utmost™
LIFE AND PENSIONS

Retirement Health Form

Personal Details

Policy number(s):

Please complete this form using black ink and capital letters

	Your details	**Your dependant's details**
Title(Mr/Mrs/Ms/Other)		
First name(s)		
Surname		
Date of Birth		
Permanent residential address		☐ *As left*

Marital status				
	Single		Single	
	Married/civil partner		Married/civil partner	
	Divorced		Divorced	
	Separated		Separated	
	Widowed		Widowed	
	Co-habiting		Co-habiting	

Contact details

Home telephone		
Mobile number		
Email		

Please complete the medical assessment form in section 2 and any other questionnaire that is applicable.
A medical assessment form for the dependant will only be required if you wish to see a quote for a joint life income for life and they are suffering from a condition.

Section 2 - Medical Assessment

	Your details	Your dependants details
Height	☐ ft ☐ ins **or** ☐ cm	☐ ft ☐ Ins **or** ☐ cm
Weight	☐ st ☐ lbs **or** ☐ kgs	☐ st ☐ lbs **or** ☐ kgs
Waist measurement	☐ ins **or** ☐ cm	☐ ins **or** ☐ cm
Are you a smoker/ have you smoked regularly in the past	☐ Yes ☐ No	☐ Yes ☐ No
Do you currently smoke?	☐ Yes ☐ No	☐ Yes ☐ No
Have you regularly smoked for the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
When did you start smoking? (mm/yy)	☐	☐
When did you stop smoking? (mm/yy)	☐	☐
How many cigarettes do you/did you smoke a day?	☐	☐
How many cigars do you/did you smoke a day?	☐	☐
How much pipe tobacco do you/did you smoke a week?	grams/ ounces ☐	grams/ ounces ☐
How much rolling tobacco do you/did you smoke a week?	grams/ ounces ☐	grams/ ounces ☐
How many units of alcohol do you drink weekly?	☐	☐

(One unit is about half a pint of normal strength beer, lager, or cider, one standard glass of wine, or a single measurement of spirit)

Have you been diagnosed with high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please specify date of diagnosis	☐ (mm/yy)	☐ (mm/yy)

Medical Assessment continued….

Please specify your last two readings

	Reading	Date
1	/	
2	/	

	Reading	Date
1	/	
2	/	

Please provide details of the medication you are currently taking for your blood pressure.

The dose prescribed, dose frequency and date medication commenced (mm/yy)

Have you been diagnosed with high cholesterol? ☐ Yes ☐ No ☐ Yes ☐ No

If yes, please specify date of diagnosis (mm/yy) (mm/yy)

Please specify your last two readings

	Reading (mmol/L)	Date
1		
2		

	Reading (mmol/L)	Date
1		
2		

Please provide details of the medication you are currently taking for your high cholesterol.

The dose prescribed, Dose frequency and Date medication commenced (mm/yy)

Please describe as much information about your health as possible before signing this form. All questions asked are relevant.

Medical Conditions

If you have ever been diagnosed with any of the following, please only complete the relevant questionnaire(s)

Other Medical Conditions

For any other conditions, not covered in the Medical Conditions list above, please complete the questions below (and the Activities of Daily Living questionnaire on page 23)

	Your details	**Your dependants details**
Condition 1		
Condition 2		
Condition 3		

Please answer as mm/yy

	Condition 1	**Condition 2**	**Condition 3**	**Condition 1**	**Condition 2**	**Condition 3**
When were you first diagnosed with this condition						
When did you last experience symptoms for this condition?						
When did you last receive medication/ treatment for this condition?						

When were you last admitted to hospital for this condition?

How many times have you been hospitalised for this condition?

Have you received any of the following treatments for this condition within the last 5 years? Please tick all that apply.

- ☐ Renal Dialysis
- ☐ Surgery
- ☐ Other

What medication are you currently taking for this condition?

