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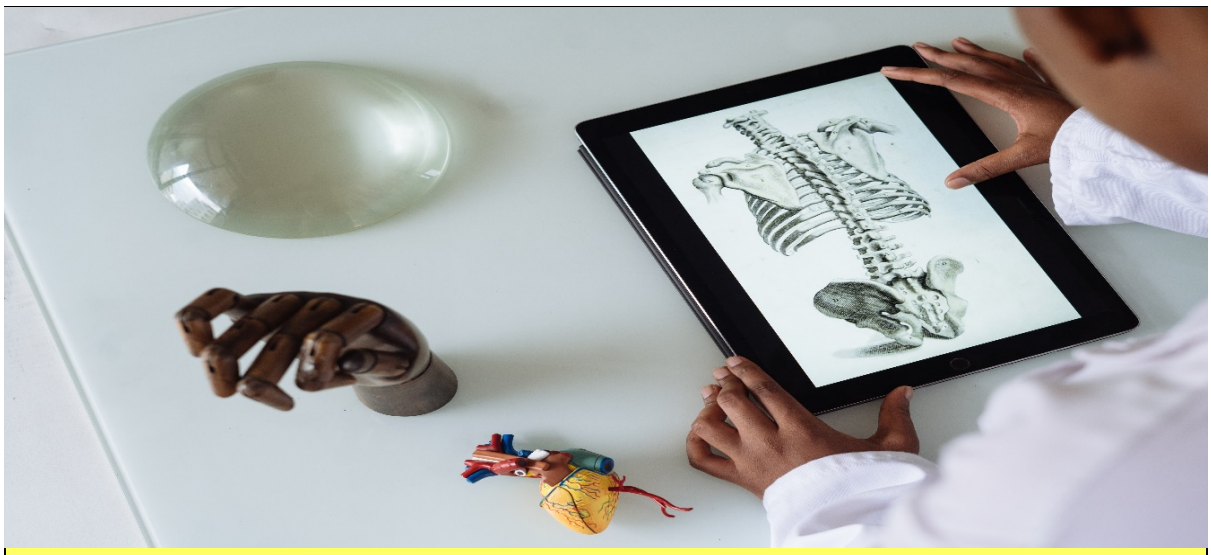
Medical Underwriting Questions Section

