



PROTECTION

Data Capture Form

This form should NOT be sent to Royal London. If received, it will remain unread and be destroyed.

Please Note that Royal London's products and the information on this application are provided for residents of the Republic of Ireland only.

1 Important information for Financial Brokers using this form

- This form can be used to capture the information from your client that you will need in order to submit an application using Royal London's online system.
- The person whose life is to be assured should provide the answers personally.
- You should keep this form for your own records.
- We will send a copy of all the questions and answers entered into the online system to you and your client.

2 Which of our product(s) would you like?

This section should be completed by all applicants.

(a) Mortgage Protection cover

Form of cover

Single Life ☐

Joint Life ☐

Amount of Life cover

Amount of Accelerated Specified Serious Illness cover

A minimum of 10% or €10,000, whichever is the higher amount, and a maximum of 100% of the Life Cover may be selected as Specified Serious Illness Cover. If left blank no Specified Serious Illness Cover is selected.

Term of cover you want

years

Mortgage interest rate

6% ☐

9% ☐

13% ☐

The amount of cover reduces over the term of your mortgage in line with a capital and interest mortgage at the selected interest rate. 13% is not available if you have Specified Serious Illness cover.

(b) Term Assurance and/or Specified Serious Illness Cover

Form of cover

Single Life ☐

Joint Life ☐

Dual Life ☐

Amount of Life cover

Life 1

Life 2*

**For Joint Life Cover, the level of cover for Life 2 must be the same as for Life 1.*

Amount of Specified Serious Illness cover

A minimum of 10% or €10,000, whichever is the higher, and a maximum of 100% of the Life Cover may be selected as Specified Serious Illness Cover. If left blank no Specified Serious Illness Cover is selected.

Type of Specified Serious Illness cover

Accelerated ☐

Standalone ☐

Standalone not available for joint life applications

Term of cover you want

years

Do you want Indexation?

Yes ☐

No ☐

With indexation, cover will increase at 3% per annum and premiums will increase at 4% per annum. If you select this option, you can opt out later.

Do you want a conversion option?

Yes ☐

No ☐

2 Which of our product(s) would you like? continued

(c) Pension Term Assurance

Eligibility

1. Are you engaged on your behalf (self employed) or as an active partner in a trade, profession or occupation Yes ☐ No ☐
2. Are you an employed person (or holder of an office of employment) Yes ☐ No ☐

If YES please answer 2.1 also:

- 2.1 If you are an employed person, is one or more of your occupations non – pensionable? Yes ☐ No ☐

*(If you are a member of an employer's Pension scheme from which you expect to receive a retirement benefit, whether in lump sum or pension, you are **not** eligible to effect this policy unless you have another source of non-pensionable earnings.)*

Retirement age (Policy expiry)
(Must be between 60 and 75)

Life 1

Amount of Life cover

Do you want Indexation? Yes ☐ No ☐

With indexation, cover will increase at 3% per annum and premiums will increase at 4% per annum. If you select this option, you can opt out later.

Do you want a conversion option? Yes ☐ No ☐

(d) Whole of Life

Form of cover

Single Life ☐

Joint Life First Death ☐

Joint Life Second Death ☐

Dual Life ☐

Do you want this policy to be eligible for relief under Section 72 of the Capital Acquisitions Tax Consolidation Act 2003, generally used for inheritance tax planning? Yes ☐ No ☐

If this policy is being used for relief under Section 72 the form of cover must be Single Life or Joint Life Second Death.

Please note, if you intend to use this policy for inheritance tax planning it is strongly recommended that you complete a Section 72 Trust Form or provide for this policy in your Will. Otherwise the policy proceeds will not qualify for relief under Section 72.

Life 1

Life 2*

Amount of Life cover

**For Joint Life Cover, the level of cover for Life 2 must be the same as for Life 1.*

Do you want Indexation? Yes ☐ No ☐

With indexation, cover will increase at 3% per annum and premiums will increase at 4.5% per annum. If you select this option, you can opt out later.

Do you want the Life Changes Option? Yes ☐ No ☐

(e) Income Protection cover

Form of cover

Personal

☐

Executive

☐

Annual amount of Income Protection cover

The maximum amount of Income Protection cover is 75% of earnings less any state benefits.

Please select the deferred period (in weeks) before which payments starts.

4 ☐

8 ☐

13 ☐

26 ☐

52 ☐

If you would like to receive part of your income cover earlier, enter the amount you would like and the period after you wish the payment to commence.

4 ☐

8 ☐

13 ☐

26 ☐

At what age should your cover end?

This must be between 55 and 70 years old.

