Care Fees Payment Plan Personal Questionnaire

Please complete all relevant sections in BLOCK CAPITALS, sign, date and return to your Financial Adviser.

This form should only be completed by the person requiring care or the legal representatives of the person needing care, if they have the legal authority to take out a Care Fees Payment Plan on their behalf. Please note that if the person needing care has become, or is becoming, mentally incapable of managing their own affairs, the Power of Attorney must be registered with the appropriate authority before it can be used as authority to act.

Index:

Note for Financial Advisers:

Please check that you have:

1. Completed the Financial Adviser section details
2. Obtained the annuitant's or legal representative's signature on both the remuneration and declaration sections
3. **Enclosed the Power of Attorney form** (if appropriate)

Then send the completed forms to MDG who will pass this on to the selected insurers:

Email: icpapps@wearemdg.com

Or

Fax: 0844 443 5234

Or

Post: MDG, Buckingham House East, The Broadway, Stanmore HA7 4EB

FriendsLife partnership justretirement

CONFIDENTIAL

Section 1: Personal details

1.1. Details of the person needing care (the annuitant)

Title

Surname

Forenames

Gender (*please tick as appropriate*) ☐ Male ☐ Female

Date of Birth D D M M Y Y Y Y

Marital Status

Nationality

Postal Address

Postcode

Telephone Number (including code)

Contact Name (if telephone number provided is for a care home)

Is this address provided above the intended place to receive care?

Yes ☐ See address above

No ☐ (Please provide details of the intended place of care below)

Postal Address

Postcode

Telephone Number (including code)

Contact Name

Please complete the following details if care is currently being provided:

Where is care being provided?

Care Home (with nursing care) ☐

Care Home (no nursing care) ☐

Hospital ☐

Own home ☐

Other ☐

Date of entry to care home (if currently in care) D D M M Y Y Y Y

If entry to the care home is imminent, please advise proposed entry date D D M M Y Y Y Y

If other please give details:

Current (or expected) fees payable:

£

☐ per calendar month ☐ 4 weekly ☐ per annum

1.2. Details of the legal representative if applicable
(Please complete this section only if you are acting in a legal capacity for the person requiring care – i.e. a valid power of attorney is in place.)

If you are funding the care of the annuitant, but are not their legal representative, please **do not** complete this form and discuss this further with your Financial Adviser.

This form should only be completed by the person requiring care or the legal representatives of the person needing care, if they have the legal authority to take out a Care Fees Payment Plan on their behalf. Please note that if the person needing care has become, or is becoming, mentally incapable of managing their own affairs, the Power of Attorney must be registered with the appropriate authority before it can be used as authority to act.

Please enclose a copy of the Power of Attorney with this application. A properly certified copy of the document or the original must be provided. Please do not send any birth or marriage certificates with this questionnaire.

Subject to medical evidence the insurance provider reserves the right to request that a Power of Attorney is appointed to act on behalf of the annuitant and/or that any existing Power of Attorney is registered.

Title	
Surname	
Forenames	
Gender (*please tick as appropriate*)	☐ Male ☐ Female
Postal Address	Postcode
Telephone Number (including code)	
Are you acting as Attorney?	☐ Yes ☐ No
Are you acting as court appointed deputy for the Court of Protection?	☐ Yes ☐ No

Section 2: Product Details & Requirements

2.1. Insurance Provider Choice
Please indicate which insurance providers you require Care Fees Payment Plan terms from.

Friends Life Limited ☐

Partnership Life Assurance Company Limited ☐

Just Retirement Limited ☐

2.2. Payment Options

a) Amount of benefit required by the care recipient

£

☐ per calendar month ☐ 4 weekly ☐ per annum

(4 weekly available with Partnership Life Assurance Company Limited only.
Friends Life Limited and Just Retirement Limited do not offer 4 weekly or annual payments)

OR

b) Amount of single premium £

c) Escalation of benefits

Nil ☐

RPI ☐

RPI + 2% ☐ (available with Friends Life only)

RPI + X%* ☐ (available with Just Retirement Limited only, maximum 3%) ☐

Fixed Rate Please state percentage. ☐ %

A maximum of 8% applies for Partnership Life Assurance Company Limited.
A maximum of 10% applies for Just Retirement Limited.
A minimum of 3% and a maximum of 10% apply for Friends Life Limited.

*Just Retirement Limited can accommodate percentage increases to two decimal places.
Friends Life Limited and Partnership Life Assurance Company Limited Assurance will round up to the next whole number if decimal places are requested.

