HEXAGON
FINANCIAL SERVICES

CONFIDENTIAL MEDICAL INFORMATION

IMPORTANT NOTICE - FAILURE TO DISCLOSE RELEVANT INFORMATION IN RESPONSE TO QUESTIONS ASKED MAY RESULT IN NON-PAYMENT OF A CLAIM

LIVES ASSURED

	LIFE ASSURED 1	LIFE ASSURED 2
First name/middle names		
Last name		
Date of birth		
Gender	Please Select	Please Select
Current Address		

EXISTING COVER

Do you have existing life or critical illness cover ?	Yes ☐ No ☐	Yes ☐ No ☐
Will this be cancelled when the new plan starts ?	Yes ☐ No ☐	Yes ☐ No ☐

OCCUPATION AND INCOME – Please note that failure to disclose relevant information may result in non-payment of a claim and the cancellation of your policy. Please answer all questions to the best of your knowledge.

Occupation		
Industry		
How many hours per week do you work?		
What % of manual work do you do?		
What manual work do you carry out? E.g. Bending, lifting, heavy machinery etc		
Do you work: Underground / underwater / offshore / with firearms / explosives / in the TA or Army Reserves? Any other hazardous environment?	Yes ☐ No ☐	Yes ☐ No ☐
Does your job involve working at heights above 40ft? Please give all relevant details		
Business miles travelled per year? (*Please exclude commuting to or from your normal place of work)*		
Do you ride a motorbike, scooter or moped? – please give details		
Have you been banned, convicted of dangerous or careless driving in the last 5 years?		
Have you had any time off work in the last 2 years due to illness or injury? Please give details		

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PASTIMES - Please note that failure to disclose relevant information may result in non-payment of a claim and the cancellation of your policy. Please answer all questions to the best of your knowledge.

Do you, or do you intend to, take part in any hazardous sports or activities – if so, just for pleasure or in competition?		
Mountaineering – how high, enclosed environments, free climbing?		
Diving – is this confined to snorkelling? To how many metres are you certified? Any other details		
Flying – other than fare paying passenger		
Gliding, horse riding, microlighting, motor sport, sailing (Transocean, powerboat, yacht racing), parachuting, potholing/caving?		
Other – additional notes can be added at the end of this form		

LIFESTYLE - Please note that failure to disclose relevant information may result in non-payment of a claim and the cancellation of your policy. Please answer all questions to the best of your knowledge.

Your height	Select your height	Select your height
Your weight	Select your weight Select your weight	Select your weigh Select your weigh
Waist size/ Dress Size	Select your waist / dress size	Select your waist / dress size
Have you ever smoked/vaped? (If yes, please confirm when you last smoked/vaped? Vaping should be disclosed regardless of whether nicotine is present)	Yes ☐ No ☐ If smoked, when did you last smoke?	Yes ☐ No ☐ If smoked, when did you last smoke?
Have you used any form of tobacco or nicotine replacement product in the last 12 months? (If yes what is your typical daily intake and is this cigarettes, cigars, vapour etc.)		
How many alcoholic drinks do you consume in an **average** week? • Pints of beer • Glasses of wine • Measure of spirit	None None None	None None None
Have you ever been advised by your doctor to reduce your alcohol intake?	Yes ☐ No ☐	Yes ☐ No ☐
Have you ever taken recreational drugs e.g. cannabis, ecstasy, heroin, cocaine or anything not prescribed by a doctor?		
During the last 5 years have you ever travelled abroad other than normal holidays of up to 30 days a year? • Please state country, time period, purpose		

Do you intend to in the future – please give details		
How often do you exercise 30 minutes or greater on a weekly basis?	None	None

DOCTORS DETAILS

What is the name, address and postcode of your doctor Telephone number of doctor		

MAIN MEDICAL SUMMARY

HAVE YOU EVER SUFFERED ANY OF THE FOLLOWING? - Please note that failure to disclose relevant information may result in non-payment of a claim and the cancellation of your policy.

