

# Impaired Life Terms



The lump sum available from an equity release scheme is based on a number of factors and one of these is life expectancy. For those who are sadly suffering from certain conditions that are likely to reduce life expectancy, they could benefit from enhanced terms. Although nobody wants to be suffering from a condition that will reduce lifespan, the enhanced terms available in these circumstances will at least provide an above average lump sum.

## Who qualifies?

Any client who has a reduced life expectancy due to an illness or medical condition can expect to receive enhanced terms. The guide overleaf shows common conditions that normally qualify.

## Who may not qualify?

Any client who is healthy or has an illness, medical condition, state of health or habit that may not reduce their normal life expectancy. Such conditions as well controlled hypertension (raised blood pressure), raised cholesterol which is well controlled on medication, obesity, asthma or smoking on their own without any associated medical impairments would not qualify.

## How is life expectancy calculated?

The client's age and gender are taken into account. Then the illness or medical condition is factored in as well as the severity of this condition e.g. Client A who is wheel-chair bound with multiple sclerosis will have a shorter life expectancy than Client B with multiple sclerosis but only minor mobility problems. Both would qualify but Client A would receive enhanced terms.

## How do I apply?

Simply complete the attached application form and return it to us. There is a £25 Impaired Life Application fee that must be sent with this application in order to cover the costs of specialist underwriting and administration. Please note that the information supplied may be confirmed with a General Practitioner's report based on personal medical records.

Hodge Lifetime is a trading name of Julian Hodge Bank Limited (Registered in England No. 743437) and Hodge Life Assurance Company Limited (Registered in England No. 837457) which are authorised and regulated by the Financial Services Authority.

Both companies are registered in England and Wales at 31 Windsor Place, Cardiff CF10 3UR.



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# Impaired Life Terms



## What medical diseases or conditions normally qualify?

The following conditions would typically be considered for enhanced terms:

Category:	Disease/Condition:	Time Limit:
Heart conditions:	Heart attack ( <b>see Note 1</b> )	Within last 10yrs
	Heart failure (including CCF- Congestive Cardiac Failure)	Current
	Heart Surgery	Within last 10yrs
	Cardiomyopathy	Current
Lung conditions:	Chronic Bronchitis	Current
	Emphysema	Current
	Bronchiectasis	Current
Kidney conditions:	Kidney Failure	Current
Liver conditions:	Cirrhosis	Current
Cancer:	Major organ ( <b>see Note 2</b> )	Within last 5yrs
	Widespread	Within last 5yrs
	Inoperable	Within last 5yrs
Stroke/CVA-Cerebro Vascular Accident:	Stroke	Within last 10yrs
Neurological:	Parkinson's disease	Current
	Motor Neurone disease	Current
	Multiple Sclerosis	Current
	Paralysis	Current
Organic Brain Disease:	Dementia	Current
	Alzheimer's	Current
	CJD	Current
	Multi-infarct Dementia	Current
Transplants:	Major organ transplant	Within last 10yrs
Others:	AIDS	Current
	Diabetes ( <b>see Note 3</b> )	Current

### Notes:

1. A heart attack alone would not automatically qualify, especially in the ages 70+. However if you are suffering restrictions, such as substantially reduced activity, then you may qualify.
2. Cancer would need to be at an advanced stage in some instances due to the improved medical treatments and nature of the cancer (for example some breast cancers or cancers of the colon may not qualify). Inoperable or wide spread cancers would generally qualify.
3. There would need to be complications with the diabetes to qualify.

The above list is by no means exhaustive and does not provide any guarantees of qualifying for enhanced terms but provides a guide as to the common conditions that would normally be considered.

# Application for Impaired Life Terms



**In the case of a joint life application, this assessment should be completed on the youngest life.**

This application for Impaired Life Terms is to accompany an application, in your name, for an equity release product provided by Hodge Lifetime.

Please disclose as much information about your health as possible before signing this form. The answers you give will be used to

assess your application, therefore you must make sure your answers are true and complete. You must make sure that you tell us all material facts. Misrepresentation of the facts may result in legal action being taken against you.