Increases are normally applied on the anniversary of the contract although Friends Life Limited and Partnership Life Assurance Company Limited offer you the option to choose the month in which the annual escalation would apply.

Month Escalation to apply if not on anniversary of contract ☐

Payments from the plan will be made in advance

Deferred Period *(please tick box)*

1 years ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐

d) Are additional death benefits required? ☐ Yes ☐ No

If yes, please note that % protection is based on the single premium for the plan less any benefit payments made. Refer to Key Features Documents for full information.

If Yes, please indicate either:

e) Short-Term Premium/Capital Protection

Please note Partnership Life Assurance Company Limited plans automatically include 6 months premium protection.
All providers automatically include 1 month 100% premium protection. Refer to Key Features Documents for full information.

For **Friends Life Limited** select either 1-3 months only or 1-3 and 4-6 months from the option below:

1-3 months ☐ 25% ☐ 50% ☐ 75%

4-6 months ☐ 25% ☐ 50% ☐ 75%

Note: 4-6 months % must not be greater than 1-3 months

For Just Retirement Limited select the option below if applicable:

☐ Option 1 – 100% protection in month 1, 50% protection in months 2-3, 25% protection in months 4-6.

☐ Option 2 – 100% in month 1, 50% in months 2-6, 25% in months 7-12.

OR

f) Long-Term Premium/Capital Protection (Decreasing Term Assurance)
AVAILABLE WITH ALL PROVIDERS

Select % of total premium to be protected

☐ 25% ☐ 50% ☐ 75% ☐ Other (1%-75%)

IMPORTANT: Not all insurance providers are able to offer capital protection, guaranteed payment periods and payment options on the same basis, please ensure you check details within each provider's Key Features Documents.

Section 3: GP & Medical Details

3.1. General Practitioner's (GP) Details

Your GP's details are required to obtain a medical report. The insurance providers may also require a Care Home Manager's Report or other further details from the care provider.

Name and full postal address of the GP who holds the medical records of the person needing care:

GP's name

Postal Address

Postcode

Telephone Number (including code)

Fax Number

How long have you (the person needing care) been registered with this GP?

If less than six months or you are expecting to change your GP, please give name and full postal address of the previous or new doctor.

GP's name

☐ Previous GP OR ☐ New GP

Postal Address

Postcode

Telephone Number (including code)

Fax Number

3.2. Medical details of care recipient

Your answers to the questions in this section and section 3.3, together with the GP and care provider information, will be used to make the relevant assessments.

Please answer all the questions asked as fully and accurately as possible before signing and submitting this form. If it is subsequently found that information provided is not accurate, the provider may be entitled to cancel the policy or adjust the amount of the benefit paid in connection with the plan.

Any changes to the answers given to the questions in this form before the plan comes into force must be notified to the insurance provider.

a) Have you attended hospital within the last 12 months? ☐ Yes ☐ No

If 'Yes' please give dates and details

b) Have you had any falls in the last 6 months: ☐ Yes ☐ No

If 'Yes' please give dates and details

c) Have you consulted any doctor or other medical practitioner about memory loss or confusion or have you been diagnosed with dementia? ☐ Yes ☐ No

If 'Yes' please give dates and details

d) Have you suffered or are you suffering from any of the following illnesses: Cancer, neurological disease, respiratory disease, heart disease, arthritis or stroke? ☐ Yes ☐ No

If 'Yes' please give dates and details

Have you consulted your current GP in the last 3 months? ☐ Yes ☐ No

3.3. Physical status of care recipient

Height	m/cm	ft/ins
Weight	kg	st/lbs

Please give details of your ability to perform the following activities of daily living:

Bowels: ☐ Continent ☐ Occasional Incontinence ☐ Incontinent

Bladder: ☐ Continent ☐ Occasional accident (max x 1 per 24 hours) ☐ Able to manage with pads or catheter ☐ Unable to manage

Grooming: ☐ Independent (with face hair/teeth/shaving) ☐ Need help

Toilet Use: ☐ Independent (on, off, dressing and wiping) ☐ Need some help, but can do some things ☐ Dependent

Feeding: ☐ Independent ☐ Need help (with cutting, spreading butter) ☐ Unable

Transfer: ☐ Independent ☐ Minor help (verbal, physical) ☐ Major help (1-2 people, physical) ☐ Immobile

Mobility: ☐ Independent ☐ Walk with verbal help of 1 person ☐ Walk with physical help of 1 person ☐ Wheelchair dependent ☐ Immobile

Dressing: ☐ Independent ☐ Need verbal help ☐ Need physical help ☐ Dependent

Stairs: ☐ Independent up and down ☐ Need help (verbal, physical or carry down) ☐ Unable

Bathing: ☐ Independent ☐ Dependent

When was care first needed and why?