Any form of cancer, leukaemia, Hodgkin's disease, tumour, lymphoma or melanoma?	Yes ☐ No ☐	Yes ☐ No ☐
Heart disorder, heart attack, angina, cardiomyopathy or murmur?	Yes ☐ No ☐	Yes ☐ No ☐
Stroke, brain haemorrhage, transient ischaemic attack, brain injury or tumour?	Yes ☐ No ☐	Yes ☐ No ☐
Multiple sclerosis, Parkinson's disease, paralysis, Alzheimer's disease, dementia or cerebral palsy?	Yes ☐ No ☐	Yes ☐ No ☐
Numbness, loss of feeling, tingling, tremor or temporary loss of muscle power?	Yes ☐ No ☐	Yes ☐ No ☐
Blindness, blurred or disturbed vision not fully corrected by glasses or contact lenses, e.g. optic neuritis or glaucoma?	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes or sugar in the urine?	Yes ☐ No ☐	Yes ☐ No ☐
Mental illness that has required hospital treatment or referral to a psychiatrist?	Yes ☐ No ☐	Yes ☐ No ☐

If you have answered YES to any of the questions above, please go to page 6 to provide additional information.

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MEDICAL HISTORY

IN THE LAST 5 YEARS ONLY, HAVE YOU HAD THE FOLLOWING? Please note that failure to disclose relevant information may result in non-payment of a claim and the cancellation of your policy. Please answer all questions to the best of your knowledge.

A lump or growth of any kind; or any mole or freckle that has bled, become painful, changed colour or increased in size?	Yes ☐ No ☐	Yes ☐ No ☐
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol? If raised blood pressure please give last reading	Yes ☐ No ☐	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Yes ☐ No ☐
Breathlessness, bronchitis, sarcoidosis or any lung disease other than asthma?	Yes ☐ No ☐	Yes ☐ No ☐
Epilepsy, dizziness or blackouts?	Yes ☐ No ☐	Yes ☐ No ☐
Deafness or any ear problem?	Yes ☐ No ☐	Yes ☐ No ☐
Arthritis, or any muscle, bone or joint disorder? (including sciatica, back, neck, shoulder or knee pain, RSI or gout)?	Yes ☐ No ☐	Yes ☐ No ☐
Disorder of the digestive system, liver, stomach, pancreas or bowel including ulcers, hepatitis, colitis or Crohn's disease?	Yes ☐ No ☐	Yes ☐ No ☐
Blood disorder or anaemia?	Yes ☐ No ☐	Yes ☐ No ☐
Thyroid disorder?	Yes ☐ No ☐	Yes ☐ No ☐
Any kidney, bladder or other genito-urinary disorder, including blood or protein in the urine, kidney cysts or multiple urinary tract infections?	Yes ☐ No ☐	Yes ☐ No ☐
Stress, anxiety, depression, insomnia, chronic fatigue or any psychiatric or eating disorder?	Yes ☐ No ☐	Yes ☐ No ☐
Any skin disorder or allergy	Yes ☐ No ☐	Yes ☐ No ☐

FEMALE: Abnormal cervical smear, mammogram or had a biopsy of the breast, cervix or uterus?	Yes ☐ No ☐	Yes ☐ No ☐
MALE: Prostate enlargement or raised PSA (prostate specific antigen)?	Yes ☐ No ☐	Yes ☐ No ☐

OTHER THAN FOR MEDICAL CONDITIONS <u>ALREADY MENTIONED</u>, IN THE LAST <u>5</u> YEARS, HAVE YOU?

Had or have been advised to have any medical investigations, scans or blood tests?	Yes ☐ No ☐	Yes ☐ No ☐
Received any form of medical attention at a hospital as an inpatient or outpatient?	Yes ☐ No ☐	Yes ☐ No ☐

If you have answered YES to any of the questions above, please go to page 6 to provide additional information.

GENERAL HEALTH

Please note that failure to disclose relevant information may result in non-payment of a claim and the cancellation of your policy. Please answer all questions to the best of your knowledge.

