For office use only
SR No.

AVIVA

Company private medical insurance

Group member application form – full medical underwriting

Important: please read this section and then complete the application in BLOCK CAPITALS and in black ink.

As part of the process of becoming a member you need to complete this form, which will be treated in the strictest confidence. It is important that you answer all the questions on this application form fully, truthfully and accurately. This is because we'll use the answers you give to determine what your policy will cover.

Even if you've already provided information under a previous Aviva Health policy or application, you must provide it to us again on this application form. If you don't answer all the questions fully, truthfully and accurately this could affect how much we pay if you make a claim and could mean we won't pay your claim at all.

As group member you have to complete and sign this form on behalf of all the people to be insured. If you are unsure about any of the information we ask for, you should check with the person who it relates to.

You must notify us immediately if there are any changes in the information provided in this form between now and the start date of the policy.

Your start date will be the date we receive and accept your completed application form at our head office. If you would like a start date in the future please advise in this box:

Date D D / M M / Y Y Y Y

We may backdate a members start date up to a maximum of 30 days from the date we receive the application form if there have been postal errors and/or delays. This may mean that the start specified is before we receive the application, but on or after the date the application has been signed.

We will give you a copy of this application if you ask for it within three months of completing it. We recommend that you keep a record of all the information that you have given us regarding this application.

If you need to tell us more about any section of this application, please write on separate paper, indicate the number of sheets here ☐ and attach it to this form

1. Company details (to be completed by the group administrator)

Company name

Policy number (if known)

Please indicate the product for which the group member (and his or her dependants if applicable) is eligible:

Optimum ☐ **Solutions** ☐ Other (please specify)

Category of employee to which group member belongs (if applicable)

Date employee joined the company D D / M M / Y Y Y Y

Group administrator's signature

Please note that we may deal with any person who is apparently authorised to represent the company (for example a director, partner, officer or senior manager) in addition to/or instead of the person nominated as group administrator.

Name (please print)

Date D D / M M / Y Y Y Y

2. Your details (to be completed by the employee)

Name

Mr, Mrs, Miss, Ms, other | First name

Surname | Other initials

Gender

Male ☐ Female ☐

Date of birth D D / M M / Y Y Y Y

Home address (your main residence)

Postcode (must be completed)

Contact numbers

Daytime telephone and area code

Evening telephone and area code

Mobile telephone

Fax

Email

3. Details of all persons to be covered (your group administrator will inform you whether to complete this section)

	Second person	Third person	Fourth person
Relationship to group member	spouse/partner ☐ son ☐ daughter ☐	son ☐ daughter ☐	son ☐ daughter ☐
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
First name			
Surname			
	Other initials	Other initials	Other initials
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Gender	male ☐ female ☐		

	Fifth person	Sixth person
Relationship to group member	son ☐ daughter ☐	son ☐ daughter ☐
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
First name		
Surname		
	Other initials	Other initials
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

If any person on this application is employed by a foreign embassy or diplomatic service please write their name here:

If we need any more information in order to process this application, we will contact you. If, for your convenience, you consent for us to speak to another person named on this application, please write their name here:

4. Medical disclosure – The questions in this section apply to <u>everyone</u> who is included in this application.

– Please ensure you answer 'yes' or 'no' to each question and then give full details where you have ticked 'yes'. Please note that in most cases we will not approach your GP for this information.

– When being asked for date of last symptoms/date of last treatment, please provide whichever date is the most recent.

4.1 Has anyone had advice from a GP or other medical professional, such as a practice nurse or physiotherapist, in the <u>2</u> years prior to their start date? <u>If you are unsure please check with your GP</u> ☐ Yes ☐ No
If you have ticked 'Yes', please give us full details.

(Please specify each medical condition as we are unable to accept generic terms such as "minor or general ailments" or "normal childhood illnesses". You do not need to tell us about general colds, vaccinations, uncomplicated pregnancies/deliveries, normal smear results with standard 3/5 yearly recall. Should your smear tests be any more regular than 3/5 yearly, please disclose and advise frequency.)

