For office use only

Opportunity number

Speedy Diagnostics 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's important that you answer all the questions on this application form fully, truthfully and accurately. This includes all known medical conditions and treatment details where requested for all intended members on the policy. This is because we'll use the answers you give to determine what your policy will cover and the price you will pay for the policy.

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 the applicant 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.

By completing this application you confirm that all people to be covered have the legal right to reside, and will be physically living, in the UK, Channel Islands or Isle of Man for the duration of the policy year other than trips abroad totalling no more than three months during the policy year. You must tell us as soon as possible if this ceases to be the case and we may cancel cover for that member.

This form needs to be returned within three months. You can return this form by email to directhealthsales@aviva.com or by post to Health Admin, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.

If you have any queries, please contact us on 0800 158 5182. Calls may be monitored and/or recorded.

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 applicant you are applying to be the policyholder and will be responsible for paying the premium. Policyholders must be aged 18 or over.

Name	Mr, Mrs, Miss, Ms, other	Surname	
	Forename	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 telephone numbers	Work inc area code	Home inc area code	Mobile
Email address			

Please tick if cover is not required for the proposer ☐

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

2. Details of all people to be covered

Second person

Relationship to applicant: spouse/partner ☐ son ☐ daughter ☐

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

Forename | Other initials

Gender: male ☐ female ☐

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

Contact telephone numbers: Work inc area code | Home inc area code | Mobile

Email address

Third person

Relationship to applicant: son ☐ daughter ☐

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

Forename | Other initials

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

Contact telephone numbers: Work inc area code | Home inc area code | Mobile

Email address

Fourth person

Relationship to applicant: son ☐ daughter ☐

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

Forename | Other initials

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

Contact telephone numbers: Work inc area code | Home inc area code | Mobile

Email address

Fifth person

Relationship to applicant: son ☐ daughter ☐

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

Forename | Other initials

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

Contact telephone numbers: Work inc area code | Home inc area code | Mobile

Email address

Sixth person

Relationship to applicant: son ☐ daughter ☐

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

Forename | Other initials

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

Contact telephone numbers: Work inc area code | Home inc area code | Mobile

Email address

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

If we need further information to process this application, we will contact you. If, however you would like to provide permission for someone else to deal with this application on your behalf, please provide the following:

Title:

First Name:

Last Name:

Date of Birth: D D / M M / Y Y Y Y

Relationship to you (if this is on behalf of a dependant who is under 16, please specify the relationship to the person you're providing permission for):

Email address:

Contact telephone number:

This permission will remain in place until the application process has completed. If you wish to nominate anyone to act on your behalf when the policy is in force, you will need to provide these details separately.

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)

Have you ever had any insurance with Aviva denied or cancelled before?

☐ Yes ☐ No

Policy number (if available):

Even if you've already provided information in a previous application, you must provide it to us again on this application form.

We may cancel the policy, or decline to provide cover, if you had previous insurance with Aviva that we cancelled for any reason. We may also cancel current or future policies.

4. Start date

The start date of the policy will generally be the date when this application is accepted by Aviva. We will not backdate the start date, but if you would like a start date in the future please state this here:

D D / M M / Y Y Y Y

5. Underwriting options **Please tick one box only, EITHER moratorium OR full medical underwriting**

Moratorium ☐

We do not cover diagnostic tests for any disease, illness or injury, or any related condition, if a member had:

- symptoms of,
- medication for,
- diagnostic tests for,
- treatment for, or
- advice about

that condition in the five years before they joined the policy.

However, we may cover a condition if a member does not have:

- medication for,
- diagnostic tests for,
- treatment for, or
- advice about

that condition during a continuous two year period after they join the policy.

If you have chosen moratorium underwriting, please ignore the next 5 pages and go to section 8.

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 diagnostic tests of any disease, illness or injury (whether or not diagnosed) for which the member has received medication, advice, diagnostic tests 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 people added to the policy in the future.

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

6. 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'. In most cases we will not approach your GP for this information.

– If you don't answer a question or if you leave a question blank, we'll assume you have nothing to tell us.

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

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

(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 tell us the frequency.)

