Group Health Questionnaire

Invicta House,
Trafalgar Place,
Brighton BN1 4FR

www.metlife.co.uk

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

Scheme name

Scheme number(s)

Intermediary firm name

Intermediary contact name

Email address

Telephone number

The following sections are to be completed by the employee.
Please read this warning carefully before completing this questionnaire

If you have any questions or require help in completing this questionnaire, please contact your employer. The information you provide will be used by MetLife Europe d.a.c., which trades as MetLife, to assess what cover can be provided to your employer's sponsored insurance scheme.

You are under a duty to take reasonable care not to make a misrepresentation to us when answering the questions in this questionnaire as your answers will influence us in our decision on whether to provide insurance cover, and if so the terms on which we will offer cover to your employer in respect of you and their sponsored scheme.

It is important that you provide true, accurate and complete information to us because if untrue, misleading or inaccurate information is given by you deliberately or recklessly or carelessly, the cover provided may be void and it may result in a claim for benefit being rejected and any premium paid in respect of the cover being retained or any benefit payable being reduced.

Before the individual cover we offer to your employer in respect of you commences, you must immediately report to us any changes in the answers you have provided in this form.

Please ensure that all questions have been answered correctly and in full before proceeding to sign and date the declaration at the end of Section 8.

If you prefer, you can send the completed questionnaire in a sealed envelope marked confidential direct to MetLife's Chief Medical Officer, at MetLife, Invicta House, Trafalgar Place Brighton BN1 4FR.

Section 1 - Personal details

Please complete in block capitals

Title

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

Full name

Date of birth

D D M M Y Y Y Y

Gender

☐ Male ☐ Female

Nationality

Marital status

Address

City

Country

Postcode

If we require further information, would you object to us contacting you directly? ☐ Yes ☐ No

Please specify agreeable methods of contact. Please tick as many as appropriate:

☐ Correspondence to your home address

☐ Messages to an email address (if selected, please provide email address)

Contact via telephone - Home / Work (if selected, please provide telephone number)

As part of the administration of the policy, personal data may be passed by us to the financial intermediary or scheme adminstrator.

Doctor's details

Please note that we may not contact your GP or doctor. It is your responsibility to ensure the completed health questionnaire is true, accurate and complete.

Name of your doctor or GP

Telephone number

Address

City

Country

Postcode

Previous doctor or GP's Name (if changed within the last 12 months)

Telephone number

Preferred location if we request that you undergo a medical examination.

Preferred contact number if we request that you undergo a medical examination.

If we require a medical examination we can consider using a health screening report or medical examination that you have undergone within the last 12 months (including those independently arranged by you or requested by another insurer or your workplace). This may allow you to avoid the inconvenience of a further examination. If this applies to you please can you confirm whether a copy of the report is in your possession, or alternatively the name and address of the insurer or company that arranged for the examination, the type of cover and policy number should you wish to do so:

Section 2 - Occupation, travel and pursuits

Occupation details

Company name

Job Title

Location of employment

Address

City Country Postcode

Telephone number

Date current employment began

D D M M Y Y Y Y

Duties and responsibilities (including but not limited to details of 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'

What is the maximum number of hours worked per week?

Please advise annual road mileage if required to drive as part of your occupation

Current basic salary

Bonuses and other remunerations

Travel details

Please give details below of any foreign travel, or residency outside of the United Kingdom, undertaken within the last two years or that is planned within the next **two** years (trips to Western Europe, North America, Japan, Australia or New Zealand or holidays of less than a month can be ignored):

Last 2 years: ☐ Not applicable

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

Intended (next 2 years): ☐ Not applicable

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

Pursuits

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

If yes, please provide full details, including details regarding experience, club membership, accidents and UK or international involvement. If you are unsure whether an activity is deemed hazardous or dangerous then it should be disclosed.