Member name	Diagnosis (if none made please describe the exact nature of symptoms suffered)	Date of consultation	Treatment received	Date of last treatment / symptoms	Any underlying cause	Specific location on body including left or right	Outcome (e.g. on-going, complete recovery, likely to recur) or for smears frequency (annually, 6 monthly)

4.2 Has anyone consulted a specialist or been admitted to hospital in the 5 years prior to their start date, (other than conditions already listed)? If you have ticked 'Yes', please give us full details. ☐ Yes ☐ No

Member name	Diagnosis (if none made please describe the exact nature of symptoms suffered)	Date of consultation	Treatment received	Date of last treatment / symptoms	Any underlying cause	Specific location on body including left or right	Outcome (e.g. on-going, complete recovery, likely to recur)

4.3 Has anyone named experienced any wisdom teeth problems (other than conditions already listed)? ☐ Yes ☐ No

Member name	Have all wisdom teeth been removed?	If not, have the remaining teeth emerged fully with no further problems? (please just answer 'yes' or 'no')

4.4 Has any person named EVER suffered from any of the following problems (other than conditions already listed)?

a) congenital/hereditary disorders e.g. autism, cystic fibrosis, Down's syndrome, haemophilia ☐ Yes ☐ No

b) auto-immune disorders e.g. SLE, HIV, hepatitis, rheumatoid arthritis ☐ Yes ☐ No

c) brain and nervous system disorders eg: epilepsy, multiple sclerosis, stroke, brain trauma, cerebral palsy, dementia/Alzheimers, paralysis ☐ Yes ☐ No

d) psychological or sleep disorders, personality/mood disorders, eating/ compulsive disorders,depression, anxiety, stress ☐ Yes ☐ No

e) blood/blood vessel and circulatory disorders, e.g. varicose veins, blood clots, haemorrhoids, narrowing of the blood vessels, varicocele ☐ Yes ☐ No

f) cancer, leukaemia, Hodgkin's disease, lymphoma, brain or spinal tumour ☐ Yes ☐ No

g) gall stones, kidney problems such as kidney stones, kidney disease or kidney infections ☐ Yes ☐ No

h) eye disorders, e.g. cataracts, retinal detachment, glaucoma, optic neuritis, macular degeneration ☐ Yes ☐ No

i) heart and cardiovascular disorders e.g. angina, heart attack, heart defects, high blood pressure, high cholesterol or rhythm disorders ☐ Yes ☐ No

j) alopecia or skin problems e.g. eczema, acne, psoriasis, keloid scars, keratoses ☐ Yes ☐ No

k) prolapse, fertility problems ☐ Yes ☐ No

l) complications of pregnancy/childbirth, endometriosis, polycystic ovarian syndrome, fibroids, caesarean section ☐ Yes ☐ No

m) joint and bone problems, fractures, tendon and ligament problems, gout, bunions, osteoporosis ☐ Yes ☐ No

n) joint and spine degeneration, wear & tear, arthritis ☐ Yes ☐ No

– If you have answered 'yes' to question n) above, please specify which type of arthritis you are suffering with e.g. osteo, rheumatoid, reactive also please specify if this affects your left or your right knee, hip etc

o) back / neck problems e.g. sciatica, disc problems, spinal fractures ☐ Yes ☐ No

– If you have answered 'yes' to question o) above, please specify the exact region of your spine affected, e.g. cervical (neck), thoracic (upper), lumbar (lower), sacral (bottom of spine)

p) lung or respiratory problems e.g. tuberculosis, chronic obstructive pulmonary disease, asthma ☐ Yes ☐ No

If you have answered 'yes' to any of the questions above, please provide us with further information by completing this section.

