



# Retirement Health Form

# Personal Details

Policy number(s):

Please complete this form using black ink and capital letters

	Your details	Your dependant's details
<b>Title (Mr/Mrs/Ms/Other)</b>	<input type="text"/>	<input type="text"/>
<b>First name(s)</b>	<input type="text"/>	<input type="text"/>
<b>Surname</b>	<input type="text"/>	<input type="text"/>
<b>Date of Birth</b>	<input type="text"/>	<input type="text"/>
<b>Permanent residential address</b>	<input type="text"/>	<input type="checkbox"/> As left
<b>Marital status</b>	Single <input type="checkbox"/> Married/civil partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Co-habiting <input type="checkbox"/>	Single <input type="checkbox"/> Married/civil partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Co-habiting <input type="checkbox"/>
<b>Contact details</b>		
Home telephone	<input type="text"/>	<input type="text"/>
Mobile number	<input type="text"/>	<input type="text"/>
Email	<input type="text"/>	<input type="text"/>

Please complete the medical assessment form in section 2 and any other questionnaire that is applicable.

A medical assessment form for the dependant will only be required if you wish to see a quote for a joint life income for life and they are suffering from a condition.

## Section 2 - Medical Assessment

	Your details	Your dependants details
Height	<input type="text"/> ft <input type="text"/> ins <b>or</b> <input type="text"/> cm	<input type="text"/> ft <input type="text"/> ins <b>or</b> <input type="text"/> cm
Weight	<input type="text"/> st <input type="text"/> lbs <b>or</b> <input type="text"/> kgs	<input type="text"/> st <input type="text"/> lbs <b>or</b> <input type="text"/> kgs
Waist measurement	<input type="text"/> ins <b>or</b> <input type="text"/> cm	<input type="text"/> ins <b>or</b> <input type="text"/> cm
Are you a smoker/ have you smoked regularly in the past	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you regularly smoked for the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When did you start smoking? (mm/yy)	<input type="text"/>	<input type="text"/>
How many cigarettes do you/did you smoke a day?	<input type="text"/>	<input type="text"/>
How many cigars do you/did you smoke a day?	<input type="text"/>	<input type="text"/>
How much pipe tobacco do you/did you smoke a week?	grams/ ounces <input type="text"/>	grams/ ounces <input type="text"/>
How much rolling tobacco do you/did you smoke a week?	grams/ ounces <input type="text"/>	grams/ ounces <input type="text"/>
How many units of alcohol do you drink weekly?	<input type="text"/>	<input type="text"/>
<b>(One unit is about half a pint of normal strength beer, lager, or cider, one standard glass of wine, or a single measurement of spirit)</b>		
Have you been diagnosed with high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify date of diagnosis	<input type="text"/> (mm/yy)	<input type="text"/> (mm/yy)

# Medical Assessment continued...

Please specify your last two readings

	Reading	Date
1	/	
2	/	

	Reading	Date
1	/	
2	/	

Please provide details of the medication you are currently taking for your blood pressure.

The dose prescribed, dose frequency and date medication commenced (mm/yy)

Have you been diagnosed with high cholesterol?

Yes  No

Yes  No

If yes, please specify date of diagnosis  (mm/yy)

(mm/yy)

Please specify your last two readings

	Reading (mmol/L)	Date
1		
2		

	Reading (mmol/L)	Date
1		
2		

Please provide details of the medication you are currently taking for your high cholesterol.

The dose prescribed, Dose frequency and Date medication commenced (mm/yy)

**Please describe as much information about your health as possible before signing this form.  
All questions asked are relevant.**

**Medical Conditions**

**If you have ever been diagnosed with any of the following, please only complete the relevant questionnaire(s)**

Heart condition	Page 7-9
Diabetes	Page 10-11
Cancer, leukaemia, lymphoma, growth, or tumour	Page 12-14
Stroke – please also complete the Activities of Daily Living questionnaire	Page 15-16
Respiratory/lung disease	Page 17-18
Multiple sclerosis – please also complete the Activities of Daily Living questionnaire	Page 19-20
Neurological disease – please also complete the Activities of Daily Living questionnaire	Page 21-22
Activities of Daily Living Questionnaire	Page 23

**Other Medical Conditions**

For any other conditions, not covered in the Medical Conditions list above, please complete the questions below (and the Activities of Daily Living questionnaire on page 23)

	<b>Your details</b>	<b>Your dependants details</b>
Condition 1		
Condition 2		
Condition 3		

**Please answer as mm/yy**

	<b>Condition 1</b>	<b>Condition 2</b>	<b>Condition 3</b>	<b>Condition 1</b>	<b>Condition 2</b>	<b>Condition 3</b>
When were you first diagnosed with this condition						
When did you last experience symptoms for this condition?						
When did you last receive medication/ treatment for this condition?						
When were you last admitted to hospital for this condition?						

