Confidential Client Medical Questionnaire

APPLICANT 1 NAME: _____

APPLICANT 2 NAME: _____

DATE: _____

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Company No.: NI 606059 Registered in Northern Ireland

IT IS YOUR DUTY TO FULLY AND ACCURATELY DISCLOSE ALL MATERIAL FACTS

PROTECTION

What Life/Critical Illness/Income Protection/ Cover do you currently have?

App 1/2/Jnt	Provider Name	Policy Number	Type of Cover	Level of Cover	Level/Indexed Decreasing	Commenced/ End Dates	Monthly Premium

Buildings and Contents Cover

Current Insurer:	
Policy Number:	
Monthly Premium:	
Renewal Date:	

Protection Requirements

Have you considered the impact if

1. **You died tomorrow?**
2. **You had a Heart Attack/ Cardiac Arrest/Stroke/Accident**
3. **You were diagnosed with Cancer/Multiple Sclerosis/Motor Neuron Disease**
4. **You were off work long term sick?**
5. **You lost your job?**

How would your and your family's lifestyle be affected?
How long would your savings last?
How much income would you have and what is the shortfall between income and outgoings?

Which of the following are important to you, for your wife/husband/partner/children in the event of serious illness or death?
Please Tick as appropriate or add your own priorities

LIFESTYLE	ESSENTIAL	DESIREABLE	NO
To remain in the family home (afford running costs)			
Wife/Husband can stay at home to look after children			
Daily Living Expenses Covered at current standards			
Car			
Pay privately for help with care			
Pay privately for Medical Treatment			
Holidays			
University Education / childcare			
Hobbies and Entertainment			
Current Toys/Gadgets/Fashion			
Deposits for children's first home.			
Wedding costs for children			
Help with children's cars			

What is the monthly income required to provide this?

Benefits 2022/23
SSP - paid by employers up to 28 weeks of sickness - £99.35 pw
ESA - £77..00 (single over 25) (£61.04 18-24) or £121.05 (couple)

How would your family react to living like this?

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GP Details

	Applicant 1	Applicant 2	
Name of Surgery/GP			
Address of Surgery			
Telephone Number			
Do you wish to see the GP report before being sent to the insurer? (This will delay your application).		**Yes/No**	**Yes/No**

Personal Details

	Applicant 1	Applicant 2
Have you ever been turned down or been offered special terms by any Company?	Yes / No	Yes / No
Have you ever made an Income Protection claim or Critical Illness claim?	Yes / No	Yes / No
Height		
Weight		
Waist size (men) / skirt size (women)		
Have you recently lost/gained weight you can't explain? If so how much and over what period and reason?		
How many of the following do you drink on average per week		
Pints of Beer, Cider or Lager:		
Small glasses of wine (175 ml):		
Large glasses of wine (250ml):		
Single measures of spirits, shots or bottles of alcopops:		
How many units between Mon-Thurs / Fri-Sun	/	/
Have you ever reduced the amount of alcohol you drink for any of the following reasons? • You were advised by a medical professional? • Alcohol was causing or contributing to health problems? • Alcohol impacted your work or your ability to carry out your day to day activities?		
Which of the following describes you:		
Have you ever smoked? including e-cigarettes.	Yes / No	Yes / No
Date started / stopped	/	/
How many cigarettes do you smoke per day?		
Smoke occasionally or socially only?	Yes / No	Yes / No
Have you ever used Nicotine replacement products?	Yes / No	Yes / No
Give dates started / stopped		
Have you ever used any of the following: Recreational drugs, for example cocaine, cannabis, ecstasy, heroin, methadone etc., Stimulants, sedatives, tranquillisers or anabolic steroids that have not been prescribed by a doctor	Yes / No	Yes / No
If yes please give details		

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Medical History

Have you EVER had or do you currently have any of the following:

Cancer, Leukaemia, Hodgkin's Disease, Lymphoma, Brain or Spinal Tumour	Yes / No	Yes / No
Heart disease (including Heart Attack, Angina, heart defects from birth or heart surgery)	Yes / No	Yes / No
Multiple Sclerosis, Optic or Retrobulbar Neuritis, Parkinson's Disease, Paralysis, Epilepsy, Alzheimer's Disease, Dementia or Cerebral Palsy	Yes / No	Yes / No
Any other disorder of the arteries (including disease in the legs or of the aorta)	Yes / No	Yes / No
Diabetes or sugar in the urine	Yes / No	Yes / No
Mental illness that has required treatment or referral to a psychiatrist	Yes / No	Yes / No
Any nervous or mental disorder – e.g. Anxiety, Stress, Depression, Schizophrenia, Suicide attempt or Nervous Breakdown	Yes / No	Yes / No
Stroke, Mini Stroke, Transient Ischaemic Attack (TIA), Brain Haemorrhage, Brain Aneurysm or Brain Damage?	Yes / No	Yes / No
Blurred or double vision, numbness, loss of feeling or muscle power, balance problems, or persistent pins and needles or facial pain serious enough to seek medical advice?	Yes / No	Yes / No

If you answered yes to any questions in this section, please complete the Further Information section

Recent Health

In THE LAST 5 YEARS have you had any of the following:

Asthma or any condition affecting your lungs or breathing (other than hay fever)?	Yes / No	Yes / No
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol	Yes / No	Yes / No
A lump, growth, polyp or tumour of any kind, or a mole or freckle that has bled, itched, become painful, changed colour or increased in size, regardless of whether or not you have consulted a doctor?	Yes / No	Yes / No
Numbness, loss of feeling or tingling of the limbs or face, loss of balance or co-ordination	Yes / No	Yes / No
Seizures, fits, fainting or blackouts	Yes / No	Yes / No
Any problems with your eyes or ears which haven't been fully corrected by glasses/hearing aids?	Yes / No	Yes / No
Any pain or restriction in movement in the back, neck, shoulder or joints (including traumatic injury), a slipped disc, sciatica, rheumatic, arthritic or muscular complaints including gout, repetitive strain injury, neuralgia or fibromyalgia?	Yes / No	Yes / No
Any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, hepatitis, colitis or Crohn's disease)	Yes / No	Yes / No
Any blood disorder	Yes / No	Yes / No
Any thyroid disorder	Yes / No	Yes / No
Any disorder of the kidney, bladder or genitor urinary system (including urinary tract infections and blood or protein in the urine)	Yes / No	Yes / No
Females only – an abnormal cervical smear/mammogram Males only – Prostrate enlargement or raised PSA	Yes / No	Yes / No
Treatment or a positive test for any disease which was transmitted sexually	Yes / No	Yes / No
Any skin disorder – eg eczema, psoriasis or any other skin disorder in the last 5 years	Yes / No	Yes / No

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Have you had any recurrent insomnia or sleeping difficulty or recurrent tiredness or fatigue in the last 5 years	Yes / No	Yes / No
Have you had memory loss, confusion or changes to your concentration levels or communication skills?	Yes/No	Yes/No

Health Consultations

Other than consultations to do with the points on the already mentioned, have you had a medical consultation **in the last 24 months** (eg doctor, consultant, psychiatrist, hospital, clinic, osteopath) How many times?	Yes / No	Yes / No
Have you ever had (or been advised to have) any medical investigation, scan, test or attended hospital **in the last 5 years**?	Yes / No	Yes / No
Are you **under routine medical review** or **awaiting a consultation** with a specialist for any medical condition?	Yes / No	Yes / No
Have you taken any medication which requires a prescription from your doctor or other health professional in the last month?	Yes / No	Yes / No
Have you ever tested positive for HIV, Hepatitis B or C or are you waiting the results of such a test	Yes / No	Yes / No
Within **the last 5 years** have you been exposed to the risk of HIV infection? (through unsafe sex, intravenous drugs abuse, blood transfusion or surgery taken outside the EU).	Yes / No	Yes / No
Have you **ever** undergone any surgical procedure outside the EU or been a recipient of blood products outside the EU	Yes / No	Yes / No
Experiencing symptoms or a condition that you're likely to seek medical advice or treatment for in the near future?	Yes / No	Yes / No
Or do you currently have any physical or mental condition that restricts or causes difficulties in performing your daily activities or your occupation?	Yes / No	Yes / No
Been absent from work or unable to perform your daily activities due to illness, disorder or injury for more than two weeks at a time in last 5 years?	Yes / No	Yes / No
Currently absent from work	Yes / No	Yes / No

