Lutine
Assurance Services Limited
Your life is our business.

Medical Conditions Questionnaire

Quote Ref. Or Proposal No. (if Known)

Complete the appropriate section(s) only after filling in the Proposal Form

Name of Life to be Assured

If you suffer, or have suffered at any time, from any of the following conditions, please complete the corresponding section(s) of this questionnaire:

Anxiety/Depression	- Section 1	Multiple Sclerosis	- Section 10
Arthritis	- Section 2	Stomach/Bowel Disorders	- Section 11
Asthma/Bronchitis	- Section 3	Diabetes	- Section 12
Epilepsy	- Section 4	Renal/Urinary Tract Disorders	- Section 13
High Blood Pressure	- Section 5	Abnormal Smears	- Section 14
High Cholesterol	- Section 6	Hysterectomy	- Section 15
Chest Pain/Heart Disease	- Section 7	Back Trouble	- Section 16
Murmurs/Structural Defect/Irregular Heartbeat	– Section 8	Growths, Cysts, Lumps & Tumours	– Section 17
Stroke/T.I.A	- Section 9		

The questions should be answered as fully as possible to avoid delay in acceptance. After answering the questions please sign the declaration on Page 10. Please answer only those sections which apply to you. Please use the space provided on Page 10, if necessary.

Section 1 Anxiety/Depression

On what date did you first consult a doctor about this?
What was the diagnosis?
How many attacks/episodes have you had since then? When were they?
Have you ever lost time off work with this complaint? Yes / No When and for how long?
What medication have you been prescribed in the past? (Please give name and dosage, if remembered) Are you taking any now? (Please give name and dosage)
When is your next follow up?
Have you ever been treated as an out-patient at a hospital? Yes / No If Yes, when and where?
Have you been treated as an in-patient? Yes / No If Yes, when, where and for how long? What treatment did you receive?
Was your anxiety/depression triggered by any particular factor? Yes / No If yes, please give details.
Have you ever attempted suicide? Yes / No If Yes, please give brief details and date.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 2 Arthritis

What form of arthritis do you have?
(for example Rheumatoid Arthritis, Osteoarthritis)

When was this first diagnosed?

Which joints are affected?
Are your movements restricted?
How much?

What is the extent of your disability?

Have you had, or been advised to have an operation? Yes / No
If Yes, please give details and dates.

What medication have you been prescribed since diagnosis? (Please give name and dosage, if remembered)
Which, if any are you still taking? (Please give name and dosage)

How often are you being followed up?
By whom?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 3 Asthma/Bronchitis

When was this first diagnosed?

On average, how many attacks do you have each year?
What was the date of the last acute attack requiring consultation with a doctor?

Does your asthma restrict or interfere with your daily activities in any way? Yes / No
If Yes, please provide details
In what circumstances is an attack brought on? (e.g. exercise, stress, allergy)

If you use a peak flow meter and record the results, please state your lowest and highest readings in the last three months.

Do you suffer from nocturnal symptoms? Yes / No
If Yes, how often per week?

What medication have you been prescribed since diagnosis? (Please give name and dosage, if remembered))
Which, if any, are you still taking? (Please give name and dosage)

Have you ever taken oral steroids as medication for your asthma? Yes / No
If Yes, please confirm when.

Do you have regular check-ups? Yes / No
How often?
By whom?

Have you ever been admitted to hospital? Yes / No
If Yes, please confirm when and was it an emergency admission?

Have you ever had time off work with asthma and/or bronchitis? Yes / No
If Yes,, when and for how long?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 4 Epilepsy

When was this first diagnosed?

Did you have a scan or any other tests? Yes / No
Please give details of the results of these, if known.

Does anything seem to bring on your attacks?

Section 4 continues overleaf

What type of attacks are they?
(i.e. “absences” (petit mal), or “fits” (grand mal))

How often do your attacks occur?
How long does each attack last?
When was the last one?

Have there been any episodes of status epilepticus? Yes / No
If Yes, when?

Have you ever lost time off work with this complaint? Yes / No
When and for how long?

What medication have you been prescribed in the past? (Please give name and dosage, if remembered)

What medication are you taking now? (Please give name and dosage)

Do you have regular check ups? Yes / No
Where and with whom?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 5 High Blood Pressure

When was this first diagnosed?
How was it discovered or why was your blood pressure measured at that particular time?

Please give the reading at that time if you know it.

Have any investigations been carried out at any time to discover a cause for this condition? Yes / No
If Yes, what were the results of these investigations?

What medication have you been prescribed in the past? (Please give name and dosage, if remembered))

What medication are you taking now? (Please give name and dosage)

Are you under treatment for any other condition? Yes / No
If yes, please confirm the name of the condition and medication (and dosage) prescribed.