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

6.2 Has anyone consulted a specialist, attended A&E, had an operation or any investigations such as scans, X-rays or biopsy, 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 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)

6.3 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')

6.4 Has any person named EVER had symptoms of or been diagnosed with 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 or erectile dysfunction problems ☐ Yes ☐ No

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

m) joint, bone or muscular 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 or muscular problems ☐ 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 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)

6.5 Has any person named had symptoms of or been diagnosed with any of the following conditions in the 10 years prior to their start date (other than conditions 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 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 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)

6.6 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 tell us the date of removal

6.7 Does anyone named use any orthotics, supports, prosthesis or hearing aids (other than those 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

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

(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)

7. Access to your health and medical information – consent form

We may need information about your circumstances to complete your application for cover. This form explains how we obtain your health, medical and other information, and why we need it. In the context of medical reports, it also gives important information about your rights, and why we ask you to sign and return it to us. You don't have to do so, but if you don't then we may not be able to assess your application for cover. If we do approach your medical practitioner, we will tell you that we have done so. We will not approach your medical practitioner as an alternative to an incomplete form.

There is an FAQ section at the end of this application form which hopefully addresses any queries you may have about this consent form.

What information we need and why we need it

If we need further information to assess your application for cover, we will need your consent to ask any relevant professionals involved in your care, whether a health or medical practitioner or other professional, for health, medical or other information. This may include a medical report and specific details about your health and lifestyle.

Where we refer to a practitioner or professional in this form, it means all or any such persons, and may include more than one such practitioner or professional in the context of a particular claim.

- We request medical reports from medical practitioners under the Access to Medical Reports Act 1988 (or if you live in Northern Ireland or the Isle of Man, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Isle of Man Access to Health Records and Reports Act 1993 respectively) (collectively referred to as "**AMRA**").

  This is specific legislation which allows insurers, like Aviva, to obtain a medical report with your consent.

  We may need to ask for additional information (such as specialist letters or test results) from your medical practitioner to give us the information we need to fully assess your application.

  Please be assured that we'll only ask for, and take into account, the medical information that we need for your application. We respect the confidentiality and privacy of your information and will ensure that your medical information isn't kept for longer than is necessary and is safe in our hands.

- You can withdraw your consent at any time before your medical practitioner sends the medical report to us by contacting the Aviva Medical Underwriting team on the telephone number noted in the FAQs at the end of this application form, or your medical practitioner directly. However, if you do withhold/withdraw your consent, we may not be able to consider your application for cover.

- You can see a copy of any medical report prepared by your medical practitioner before they send it to us. If you would like to do this, let us know by ticking the box below and we'll tell your medical practitioner so they can keep the report for you. You will then have 21 days to arrange to see it, following which your medical practitioner will send it to us, unless you tell us that you are withdrawing consent for us to access the report.

- You can ask your medical practitioner for a copy of the medical report at any time. They should keep a copy for up to six months after sending it to us. If you would like to see a copy of the report at a later date, you can speak to your medical practitioner or ask us and we can provide it with their consent.

- If you think any part of the medical report is incorrect or misleading, you can ask your medical practitioner to amend it. If your medical practitioner refuses, you can ask them to attach a statement outlining your views to the report. Alternatively, you can withdraw your consent for us to have access to your medical report.

In some circumstances the medical practitioner may decide, in the interests of your health, or to respect the interests of other persons, that you should not see all or part of the medical report. The medical practitioner will tell you of this and you will have the right to see any remaining part of the report. If your medical practitioner decides that you should not see any of the report, it may be that they will not give it to us without your consent.

What types of health/medical information we ask for

To complete the application, we may need to see the following items:

- a medical report prepared by your medical practitioner or a report prepared by another health practitioner or other professional, which may include information about:
  - your medical history, including details of any relevant illnesses, trauma, hospital admissions, medical consultations, referrals, tests or investigations and treatments you may have had;
  - your current state of health, including any care, medication or treatment you're receiving and the results of any referrals or tests you're waiting for;
  - copies of correspondence between medical practitioners eg referral letters and clinic letters; and/or
- medical or other healthcare records.

More information

If you have any questions about your rights under the Access to Medical Reports Act 1988 (or if you live in Northern Ireland or the Isle of Man, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Isle of Man Access to Health Records and Reports Act 1993 respectively) or the process of getting, assessing or storing medical information, please write to: Health Underwriting, Pomona Business Centre, 6 Pear Street, Sheffield, S11 8JJ.

By signing this form you confirm that:

- you've read and understood this form;
- you consent to us, our agents or sub-contractors seeking a (i) medical report from your medical practitioner(s) under AMRA or (ii) a report from your health practitioner or other professional; and
- you consent to any medical practitioner, institution or person who has been involved in your care or treatment to release and provide to us and any third parties acting on our behalf any relevant information concerning your physical and/or mental health which we consider is required to process your application with us. We'll use this form as proof that you've given us your consent to request other relevant information from your medical practitioner, health practitioner or other professional.