COVID-19

Regardless of anything you've told us about have any of the following applied to you in the last 3 months

Tested positive for Coronavirus?	Yes/No	Yes/No
Been personally advised to self-isolate by a medical professional or NHS 111 but have not been diagnosed with Coronavirus and are still self-isolating?	Yes/No	Yes/No
Had direct contact with someone who's been confirmed or suspected to have Coronavirus? You can answer no if the only contact is related to working within the medical profession.	Yes/No	Yes/No
Do you have continuing symptoms, suspected to be Coronavirus such as a continuous cough, high temperature, loss of taste or smell, fatigue or body aches?	Yes/No	Yes/No

If you have answered yes to any of the above, please provide further details, including dates, symptoms, duration, and treatment.

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If you answered Yes to any questions – please provide further details

	Applicant 1	Applicant 2
Name of Condition		
Date first occurred		
Date of last symptoms		
How often do symptoms occur/have symptoms occurred?		
Please give details of symptoms?		
Do you / or have you taken medication?		
From when and for how long?		
Details of Medication taken Name / mg		
How many days have you been off work? Give approximate dates:		
Have you been referred to anyone other than your GP? Provide details		
Have you had scans/test Give details: dates/outcome:		
Have you had, or will you have an operation, or will you need an operation in the future? Give details and dates		
Does condition restrict you from carrying out routine daily activities		
Is the condition ongoing?		
Are you able to carry out your normal duties? If not, please give details		
Are you fully recovered? If not, please give details.		

Additional Information:

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If you answered Yes to any questions – please provide further details

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Name of Condition		
Date first occurred		
Date of last symptoms		
How often do symptoms occur/have symptoms occurred?		
Please give details of symptoms?		
Do you / or have you taken medication		
From when and for how long?		
Details of Medication taken Name / mg		
How many days have you been off work? Give approximate dates:		
Have you been referred to anyone other than your GP? Provide details		
Have you had scans/test Give details: dates/outcome:		
Have you had, or will you have an operation, or will you need an operation in the future? Give details and dates		
Does condition restrict you from carrying out routine daily activities		
Is the condition ongoing?		
Are you able to carry out your normal duties. If not, please give details		
Are you fully recovered? If not, please give details		

Additional Information:

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Have you been referred to anyone other than your GP? Provide details		
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Does condition restrict you from carrying out routine daily activities		
Is the condition ongoing?		
Are you able to carry out your normal duties? If not, please give details.		
Are you fully recovered? If not, please give details.		

Additional Information:

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	Applicant 1	Applicant 2
Name of Condition		
Date first occurred		
Date of last symptoms		
How often do symptoms occur/have symptoms occurred?		
Please give details of symptoms?		
Do you / or have you taken medication		
From when and for how long?		
Details of Medication taken Name / mg		
How many days have you been off work? Give approximate dates:		
Have you been referred to anyone other than your GP? Provide details		
Have you had scans/test Give details: dates/outcome:		
Have you had, or will you have an operation, or will you need an operation in the future? Give details and dates		
Does condition restrict you from carrying out routine daily activities		
Is the condition ongoing?		
Are you able to carry out your normal duties? If not, please give details.		
Are you fully recovered? If not, please give details.		

Additional Information:

If you answered Yes to any questions – please provide further details

Asthma Questionnaire

Please complete if you suffer from/are being treated for Asthma

When did you last experience symptoms of this condition?		
Have you been admitted to hospital within the last 2 years with this condition?		
How many days have you taken oral steroid tablets in the last 2 years?		
How many days have you taken off work or been unable to follow your normal daily activities, because of this condition in the last 2 years?		

Diabetes Questionnaire

Please complete if you suffer from / are being treated for diabetes

Type of diabetes – type 1 or 2		
Date of your last review		
Most recent HBA1C reading		
Have you been on insulin since diagnosis?		
Have you been advised of protein in urine?		
Do you experience tingling or numbness in fingers or toes?		
Have you had any hospital admissions due to your diabetes? If yes please give dates and frequency		
Are you on treatment for raised blood pressure or raised cholesterol due to diabetes?		

Blood Pressure Questionnaire

Please complete if you are being treated/under review for your blood pressure

Date blood pressure was first noted to be raised/lowered		
Date of last blood pressure reading		
Actual reading		
Are you taking medication for this		
Type of medication		
How often is your blood pressure monitored		
Has your treatment been changed in the last 6 months or has the doctor reduced the time between reviews		
Have you ever had any heart or circulatory problems or raised cholesterol?		
Have you ever had any kidney problems such as protein in your urine?		
Do you experience any symptoms or side effects, such as dizziness or headaches?		
Have you ever not taken or stopped treatment without your doctor's approval?		
Are you awaiting hospital referral or investigations for your condition?		

Cholesterol Questionnaire

Please complete if you are being treated/under review for your cholesterol

Date cholesterol was first noted to be raised		
Date of last cholesterol reading		
Actual reading		
Are you on medication?		
Details of medication		
How often is your cholesterol monitored?		
Has your treatment been changed in the last 12 months or has the doctor reduced the time between reviews?		

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Depression/Anxiety/Stress Questionnaire

Please complete if you are being treated/under review for Depression/Anxiety/Stress

Which condition do you suffer from?	
Have you seen any other health professional apart from your GP in relation to your depression/anxiety/stress?	
Have you had any change to your treatment in the last year?	
Please provide details of current medication?	
When did you last experience symptoms of depression/anxiety?	
Have you ever experienced suicidal thoughts/feelings; self-harmed or attempted suicide?	
Was your depression/anxiety linked to a specific event?	
Have you taken any time off work in relation to this condition?	
If yes please give dates	

Family History

Have either of your natural parents, brothers or sisters suffered or died before the age of 65 from any of the following:

	Applicant 1	Applicant 2
Heart Attack, Angina or Stroke	Yes / No	Yes / No
Type 2 Diabetes	Yes / No	Yes / No
Cardiomyopathy	Yes / No	Yes / No
Breast, Ovarian, Colon or Bowel Cancer	Yes / No	Yes / No
Cancer of another site (cancer other than of the ovary, breast, colon or bowel) including lymphoma	Yes / No	Yes / No
Familial Adenomatous Polyposis (FAP) / Polyposis Coli	Yes / No	Yes / No
Multiple Sclerosis	Yes / No	Yes / No
Motor Neurone Disease (MND)	Yes / No	Yes / No
Muscular Dystrophy	Yes / No	Yes / No
Huntington's Disease	Yes / No	Yes / No
Parkinson's Disease	Yes / No	Yes / No
Alzheimer's Disease	Yes / No	Yes / No
Polycystic Kidney Disease	Yes / No	Yes / No
Any other inherited condition that runs in your family and that you have had or been advised to have screening for	Yes / No	Yes / No
None of these, don't know as I have no further contact with family members or don't know as I am adopted	Yes / No	Yes / No

If Yes to Family History please provide further information

Disease		
Family Member		
Age Diagnosed		

Disease		
Family Member		
Age Diagnosed		

Is your mother still alive	Yes / No	Yes / No
Please state the age she is now or the age she died: If dead, please give exact age at death	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n
Is your father still alive	Yes / No	Yes / No
Please state the age he is now or the age he died: If dead, please give exact age at death	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n	Under 60 – y/n 60 – 80 – y/n Over 80 – y/n
If you are unsure of any of the answers, please tell us why:	Yes / No	Yes / No

