For office use only
SR No.

Corporate Healthcare

Group Member Application Form - Moratorium

Please read through the following before completing this application in BLOCK CAPITALS and in black ink.

All information supplied will be treated in strict confidence.

All material facts relating to these questions **must** be disclosed. Failure to do so may invalidate the policy. A material fact is one which is likely to influence an insurer in the assessment and acceptance of this application. If you are in any doubt as to whether a fact is material then it should be disclosed.

As Group Member you should answer all questions and sign the declaration on behalf of all persons to be insured.

A copy of this application will be supplied to you on request within three months of completion. You should keep a record (including copies of all letters) of all information supplied to us for the purpose of joining this policy.

Calls may be monitored and/or recorded.

1. To be completed by the Group Administrator

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

Optimum ☐ **Solutions** ☐

Category of employee to which Group Member belongs

Joining Date

Group Administrator's Signature

Please note that we may deal with any person who is apparently authorised to represent the company (e.g a director, partner, officer or Senior manager) in addition to/or instead of the person nominated as Group Administrator.

Name *(please print)*

Date

2. Company Details

Company Name

Policy number (if known)

3. Your details (to be completed by employee)

Name

Mr, Mrs, Miss, Ms, other: Surname:

Forename: Other initials:

Sex

Male ☐ Female ☐ Date of birth / /

Address

Postcode: *(must be completed)*

Contact numbers

Daytime telephone number and area code

Evening telephone number and area code

Mobile telephone number

Fax number

Employee Category (as detailed on Company Application)

4. Details of all other persons to be covered *(Your Group Administrator will inform you whether to complete this section)*

	Group Member	Second person			Third person	
Relationship to Group Member		spouse/partner	son	daughter	son	daughter
Title		Mr, Mrs, Miss, Ms, other			Mr, Mrs, Miss, Ms, other	
Surname						
Forename						
		Other initials			Other initials	
Sex		male	female			
Date of birth		/ / age			/ / age	
Occupation *(please give full details)*						

	Fourth person		Fifth person		Sixth person	
Relationship to Group Member	son	daughter	son	daughter	son	daughter
Title	Mr, Mrs, Miss, Ms, other		Mr, Mrs, Miss, Ms, other		Mr, Mrs, Miss, Ms, other	
Surname						
Forename						
	Other initials		Other initials		Other initials	
Date of birth	/ / age		/ / age		/ / age	
Occupation *(please give full details)*						

If any of the persons to be covered are usually resident at a different address to that shown overleaf, please give details.

Name			
Usual place of residence			
Postcode *(must be completed)*			

5. Pre-existing medical conditions

Benefits will not be available for the treatment of any disease, illness or injury (whether or not diagnosed) or of any other disease, illness or injury related to or associated with it if:

- the insured person had symptoms of, medication or treatment for, or advice about such a disease, illness or injury within five years before his or her date of entry,
  and
- there has not been a clear two year period after the date of entry during which the insured person has been free of medication for, treatment for, and advice about such a disease, illness or injury or related / associated condition.

6. Declaration

I declare that:

(a) I understand and accept section 5 on pre-existing medical conditions.

(b) I will advise if there are any changes in the information given on this application which occur between the date of signing and the date of commencement of cover under the policy.

(c) To the best of my knowledge and belief the information given on this application is true and complete. I agree to accept and conform to the terms of the policy. (A specimen copy of the Policy Wording is available from your Group Administrator).

(d) I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.

(e) I understand that if Aviva needs to investigate or establish material facts this may delay the claims process.

(f) On behalf of all persons to be covered I confirm consent to the computer and other processing and use (which may be in any part of the world) of personal and medical details by the data controllers and relevant third parties (including disclosure to the Policyholder and to relevant intermediaries and medical providers) for the purposes of this application, policy administration, service provision, reinsurance, fraud prevention, claims assessment and validation. The data controllers are Aviva Health UK Limited, Aviva Insurance UK Limited and Aviva Life & Pensions UK Limited. Also, relevant details of persons to be covered may be processed in order to tell them from time to time (by post, telephone, email, fax or other means) about products or services which may be of interest from Aviva Group and connected providers. Any person not wishing to receive such contact may write to Aviva, FREEPOST, Mailing Exclusion Team, PO Box 6412, Derby, DE1 1SB.

Group Member's signature _____ Date (must be completed) _____

If you have any cause to make a complaint

Our aim is to provide a first class standard of service to our policyholders and members, and to do everything we can to ensure that you are satisfied. However, should you ever feel that we have fallen short of this standard and that you have cause to make a complaint, please contact your Group Administrator in the first instance.

If you remain dissatisfied, please write with full details to:

The Complaints Co-ordinator
Aviva Health UK Limited
Chilworth House
Hampshire Corporate Park
Templars Way, Eastleigh
Hampshire SO53 3RY.

In the unlikely event that the matter is not resolved, then your complaint can be referred to the Quality Manager at the same address. It is very rare that matters cannot be resolved amicably.

If you are still unhappy with the outcome, you may ask the Financial Ombudsman Service to investigate by writing to:

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR
Telephone: 0845 080 1800
Email: enquiries@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

Please note that the Financial Ombudsman Service will not consider your complaint until you have given us the opportunity to resolve the matter directly with you.

We have every reason to believe that you will be totally satisfied with your Aviva Policy, and with our service. Nevertheless, we have provided the above information to assist you should you ever feel that you have cause to make a complaint.

Aviva Health UK Limited. Registered in England Number 2464270. Registered Office 8 Surrey Street Norwich NR1 3NG.
This insurance is underwritten by Aviva Insurance UK Limited. Registered in England Number 99122,
Registered Office 8 Surrey Street Norwich NR1 3NG.
Authorised and regulated by the Financial Services Authority.
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www.aviva.co.uk/health

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