Reference/Policy No _____

Name

Name of person insured/parent or guardian of person insured

Signature

Signature of person/parent or guardian of person insured

D D / M M / Y Y Y Y

Today's date

Please note

If you are signing this form on behalf of someone else, please provide their full name, date of birth and relationship to you.

Please tick this box if you wish to see any medical report or health information before it is sent to Aviva: ☐

Please note: if AMRA applies and you want to view your medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact them to request the report to allow you to view it before it is sent to us.

Name

Name of person insured/parent or guardian of person insured

Signature

Signature of person/parent or guardian of person insured

D D / M M / Y Y Y Y

Today's date

Please note

If you are signing this form on behalf of someone else, please provide their full name, date of birth and relationship to you.

Please tick this box if you wish to see any medical report or health information before it is sent to Aviva: ☐

Please note: if AMRA applies and you want to view your medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact them to request the report to allow you to view it before it is sent to us.

Name

Name of person insured/parent or guardian of person insured

Signature

Signature of person/parent or guardian of person insured

D D / M M / Y Y Y Y

Today's date

Please note

If you are signing this form on behalf of someone else, please provide their full name, date of birth and relationship to you.

Please tick this box if you wish to see any medical report or health information before it is sent to Aviva: ☐

Please note: if AMRA applies and you want to view your medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact them to request the report to allow you to view it before it is sent to us.

Name

Name of person insured/parent or guardian of person insured

Signature

Signature of person/parent or guardian of person insured

D D / M M / Y Y Y Y

Today's date

Please note

If you are signing this form on behalf of someone else, please provide their full name, date of birth and relationship to you.

Please tick this box if you wish to see any medical report or health information before it is sent to Aviva: ☐

Please note: if AMRA applies and you want to view your medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact them to request the report to allow you to view it before it is sent to us.

Name

Name of person insured/parent or guardian of person insured

Signature

Signature of person/parent or guardian of person insured

D D / M M / Y Y Y Y

Today's date

Please note

If you are signing this form on behalf of someone else, please provide their full name, date of birth and relationship to you.

Please tick this box if you wish to see any medical report or health information before it is sent to Aviva: ☐

Please note: if AMRA applies and you want to view your medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact them to request the report to allow you to view it before it is sent to us.

Name

Name of person insured/parent or guardian of person insured

Signature

Signature of person/parent or guardian of person insured

D D / M M / Y Y Y Y

Today's date

Please note

If you are signing this form on behalf of someone else, please provide their full name, date of birth and relationship to you.

Please tick this box if you wish to see any medical report or health information before it is sent to Aviva: ☐

Please note: if AMRA applies and you want to view your medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact them to request the report to allow you to view it 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)	Email address

Please provide your GP's email address to avoid delays in the completion of your underwriting terms.

8. Important notes

Privacy Notice

Aviva Health UK Limited and Aviva Insurance Limited are the main companies responsible for your Personal Information (known as the controller). Where the cover was taken out online, directly with Aviva, then Aviva UK Digital Limited will also be a controller for the sale and distribution of the product.

We collect and use Personal Information about you in relation to our products and services. Personal Information means any information relating to you or another living individual who is identifiable by us. The type of Personal Information we collect and use will depend on our relationship with you and may include more general information (e.g. your name, date of birth, contact details) or more sensitive information (e.g. details of your health or criminal convictions).

Some of the Personal Information we use may be provided to us by a third party. This may include information already held about you within the Aviva group, information we obtain from publicly available records, third parties and from industry databases, including fraud prevention agencies and databases.

This notice explains the most important aspects of how we use your Personal Information, but you can get more information by viewing our full privacy policy at aviva.co.uk/privacypolicy or requesting a copy by writing to us at: The Data Protection Team, Aviva, PO Box 7684, Pitheavlis, Perth PH2 1JR. If you are providing Personal Information about another person you should show them this notice.

We use your Personal Information for a number of purposes including providing our products and services and for fraud prevention.

We also use profiling and other data analysis to understand our customers better, e.g. what kind of content or products would be of most interest, and to predict the likelihood of certain events arising, e.g. to assess insurance risk or the likelihood of fraud.