Do you want Indexation?

Yes ☐

No ☐

With indexation, cover will increase at 3% per annum and premiums will increase at 3.5% per annum. If you select this option, you can opt out later.

For Executive Income Protection only, specify the annual cover required in respect of employer pension contributions (if any).

The maximum amount of employer pension contributions you can protect is 35% of earnings subject to a monetary maximum of €50,000. Annual pension contributions will always be paid after the longest deferred period selected above.

3 Product and Personal

This section should be completed by all applicants

All cover types

How do you wish to pay the premiums?

Monthly by Direct Debit ☐

Annually ☐

Date of birth:

First person to be covered

D M Y

Second person to be covered

D M Y

Have you smoked or used any tobacco or nicotine replacement or e-cigarettes in the last 12 months?

Yes ☐ No ☐

Yes ☐ No ☐

We may require you to perform a simple test to confirm this.

Personal Information

First name:

Surname:

Title:

Gender:

Male ☐ Female ☐

Male ☐ Female ☐

Marital status:

Contact details

Main contact phone number:
This must be provided

Other phone number:

E-mail:

Home address

Street:

Area:

Town:

County/Area Code:

Is this to replace an existing Royal London or Caledonian Life Policy?

Yes ☐ No ☐

Yes ☐ No ☐

If yes, please provide the policy reference (s)

4 Policy Owner (if different to person(s) covered)

For Executive Income Protection enter Employer details

Name:

Street:

Area:

Town:

Relationship of Policy Owner to person(s) covered and insurable interest

If you require this policy to be written in trust then select the type of trust and submit a completed trust form.

Directors ☐ Flexible ☐ Married Women's ☐ Section 72 ☐ Partners ☐ Other ☐

Your policy will not be placed in trust until Royal London has received a fully completed trust deed.

Executive Income Protection is only available if the Policy Owner is a company registered in Ireland under the Companies Acts.

5 Doctor Details

This section should be completed by all applicants

First person to be covered

Name and address of your doctor

Telephone no.

Second person to be covered

Name and address of your doctor

Telephone no.

If you have been attending this doctor for **less than one year**, please give details of your previous doctor(s)

Name and address of this doctor

Telephone no.

If you have been attending this doctor for **less than one year**, please give details of your previous doctor(s)

Name and address of this doctor

Telephone no.

6 Lifestyle

You must answer these questions honestly and in full. If you give any incomplete or inaccurate answers this may result in the policy being cancelled from inception or any subsequent claim not being paid.

| | First person to be covered | Second person to be covered |
|--|---|---|
| If you have smoked or used any tobacco or nicotine replacement in the last 12 months, please advise amount per day. | | |
| Cigarettes (per day, including roll-ups) | <input type="text"/> | <input type="text"/> |
| Cigars (per day) | <input type="text"/> | <input type="text"/> |
| Pipes (grams per day) | <input type="text"/> | <input type="text"/> |
| Electronic cigarettes (Use/Don't use) | <input type="checkbox"/> Use <input type="checkbox"/> Don't | <input type="checkbox"/> Use <input type="checkbox"/> Don't |
| Other nicotine replacement (Use/Don't use) | <input type="checkbox"/> Use <input type="checkbox"/> Don't | <input type="checkbox"/> Use <input type="checkbox"/> Don't |
| Your height | <input type="text"/> feet <input type="text"/> inches or <input type="text"/> cm | <input type="text"/> feet <input type="text"/> inches or <input type="text"/> cm |
| Your weight <i>If you are currently pregnant, please tell us your weight immediately before your pregnancy</i> | <input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg | <input type="text"/> st <input type="text"/> lbs or <input type="text"/> kg |
| How many units of alcohol do you drink in a typical week? <i>(One pint of beer or 175ml glass of wine = 2 units, One 25ml measure of spirits = 1 unit)</i> | <input type="text"/> units | <input type="text"/> units |
| Have you ever been given medical advice to reduce your alcohol intake or had, or been advised to have, any form of treatment or counselling relating to your alcohol intake? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you used illegal or recreational drugs during the last 10 years? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you lived, worked or travelled outside of the European Union, North America, Australia, New Zealand or Japan in the last 2 years or is it your intention to do so in the next 2 years? <i>Ignore holidays of up to a month</i> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If yes, please give us the area visited together with the reason, frequency and duration of each visit.

First person to be covered

Second person to be covered

Do you, or do you intend to, take part in hazardous sports or activities of any kind e.g. aviation (other than as a fare-paying passenger), climbing, diving or motor sports?

