Health & Lifestyle Questionnaire

PO Box 1411
Sunderland
SR5 9RB

www.metlife.co.uk

Policy details

This section is for completion by the financial intermediary. Where there is no financial intermediary, this section is for completion by the employer.

Name of employer

Policy number(s)

Intermediary firm name

Intermediary contact name

Intermediary email address

The remaining sections of this form are to be completed by the employee.

Guidance notes for the employee completing this form:

Purpose

Your employer's group insurance policy has requested a level of benefit for you which requires individual assessment. Completion of this Health & Lifestyle Questionnaire will allow MetLife to gather the information required to complete this activity.

What happens next

Once we have received a completed version of this form we will assess its contents. On occasion we may need additional information, either from your GP or any other medical professionals you may have seen. We may also request a medical examination to complete our review. All costs relating to such reports and exams are met by MetLife. Examination reports can also be shared with you upon request.

When all the required information has been received we will determine the level of cover that can be offered and the terms applicable.

Once complete

When a decision has been made we will update your employer. Please note, in some instances, we may also notify the intermediary associated with your employer's group insurance policy. It is only our decision that will be shared and all information relating to the decision is treated in the strictest confidence.

Further questions

If you have any questions or require help in completing this questionnaire please contact your employer or alternatively you can contact MetLife via **0800 917 1888** or **medical.underwriting@metlife.uk.com**.

Important information

Please ensure that you answer all sections in this Health & Lifestyle Questionnaire fully, truthfully and accurately before signing and dating the declaration in Section H. If you do not, this could affect the payment of benefits under the policy, including reducing the amount payable in the event of a claim or even rejection of the policy entirely.

As part of the administration of the policy, personal data / information may be passed by us to the financial adviser or intermediary for the policy. If you prefer, you can send this form in a sealed envelope marked 'Confidential' direct to MetLife's Chief Medical Underwriter at MetLife, PO Box 1411, Sunderland, SR5 9RB.

Section A: Personal details

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other - please specify

Forename(s)

Surname

Gender

☐ Male ☐ Female

Date of birth (dd/mm/yyyy)

Home address

Postcode

Additional contact details

We may need to contact you for further information including medical details. We would prefer to get in touch by email or phone as this will allow us to contact you quickly for a faster response – if you are happy for us to do this, please provide your details below. We will not use this information for any other purpose than for the processing of this questionnaire.

Preferred email address

Preferred contact telephone number(s)

Doctor's details

Please note that we may or may not contact your GP. Please provide the full address and contact telephone number of the health centre where your medical records are held.

Doctor or GP name

Surgery name

Address

Postcode

Telephone number

Recent medical examinations

Using the questions below please indicate whether you have undergone a medical examination or health screening in the last 12 months (including those independently arranged by you or requested by another insurer or your workplace). Whilst we do not require a copy of the examiner's report at this stage, we may do so in the future.

a. Have you attended an insurance medical exam or health screening within the last 12 months? (if yes, please also answer part b below) ☐ Yes ☐ No

b. Do you have a copy of the examination report in your possession? ☐ Yes ☐ No

If you do not have a copy of the examiner's report please provide the details of the company who will hold a copy in the table below:

Company name	Policy type	Policy number

Section B: Insurance history

Have you ever been refused cover, charged extra, accepted at special terms, or withdrawn from any application for life, income protection, critical illness or private medical insurance?

☐ Yes ☐ No

If yes, please provide full details in the box provided below including type of cover, decision type, date of decision and reasons for the decision, if known.

Section C: Occupation, travel & pursuits

Occupation details

Company name

Company address

Postcode

Job title

Date current employment began

Duties and responsibilities (including but not limited to details of driving, any physical or manual work including lifting, carrying or working on your feet for long periods)

Does your role require you to work offshore, underwater, underground or at heights above 15 metres?
If yes, please provide details, otherwise state 'not applicable'.

Current basic salary

Bonuses and other remunerations

Travel details

As part of your occupation will you be required to travel outside of the United Kingdom in the next 2 years ? (trips to Europe, North America, Japan, Australia & New Zealand can be ignored): ☐ Yes ☐ No

If yes, please provide details of your intended travel in the table below:

Country	Town / City	Date of visit (month / year)	Reason for visit	Duration of visit(s)

Pursuits

Do you participate in or have an intention of participating in any hazardous activities or sports (including but not limited to private aviation, aviation related sports, mountaineering or rock climbing, motorsports or diving)? ☐ Yes ☐ No

(You can ignore one-off experience days, for example a parachute jump, a track day or scuba dive).

If yes, please provide full details in the table below:

Pursuit	Frequency	Location	Qualifications or licences (if any)	Extent of Activity
	(number of dives / races / climbs / flights / hours per annum)	(countries / waters / mountains etc)		(maximum height, depth, engine size / class etc)

Section D : Family history

Have either of your parents or any brothers or sisters been diagnosed with any of the following before the age of 65?