Member name	Question letter	Diagnosis (if none made please describe the exact nature of symptoms suffered)	Date of consultation	Treatment received	Date of last treatment / symptoms	Any underlying cause	Outcome of treatment (e.g. on-going, complete recovery, likely to recur)

4.5 Does anyone named have, or have they ever had, any pins, plates, screws or other internal fixations inserted other than any already listed? ☐ Yes ☐ No

Member name	Nature of fixation	Condition necessitating fixation	Specific location on body including left or right	If no longer present please advise date of removal

4.6 Does anyone named use any orthotics, supports, prosthesis, hearing aids, cosmetic implants, dentures, braces or dental implants (other than any already listed)? ☐ Yes ☐ No

Member name	Nature of aid/support/implant	Condition necessitating aid, support or implant	Specific location on body including left or right

4.7 Is any person named taking, or have they taken any medication in the 2 years, prior to their start date? ☐ Yes ☐ No
If you have ticked 'Yes', please give us full details.

(Please include details of any hormone replacement therapy or any "over the counter" medication. You do not need to tell us about medication taken purely for contraceptive purposes or "over the counter" painkillers/cold and flu remedies taken for less than 5 consecutive days.)

Member name	Name of Medication	Condition necessitating medication	Diagnosis	Date of last treatment	Outcome (e.g. on-going, complete recovery, likely to recur)

4.8 Has any person named suffered from any of the following conditions in the 10 years prior to their start date (other than any already listed)?

a) gastric, digestive or bowel problems, e.g. irritable bowel syndrome, change in bowel habit, ulcers, repeated indigestion, hernia, Crohn's disease, ulcerative colitis, coeliac disease ☐ Yes ☐ No

b) migraines or repeated headaches ☐ Yes ☐ No

c) bladder and other urinary problems, prostate disorders e.g. incontinence, urinary frequency problems, blood/protein in urine ☐ Yes ☐ No

d) glandular or hormonal problems, e.g. diabetes, thyroid disorders ☐ Yes ☐ No

e) menstrual problems such as irregular or abnormal periods, lack of periods ☐ Yes ☐ No

f) ear, nose and throat problems e.g. hearing loss or tinnitus, sinusitis, tonsillitis, deviated nasal septum ☐ Yes ☐ No

g) any lumps, growths, cysts or polyps, or any mole or freckle that has bled, become painful, changed size or colour ☐ Yes ☐ No

h) hay fever and any other allergies ☐ Yes ☐ No

If you have answered 'yes' to any of the questions above, please provide us with further information by completing this section.

Member name	Question letter	Diagnosis (if none made please describe the exact nature of symptoms suffered)	Date of consultation	Treatment received	Date of last treatment / symptoms	Any underlying cause	Outcome (e.g. on-going, complete recovery, likely to recur)

5. Consent to obtain a medical report

In order for us to determine your underwriting terms, we may need to contact your doctor(s) for a medical report. If we do approach your doctor, we will tell you that we have done so. We will not approach your doctor as an alternative to an incomplete form.

However, before we can apply for a medical report from you/your dependant's doctor(s) we need consent to do so. A declaration for this appears on the next page. You should be aware that you have certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. The main points of the Act are:

a) we will write to you at the same time as we contact your doctor. If you indicate that you wish to see the report, we will tell your doctor that you have asked to see the report and you will have 21 days to contact your doctor to make arrangements to do so. When you have seen the report the doctor may not send it to us until you have given your consent to do so.

   If you do not contact your doctor within 21 days the report will be sent to us.

b) you can ask your doctor if he/she will amend any part of the report which you consider to be incorrect or misleading. If your doctor is not in agreement, you may attach your comments.

c) during the six months after we have received your report you may ask your doctor for a copy. If you ask for a personal copy of the report the doctor can charge you a fee to cover the cost.

d) in some circumstances the doctor may decide, in the interest of your health, or to respect the interest of other persons, that you should not see all or part of the report. The doctor will tell you of this and you will have the right to see any remaining part of the report. If your doctor decides that you should not see any of the report, he will not give it to us without your consent.

e) you do not have to give us your consent (but without it we may be unable to proceed with your application).