Medication	Dose prescribed	Frequency	Date medication commenced

Heart attack, angina and other heart conditions questionnaire

☐ Not Applicable

Please indicate who is completing

☐ You ☐ Your dependent Name:

Please complete a separate heart conditions questionnaire if one is required for both you and the dependant

Have you ever been diagnosed with any of the following? (Please tick all that apply)

Diagnosis	Date of diagnosis	No. of occurrences	Ongoing?
Heart attack (Myocardial Infarction)			
Angina			
Heart Failure			
Aortic aneurysm			
Cardiomyopathy			
Heart valve disorders			
Atrial fibrillation (AF)			
Other irregular heart rhythm			
Other:			

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

	Never	Some of the time	Most of the time	Always
Symptoms at rest				
Breathlessness walking from room to room				
Breathlessness climbing stairs				
Chest pains on minor to moderate activity				
Chest pains on severe exertion				
Swollen ankles				
Episodes of dizziness				
Episodes of blackouts				

Heart attack, angina and other heart conditions continued

If surgery has been carried out, please state type of procedure and date of most recent surgery. (please tick all that apply)

☐	Coronary artery bypass graft (CABG)	No. of arteries treated	☐	Date(mm/yy)	
☐	Coronary angioplasty/stents	No. of arteries treated	☐	Date(mm/yy)	

☐	Mitral valve replacement	Successful?	☐	Yes	☐	No Date (mm/yy)	
☐	Aortic valve replacement	Successful?	☐	Yes	☐	No Date (mm/yy)	
☐	Tricuspid valve replacement	Successful?	☐	Yes	☐	No Date (mm/yy)	
☐	Pacemaker	Successful?	☐	Yes	☐	No Date (mm/yy)	
☐	Cardioversion/ablation	Successful?	☐	Yes	☐	No Date (mm/yy)	
☐	Aortic aneurysm repair	Successful?	☐	Yes	☐	No Date (mm/yy)	

What medication are you CURRENTLY taking? Please list all medication prescribed for your heart condition:

Name of heart condition	Name of medication	Dose prescribed	Frequency	Date medication commenced

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

Are you currently under the care of a cardiologist? ☐ Yes ☐ No Last consultation date ☐

Is any future treatment planned? ☐ Yes ☐ No

Heart attack, angina and other heart conditions continued…

If yes, please give details

Please advise date and result of any stress (exercise) ECG testing e.g. using a bicycle or treadmill

Date	Result (Normal/ Abnormal/ Other)

Please provide any further information you think may be important (e.g. dates of multiple surgery)

Diabetes questionnaire

☐ Not Applicable

Please indicate who is completing

☐ You ☐ Your dependant Name: _____

Please complete a separate diabetes questionnaire if one is required for both you and the dependent

When was your diabetes diagnosed? ☐ mm/yy

Is your diabetes? ☐ Type 1 ☐ Type 2

How is your diabetes controlled? ☐ Diet only ☐ Insulin
☐ Non-insulin (tablet/injection)

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

Name of medication	Dose prescribed	Frequency	Date medication commenced

Have you been diagnosed with any of the following diabetic complications? (Please tick all that apply.

☐ Heart disease
☐ Neuropathy
☐ Amputation
☐ Retinopathy (excluding other eye disease)
☐ Kidney disease (protein in urine)
☐ Peripheral vascular disease (with ulceration)

Please give last two reading for HbA1c:

Reading 1: ☐ ☐ mm/yy

Reading 2: ☐ ☐ mm/yy

Diabetes continued…

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

☐ Yes If yes, when? ☐ mm/yy
☐ No

How often do you monitor your blood glucose levels Number of times: ☐

Frequency, please tick as appropriate

☐ Daily ☐ Weekly ☐ Fortnightly ☐ Four-weekly
☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Annually

Please provide any further information you think may be important.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

☐ Not Applicable

Please indicate who is completing

☐ You ☐ Your dependant Name:

Please complete a separate questionnaire if one is required for both you and the dependent. If you have a history of more than one type of cancer please complete a separate questionnaire for each.

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

Where was the tumour located?

When was the tumour/condition first diagnosed?

Was the tumour: ☐ Benign ☐ Pre-cancerous ☐ Malignant

Do you know the staging of the tumour?

☐ TNM
☐ Modified Astler-Coller (MAC)
☐ Figo classification
☐ Dukes classification
☐ Clark level
☐ Breslow thickness
☐ Ann Arbor classification

Do you know the grading of the tumour?