Please provide details of any other facts or comments, which your GP may not know about?

Section 4: Important Information

Section 4.1: Notice of statutory rights
Under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Access to Health Records and Reports (Isle of Man) Act 1993.

Each insurance provider will apply for a medical report from your current GP and may apply to any doctor who has at any time attended you. The declaration you provide in Section 5 gives us your consent to apply for such a report if we need to.

Your rights

- You do not have to give your consent but, without it, the insurance providers will not be prepared to accept your application.
- If you do give your consent, you can indicate whether or not you wish to see any report before it is sent to us.

If you indicate that you do not wish to see any report:

- The doctor can forward it to us immediately and we should be able to process your application without delay.
- You can, however, still change your mind at any time within six months of this declaration and notify the doctor that you wish to see the report.
- If the doctor has already forwarded the report to us, he/she will send you a copy and, if he/she has not, he/she will give you 21 days to arrange to see the report before it is forwarded to the insurance providers.

If you indicated that you do wish to see any report:

- This may delay the processing of your quotation/application.
- The doctor is allowed to charge you a fee to cover the cost of supplying you with the report.
- You should follow the procedures outlined below.

Procedures for access to reports

1. If you indicate now that you do wish to see any report, the relevant insurance provider will notify you if it requests a medical report and will inform the doctor of your wishes. You will then have 21 days to contact the doctor to arrange to see it.
2. If you do see a report, the doctor must obtain your consent to the report before sending it to the insurance providers.
3. You have the right to request that the doctor amend any part of a report you consider incorrect or misleading and you can attach your written views on any part the doctor refuses to amend.
4. The doctor does not have to let you see any part of a report that he/she considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his/her intentions towards you. The doctor also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented to the disclosure or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report he/she must notify you of that fact.

Care provider reports

If you are currently receiving care, your declaration in section 5 gives the selected insurance providers permission to request a report regarding your physical and mental health and welfare from the care provider.

Section 5: Declaration and Consent

5.1. Using your personal information

Your personal data will be processed fairly and securely in accordance with the Data Protection Act 1998 (the "Act"). Details of your rights under the Act, the data which an insurance provider holds about you and how that data is used can be obtained by writing to the insurance provider's 'Data Protection Officer' at their registered address. You may be charged a small fee to obtain a copy of your Personal Data from an insurance provider.

The information which you provide to the insurance providers will be used:

- To set up and administer your plan
- To underwrite your plan
- To calculate the plan premium/benefits
- For claims management
- For customer concern analysis (if appropriate)
- For research and statistical analysis
- For fraud prevention

The insurance providers that you have selected may have to share your information with other companies within their own group of companies as well as reinsurers and service providers. These organisations will only use your information for the purposes detailed above. They may also share information with your Financial Adviser.

Other than as disclosed above, none of the insurance providers will disclose any of your information to any other body or organisation outside of their group of companies except to prevent fraud or if required to do so by law.

Your information will only be used when necessary and will only be available to those who need to see it. For example, medical records will be used only for the reasons set out above and will be seen only by those authorised by each insurance provider.

Please note that during the processing and administration of your plan, information may be transferred outside the European Economic Area. Should this occur, the relevant insurance provider will ensure that appropriate measures are in place to safeguard your personal data to comply with their obligations under the Data Protection Act 1998.

5.2. Declaration and consent – the Annuitant or Legal Representative must read, complete and sign this document

1. I request the insurance providers selected in this form to provide me with terms for their Care Fees Payment Plan contract.
2. I confirm that all statements made in this form shall be deemed to have been made directly to the insurance providers selected on this form.
3. I confirm that the information provided in this form whether in my own handwriting or not is true and accurate and that I have answered the questions as fully as possible. I understand that in the event incorrect information is given, Partnership Life Assurance Company Limited / Friends Life Limited/Just Retirement Limited may be entitled to cancel the policy or adjust the amount of the benefit paid in connection with the plan.
4. I must inform the insurance providers without delay if there is a change to my health or circumstances before the commencement of the plan. Failure to do so may result in the amendment of the terms of the plan and may invalidate any future claim.
5. The Care Fees Payment Plan will come into force when I have accepted the terms offered and the purchase price is received by the insurance provider.
6. I have read the notice regarding the use of my personal information and have been made aware of my rights under the Data Protection Act 1998. By signing this form I consent to the use of my personal data in accordance with the Data Protection Notice set out in section 5.1 of this form.
7. I give permission for each insurance provider to use the information I give for administration, underwriting, claims, research and statistical purposes, and they may pass information about my physical or mental health or condition to companies working on behalf of the insurance providers, third party insurers, reinsurers and medical practitioners.
8. I agree that my information may be passed to third parties for the prevention or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.
9. I agree that a copy of this consent can be treated as the original.

