

## Filling in this form

This medical questionnaire should be completed by the employee.

Treatment of any medical condition or related condition that is already specifically excluded from benefit by your current insurer is not eligible for benefit under our plan. We will also exclude from benefit, claims for treatment for any existing medical condition which you do not disclose to us in answer to the following questions. It is therefore important that you answer these questions accurately.

You must advise us of any changes in your personal circumstances, including your state of health and that of anyone to be included on your plan, that take place between signing this questionnaire and the start date of your plan with us. We reserve the right to alter your acceptance terms in light of any such changes.

Please note: based upon the information provided Standard Life Healthcare reserves the right to decline this application.

**If you answer "yes" to any of these questions please give as much detail as possible overleaf, as failure to do so may prevent us assessing your application.**

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| 1) During the last 3 years, have you or any member of your family included in this application:  | (please tick)  |
| i) claimed under a private medical insurance plan?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| ii) attended either an NHS or private hospital for in-patient, day-patient or out-patient treatment?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| iii) been referred for specialist consultations or investigations either privately or under the NHS?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2) Do you, or any member of your family included in this application, have any medical condition or symptoms that require treatment or medication, a visit to your GP, hospital appointments (whether on an in-patient, day-patient or out-patient basis) or further checkups? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3) Have you or any member of your family included in this application ever received treatment or diagnosis for cancer, heart condition (including heart attack or angina), a stroke or any psychiatric related illness/problems?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4) Do any special exclusions apply to you, or any member of your family included in this application, under your existing private medical insurance plan?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |

## Declaration

I declare that, to the best of my knowledge and belief, the information provided by me on this form, and any supplementary information forming part of this application is full, true and correct in every respect. I understand that any existing medical condition which should have been disclosed in answer to these questions will not be eligible for benefit.

Name of employee

Signature

Date of birth

Name of company

Date



**Full details**

Please give as much information as you can including details of the illness, type of treatment, whether treatment is ongoing and dates of any hospital stays.

1)


2)


3)


4)
