



# HEALTH QUESTIONNAIRE

The comprehensive personal health summary is designed to help us to set up your financial protection. Once you have completed the following information, please return to Lexington prior to your meeting.

**The information that you provide us in this questionnaire is strictly confidential**

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**LEXINGTON**  
WEALTH MANAGEMENT

# PERSONAL INFORMATION

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## About You

Title

Your Full Name

What is your height without shoes?

cm

What is your weight?

kg

What is your waist/dress size?)

## Doctors Surgery

Doctors Name

Doctors Telephone Number

Length of Relationship

Surgery Address

# OCCUPATION

What is your occupation?

What is your employment status?

Do you work in any of the following? (tick all that apply)

- |                                                                                                               |                                                                                       |
|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> Outside at heights over 15 metres (50ft) for more than 5 hours during a typical week | <input type="checkbox"/> Offshore in the oil, gas or fishing industry                 |
| <input type="checkbox"/> The Armed Forces or as a member of the Armed Forces Reserves                         | <input type="checkbox"/> As a full-time barman, barmaid or landlord in a public house |
| <input type="checkbox"/> Flying as a pilot or member of a flight crew (excluding cabin crew or Armed Forces)  | <input type="checkbox"/> Underwater or underground, for example mining, tunnelling    |
| <input type="checkbox"/> Motor car sport driving or motorcycle sport riding                                   |                                                                                       |

If you have ticked any of the above, please give further details including percentage of time and height/depth (if applicable)

Do you use heavy machinery or power tools as part of your job?

☐ Yes ☐ No

Do you drive any vehicles as part of your work?

☐ Yes ☐ No

Do you work less than 16 hours per week?

☐ Yes ☐ No

If you are unemployed, a student, a houseperson, retired or a pensioner then answer no to this question.

What is your average business mileage?

## Salary

What are your employed earnings?

What are your self-employed earnings?

What was your income for the last tax year?

From Occupation

From Investment

From Other

# EXISTING COVER

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Do you have any existing cover on your life for family or mortgage purposes that you have not already provided to Lexington?

☐ Yes ☐ No

If **YES** to the above question, please provide details below:

Policy Type

Sum Assured

Insurer

Reason for cover

## Special Insurance Terms

Have you ever had any insurance application declined or accepted on special terms? ☐ Yes ☐ No

If yes, please give further details:

# ACTIVITY

## Travel & Transport

In the last 5 years, have you lived, worked, or travelled for more than one months' duration outside of Western Europe, North America, Australia, New Zealand?

☐ Yes ☐ No

In the next 12 months, do you intend spending more than 4 weeks overall in the Middle East, Africa, Centra or South America, Asia, Ukraine, Russia or New Guinea?

☐ Yes ☐ No

During the next 2 years do you intend to spend more than 28 consecutive days outside the UK?

☐ Yes ☐ No

If **YES** to any of the above, please provide details below

Do you ride a motorbike? ☐ Yes ☐ No

If **YES**, do you:

Ride it on road? ☐ Yes ☐ No Ride it off road? ☐ Yes ☐ No

## Hazardous Sports

Do you take part in hazardous sports? ☐ Yes ☐ No

If **YES**, please give details below

Name of activity:

List qualifications:

Governing Body or Assoc.:

Where do you take part in this activity?

How many times a year do you take part?

If applicable what heights/depths?

Do you ever take part alone? ☐ Yes ☐ No

## Smoking

Do you currently smoke? ☐ Yes ☐ No

If **YES**, what do you smoke? and how many units do you smoke per day?

|                                     | Number of units |
|-------------------------------------|-----------------|
| <input type="checkbox"/> Cigarettes |                 |
| <input type="checkbox"/> Cigars     |                 |
| <input type="checkbox"/> Vape       |                 |

Have you ever smoked in the past? ☐ Yes ☐ No

If **YES**, how many would you smoke a day?

If **YES**, when did you stop smoking?

## Alcohol Consumption

What is your average weekly consumption of alcohol in units?

(1 unit – ½ pint beer, 1 glass or wine, or 1 measure of spirits).

| Beer                 | Wine                   | Spirits                |
|----------------------|------------------------|------------------------|
| <input type="text"/> | £ <input type="text"/> | £ <input type="text"/> |

How many days a week do you normally drink alcohol?

Have you ever been advised to reduce the amount you drink by your GP?

## Recreational Drugs

In the last 10 years, have you ever taken any recreational drugs? ☐ Yes ☐ No

# MEDICAL HISTORY

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## Family History

Have any of your parents, brothers or sisters, before the age of 65, died or suffered from diabetes, heart disease, stroke, kidney disease, cancer, multiple sclerosis, paralysis, brain disorder?