You do not need to disclose non-hazardous team sports such as football, rugby or hurling

Yes ☐ No ☐ Yes ☐ No ☐

If yes, please give details.

First person to be covered

Second person to be covered

7 Employment

This section should be completed by all applicants

First person to
be covered

Second person to
be covered

Please state your occupation

Only answer the rest of the employment questions if you are applying for Income Protection

Are you involved in any of the following industries?

(a) Defence forces or reservist for Defence Forces

Yes ☐

No ☐

(b) Oil or gas platform work

Yes ☐

No ☐

(c) Working with explosives or any other hazardous materials

Yes ☐

No ☐

(d) Tunnelling or underground work

Yes ☐

No ☐

(e) Working at sea or commercial diving

Yes ☐

No ☐

Are you

(a) Employed?

Yes ☐

(b) Self-Employed?

Yes ☐

(c) A Shareholding Director?

Yes ☐

If you are Self-Employed or a Shareholding Director, how many employees (including sub-contractors) work for you?

How much did you earn (pre-tax) over the last 12 months?

Including overtime, commission and bonuses but not including investment income or income from other sources.

Do you have another occupation in addition to the one stated above?

Yes ☐

No ☐

If 'Yes', please state that occupation

Does your job involve manual work, driving or working at heights?

Yes ☐

No ☐

If 'Yes', please provide detail

(a) Manual work (% of time)

(b) Driving (business km per year, excluding commuting)

(c) Working at heights (% of time)

Typical height (feet)

If you perform any manual work, please record typical manual duties.

Within the last 2 years have you had more than 10 consecutive days off work due to health issues or are you currently off work?

Yes ☐

No ☐

If yes, give details of all periods of absence, applicable dates and reasons.

8 Health

You must answer these questions honestly and in full. If you give any incomplete or inaccurate answers this may result in the policy being cancelled from inception or any subsequent claim not being paid.

| | First person to be covered | Second person to be covered |
|--|--|--|
| Have you ever had any of the following: | | |
| (a) Any form of cancer, tumour, lymphoma, Hodgkin's disease, leukaemia, melanoma or any brain or spinal growth or cyst? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (b) Disease or disorder of the heart (including valves) or circulatory system, heart attack, angina, cardiomyopathy, disease of the arteries or peripheral vascular disease? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (c) A stroke, transient ischaemic attack (TIA/mini-stroke), brain haemorrhage, aneurysm, brain injury or surgery to your blood vessels in the brain or neck? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (d) Multiple sclerosis, Parkinson's disease, epilepsy, fit or seizure, Alzheimer's disease, dementia, cerebral palsy, muscular dystrophy, motor neurone disease or had any other neurological disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (e) Depression, anxiety, stress, insomnia, chronic fatigue syndrome, eating disorders or have you been referred to a psychiatrist or hospital clinic as a result of any mental illness? <i>If you currently suffer, or have ever suffered from stress, anxiety or depression please also complete the questions on page 14.</i> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (f) Diabetes, raised blood sugar or sugar in the urine, thyroid problems, goitre or glandular fever? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (g) A positive test for HIV/AIDS or Hepatitis B or C, or are you awaiting the results of such a test? <i>If the result of a test you're waiting on turns out to be negative, the fact you had a test won't affect the terms we offer you.</i> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If yes is answered to any question, please record details.

First person to be covered

Second person to be covered

8 Health continued

Apart from anything you have already told us about, during the **last 5 years** have you had any of the following:

- (h) Raised blood pressure, raised cholesterol, chest pain or irregular heart beat?

If you have raised blood pressure please also complete the questions on page 12. If you have raised cholesterol please also complete the questions on page 13.

- (i) Numbness, pins and needles, optic neuritis, double/blurred vision, tremor, tingling, muscle weakness, loss or reduced power in limbs, or persistent tiredness or fatigue?

Please answer 'yes' whether seen by a doctor or not

- (j) Any form of arthritis, gout, joint or ligament pain or neck, back, spine or muscle pain or stiffness?

- (k) Any disorder affecting your ears or hearing, or your eyes or vision that is not wholly corrected by spectacles or lenses?

- (l) A tumour, lump, cyst, polyp, growth or a mole or naevus that has bled, changed in appearance or become painful?

Please answer 'yes' whether seen by a doctor or not.

- (m) Asthma, bronchitis, sarcoidosis, emphysema or any other disorder affecting your lungs or breathing?

- (n) Any disorder of the digestive system, liver, stomach, pancreas or bowel (including any ulcer, hepatitis, colitis, Crohn's disease or Barrett's oesophagus)?

- (o) Haemochromatosis, anaemia, vitamin b12 deficiency, clotting disorders or any other blood disorders?

