

ANNUITY PLUS QUESTIONNAIRE.

Please note that this questionnaire covers a limited number of medical/lifestyle conditions. If you have medical/lifestyle conditions that are not covered by this form then you should consider completing a full medical questionnaire as you may be entitled to more pension income.

You need to make sure any medical and/or lifestyle information you give us is both accurate and complete so that we can pay you the maximum level of income you're entitled to.

We may request a report from your doctor after your income starts in order to check any medical and/or lifestyle information you've given us. If we find the report does not support what you've told us and we've paid you too much, we may reduce what we're paying you and, at worst, you may receive our standard annuity rate. We will then take back any overpayments from you.

1 CLIENT DETAILS

	ABOUT YOU	SPOUSE, REGISTERED CIVIL PARTNER OR DEPENDANT
Mr/Mrs/Miss/Ms/other	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Full first name(s)	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female

2 HEALTH DETAILS

So that you can obtain the best possible pension annuity, it is important that you disclose as much information as you can about your health and lifestyle. Please answer the questions in each section as fully as you can and **it is important you provide readings where appropriate.**

	FIRST OR SINGLE LIFE	SPOUSE, REGISTERED CIVIL PARTNER OR DEPENDANT
SMOKING		
Are you currently a smoker and have been for the past 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate the average number of:	<input type="text"/>	<input type="text"/>
Manufactured cigarettes you smoke per day	<input type="text"/>	<input type="text"/>
Cigars you smoke per day	<input type="text"/>	<input type="text"/>
Ounces/grams of pipe or cigarette tobacco you smoke per day	<input type="text"/> oz <input type="text"/> grams	<input type="text"/> oz <input type="text"/> grams
HEIGHT/WEIGHT		
Height (ft/ins or cms)	<input type="text"/> ft <input type="text"/> ins <input type="text"/> cms	<input type="text"/> ft <input type="text"/> ins <input type="text"/> cms
Weight (st/lbs or kgs)	<input type="text"/> st <input type="text"/> lbs <input type="text"/> kgs	<input type="text"/> st <input type="text"/> lbs <input type="text"/> kgs

Please complete these sections only if you have been diagnosed by your doctor as suffering from one or more of the following conditions. It is important you provide readings where appropriate:

FIRST OR SINGLE LIFE

SPOUSE, REGISTERED CIVIL PARTNER OR DEPENDANT

HIGH BLOOD PRESSURE

Have you been diagnosed with raised or high blood pressure by your doctor?

Yes No

Yes No

Were you diagnosed more than 12 months ago?

Yes No

Yes No

Please advise your latest blood pressure reading (eg. 140/80) taken by your GP, home kit or chemist

/

/

Number of different prescribed drugs (eg. Atenolol, Ramipril) per day you currently take for high blood pressure

None 1
 2 3 or more

None 1
 2 3 or more

Name(s) of medication(s) taken

HIGH CHOLESTEROL

Have you been diagnosed with raised or high cholesterol by your doctor?

Yes No

Yes No

Were you diagnosed more than 12 months ago?

Yes No

Yes No

Please advise your latest cholesterol reading (eg. 4.5 mmol/l) taken by your GP, home kit or chemist

mmol/l

mmol/l

Number of different prescribed drugs (eg. statins) per day you currently take for high cholesterol

None 1
 2 3 or more

None 1
 2 3 or more

Name(s) of medication(s) taken



We will be unable to accept readings for high blood pressure (often referred to as hypertension) more than six months old, and high cholesterol readings that are more than one year old. Please obtain updated readings if required.

TYPE 2 DIABETES

Do you suffer from Type 2 Diabetes that is controlled by diet only (that is not by injection or tablet)?

Yes No

Yes No



If you have Diabetes that is treated by tablet or injection, or any complication, then you may want to complete the full medical questionnaire.

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FOR ADVISERS USE ONLY

Name

Telephone number

CONTACT US

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