Pursuit	Frequency (No. of dives / races / climbs / flights / hours per annum)	Location (countries / waters / mountains etc)	Qualifications or licences if any	Extent of Activity (maximum height, depth, engine size / class etc)

Section 3 - Existing cover

Do you have any life, income protection, critical illness or private medical insurance cover? If yes, please provide full details (policy number, insurer, benefit amount, description of cover) ☐ Yes ☐ No

Are you currently applying, or intending to apply, to any other insurance company for life, income protection, critical illness or private medical insurance or have you made any such application within the past 12 months? If yes, please provide full details (policy number, insurer, benefit amount, description of cover) ☐ Yes ☐ No

Have you ever been refused cover, charged extra, accepted at special terms for, or withdrawn from any application for life, income protection, critical illness or private medical insurance? If yes, please provide full details including type of cover, decision and reasons for the decision, if known. ☐ Yes ☐ No

Section 4 - Family history

Before attaining the age of 65, have either of your parents or any brothers or sisters suffered or died from any of the following:

heart disease;	☐ Yes	☐ No	☐ Don't Know
cancer;	☐ Yes	☐ No	☐ Don't Know
diabetes;	☐ Yes	☐ No	☐ Don't Know
stroke;	☐ Yes	☐ No	☐ Don't Know
multiple sclerosis;	☐ Yes	☐ No	☐ Don't Know
Alzheimer's disease;	☐ Yes	☐ No	☐ Don't Know
muscular dystrophy;	☐ Yes	☐ No	☐ Don't Know
Parkinson's disease;	☐ Yes	☐ No	☐ Don't Know
motor neurone disease;	☐ Yes	☐ No	☐ Don't Know
haemochromatosis;	☐ Yes	☐ No	☐ Don't Know
Huntington's disease;	☐ Yes	☐ No	☐ Don't Know
polycystic kidney disease;	☐ Yes	☐ No	☐ Don't Know
polyposis of the colon; or	☐ Yes	☐ No	☐ Don't Know
any other potentially hereditary disease or disorder?	☐ Yes	☐ No	☐ Don't Know

If yes, please provide full details.

Relationship	Diagnosis or cause of death	Age at diagnosis or death	Current age

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 5 - Health and other information

> You are under a duty to take reasonable care not to make a misrepresentation to us. It is important that you provide true, accurate and complete information to us because if untrue, misleading or inaccurate information is given by you deliberately or recklessly or carelessly, the insurance cover provided may be void and it may result in a claim for benefit being rejected and any premium paid in respect of the cover being retained or any benefit payable being reduced.

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

1. Height: Feet or metres

2. Weight: Stones or kilograms

   Date last weighed D D M M Y Y Y Y

   Has your weight changed by more than 1 stone or 6 kgs at any time in the last 12 months?
   If yes, please provide full details. ☐ Yes ☐ No

   Do you participate in any regular exercise?
   If yes, please provide details including activity, frequency and duration ☐ Yes ☐ No

3. Weekly alcohol consumption in units (a pint of beer is 3 units, 125ml glass of wine is 1.5 units and 25ml spirit is 1 unit).

4. Have you ever been advised to reduce your alcohol consumption?
   If yes, please provide full details. ☐ Yes ☐ No

5. Do you currently smoke cigarettes, cigars or a pipe or use other nicotine based products (for example, chewing tobacco or nicotine replacement products such as patches or gum), or have you done so in the last 12 months? ☐ Yes ☐ No

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

   b. If you have ceased smoking in the last 12 months please state date D D M M Y Y Y Y

6. Have you ever used recreational drugs? i.e. drugs taken other than as treatment for a medical condition, such as ecstasy, cannabis, cocaine or heroin). ☐ Yes ☐ No

If yes please give details:

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

7. Have you ever tested positive for HIV, Hepatitis B or C 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 affect on your acceptance terms). ☐ Yes ☐ No

8. Within the last 5 years, have you tested positive or been treated for any disease which was transmitted sexually? Or are you awaiting such a test? ☐ Yes ☐ No

Explain fully any ''Yes'' answers to questions 7 to 8 below.

Diagnosis / name of test	When (month / year)	Results Results (or if pending date result(s) due?)	Any treatment / advice sought / given or planned

9. Do you currently have or have you ever had any of the following:

a. Cancer, leukaemia, Hodgkin's disease, lymphoma, melanoma or brain or spinal tumour? ☐ Yes ☐ No

b. Disease or disorder of the heart, arteries or veins, including heart attack, angina, cardiomyopathy, heart murmur, heart valve defect? ☐ Yes ☐ No

c. Stroke, Transient Ischaemic Attack (TIA) or brain haemorrhage, recurrent headaches or migraine? ☐ Yes ☐ No

d. Diabetes, raised blood sugar or sugar in the urine? ☐ Yes ☐ No

e. Disease or disorder of the brain, spinal cord or nerves including multiple sclerosis, epilepsy or fits or paralysis? ☐ Yes ☐ No

f. Any neurological symptoms including numbness and tingling of the limbs or face, visual disturbance including blurred vision or double vision, dizziness or optic neuritis? ☐ Yes ☐ No

g. Any chronic tiredness, fatigue, post viral fatigue or myalgic encephalopathy (ME)? ☐ Yes ☐ No

h. Any form of mental illness that has required hospital treatment or referral to a psychiatrist? ☐ Yes ☐ No

Explain fully any ''Yes'' answers to questions 9 a. to 9 h. on the following page.

Letter (A-H) Diagnosis Date D D M M Y Y Y Y

Diagnosis or full description of symptoms if diagnosis unknown*

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

* such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any.

Letter (A-H) Diagnosis Date D D M M Y Y Y Y

Diagnosis or full description of symptoms if diagnosis unknown*

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

* such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any.

Letter (A-H) Diagnosis Date D D M M Y Y Y Y

Diagnosis or full description of symptoms if diagnosis unknown*

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

* such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any.

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

	Question	Yes	No
a.	A lump or growth of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size?	☐ Yes	☐ No
b.	Chest pain, irregular heart beat, raised blood pressure, or raised cholesterol?	☐ Yes	☐ No
c.	Any disease or disorder of the stomach, oesophagus, pancreas, bowel or digestive system (including gastric or duodenal ulcer, colitis, irritable bowel syndrome or Crohn's disease)?	☐ Yes	☐ No
d.	Any disease or disorder of the liver including hepatitis?	☐ Yes	☐ No
e.	Any disease or disorder of the kidney, bladder, or genito-urinary system (including blood or protein in the urine or recurrent urinary tract infections)?	☐ Yes	☐ No
f.	Asthma, bronchitis or any other disorder of the lungs?	☐ Yes	☐ No
g.	Any blood disorder including anaemia?	☐ Yes	☐ No
h.	Any thyroid problem?	☐ Yes	☐ No
i.	Any pain or other disease, disorder or injury relating to your back, neck, joints, bones, or muscles including arthritis or rheumatism?	☐ Yes	☐ No
j.	Any disease or disorder of the ears and eyes including impaired vision and deafness (you do not need to disclose non-progressive sight problems fully corrected by glasses or contact lenses)?	☐ Yes	☐ No
k.	Any anxiety, depression, stress, low mood, nervous breakdown, insomnia or eating disorder that has persisted for more than three weeks or for which you have sought advice or treatment from a healthcare professional?	☐ Yes	☐ No

Letter (A-K) Date of onset condition Diagnosis or full description of symptoms if diagnosis unknown*

D D M M Y Y Y Y

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

*Such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any

Letter (A-K) Date of onset condition Diagnosis or full description of symptoms if diagnosis unknown*

D D M M Y Y Y Y

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

*Such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any

Explain fully any ''Yes'' answers to questions 10 a. to 10 k. from the previous page.

Letter (A-K) Date of onset condition Diagnosis or full description of symptoms if diagnosis unknown*

D D M M Y Y Y Y

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

*Such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any

Explain fully any ''Yes'' answers to questions 10 a. to 10 k. from the previous page.

Letter (A-K) Date of onset condition Diagnosis or full description of symptoms if diagnosis unknown*

D D M M Y Y Y Y

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

*Such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any

Explain fully any ''Yes'' answers to questions 10 a. to 10 k. from the previous page.

