PHOENIX WEALTH

FAMILY SUNTRUST

SCHEME PENSION HEALTH QUESTIONNAIRE

Phoenix Wealth, Self Invested Pensions, PO Box 1394, Peterborough, PE2 2TQ.

When to use this form

This form is to be used when you wish to request a Scheme Pension illustration, and on any subsequent review of your Scheme Pension, taking into account your health details.

Important notes

Information in this form is confidential when completed.

- If you need any extra help, please contact the Financial Adviser
- If you need more space to answer any questions simply attach a separate sheet with a note of the part, the question number and the extra information you want to tell us.

Please read this before completing the form.

- In this form the words 'I', 'you', 'your', 'me' and 'my' refer to the Participant/individual, as appropriate, by whom this request is being made.
- 'We' and 'us' means the Scheme Administrator of the Family Suntrust Scheme, Phoenix Wealth Services Limited.
- We abide by the Association of British Insurers policy on genetics, therefore you do not need to tell us about any genetic test you might have had.

1. FAMILY SUNTRUST SCHEME DETAILS (IF KNOWN)

Scheme name	Family Suntrust Scheme (the 'Scheme')
Scheme number	P X ☐☐☐☐☐☐☐☐

2. YOUR DETAILS

Full name (inc title)	
Permanent home address (inc postcode)	
Gender	☐ Male ☐ Female
Date of birth	☐☐/☐☐/☐☐☐☐

3. MEDICAL INFORMATION

Important: Please disclose as much information about your health as possible before signing and dating this form. The Scheme Pension illustration will be provided on the basis of the medical information supplied. Failure to disclose material facts about your health may result, but is not limited to, a reduced pension. Please read the declaration at the end of this form carefully for more information. Material facts are those we would regard as likely to influence the level of Scheme Pension. If you are unsure whether certain facts are material they should be disclosed.

Please enclose copies of any available hospital letters and a copy of your latest repeat prescription form, if possible.

3.1 Height (without shoes)	ft ins or cms
3.2 Weight (in normal indoor clothing)	st lbs or kgs
3.3 Do you smoke?	☐ Never ☐ No ☐ Yes
3.3.1 If yes what is your average daily level?	☐ Manufactured cigarettes ☐ Cigars ☐ oz of Tobacco ☐ Hand-rolled cigarettes ☐ Pipe
3.4 How many units of alcohol do you drink weekly?	☐ A unit of alcohol is equivalent to half a pint of normal strength beer, lager or cider, one standard glass of wine or a single measure of spirit.
3.5 Do you have high blood pressure (hypertension)?	☐ No ☐ Yes
3.5.1 If yes, please specify the last reading	☐☐☐/☐☐☐ Date of reading ☐☐/☐☐/☐☐☐☐
3.5.2 What are the number and name(s) of the medication(s) taken, eg Atenolol, Ramipril?	
3.6 Do you have high cholestrol?	☐ No ☐ Yes
3.6.1 If yes, please specify the last reading	☐☐☐ mmol/l Date of reading ☐☐/☐☐/☐☐☐☐
3.6.2 What are the number and name(s) of the medication(s) taken eg Simvastatin?	

3.7 If you have ever suffered with any of the following please tick the appropriate box and complete the relevant questionnaire

☐ Heart attack, angina or any other heart condition.
(Please complete the questionnaire in Part 4 starting on page 5.)

☐ Diabetes.
(Please complete the questionnaire in Part 5 starting on page 7.)

☐ Cancer, leukaemia, Hodgkins disease, lymphoma, growth or tumour.
(Please complete the questionnaire in Part 6 starting on page 9.)

☐ Stroke.
(Please complete the questionnaire in Part 7 starting on page 11.)

3.8 If you have ever suffered with any of the following please tick the appropriate box and provide full details in the space below.

- ☐ Chronic respiratory disease.
  (Name of condition, treatment required, impact on daily living.)
- ☐ Kidney or liver disease.
  (Specify type of disease, list investigations, whether dialysis required, medication required.)
- ☐ Mulitple scierosis.
  (Specify any mobility restrictions (eg wheelchair bound), severity of condition, investigations and treatment required.)
- ☐ Alzheimer's disease, dementia or Parkinson's disease.
  (Specify symptoms, treatment, assistance required and any complications, eg pressure sores.)
- ☐ Any other serious illness or condtion.
  (Please give full details below.)

Important: Please give the full name of medical condition(s) both past and present and answer all applicable questions 3.9 – 3.17.