Have tests on your urine always been normal? Yes / No
If no, please give details.

Do you have regular checks? Yes / No
Where and with whom?

Please confirm most recent blood pressure reading and the date it was taken.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 6 High Cholesterol

When was this first diagnosed?
How was it discovered or why was your cholesterol measured at that particular time?

Please give the reading at that time if you know it.

Have any investigations been carried out? Yes / No
If Yes, please confirm what investigations and the results.

What medication have you been prescribed in the past? (Please give name and dosage, if remembered)

What medication are you taking now? (Please give name and dosage)

Are you under treatment for any other condition? Yes / No
If Yes, please confirm the name of the condition and the medication (and dosage) prescribed.

Do you have regular checks?
Where and with whom?

Please confirm most recent cholesterol reading and the date it was taken.

Date Taken: Total Cholesterol:

Triglycerides: HDL: LDL:

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 7 Chest Pain / Heart Disease

What were your symptoms?
When did your symptoms first occur and for how long?

Please confirm what investigations were carried out and the results.

Please confirm the exact diagnosis made.

What medication have you been prescribed in the past? (Please give name and dosage, if remembered)

What medication are you taking now? (Please give name and dosage)

Have you had or are you due to have any surgery? Yes / No
If Yes, please confirm the type of surgery and date

Do you have regular follow ups? Yes / No
Where and with whom?

What was the date of the most recent symptoms/attack?

Do you have any current symptoms? Yes / No
If Yes please provide full details

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 8 Heart Murmurs / Structural Defects / Irregular Heartbeat

When did your symptoms first occur and for how long?
What were your symptoms?

Please confirm what investigations were carried out and the results.

Please confirm the exact diagnosis made.

What medication have you been prescribed in the past? (Please give name and dosage, if remembered)

What medication are you taking now? (Please give name and dosage)

Have you had or are you due to have any surgery? Yes / No
If Yes, please confirm the type of surgery and date.

Do you have regular follow ups? Yes / No
Where and with whom?

What was the date of the most recent symptoms?

Do you have any current symptoms? Yes / No
If Yes, please provide full details

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 9 Stroke / T.I. A (Transient Ischaemic Attack)

When did your symptoms first occur and for how long?
What were your symptoms?

Please confirm what investigations were carried out and the results.

Please confirm the exact diagnosis made.

What medication have you been prescribed in the past? (Please give name and dosage, if remembered)

What medication are you taking now? (Please give name and dosage)

Have you had or are you due to have any surgery? Yes / No
If Yes, please confirm the type of surgery and date

Do you have regular follow ups? Yes / No
Where and with whom?

What was the date of the most recent symptoms?

Do you have any current symptoms? Yes / No
If Yes, please provide full details.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 10 Multiple Sclerosis

When did your symptoms first occur and for how long?
What were your symptoms?

Please confirm what investigations were carried out and the results.

Please confirm the date the diagnosis of Multiple Sclerosis was made.

Please confirm the type of Multiple Sclerosis i.e. Relapsing/Remitting or Progressive.

What was the date of your most recent symptoms?

Do you have any current symptoms? Yes / No
If Yes, do you have symptoms such as:

Limping, mild sensory or visual disturbances? Yes / No

Mild paralysis, occasional incontinence, mild thought disturbances, partial assistance required or a walking cane required? Yes / No

Constant assistance required such as crutches or a wheelchair? Yes / No

What medication have you received in the past? (please give name and dosage, if remembered)

What medication are you taking now? (Please give name and dosage)

Do you have regular follow ups? Yes / No
Where and with whom?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 11 Stomach / Bowel Disorders

When did your symptoms first occur and for how long?
What were the symptoms?

Please confirm what investigations were carried out and the results.

What was the diagnosis? (e.g. Crohns Disease, Ulcerative Colitis, Hernia, Reflux)

Was any medication prescribed? (Please give name and dosage, if remembered)

Are you still taking any medication? Yes / No
(Please give name and dosage)

Have you had an operation? Yes / No
When was it performed and what kind was it?

Have you had any problems since? Yes / No
If Yes, please provide full details.

Section 11 continues overleaf

Are you due to have any operations in the future for this condition?
If yes, please provide full details of type of surgery and date.

Do you currently have any symptoms? Yes / No
If yes, please provide full details.

When was the last recurrence of the condition?

Please confirm if a full recovery has been made.

Are you being followed up? Yes / No

Where and by whom?
If follow ups have ceased please confirm when.