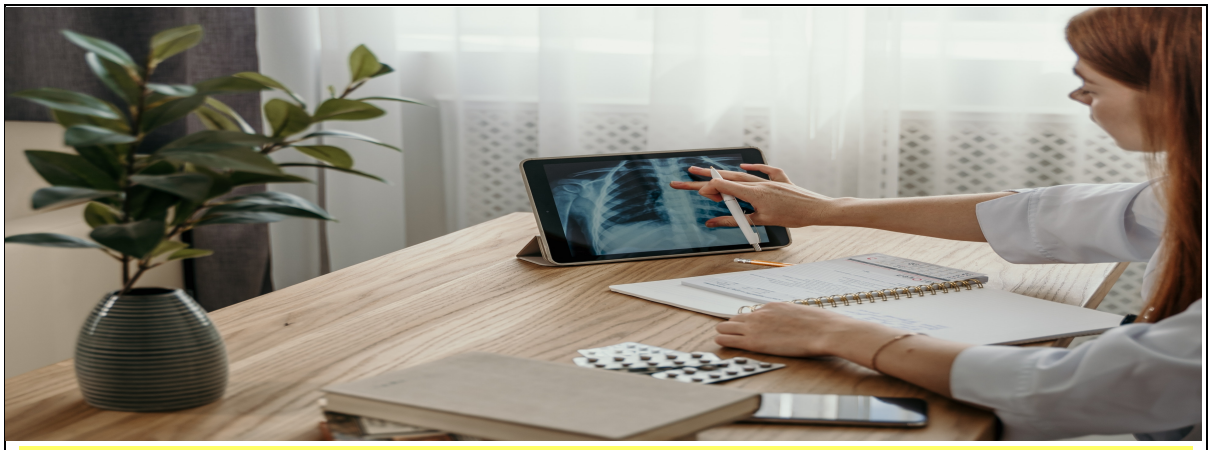


Details – this is your medical details which the insurers rely to make a decision on cover.	**Applicant 1**	**Applicant 2**
Name		
Do you smoke? (Including vaping in last 12mths)	Yes ☐ No ☐	Yes ☐ No ☐
If yes number per day	No. 0	No. 0
Please give your weight	53.07kg or 8st 5lb	53.07kg or 8st 5lb
Please give your height in feet & inches	Ft 5 in 0	Ft 5 in 0
Number of pints of ordinary strength larger/cider/bear in a week	No. 0	No. 0
Number of pints of premium strength larger/cider/bear in a week	No. 0	No. 0
Number of glasses of wine in a week	No. 0	No. 0
Number of single measures of spirits or alcopops in a week	No. 0	No. 0
I do not drink	☐	☐
Ever been told to stop drinking by a doctor	Yes ☐ No ☐	Yes ☐ No ☐
Ever used recreational drugs	Yes ☐ No ☐	Yes ☐ No ☐

Medical Questions - continued		
	Applicant 1	**Applicant 2**
1.Have you ever had any of the following conditions? chest pain,angina,heart attack, heart enlargement, heart failure, heart value defect or any other heart condition, stroke,mini stroke,translent ischemic attack (TIA), brain haemorrhage,brain aneurysm or brain damage, peripheral vascular or any disease or disorder of the aorta or arteries, Diabetes or sugar in the urine, Any condition of the central nervous system (brain, spinal cord, and nerves),multiple sclerosis, optic neuritis, cerebral palsy,paralysis,parkinsons disease,Alzhheimers disease or dementia, Blurred or double vision, numbness, loss of feeling or muscle power, balance problems, or persistent pins and needles, or facial pain serious enough to seek medical advice, Cancer, Hodgkin's disease, lymphoma, leukemia, melanoma, or a cyst or tumor of the brain or spine, A positive test for HIV/AIDS, Hepatitis B or C?	Yes ☐ No ☐	Yes ☐ No ☐
If yes to any of the above condition name		
when was it diagnosed		
What medication are you taking for this		
What is the date last affected		
How many days off work in the last year?	0	0
Diabetes only date of last HbA1c blood test		
Blood Test result between 50-96.7 or higher		
NONE OF THE ABOVE	☐	☐

2. **Within the last four years**, have you had, or have you taken medication for, or been advised to take medication or have treatment for any of the following						
Mental illness including anxiety, stress or depression, insomnia, or eating disorders, regardless of whether or not you have seen your doctor?	Yes ☐	No ☐		Yes ☐	No ☐	
Asthma or any condition affecting your lungs or breathing (other than hay fever)?	Yes ☐	No ☐		Yes ☐	No ☐	
If yes to Asthma please add	**Applicant 1**			**Applicant 2**		
Date first diagnosed						
Date of last incident						
Name medication taking						
Dosage						
How many days have you had off work in last 2 years	0			0		
Does your occupation aggravate your asthma or has it done in the past?	Yes ☐	No ☐		Yes ☐	No ☐	
Raised blood pressure or raised cholesterol other than fully resolved pregnancy related high blood pressure?	Yes ☐	No ☐		Yes ☐	No ☐	
A lump, growth, polyp or tumor of any kind, or a mole or freckle that has bled, itched, become painful, changed colour or increased in size, regardless of whetheer or not you have consulted a doctor?	Yes ☐	No ☐		Yes ☐	No ☐	
Any problems with your eyes or ears which isn't fully corrected by glasses, contact lenses, laser treatment or by hearing aids?	Yes ☐	No ☐		Yes ☐	No ☐	
Any pain or restriction in movement in the back, neck, shoulder or joints (including traumatic injury), a slipped disc, sciatica, rheumatic, arthritic or muscular	Yes ☐	No ☐		Yes ☐	No ☐	

