Immediate Lifetime Care and Secured Lifetime Care

Confidential indicative quotation request form.

To enable an indicative quotation to be issued, please complete all relevant questions (including the Frailty section on all occasions). Please return to lifetimecare@aviva.com with "Quote request" in the subject line.

Please Note:

1. If you require more than an indicative figure please complete an application form which will allow us to obtain the necessary medical/nursing home report. Although the quotation is as accurate an assessment as we can make at this stage, the final terms we can offer, when we have further medical information may differ.
2. Lifetime Care will usually be able to provide this type of Illustration within two working days.
3. We cannot quote for a client below the age of 60
4. We can only provide an illustration where the client requires care because they need assistance with everyday tasks or because they are suffering from some form of mental impairment, such as Alzheimer's disease, or Senile Dementia, which requires supervision.

Please note: no advice charges will be included in this indicative illustration. The fee facilitation service is available for all new business and details of the advice charge will be shown on the offer terms if this is requested on the application form. The level of advice charge is subject to agreement between the proposer and the adviser.

Financial Adviser's Name	
Company Name and Address	
Telephone Number	
Fax Number	
E-Mail Address	
Please indicate how you require this Illustration to be returned to you	**Post** ☐ **Fax** ☐ **Call back** ☐ **E-mail** ☐
Special Instructions?	
Client's Name	**Title** ____ **Surname** ____ **Forenames** ____
Personal Details	**Male** ☐ **Female** ☐ **Date of Birth** D D M M Y Y Y Y
Care Details	**Residential Home** ☐ **Nursing Home** ☐ **Care at Home** ☐ **Date admitted to care:** ____
Benefit Details	**Long Term Care Benefit required £** ____ **p.m.**
Escalation Rate **Escalation Date**	None ☐ 5% ☐ RPI ☐ RPI+2% ☐ Other % ____ Between 3% and 10% Anniversary ☐ April ☐ Other ☐ ____
Secured Lifetime Care Only	**Benefit Waiting Period (years) 1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐
Premium Protection	**% of Premium** None ☐ 25% ☐ 50% ☐ 75% ☐
Please note that Premium Protection is **not** available with Secured Lifetime Care. For more details about death benefit please call New Business on: 0345 30 30 430	**Choose :** **Long Term** ☐ (until monthly benefit paid > death benefit) **OR** **Short Term** – First 3 months 25% ☐ 50% ☐ 75% ☐ followed by next 3 months 25% ☐ 50% ☐ 75% ☐

Care Recipient Name...

The illustration we will provide will be based entirely on the information given on this form. The accuracy of the illustration will therefore depend on the accuracy of the information provided. Any information in this form will be held and used by Aviva (or any company acting on behalf of Aviva) to provide an indicative quotation.

General

Is the Care Recipient bed-ridden?	Yes ☐	No ☐
Is the Care Recipient *permanently* wheelchair-bound?	Yes ☐	No ☐
Can the Care Recipient weight bear or walk with personal assistance	Yes ☐	No ☐
Has the Care Recipient fallen in the last 6 months?	Yes ☐	No ☐

☐ Dementia

Multi-infarct dementia (or Vascular dementia) is usually dementia caused by a stroke. In this event, please complete both dementia and stroke sections.

Types of dementia to be regarded as "Other" include:
Alzheimer's disease, Senile dementia, Pre-senile dementia, Pick's disease

'Symptoms' include memory loss, personality change, loss of day-to-day living skills.

Note: *The date of first diagnosis by a doctor or health care professional is* ***not*** *required.*

What type is it?

☐ Multi-Infarct Dementia

☐ Other

Has this been formally diagnosed? Yes ☐ No ☐

How severe is it?

☐ **Severe** *(fails to recognise friends/relations)*

☐ **Moderate** *(Confusion, some wandering etc.)*

☐ **Mild** *(Short term memory problems only)*

When were the symptoms first noticed by a close friend or relative?

Approximate Date D D M M Y Y Y Y

When was professional paid-for care first needed?

Approximate Date D D M M Y Y Y Y
(please only complete if relevant to the dementia)

☐ Stroke

Alternative names
Cerebrovascular accident (CVA)
Transient Ischaemic attack (TIA)
Cerebral infarct
Cerebral thrombosis
Cerebral haemorrhage
Temporal arterial sclerosis

What is the degree of ongoing paralysis?