We may carry out automated decision making to decide on what terms we can provide products and services, deal with claims and carry out fraud checks. More information about this, including your right to request that certain automated decisions we make have human involvement, can be found in the “Automated Decision Making” section of our full privacy policy.

We may use Personal Information we hold about you across the Aviva group for marketing purposes, including sending marketing communications in accordance with your preferences. If you wish to amend your marketing preferences please contact us at contactus@aviva.com or by writing to us at: Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD. More information about this can be found in the “Marketing” section of our full privacy policy.

Your Personal Information may be shared with other Aviva group companies and third parties (including our suppliers such as those who provide claims services and regulatory and law enforcement bodies). We may transfer your Personal Information to countries outside of the UK but will always ensure appropriate safeguards are in place when doing so.

You have certain data rights in relation to your Personal Information, including a right to access Personal Information, a right to correct inaccurate Personal Information and a right to erase or suspend our use of your Personal Information. These rights may also include a right to transfer your Personal Information to another organisation, a right to object to our use of your Personal Information, a right to withdraw consent and a right to complain to the data protection regulator. These rights may only apply in certain circumstances and are subject to certain exemptions. You can find out more about these rights in the “Data Rights” section of our full privacy policy or by contacting us at dataprt@aviva.com.

From time to time, we would like to tell you about other products or services which we believe may interest you. If you are happy for us to do this please tick the relevant boxes below. You can opt out at any time.

☐ Post ☐ Email ☐ SMS ☐ Phone

Change your marketing preferences at any time by emailing us at contactus@aviva.com or writing to us at Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD. If you are registered for MyAviva you can change your marketing preferences at any time from within your account.

9. Declaration

By signing below, I confirm that:

a. I have read Section 5 on underwriting options and have chosen the option I want to apply to my policy.

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

c. I have answered the questions fully, truthfully and accurately and I understand that if I don't correctly declare medical conditions and treatment (where requested), this could affect how much Aviva will pay if a member makes a claim and could mean Aviva won't pay their claim at all. I have checked any answers or statements on this form that are not in my own handwriting and they are correct.

d. 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).

e. I have received the Direct Debit guarantee (if applicable), 'Your guide to applying for cover' booklet, the Speedy Diagnostics brochure and the Speedy Diagnostics Insurance Product Information Document and have access to the ABI Guide to Buying Private Medical Insurance, available from abi.org.uk.

f. I agree on behalf of all people 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.

g. all people to be covered have the legal right to reside, and will be physically living, in the UK, Channel Islands or Isle of Man for the duration of the policy year other than trips abroad totalling no more than three months during the policy year.

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

Applicant's signature

Date (must be completed) D D / M M / Y Y Y Y

Print name

10. How you wish to pay – payment must be made from a UK bank account

Third party payer details

If the person paying the premiums is not the policyholder please complete the following details:

Company name (if applicable)

Title: Forename:

Surname: Date of birth: D D / M M / Y Y Y Y

Email address:

Address (main residence):

Country: Postcode:

Telephone number:

Relationship to policyholder: 1) Employer ☐ 2) Family member ☐ 3) Other ☐
Please tick box which applies to you

If a third party pays your premium(s) on your behalf by direct debit, that third party will know your name and the amount of your premium(s). Also, we are obliged to tell them in advance of any changes to your premium(s).

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

Please tick the payment method you wish to use.

Direct Debit monthly ☐ yearly ☐

If selected, please complete the instructions to your bank at the end of this form.

Credit Card monthly ☐ yearly ☐ MasterCard/Visa only

To assist with cardholder data security, we (Aviva) request that you do not record credit card details on this form.

When we receive your application, we will call you to take your card details over the phone. This way your card details can be securely processed. Please ensure that you have put a telephone contact number on this application.

Please do not forget to complete the payment details at the end of this form

Checklist - have you:

- ☐ fully completed your details?
- ☐ fully completed the details for everyone to be covered on this policy?
- ☐ 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 every part of section 6
- ☐ attached any additional sheets to this application and indicated (on the front page) how many?
- ☐ completed the payment details at the end of this form?
- ☐ put your telephone details on the front page if you wish to pay by credit card?

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

Frequently asked questions (FAQs) about the consent form

1. **When does AMRA apply?**

   "AMRA" is the collective term we use in the form to refer to the relevant legislation regulating access to medical records, that is: the Access to Medical Reports Act 1988 or if you live in Northern Ireland or the Isle of Man, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Isle of Man Access to Health Records and Reports Act 1993 respectively).