How many times have you been hospitalised for this condition?

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Have you received any of the following treatments for this condition within the last 5 years? Please tick all that apply.

- Renal Dialysis
- Surgery
- Other

What medication are you currently taking for this condition?

Medication	Dose prescribed	Frequency	Date medication commenced

# Heart attack, angina and other heart conditions questionnaire

Not Applicable

Please indicate who is completing

You     
  Your dependent     
 Name:

**Please complete a separate heart conditions questionnaire if one is required for both you and the dependant**

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

Diagnosis	Date of diagnosis	No. of occurrences	Ongoing?
Heart attack (Myocardial Infarction)			
Angina			
Heart Failure			
Aortic aneurysm			
Cardiomyopathy			
Heart valve disorders			
Atrial fibrillation (AF)			
Other irregular heart rhythm			
Other:			

**Does your heart condition 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"/>

## Heart attack, angina and other heart conditions continued

If surgery has been carried out, please state type of procedure and date of most recent surgery. (please tick all that apply)

<input type="checkbox"/>	Coronary artery bypass graft (CABG)	No. of arteries treated	<input type="checkbox"/>	Date(mm/yy)	<input type="text"/>			
<input type="checkbox"/>	Coronary angioplasty/stents	No. of arteries treated	<input type="checkbox"/>	Date(mm/yy)	<input type="text"/>			
<input type="checkbox"/>	Mitral valve replacement	Successful?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Date (mm/yy)	<input type="text"/>
<input type="checkbox"/>	Aortic valve replacement	Successful?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Date (mm/yy)	<input type="text"/>
<input type="checkbox"/>	Tricuspid valve replacement	Successful?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Date (mm/yy)	<input type="text"/>
<input type="checkbox"/>	Pacemaker	Successful?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Date (mm/yy)	<input type="text"/>
<input type="checkbox"/>	Cardioversion/ablation	Successful?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Date (mm/yy)	<input type="text"/>
<input type="checkbox"/>	Aortic aneurysm repair	Successful?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Date (mm/yy)	<input type="text"/>

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

Name of heart condition	Name of medication	Dose prescribed	Frequency	Date medication commenced

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

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

Is any future treatment planned?  Yes  No



## **Heart attack, angina and other heart conditions continued...**

If yes, please give details

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

Date	Result (Normal/ Abnormal/ Other)

Please provide any further information you think may be important (e.g. dates of multiple surgery)

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# Diabetes questionnaire

Not Applicable

Please indicate who is completing

You

Your dependant

Name:

**Please complete a separate diabetes questionnaire if one is required for both you and the dependent**

When was your diabetes diagnosed?

mm/yy

Is your diabetes?

Type 1

Type 2

How is your diabetes controlled?

Diet only

Insulin

Non-insulin (tablet/injection)

**Please list all the medication you currently take, and how often you take each of them, the dosage and date medication commenced**

Name of medication	Dose prescribed	Frequency	Date medication commenced

**Have you been diagnosed with any of the following diabetic complications? (Please tick all that apply.)**

- Heart disease
- Neuropathy
- Amputation

- Retinopathy (excluding other eye disease)
- Kidney disease (protein in urine)
- Peripheral vascular disease (with ulceration)

**Please give last two reading for HbA1c:**

Reading 1:   mm/yy

Reading 2:   mm/yy

## Diabetes continued...

Have you ever been admitted into hospital as a result of your diabetes?

  

Yes  
No

If yes, when?  mm/yy

How often do you monitor your blood glucose levels      Number of times:

  

Frequency, please tick as appropriate

  

Daily  
Monthly

  

Weekly  
Quarterly

  

Fortnightly  
Half yearly

  

Four-weekly  
Annually

Please provide any further information you think may be important.

# Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Not Applicable

Please indicate who is completing

You

Your dependant

Name:

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

**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?**

  
  
  

TNM

Modified Astler-Coller (MAC)

Figo classification

Dukes classification

  
  

Clark level

Breslow thickness

Ann Arbor classification

**Do you know the grading of the tumour?**

  

Grade 1 (Low Grade)

Grade 3 (High Grade)

  

Grade 2 (Intermediate Grade)

Unknown

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

  
  

Carcinoma-in-situ (stage O, Tis, Ta)

Only local tumour growth

Tumour spread to distant organs (distant metastases)

  

Tumour invaded adjacent lymph nodes

Tumour invaded distant lymph nodes

## Cancer, leukaemia, lymphoma, growth or tumour continued...

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

Current Prostate Specific Antigen (PSA) level:	<input type="text"/>	Pre-treatment (PSA) level:	<input type="text"/>
Date recorded (mm/yy):	<input type="text"/>	Date recorded (mm/yy):	<input type="text"/>
Gleason Score:	<input type="text"/>		
Date recorded (mm/yy):	<input type="text"/>		

**In case of breast cancer, please advise where known**

Breast Cancer Hormone Receptor Status

**Did you have, or are you due to have, any of the following as a result of your tumour or malignant condition (e.g. Leukaemia)**

Surgery

Type of surgery	Date (mm/yy)

	Date commenced (mm/yy)	Date ended (mm/yy)
<input type="checkbox"/> Chemotherapy		
<input type="checkbox"/> Radiotherapy (including brachytherapy)		
<input type="checkbox"/> Bone marrow/stem cell treatment		
<input type="checkbox"/> Hormone therapy		
<input type="checkbox"/> Other (BCG, HIFU, Immunotherapy)		

Please give full details and advise of date of treatment:

**Has there been any recurrence in the same location?**

Yes

No

## Cancer, leukaemia, lymphoma, growth or tumour continued...

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

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

mm/yy

Have you now been discharged?

Yes

No

Please provide any further information you think may be important.

Please complete the Activities of Daily Living questionnaire on page 23

# Stroke questionnaire

Not Applicable

Please indicate who is completing this questionnaire

You

Your dependant

Name:

**Please complete a separate questionnaire if one is required for both you and the dependent.**

**Please advise which of the following you have been diagnosed with:**

- CVA (Cerebrovascular Accident – major stroke)
- Cerebral haemorrhage/bleed
- SAH (Subarachnoid Haemorrhage)
- TIA (Transient Ischaemic Attack – mini stroke)

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

**Please advise of any of the following ongoing problems due to your stroke:**

- Speech difficulties
- Paralysis leg
- Vision impairment
- Short-term memory loss
- Paralysis arm

**What medication are you currently taking for this condition?**

Name of medication	Dose prescribed	Frequency	Date medication commenced

## Stroke continued...

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

Still under follow-up

Discharged

Please provide any further information you think may be important.

Please complete the Activities of Daily Living questionnaire on page 23



# Respiratory/lung disease questionnaire

Not Applicable

Please indicate who is completing this questionnaire

You

Your dependant

Name:

**Please complete a separate respiratory/lung disease questionnaire if one is required for both you and the dependent.**

**Please advise which of the following you have been diagnosed with:**

	Date of Diagnosis
<input type="checkbox"/> Chronic obstructive airways/pulmonary disease (COAD/COPD)	<input type="text"/> mm/yy
<input type="checkbox"/> Emphysema	<input type="text"/> mm/yy
<input type="checkbox"/> Bronchiectasis	<input type="text"/> mm/yy
<input type="checkbox"/> Pneumoconiosis (a type of lung disease relation to occupation)	<input type="text"/> mm/yy
<input type="checkbox"/> Asbestosis	<input type="text"/> mm/yy
<input type="checkbox"/> Asthma	<input type="text"/> mm/yy
<input type="checkbox"/> Pleural plaques	<input type="text"/> mm/yy
<input type="checkbox"/> Sleep apnoea	<input type="text"/> mm/yy
<input type="checkbox"/> Other, please specify <input type="text"/>	

**Is your current lung function:**

Unaffected

Moderately Impaired (FEV1 50%-70%)

Minimally Impaired (FEV1 greater than (70&)

Severely Impaired (FEV1 less than 50&)

**Do any of the following apply due to your respiratory lung condition?**

	Never	Some of the time	Most of the time	Always
Chest Infections	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Need for home oxygen	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Need for continuous positive airway pressure (CPAP) breathing machine	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signs of cor pulmonale (right heart failure due to lung disease)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Breathlessness walking from room to room	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Breathlessness climbing stairs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Breathlessness when lying flat	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Oral steroids (in tablet form only e.g. Prednisolone)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**How many times have you been admitted to hospital for your respiratory/lung disease?**

**Date of last admission (mm/yy):**

## **Respiratory/lung disease continued...**

What medication are you currently taking for this condition?

