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 complete the form fully, truthfully and accurately. Please remember that the details you give will be used to assess the terms and the extent of benefits we can offer you. Even if you have already told us something in a previous application you must tell it to us again as our systems may not identify the previous information.

If you do not tell us all relevant information, or you provide incorrect information, this may result in the non-payment of a claim. If you are in any doubt whether or not certain information is relevant, please tell us.

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.

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, at our discretion, 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

Sex

Male ☐ Female ☐

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

Address

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
Sex	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 everyone who is included in this application

For questions 4.1 - 4.4 please make sure that there is a tick in either the 'Yes' or 'No' box. We will not ask your GP for information if you have not fully completed this form. If both boxes are left blank, or you have ticked 'Yes' and not given us further details, we will be unable to complete your underwriting and will return the form to you.

For sections 4.1 and 4.2 please tell us details of any check-ups and their results. Please also tell us about any examinations that anyone has had, such as blood tests or smear tests, how often the tests were done and reason for having these.

4.1. Has anyone had advice from a GP or other medical professional, such as a practice nurse or physiotherapist, during the past 2 years? If you have ticked 'Yes', please give us full details. ☐ Yes ☐ No

Member name	Nature of symptoms/ diagnosis	Date(s) of consultation	Treatment received	Date of last treatment/ symptoms	Any future treatment/ advice planned?

4.2. Has anyone consulted a Specialist or been admitted to hospital in the past 5 years?
If you have ticked 'Yes', please give us full details. ☐ Yes ☐ No

Member name	Nature of symptoms/ diagnosis	Date(s) of consultation	Treatment received	Date of last treatment/ symptoms	Any future treatment/ advice planned?

4.3 Other than conditions already listed: ☐ Yes ☐ No

- **is anyone taking, or have they taken regularly in the past 5 years, any medication?**

or

- **has anyone suffered any ongoing, long-term or recurrent medical condition?**

If you have ticked 'Yes' for either point, please give us full details of the conditions/symptom needing treatment, including any medicines that you take (whether prescribed by a GP or bought 'over the counter' without a prescription). Please include details of any hormone replacement therapy or medication, other than that taken solely for contraceptive purposes.

Member Name	Nature of symptoms/ diagnosis	Date(s) of consultation	Treatment received	Date of last treatment/ symptoms	Any future treatment/ advice planned?

4.4. Other than any conditions you have already told us about, has anyone EVER suffered from, or received treatment or advice ('advice' includes any consultations with a specialist and/or complementary therapist such as a physiotherapist, optician, herbalist or acupuncturist) for:

a)	**heart and cardiovascular disorders** for example high blood pressure, angina, high cholesterol, heart rhythm disorders	☐ Yes	☐ No
b)	**blood / blood vessel and circulatory disorders** for example anaemia, haemophilia, varicose veins, deep vein thrombosis, narrowing of the blood vessels	☐ Yes	☐ No
c)	**glandular disorders** for example diabetes, thyroid conditions, hormonal problems	☐ Yes	☐ No
d)	**urinary problems** for example bladder, kidney or urinary infections, kidney stones, incontinence, cystitis, urinary frequency problems	☐ Yes	☐ No
e)	**gastric / digestive disorders** for example repeated indigestion, irritable bowel syndrome, haemorrhoids, change in bowel habit, hernia, gallbladder or liver problems, hepatitis, ulcers	☐ Yes	☐ No
f)	**respiratory disorders** for example asthma, bronchitis, pneumonia, lung or respiratory tract problems	☐ Yes	☐ No
g)	**ear, nose, throat and eye disorders** for example deafness or hearing problems, ear infections, cataracts, tonsillitis, sinusitis, wisdom teeth. If you have told us about wisdom teeth problems, please tell us if they have been removed and if not, have any remaining wisdom teeth emerged fully with no further problems.	☐ Yes	☐ No
h)	**back / neck disorders** for example sciatica, arthritis or degenerative changes, disc problems, fractures. Please tell us which area of the spine was affected for example cervical (neck), thoracic (upper back), lumbar (lower back) or sacral (bottom of the spine)	☐ Yes	☐ No
i)	**joints and bones** for example bone, tendon or ligament problems, bunions, gout, fractures, arthritis, sprains and strains Please tell us which part of you body was affected, for example left knee / right elbow	☐ Yes	☐ No
j)	**men's health** for example prostate problems, prolapse, fertility problems	☐ Yes	☐ No
k)	**women's health** for example complications of pregnancy / childbirth, menstrual irregularities, menopause, fibroids, endometriosis, prolapse, abnormal smears, polycystic ovarian syndrome, fertility problems. If you have previously had an abnormal smear, please tell us how often you have your smear tests	☐ Yes	☐ No
l)	**cancer** if you have been discharged from follow-up, please tell us when this was	☐ Yes	☐ No
m)	**cysts / polyps** for example cysts, polyps, lumps, moles, lesions, nodules, abnormal growths. Please tell us which part of you body was affected, and was this was benign (non-cancerous) or malignant (cancerous). Please also tell us if you still have this condition	☐ Yes	☐ No
n)	**skin disorders and allergies** for example hay fever, eczema, acne, psoriasis, rashes, alopecia, keloid scars	☐ Yes	☐ No
o)	**psychological or sleep disorders** for example depression, stress, anxiety, behavioural disorders (eating/compulsive disorders), schizophrenia, bipolar disorder, insomnia	☐ Yes	☐ No
p)	**brain and nervous system disorders** for example epilepsy, migraine, repeated headaches, stroke, multiple sclerosis, cerebral palsy, brain trauma, dementia or Alzheimer's disease	☐ Yes	☐ No
q)	**implants, prostheses or cosmetic surgery** for example pins, plates, screws, medical or cosmetic implants, orthotics or supports. If you tell us that you have had pins, plates or screws, please tell us whether or not they have been removed	☐ Yes	☐ No
r)	**autoimmune disorders** for example systemic lupus erythmatosis, HIV, rheumatoid arthritis,	☐ Yes	☐ No
s)	**congenital disorders** for example autism, cystic fibrosis, Down's syndrome, spina bifida	☐ Yes	☐ No

