


For customers

Blood disorder or anaemia questionnaire

To be completed by the insured person.

Please complete this form in BLOCK CAPITALS and in ballpoint pen.

Whenever you see this icon , you may have to send us additional information.

1. Insured person's details

Policy/Reference number

Title

Mr / Mrs / Miss / Ms / Other – please specify

Full forename(s)

Surname

Date of birth (dd/mm/yyyy)

If you don't answer the questions fully and accurately, we may not pay a claim, and the whole policy may be cancelled, not just the benefit under which you're claiming.

2. Medical questions

2.1 What's the exact medical diagnosis?

2.2 How long ago were you diagnosed?

Years

months

2.3 Are you currently receiving medication?

Yes No

2.4 Are you currently receiving treatment?

No

Yes – give full details, including how often you have it

2. Medical questions – continued

2.5 Do you have your blood levels checked?

- No
 Yes – give full details

2.6 Are you waiting for any investigations?

- No
 Yes – give full details

2.7 If you've been diagnosed with anaemia, please answer the following questions.

a. If known, what's the type of anaemia?

- Iron deficiency anaemia
 Sickle cell anaemia
 Thalassaemia
 Other
 Unknown

If you ticked 'Other' or 'Unknown' above, give full details, where possible.

b. If you have iron deficiency anaemia, has an underlying cause been found?

- No
 Yes – give full details

c. Have you been advised by a medical practitioner that your blood levels have returned to normal?

- No
 Yes – give full details

3. Declaration

I acknowledge this questionnaire forms part of my application. To the best of my knowledge, the information and statements made in this questionnaire are true and complete. If the statements aren't true and complete and/or I don't tell Aegon about any changes before the policy starts, then it **might result in loss or cancellation of the protection**. I confirm that I've read over any answers that I didn't fill in and they're correct.

Date

D	D	M	M	2	0	Y	Y
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Signature

X												X
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