A material fact is something which may influence our assessment of your proposal. If you are unsure whether a particular fact is material, please be sure to note it down and inform your Financial Adviser.

(Please use block capitals and black ink)

Title: Mr  Mrs  Miss  Ms  Other (please specify)

Surname  Male  Female

Forename(s)  Date of Birth

### Marital status:

Single  Married  Civil partnership  Separated/Divorced  Widowed

Height: ft  ins  or cms

Weight: st  lbs  or kgs

Do you currently smoke? Yes  No  Never

If you previously smoked, please advise the year you stopped

If you are a regular cigarette smoker and have been for the last 10 years or more, please indicate your average daily level:

Cigarettes a day  Hand-rolled ozs a week

Cigars a day  Pipe, ozs a week

On average, how many units of alcohol do you drink each week?

(A unit of alcohol is equivalent to half a pint of normal strength beer, lager or cider, one standard glass of wine or a single measure of spirits).

Are you currently living in:

Own home

Residential care home

Nursing home or hospice

Do you currently:

Live alone

Live with someone else

Have a 24hr carer living in

If you have ever suffered with any of the following medical conditions please tick the appropriate box and complete the relevant supplementary questionnaire(s). When completing the questionnaire, please provide as much information as you can. If you are unsure if something is relevant, put it down anyway as it may be helpful to us.

Heart attack, angina or other heart condition – complete the heart disease questionnaire on page 4.

Diabetes – complete the diabetes questionnaire on page 5.

Cancer, malignant growth or tumour, melanoma, leukaemia, Hodgkin's disease, lymphoma, brain tumour – complete the tumour questionnaire on page 6.

Stroke, CVA, TIA (mini-stroke) or subarachnoid haemorrhage – complete the stroke questionnaire on page 7.

Chronic respiratory disease – complete the respiratory questionnaire on page 8.

Chronic kidney or liver disease or organ failure – complete the organ failure or disease questionnaire on page 9.

Multiple Sclerosis, Motor Neurone disease, Muscular Dystrophy, Paralysis, Parkinson's Disease – complete the neurological questionnaire on page 10.

Alzheimer's disease, dementia – complete the dementia questionnaire on page 11.

Any other serious illness or condition – complete the other serious condition questionnaire on page 12.

## FUNCTIONAL PROFILE

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

Level of assistance required is classified as follows:

- Major**            Always require both assistive devices and personal help on a daily basis
- Moderate**       Requires assistive device and some personal help on a daily basis
- Minor**            Requires assistive device, but no other help or supervision on a daily basis  
or requires occasional help, without assistive device
- Independent**    No help, supervision or assistive device required

	Major	Moderate	Minor	Independent
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring to bed or chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide full details of care required, reason and for how long it has been required, plus type of assistive device used. Continue on pages 16 & 17 if necessary.

For example: Walks with frame due to weakness in legs following a stroke, requires a wheelchair outside. Bladder incontinence, catheter for 2 years due to multiple sclerosis. Bedridden. Need help cutting food, lifting kettle, doing up buttons etc.

PLEASE REMEMBER TO COMPLETE THE SUPPLEMENTARY  
QUESTIONNAIRE FOR EACH RELEVANT MEDICAL CONDITION

## Supplementary questions – HEART DISEASE

<p><b>What heart condition has been diagnosed?</b> If more than one condition, please list all relevant conditions.</p>	
<p><b>When was the condition(s) first diagnosed?</b></p>	
<p><b>Have you required any surgery for the condition(s)?</b> If so, what type of surgery was performed? If appropriate, please include number of vessels, arteries involved.</p>	
<p><b>When was the operation(s) performed?</b></p>	
<p><b>Has any subsequent surgery been required or is any planned?</b> If so, please provide details.</p>	
<p><b>Are any future investigations or treatment planned?</b> If so, please give details.</p>	
<p><b>Other than for surgery, have you needed to be admitted to hospital for this condition?</b> If so, please provide reason, date(s) and how long you were an inpatient for.</p>	
<p><b>Please list all medication (including dosage) you are currently taking?</b></p>	
<p><b>What symptoms do you currently experience and how often?</b></p>	
<p><b>Are your daily activities restricted?</b> Please provide full details.</p>	
<p><b>Do you suffer from any of the following?</b> Chest pains, breathlessness at rest, breathlessness on walking or climbing stairs, episodes of dizziness or blackouts, swollen ankles. If yes, please provide details including how often experienced.</p>	
<p><b>Are you currently under the care of a cardiologist?</b> If so, how often do you attend and when was your last follow up?</p>	
<p><b>If known, what was your latest blood pressure reading and cholesterol level?</b></p>	
<p><b>Please provide any other information you think may be useful in the assessment of your application.</b> Continue on pages 16 &amp; 17 if necessary.</p>	

## Supplementary questions – DIABETES

When was your diabetes first diagnosed?	
Is your diabetes treated by diet only?	
Do you require Insulin? If so, when was this started?	
Please list all the medication (including dosage) you are currently taking.	
<p>Do you suffer from any of the following complications? If yes, please provide full details.</p> <p>For example: Coronary heart disease, diabetic neuropathy (i.e. numbness in feet, gangrene), renal disease or protein in urine, high blood pressure or high cholesterol.</p>	
<p>In the last 5 years have you ever suffered a hypoglycaemic attack or diabetic coma. If so, please provide details and dates.</p>	
<p>Have you ever been admitted to hospital as a result of your diabetes? If so, please provide details.</p>	
How often do you attend for check ups and when was your last one?	
If known, please advise your latest blood glucose result or HbA1c.	
If known, please advise your last blood pressure reading and cholesterol level.	
How has your overall diabetic control been described by your GP or nurse, i.e excellent, good, satisfactory or poor.	
<p>Please provide any other information you think may be useful in the assessment of your application.</p> <p>Continue on pages 16 &amp; 17 if necessary.</p>	

## Supplementary questions – TUMOUR

What is the name or type of tumour/ malignant condition?	
Where was the tumour located?	
When was it first diagnosed?	
Has there been any recurrence or spread of the tumour/condition? If yes, please provide full details including where and date diagnosed.	
Has surgery been performed? If so, please provide type of operation(s) carried out and date(s).	
What investigations were carried out to confirm the diagnosis?	
Have you required, chemotherapy, radiotherapy, or bone marrow transplant? If so, please provide details including dates started and finished.	
What medication are you currently receiving?	
Are any further investigations, treatment or surgery planned? If so, please provide full details.	
Have you been discharged from follow up? If not, how often do you attend and when was your last one?	
Has your consultant advised you that your condition is in remission?	
Please provide any other information you think may be useful in the assessment of your application. Continue on pages 16 & 17 if necessary.	

## Supplementary questions – STROKE

<p>Please advise the condition(s) you have suffered from:</p>	<p><input type="checkbox"/> CVA (Cerebrovascular Accident – major stroke)</p> <p><input type="checkbox"/> TIA (Transient Ischaemic Attack – mini-stroke)</p> <p><input type="checkbox"/> Subarachnoid Haemorrhage (SAH)</p>
<p>Have you had more than one episode? If so, please provide details.</p>	
<p>What date(s) did you suffer from the condition?</p>	
<p>What parts of the body were affected?</p>	
<p>Have you made a full recovery? If not, what residual symptoms do you suffer from and to what degree?</p>	
<p>Please list all medication, (including dosage) you are currently receiving?</p>	
<p>Are you currently undergoing rehabilitation, physiotherapy, psychotherapy or speech therapy? If so please provide details.</p>	
<p>Are you still under follow up or have you been discharged?</p>	
<p>If known, please advise your latest blood pressure reading.</p>	
<p>Has an Enduring or Lasting Power of Attorney been granted to another party? If so, has this been registered with the Court of Protection or Office of the Public Guardian (OPG)?</p>	
<p>Please provide any other information you think may be useful in the assessment of your application. Continue on pages 16 &amp; 17 if necessary.</p>	

