For office use only

Opportunity number

Healthier Solutions Application (FMU/Moratorium)

AVIVA

For internal use only
Voluntary scheme name:

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 proposer 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.

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. Your details As proposer you are applying to be the policyholder and will be responsible for paying the premium.

Name — Mr, Mrs, Miss, Ms, other | Surname

Forename | Other initials

Sex — ☐ Male ☐ Female

Date of birth — D D / M M / Y Y Y Y

Address

Postcode (must be completed)

Contact telephone numbers — Daytime inc area code | Evening inc area code | Mobile

Email address

Please tick if cover is not required for the proposer ☐

If cover is not required for the proposer then the second person will become the main member under this policy.

2. Details of all persons to be covered

	Second person	Third person	Fourth person
Relationship to proposer	spouse/partner / 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	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 proposer	son / daughter	son / daughter
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
Surname		
Forename		
	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:

3. Previous Cover Details

If you are currently, or have previously been, a customer of Aviva, please complete the following:

Policy number

Member number
(if applicable)

Date previous cover ceased
(if applicable) / /

Please note that if you have a previous or current policy with Aviva you are still required to complete all the relevant sections of this application in full, disclosing all material facts.

4. Benefit Options

You can choose from the following options to either enhance the healthcare benefits provided by Healthier Solutions, or to help to contain cost. Please refer to the Healthier Solutions terms and conditions for details of these options. Please indicate which options you require by ticking the appropriate boxes.

Reduced out-patient cover and selected benefit reduction ☐

Other treatment and therapies ☐

Dental and optical benefits ☐

Psychiatric treatment ☐

Hospital list
If none selected, the hospital list will be the Key hospital list
☐ Extended ☐ Signature ☐ Fair+Square (available to existing Fair+Square hospital list holders only) ☐ Trust

If selecting the Trust hospital list, please advise your first choice of hospital, in the event of a claim, in the box below.

Member excess
If none selected, member excess will be £0
☐ £100 ☐ £200 ☐ £500 ☐ £1,000

Six week option ☐

Protected no claim discount ☐

5. Start date

The start date of the policy will generally be the date when this application is accepted by Aviva. However, if you require a start date in the future please state this here: D D / M M / Y Y Y Y

6. Underwriting Options

Please tick one box only, EITHER Moratorium OR Full Medical Underwriting

Moratorium ☐

Pre-existing medical conditions

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

the member 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 member has been free of medication for, treatment for, and advice about such a disease, illness or injury or related condition.

If you have chosen Moratorium underwriting, please ignore the next 4 pages and go to section 9.

OR

Full Medical Underwriting ☐

We will ask you a series of questions about the past health of everyone on this application.

Benefits will not be available to members for the treatment of any disease, illness or injury (whether or not diagnosed) for which the member has received medication, advice or treatment or of which the member has experienced symptoms prior to the date of acceptance of this application, or any related condition, unless fully disclosed on this application and accepted by Aviva Health UK Limited. An additional application in our prescribed form will be required for any persons added to the policy in the future.

If you have chosen Full Medical Underwriting, please complete all the remaining sections of this form.

7. Medical Disclosure - the questions in this section apply to everyone who is included in this application

For questions 7.1 - 7.4 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 7.1 and 7.2 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.

7.1. 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?

7.2. 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?

7.3 Other than conditions already listed:
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? ☐ Yes ☐ No

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?

7.4. 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 condtion
☐ 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?

8. 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:

I have been informed of, and understand my rights under the Access to Medical Reports Act 1988 (or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991).

In connection with the insurance applied for, I consent to the provision of any and/or all of my medical records to Aviva. Accordingly, I hereby authorise 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 consent to the:

- processing (by computer or otherwise);
- use (which may happen outside the European Economic Area) for the purpose of medical underwriting, claims assessment and validation, fraud prevention, policy administration, service provision and reinsurance; and
- disclosure to the policyholder, relevant intermediaries and medical service providers

of personal and medical details supplied in support of this application.

I agree that a copy of this consent shall have the validity of the original.

The data controllers are Aviva Health UK Limited, Aviva Insurance UK Limited and Aviva Life & Pensions UK Limited.

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

9. Declaration

I declare that:

a. I understand and accept section 6 on pre-existing medical conditions.