☐ Yes ☐ No

If **YES**, please give details:

Have you ever been asked to take a test for anything hereditary? ☐ Yes ☐ No

## Sexual Health

Have you ever tested positive for aids or HIV or awaiting the results of such a test? ☐ Yes ☐ No

Have you ever tested positive for have been treated for an STD? ☐ Yes ☐ No

## Coronavirus (Covid-19)

Have you ever been treated in hospital due to Coronavirus? ☐ Yes ☐ No

If **YES**, please give details:

## Medical Conditions

Have you at any time suffered from, or had, or been advised to have, any medical investigation or consultation, advice, operation or treatment for any of the following? If yes, please tick appropriate box and give details in notes section.

|                                                                                                                                                  | YES                      | NO                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Heart attack, Chest pain, Palpitations, Heart murmur                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Any disease or abnormality of your heart, arteries or veins                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer, Tumour, Any mole or any other growth or lump either malignant or benign, or leukaemia                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of any lump or growth for which you have not yet sought medical advice                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Multiple sclerosis, optic or retro bulbar neuritis, any possible disorder of your brain or nervous system, or any disease affecting your muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes or sugar in your urine.                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis, rheumatism or any form of neck or spinal trouble.                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Any form of nervous or mental disorder, or have you ever required tranquilisers or anti-depressants.*                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Any problem disease or abnormality affecting your lungs, bowel, stomach, bladder, kidneys or liver.                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Any problem disease or abnormality affecting your ears, hearing, balance, eyes or vision (not wholly correctable by glasses or lenses.           | <input type="checkbox"/> | <input type="checkbox"/> |

\*Please provide further details in appendix

If yes to any of the above, please give details:

When did it first occur?

Duration of symptoms

Has the diagnosis been confirmed?

☐ Yes ☐ No

Treatment you are receiving/expecting to receive:

Time since last attack?

Amount of time you had had off work because of it

Do you have recurrent symptoms?

☐ Yes ☐ No

Do they restrict you in any way?

☐ Yes ☐ No

Have you seen a specialist?

☐ Yes ☐ No

What medical investigations have been performed?

What were the results?

How many times have you been admitted to hospital?

When was the last time you were admitted to hospital?

Is an operation planned?

☐ Yes ☐ No

Are you fully Recovered?

☐ Yes ☐ No

Are you waiting for any follow ups or reviews?

☐ Yes ☐ No

When did you last see your GP?

## Illness & Injury

Have you ever had a blood test, medical investigation, counselling or are you currently having treatment for any other medical condition, illness or injury not already mentioned?:

☐ Yes ☐ No

If yes, please give further details:

Have you ever had any other illness, injury or disability not previously mentioned which has kept you off work for a total of 2 weeks or more?

☐ Yes ☐ No

If yes, please give further details:

## Medical Report

Will you require to see any medical report before it is submitted to the providers:

☐ Yes ☐ No

# DIRECT DEBIT

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## Direct Debit Instructions

Please provide your bank details below so that we can set up the direct debit.

Bank/Building Society:

Address:

Name of Account Holder

Account Number:

Sort Code:

## DECLARATION

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☐ I confirm that to the best of my knowledge and belief, all statements made are true and complete and have been recorded accurately in this questionnaire.

Signature

Date

# APPENDIX

## Additional questions regarding mental health

If you have answered yes to "Any form of nervous or mental disorder, or have you ever required tranquilisers or anti-depressants." to the medical condition question on page 8, then please provide further details below.

When did you first have symptoms?

Have you ever tried to take your own life? ☐ Yes ☐ No

Had thoughts about taking your own life? ☐ Yes ☐ No

Have you intentionally harmed yourself? ☐ Yes ☐ No

Have you thought about intentionally harming yourself? ☐ Yes ☐ No

In the last 5 years who have you seen for this? (please tick all that apply)

- |                                                                               |                                                                                                        |                                                              |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> A Doctor or nurse at GP surgery                      | <input type="checkbox"/> A cognitive behavioural therapist (CBT), psychologist or counsellor           | <input type="checkbox"/> A psychiatrist or psychiatric nurse |
| <input type="checkbox"/> Inpatient specialist support at a hospital or clinic | <input type="checkbox"/> Alcohol or drug specialist support, such as alcoholics or narcotics anonymous | <input type="checkbox"/> None of these                       |

Which of the following apply to you? (please tick all that apply)

- |                                                                                 |                                                                                         |                                                      |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> I'm taking prescribed medication                       | <input type="checkbox"/> I'm having therapy (such as CBT, counselling or psychotherapy) | <input type="checkbox"/> I'm waiting to have therapy |
| <input type="checkbox"/> I used to take prescribed medication but don't anymore | <input type="checkbox"/> I used to have therapy but don't anymore                       | <input type="checkbox"/> None of these               |

When did you last take prescribed medication or have therapy for this?

Have you ever stopped taking prescribed medication without being told to do so by a doctor or nurse? ☐ Yes ☐ No

How many separate episodes of symptoms have you had? (An episode is a period of time where you have symptoms. It ends when you haven't had symptoms for 6 months or more.)

- ☐ I've had 1 episode      ☐ I've had 2 or 3 episodes      ☐ I've had more than 3 episodes

In the last year, have you been advised any of the following regarding your medication?  
(please select all that apply)

- ☐ I was advised to start my medication      ☐ I was advised to increase my medication  
☐ I was advised to reduce my medication      ☐ I was advised to change my medication  
☐ None of these

## Notes

Please use the area below to provide us with any other details you think we need to know.