# Smoking review questionnaire

## Your details

Name

Policy number(s)

## Why we are asking you for this information

We'd like some information about your health and activities, so we can consider your request to review the smoker status on your policy.

## What you need to know before completing the questionnaire

You must take reasonable care to answer the questions fully, honestly, and accurately, to the best of your knowledge.
If you don't answer the questions correctly your policy may be cancelled, or its terms may be changed, or your claim may be rejected or not fully paid.

If your health has deteriorated since the start of your policy, it is likely that the smoker review will be rejected. If this happens, your policy will continue on the current basis.

## Please answer the following questions

1 Please provide accurate information about your use of cigarettes including roll ups, vapes and e-cigarettes containing nicotine, cigars, pipes or any other tobacco or nicotine products including patches and gum.

- ☐ Regular, occasional or social use
- ☐ Completely stopped less than 12 months ago
- ☐ Completely stopped 1-3 years ago
- ☐ Completely stopped 3-5 years ago
- ☐ Completely stopped more than 5 years ago
- ☐ Never used

2 If regular, occasional or social user, please indicate the amount smoked below:

## Underwriting – Height and weight

What is your height? ft in or m

What is your weight? st lb or kg

## Underwriting – Past health

**Do you currently have, or have you ever had:**

**diabetes, raised blood glucose or sugar in the urine?**

☐ Yes ☐ No – go to next question

Select all that apply.

If you have selected type 1 or 2 diabetes please answer the diabetes additional questions on page 5.

- ☐ type 1 diabetes
- ☐ type 2 diabetes
- ☐ other condition(s)

If you have selected other condition(s) please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

## Underwriting – Past health (continued)

**any heart disease or disorder, such as heart attack, angina, heart related chest pain, heart enlargement, heart failure, irregular or rapid heart beat, heart valve defect, or any other heart condition?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition and complete the general medical additional questions on page 8.

_____

**a disorder or abnormality of the blood vessels or arteries such as narrowing, blockages, blood clots or deep vein thrombosis (DVT)?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical questions on page 8.

_____

**a stroke, transient ischaemic attack (TIA), mini stroke, brain haemorrhage, brain aneurysm or any damage or surgery to the brain?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

_____

**cancer, leukaemia, Hodgkin's disease, melanoma, lymphoma, brain or spinal tumours or growths?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

_____

## Underwriting – Recent health

**In the last 5 years, unless you have already told us earlier in this questionnaire, have you had, or been advised to take any medication or have treatment for:**

**raised blood pressure or raised cholesterol?**

☐ Yes ☐ No – go to next question

If "Yes" please answer the raised blood pressure or raised cholesterol additional questions on page 5.

☐ raised blood pressure
☐ raised cholesterol

**any respiratory or lung disease or disorder such as asthma, bronchitis or COPD?**

☐ Yes ☐ No – go to next question

Select all that apply.

If "Yes" to asthma, please complete the additional asthma questions on page 6.

☐ asthma
☐ other respiratory disease or disorder

If "Yes" to "other respiratory disease/disorder", please provide the name of the condition and complete the general medical questions on page 8.

_____

**any lump, cyst, growth or polyp, or a mole or freckle that has bled or changed in appearance?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

_____

**anaemia or other blood disorders such as haemochromatosis or haemophilia?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

_____

## Underwriting – Recent health (continued)

This question is only for female lives.

**any gynaecological disease or disorder, or any conditions of the breast, ovary or uterus, which have required medical advice, including abnormal mammogram or abnormal cervical smear, or a positive test for Human Papillomavirus (HPV)?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

This question is only for male lives.

**any disease or disorder of the prostate or testicle, such as raised Prostate Specific Antigen (PSA)?**

☐ Yes ☐ No – go to next question

If "Yes" please provide the name(s) of the condition(s) and complete the general medical additional questions on page 8.

## Underwriting – Current health

**Other than for the conditions you have already told us about earlier in this questionnaire:**

**are you aware of any symptoms that you intend to seek medical advice or treatment for, or are you waiting for any test results, appointments or investigations with your doctor or other medical professional?**

☐ Yes ☐ No – go to next question

☐ intend to seek medical advice or treatment

☐ waiting for a test result, appointment or investigation

If "Yes" to "intend to seek medical advice or treatment";
Please give full details of why you are intending to seek medical advice or treatment.

When do you intend to do this?