Have you ever been off work with this complaint? Yes / No
If Yes, when and for how long.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 12 Diabetes

When was this first diagnosed?

Please give the name and address of the doctor or clinic treating you.

Do you follow a strict diet?

Is your diabetes treated with:

Diet alone? Yes / No

Diet and tablets? Yes / No Please confirm what tablets are taken : _____

Diet and insulin? Yes / No Dosage: AM Units PM Units

Insulin alone? Yes / No Dosage: AM Units PM Units

Has your treatment been changed during the last 2 years?
If so, please give details.

Please indicate your usual test results by circling the appropriate level.

i. Blood Glucose	less than 8	8.1-9	9.1-11	11 or more
ii. Urine Glucose	negative	Glucose +	Glucose ++	Glucose +++ or more

What was the date and the result of your latest HbA1C glycosylated haemoglobin? Date: Result:

Since treatment began, have you ever had a diabetic coma? Yes / No
Please give dates and any details you know.

Do you, or have you ever suffered from any disease of the heart or circulation, eyes, blood pressure, kidneys (e.g. albumin or protein in urine) or nervous system (e.g. numbness or tingling)? Yes / No
If yes, please provide full details.

Have you ever been off work with this complaint? Yes / No
If Yes, please confirm when and for how long.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 13 Renal/Urinary Tract Disorders

When did your symptoms first occur and for how long?
What were the symptoms?

Have you ever had any investigations? (e.g. cystoscopy, blood tests) Yes / No
If yes, please provide full details to include dates and results.

Please confirm the exact diagnosis and when it was made. (e.g. Cystitis, Kidney Stones, Prostatitis, Pyelonephritis)

Please give details of treatment (name of medication and dosage,, operations etc)

a. Currently

b. In the past

c. Are you due to have any surgery? If yes, please confirm type of surgery and date.

If your symptoms have occurred more than once please give dates and durations.

Are you being followed up? Yes / No
Where and by whom?
If follow ups have ceased please confirm when.

Have you ever been off work with this complaint? Yes / No
If Yes, when and for how long.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 14 Abnormal Smears

Have you ever had an abnormal smear? Yes / No
Please state the date, the diagnosis (if known) and the treatment given.

If you have had normal smears subsequently, please give the dates.

Are you being followed up now? Yes / No
How often and by whom?
If not, when was the last follow up?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 15 Hysterectomy

Have you ever had a hysterectomy? Yes / No
Please give the date and the reason for the operation including confirmation if there was any question of malignancy.

If you received any treatment afterwards, please give full details.

Are you being followed up now? Yes / No

How often and by whom?

If not, when was the last follow up?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 16 Back Trouble

Do you know the precise diagnosis?
Please give details.

Has it kept you off work or affected your lifestyle? Yes / No
If yes, please give relevant dates, durations and details.

Please give details of treatment e.g. names of medication and dosage, physiotherapy etc

a. Currently

b. In the past (if remembered)

c. Are you due to have any surgery? If yes, please confirm the type of surgery and date.

Do you still have symptoms? Yes / No
If no, when was the last time?

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Section 17 Growths, Cysts, Lumps & Tumours

When was it discovered?

What symptoms were / are being experienced?

Where precisely was it?
Is it still there or has it been removed?

If it has been removed, please tell us:

a. When?

b. By Whom? (e.g. surgeon, GP)

c. Where? (e.g. name of hospital)

d. How? (e.g. local anaesthetic, full operation, cryosurgery)

e. How long were you off work?

What treatment have you had following its removal? (e.g. name of medication and dosage, radiotherapy or chemotherapy)

Were any investigations carried out? Yes / No
If yes, please confirm the results.

What in medical terms was the exact diagnosis?
Please also confirm whether benign or malignant.
If malignant, please confirm the staging. (e.g. TNM Classification)

For how long were you followed up and how often?

Are you being followed up or on any treatment now? Yes / No
If yes, please give details.

After answering the questions in this section please complete any other relevant sections and then sign the declaration on Page 10.

Additional Information:

Declaration

I declare that the answers I have provided are truthful to the best of my knowledge, and that I have not withheld any information which may influence the acceptance of my application/proposal. I understand that if any of the answers are later found to be untrue, inaccurate, or intended to mislead the insurers, the insurers will be entitled to declare this insurance invalid and not pay claims or not fully pay claims.

I undertake to inform the insurers of any changes to the answers and information I have provided after the proposal form has been completed and up to the date it is accepted by the insurers.

Signature of Life to be Assured **Date**

Please return form to: Lutine Assurance Services Limited, Underwriting Team, PO Box 1189, Doncaster, DN1 9RP Tel: 0344 854 2074 Fax: 0844 412 4139