Condition 1	
Condition 2	
Condition 3	

3.9 When did you last suffer symptoms or receive medication/treatment for this condition?

Ongoing/within last 6 months	☐ Condition 1	☐ Condition 2	☐ Condition 3
6 months to 2 years ago	☐ Condition 1	☐ Condition 2	☐ Condition 3
2 to 5 years ago	☐ Condition 1	☐ Condition 2	☐ Condition 3
More than 5 years ago	☐ Condition 1	☐ Condition 2	☐ Condition 3

3.10 How long have you suffered from this condition/when were you first diagnosed?

0 - 1 years	☐ Condition 1	☐ Condition 2	☐ Condition 3
1 - 5 years	☐ Condition 1	☐ Condition 2	☐ Condition 3
5 - 10 years	☐ Condition 1	☐ Condition 2	☐ Condition 3
More than 10 years	☐ Condition 1	☐ Condition 2	☐ Condition 3

3.11 When were you last hospitalised for this condition?

Never	☐ Condition 1	☐ Condition 2	☐ Condition 3
0 - 1 years ago	☐ Condition 1	☐ Condition 2	☐ Condition 3
1 - 5 years ago	☐ Condition 1	☐ Condition 2	☐ Condition 3
More than 5 years ago	☐ Condition 1	☐ Condition 2	☐ Condition 3

3.12 What treatment have you received in the last two years for this condition?

Nothing	☐ Condition 1	☐ Condition 2	☐ Condition 3
1-2 different prescribed medications daily	☐ Condition 1	☐ Condition 2	☐ Condition 3
3+ different prescribed medications daily	☐ Condition 1	☐ Condition 2	☐ Condition 3
Special treatment eg surgery radiotherapy, chemotherapy or renal dialysis	☐ Condition 1	☐ Condition 2	☐ Condition 3
Please list the names of all current medications			

3.13 Concerning your mobility in respect of this condition, are you

Fully independent	☐ Condition 1	☐ Condition 2	☐ Condition 3
Able to walk only with assistance, e.g. stick, frame	☐ Condition 1	☐ Condition 2	☐ Condition 3
Permanently and irreversibly wheelchair bound	☐ Condition 1	☐ Condition 2	☐ Condition 3
Permanently and irreversibly in need of daily nursing care	☐ Condition 1	☐ Condition 2	☐ Condition 3
Permanently and irreversibly bedridden	☐ Condition 1	☐ Condition 2	☐ Condition 3

Respiratory disease(s)

Please specify condition.

3.14 Do you have the following:

Minimally impaired respiratory function (FEV1 >70%)	☐ No	☐ Yes
Moderately impaired respiratory function (FEV1 50-70%)	☐ No	☐ Yes
Severely impaired respiratory function (FEV1 <50%)	☐ No	☐ Yes

3.15 Do any of the following also apply:

Recurrent respiratory infections	☐ No	☐ Yes
Need for home oxygen	☐ No	☐ Yes
Signs of cor pulmonale (right heart failure due to lung disease)	☐ No	☐ Yes

Mulitple scierosis

3.16 Do you have or have you ever had any of the following:

Bladder involvement	☐ No	☐ Yes
Secondary infection (eg pneumonia)	☐ No	☐ Yes
Brain stem involvement	☐ No	☐ Yes
Frequent use of IV prednisolone	☐ No	☐ Yes

Dementia/Alzheimer's disease/Parkinson's disease

3.17 Do you have, or have you had, any of the following:

Incontinence	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Mild dementia	☐ No	☐ Yes
Moderate dementia	☐ No	☐ Yes
Severe dementia	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes

4. SUPPLEMENATRY INFORMATION - HEART ATTACK, ANGINA OR ANY OTHER HEART CONDITION

Important: Only complete if you have indicated in question 3.7 on page 2 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your heart condition.

4.1 Have you ever been diagnosed with any of the following:

☐ Heart attack ☐ Aortic aneurysm ☐ Atrial fibrillation (AF) ☐ Angina ☐ Enlarged heart

☐ Heart valve disorders ☐ Heart failure ☐ Cardiomyopathy ☐ Other (please specify)

Please provide full details including date(s) of diagnosis, all subsequent hospital treatments and current symptoms.

4.2 If you have ticked the box for angina, do you continue to suffer from this?

☐ No ☐ Yes

If yes, please give full details.

