ROYAL LONDON IRELAND

Medical Examination Form

Name:

Date of Birth: D D M M Y Y Y Y

Policy Reference:

1. Medical questionnaire

Answers by the Life to be Assured to questions put to him/her by the Medical Examiner. We would appreciate details regarding dates of diagnosis, treatment, name and address of specialists that may have been attended and whether a full recovery has been made.

The Disability Act 2005 prohibits processing of genetic data in relation to insurance. Therefore you should not disclose any genetic test or the results of any genetic test you may have had. You must however, tell us if you are having treatment or have had treatment for, or are experiencing symptoms of a genetic condition. You will also be asked to give us full information about your family history, including all genetic conditions.

			If **YES**, please provide details:
1.	Have you ever suffered from or had investigations or required medical attention for the following:		
a.	Anxiety, depression, eating disorder, nervous breakdown, psychiatric disorder, stress or insomnia?	Yes ☐ No ☐	
b.	Asthma, bronchitis, pleurisy, pneumonia, tuberculosis, sarcoidosis, persistent cough or any disease of the lungs?	Yes ☐ No ☐	
c.	Fainting, epilepsy, blackouts, any tremor, dizziness, numbness, pins and needles, or visual disturbance not corrected by lenses?	Yes ☐ No ☐	
d.	Multiple sclerosis, any form of paralysis, or any disease or disorder of the nervous system?	Yes ☐ No ☐	
e.	Stroke, high blood pressure, chest pain, palpitations, breathlessness, high cholesterol, heart attack, angina or any disease or disorder of the heart or circulatory system?	Yes ☐ No ☐	
f.	Diabetes or any disorder of the kidneys, bladder, urinary or reproductive system?	Yes ☐ No ☐	
g.	Recurrent indigestion, gastric or duodenal ulcer, irritable bowel syndrome, colitis, Crohn's disease or any disease or disorder of the stomach, bowel, liver, pancreas or spleen?	Yes ☐ No ☐	
h.	Rheumatoid arthritis, Osteoarthritis, rheumatic fever, gout, disc problems, whiplash, sciatica, or any disorder of the back, neck or joints?	Yes ☐ No ☐	
i.	Any form of cancer, tumour, lump, cyst, mole, swollen glands or growth?	Yes ☐ No ☐	If **YES**, confirm date, site and whether benign or malignant:
j.	Any disorder of the skin, eyes, ears or any defect of hearing or sight?	Yes ☐ No ☐	

1. Medical questionnaire continued

2. Have you:

If **YES**, please provide details

a. Had any disease, injury or disability not mentioned above? Yes ☐ No ☐

b. Had or are you contemplating any other medical investigations, blood tests or check-ups with a GP or specialist? Yes ☐ No ☐

3. Are you taking any medicine or drug at present (whether prescribed or not)? Yes ☐ No ☐

If **YES**, please provide the name of the drug and reason

4. Have you:

If **YES**, please provide details

a. Ever taken drugs for other than medical purposes? Yes ☐ No ☐

b. Ever had in-patient treatment for alcohol or drug abuse or been given medical advice to reduce or stop your alcohol intake? Yes ☐ No ☐

5. Have you ever tested positive for HIV, hepatitis B or hepatitis C or are you awaiting the results of such a test? Yes ☐ No ☐

If **YES**, please provide details

6. Have you had at any time in the past or are you on a waiting list for: a surgical operation, X-Ray,ECG, blood test, investigation or treatment at a hospital, clinic or nursing home? Yes ☐ No ☐

If **YES**, please provide details

7. Do you drink alcohol? (If **YES**, please advise) Yes ☐ No ☐

a. How many units of alcohol per week? Units

b. Has this level changed in the past 10 years? Yes ☐ No ☐

If **YES**, please provide full details

8. Do you smoke or use e-cigarettes or any other nicotine replacement products? (If **YES**, please advise) Yes ☐ No ☐

a. What is your daily consumption? Cigarettes/Cigars/Tobacco/Nicotine Replacement Product *(please circle one type)*

b. If non smoker now, please advise whether you smoked or used e-cigarettes or any other nicotine replacement products in the past? Yes ☐ No ☐

If **YES**, please advise your previous daily consumption and when you stopped smoking/using e-cigarettes or a nicotine replacement product.

Cigarettes/Cigars/Tobacco/Nicotine Replacement Product *(please circle one type)*

Stopped: D D M M Y Y Y Y

1. Medical questionnaire continued

9. Is there any family history of kidney disease, diabetes, stroke, hypertension, heart disease, cancer, multiple sclerosis or hereditary/familial disorder (such as Huntington's Disease, Polycystic Kidney Disease)? Yes ☐ No ☐ If cancer, please state location and type and age at diagnosis:

Relative	Age	If living, please advise state of health	Age at diagnosis	If deceased, please advise cause of death and age
Father				
Mother				
Sisters				
Brothers				

We understand this information is very personal. It will only be used to underwrite your application, in the event of a claim or if your case is selected for review – internal, by our Reassurers or Medical experts.

Our Privacy Notice explains how we use your personal data, how long we keep your personal data for, our 'lawful basis' for processing your personal data and your rights under data protection laws applicable in Ireland. You will find the full Privacy Notice at **www.royallondon.ie/privacy-policy.**

I declare that to the best of my knowledge and belief, the information I have given in response to the questions asked in this questionnaire is true and complete and that these questions have been answered honestly and with reasonable care. I acknowledge that Royal London Ireland will use the information I give to assess the policy application.

