Care Fees Payment Plan Personal Questionnaire

Please indicate which insurance companies you require Care Fees Payment Plan offer terms from.

Lifetime Care ☐

Partnership ☐

Financial Adviser Details

Financial Adviser's Name

Company Name

Company Address

Tel. no.

Fax. no.

Email Address

FSA reference no.

Do you hold the CF8 qualification? ☐ Yes ☐ No

It is an FSA requirement that we provide data as to whether advice was given on the sale of this product.

Was financial advice given? ☐ Yes ☐ No (Tick one)

CONFIDENTIAL

Please complete all relevant sections of the form in BLOCK CAPITALS, sign, date and return to your financial adviser.

This form should only be completed by the legal representatives of the person needing care if they have the legal capacity to effect a Care Fees Payment Plan on receipt of the offer terms. (Please note that if the person needing care has become or is becoming mentally incapable of managing their own affairs, an Enduring/Lasting Power of Attorney (property and affairs) must be registered with the Court of Protection.)

1. Details of the person needing care

(Unless section 2 is completed, the person needing care will be the applicant for the Care Fees Payment Plan)

Title	
Surname	
Forenames	
Male	☐
Female	☐
Date of birth	
Marital Status	
Postal Address	
Postcode	
Telephone Number *including code*	
Contact Name *(if care home)*	

Is this address the intended place to receive care?

Yes ☐

No ☐

If 'No' please provide details of the intended place of care, and expected entry date.

Postal Address

Postcode

Telephone Number
including code

Contact Name

Please complete the following details if care is currently being provided.

Where is care being provided?

Care Home (with nursing care) ☐

Care Home (no nursing care) ☐

Own home ☐

Other ☐

If other, please provide details

Please advise date of entry to Care Home if applicable

If entry is imminent, please advise expected entry date

Current fees payable £ per calendar month/4 weekly period*
*(*Please delete as appropriate)*

2. Details of the legal representative

(Please complete this section only if you are acting in a legal capacity for the person needing care)

Title

Surname

Forenames

Male

Female

Postal Address

Postcode

Telephone Number *including code*

Are you acting as Attorney? Yes ☐ No ☐

If 'Yes' is the Enduring/Lasting Power of Attorney (property and affairs) registered with the Court of Protection? Yes ☐ No ☐

Are you acting as court appointed deputy for the Court of Protection? Yes ☐ No ☐

If you are acting in a legal capacity for the person needing care, please enclose a certified copy of the appropriate authority or equivalent documentation if you live in Scotland. Please do not send birth or marriage certificates to Medicals Direct at this stage. These can be sent directly to the insurance provider later if required.

3. Details of the applicant

*(Please complete this section only if you are different from the person needing care and are **not** acting in a legal capacity for them)*

Title

Surname

Forenames

Male

Female

Postal Address

Postcode

Telephone Number *including code*

If you are a relative of the person needing care, please describe the nature of your relationship

4. Payment Option

a) Amount or benefit required £

Per 4 weeks/month/quarter/half-year/year

OR

b) Amount of single premium £

c) Escalation

Nil ☐

RPI ☐

RPI +2% ☐

National Average Earnings ☐

Fixed Rate
Please state percentage required %

Increases are normally applied on the anniversary of the contract

d) Do you want payments from the plan to be made

In advance ☐

In arrears ☐

Deferred Period *(please tick box)*

1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐

e) Are additional death benefits required?

Yes ☐

No ☐

If 'Yes' please indicate either f)

Capital Protection Percentage

25% ☐

50% ☐

75% ☐

OR

g) Guaranteed Payment Period Months/Years

Note: *Not all insurance providers are able to offer capital protection, guaranteed payment periods and payment options on the same basis.*

5. Doctor's Details

Name and full postal address of the doctor who holds the medical records of the person needing care

Doctor's name

Address

Postcode

Telephone Number ***including code***

Fax Number

How long has the person needing care been registered with this doctor?

If less than six months, please give name and full postal address of previous doctor.

Doctor's name

Address

Postcode

Telephone Number ***including code***

Fax Number

The doctor's details are needed to obtain a medical report for the insurance providers so they can offer you terms for their plan. Some providers may also request a home report from the care provider.