Letter (A-K) Date of onset condition Diagnosis or full description of symptoms if diagnosis unknown*

D D M M Y Y Y Y

Investigations - tests undertaken (with dates and results if known)

Past treatment (with date ceased)

Current treatment (if any)

Current status

*Such as nature / severity of the symptoms experienced, duration and frequency of recurrences, if any

11. Unless already disclosed in questions 6 to 10, have you, in the last 5 years, other than for colds, flu and contraception:

a. Been prescribed medicines, counselling, therapy or any other form of treatment? ☐ Yes ☐ No

b. Undergone or been advised to have any medical investigations, x-ray, scan, or blood tests or any form of surgery? ☐ Yes ☐ No

Explain fully any ''Yes" answers to questions 11 a & b below:

Date D D M M Y Y Y Y

Reason

Type of tests or investigations

Diagnosis

Treatment (and if now ceased, date ceased)

Current status

Explain fully any ''Yes" answers to questions 11 a & b below:

Date D D M M Y Y Y Y

Reason

Type of tests or investigations

Diagnosis

Treatment (and if now ceased, date ceased)

Current status

Explain fully any ''Yes" answers to questions 11 a & b below:

Date D D M M Y Y Y Y

Reason

Type of tests or investigations

Diagnosis

Treatment (and if now ceased, date ceased)

Current status

12. When did you last see your GP and for what reason?

Date D D M M Y Y Y Y

Reason

Outcome / diagnosis / treatment (if any)

13. Have you attended your GP for any other reason(s) in the last 12 months? ☐ Yes ☐ No

If so please give details below (visits for colds, flu and contraceptive advice can be omitted). Explain fully any ''Yes'' answers to question 13 below.

Date of onset condition D D M M Y Y Y Y

Reason

Type of tests investigations

Diagnosis

Treatment (and if now ceased, date ceased)

Current status

Date of onset condition D D M M Y Y Y Y

Reason

Type of tests investigations

Diagnosis

Treatment (and if now ceased, date ceased)

Current status

14. Are you aware of any other symptoms or medical conditions not already disclosed where you intend to seek medical advice or are you awaiting the results of any medical investigations? ☐ Yes ☐ No

If yes, please provide details.

15. How many days sick leave from work have you had in the last two years?

16. How many periods of absence did the answer in 15. arise from?

17. What was the duration and reason for the longest period?

Section 6 - Data Protection

MetLife is the 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 7 - 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 overleaf, 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 to assess what cover can be provided to your employer's sponsored insurance scheme. 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 ☐ I do not want to see any report before it is sent to MetLife.

Section 8 - Declaration and consent

You are under a duty to take reasonable care not to make a misrepresentation to us when answering the questions in this questionnaire as your answers will influence us in our decision on whether to provide cover, and if so the terms on which cover is offered to your employer's sponsored insurance scheme. Should there be any change to your answers to the questions prior to the individual cover we offer to your employer in respect of you commencing, you must immediately inform us.

It is important that you provide true, accurate and complete information to us because if untrue, misleading or inaccurate information is given by you deliberately or recklessly or carelessly, the insurance cover provided may be void and it may result in a claim for benefit being rejected and any premium paid in respect of the cover being retained or any benefit payable being reduced.

By signing below:

I declare that I have taken reasonable care not to make a misrepresentation to MetLife in answering the questions in this questionnaire. I declare that the answers to the above questions are true, accurate and complete. I understand that if I have provided untrue, misleading or inaccurate information deliberately or recklessly or carelessly before the cover in respect of me commences, the cover under the policy / policies may be void and it may result in any claim for benefit being rejected and any premium paid in respect of the cover being retained or the benefit payable being reduced.

I understand that I must notify MetLife of any change in the answers to the above questions before the policy / policies cover in respect of me commence(s). I also understand that any cover will come into effect when MetLife have accepted this questionnaire and they have received the first payment of premium. I have read and I understand the explanation above of my rights under the Access to Medical Reports Act 1988 and / or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. I consent to MetLife applying to my doctors to obtain medical reports and my medical notes and records. I consent to MetLife requesting information from any doctor 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 consultant to release copies of my medical notes and records to MetLife and I authorise my doctor to provide a report on production by MetLife of a copy of this consent. I confirm that a copy of this signed consent shall have the same validity as the original.

Signature of employee

Printed name

Date

D D M M Y Y Y Y

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