<b>Name of medication</b>	<b>Dose prescribed</b>	<b>Frequency</b>	<b>Date medication commenced</b>

Please provide any further information you think may be important.

# Multiple Sclerosis questionnaire

Not Applicable

Please indicate who is completing this questionnaire

You       Your dependant

Name:

**Please complete a separate Multiple Sclerosis questionnaire if one is required for both you and the dependant.**

When was your Multiple Sclerosis diagnosed?       mm/yy

Please advise subtype, if known:

Relapsing Remitting       Secondary Progressive  
 Primary Progressive       Progressive Relapsing

Please advise number of attacks in the last 5 years:

How many times have you been admitted to hospital for your Multiple Sclerosis?

Date of last admission (mm/yy)

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Do you have, or have you had, any of the following in relation to your multiple sclerosis?

- Bladder Incontinence/Self-Catheterisation
- Impairment of Vision
- Secondary Infection
- Impairment of Speech
- Progressive Mental Deterioration
- Paralysis of A Limb
- Use of Steroids on more than 1 occasion

## ***Multiple Sclerosis continued...***

Please provide any further information you think may be important.

**Please complete the Activities of Daily Living questionnaire on page 23**

## Other Neurological condition questionnaire

Not Applicable

Please indicate who is completing this questionnaire

You

Your dependant

Name:

**Please complete a separate neurological questionnaire if one is required for both you and the dependent.**

**Please advise which of the following you have been diagnosed with:**

- Senile Dementia
- Vascular Dementia
- Alzheimer's Disease
- Parkinson's Disease
- Motor Neurone Disease
- Other

**Date of diagnosis (mm/yy)**


If other, please specify (including date of diagnosis)

**How many times have you been admitted to hospital for your condition?**


**Date of last admission (mm/yy)**

**Do you have, or have you had, any of the following symptoms in relation to your neurological condition?**

- Pressure Sores
- Falls

- Tremors
- Seizures

**What medication are you currently taking in relation to your neurological condition?**

Name of medication	Dose prescribed	Frequency	Date medication commenced

**Other Neurological condition continued...**

Please advise last MMSE (Mini Mental State Examination) score, if known

/30

Please provide any further information you think may be important.

Please also complete the Activities of Daily Living questionnaire on page 23

## Activities of Daily Living (ADL) questionnaire

Please indicate who is completing this questionnaire

You

Your dependant

Name:

**Please complete a separate ADL questionnaire if one is required for both you and the dependent.**

**Please tick one box from each of the following that most closely reflects your current condition**

**Please advise relevant diagnosis in relation to which you are completing this questionnaire**

### Dressing

Independent (Including Buttons, Zips, Laces etc...)

Dependent, required full assistance

Needs help, but can do about half unaided

### Mobility

Bedridden

In need of daily nursing care

Wheelchair use – permanent

Wheelchair use – non-permanent

Walk with assistance (frame/stick etc...)

Independent (needs no assistance)

### Transferring

Unable, no sitting balance

Major help, can sit unaided

Minor help

Independent

### Bladder

Occasional accident (once a week)

Continent

Incontinent/catheterised/unable to manage alone

### Bowels

Incontinent (or requires enema)

Occasional accident (once a week)

Continent

### Bathing

Dependent

Need some assistance

Independent

## Activities of Daily Living (ADL) continued...

### Feeding

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

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

- Rapid deterioration       Stable  
 Deteriorating (impact to 2 or more ADLs/Acute Episodes)

## How Utmost use your personal information

We take care of the personal information you provide and that we hold for you. For full details of how we handle your data, please see our Privacy Notice on our website at [www.utmost.co.uk](http://www.utmost.co.uk). If you don't have internet access or would prefer a printed copy please call us.

## Declaration and Consent

By signing below I/we understand/consent and accept that:

- To the best of my/our knowledge the information entered on this form is true and accurate
- I/We understand that my/our answers to the Retirement Health Form questions will be used to produce a comparison quote, using the Money Advice Service website tool ([moneyadviceservice.org.uk/annuitiesquotes](http://moneyadviceservice.org.uk/annuitiesquotes))

Your signature

Date

Your dependant's signature

Date





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REST ASSURED

Calls may be recorded for training or monitoring purposes.

Contact us at: Walton Street, Aylesbury, Bucks, HP21 7QW Tel : 0330 159 1530 Fax : 0845 835 5765 : [www.utmost.co.uk](http://www.utmost.co.uk)  
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