☐ Grade 1 (Low Grade)
☐ Grade 3 (High Grade)
☐ Grade 2 (Intermediate Grade)
☐ Unknown

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

☐ Carcinoma-in-situ (stage O, Tis, Ta)
☐ Only local tumour growth
☐ Tumour spread to distant organs (distant metastases)
☐ Tumour invaded adjacent lymph nodes
☐ Tumour invaded distant lymph nodes

Cancer, leukaemia, lymphoma, growth or tumour continued…

In the case of prostate cancer, please advise where known

Current Prostate Specific Antigen (PSA) level:		Pre-treatment (PSA) level:	
Date recorded (mm/yy):		Date recorded (mm/yy):	

Gleason Score:	
Date recorded (mm/yy):	

In case of breast cancer, please advise where known

Breast Cancer Hormone Receptor Status	

Did you have, or are you due to have, any of the following as a result of your tumour or malignant condition (e.g. Leukaemia)

☐ Surgery

Type of surgery	Date (mm/yy)

		Date commenced (mm/yy)	Date ended (mm/yy)
☐	Chemotherapy		
☐	Radiotherapy (including brachytherapy		
☐	Bone marrow/stem cell treatment		
☐	Hormone therapy		
☐	Other (BCG, HIFU, Immunotherapy)		

Please give full details and advise of date of treatment:

Has there been any recurrence in the same location? ☐ Yes ☐ No

Cancer, leukaemia, lymphoma, growth or tumour continued…

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

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

_____ mm/yy

Have you now been discharged? ☐ Yes ☐ No

Please provide any further information you think may be important.

Please complete the Activities of Daily Living questionnaire on page 23

Stroke questionnaire

☐ Not Applicable

Please indicate who is completing this questionnaire

☐ You ☐ Your dependant Name: _____

Please complete a separate questionnaire if one is required for both you and the dependent.

Please advise which of the following you have been diagnosed with:

☐ CVA (Cerebrovascular Accident – major stroke)
☐ Cerebral haemorrhage/bleed
☐ SAH (Subarachnoid Haemorrhage)
☐ TIA (Transient Ischaemic Attack – mini stroke)

Episode/type (e.g. CVA, TIA	Date	Part of body affected	Duration of initial symptoms	Duration until full recovery

Please advise of any of the following ongoing problems due to your stoke:

☐ Speech difficulties
☐ Paralysis leg
☐ Vision impairment
☐ Short-term memory loss
☐ Paralysis arm

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Stroke continued…

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

☐ Still under follow-up ☐ Discharged

Please provide any further information you think may be important.

Please complete the Activities of Daily Living questionnaire on page 23

Respiratory/lung disease questionnaire

☐ Not Applicable

Please indicate who is completing this questionnaire

☐ You ☐ Your dependant Name:

Please complete a separate respiratory/lung disease questionnaire if one is required for both you and the dependent.

Please advise which of the following you have been diagnosed with:

		Date of Diagnosis	
☐	Chronic obstructive airways/pulmonary disease (COAD/COPD)		mm/yy
☐	Emphysema		mm/yy
☐	Bronchiectasis		mm/yy
☐	Pneumoconiosis (a type of lung disease relation to occupation)		mm/yy
☐	Asbestosis		mm/yy
☐	Asthma		mm/yy
☐	Pleural plaques		mm/yy
☐	Sleep apnoea		mm/yy
☐	Other, please specify		

Is your current lung function:

☐ Unaffected
☐ Moderately Impaired (FEV1 50%-70%)
☐ Minimally Impaired (FEV1 greater than (70&)
☐ Severely Impaired (FEV1 less than 50&)

Do any of the following apply due to your respiratory lung condition?

	Never	Some of the time	Most of the time	Always
Chest Infections				
Need for home oxygen				
Need for continuous positive airway pressure (CPAP) breathing machine				
Signs of cor pulmonale (right heart failure due to lung disease)				
Breathlessness walking from room to room				
Breathlessness climbing stairs				
Breathlessness when lying flat				
Oral steroids (in tablet form only e.g. Prednisolone)				

How many times have you been admitted to hospital for your respiratory/lung disease?

