INVESTNSHARE
Financial Advice You Can Trust

Medical Insurance Form

* Required

Contact Details

1. Full Name *

Ms. Jo Smyth

2. Telephone *

02812345678

3. Email Address *

4. Home Address *

Private Medical information

5. Date of Birth: *

6. Height *

e.g., 5 ft 7 in or 1.65 m

7. Male - Waist size / Female - Dress Size: *

8. Weight *

10 st 10 lbs or 70 kg

9. DO YOU CURRENTLY HAVE, OR HAVE HAD, ANY OF THE FOLLOWING: *

	Yes	No
Cancer, Leukaemia, Hodgkin's disease, Lymphoma brain or spinal tumour?	◯	◯
Heart Disease (including heart attack, angina, heart defects from birth or heart surgery)?	◯	◯
Blindness, blurred or disturbed vision not fully corrected by glasses or contact lenses, e.g. optic neuritis or glaucoma?	◯	◯
Stroke, Brain Haemorrhage, PIA, Brain Tumour or injury?	◯	◯
Multiple Sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia or cerebral palsy?	◯	◯
Numbness, loss of feeling, tingling, tremor or temporary loss of muscle power?	◯	◯
Diabetes or sugar in the	Yes ◯	No ◯

urine?		
Mental illness that has required treatment or referral to a psychiatrist?		

Health Habits

10. Have you recently lost or gained weight by more than 15 lbs / 7kg? *

- Yes
- No

11. If yes, by how much, over what length of time and for what reason?

12. How many times a week do you exercise for at least 30 minutes? *

Exercise is defined as any activity that causes an increase in body temperature, breathing and/or heart rate. Exercise can include sports like running or cycling or a lifestyle activity like a brisk walk or gardening.

13. Which statement best describes your tobacco usage? *

- Yes - I currently, or have in the past, used tobacco or nicotine products
- No - I've never used tobacco or nicotine products

14. If yes, what do/did you smoke and, on average, how many do/did you smoke a day? If you longer smoke, how long ago was that?

15. Have you been banned from driving or been involved in a road traffic accident that was your fault in the last 5 years, or do you have any motoring prosecutions pending? *

- ◯ Yes
- ◯ No

16. Except in relation to your occupation, have you travelled on a motorcycle on the road in the last 12 months? *

- ◯ Yes
- ◯ No

17. On average how many units of alcohol do you drink per week? What is your normal alcoholic drink? *

1 unit = a single measure of spirits, 1 glass of wine, or a half-pint of beer

18. Have you ever been advised to reduce your drinking on medical grounds? *

- ◯ Yes
- ◯ No

19. Have you ever taken non-prescription drugs? *

e.g. heroin, ecstasy, cocaine

- ◯ Yes
- ◯ No

20. Have you lived or worked outside of the UK for more than 3 months in the last 5 years, or do you intend to do so in the next 12 months? *

- ◯ Yes
- ◯ No

21. Have you ever tested positive for HIV, Hepatitis B or C, or are awaiting the results of such a test? *

- ◯ Yes
- ◯ No

22. Within the last 5 years have you been exposed to the risk of HIV infection? *

HIV can be caught through unsafe sex, intravenous drug abuse, blood transfusions undertaken outside the EU/UK or surgery taken outside the EU/UK). If the result is negative, the fact of having an HIV test will not in itself have any effect on your application terms for insurance.

- ◯ Yes
- ◯ No

Hobbies / Past Times

23. Do you intend to take part in hazardous activities or sports? *

e.g., motor sport, mountaineering, diving or aviation

- ◯ Yes
- ◯ No

24. If yes, please detail below

Recent Medical Information

25. IN THE LAST 5 YEARS HAVE YOU HAD ANY OF THE FOLLOWING *

	Yes	No
A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth?	◯	◯
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol?	◯	◯
Asthma, bronchitis, or any other respiratory disorder?	◯	◯
Deafness or any ear problem?	◯	◯
Seizures, fits, fainting or blackouts?	◯	◯
Any disorder of the eyes or ears, including blurred or double vision, or impaired hearing (You can ignore sight problems corrected by	◯	◯