Occupation Details

What % of your time would you spend doing manual work (standing, walking, lifting, carrying, moving goods, working with tools or machinery)		
Please provide details of machines/tools used.		
What manual work do you carry out		
What % of your time do you spend driving		
Business miles travelled per year (not commuting to and from work)		
Hours worked per week		
Are you likely to travel as part of your occupation to countries where there are areas of internal conflict or insecurity (other than as a member of the Armed Forces)?	Yes / No	Yes / No
Do you work outside of the UK for more than 90 days a year?	Yes / No	Yes / No
Do you have a second job? If yes, what is your occupation?	Yes / No	Yes / No

Does your occupation involve any of the following:-

Working at heights over 15 metres / 50 feet	Yes / No	Yes / No
If so, what is the highest & average height you work at and how often?		
Working under ground	Yes / No	Yes / No
Working under water	Yes / No	Yes / No
Working offshore (eg oil, gas industry)	Yes / No	Yes / No
Working with explosives or firearms	Yes / No	Yes / No
Armed forces	Yes / No	Yes / No
Professional Sports	Yes / No	Yes / No
Aviation (except as a fare paying passenger)	Yes / No	Yes / No

If you answered yes to any of the questions in Occupation Details, please give further details below:

Applicant 1	**Applicant 2**

Lifestyle

How many times a week do you exercise for at least 30 mins:		
Have you ridden a motor cycle on the road in the last 12 months?		
If Yes: what is the cc capacity of your bike?		
How long have you held a motorbike licence?		
What mileage do you do per year?		

Lifestyle Continued:

Have you ever been banned from driving, in a road traffic accident that was your fault or do you have any motoring prosecutions pending?	Yes / No	Yes / No
If yes – how may driving bans have you had		
How many accidents have you had which were your fault:		
Have you had any further points on your licence since your ban?	Yes / No	Yes / No

Residency / Overseas Travel / Sport

During the last three years, have you spent more than 90 days in total in Africa, the Caribbean, Russia, Thailand or Ukraine?	Yes / No	Yes / No
Are you currently living outside of, or during the next 12 months do you intend to spend more than 30 days outside of:		
{The EU or other Western European countries}, {North America}, {Australia or New Zealand}	Yes / No	Yes / No
Do you take part in any of the following activities?		
Underwater diving	Yes / No	Yes / No
Mountaineering or rock climbing	Yes / No	Yes / No
Caving or potholing	Yes / No	Yes / No
Any extreme sport, for example bungee jumping (other than one-off bungee jumps), white water rafting, cliff or free diving, etc.	Yes / No	Yes / No
Flying (other than as a fare paying passenger), hang gliding or paragliding, parachuting, skydiving or base jumping	Yes / No	Yes / No
Motorcar or motorbike racing	Yes / No	Yes / No
Powerboat racing	Yes / No	Yes / No
Trans-ocean sailing or offshore racing	Yes / No	Yes / No
Full contact martial arts, combat sport or boxing	Yes / No	Yes / No
Equestrian sport or private hacking / Horse Riding	Yes / No	Yes / No
Winter sports other than holiday skiing or snowboarding for pleasure	Yes / No	Yes / No

Additional Information

If you take part in Motor Sports please ensure you have included the following information:-
TYPE of racing, MAKE, MODEL and CC of vehicle
How many races and which circuits you race at
How long you have been racing
Give details of any injuries

Direct Debit Details

Account Holder	
Name of Bank	
Branch	
Sort Code	
Account Number	
Preferred Date of Collection (1^{st} – 28^{th})	

Agreed follow up/Action

Mortgage:

Protection/Income Protection:

Buildings and Contents Insurance:

Wills/Pensions/Investments/Commercial Insurance: