


For customers

Raised blood pressure 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 When was your blood pressure first noted to be raised? (dd/mm/yyyy)

2.2 How was it discovered or why was your blood pressure measured at that time?

2.3 Please tell us what your blood pressure readings were at the time (if known).

2.4 Have you had time off work in the last five years?

No

Yes – tell us when and for how long

2.5 What treatment have you received in the past, including details and dates?

2. Medical Questions – continued

2.6 What tablets (including drug name and dosage) are you currently being prescribed and how often do you take them?

2.7 Have you undergone any investigation with regard to your condition, for example electrocardiogram, chest x-ray, kidney scan?

No

Yes – give full details, dates and results

2.8 Are you having regular follow-up checks with your GP or at hospital?

No

Yes – tell us how often and who with

2.9 When was your blood pressure last checked?

D	D	M	M	Y	Y	Y	Y
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2.10 What were the results (give exact readings if known)?

2.11 Have you ever had your blood lipid level checked (for cholesterol, triglycerides, etc)?

No

Yes – give details and dates (give exact readings if known)

2.12 Have you ever had a stroke or any kidney, heart or eye problems?

No

Yes – give full details

2.13 Have your urine checks always been normal?

No

Yes

2.14 Do you smoke?

No

Yes – tell us what and how much a day

2.15 Do you drink alcohol?

No

Yes – tell us how much you drink a day

2. Medical Questions – continued

2.16 Have any of your parents, brothers or sisters died or suffered from heart disease, stroke, high blood pressure, diabetes or kidney disease?

No

Yes – give full details

2.17 Can you give us any extra information that will help us to consider your application?

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 complete and that they're correct.

Date

D	D	M	M	2	0	Y	Y
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Signature

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