## Supplementary questions – RESPIRATORY DISEASE

What is the full name of your condition?	
Is there an underlying cause for your condition?	
How long have you had the condition?	
Please describe the nature and severity of the symptoms you currently experience?	
Are your symptoms constant or do you have intermittent attacks?	
If intermittent, how often do you have attacks?	
What impact do your symptoms have on your daily activities? For example, walking, climbing stairs etc.	
Do your symptoms wake you at night? If so, how often?	
Do you require oxygen, regular nebulisers or oral steroids? If so, please provide details.	
What medication, including inhalers do you currently receive? Please include dosage(s) and how often taken.	
Have you required any hospital admissions for this condition? If so, please advise when, the treatment required and how long you were an inpatient for.	
Do you know the results of your current lung function, i.e. peak flow rate?	
Please provide any other information you think may be useful in the assessment of your application. Continue on pages 16 & 17 if necessary.	

## Supplementary questions – ORGAN FAILURE OR DISEASE

Please advise organ(s) affected.	
Please specify type of disease or diagnosis.	
Was there any underlying cause? Please provide details.	
When was the disease first diagnosed?	
Do you know the stage of your disease, i.e. Stage 4 or end stage renal disease? If so, when was this diagnosed?	
Do you receive dialysis? If so, please advise type and how often performed.	
Have you had a transplant, or are you on the waiting list? If so, please provide details.	
Have you required any other surgery or hospital treatment? If so, please provide details and dates.	
Please list all medication (including dosage) you are currently receiving.	
Do you know the results of your latest investigations or laboratory tests? If so, please provide details.	
How often do you attend follow ups with a hospital consultant and when was your last one?	
Please provide any other information you think may be useful in the assessment of your application. Continue on pages 16 & 17 if necessary.	

## Supplementary questions – NEUROLOGICAL

What condition do you suffer from?	
When was it first diagnosed?	
Was there any underlying cause? If so, please provide details.	
What parts of the body are affected and to what extent?	
Please describe the nature and severity of all symptoms you currently experience?	
Are these symptoms constant or intermittent? If intermittent, how often do they occur?	
Please list all medication (including dosage) you are currently receiving.	
Have you required any hospital admissions for this condition? If so, please advise reason, duration and dates.	
What investigations have been performed? Or are any planned? Please provide details.	
Do you or have you received any specialist treatments or therapy for this condition? If so, please provide details.	
Please provide any other information you think may be useful in the assessment of your application. Continue on pages 16 & 17 if necessary.	

## Supplementary questions – DEMENTIA

What condition are you suffering from?	
When was the condition diagnosed?	
Please describe your current symptoms, including severity.	
Are these symptoms constant or intermittent? If intermittent, how often do they occur?	
What assistance do you require in everyday tasks?	
What medication (including dosage) are you currently receiving?	
What investigations have been performed?	
Have you required any hospital admissions for this condition? If so, please advise reason, duration and dates.	
Do you or have you received any specialist treatments or therapy for this condition? If so, please provide details.	
Has an Enduring or Lasting Power of Attorney been granted to another party? If so, has this been registered with the Court of Protection or Office of the Public Guardian (OPG)?	
Please provide any other information you think may be useful in the assessment of your application. Continue on pages 16 & 17 if necessary.	

## Supplementary questions – OTHER SERIOUS CONDITION

Please note that high blood pressure and high cholesterol that is controlled by treatment, with no other associated medical condition, does not qualify for an enhancement.

What condition are you suffering from?	
When was it diagnosed?	
Is there any underlying cause?	
What parts of your body are affected and to what degree?	
Please describe the nature and severity of the symptoms you are currently suffering from.	
<b>Are these symptoms constant or intermittent?</b> If intermittent, please advise how often they occur.	
<b>Are your daily activities restricted?</b> If so, please provide full details.	
<b>What investigations or tests have been carried out?</b> Or are any planned?	
<b>Have you required surgery for this condition or is any planned?</b> Please provide details and dates.	
<b>Are you under the care of a specialist?</b> If so, how often do you attend for follow up and when was your last consultation?	
<b>What medication, (including dosage) are you currently receiving?</b>	
<b>Have you needed to be admitted to hospital for this condition?</b> If so, please advise reason, duration and dates.	
<b>Have you received any specialist treatments or therapy for this condition?</b> If so, please provide full details.	
<b>Please provide any other information you think may be useful in the assessment of your application.</b> Continue on pages 16 & 17 if necessary.	