If "Yes" to "waiting for a test result, appointment or investigation";
What type of test result, appointment or investigation are you awaiting?

When do you expect the result to be available or for the appointment or investigation to take place?

**in the last 2 years have you had any medication or treatment that lasted more than four weeks? (You don't need to tell us about oral contraceptive pill, iron supplements during pregnancy, hormone replacement therapy (HRT) or treatment for minor accidents.)**

☐ Yes ☐ No – go to next question

If "Yes", do these treatments relate only to medical conditions you have already told us about?

☐ Yes ☐ No

If "No", please give full details of the type of drugs, medicines, tablets or other treatment and the condition or symptoms being treated.

**Are you currently off work, working reduced hours, or in the last 2 years, had more than 10 consecutive days off work or altered your duties due to sickness or injury?**

☐ Yes ☐ No – go to next question

If "Yes", in total how many days was this?

Please provide the reasons for the absence.

## Underwriting – Current health (continued)

**Other than for the conditions you have already told us about earlier in this questionnaire:**

**in the last 3 months have you had any symptoms of ill health, such as unexplained bleeding, weight loss, change of bowel habit, unexplained lump or growth, breathing problems or shortness of breath, or a cough that's lasted for 4 weeks or more?**

☐ Yes ☐ No – go to next question

Select all that apply.

- ☐ unexplained bleeding
- ☐ unexplained weight loss
- ☐ change of bowel habit
- ☐ unexplained lump or growth
- ☐ breathing problems or shortness of breath
- ☐ a cough that's lasted 4 weeks or more
- ☐ other symptoms of ill health

If "Yes" to "other symptoms of ill health", what symptoms of ill health do you have?

_____

If "Yes" to any of the options, please answer the following questions:

When did this start?

_____

Have you seen a doctor for this? ☐ Yes ☐ No

If "Yes", (to Have you seen a doctor for this?), are you awaiting any further tests, investigations or referral to a specialist? ☐ Yes ☐ No

If "Yes", (to Are you awaiting any further tests, investigations or referral to a specialist?), when is the next appointment due?

_____

If "No", (to Have you seen a doctor for this?), are you intending to see a doctor? ☐ Yes ☐ No

If "Yes" (to Are you intending to see a doctor?), when do you expect to be seen?

_____

## Underwriting – Doctor

Has your client been registered with a doctor in the last 6 months? ☐ Yes ☐ No

If "Yes", please provide the doctors details.

Dr Initials _____

Surname _____

Address

_____

Telephone _____

**Asking for this doesn't mean we'll automatically request a medical report.**

**If you have answered "Yes" to the any of the questions where additional information is needed, please complete the appropriate additional questions below. If not, please move to the next section.**

## Underwriting – Additional questions

### Diabetes additional questions

How long ago was your diabetes diagnosed? _____

Since you were told you had diabetes, have you been admitted to hospital for one night or more due to your diabetes? ☐ Yes ☐ No

Have you ever had, been advised to have or are you waiting to have laser treatment to your eyes due to diabetes? ☐ Yes ☐ No

Have you ever been told by your GP or any medical professional that you have protein in your urine due to diabetes? ☐ Yes ☐ No

Do you have, or have you ever had, tingling, numbness or loss of sensation in your fingers, toes or feet due to diabetes? ☐ Yes ☐ No

What was your latest HbA1c? _____

When was this taken? _____

### Raised blood pressure additional questions

How long ago was your blood pressure first found to be raised? _____

Are you currently receiving any treatment or medication for your blood pressure? ☐ Yes ☐ No

How long ago was your blood pressure last checked by a doctor or nurse? _____

Have you been told by a doctor or nurse that your blood pressure is normal? ☐ Yes ☐ No ☐ Don't know

Have you had or are you waiting for any hospital tests or investigations related to your raised blood pressure, such as heart investigations, kidney tests or eye screening? ☐ Yes ☐ No

### Raised cholesterol additional questions

Have you been told that your raised cholesterol is linked to a family history of raised cholesterol? ☐ Yes ☐ No

How long ago was your cholesterol first found to be raised? _____

Are you currently receiving any treatment or medication for your cholesterol? ☐ Yes ☐ No

How long ago was your cholesterol last checked by a doctor or nurse? _____

Have you been told by a doctor or nurse that your cholesterol is normal? ☐ Yes ☐ No ☐ Don't know

Have you had or are you waiting for any hospital tests or investigations related to your raised cholesterol, such as heart investigations, kidney tests or eye screening? ☐ Yes ☐ No

**Asthma additional questions**

**Please answer all of the questions in this section. However, not all information may be required when keying the questionnaire into our online system.**

Have you been admitted to hospital for your asthma within the last 5 years?

