Care Fees Plan Questionnaire

Please complete all relevant sections in BLOCK CAPITALS.

Please sign and date the form in Section 5 and return the whole questionnaire to your Financial Adviser.

This form should be completed by the person requiring care. The legal representatives of the person needing care may complete the form if they have the legal authority to take out a Care Fees Plan on the customer's 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 accepted.

Please note that we will not be able to process the questionnaire, or request the necessary medical reports without a valid signature and Power of Attorney.

Index:

Note for Financial Advisers:

Please check and confirm 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 form(s) to MDG who will pass this on to the selected insurers:

- email: icpapps@wearemdg.com
- Fax: 0844 443 5234
- Post: MDG, Buckingham House East, The Broadway, Stanmore HA7 4EB

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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	

1.2 Care Details:

Please confirm where the care is being provided/expected to be provided:

A Care Home (with nursing care)	☐	Hospital	☐
A Care Home (with no nursing care)	☐	Your own home	☐
A PWD (Person with Dementia) Home	☐	Other (please provide details)	

If the care is expected to be provided in a Care Home, please confirm the date you entered the Care Home/expect to enter the Care Home:

D D M M Y Y Y Y

If you have care at home, please confirm the date when you first started receiving care from a Registered Care Provider:

D D M M Y Y Y Y

Please confirm where the care is being provided/expected to be provided or home address if not yet known:

Address	Postcode
Telephone Number (including code)	
Fax number (if available)	
Email address (if available)	
Contact Name	

If you are receiving care in your own home, please provide full details of the carer and/or agency details

Full name and address (if different from above)	
Telephone Number (including code)	
Fax number (if available)	

Email address (if available)	
Contact Name	

Is care currently being provided by a friend or family member? ☐ Yes ☐ No

Please confirm the current (or expected) level of fees payable:

£ ☐ ☐ per calendar month ☐ 4 weekly ☐ per annum

1.3 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 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
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

Please Note: If you are acting on behalf of the care recipient we will not be able to process this application unless a copy of the Power of Attorney document is provided.

Section 2: Product Details & Requirements

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

Aviva ☐
Partnership Life Assurance Company Limited ☐

2.2. Payment Options
Please indicate which benefits you would like terms to be provided on.

Please note that not all insurance providers are able to offer capital protection, guaranteed payment periods and payment options on the same basis. Therefore, please ensure you check details within each provider's Key Features for full information on the benefits available.

Please also note that all providers make payments from their plans in advance.

Please confirm the:

a) Amount of benefit required by the care recipient

£

☐ per calendar month ☐ 4 weekly ☐ per annum

(4 weekly is available with Partnership Life Assurance Company Limited only.)

OR

b) Amount of single premium £

c) Escalation of benefits

Nil ☐
RPI ☐
RPI + 2% ☐ (available with Aviva only)

Fixed Rate - please state percentage* ____ % (a maximum of 8% applies for Partnership Life Assurance Company Limited)

(a minimum of 3% and a maximum of 10% apply for Aviva)

*Please state a whole number. Aviva and Partnership Life Assurance Company Limited will round up to the next whole number if are requested.

Increases are normally applied on the anniversary of the contract although you can choose the month in which the annual escalation would apply.

If you would like the escalation to be applied on a specific, please confirm the month this should be applied: ____

d) Deferred Period *(please tick the relevant box if you would like payments to be deferred for a specified period)*

None ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐

e) Death Benefits

Please indicate whether you would like terms to be provided with the following death benefits

Please note that:

- All Partnership Life Assurance Company Limited plans automatically include 6 month's premium protection of 100% protection in month 1, 50% protection in months 2-3 and 25% protection in months 4-6
- All Aviva plans automatically include 1 months premium protection at 100%
- Please refer to each provider's Key Features Document for full information.

Would you like a quote with no death benefits included: ☐ Yes ☐ No

Short Term Premium/Capital Protection

- This option is only available from Aviva
- If you select 4-6 months cover, you must also select 1-3months cover
- The 4-6 months cover must not be greater than the 1-3 months cover

1-3 month's cover: ☐ 25% ☐ 50% ☐ 75%

4-6 month's cover: ☐ 25% ☐ 50% ☐ 75%

Long Term Premium/Capital Protection (Decreasing Term Assurance)

- This option is available from both providers
- Please select the % of the total premium to be protected

☐ 25% ☐ 50% ☐ 75% _____ % Other (1-75%)

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.

Please provide the name and full postal address of the GP who holds the medical records of the person needing care:

GP's name

Address

Postcode

Telephone Number (including code)

Fax Number

Email address

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

years months

If you have been registered with your GP for less than six months or you are expecting to change your GP, please provide the name and full postal address of the previous or new doctor.

GP/Surgery name

☐ Previous GP OR ☐ New GP

Address

Postcode

Telephone Number (including code)

Fax Number

Email address

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 by the insurance providers to confirm terms.

Therefore, please answer all the questions as fully and accurately as possible before signing and submitting this form. If it is subsequently found that any 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.

If any of the answers given to the questions in this form change before the plan comes into force, you must notify the relevant insurance provider(s).

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

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

If 'Yes' please give dates and details

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

If 'Yes' please give dates and details

d) 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

e) 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

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:

Mobility	☐	Independent	☐	Walk with verbal help of 1 person	☐	Walk with physical help of 1 person	☐	Wheelchair dependent	☐ Immobile
Stairs:	☐	Independent up and down	☐	Need help (verbal, physical or carry down)	☐	Unable			
Transfer:	☐	Independent	☐	Minor help (verbal, physical)	☐	Major help (1-2 people, physical)	☐	Immobile	
Toilet Use:	☐	Independent (on, off, dressing, wiping)	☐	Need some help, but can do some things	☐	Dependent			
Bowels:	☐	Continent	☐	Needs pads	☐	Incontinent	☐	Stoma independent	☐ Stoma dependent
Bladder:	☐	Continent	☐	Needs pads	☐	Catheterised, independent	☐	Catheterised, dependent	
Grooming:	☐	Independent (with face, hair/teeth/ shaving)			☐	Need help			
Bathing:	☐	Independent			☐	Dependent			
Dressing:	☐	Independent	☐	Need verbal help	☐	Need physical help	☐	Dependent	
Feeding:	☐	Independent	☐	Need help (with cutting, spreading butter)	☐	Unable			

When was care first needed and why?

Please use this box to provide any further information continued from your previous answers, or that you would like us to take into account when assessing your application.

Section 4: Important Information

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 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 or Aviva 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 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 Plan until a policy is issued.
11. I give permission for Partnership Life Assurance Company Limited or Aviva, 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 provider 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 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 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 & Aviva? ☐ 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 to act on behalf of the Annuitant 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

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

6.1. Adviser Charge

Please complete section a **or** b

a)

If you do not require an Adviser Charge to be applied to the premium please tick here: ☐

OR

b)

If you have agreed an Adviser Charge with your Financial Adviser that you wish to be included with the premium quoted, please indicate the amount below and sign the authorisation that follows. The Adviser Charge will be transferred to your Financial Adviser on your behalf when the policy has started.

Percentage of Premium included ____ %

OR

Amount of Adviser Charge included £

c) 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 or Aviva 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

Aviva

Tel: 0345 303 0430 – calls may be recorded
Website: www.aviva.co.uk
email: LTCNBImmediate@aviva.com

Partnership Life Assurance Company Limited

Tel: 0333 043 7040 (Local call rates apply)
Website: www.partnership.co.uk
Email: ltc@partnership.co.uk