4.3 If surgery has been carried out please state type of procedure.

☐ Coronary artery bypass graft (CABG)	How many arteries? ☐	Date ☐☐/☐☐/☐☐
☐ Angioplasty/stents	Number of arteries treated ☐	Date ☐☐/☐☐/☐☐

Other surgery (please give details and date of procedure)

4.4 Does your heart condition affect you in any of the following ways?

Breathlessness walking from room to room	☐ Never	☐ Occasionally	☐ Always
Breathlessness climbing stairs	☐ Never	☐ Occasionally	☐ Always
Chest pains on minor to moderate activity	☐ Never	☐ Occasionally	☐ Always
Chest pains on severe exertion only	☐ Never	☐ Occasionally	☐ Always
Swollen ankles	☐ Never	☐ Occasionally	☐ Always
Episodes of dizziness or blackouts	☐ Never	☐ Occasionally	☐ Always

4.5 Please give, if known, your latest reading for:

Blood pressure	☐☐☐/☐☐☐
Date of reading	☐☐/☐☐/☐☐
Cholestrol	☐☐☐ mmol/l
Date of reading	☐☐/☐☐/☐☐

4.6 What medication are you currently taking? Please list all medication prescribed for your heart condition

Name of medication	
Name of heart condition	
Dose prescribed	
Name of medication	
Name of heart condition	
Dose prescribed	
Name of medication	
Name of heart condition	
Dose prescribed	
Name of medication	
Name of heart condition	
Dose prescribed	

4.7 Are you currently under the care of a cardiologist?

☐ No ☐ Yes

Last consultation date	☐☐/☐☐/☐☐
Name of cardiologist	
Name of hospital	

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

☐ Never ☐ Once ☐ Twice ☐ Three times ☐ More than three times

4.9 Is any future treatment planned?

☐ No ☐ Yes

If yes, please give details:

4.10Are you awaiting the results of any investigations?

☐ No ☐ Yes

If yes, please advise for what and the date:

Please provide any further information you think may be important, including any family history of cardiovascular (heart) disease or the date of any stress (exercise) ECG testing, eg using a bicycle or treadmill.

5. SUPPLEMENTARY INFORMATION - DIABETES

Important: Only complete if you have indicated in question 3.7 on page 2 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your diabetes.

5.1 When was your diabetes diagnosed?

☐☐/☐☐/☐☐

5.2 How is your diabetes controlled?

Diet ☐ Non-insulin (tablet) ☐ Insulin ☐

Please list all the medication you currently take, and how often you take each of them

If this has changed, please state your previous treatment regime and the date it altered

5.3 Do you suffer from any of the following diabetic complications?

☐ Coronary heart disease	☐ Problem with your eyes (retinopathy)	☐ Diabetic neuropathy (loss of sensation)
☐ Renal disease (protein in urine)	☐ Elevated blood pressure	☐ Poor circulation

If you have ticked any of the above please give details

5.4 How often do you monitor your own blood glucose levels?

Blood glucose results	☐☐☐ mmol/l	
	☐ Fasting ☐ non-fasting	Date ☐☐/☐☐/☐☐☐☐
	☐ HbA1c	Date ☐☐/☐☐/☐☐☐☐
Cholestrol level	☐☐☐ mmol/l	Date ☐☐/☐☐/☐☐☐☐
Blood pressure	☐☐☐/☐☐☐	Date ☐☐/☐☐/☐☐☐☐

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

☐ No ☐ Yes If yes, when?

Please provide any further information you think may be important, including any family history of diabetes, if known

6. SUPPLEMENTARY INFORMATION - CANCER, LEUKAEMIA, HODGKIN DISEASE, LYMPHOMA, GROWTH OR TUMOUR

Important: Only complete if you have indicated in question 3.7 on page 2 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your cancer to confirm the type of cancer, stage, grade and treatment received.

6.1 What is the name or type of tumour/malignant condition?

6.2 Where was the tumour located?

6.3 When was the tumour/condition first diagnosed?

☐☐/☐☐/☐☐☐☐

6.4 Was the tumour

☐ Benign ☐ Pre-cancerous ☐ Malignant

6.5 Do you know the staging and/or grading of the tumour, for example TNM or Duke classification?

☐ No ☐ Yes

If yes, please give details

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

☐ Only tiny tumour growth (carcinoma in-situ)	☐ Only local tumour growth
☐ Tumour invaded adjacent lymph nodes	☐ Tumour invaded distant lymph nodes
☐ Tumour spread to distant organs (distant metastases)	

If yes, where:

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

Current Prostate Specific Antigen (PSA) level	
Date	/ /
Pre-treatment PSA level	
Date	/ /
Gleason score	
Date	/ /

6.8 Has there been any spread of the tumour?

☐ No ☐ Not known ☐ Yes

If yes, please describe where:

6.9 Has there been any recurrence?

☐ No ☐ Yes

If yes, please give details:

6.10 Did you have, or are you due to have, any of the following?

☐ Surgery

Type of surgery and date commenced:

☐ Chemotherapy	Date commenced: / /	Date ended: / /
☐ Radiotherapy	Date commenced: / /	Date ended: / /
☐ Bone marrow transplant	Date commenced: / /	Date ended: / /

Medication	Dose/frequency	Date commenced	Date ended

☐ Other

Please give details:

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

☐☐/☐☐/☐☐☐☐

6.12 Have you been discharged?

☐ No ☐ Yes

Please provide any further information you think may be important, including any family history of cancer, if known:

7. SUPPLEMENTARY INFORMATION – STROKE

Important: Only complete if you have indicated in question 3.7 on page 2 that you suffer/have suffered from this condition. Please provide us with as much information as you can. If you are unsure if something is relevant, put it down anyway, it may be helpful to us. If you are unsure about the details of any material facts or dates check the details to ensure they are accurate to the best of your knowledge and belief. Please enclose copies of any available hospital letters or reports about your stroke(s).