Your answers to the questions on this form will be used to assess your request by the selected insurance providers. All facts that are likely to influence the terms offered must be disclosed since part of the plan's benefit might be forfeited if you subsequently apply for a plan and relevant information is withheld. If you are unsure if a fact is likely to affect the insurance provider's decision, you should disclose it. Any changes to the answers given in this form before the plan comes into force must be notified to the insurance provider.

6. Medical details of care recipient

a) What is your height? m/cm ft/ins

b) What is your weight? kg st/lbs

c) Have you visited your GP or attended hospital within the last 12 months?

Yes ☐ No ☐

If 'Yes' please give dates and details

d) Have you had any falls in the last 12 months?

Yes ☐ No ☐

If 'Yes' please give dates and details

e) Have you consulted any doctor or other medical practitioner about memory loss or confusion or been diagnosed with dementia?

Yes ☐ No ☐

If 'Yes' please give dates and details

f) Are you now or have you within the last two years been on a diet, treatment or taking any pills or drugs?

Drug/treatment/diet	Dosage (if applicable)	Frequency (if applicable)

(If 'Yes' please give details below)

g) Have you suffered or are you suffering from any major illnesses such as cancer, heart disease, Parkinson's disease or stroke?

Yes ☐ No ☐

If 'Yes' please give dates and details

7. Functional Profile of the Care Recipient

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

Level of assistance is classified as follows:

Major – Always require both assistive devices and personal assistance

Moderate – Requires assistive device and some personal assistance

Minor – Requires assistive device but no other help or supervision

Independent – No help, supervision or assistive device required

	Major Assistance	Moderate Assistance	Minor Assistance	Independent
Mobility	☐	☐	☐	☐
Washing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Continence	☐	☐	☐	☐

b) When was care first needed and why?

8. Authority to my Financial Adviser

If the applicant is the legally appointed representative (e.g. an Attorney or as a court appointed deputy for the Court of Protection), the details of whom they are representing should be inserted above the signature.

Example: Mr John Smith by his Attorney Mr David Smith

I, the applicant, authorise my financial adviser to pass on a copy of this form to any selected insurance provider, and any third party working for a selected insurance provider, so that the selected insurance provider is able to offer me terms for its Care Fees Payment Plan.

Full Name of person signing	
Capacity of person signing	
Signed (Applicant)	
Date	

9. Access to a Medical Report

a. Important Notes

Before the insurance provider can provide you (the applicant) with terms for its Care Fees Payment Plan it may need to obtain a medical report from any doctor who has attended the person needing care.

Please read this section carefully as it sets out the rights of the person needing care under The Access to Medical Reports Act 1988, or the Access to Personal Files and Medical Reports (NI) Order 1991 or the Isle of Man: Access to Medical Records and Reports Act 1993.

To apply for a medical report both the insurance provider and Medicals Direct Screenings Limited (hereinafter referred to as Medicals Direct), a firm working for each insurance provider, will need the consent of the person needing care, or of their legal representative. Consent is given by signing Section 10 below.

Medicals Direct or one of the insurance providers may ask for the person needing care to contact their doctor if there is a delay returning the medical report.

By signing Section 10 below, authority is given to the Chief Medical Officer of Medicals Direct on receipt of a medical report, to forward a copy of it to the Chief Medical Officer of each insurance provider selected by you and your financial adviser.

b. Access to Medical Reports

The person needing care has three possible courses of action:

1. Consent can be given without asking to see the doctor's report before it is sent to the Chief Medical Officer of Medicals Direct. The doctor will then send the report direct to the Chief Medical Officer of Medicals Direct.
2. Consent can be given but the person needing care may ask to see the report before it is sent. The person needing care will have up to 21 days, from the date their doctor is notified they wish to see the report to make appropriate arrangements with their doctor. If contact is not made during this 21-day period, the doctor will be able to forward the report to the Chief Medical Officer of Medicals Direct without the care recipient seeing it in advance.

   The doctor can be asked to change the report if it is incorrect or misleading. If the doctor refuses, the person needing care or their legal representative may add their own comments to the report before it is sent to the Chief Medical Officer of Medicals Direct.
3. Consent can be withheld but the insurance provider may not be able to offer terms for its Care Fees Payment Plan.

Whether or not a request has been made to see the report before it is sent, the doctor may be asked for a copy of it within six months of it being sent to the Chief Medical Officer at Medicals Direct. The doctor may make a reasonable charge for his services.

