

more2life

Health and lifestyle questionnaire

Medical underwriting reference number:

	First Applicant	Second Applicant
Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/>	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/>
Surname
First name(s)
Date of birth / / / /

	First Applicant	Second Applicant
Weight (metric/imperial)
Height (metric/imperial)
If you smoke manufactured cigarettes, have you smoked 10 or more cigarettes per day for the last 10 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you smoke rolling tobacco, have you smoked more than 3oz or 85g per week for the last 10 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with high blood pressure, requiring ongoing medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with diabetes, requiring insulin or tablet treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you suffered from a stroke (CVA), excluding mini-strokes (TIAs)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with angina, requiring ongoing medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with cancer (excluding skin cancer and benign tumours) requiring surgery, chemotherapy or radiotherapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with Parkinson's disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with multiple sclerosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you taken early retirement on the grounds of ill health?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>