- (p) Any disorder of the kidney, bladder or prostate, including blood or protein in the urine or raised PSA (Prostate Specific Antigen)?

**First person
to be covered**

**Second person
to be covered**

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

If yes is answered to any question, please capture details.

First person to be covered

Second person to be covered

8 Health continued

Apart from anything you have already told us about, during the **last 3 years** have you:

- (q) Regularly been prescribed medication or treatment lasting for a period of 4 consecutive weeks or more, or have you been under review from your doctor or a medical professional?
You do not need to tell us about contraception, fertility, dental treatment or reviews purely in relation to pregnancy.

First person
to be covered

Second person
to be covered

Yes ☐ No ☐

Yes ☐ No ☐

- (r) Been referred to a specialist, undergone or been advised to have any tests or investigations?
For example: Abnormal smear or mammogram, biopsy, colonoscopy, scans or blood tests. You do not need to tell us about investigations which were purely for pregnancy, infertility or simple fractures.

Yes ☐ No ☐

Yes ☐ No ☐

- (s) Apart from anything you have already told us about, are you awaiting referral, investigations, results or treatment for anything else or do you have any other symptoms for which you have not yet sought medical advice?
For example: Bleeding from the bowels or change in bowel habit, persistent cough, weight loss, onset of fits or seizures, dizziness, blackouts or fainting.

Yes ☐ No ☐

Yes ☐ No ☐

If yes is answered to any question, please capture details.

8 Health continued

Family medical history – have any of your natural parents, brothers or sisters ever been diagnosed with or died from any of the following before age 60.

Heart Attack or Angina, Cancer (including Leukaemia or Lymphoma), Multiple Sclerosis, Muscular Dystrophy, Motor Neurone Disease, Cardiomyopathy, Polycystic Kidney Disease, Familial Colon Polyps, Stroke, Diabetes, Huntington's Disease, Alzheimer's Disease, Parkinson's Disease, Haemochromatosis.

First person to be covered

Yes ☐ No ☐

Second person to be covered

Yes ☐ No ☐

If YES then please provide details. If the condition is cancer, please be specific as to the type of cancer.

First person to be covered

| Relative | Medical Condition | Age at Diagnosis |
|----------|-------------------|------------------|
| | | |
| | | |
| | | |

Second person to be covered

| Relative | Medical Condition | Age at Diagnosis |
|----------|-------------------|------------------|
| | | |
| | | |
| | | |

If YES and you have had any tests or check-ups as a result of relative's medical condition, please capture details here. In line with the Disability Act 2005, the results of any genetic tests **should not** be disclosed.

First person to be covered

Second person to be covered

Have you ever had an application for Life, Specified Serious Illness or Income Protection cover declined, postponed or had special terms applied to it?

First person to be covered

Yes ☐ No ☐

Second person to be covered

Yes ☐ No ☐

If you are currently applying for Specified Serious Illness cover, do you intend taking out total cover (including this application and any existing cover in force with this or any other company) in excess of €500,000 Specified Serious Illness cover?

Yes ☐ No ☐

Yes ☐ No ☐

If you are currently applying for Income Protection cover, do you have any existing Income Protection cover in force or do you intend taking out any other Income Protection cover?

Yes ☐ No ☐

Yes ☐ No ☐

If you are currently applying for Life cover, do you intend taking out total cover (including this application and any existing cover in force with this or any other company) in excess of €5,000,000 Life cover?

Yes ☐ No ☐

Yes ☐ No ☐

If yes, please provide details of type and amount of cover, name of insurer and if applicable, reason for special terms.

First person to be covered

Second person to be covered

9 Health – Blood Pressure

Only complete this section if you have had raised blood pressure in the last 5 years

| | First person to be covered | Second person to be covered |
|---|--|--|
| Are you awaiting a hospital referral or investigations for this condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you had any of the following? | | |
| (a) Kidney problems or protein in your urine | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (b) Angina, a heart attack or stroke, a TIA or blocked or narrow arteries in your legs | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (c) An ECG or heart test that was abnormal or needed further investigation | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (d) Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (e) Eye problems as a result of your condition | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Are you currently on prescribed treatment to control your blood pressure? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If no , have you ever not taken or stopped treatment without your doctor's approval? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you been told that your blood pressure no longer needs to be reviewed by a medical professional? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| When was your blood pressure first noticed to be raised? | <input type="text"/> | <input type="text"/> |
| If you know the result of your last blood pressure reading, What was the first or top number? | <input type="text"/> | <input type="text"/> |
| What was the second or bottom number? | <input type="text"/> | <input type="text"/> |
| If you do not know the result of your last blood pressure, did your doctor or nurse tell you whether your last blood pressure reading was (select one) | | |
| (a) High and needs to be reduced | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Satisfactory but slightly raised | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Normal | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Low | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Don't know | <input type="checkbox"/> | <input type="checkbox"/> |
| What was the outcome of your last review of your blood pressure? (select all that apply) | | |
| (a) Advised to start or increase treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Treatment remained the same or has been decreased | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Treatment was stopped | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Advised to attend a review in less than 6 months | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Advised to attend a review in 6 months time or later | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Discharged from follow up | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Referred to a specialist | <input type="checkbox"/> | <input type="checkbox"/> |