The doctor is entitled to withhold some or all of the information contained in the report if:

(a) They feel it may be harmful to the person needing care or

(b) it would indicate their intentions in respect of the person needing care or

(C) it would reveal the identity of another person without their consent (other than provided by another health professional in their professional capacity in relation to the provision of care.)

9. Access to a Medical Report *continued*

The medical report the doctor fills in requests the following information about the person needing care:

- Their current and recent health

– Last time the doctor was consulted and their state of health at that time

– Details of blood pressure readings, urine tests or other investigations in the previous 12 months

– Details of any treatment and drugs being prescribed

– Details of height, weight and build

– Signs of noticeable impairment in cognitive ability

– Requiring assistance with everyday tasks like washing and dressing

– Any health deterioration over the last 6 months

- Their past health

– Details of significant illnesses or accidents

The report does not request the doctor to reveal information about

– Negative tests for HIV, hepatitis B or C

– Any sexually-transmitted diseases

– Predictive genetic test results.

If the person needing care has any questions about their rights under the appropriate Act or questions relating to the process of getting, assessing or storing medical information, please write to:

Medicals Direct Screenings Ltd.,
ICP,
Poolgate House,
68 Park Street,
Lincoln,
LN1 1UR

10. Declaration and Consent

In this section the terms “we”, “our” and “us” would only apply if the applicant is not the person needing care or that person’s legal representative acting on their behalf.

General

I, the applicant, confirm that I want those insurance providers selected in this form to provide me with offer terms for their Care Fees Payment Plan.

I/We* confirm that all declarations made in this form shall be deemed to have been made directly to the insurance providers selected on this form.

I/We* confirm we have read pages 1 to 10.

I/We* confirm that any copy of this form which is sent to Medicals Direct by my financial adviser and is subsequently forwarded to the insurance providers selected on this form, or any party involved in providing the report, shall be as valid as the original.

Use of personal data

I/We* understand that any information in this form will be held and used by each insurance provider, and by the insurance company’s reinsurer (or any company acting on its behalf including Medicals Direct) to provide terms for its Care Fees Payment Plan.

I/We* understand that the information in this form will be used by the insurance provider to set up and administer its Care Fees Payment Plan if I/we* accept its terms. I/We* understand that my/our* details may be disclosed in confidence to other companies within each insurance provider’s group or companies acting on their instructions (possibly to companies outside of the European Economic Area) for these purposes. By signing this Section of this form I/we* consent to such use of my/our* personal data.

Each insurance provider may disclose some of this information to companies within its group and other carefully selected organisations for marketing purposes to inform me/us* of any products and services which may be of interest.

- ☐ I/we* do want an insurance provider to use the information supplied to let me/us* know about other products and services it offers.
- ☐ I/we* do not want an insurance provider to use the information supplied to let me/us* know about other products and services it offers.

Please tick one of the boxes.

Health Information

I/We* declare that to the best of my/our* belief, all of the information provided in this form is true and complete in every particular, and I/we* have not withheld any material fact. (A material fact is one that an insurer would regard as likely to influence the terms and conditions it would offer for its Care Fees Payment Plan.)

I/We* agree to disclose to the insurance provider any occurrences affecting the health of the person needing care after this form is signed and before the Care Fees Payment Plan commences.

Consent to obtain medical reports

The person needing care (or their legal representative) declares they have read the important notes and information relating to their rights under the appropriate Act, which allows a doctor to provide a report from their medical records.

The person needing care (or their legal representative) agrees:

(i) that Medicals Direct and the insurance provider can ask any doctor who has treated him/her at any time for information about their health; and

(ii) to that doctor providing the Chief Medical Officer of Medicals Direct and the insurance provider with the medical information requested; and

(iii) that the Chief Medical Officer of Medicals Direct can forward the medical report to the Chief Medical Officer of each selected insurance provider.

☐ I, the person needing care, do not want to see the report before it is sent to Medicals Direct

☐ I, the person needing care, do want to see the report before it is sent to Medicals Direct

Please tick one of the boxes.

If the person needing care is unable to sign, the form should be signed by their personal representative. Please insert below the name and capacity of the person signing e.g. Mr John Smith by his Attorney Mr David Smith. Please enclose a certified copy of the appropriate authority with the completed questionnaire.

Full name of person signing

Capacity of person signing

Signature of person needing care or their legal representative acting on their behalf

Date:

Signature of the Applicant (if you are not the person needing care or their legal representative)

Date:

A copy of this form is available on request.

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