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

c. To the best of my knowledge and belief the information given on this form is true and complete. I agree to accept and conform to the terms of the policy when issued. (A copy of the terms and conditions is available on request).

d. I confirm that I have checked and found correct any answers or statements on this form 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. I have received the ABI Guide to Buying Private Medical Insurance, Direct Debit guarantee (if applicable), 'How you can apply for cover' booklet and the Healthier Solutions brochure.

g. For the hospital list that I have chosen I have checked that there is a hospital within reasonable distance from my home.

h. On behalf of all persons to be covered I confirm consent to the computer and other processing and use of personal and medical details by the data controllers and relevant third parties (which may include disclosure to the policyholder, relevant intermediaries and medical service providers) for the purposes of this application, policy administration, service provision, reinsurance, claims validation and fraud prevention. (Processing may be in any part of the world although we will ensure that adequate standards of data protection within the meaning English law apply. 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.)

Proposer's signature

Date (must be completed) / /

Print name

10. How you wish to pay Please tick one of the methods listed below.

Please note that if you wish to pay monthly, premiums will be requested each month on the same date as the start date.

Direct Debit ☐ monthly ☐ annual

If selected, please complete the instructions to your bank on the perforated slip attached to this application.

Cheque ☐ annual Annual only

If selected, please make cheque payable to Aviva Health UK Limited and attach to this application

Credit Card ☐ monthly ☐ annual Mastercard/Visa only

If selected, please complete the Credit Card authorisation form on the perforated slip attached to this application.

Please do not forget to complete the payment details on the next page

Checklist - have you:

- ☐ fully completed your details?
- ☐ fully completed the details for everyone to be covered on this policy?
- ☐ ticked all the benefit options that you want (if any)?
- ☐ ticked the underwriting option that you want?
- ☐ completed the medical details and consent form (if you have chosen FMU underwriting)? This includes ticking either 'yes' or 'no' for sections 7.1, 7.2 and 7.3 and every part of section 7.4.
- ☐ attached any additional sheets to this application and indicated (on the front page) how many?
- ☐ completed the payment details on the next page?

Please return completed form to:

Medisave Independent Healthcare
FREEPOST NAT12295
Lisburn
BT28 2BR

For agent's use only

Agent's name and address

Medisave Independent Healthcare
Beech House
45 Beechland Drive
Lisburn
BT28 1HS

Agency ref Y1098

For office use only

Plan code

Scheme code

Campaign code

Coupon code

Policy number

Rate key

Credit card authorisation form

Mastercard and Visa only

Please complete these instructions if you wish to pay your premium by credit card.

Please tick as appropriate Mastercard ☐ Visa ☐ Expiry date ☐☐/☐☐

Name as on credit card

Credit card number

To Aviva Health UK Limited

I authorise you, until further notice in writing, to charge my Mastercard/ Visa account with unspecified amounts in respect of premiums as and when they become due.

Annual cheque payment

If you intend to pay by cheque please tick the box below and attach your cheque securely to this application and return it to Aviva Health UK Limited.

Cheque attached Please tick ☐ Premium amount

Direct Debit payment

AVIVA

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form **including official use only box** and send to: Aviva Health UK Limited, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.

DIRECT Debit

Service User Number | 8 | 5 | 3 | 8 | 2 | 0 |

1. The Manager of ____ Bank/Building Society

Full address of your Bank/Building Society

Postcode

2. Name of account holder(s)

3. Sort code

4. Account number

5. Reference number

Please note that Aviva Health UK Limited may retain the Direct Debit Instruction (DDI) until the policy is activated, at which point the DDI will be processed.

For Aviva Health UK Limited official use only

This is not part of the instruction to your Bank/Building Society

6. Tick your preferred payment option: ☐ Monthly ☐ Annual

7. **Instruction to the Bank/Building Society**

Please pay Aviva Health UK Limited Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Aviva Health UK Limited and, if so, details will be sent electronically to my Bank / Building Society.

Signature(s) Date

Banks/Building Societies may not accept Direct Debit instructions for some types of account.

This guarantee should be detached and retained by the payer

The Direct Debit Guarantee

DIRECT Debit

This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits

If there are any changes to the amount, date or frequency of your Direct Debit Aviva Health UK Limited will notify you 7 working days in advance of your account being debited or as otherwise agreed. If you request Aviva Health UK Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.

If an error is made in the payment of your Direct Debit, by Aviva Health UK Limited or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society

– If you receive a refund you are not entitled to, you must pay it back when Aviva Health UK Limited asks you to

You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

Please return completed form to:

Medisave Independent Healthcare
FREEPOST NAT12295
Lisburn
BT28 2BR