Date of last admission (mm/yy):

Respiratory/lung disease continued…

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Please provide any further information you think may be important.

Multiple Sclerosis questionnaire

☐ Not Applicable

Please indicate who is completing this questionnaire

☐ You ☐ Your dependant Name:

Please complete a separate Multiple Sclerosis questionnaire if one is required for both you and the dependant.

When was your Multiple Sclerosis diagnosed? ☐ mm/yy

Please advise subtype, if known:

☐ Relapsing Remitting
☐ Primary Progressive
☐ Secondary Progressive
☐ Progressive Relapsing

Please advise number of attacks in the last 5 years: ☐

How many times have you been admitted to hospital for your Multiple Sclerosis? ☐

Date of last admission (mm/yy) ☐

What medication are you currently taking for this condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Do you have, or have you had, any of the following in relation to your multiple sclerosis?

☐ Bladder Incontinence/Self-Catheterisation
☐ Impairment of Vision
☐ Secondary Infection
☐ Impairment of Speech
☐ Progressive Mental Deterioration
☐ Paralysis of A Limb
☐ Use of Steroids on more than 1 occasion

Multiple Sclerosis continued…

Please provide any further information you think may be important.

Please complete the Activities of Daily Living questionnaire on page 23

Other Neurological condition questionnaire

☐ Not Applicable

Please indicate who is completing this questionnaire

☐ You ☐ Your dependant Name:

Please complete a separate neurological questionnaire if one is required for both you and the dependent.

Please advise which of the following you have been diagnosed with:	**Date of diagnosis (mm/yy)**
☐ Senile Dementia	
☐ Vascular Dementia	
☐ Alzheimer's Disease	
☐ Parkinson's Disease	
☐ Motor Neurone Disease	
☐ Other	

If other, please specify (including date of diagnosis)

How many times have you been admitted to hospital for your condition?

Date of last admission (mm/yy)

Do you have, or have you had, any of the following symptoms in relation to your neurological condition?

☐ Pressure Sores
☐ Falls
☐ Tremors
☐ Seizures

What medication are you currently taking in relation to your neurological condition?

Name of medication	Dose prescribed	Frequency	Date medication commenced

Other Neurological condition continued…

Please advise last MMSE (Mini Mental State Examination) score, if known /30

Please provide any further information you think may be important.

Please also complete the Activities of Daily Living questionnaire on page 23

Activities of Daily Living (ADL) questionnaire

Please indicate who is completing this questionnaire

☐ You ☐ Your dependant Name:

Please complete a separate ADL questionnaire if one is required for both you and the dependent.

Please tick one box from each of the following that most closely reflects your current condition

Please advise relevant diagnosis in relation to which you are completing this questionnaire

Dressing

☐ Independent (Including Buttons, Zips, Laces etc...)
☐ Needs help, but can do about half unaided
☐ Dependent, required full assistance

Mobility

☐ Bedridden
☐ Wheelchair use – permanent
☐ Walk with assistance (frame/stick etc...)
☐ In need of daily nursing care
☐ Wheelchair use – non-permanent
☐ Independent (needs no assistance)

Transferring

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

Bladder

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

Bowels

☐ Incontinent (or requires enema)
☐ Continent
☐ Occasional accident (once a week)

Bathing

☐ Dependent
☐ Independent
☐ Need some assistance

Activities of Daily Living (ADL) continued…

Feeding

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

Please advise any progression in the last 5 years:

☐ Rapid deterioration ☐ Stable
☐ Deteriorating (impact to 2 or more ADLs/Acute Episodes)

How Utmost use your personal information

We take care of the personal information you provide and that we hold for you. For full details of how we handle your data, please see our Privacy Notice on our website at www.utmost.co.uk. If you don't have internet access or would prefer a printed copy please call us.

Declaration and Consent

By signing below I/we understand/consent and accept that:

- To the best of my/our knowledge the information entered on this form is true and accurate
- I/We understand that my/our answers to the Retirement Health Form questions will be used to produce a comparison quote, using the MoneyHelper website tool www.moneyhelper.org.uk/en/pensions-and-retirement/taking-your-pension/compare-annuities.

Your signature		**Date**	
Your dependant's signature		**Date**	