complaints including gout, repetitive strain injury, neuralgia or fibromyalgia?				
Crohn’s disease or ulcerative colitis?	Yes ☐	No ☐	Yes ☐	No ☐
3. Apart from any conditions you've already told us about in the previous sections in this application, within the last **two years,** have you?				
Had any medication or treatment that lasted more than four weeks?	Yes ☐	No ☐	Yes ☐	No ☐
Been referred to, treated at or had any investigations at a hospital or clinic?	Yes ☐	No ☐	Yes ☐	No ☐
Been absent from work or unable to perform your daily activities due to illness, disorder or injury for more than two weeks at a time?	Yes ☐	No ☐	Yes ☐	No ☐
4. Apart from any conditions scans, tests or investigations you’ve already told us about in this application are you currently;				
Waiting for the results off any test or investigation?	Yes ☐	No ☐	Yes ☐	No ☐
Do you currently have any physcal or mental conditions that restrict or causes difficulties in performing your daily activiities or your occupation?	Yes ☐	No ☐	Yes ☐	No ☐
Apart from any visit related to contraception or pregnancy, **or to conditions you've already told us about**, how many times have you visited a doctor in the **last 12 months?**	Number 0		Number 0	



Family History

1. Have any of your natural parents, brothers or sisters been diagnosed with, or died from, any of the following **before age 60? (No need to include half brothers or sisters)**

Heart attack, angina or stroke		Yes ☐	No ☐	Yes ☐ No ☐
(females only) Breast, ovarian,,colon,bowel cancer				
(Males only) Colon or bowel cancer				
(only if your under 49) Polycystic kidney disease				
(only if your under 49) Cardiomyopathy				
(only if your under 55) Muscular dystrophy				
(only if your under 55) Huntingtons disease				
(only if your under 60) Motor neurone disease				
(only if your under 60) Alzheimers disease				
(only if your under 40) Familial adenomatous polyposis FAP polyposis coli				
(only if your under 64) Parkinsons disease				
(only if your under 64) Cancer of another site (other than ovary,breast,colon,bowel) including lymphona				
type 2 diabetes				
Multiple scerosis				

Any other inherited condition that runs in your family and that you have had or been advised to have screening for	Yes ☐	No ☐	Yes ☐	No ☐
What is the condition your family has suffered from ?				
If Yes, which family member and age ?				
Are you under any form of follow up or testing programme regarding your family history?	Yes ☐	No ☐	Yes ☐	No ☐
If yes what was the date you were last screened				
Do not know as i have no further contact with family members or do not know as i am adopted.	☐		☐	
Residency,Travel, and Sports				
1. During the last three years, have you spent more than 90 days in total in Afirica,the Caribbean,Russia,Thailand or ukraine?	Yes ☐	No ☐	Yes ☐	No ☐
2. Are currently living outside off, or during the next 12 months, do you intend to spend more than 30 days outside of the EU, other western european countries, Norht America,Austrialla, or New Zealand?	Yes ☐	No ☐	Yes ☐	No ☐
3. If you answered yes to question 2, in the next 12 months do you expect to spend more than six months outside the UK?	Yes ☐	No ☐	Yes ☐	No ☐
4. Do you take part in any of the following activiities?	Yes ☐	No ☐	Yes ☐	No ☐
underwater diving				
mountaineering or rock climbing				
flying (other than as a fare paying passenger), hang gliding, or paragliding				
motorcar or motor bike racing				
caving or potholing				

powerboat racing		
trans ocean sailing or offshore racing		
full contact martial arts, combat sport or boxing		
any extreme sport, bungee jumping (other than one off bungee jumping), white water rafting, cliff or free diving etc.		
equestrian sport other than private hacking		
winter sport other than holiday skiing or snowboarding for pleasure.		
underwater diving		
mountaineering or rock climbing		
None of the above	☐	☐
3. Are you likely to travel as part of your occupation to countries where there are areas of internal conflict.	Yes ☐ No ☐	Yes ☐ No ☐
3b Are you a member of the Armed Forces Reserves or Territorial Army?	Yes ☐ No ☐	Yes ☐ No ☐
4. is your work clerical/admin and based in an office environment for at least 75% of a typical working day?	Yes ☐ No ☐	Yes ☐ No ☐
5. Does your occupation require you to drive (other than commuting to and from work?) and if so what is your average annual busines mileage	Yes ☐ No ☐	Yes ☐ No ☐
If yes please give annual milage		
6. Do you work outsiide of the UK for more than 90 Days a year?	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you have more than one occupation?	Yes ☐ No ☐	Yes ☐ No ☐
If yes please input your second job title.		

Doctor Details
Surgery Name:
Surgery address :
Tel:

Once completed save your form and email to **david.wilkinson@look4mortgages.co.uk** with the rest of your verification documents requested.