ILL HEALTH FORM

You will need to complete this application form if you would like to apply for your retirement savings on the grounds of ill health and you have one of the following plans with Royal London:

- **Pension Portfolio Plan (Personal Pension, Core Investments for Self Invested Personal Pension & Income Release Plan)**
- **Retirement Solutions Plan (Group Personal Pension Plan or Group Stakeholder Pension Plan)**
- **Individual Pension Plan (Stakeholder Plans)**
- **Talisman Pension Plan**

1 Important information

Please read this section carefully before completing this application form.

- Please use BLOCK CAPITALS and black ink when completing this form.
- Sections 2 & 4 should be completed by the plan holder. Section 5 should be completed by the doctor.
- Your completed form should be returned to us at **PO box 296, Wilmslow, Cheshire SK9 1WJ**

2 Your details

Please complete this section with your details.

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please specify) ☐

Forename(s) ☐

Surname ☐

Occupation ☐

Home address ☐

☐

☐ **Postcode** ☐

Contact telephone number ☐

Email address ☐

2 Your details continued

Nature of disability

When were you last able to undertake any part of the duties of your occupation? D D M M Y Y Y Y

Plan number

3 Privacy notice

This section should be read by all applicants.

We, The Royal London Mutual Insurance Society Limited will use your information together with other information for insurance, administration, underwriting, statistical analysis, claims handling, research, customer services and to undertake home visits to discuss the claim. We will disclose your information to our service providers, agents and business partners for these purposes.

We may pass your personal information to a third party to assist with the management of your claim. This might include a home visit, a telephone assessment, a medical note review or functional capacity assessment or other medical related services. By returning this form you consent to our processing your sensitive personal data such as health data for the above purposes.

We may monitor and record phone calls and retain these for the purposes of training and quality assurance, and to ensure we have an accurate record of your instructions.

Under the terms of the Data Protection Act 1998, you are entitled to ask for a copy of the information we hold on you and to have any inaccuracies in your information corrected. We are allowed to charge a fee for this. If you have any questions about how we will use your personal information please contact the Data Protection Officer, Royal London House, Alderley Road, Wilmslow, Cheshire, SK9 1PF.

4 Notice of your statutory rights for access to medical reports

This section should be read and signed by the plan holder.

Before we can apply for a medical report (section 5) from a doctor who has cared for you, we need your consent in the space indicated at the end of this section. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as appropriate) and the procedure for dealing with reports.

You do not have to give your consent but without it we will not be prepared to consider your application for retiral on grounds of ill-health.

If you do give your consent, you can say whether you wish to see the report before it is sent to our Principal Medical Officer.

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

- You should complete section 2, sign the declaration, and forward this form to your doctor to complete section 5.
- The doctor can return the form as soon as he has completed section 5, and we will be able to process your claim without delay.
- You can, however, still change your mind and notify the doctor that you wish to see the report at any time within six months. If the doctor has already returned the report to us he will make arrangements to let you see a copy and, if not, he will give you 21 days to arrange to see it.

If you indicate that you do wish to see any report

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

Procedures for access to medical reports

- If you indicate that you wish to see the report, you should complete section 2, sign the declaration, and forward this form to your doctor to complete section 5. You will then have 21 days to contact the doctor to make arrangements for you to see the report.
- Once you have seen the report, before it is sent to us, the doctor cannot submit it unless he has your consent. Remember that without your consent we will not be prepared to consider your application.
- Once you have seen the report, you can write to the doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you or the doctor are not in agreement and which the doctor is not prepared to alter.

4 Notice of your statutory rights for access to medical reports continued

- The doctor is not obliged to let you see any part of the report if, in his opinion, it would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the doctor's intentions towards you. He 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 or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report.

Declaration

- I consent to Royal London asking for information including copies of my full medical records from any medical practitioner, hospital, specialist, employer or any other person Royal London feels necessary, and I consent to the giving of this information. I understand that this information may be given to a third party, for example a medical examiner or reassurer, so that my claim can be assessed.
- I declare that the information in this claim form is true and complete, to the best of my knowledge and belief.
- To ensure that my information is accurate, I agree to inform Royal London of any changes to my personal circumstances, by writing to them.
- I declare that I have read the statement in section 4 notifying me of my rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as appropriate), and consent to my doctor providing medical reports including copies of my Full Medical Records to Royal London, so that they can deal with my claim.
- Please tick the box below if you **do** want to see any medical reports before they are sent to Royal London.
- Yes I **do** want to see my medical report. I understand that it will not be sent to Royal London until I have seen it, and they will not be able to make a decision on my claim until then. ☐

Signature _____ **Date** D D M M Y Y Y Y

For office use only

Plan number _____

5 Illness details

This section should be completed by your doctor.