A. Heart disease, myocardial infarction (heart attack), angina or cardiomyopathy	☐ Yes	☐ No
B. Diabetes	☐ Yes	☐ No
C. Stroke	☐ Yes	☐ No
D. Any form of cancer	☐ Yes	☐ No
E. A neurological condition of either Multiple Sclerosis, Alzheimer's disease, Muscular Dystrophy, Parkinson's disease, Motor Neurone Disease or Huntington's disease	☐ Yes	☐ No
F. Polyposis of the colon, Polycystic kidney disease or any other potentially hereditary disease or disorder	☐ Yes	☐ No

If you have answered yes to any of the questions above please provide full details in the table below.
Please use a separate row if a relative has been diagnosed with more than one of the conditions named above.

Relationship	Diagnosis or cause of death	Age at diagnosis or death
(i.e. father, mother, brother, sister)	(if the condition is cancer please advise the primary site, if known)	

Genetic testing

If you have had a genetic test, you do not need to tell us the result if this application is for:

i. £500,000 or less of life cover

ii. £300,000 or less of Critical Illness cover

iii. £30,000 or less of benefit per annum for an income protection policy

For coverage above these thresholds you may need to tell us about certain genetic test results which have been approved for use by insurers by the Government's Genetics and Insurance Committee. Please ask us for details of the current position or visit www.abi.org.uk. If you do need to tell us please contact us directly. Please note however if you have had a test and the results are in your favour i.e. you are not susceptible to developing the genetic condition, you can choose whether to tell us the results or not. You must tell us, if you think you are having treatment for, or are experiencing symptoms of, a genetic condition.

Section E: Health information

You may wish to consult your doctor or GP if you need assistance in completing this section.

Q1. Please provide your latest height and weight measurements in the boxes below:

Height:

Feet or inches or cms or feet & inches

Weight:

Stones / Pounds or kgs or stones & pounds

Q2. Do you drink alcohol? ☐ Yes ☐ No

If yes, please provide details of your typical weekly alcohol consumption in the boxes provided below:

Lager/Cider/Beer		pints
Glasses of wine		125mls
Measures of spirits		25mls

Q3. Have you ever been advised to reduce your alcohol consumption? ☐ Yes ☐ No

If yes, please provide full details.

Date advice given (dd/mm/yyyy)

Reason(s) for advice

Alcohol consumption at the time the advice was given

Q4. Have you smoked or used any form of tobacco or nicotine based products within the last 12 months? (nicotine products include patches, gum, e-cigarettes) ☐ Yes ☐ No

a. If yes, please state your average daily consumption. per day

Q5. Have you in the last 5 years used any recreational drugs? (i.e. drugs taken other than as treatment for a medical condition, such as anabolic steroids, ecstasy, cocaine or heroin) ☐ Yes ☐ No

If yes, please provide full details in the table below:

Name of drug	When (month / year)	Date last used	Any treatment / advice sought / given

Q6. Have you ever tested positive for HIV or any form of Hepatitis (other than Hepatitis A) or are you awaiting the results of such a test? (If the result is negative, the fact of having an HIV test, will not, in itself, have any effect on your acceptance terms). ☐ Yes ☐ No

If yes, please provide full details in the table below:

Diagnosis / name of test	When (month / year)	Results (or if awaited date results due)	Any treatment / advice sought / given or planned

Q7. Do you currently have or have you ever had any of the following?

a. Any form of Cancer, Hodgkin's disease, Leukaemia, Lymphoma, brain or spinal tumour ☐ Yes ☐ No

b. Any disease or disorder of the heart, arteries or veins, including heart disease, angina, myocardial infarction, heart murmur, heart valve defect or cardiomyopathy ☐ Yes ☐ No

c. Any disorder or injury of the brain or spinal cord, brain haemorrhage, stroke or TIA (transient ischaemic attack) ☐ Yes ☐ No

d. Any form of diabetes ☐ Yes ☐ No

e. Any neurological disease or disorder such as paralysis, multiple sclerosis, epilepsy, Parkinson's, Optic neuritis, muscular dystrophy, dementia or Alzheimer's disease ☐ Yes ☐ No

f. Any mental health problem that has required a hospital admission or to be seen by a psychiatrist or other specialist mental health services ☐ Yes ☐ No

If you have answered yes to any of the questions above please provide full details to each in the table below.

