property Plan Application Form

## Intermediary Details

Intermediary Name

Telephone Number  Email Address

## Applicant Details

Applicant One

Applicant Two

Name

Application Number

Doctor's Name

Doctor's Address   
Postcode

This Application Form should be completed in conjunction with a Property Plan Application Form, which can be downloaded from our website – [www.retirement-plus.co.uk](http://www.retirement-plus.co.uk)

## Health Questionnaire

Please be aware that if you have not answered 'Yes' to at least one of the parts in this Question, for at least one applicant, it is unlikely that we will be able to improve our standard Property Plan terms.

If you have misrepresented your state of health you will not be offered the product.

Applicant One

Applicant Two

1) Have you had or are you currently suffering from one or more of the following diseases?

a) Heart disease, excluding raised blood pressure?

b) Diabetes that requires insulin treatment?

c) Stroke or paralysis?

d) Longstanding breathing problems (excluding asthma)?

e) Circulatory disease?

f) Liver disease that requires long term treatment?

g) Longstanding obesity?

h) Hepatitis C or HIV infection?

	Yes	No	Yes	No
a) Heart disease, excluding raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Diabetes that requires insulin treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Longstanding breathing problems (excluding asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Circulatory disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Liver disease that requires long term treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Longstanding obesity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Hepatitis C or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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2) Do you smoke or use any tobacco products?

If Yes, please give details:

a) Cigarettes (number per week)

b) Other (specify and state number per week)

Applicant One Applicant Two

Input fields for cigarette consumption

Input fields for other tobacco products

3) What is your alcohol consumption per week?

One unit is the equivalent of one glass of wine, or a half pint of normal strength beer, or a single pub measure of spirits

Input fields for alcohol consumption

Units

Units

4) Have you ever been advised to reduce your consumption of tobacco or alcohol?

Yes No Yes No

Response checkboxes for question 4

If you have answered 'Yes' to the above, please give details.

Large text area for providing details for question 4

5) a) What is your height (without shoes)?

Height input for Applicant One

Height input for Applicant Two

b) What is your weight (in indoor clothing)?

Weight input for Applicant One

Weight input for Applicant Two

Further Details

If you have answered 'Yes' more than once in Question 1 then please answer the questions below

Condition

Applicant One

Applicant Two

What was the diagnosis?

Diagnosis input for Applicant One

Diagnosis input for Applicant Two

When was the diagnosis made?

Diagnosis date input for Applicant One

Diagnosis date input for Applicant Two

Are you still experiencing symptoms?

Yes No

Yes No

Response checkboxes for Applicant One

Response checkboxes for Applicant Two

If so, please describe them

Text area for describing symptoms (Applicant One)

Text area for describing symptoms (Applicant Two)

Applicant One

Applicant Two

When did you last see your GP with this condition?

Have you consulted a specialist?

Yes

No

Yes

No

If so, please give the name and hospital

What investigations were done?

What were the results?

Are you waiting any results?

Yes

No

Yes

No

If so, please give the likely date for the results if known

Are you waiting any follow up or review?

Yes

No

Yes

No

If so, please give details

What medication/treatment has been prescribed for you?

## Access to Medical Reports

Retirement Plus will, via its agent, Third Party Claims Management Limited, who is responsible for underwriting your application, wish to approach your doctor for a medical report concerning your health. The report will be gathered by Medical Evidence Report Services, a company who specialise in gathering medical evidence.

Before this is done you will be notified so that you can, if you wish, exercise your rights under the Access to Medical Reports Act 1988 or the Access to Personal Files.

### Your rights

Your rights are summarised below:

- ▶ You may arrange to see the report before it is sent to Third Party Claims Management or during the 6 months after that;
- ▶ You may withhold your consent to your doctor sending the report to Third Party Claims Management or their agent;
- ▶ You have the right to ask your doctor to change parts of the report that you consider inaccurate or misleading. If your doctor is not in agreement with the changes you may add your own comments to the report

You should be aware that your doctor is able to withhold the report (or part of it) from you if he believes you would be harmed by seeing it. We may from time to time need to process personal data about you which the Data Protection Act 1998 defines as sensitive, including this health information. By providing this data you signify your consent to such data being processed by Retirement Plus and any subsequent owner of your Property Plan.

Space for further information

### Declarations

- ▶ I declare that the above is true and complete to the best of my knowledge and belief
- ▶ I will tell Retirement Plus immediately in writing if there is a change in my health or any other matter which affects this application form between the date I signed this form and when I enter into the Property Plan
- ▶ I agree that this Declaration and any other statement made by me will be used in the calculation of any terms offered
- ▶ I have read the notes describing my/our rights under the Access to Medical Reports Act 1988 and I consent to Medical Evidence Report Services seeking information from any doctor who has attended me concerning my physical or mental health and I authorise the giving of that information. I understand that such a report will be requested
- ▶ I wish to see the report before it is sent to Medical Evidence Report Services. Unless I have ticked this box  I confirm that I do not wish to see a copy of the report before it is sent. I am aware that I may approach my doctor with a request to see a copy within 6 months of its completion
- ▶ I agree that a copy of this form shall have the same validity as the original

	Applicant One	Applicant Two
Signature	<input type="text"/>	<input type="text"/>
Name	<input type="text"/>	<input type="text"/>
Date	<input type="text"/>	<input type="text"/>

For office use only

## Broker Contact Centre

Retirement Plus Ltd, Newcombe House, 45 Notting Hill Gate, London W11 3LQ

Open Monday to Friday 9am to 5pm

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[www.retirement-plus.co.uk](http://www.retirement-plus.co.uk)

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