Patient name

Date of birth D D M M Y Y Y Y

Address

Postcode

Plan number

Scheme name

1 (a) When did your patient first register with the practice? D D M M Y Y Y Y

(b) From what date do their records commence? D D M M Y Y Y Y

(c) If the period covered by the records is not continuous please give dates and reasons, if known, for any gaps.

2 (a) In respect of your patient's current inability to work, when was he/she first seen by you, any other doctor, hospital or alternative health practitioner? D D M M Y Y Y Y

(b) From what illness, injury or condition are they suffering?

(c) Can you please confirm who reached the diagnosis?

(d) From what date were they first certified as unfit to work? D D M M Y Y Y Y

(e) If that certification has not been continuous to date please give dates and reasons.

(f) Please provide full details of your patient's descriptions of their symptoms including when they first started, their frequency, severity and duration.

3 Has your patient previously consulted you or any other doctor for treatment or advice for this or any related condition? If so please provide full details especially dates, treatment and any time off work.

For office use only

Plan number

5 Illness details continued

4 (a) Please provide details of any treatment that has been given.

(b) If medication has been prescribed please state dosage and whether any changes have been made.

(c) To your knowledge has your patient fully complied with the treatment suggested? Yes ☐ No ☐

(d) Please clarify if there are any changes planned to the treatment.

5 Please provide full details of any person whom your patient has seen or is being referred to.

Name Speciality

Hospital address

Postcode

Name Speciality

Hospital address

Postcode

Please forward copies of any specialist reports in your possession.

6 Please give details of any tests or investigations either carried out or pending, including dates and results if known.

7 (a) Has your patient ever suffered from any other significant illness, injury or condition? If 'Yes', please give dates and details. Yes ☐ No ☐

(b) Has your patient ever previously suffered from anxiety, stress, depression, any other mental disorder, unexplained fatigue or psychosomatic conditions? Yes ☐ No ☐

(c) Is there any history of alcohol or drug misuse? If 'Yes', please give details. Yes ☐ No ☐

8 What is your patient's occupation and what do you understand to be the nature of that occupation, e.g. sedentary, light manual or heavy manual?

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Plan number

5 Illness details continued

9 As a result of your most recent clinical examination please describe your patient's current abilities using the following scale:

0 = Unknown; 1 = no function at all; 2 = very reduced function; 3 = moderately reduced function; 4 = slightly reduced function; 5 = normal function.

Walking		Climbing (ladders/stairs)	
Sitting		Lifting	
Standing		Driving	
Bending		Reaching over shoulders	
Hand grip		Cognitive function	

Date of this most recent clinical examiniation D D M M Y Y Y Y

10 (a) Is your patient's condition improving, static or deteriorating?

(b) Do you think your patient will be able to return to work? Yes ☐ No ☐

(c) In your professional opinion, is the life expectancy of this patient less than one year? Yes ☐ No ☐

11 Are there any social, domestic or employment issues that are or have been impacting upon your patient's inability to work? If 'Yes', please give details. Yes ☐ No ☐

12 In respect of this illness, injury or condition have you or any of your partners completed any other such forms, or provided medical reports, for another insurance company, solicitor or third party? If 'Yes', please provide brief details. Yes ☐ No ☐

13 Your patient has been given details of their rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as appropriate). Could you please indicate if your patient has requested any adjustment to the answers you have given above?

Once again, if you have any specialist reports that would assist our assessment of this application could you please send us copies.

Signature of doctor **Date** D D M M Y Y Y Y

Name of doctor

Address

Postcode

Any fee for this certificate must be borne by your patient, this includes any VAT charged by the surgery.

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Plan number

Royal London
1 Thistle Street, Edinburgh EH2 1DG
royallondon.com

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