Please read the declaration and complete the boxes below:

Authorisation for the release of medical information

I have read the section about my rights under the Access to Medical Reports Act 1988 (or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991). I agree to the provision of any and/or all of my medical records to Aviva in connection with this application.

By signing below, I give my permission to any institution or person (including, but not limited to, hospitals, doctors, nurses and health professionals) who has been involved in my treatment both past and present, to provide Aviva (and third parties acting on its behalf) with any information, including full medical records, reports or notes, concerning my physical or mental health.

I also give my permission for any medical exclusions that are applied to my policy as a result of information provided on this form or from my medical records, to be disclosed to my insurance intermediary (if I am using one) and my group administrator for the purposes of advising on or administering the policy.

We need details for each person to be insured by the policy.

Name		GP's name	
Signature		Date	/ /

(signature of parent/guardian for children under 16).

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

Name		GP's name	
Signature		Date	/ /

(signature of parent/guardian for children under 16).

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

Name		GP's name	
Signature		Date	/ /

(signature of parent/guardian for children under 16).

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

Name		GP's name	
Signature		Date	/ /

(signature of parent/guardian for children under 16).

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

Name		GP's name	
Signature		Date	/ /

(signature of parent/guardian for children under 16).

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

Name		GP's name	
Signature		Date	/ /

(signature of parent/guardian for children under 16)

I DO NOT wish to see the report before it is sent to Aviva (*please delete if you wish to see the report before it is sent to us).*

Details of family doctors – please give details of the GPs for everyone covered by the policy. If there are more than 2 GPs, please use a separate piece of paper

GP's name	Address	Tel (incl STD code)	Fax

6. Important notes

Use of personal information

We'll use the information you give us to:

- process and underwrite your application
- decide if we can offer cover and on what terms
- administer your policy and handle any claims
- help detect and prevent fraudulent activity.

Other companies from across the Aviva group, or third parties who provide services to us, in any country (including those outside the European Economic Area) could also use your information in this way. If they do, we'll make sure they agree to treat your information with the same level of protection as we would.

We may share your information with regulatory bodies, other insurers (directly or using shared databases), your insurance intermediary, or third parties providing services to them.

To keep our products and services competitive and suitable for customers' needs, we may also use your information for research and customer profiling.

From time to time, we may tell you about other products or services which may be of interest. Please tick this box if you don't want us to. ☐

7. Declaration

By signing below, I confirm that;

a. I will advise you if there are any changes in the information given on this form between now and the start date of cover under the policy.

b. to the best of my knowledge and belief the information given on this form is true and complete. I have checked any answers or statements on this form that are not in my own handwriting and they are correct.

c. I agree that if my application is accepted, the terms and conditions of the policy will be Aviva's standard at that time. (A copy of the terms and conditions is available on request).

d. I am aware that benefits will not be available to insured persons (those named in sections 1 and 2) for the treatment of any disease, illness or injury (whether or not diagnosed) for which the insured person has received medication, advice or treatment or for which the insured person has experienced symptoms before the date that this application is accepted, or any related condition unless fully disclosed on this application and accepted by Aviva Health UK Limited.

e. I agree on behalf of all persons to be covered to Aviva processing all information associated with my application and resulting policy as set out in the important notes section of this application.

(You are signing this form on behalf of all persons to be covered. You must inform them how their data, including medical information, will be used).

Your signature

Date (must be completed) / /

Print name

Checklist – have you:

☐ fully completed the personal details for everyone on the policy?

☐ fully completed section 4?

☐ fully completed section 5 regarding consent to obtain medical information (you do not have to do so, but we may not be able to offer cover if you don't)?

Please do not forget to read the declaration and then sign and date the form.

For agent's use only

Agent's name	
and address	
Agency ref	
For office use only	
Plan code	
Scheme code	
Campaign code	
Coupon code	
Policy number	
Rate key	
Capital Option district	