Where I have provided information in respect of another person (such as family medical history), I have their consent to do so and that person understands that their personal information is being processed in line with the Royal London Ireland Privacy Policy, which I have provided to them.

Also, I agree to inform Royal London Ireland of any changes to the answers and statements in this questionnaire between now and the commencement of the policy.

I understand that if I didn't answer the questions asked in this questionnaire fully, honestly and to the best of my knowledge and with reasonable care, and misrepresentation is discovered or, if I didn't tell Royal London Ireland about a change to anything that would affect any of the answers to the specific questions in this questionnaire between the date of the application and the cover start date, this may result in:

- delays in the processing of a claim;
- a reduction in the claim amount or a refusal of a claim;
- the policy being treated as if it had been entered into on different terms; or
- the policy being cancelled from the start date with any subsequent claim not being paid.

By signing below, I consent to Royal London Ireland processing the medical and other information that I have provided in this questionnaire in accordance with this declaration.

Signatures		Date of signature/s
Signature of the Life to be Assured:		D D M M Y Y Y Y
Signature of Medical Examiner:		D D M M Y Y Y Y

2. Examination of the Life to be Assured

10. Is the Life to be Assured a patient of your surgery?
If the Life to be Assured is not a patient, please delete all medical data on completion of the examination.

Yes ☐ No ☐ If **YES**, please advise for how long

11. Please describe the general appearance and build.

12. Is there any apparent abnormality?

Yes ☐ No ☐ If **YES**, please provide full details

13. Height ____ feet ____ inches ____ or cm

14. Weight ____ st ____ lb ____ or kg

15. Chest girth – Inspiration ____ in ____ or cm

16. Chest girth – Expiration ____ in ____ or cm

17. Abdominal girth ____ in ____ or cm

18. Has the weight changed in the last year?

Yes ☐ No ☐ If **YES**, please provide full details

Please examine the following systems and report any abnormalities found.

19. Cardio-Vascular System

a. Is there any abnormality?

Yes ☐ No ☐ If any known abnormality, please give date and result of all investigations

b. Is there any abnormality of the heart sounds and rhythm?

Yes ☐ No ☐

c. Please advise the position of the apex beat.

d. Please describe all murmurs. If murmur is audible please advise whether systolic/diastolic, appears functional (innocent or not and grade intensity i.e. (1–4/6)

e. Blood Pressure

	First reading	Subsequent reading *(required if the 1st reading is over 140/90, 5th phase)*	Further reading on another day *(required if the BP readings are persistently raised)*
Systolic			
Diastolic *(to be at fifth phase i.e. cessation of sound)*			
Pulse Rate/Rhythm *(if over 90 please recount at the end of the examination)*			

2. Examination of the Life to be Assured continued

20. Respiratory System
Is there any abnormality in the respiratory movements and sounds?

Yes ☐
No ☐

If there is evidence of past or present disease please record Peak Flow Rate

21. Nervous System

a. What is the condition of the ears?

Please comment on hearing in both ears

b. What is the condition of the eyes?

Please comment on vision in both eyes

c. Are there any abnormalities of the reflexes, the motor or sensory systems?

Yes ☐
No ☐

If **YES**, please provide full details

d. Are there any abnormalities of co-ordination?

Yes ☐
No ☐

If **YES**, please provide full details

22. Digestive Organs

a. Is there any abnormality of the teeth, gums, tongue or throat?

Yes ☐
No ☐

If **YES**, please provide full details

b. Is there any abnormality of the abdomen apparent on palpation?

Yes ☐
No ☐

If **YES**, please provide full details

c. Is there any evidence of hernia?

Yes ☐
No ☐

If **YES**, please provide full details

23. Musculo Skeletal
Is there any muscular or bony abnormality, or impairment of spinal or joint function?

Yes ☐
No ☐

If **YES**, please provide full details

24. Genito-urinary System
Is there any evidence of disease of the bladder or kidneys or any other part of the Urogenital System? (Examination is not required)

Yes ☐
No ☐

If **YES**, please provide full details

2. Examination of the Life to be Assured continued

25. Urine

The sample should be passed at the time of the examination. If protein/blood/glucose are found – please repeat urinalysis on an early morning sample (fasting where glycosuria) – if the abnormality persists please send sample to the laboratory for microscopic urinalysis/C&S. Repeat samples are not required for those menstruating where blood is found in the urine.

a.	Is albumen present?	Yes ☐	No ☐	If **YES**, please provide full details
b.	Is sugar present?	Yes ☐	No ☐	
c.	Is blood present?	Yes ☐	No ☐	
d.	Is there any other abnormality?	Yes ☐	No ☐	

26. Female Lives

a.	Any history of an abnormal smear test/mammogram or breast ultrasound?	Yes ☐	No ☐	If **YES**, please provide full details
b.	Is there history of complications related to pregnancy?	Yes ☐	No ☐	
c.	Is she currently pregnant?	Yes ☐	No ☐	

27. Additional Observations

Is there anything else you would like to bring to the Company's notice, or have you suggested anything to the client that should be followed up on or warrants further investigation?

Signed:

Qualifications:

Date: D D M M Y Y Y Y

Name and Address:
(in capitals please, required for payment)

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