Yes No

	Yes	No
corrected by glasses or contact lenses)?		
Arthritis, back pain, sciatica, neck, knee or wrist pain or any other joint, bone or muscle disorder (including RSI)?	○	○
Any disorder of the digestive system, liver, stomach, pancreas or bowel (including ulcers, hepatitis, colitis, or Crohn's disease)?	○	○
Any blood disorders?	○	○
Any thyroid disorders?	○	○
Any disorder of the kidney, bladder or genito-urinary system (including urinary tract infections and blood or protein in the urine)?	○	○
Any gynecological disorders: abnormal smear test, etc?	○	○
Prostate enlargement?	○	○
Depression, anxiety, stress, fatigue or nervous breakdown?	○	○
Any skin disorder or allergy?	○	○
Have you ever had (or been advised to have) any medical investigation, scan, test or attended hospital in the last 5 years?	○	○
Are you awaiting any medical consultation, check-up, investigation, scans or tests?	○	○
Have you ever undergone any surgical procedure outside the EU/UK or been a recipient of blood products outside the EU/UK?	○	○

26. Other than consultations to do with the above points, have you had a medical consultation in the last 12 months? *

e.g., Doctor, Consultant, Psychiatrist, Hospital, Clinic Osteopath. You do not need to give details of occasional consultations with your GP for just colds or flu, or for consultations for oral contraceptive pills, smear tests, well woman/man check-ups where the results are normal.

27. If you answered 'Yes' to any of the above questions, please outline the details for each condition, giving the following information, if applicable.

Name of Condition. Date First Occurred. Date Last Occurred. Details of any prescribed treatment or medication? Have your fully recovered? When was your most recent time off work relating to above condition? Are you receiving treatment for this condition? Will you have to have any operation / treatment in the future related to this condition? If so, can you specify the dates this is to occur?

Family Medical History

28. Have either of your natural parents, brothers or sisters been diagnosed with or died before the age of 65 from any of the following? *

	Yes	No
Cancer?	◯	◯
Heart Disease?	◯	◯
Stroke?	◯	◯
Diabetes?	◯	◯
Multiple Sclerosis?	◯	◯
Huntington's Disease?	◯	◯
Polycystic Kidney disease?	◯	◯
Polyposis of the colon?	◯	◯
Alzheimer's?	◯	◯
Parkinson's Disease?	◯	◯
Any other hereditary disorder?	◯	◯

29. If you answered "Yes" to any of the questions in this section, please provide details below.

Please list Family Member (Father, Mother, etc.), their condition and age they were diagnosed

Your Occupation

30. What is your occupation? *

31. What is your Salary? *

32. How long do you receive sick pay from your employer? *

33. How much sick pay do you receive? *

34. DOES YOUR OCCUPATION INVOLVE ANY OF THE FOLLOWING *

	Yes	No
Working underground ?	◯	◯
Working offshore? *i.e., oil or gas industry*	◯	◯
Armed Forces?	◯	◯
Working underwater?	◯	◯
Working with explosives or firearms?	◯	◯
Professional Sports?	◯	◯
Aviation (except as a fare paying passenger)?	◯	◯

35. Do you work at heights over 10 feet? If so, what is the highest and average height you work at, and how often? *

36. What percentage of time would you say you spend doing manual work? *

37. What percentage of time would you say you spend driving? *

38. How many business miles do you travel per year? *

39. How many hours do you work per week? *

40. Are you currently absent from work? *

- ◯ Yes
- ◯ No

41. How many times have you been off work because of illness, an accident, or unemployment, for more than 2 weeks, in the last 5 years? *

42. Do you have a second job? *

- ◯ Yes
- ◯ No

Second Occupation

43. What is your second occupation?

44. What percentage of time would you say you spend doing manual work in your second job?

45. How many business miles do you travel per year in your second job?

46. How many hours do you work per week in your second job?