10 Health – Cholesterol

Only complete this section if you have had raised cholesterol in the last 5 years

| | First person to be covered | | Second person to be covered | |
|--|-------------------------------|-----------------------------|--------------------------------|-----------------------------|
| Are you awaiting hospital referral or investigation for this condition? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you had any of the following? | | | | |
| (a) Kidney problems or protein in your urine | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Angina, a heart attack or stroke, a TIA or blocked or narrow arteries in your leg | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) An ECG or heart test that was abnormal or needed further investigation | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Chest pain that required attendance at an Accident and Emergency department or any clinic or hospital | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Eye problems as a result of your condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| When was your cholesterol first noticed to be raised? | <input type="text"/> | | <input type="text"/> | |
| If your cholesterol was diagnosed before the age of 31 please confirm if any of your first degree relatives (mother, father, sister or brother) were diagnosed with high cholesterol or had heart disease below the age of 40? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you currently on prescribed treatment to control your cholesterol? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If no , have you stopped taking any cholesterol lowering medication without being advised to do so by your doctor? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you been told that your cholesterol no longer needs to be reviewed by a medical professional? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| How regularly is your doctor or nurse checking your cholesterol? (select one) | | | | |
| a) Less often than yearly | <input type="checkbox"/> | | <input type="checkbox"/> | |
| b) Yearly | <input type="checkbox"/> | | <input type="checkbox"/> | |
| c) More often than yearly | <input type="checkbox"/> | | <input type="checkbox"/> | |
| If you know the result of your last cholesterol test, what was it? | <input type="text"/> | | <input type="text"/> | |
| <i>The reading should be given as a number with one decimal place in the format 6.5</i> | | | | |
| If you do not know the result of your last cholesterol reading; did your doctor or nurse tell you whether your last cholesterol reading was (select one) | | | | |
| (a) High and needs to be reduced | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (b) Satisfactory but slightly raised | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (c) Normal | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (d) Low | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (e) Don't know | <input type="checkbox"/> | | <input type="checkbox"/> | |
| What was the outcome of the last review of your cholesterol? (select all that apply) | | | | |
| (a) Advised to start or increase treatment | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (b) Advised to attend a review within 6 months | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (c) Treatment remained the same or has been decreased | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (d) Treatment was stopped | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (e) Advised to attend a review in 6 months time or later | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (f) Referred to a specialist | <input type="checkbox"/> | | <input type="checkbox"/> | |
| (g) Discharged from follow up | <input type="checkbox"/> | | <input type="checkbox"/> | |

11 Health – Stress, anxiety and depression

Only complete this section if you have ever suffered from stress, anxiety or depression

| | First person to be covered | Second person to be covered |
|--|--|--|
| Have you had any of the following? | | |
| (a) Manic depression | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Bipolar disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Schizophrenia | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) None of the above | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you awaiting hospital or specialist referral for this condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you ever taken an overdose of drugs, attempted suicide, attempted to harm yourself, or had any thoughts or intentions to do so? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| When did you last experience symptoms of this condition? | <input type="text"/> | <input type="text"/> |
| Which of the following have you visited regarding this condition in the last five years? (select all that apply) | | |
| (a) GP / GP Surgery nurse | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Community Psychiatric Nurse | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Cognitive behavioural therapy (CBT) or counselling | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Hospital specialist or psychiatrist | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Inpatient treatment at hospital / clinic | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Support for alcohol or drug abuse / rehabilitation | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) None of the above | <input type="checkbox"/> | <input type="checkbox"/> |
| How many days have you taken off work because of this condition in the last 2 years? | <input type="text"/> | <input type="text"/> |
| How many separate episodes of symptoms have you experienced in the last 5 years? (select one) | | |
| (a) Once only | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Two or three times | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Recurrent | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently prescribed medication for this condition or receiving counselling or cognitive behavioural therapy (CBT)? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



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