   A report will be covered by AMRA if it is a report about your health and it has been prepared by a medical practitioner who is or has been responsible for your clinical care. If AMRA applies there are certain rules that govern the report which are set out in the consent form (earlier in this application).

2. **What is a 'medical practitioner'?**

   Under AMRA, a medical practitioner is one who is registered with the General Medical Council. This covers consultants and GPs, however would not cover, for example, a physiotherapist. If in doubt, you should ask your health practitioner.

3. **What if I have received care or treatment from someone who is not a medical practitioner (eg. a physiotherapist) and Aviva needs a report?**

   The consent form earlier in this application covers the provision of both medical reports under AMRA and non-AMRA reports.

   If you have received care or treatment from someone who is not classed as a 'medical practitioner' under AMRA, then we will still ask you to sign the consent form as your consent shows your health practitioner that you have agreed that they can provide the information we are requesting, which they are likely to need under the relevant data protection laws.

   Please note that for non-AMRA reports, the provisions of AMRA as noted in the consent form will not apply, such as your rights to view the report before it is sent to us. However if the person providing the report or information is comfortable for you to see it, then we are too. Please see Q6 for more information.

4. **What if Aviva needs other information or documents?**

   We will usually request a medical report however, in some cases, it may be necessary for us to ask for different information or documents. This is why the consent you give on the form allows us to request relevant records and information from any medical practitioner, institution or person who has been involved in your care or treatment (including hospitals, doctors, nurses, health and other professionals, government departments, local authorities and other insurance companies).

   We therefore ask for your consent in advance (through the consent form earlier in this document) at the start of the application, to save having to do so at a later stage and causing any unnecessary delays. Don't worry though, we will only ever ask for documents or information if they are necessary for our assessment of your application for cover.

5. **Can I withdraw my consent?**

   You can withdraw your consent for the relevant medical practitioner or treatment provider to provide us with any reports, documents or information at any time up to the point they send the information to us. To do this, you can contact either your medical practitioner directly or telephone the Aviva Medical Underwriting team on **0800 158 5182**. Calls may be monitored and/or recorded.

   Once we have received the medical report, non-medical report or other medical/health information, we process and use it in accordance with the terms of our Privacy Policy to administer and assess the application and do not rely on consent for this. If we need a document or information and you have either not provided consent or withdrawn it, then this may impact upon our ability to assess your application for cover.

   If you do not want to progress the application at any point, you are always free to do so by contacting the Aviva Medical Underwriting team on the telephone number provided in this FAQ section.

6. **I'd like to see the report/information before it is sent to you – how does that happen?**

   If AMRA applies and you want to view the medical report before it is sent to us, you'll need to arrange an appointment with your medical practitioner. Your report will be held for 21 days from the date we contact your medical practitioner to request the report to allow you to view it before it is sent to us.

   If AMRA doesn't apply and you want to view any relevant report or information before it is sent to us, you'll need to let us know and we can tell you who we'll be seeking the information from. You'll then need to speak to the person providing the report/ information to check they are comfortable to arrange this – if they are, then so are we.

7. **How long does my consent last?**

   The consent you give on this form lasts until the earlier of (i) the completion of the current application or (ii) 12 months from the date on which the consent was given. This means that if we need further information in respect of the current application more than 12 months after your original consent was given, we'll ask for it again. Also, as your consent only relates to the current application, if you start a new application with us we'll need to ask for a fresh consent to allow us to request the necessary information to assess that new application for cover.

8. **What if I have further questions?**

   If your query isn't covered by these FAQs, then please feel free to contact the Aviva Medical Underwriting team on **0800 158 5182** (calls may be monitored and/or recorded) to discuss further or obtain more information.

AVIVA

INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

DIRECT Debit

Please fill in the whole form using a ball point pen and send it to: Aviva Health UK Limited, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.

Name and full postal address of your Bank or Building society

To The Manager — Bank/Building Society

Address

Postcode

Name(s) of Account Holder(s)

Bank/Building Society account number

Branch Sort code

Reference

Service user number

8	5	3	8	2	0

Instruction to your Bank or 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 passed electronically to my Bank/Building Society.

Signature(s)

Date

Banks and 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 seven 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.

Need this in a different format?

Please get in touch if you would prefer this application (**GEN7208**), in large print, braille or as audio.

How to contact us


0800 158 3348


contactus@aviva.com


aviva.co.uk