



For office use only

Opportunity number



Healthier Solutions Application (FMU/Moratorium)

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	<input type="checkbox"/> Male	<input type="checkbox"/> 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	<input type="checkbox"/> spouse/partner <input type="checkbox"/> son <input type="checkbox"/> daughter	<input type="checkbox"/> son <input type="checkbox"/> daughter	<input type="checkbox"/> son <input type="checkbox"/> 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	<input type="checkbox"/> male <input type="checkbox"/> female		
	Fifth person	Sixth person	
Relationship to proposer	<input type="checkbox"/> son <input type="checkbox"/> daughter	<input type="checkbox"/> son <input type="checkbox"/> daughter	If any person on this application is employed by a foreign embassy or diplomatic service please write their name here:
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other	
Surname			<input type="text"/>
Forename			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:
	Other initials	Other initials	
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	<input type="text"/>

3. Previous Cover Details

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

Policy number	<input type="text"/>	Date previous cover ceased (if applicable)	<input type="text"/>
Member number (if applicable)	<input type="text"/>		

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	<input type="checkbox"/>
Other treatment and therapies	<input type="checkbox"/>
Dental and optical benefits	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>
Hospital list <small>If none selected, the hospital list will be the Key hospital list</small>	<input type="checkbox"/> Extended <input type="checkbox"/> Signature <input type="checkbox"/> Fair+Square <small>(available to existing Fair+Square hospital list holders only)</small> <input type="checkbox"/> Trust
Member excess <small>If none selected, member excess will be £0</small>	<input type="checkbox"/> £100 <input type="checkbox"/> £200 <input type="checkbox"/> £500 <input type="checkbox"/> £1,000
Six week option	<input type="checkbox"/>
Protected no claim discount	<input type="checkbox"/>

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

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:

6. Underwriting Options **Please tick one box only, EITHER Moratorium OR Full Medical Underwriting**

Moratorium	<input type="checkbox"/>	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.
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If you have chosen Moratorium underwriting, please ignore the next 4 pages and go to section 9.

OR

Full Medical Underwriting	<input type="checkbox"/>	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.
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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?

Yes No

If you have ticked 'Yes', please give us full details.

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:

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?

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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
b) blood / blood vessel and circulatory disorders for example anaemia, haemophilia, varicose veins, deep vein thrombosis, narrowing of the blood vessels	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
c) glandular disorders for example diabetes, thyroid conditions, hormonal problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
d) urinary problems for example bladder, kidney or urinary infections, kidney stones, incontinence, cystitis, urinary frequency problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
e) gastric / digestive disorders for example repeated indigestion, irritable bowel syndrome, haemorrhoids, change in bowel habit, hernia, gallbladder or liver problems, hepatitis, ulcers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
f) respiratory disorders for example asthma, bronchitis, pneumonia, lung or respiratory tract problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
j) men's health for example prostate problems, prolapse, fertility problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
l) cancer if you have been discharged from follow-up, please tell us when this was	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
n) skin disorders and allergies for example hay fever, eczema, acne, psoriasis, rashes, alopecia, keloid scars	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
o) psychological or sleep disorders for example depression, stress, anxiety, behavioural disorders (eating/compulsive disorders), schizophrenia, bipolar disorder, insomnia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
r) autoimmune disorders for example systemic lupus erythmatosis, HIV, rheumatoid arthritis,	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
s) congenital disorders for example autism, cystic fibrosis, Down's syndrome, spina bifida	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

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	<input type="text"/>	GP's name	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
	(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	<input type="text"/>	GP's name	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
	(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	<input type="text"/>	GP's name	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
	(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	<input type="text"/>	GP's name	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
	(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	<input type="text"/>	GP's name	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
	(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	<input type="text"/>	GP's name	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/>
	(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

Cheque annual Annual only

Credit Card monthly annual Mastercard/Visa only

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

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

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	Medisave Independent Healthcare
Agent's name and address	Beech House
	45 Beechland Drive
	Lisburn
	BT28 1HS
Agency ref	Y1098

For office use only	
Plan code	<input type="text"/>
Scheme code	<input type="text"/>
Campaign code	<input type="text"/>
Coupon code	<input type="text"/>
Policy number	<input type="text"/>
Rate key	<input type="text"/>

Please return completed form to:

Medisave Independent Healthcare

FREEPOST NAT12295

Lisburn

BT28 2BR

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.
Aviva Health UK Limited, Head Office: Chilworth House Hampshire Corporate Park Templars Way Eastleigh Hampshire SO53 3RY.
www.aviva.co.uk/health

