Medical & Data Capture Form

The information requested in these pages is entirely confidential and will only be passed on to providers recommended.

The personal and financial information provided in this document will be used in assisting your independent financial adviser in offering you the best advice as required by the Financial Services and Markets Act 2000. The personal data provided will be stored and used in accordance with the Data Protection Act 1998.

It is important that the information you supply regarding your medical history is as accurate as possible, as a non-disclosure of information could lead to a provider declining a claim.

03300 949 409

www.mymortgageprotectionexperts.co.uk

My Mortgage & Protection Experts Ltd Company Registration: 12165909

	Applicant 1	Applicant 2
Name(s)		
DOB		

JOB TITLE		
Salary		
Total Income/Outgoings		

Does your job, or jobs involve working in any of the following?
Working above 40ft (more than 10% of the time), in the armed forces, in the fishing industry, In the offshore oil or gas industry, underwater, with explosives, as a sports professional, licensed trade or underground.)

If yes to any of the above which

How much of your time at work is clerical/admin (%)?

	%	%

How many hours do you work per week?

	hours	hours

What is the nature of your business?

How many business miles do you travel on average per annum?

	miles	miles

Are you making any other applications for Life cover, Health Insurance, or Critical Illness cover or have you done so within the last 12 months?

	Yes/No	Yes/No

If yes, please provide details;

Do you currently live outside the United Kingdom?

	Yes/No	Yes/No

Do you plan to live outside the United Kingdom?

	Yes/No	Yes/No

In the past 5 years have you lived or worked abroad?

	Yes/No	Yes/No

If yes to any of the above, please state:

Country:		

Do you, or are you likely to take part in any of the following activities?
Flying, caving, potholing, diving, hang gliding, motor car sport, motor cycle sport, parachuting, powerboat racing, rock climbing, mountaineering, sailing, sky diving, or any other extreme sport.

	Yes/No	Yes/No

If yes, please give details to which activity(s) you take part in

What is your height without shoes?

What is your weight in indoor clothes?
If you are pregnant, please give your weight immediately prior to this pregnancy

What is your waist measurement?

Do you smoke?

	Yes/No	Yes/No

Number of cigarettes/cigars smoked a day?

What is your weekly alcohol consumption in units?

	units	units

In the last 5 years has your alcohol consumption ever been higher?

	Yes/No	Yes/No

Have you ever tested positive for HIV, Hepatitis B or C or are you waiting the results of such a test?
A negative HIV or Hepatitis test result will not, of itself, have any affect on your acceptance terms for insurance.

	Yes/No	Yes/No

In the last 5 years have you been exposed to the risk of HIV infection? (This can be caught through unsafe sex, injecting a non-prescription drug, treatment with a blood transfusion or surgery undertaken outside any of the following countries)

United Kingdom, Australia, Austria, Belgium, Canada, the Channel Islands, Denmark, Finland, France, Germany, Greece, Holland, Isle of Man, Italy, Luxembourg, New Zealand, Portugal, Republic of Ireland (Eire), Spain, Sweden and the USA.

	Yes/No	Yes/No

Have you ever been diagnosed with another STI?

	Yes/No	Yes/No

In the last 5 years have you used recreational drugs, other than cannabis, for example ecstasy, cocaine or heroin?
Where examples are shown they are not intended to be a complete list. There are no legal implications in responding to this question.

	Yes/No	Yes/No

Are you presently on any medication or drugs?

	Yes/No	Yes/No

If yes, please provide details

Do you currently have, or have you ever had, any of the following?
Heart attack, angina, or any heart defect or murmur?

	Yes/No	Yes/No

A stroke, transient ischemic attack (TIA) or brain hemorrhage?

	Yes/No	Yes/No

Any other disease or disorder of the arteries, including disease in the legs or of the aorta? This question does include aneurysm, blockage or narrowing of an artery, intermittent claudication and inflammation of an artery.

	Yes/No	Yes/No

Cancer, lymphoma, Hodgkinson's Disease, Brain or Spinal Tumor (including benign growths) or Leukemia?

	Yes/No	Yes/No

Any form of neurological disorder, multiple sclerosis, visual disturbances including optic or retrobulbar neuritis, epilepsy, fits, myotonic (muscular) dystrophy or paralysis e.g. Parkinson's disease, motor neuron disease, cerebral palsy?

	Yes/No	Yes/No

Diabetes, or sugar in the urine?

	Yes/No	Yes/No

Asthma?

	Yes/No	Yes/No

Mental illness that has required hospital consultation or treatment, or referral to a community mental health team or a psychiatrist

	Yes/No	Yes/No

In the last 12 months have you had any other medical condition or any other symptoms, illness or injury, not mentioned previously?

	Yes/No	Yes/No

If yes, please provide details

In the last 5 years have you had any other medical condition or symptoms, illness or injury, not mentioned previously?

	Yes/No	Yes/No

If yes, please provide details

Have you ever had more than two continuous weeks off work due to illness?

	Yes/No	Yes/No

Doctors Details

Name		
Address		
Phone		
Known for how long?		

Have any of your natural parents, brothers or sisters, before the age of 65, been diagnosed with or died from any of the following conditions;

Condition	Affected?	Applicant 1/2 or both	Age first affected	Age now	Who was affected
Diabetes	Yes/No				
Cardiomyopathy	Yes/No				
Cancer of the Breast	Yes/No				
Cancer of the Ovary	Yes/No				
Cancer of the Colon (Bowel)	Yes/No				
Polyposis Coli (Familial Adenomatous)	Yes/No				
Polycystic Kidney Disease	Yes/No				
Myotonic (Muscular) Dystrophy	Yes/No				
Motor Neurone Disease	Yes/No				
Alzheimer's Disease	Yes/No				
Parkinson's Disease	Yes/No				
Huntingdon's Disease	Yes/No				
Multiple Sclerosis	Yes/No				
Cancer of any other type	Yes/No				
Heart Attack	Yes/No				
Angina	Yes/No				
Stroke	Yes/No				

If 'yes' to any of the above, please advise if they made a full recovery and when

If the person is now deceased, please state the date of death

	Applicant 1	Applicant 2
	Yes/No	Yes/No

Any other hereditary diseases?

What disease? _____ _____

Who was affected? _____ _____

At what age? _____ _____

I/We confirm that the information supplied on this form is accurate to the best of my/our knowledge.

I/We authorise My Mortgage & Protection Experts to use this data for the purpose of applying for my/our protection policies with the relevant providers.

I/We do want to see any medical reports requested ☐

I/We do not want to see any medical reports requested ☐

I/We do not want to be marketed to by the relevant providers ☐

Bank Details

Bank Name	
Banks Address	
Name of account holder	
Sort Code	
Account Number	
Start Date	

Please note that further information may be requested by My Mortgage & Protection Experts prior to submission of any applications. The provider may also ask for further information from you directly i.e. medical practitioner or ask for a medical screening test to be completed prior to offering terms.

	Applicant 1		**Applicant 2**
Name	_____	Name	_____
Signature	_____	Signature	_____
Date	_____	Date	_____

Notes: