Discounted Gift Trust

Health questionnaire

Completion

You should complete this form if you are requesting to be underwritten in connection with a Discounted Gift Trust only.

Please complete this form in blue or black ink using BLOCK CAPITALS throughout. Please tick boxes where applicable and follow the instructions provided in each section.

Section 1 Your details

	First Applicant/Settlor	Second Applicant/Settlor (if applicable)
Sex (please tick)	Male ☐ Female ☐	Male ☐ Female ☐
Title (please tick)	Mr ☐ Mrs ☐ Miss ☐	Mr ☐ Mrs ☐ Miss ☐
	Other (in full)	Other (in full)
First name(s)		
Last name(s)		
Date of birth (dd/mm/yyyy)		
Country and place of birth		
Nationality		
Current residential address and postcode (in full)		

Section 2 Lifestyle details

	First Applicant/Settlor	Second Applicant/Settlor (if applicable)
1. Please state your height.	feet ☐ inches ☐ cm ☐	feet ☐ inches ☐ cm ☐
2. Please state your weight.	pounds ☐ kg ☐	pounds ☐ kg ☐
3. In the past 12 months have you used tobacco products (cigarettes, cigar or chewing)? If yes, please state your daily consumption.	Yes ☐ No ☐	Yes ☐ No ☐

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Section 2 Lifestyle details continued

	First Applicant/Settlor	Second Applicant/ Settlor (if applicable)
4. Do you expect or intend to seek a medical opinion within the next 8 weeks? If yes, please state full details in **section 4**.	Yes ☐ No ☐	Yes ☐ No ☐
5. Has any insurer ever declined, postponed or accepted an application on your life on special terms, or have you withdrawn an application? If yes, please state the company(ies), reason(s) and date(s) in **section 4**.	Yes ☐ No ☐	Yes ☐ No ☐

Current medical attendant

Please provide details of your usual medical attendant/attending physician below. If you have no usual medical attendant/ attending physician, please provide details of the last doctor you consulted and the reason.

	First Applicant/Settlor	Second Applicant/Settlor (if applicable)
Name of doctor		
Number of years attended		
Address (in full)		
Postcode		
Country		
Date of last visit (dd/mm/yyyy)		
Reason for last visit		
Results of last visit		

(If you require more space, please continue in **section 8**.)

Please note all questions must be answered in full, any questions answered with "N/A", "-" or "/" are not acceptable. If you answer yes to any question please provide additional information in **section 4**.

Section 3 Medical questions

	First Applicant/Settlor	Second Applicant/ Settlor (if applicable)
6. Please state the specific amount of your average weekly consumption of alcohol (quantity and type).	beer (in litres) ☐ wine (75cl bottles) ☐ spirits (measures) ☐	beer (in litres) ☐ wine (75cl bottles) ☐ spirits (measures) ☐

Do you have or have you ever had any of the following?

7. Heart or circulatory disorders e.g. high blood pressure, stroke, chest pains, heart murmur, palpitations, rheumatic fever, blood vessel disorders, elevated cholesterol?	Yes ☐ No ☐	Yes ☐ No ☐
8. Respiratory or lung trouble e.g. asthma, bronchitis, persistent cough, tuberculosis?	Yes ☐ No ☐	Yes ☐ No ☐
9. Disorders of the digestive system, gall bladder or liver e.g. duodenal ulcer, bleeding from the bowel, hepatitis?	Yes ☐ No ☐	Yes ☐ No ☐
10. Disease or disorder or infection of the kidneys, bladder or reproductive organs e.g. protein or blood in the urine, stones, prostatitis, venereal disease, bilharzia?	Yes ☐ No ☐	Yes ☐ No ☐
11. Nervous, neurological or mental complaint e.g. fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety state, depression?	Yes ☐ No ☐	Yes ☐ No ☐