## NOTICE OF STATUTORY RIGHTS

A medical report may not be required to support your application, but if it is, Hodge Lifetime reserves the right to apply for a medical report from any doctor who has at any time attended you.

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, before we can ask a doctor to fill in a report, we need your signed permission.

### Your rights under the act are as follows:

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application or be able to offer you the best possible terms.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell you that we have requested a report and also ask the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

Please note that if you indicate that you do wish to see the report, there may be a delay in processing your application. The doctor is also allowed to charge you a fee to cover the cost of supplying you with the report.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will accompany the report.

Your doctor can withhold access to the report if he/she feels that it would cause physical or mental harm to you or others. He/she also does not have to let you see any part of the report that would be likely to disclose information about, or identify, another person who has supplied information about you, unless that person has given permission, or the information has been provided by another health professional who has cared for you.

### The medical report your doctor completes asks about the following:

#### Your current health

- Any care, medication or treatment you are currently receiving
- The results of referrals or tests you have received or are waiting for

#### Your past health

- Details of any serious illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor.

### We will ask your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C
- Any sexually-transmitted diseases unless there could be long-term effects on your health
- Predictive genetic test results unless there is a favourable test result that shows that you have not inherited a condition your family suffers from

## DECLARATION AND CONSENT

**Please read, complete and sign this section.**

I declare that to the best of my knowledge and belief the statements in the application for Impaired Life Terms are true and complete. I understand that any misrepresentation may result in legal action.

I agree that Hodge Lifetime, or its appointed medical underwriter, may obtain medical information from any doctor who, at any time, has attended me, about anything that affects my physical or mental health, and/or any insurance office to which a proposal has been made on my/our life and I authorise the giving of such information. This consent shall remain valid throughout the duration of my Hodge Lifetime equity release plan and after my death.

I authorise Hodge Lifetime to pass medical information to any medical examiner or company arranging these examinations on behalf of Hodge Lifetime, or onto any insurer or reinsurer associated with underwriting the risk for them.

I understand that I must inform Hodge Lifetime without delay if there is a change in my health or circumstances before the commencement of my plan with them. Failure to do so may result in legal action.

I agree that a copy of this consent can be treated as the original.

I acknowledge and accept that the application for Impaired Life Terms is part of my application to Hodge Lifetime and that the personal information provided is subject to the personal information declarations included in the application form.

I have read and understood my rights under the Access to Medical Reports Acts.

I enclose a cheque for £25 in respect of this Impaired Life Application.

**Please indicate if you wish to see the medical report from your doctor before it is sent to Hodge Lifetime or their appointed medical underwriter.**

Yes

No

**Please Note: Hodge Lifetime reserve the right to decline any application.**

Name  
(BLOCK CAPITALS)

Signature

Date

Signed as

Applicant

Power of Attorney

(Hodge Lifetime will obtain a full medical report for all applicants where a Power of Attorney signs this application on behalf of the applicant)

Date

Doctor's name  
(General Practitioner)

Practice address

Postcode

Doctor's  
telephone number

Hodge Lifetime or its appointed medical underwriter may need to clarify information in your Application for Impaired Life Terms. Please provide a daytime number for this purpose.

If you have any questions please contact us on:

**Freephone 0800 731 4076**

or at the following address:

Hodge Lifetime, 30 Windsor Place, Cardiff CF10 3UR

[www.hodgelifetime.com](http://www.hodgelifetime.com)

## ADDITIONAL INFORMATION

The following pages are provided for any further information you think may be useful, in the assessment of your application.

## ADDITIONAL INFORMATION

# Freephone 0800 731 4076

Hodge Lifetime, 30 Windsor Place, Cardiff CF10 3UR  
[www.hodgelifetime.com](http://www.hodgelifetime.com)

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