☐ **Severe** *(Total loss of use of any limb or partial loss of use of more than two limbs)*

☐ **Moderate** *(Partial loss of use of one/two limbs)*

☐ **Mild/None** *(Care Recipient suffers from little or no paralysis)*

Approximately when was the first incidence? D D M M Y Y Y Y

And the last incidence? D D M M Y Y Y Y

☐ Arthritis/Joint Disorder

If the Care Recipient suffers from broken bones please enter this in the 'Other serious illness' section below. (NOT in this section)

What type is it?

☐ Rheumatoid Arthritis

☐ Osteoarthritis/Joint replacement/Fracture

☐ Osteoporosis

☐ Other (please specify)____

How severe is it?

☐ **Severe** *(Care Recipient suffers a lot of pain/significant disability)*

☐ **Moderate** *(Care Recipient suffers some pain)*

☐ **Mild** *(Care Recipient suffers little or no pain and no disability)*

Care Recipient Name...

☐ **Heart or Circulatory Disease** **Valve disorder** would include: Mitral incompetence Mitral regurgitation Mitral prolapse Aortic incompetence Aortic regurgitation Aortic prolapse	**What type is it?** — **Approx date of last incidence** ☐ Myocardial Infarction (Heart attack) — D D M M Y Y Y Y ☐ Angina — D D M M Y Y Y Y ☐ Valve disorder — D D M M Y Y Y Y ☐ Congestive Cardiac Failure (Heart failure) — D D M M Y Y Y Y ☐ Hypertension (Raised blood pressure) — D D M M Y Y Y Y ☐ Other (please specify) ____________________ — D D M M Y Y Y Y **Please indicate the date of last occurrence next to each condition ticked.** **How severe is it?** ☐ **Severe** *(Chest pain at rest, breathlessness)* ☐ **Moderate** *(Chest pain with light exercise e.g. walking)* ☐ **Mild** *(Chest pain on heavier exercise e.g. running)*
☐ **Neurological Disease**	**What type is it?** ☐ Parkinson's disease ☐ Multiple Sclerosis ☐ Motor Neurone Disease ☐ Other (please specify) **not to include Dementia** ____ **Approximately when was it diagnosed?** D D M M Y Y Y Y **How severe is it?** ☐ **Severe** *(Confined to wheelchair, signs of dementia, severe tiredness)* ☐ **Moderate** *(Requires walking aids, increased tiredness)* ☐ **Mild** *(No walking aids required, periods of tiredness)* **How much has it deteriorated in the last 6 months?** ☐ **Significant** *(e.g. Care Recipient has gone from crutches to wheelchair)* ☐ **Moderate** *(e.g. Care Recipient cannot walk as far as previously able)* ☐ **Little or no deterioration** *(e.g. Little change to Care Recipient's mobility)*
☐ **Respiratory Disease**	**What type is it?** ☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Other (please specify) ____ **Approximately when was the last incidence?** D D M M Y Y Y Y **How severe is it?** ☐ **Severe** *(Care Recipient always breathless)* ☐ **Moderate** *(Care Recipient becomes breathless on mild exercise e.g. walking)* ☐ **Mild** *(Occasional episodes of breathlessness on mild exercise)*
☐ **Frailty**	**How much has it deteriorated in the last 6 months?** ☐ **Significant** ☐ **Moderate** ☐ **Little or no deterioration**

Care Recipient Name...

☐ **Cancer**	**What type is it?** Please specify____ **Approximately when was it diagnosed?** D D M M Y Y Y Y **Approximately when was the last recurrence?** D D M M Y Y Y Y **Is it Operable?** ☐ **Yes** ☐ **No** **How severe is it?** ☐ **Severe** *(Rapid weight loss, extreme frailty, rapid deterioration)* ☐ **Moderate** *(Some weight loss, some frailty)* ☐ **Mild** *(Few symptoms, in remission)*
☐ **Other serious illness**	**Please specify** ____ ____
☐ **Current treatment/ Medication**	**Please specify** ____ ____

Activities of Daily Living

Please give details of the Care Recipient's ability to physically perform the following activities of daily living

N.B. Reminding or directing the Care Recipient alone does not qualify as an ADL failure
* For either bladder or bowel only, tick Minor. For both tick Moderate. Major only applies if Care Recipient has lost total control of either.

	Major Assistance	Moderate Assistance	Minor Assistance	Independent
Mobility	☐	☐	☐	☐
Washing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Feeding *(not cooking or cutting up)*	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Continence*	☐	☐	☐	☐

Level of assistance is classified as follows:

Major – always requires both assistive device 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

Other relevant information **Please continue on separate sheet (if necessary)**	____ ____

| **Retirement** | Investments | Insurance | Health |

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