Section 3 Medical questions continued

		First Applicant/Settlor		Second Applicant/ Settlor (if applicable)	
12.	Ear, eye, nose, throat or skin disorders e.g. ear discharge, defective vision, recurrent tonsillitis, porphyria, psoriasis, dermatitis?	Yes ☐	No ☐	Yes ☐	No ☐
13.	Disorders or disease of muscles, bones, joints, limbs or spine e.g. rheumatism, arthritis, gout, slipped disc, other back or neck troubles?	Yes ☐	No ☐	Yes ☐	No ☐
14.	Diabetes, sugar in urine, blood or spleen disorders, thyroid or other glandular disorders?	Yes ☐	No ☐	Yes ☐	No ☐
15.	Cancer, leukaemia, tumour or growth of any kind?	Yes ☐	No ☐	Yes ☐	No ☐
16.	Are any medicines or drugs currently prescribed for you, or are you receiving any medical or psychiatric treatment or advice or awaiting surgery?	Yes ☐	No ☐	Yes ☐	No ☐
17.	Have you ever been counselled or treated in connection with alcohol or drugs?	Yes ☐	No ☐	Yes ☐	No ☐

Notice of your statutory rights for access to medical reports

You should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as appropriate or any re-enactment thereof) and the procedures for dealing with such reports.

You do not have to give your consent but without it we will not be able to verify your state of health which could jeopardise the value of the discount under the Discounted Gift Trust. If you do give your consent, you can say whether you wish to see the report before it is sent to our Chief Underwriter.

If you indicate you do not wish to see any report

Your doctor can return the report to us immediately, and we can commence underwriting without delay.

You can, however, still change your mind and notify your doctor that you wish to see the report at any time within six months. If the doctor has already returned the report to us he will make arrangements to let you see a copy and, if not, he will give you 21 days to arrange to see it.

If you indicate you do wish to see any report

This may delay the processing of your application. The doctor is allowed to charge you a fee to cover the cost of supplying you with a copy of the report.

You should follow the procedures outlined below.

Procedures for access to medical reports

If you say you wish to see the report, we will tell you at the same time we write to your doctor, and we will tell them that you wish to see the report. You will then have 21 days to contact the doctor to arrange to see the report.

Once you have seen the report, the doctor cannot submit it to us without your consent. If you do not give us your consent, we will not be able to verify your state of health and as such be unable to estimate the value of the discount under the Discounted Gift Trust.

Once you have seen the report, you can write to the doctor asking them to amend any part of the report you consider to be incorrect or misleading, and have attached to the report a statement of your view of any part where you and your doctor are in disagreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of the report if, in their opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the doctor's intentions toward you. They also do not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report.

Section 4 Your additional notes

If you have no additional notes, please continue to Section 5 - Your declaration.

Section 5 Your declaration

Data Protection Act

Any data you provide to RL360° may be shared, if allowed by law, with other companies both inside and outside of the RL360° Group and to persons who act on your behalf. Data and information about you can be transferred outside of the Isle of Man and RL360° may be required to provide it to its regulator, its government or anyone else required by law.

RL360° will use your data and information to allow for the administration of your policy, prevent crime, prosecute criminals and for market research and statistics. RL360° will, at all times, make sure that your data and information is only used in ways that are allowed by law.

The Isle of Man Data Protection Act 2002 allows you, after paying a small fee, to receive a copy of the data and information RL360° holds about you.

For further information please write to: Data Protection Officer, RL360°, RL360 House, Cooil Road, Douglas, Isle of Man, IM2 2SP, British Isles.

Confirmation of your understanding

I/We understand that this *Health Questionnaire*, my/our application, all supporting forms, questionnaires, statements, reports and any other information shall form the basis of the contract between me/us and RL360 Insurance Company Limited (the Company).

I/We understand that the Company can bring my/our contract to an end if I/we have failed to detail any facts that may influence the Company's decision to accept this application.

I consent to RL360° seeking medical information from any doctor who has at any time attended me concerning anything which affects my physical or mental health, and I authorise the giving of such information. I have had written notice of my statutory rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as appropriate or any statutory re-enactment thereof).

	First Applicant	**Second Applicant (if applicable)**
Signed		
Date (dd/mm/yyyy)		
Please tick appropriate box:	☐ I do wish to see any report before it is sent to RL360°	☐ I do wish to see any report before it is sent to RL360°
	☐ I do not wish to see any report before it is sent to RL360°	☐ I do not wish to see any report before it is sent to RL360°

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