☐ Yes ☐ No

If "Yes" when were you admitted?

☐ Within the last 6 months
☐ 6 to 12 months ago
☐ 1 to 2 years ago
☐ 2 to 3 years ago
☐ 3 to 5 years ago

If you were admitted within the last year please confirm which month.

_____

How many times have you been prescribed steroid tablets for your asthma in the last year, e.g. prednisolone? You do not need to tell us about steroid inhalers.

☐ none
☐ once
☐ two times
☐ more than two times

Did you have a chest infection at the time you were prescribed steroid tablets?

☐ Yes ☐ No

How often do you have symptoms such as wheezing, breathlessness, a cough or tight chest?

☐ less than 2 days a week
☐ 3 to 6 days a week
☐ every day and up to 2 nights a week
☐ every day and more than 2 nights a week

How many days have you lost from work or been unable to carry out your normal daily activities in the last year due to your asthma?

_____

| General medical additional questions | Condition 1 |
|---|---|
| Please provide the name of the medical condition, illness or injury. | |
| When were you first diagnosed with this condition? | |
| Please tell us the nature, severity and frequency of any symptoms you have had, or are having. | |
| When were your last symptoms? | |
| Have you had any tests or investigations for this condition? | ☐ Yes ☐ No |
| If "Yes", please provide full details, including the types of tests, dates and results. | |
| Have you required any treatment for this condition? | ☐ Yes ☐ No |
| If "Yes", please provide full details, including type of treatment, names of medications and dates. | |
| Are you waiting for any tests, investigations or treatment | ☐ Yes ☐ No |
| If "Yes", please provide details including type of test, investigation or treatment, and the planned date. | |
| How many days have you lost from work or been unable to carry out your normal daily activities in the past 3 years due to this condition? | |
| When was this? | |

| General medical additional questions | Condition 2 |
|---|---|
| Please provide the name of the medical condition, illness or injury. | |
| When were you first diagnosed with this condition? | |
| Please tell us the nature, severity and frequency of any symptoms you have had, or are having. | |
| When were your last symptoms? | |
| Have you had any tests or investigations for this condition? | ☐ Yes ☐ No |
| If "Yes", please provide full details, including the types of tests, dates and results. | |
| Have you required any treatment for this condition? | ☐ Yes ☐ No |
| If "Yes", please provide full details, including type of treatment, names of medications and dates. | |
| Are you waiting for any tests, investigations or treatment | ☐ Yes ☐ No |
| If "Yes", please provide details including type of test, investigation or treatment, and the planned date. | |
| How many days have you lost from work or been unable to carry out your normal daily activities in the past 3 years due to this condition? | |
| When was this? | |

| General medical additional questions | Condition 3 |
|---|---|
| Please provide the name of the medical condition, illness or injury. | |
| When were you first diagnosed with this condition? | |
| Please tell us the nature, severity and frequency of any symptoms you have had, or are having. | |
| When were your last symptoms? | |
| Have you had any tests or investigations for this condition? | ☐ Yes ☐ No |
| If "Yes", please provide full details, including the types of tests, dates and results. | |
| Have you required any treatment for this condition? | ☐ Yes ☐ No |
| If "Yes", please provide full details, including type of treatment, names of medications and dates. | |
| Are you waiting for any tests, investigations or treatment | ☐ Yes ☐ No |
| If "Yes", please provide details including type of test, investigation or treatment, and the planned date. | |
| How many days have you lost from work or been unable to carry out your normal daily activities in the past 3 years due to this condition? | |
| When was this? | |

## Declaration

I declare that:

- I have completed the information on this form fully, honestly, and accurately, to the best of my knowledge.
- I am aware that if I haven't answered the questions correctly my policy may be cancelled, or its terms may be changed, or a claim may be rejected or not fully paid. Cancelling a policy means that no cover or other benefits will be provided.
- I have read the Zurich data protection leaflet 'Your privacy is important to us' and I agree to the personal information I have provided in this form being used in the ways described.

Signature

Date of signature

D D M M Y Y Y Y

Please return this form
by email - Life.service@uk.zurich.com
by post - Protection Operations, PO Box 4157, Swindon, SN4 4QB



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