7.1 Please advise which of the following you have suffered from

☐ CVA (Cerebrovascular Accident – major stroke)

☐ TIA (Transient Ischaemic Attack – mini-stroke)

☐ Subarachnoid Haemorrhage (SAH)

Episode/type (eg stroke, TIA)	Date	Part of body affected	Duration of symptoms	Duration until full recovery

Please tick one box from each of the following questions 7.2 to 7.9 that most closely reflects your current condition as a result of your stroke.

7.2 Dressing

- ☐ Dependent, require full assistance
- ☐ Need help, but can do about half unaided
- ☐ Independent (including buttons, zips, laces, etc.)

7.3 Mobility

☐ Bedridden	☐ In need of daily nursing care
☐ Wheelchair dependent	☐ Walk with assistance (frame/stick, etc)
☐ Independent (needs no assistance)	

7.4 Transfering

☐ Unable, no sitting balance	☐ Major help
☐ Minor help, can sit unaided	☐ Independent

7.5 Bladder

- ☐ Incontinent/catheterised/unable to manage alone
- ☐ Occasional accident (once a week)
- ☐ Continent

7.6 Bowels

☐ Incontinent	☐ Occasional accident (once a week)	☐ Continent

7.7 Bathing

☐ Dependent	☐ Independent

7.8 Feeding

☐ Unable (naso-gastric tube/PEG tube in place)	☐ Needs some help cutting, spreading butter, etc
☐ Independent	

7.9 Other residual problems

☐ Speech difficulties	☐ Vision impairment
☐ Paralysis arm	☐ Paralysis leg

7.10 Please give your last blood pressure reading, if known

Blood pressure ☐☐☐/☐☐☐ Date ☐☐/☐☐/☐☐☐☐

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

7.12 What is the name of your consultant?

7.14 What is the name of the hospital?

Please provide any further information you think may be important, including any family history of cerebrovascular disease, if known.

8. DECLARATION AND CONSENT

I understand that:

- I have checked any statements in this application that are not in my handwriting. They are correct.
- To the best of my knowledge and belief, the statements made in this form are correct and complete.
- I understand by submitting this form that Phoenix Wealth Services Limited (and any action it takes e.g. investigating the claim, accepting proofs of claim) shall not be held to admit the validity of any claim nor to have waived any of its rights in defence arising under this Scheme.

Family Suntrust Scheme Pension Health Questionnaires – Fair Processing notice

Phoenix Wealth Services Limited, a member of the Phoenix Group, will hold and use the personal and sensitive personal data you provide to set up and administer your policy/plan and for business analysis. To enable us to ensure pension payments are calculated appropriately we will periodically recollect medical and health information from you. Your medical and health information will be held securely; access to your sensitive personal information will be strictly controlled and will only be shared with essential staff involved in the administration of your policy/plan.

We may transfer your personal data outside the European Union, in particular to Switzerland which has been judged by the EU to have Data Protection standards equivalent to the EU. Where transfers to other Phoenix companies are made, we have implemented Binding Corporate Rules approved by EU regulators as providing adequate protection for your personal data. We also use EU approved data privacy contract clauses for other transfers.

By signing this form you consent to the use of your personal and sensitive personal data for the reasons set out above. You also agree to Phoenix Wealth Services Limited passing this data onto: (1) your professional adviser(s) as notified to us by you from time to time; and (2) such other third parties as may be necessary in connection with the provision and administration of your policy/plan or the Scheme (if applicable), including our professional advisers.

Phoenix Wealth Services Limited would like to use your contact details and share them with companies within the Phoenix Group to enable us and them to send you information about other products and services. Your health or medical information will not be used for marketing purposes. You may be contacted by post, telephone or email.

If you do not wish us to do this please tick this box ☐

Otherwise we will assume that you are happy to receive this information and to be contacted in this way for the time being. Personal information regarding beneficiaries will not be used for marketing purposes. You may change your mind at any time by writing to the Data Protection Officer, 1 Wythall Green Way, Wythall, Birmingham, B47 6WG.

Signature:

✖

Date:

☐☐ / ☐☐ / ☐☐☐☐

Full name (inc title)	

If you would like a copy of the completed application form please ask us.

FSTAPPHQUWSP | March 2018