One column should be used for each condition. Please provide as much detail as possible using all available boxes to avoid delays in processing your application.	Please state the question number applicable (e.g. 7a, 7b, 7c etc.):		
	Q.	Q.	Q.
Details of your diagnosis			
Date of your diagnosis (month & year)			
Details of any investigations which have taken place (please include the date of each investigation and the result if known)			
Details of any past treatment (this includes any medication, surgery or advice) and their respective dates			
Details of any current treatment (this includes any medication, advice or planned surgery)			

Q8. In the last 5 years have you had any of the following?

a. A lump, cyst, tumour or growth of any kind, or any mole or freckle that has bled, become painful or increased in size, or any other disease or disorder of the skin? ☐ Yes ☐ No

b. Chest pain, irregular heart beat, raised blood pressure, or raised cholesterol? ☐ Yes ☐ No

c. Abdominal pain or disease or disorder of the oesophagus, stomach, pancreas, spleen, gallbladder, liver, bowel or digestive system (including gastric or duodenal ulcer, hepatitis, colitis, irritable bowel syndrome or Crohn's disease)? ☐ Yes ☐ No

If you have answered yes to any of the questions above please provide full details to each in the table below:

One column should be used for each condition. Please provide as much detail as possible using all available boxes to avoid delays in processing your application.	Please state the question number applicable (e.g. 8a, 8b, 8c etc.):		
	Q.	Q.	Q.
Details of your diagnosis			
Date of your diagnosis (month & year)			
Details of any symptoms experienced (if relevant include the parts of the body affected and the severity & frequency of any symptoms)			
If known please give the cause			
Date of your last symptoms (month & year)			
What investigations or tests have taken place - if possible please include the type, date and result of each investigation and test			
Past medication, treatment or advice (please provide date ceased against each entry)			
Current medication, treatment or advice			
Has any time off work been taken as a result (YES/NO)? If 'yes' please provide your dates of absence from work			
Has a full recovery been made (YES/NO)? If no please provide details of any ongoing issues			

Q8 continued. In the last 5 years have you had any of the following?

d. Any disease or disorder of the kidney, bladder, prostate, urinary or reproductive system (including renal failure and blood, sugar or protein in the urine)? ☐ Yes ☐ No

e. Asthma, bronchitis, shortness of breath or any other disease or disorder of the lungs? ☐ Yes ☐ No

f. Any pain or disease or disorder of, or injury to, your back, neck, or any other joints, bones or muscles, including arthritis or rheumatism? ☐ Yes ☐ No

g. Numbness/tingling of the limbs or face, migraines or visual disturbance including blurred vision, double vision or fainting, dizziness? ☐ Yes ☐ No

If you have answered yes to any of the questions above please provide full details to each in the table below:

One column should be used for each condition. Please provide as much detail as possible using all available boxes to avoid delays in processing your application.	Please state the question number applicable (8d), 8e), 8f), 8g)		
	Q.	Q.	Q.
Details of your diagnosis			
Date of your diagnosis (month & year)			
Details of any symptoms experienced (if relevant include the parts of the body affected and the severity & frequency of any symptoms)			
If known please give the cause			
Date of your last symptoms (month & year)			
What investigations or tests have taken place - if possible please include the type, date and result of each investigation and test			
Past medication, treatment or advice (please provide date ceased against each entry)			
Current medication, treatment or advice			
Has any time off work been taken as a result (YES/NO)? If 'yes' please provide your dates of absence from work			
Has a full recovery been made (YES/NO)? If no please provide details of any ongoing issues			

Q8 continued. In the last 5 years have you had any of the following?

h. Any disease or disorder of the eyes and ears including impaired vision and deafness (you do not need to disclose non progressive sight problems fully corrected by glasses or contact lenses)? ☐ Yes ☐ No

i. Any anxiety, stress, depression, low mood, nervous breakdown, eating disorder or any other mental health problem that has persisted for more than 3 weeks or for which you have sought advice or treatment from a medical professional? ☐ Yes ☐ No

j. Any chronic tiredness, fatigue, post viral fatigue or myalgic encephalomyelitis? ☐ Yes ☐ No

If you have answered yes to any of the questions above please provide full details to each in the table below:

One column should be used for each condition. Please provide as much detail as possible using all available boxes to avoid delays in processing your application.	Please state the question number applicable (e.g. 8h), 8i), 8j)		
	Q.	Q.	Q.
Details of your diagnosis			
Date of your diagnosis (month & year)			
Details of any symptoms experienced (if relevant include the parts of the body affected and the severity & frequency of any symptoms)			
If known please give the cause			
Date of your last symptoms (month & year)			
What investigations or tests have taken place - if possible please include the type, date and result of each investigation and test			
Past medication, treatmentor advice (please provide date ceased against each entry)			
Current medication, treatment or advice			
Has any time off work been taken as a result (YES/NO)? If 'yes' please provide your dates of absence from work			
Has a full recovery been made (YES/NO)? If no please provide details of any ongoing issues			

Q9. Unless already disclosed have you in the last 5 years been required or advised to:

i) Take any medication, or

ii) Receive any other forms of treatment, or

iii) Undergo any tests or investigations (including but not limited to X-rays, scans, blood tests or any form of surgery), or

Iv) Remain under follow up, review or monitoring for any medical condition?