10. I am aware the insurance providers are under no obligation to accept my application or provide me with a Care Fees Payment Plan until a policy is issued.
11. I give permission for Partnership Life Assurance Company Limited/Friends Life Limited/Just Retirement Limited, as selected, to approach my care provider from time to time for confirmation that I am still entitled to benefit.
12. I acknowledge and agree that if I do not select all of the insurance providers in this form then my contact with regard to this application will only be with the insurance providers that I have selected.
13. I authorise my Financial Adviser to pass on a copy of this form to any insurance provider I select, and any third party working for the selected insurance provider, so that they are able to offer me terms for their Care Fees Payment Plan.
14. I am aware of my rights under the Access to Medical Reports Act 1988 and have read my rights under the relevant legislation governing access to medical records.
15. Each insurance provider selected on this form may obtain medical and care information from any doctor and care provider who, at any time, has attended me, about anything that affects my physical or mental health and/or any insurance office to which an application has been made on my life and I authorise the giving of such information. This consent shall remain valid throughout the duration of any insurance that may be provided and after my death.
16. I give permission for my care home manager/care provider to disclose information to the insurance provider about my physical and mental health and welfare in order to obtain terms for a Care Fees Payment Plan.

Signatures

By signing this form you are consenting to the insurance providers using your Personal Data, including sensitive information such as your medical records, for the purposes explained above and agreeing to the declarations set out in Section 5.

Do you wish to see the medical reports from your doctor before they are sent to Partnership Life Assurance Company Limited/Friends Life Limited/Just Retirement Limited? ☐ Yes ☐ No

Annuitant Signature

Print Annuitant Name

Date D D M M Y Y Y Y

OR

Signature of Annuitant's Legal Representative

Print Name of Annuitant's Legal Representative

Date D D M M Y Y Y Y

Please enclose an original or certified copy of the legal authority i.e. power of attorney.

A copy of this form is available on request.

This document is available in Braille, large type and audio tape.

Section 6: Financial Adviser Details and Remuneration

6.1. Financial Adviser Remuneration (to be completed by the applicant or legal representative)

Adviser Charge

If you have agreed a Fee with your Financial Adviser and therefore do not require an Adviser Charge to be applied to the premium please tick here: ☐

If you have agreed with your Financial Adviser for an Adviser Charge to be added with the premium please indicate below.

Percentage of Premium added ____ %

OR

Amount of Adviser Charge added £ ____

Authorisation to deduct an Adviser Charge

If you have received financial advice, your Financial Adviser may have asked your provider to facilitate a payment for advising on and recommending your annuity. This is known as the adviser charge, and is the amount you will have agreed to pay the adviser from your single premium.

Please sign the box below to confirm your agreement to the Adviser Charge:

I authorise Partnership Life Assurance Company Limited/Friends Life Limited/Just Retirement Limited to deduct the Adviser Charge from my total investment as it relates to advice received in connection with this product. The amount of adviser charge will be shown in the quotation.

Signature of applicant

Date D D M M Y Y Y Y

6.2. Financial Adviser Details (for Financial Adviser use only)

Financial Adviser Name

Company Name

Company Address

Postcode

Telephone Number

Fax Number

Email Address

Financial Services Register Number

Do you hold CF8 or another FCA approved Long Term Care Qualification? ☐ Yes ☐ No

Was financial advice given? ☐ Yes ☐ No

MDG

Tel: 0845 108 0445
Fax: 0844 443 5234
Email: icpapps@wearemdg.com
Medicals Direct Screenings Ltd (ICP)
Buckingham House East
The Broadway
Stanmore
Middlesex HA7 4EB

Friends Life Limited

Tel: 0845 303 0430 – calls may be recorded
Website: www.friendslife.co.uk/lifetimecare
Email: LTCNBImmediate@friendslifeservices.co.uk
Head office: PO Box 1810, Bristol BS99 5SN.

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