If you have ticked 'Yes' to any of the questions in this section, please give us full details on this page (put the appropriate letter next to each answer in the second column, for example f) asthma).

Member Name	Letter	Nature of symptoms/ diagnosis	Date(s) of consultation	Treatment received	Date of last treatment/ symptoms	Any future treatment/ advice planned?

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) If you tell us (in the declaration) that you do not wish to see the report, we will not tell you if we apply for one. However, if before such a report is sent to us you write to your doctor and ask to see it, you will have 21 days to contact your doctor about arrangements for you to see the report.

b) If you indicate (in the declaration) that you wish to see the report, we will write to you at the same time as we contact your doctor. 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 see it. 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.

c) 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.

d) 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 reasonable fee to cover the cost.

e) 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.

f) You do not have to give us your consent (but without it we may be unable to proceed with your proposal).

Please read the declaration and complete the boxes below:

Use of personal information

Aviva may use the information supplied to administer the policy. It may be processed by any company within the Aviva Group, by reinsurers and by third parties who provide services to Aviva. It may be transferred to any country, including those outside the European Economic Area, for any of these purposes. Any information may be used for underwriting or claims handling purposes and disclosed in confidence to the policyholder, regulatory bodies, other insurance companies (directly or via shared databases), to other Aviva Group companies and our insurance intermediary (including third parties providing services to them).

In addition, Aviva or, if applicable, the business partner that introduced us to Aviva, may use the information in Sections 2 and 3 to advise us by post or telephone of other products and services offered by the Aviva Group Companies or by the business partner.

Please tick this box if you do not wish to receive this material. ☐

In the event of a claim, the information supplied in this application and the claim form, together with other relevant information relating to the claim may, on request, be supplied to other insurers or to relevant registers or databases. All information supplied, including information relating to health and activities, may be saved and / or printed by our insurance intermediary as part of the application process and may be disclosed by Aviva to our insurance intermediary as a record of the application.

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.

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

Checklist - have you:

- ☐ fully completed the personal details for everyone on the policy?
- ☐ ticked either 'yes' or 'no' for section 4.1?
- ☐ ticked either 'yes' or 'no' for section 4.2?
- ☐ ticked either 'yes' or 'no' for section 4.3?
- ☐ ticked either 'yes' or 'no' for **every** part of section 4.4?
- ☐ 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.

6. 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. On behalf of all persons to be covered I confirm that Aviva may use the information supplied to administer the policy. It may be processed by any company within the Aviva Group, by reinsurers and by third parties who provide services to Aviva. It may be transferred to any country, including those outside the European Economic Area, for any of these purposes. Any information may be used for underwriting or claims handling purposes and disclosed in confidence to the policyholder, regulatory bodies, other insurance companies (directly or via shared databases), to other Aviva Group companies and our insurance intermediary (including third parties providing services to them).

   In addition, Aviva or, if applicable, the business partner that introduced us to Aviva, may use the information in Sections 2 and 3 to advise us by post or telephone of other products and services offered by the Aviva Group Companies or by the business partner.

   Please tick this box if you do not wish to receive this material. ☐

   In the event of a claim, the information in supplied in this application and the claim form, together with other relevant information relating to the claim may, on request, be supplied to other insurers or to relevant registers or databases. All information supplied, including information relating to health and activities, may be saved and / or printed by our insurance intermediary as part of the application process and may be disclosed by Aviva to our insurance intermediary as a record of the application.

Your signature

Date (must be completed) DD / MM / YYYY

Print name

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	

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