(Treatments and advice for colds/flu and contraception can be ignored) ☐ Yes ☐ No

If yes, please provide full details of all such occurrences in the table below:

Date	Reason	Details of any investigations or tests performed	Results and diagnosis	Details of any medication and treatment	Current status

Q10. Have you in the last 12 months attended, been advised to attend or been referred to a medical professional for any other reason not already disclosed? ☐ Yes ☐ No

If yes, please provide full details in the table below (treatments and advice for colds/flu and contraception can be ignored):

Date	Reason	Details of any investigations or tests performed	Results and diagnosis	Details of any medication and treatment	Current status

Q11. Within the last 2 years have you been absent from work due to illness or injury for a period of more than 10 consecutive working days? ☐ Yes ☐ No

If yes, please provide full details in the table below:

Date	Reason	Details of any investigations or tests performed	Results and diagnosis	Details of any medication and treatment	Current status

Section F - Data Protection notice

MetLife is a data controller in respect of any personal data you provide to us. The ways in which MetLife may collect, share or process your personal data are explained in MetLife's Privacy Notice. MetLife's Privacy Notice also explains your rights regarding your personal data. A copy of MetLife's Privacy Notice is available on our website: **www.metlife.co.uk**.

Should you have any questions or concerns, please contact the MetLife Data Protection Officer at **dataprotectionuk@metlife.com**.

Section G - Access to medical records

It may be necessary for us to ask any doctor who has attended you to provide us with a medical report, but before we can do this, we need your consent. Before signing the declaration below, you should know that you have certain rights under the Access to Medical Reports Act 1988 and or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. You do not have to give your consent, but if you do not, we may be unable to proceed with processing this questionnaire.

You can say whether you wish to see the report before it is sent to us. We will then tell you if we request a report from your doctor. We will also inform your doctor that you wish to see the report before it is sent to us. You will then have 21 days to contact your doctor to arrange to see this report. If you choose not to see the report before it is sent, you can ask your doctor for a copy within 6 months of it being supplied to us.

If you consider any part of the report to be misleading, you can ask your doctor to amend it. If your doctor refuses, you may add your own written comments. Your doctor does not have to let you see any part of the report if, in their opinion, you or others would be harmed by it, or if the report contains information about another person, unless that person consents to you seeing the report. You will be informed if any part of the report is affected in this way. If the whole report is affected, your doctor will not send it to us unless you agree.

Please note that if you do wish to see any report before it is sent to us, then this may cause the processing of this questionnaire to take longer than would otherwise be the case.

☐ I do want to see any report before it is sent to MetLife.

☐ I do not want to see any report before it is sent to MetLife.

Section H - Declaration and consent

By signing below, I confirm that I have read and I understand the explanation above of my rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as applicable).

I consent to MetLife requesting my medical reports and any supporting documentation from any doctor or medical practitioner who has treated me in respect of any medical condition affecting my physical or mental health. I authorise my treating doctor and my treating medical practitioner to release copies of my medical reports and any supporting documentation to MetLife on production of this consent. I confirm that a copy or electronic copy of this form and the signed consent shall have the same validity as the original.

I consent to MetLife obtaining information from other insurers about prior applications that I have made for any life, accident, sickness or private medical insurance.

I consent to MetLife having permission to share medical and any other underwriting evidence or information with the policyholder, re-insurers, trustees, my employer, service providers, third party administrators and MetLife's Chief Medical Officer as and when required in order to manage the employee benefit arrangements that I am a member of.

I consent to MetLife disclosing limited medical or other reasons for non-standard decisions (but not medical reports or other underwriting evidence) to insurance intermediaries or other insurers, where asked to do so.

I confirm that I have read the Data Protection section above and understand how to access MetLife's Privacy Notice.

I declare that the information disclosed by me in this Health & Lifestyle Questionnaire is true, accurate and complete. I understand that if I have provided misleading information this could affect the payment of benefits under the policy, including reducing the amount payable in the event of a claim or even rejection of the policy entirely.

Signature of employee

Printed name

Date (dd/mm/yyyy)

Please ensure that:

- ✓ All questions have been fully completed.
- ✓ You have ticked whether you wish to see any medical report prior to being sent to MetLife under Section G.
- ✓ You have signed and dated the form above.

Please return this completed form to:

Email: **medical.underwriting@metlife.uk.com**

Address: Chief Medical Underwriter, MetLife, PO Box 1411, Sunderland, SR5 9RB

metlife.co.uk