Are you currently experiencing any symptoms or disorders for which you have not consulted a doctor?	Yes ☐ No ☐	Yes ☐ No ☐
Are you currently taking drugs, medicines or tablets or receiving any other treatment not already mentioned?	Yes ☐ No ☐	Yes ☐ No ☐
Are you currently awaiting a medical consultation or hospital appointment, or awaiting the results of any tests?	Yes ☐ No ☐	Yes ☐ No ☐
Have you ever tested positive for HIV, hepatitis B or C or are you awaiting the results of a test? (If the result was negative, the fact that you have had an HIV test will not affect your application for insurance)	Yes ☐ No ☐	Yes ☐ No ☐
Within the last 5 years have you been exposed to the risk of HIV infection? (This can be through unsafe sex, intravenous drug use or blood transfusions or surgery outside the EU)	Yes ☐ No ☐	Yes ☐ No ☐
Within the last 5 years have you tested positive or been treated for any disease which was transmitted sexually?	Yes ☐ No ☐	Yes ☐ No ☐

If you have answered YES to any of the questions above, please go to page 6 to provide additional information.

ADDITIONAL INFORMATION: IF YOU HAVE ANSWERED YES TO ANY DISCLOSURES THROUGHOUT THE FORM, PLEASE NOW GIVE FULL DETAILS. If needed, please use the notes section at the bottom of the form

Condition diagnosed 1		
Date first occurred D/M/Y		
Date last occurred/suffered D/M/Y		
What are/were the symptoms How often do symptoms occur/ed Any medication – please give full details		
Are you still on medication/or receiving treatment?		
How many days off work have you had relating to the condition? Date you returned to work:		
Dates, type and results of all investigations carried out? Latest readings if applicable?		
Are you due to have an operation, future treatment or awaiting an appointment? Please give dates		
Any other relevant information and details. Please give us as much detail as you can…		

Condition diagnosed 2		
Date first occurred D/M/Y		
Date last occurred/suffered D/M/Y		
What are/were the symptoms How often do symptoms occur/ed Any medication – please give full details		
Are you still on medication/or receiving treatment?		
How many days off work have you had relating to the condition? Date you returned to work:		
Dates, type and results of all investigations carried out? Latest readings if applicable?		
Are you due to have an operation, future treatment or awaiting an appointment? Please give dates		
Any other relevant information and details. Please give us as much detail as you can…		

ADDITIONAL NOTES: Any other notes or details about disclosures made in this form

Are there any other details you feel the provider should be aware of? - FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON-PAYMENT OF A CLAIM

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FAMILY HISTORY:

HAVE ANY PARENTS, BROTHERS OR SISTERS EVER HAD THE FOLLOWING BEFORE THE AGE OF 65?

IF YES TO ANY OF THE BELOW, PLEASE STATE DIAGNOSIS, FAMILY MEMBER AND AGE AT DIAGNOSIS Alzheimer's disease? Cancer? Diabetes? Haemochromatosis? Heart disease? (incl. Cardiomyopathy, heart attack or angina) Huntington's disease? Kidney failure or polycystic kidney disease? Motor neurone disease? Multiple sclerosis? Parkinson's disease? Polyposis of the colon? Stroke? Any other hereditary disorder?		
Please tick this box if you are unable to answer this section due to being adopted or similar circumstances:	☐	☐

TRUSTS – TO BE DISCUSSED WITH YOUR ADVISOR

Will any life cover be placed into Trust?	Yes ☐ No ☐	Yes ☐ No ☐
Additional Trustees: Name: Date of Birth: Address: Additional Trustees: Name: Date of Birth: Address: Additional Trustees: Name: Date of Birth: Address:		
Please state names and addresses of specific beneficiaries: Please indicate the share in percentage:		

PAYMENT DETAILS FOR DIRECT DEBIT

Account Holder :

Name of Bank :

Account number :

Sort Code :

Ideal Collection date :

Submit Form