

For office use only

SR No.



Company private medical insurance

Group member application form - Full Medical Underwriting

Important: please read this section and then complete the application in BLOCK CAPITALS and in black ink.

As part of the process of becoming a member you need to complete this form, which will be treated in the strictest confidence. It is important that you complete the form fully, truthfully and accurately. Please remember that the details you give will be used to assess the terms and the extent of benefits we can offer you. Even if you have already told us something in a previous application you must tell it to us again as our systems may not identify the previous information.

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

As group member you have to complete and sign this form on behalf of all the people to be insured. If you are unsure about any of the information we ask for, you should check with the person who it relates to.

We will give you a copy of this application if you ask for it within three months of completing it. We recommend that you keep a record of all the information that you have given us regarding this application.

If you need to tell us more about any section of this application, please write on separate paper, indicate the number of sheets here and attach it to this form

1. Company details (to be completed by the group administrator)

Company name

Policy number (if known)

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

Optimum **Solutions** Other (please specify)

Category of employee to which group member belongs (if applicable) Date employee joined the company

Group administrator's signature Please note that we may deal with any person who is apparently authorised to represent the company (for example a director, partner, officer or senior manager) in addition to/or instead of the person nominated as group administrator.

Name (please print) Date

2. Your details (to be completed by the employee)

Name First name

Surname Other initials

Sex Male Female Date of birth

Address

Postcode (must be completed)

Contact numbers Daytime telephone and area code Evening telephone and area code
Mobile telephone Fax

Email

4.2. 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?

4.3 Other than conditions already listed:
 Yes No

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

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

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

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

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

a) heart and cardiovascular disorders for example high blood pressure, angina, high cholesterol, heart rhythm disorders	<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

Checklist - have you:

- fully completed the personal details for everyone on the policy?
- ticked either 'yes' or 'no' for section 4.1?
- ticked either 'yes' or 'no' for section 4.2?
- ticked either 'yes' or 'no' for section 4.3?
- ticked either 'yes' or 'no' for **every** part of section 4.4?
- fully completed section 5 regarding consent to obtain medical information (you do not have to do so, but we may not be able to offer cover if you don't)?

Please do not forget to read the declaration and then sign and date the form.

6. Declaration

I declare that:

- a. 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.
- b. 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.
- c. I confirm that I have checked and found correct any answers or statements on this form that are not in my own handwriting.
- d. I understand and accept that benefits will not be available to insured persons (those named in sections 1 and 2) for the treatment of any disease, illness or injury (whether or not diagnosed) for which the insured person has received medication, advice or treatment or for which the insured person has experienced symptoms before the date that this application is accepted, or any related condition unless fully disclosed on this application and accepted by Aviva Health UK Limited.
- e. I understand that if Aviva needs to investigate or establish material facts this may delay the claims process.
- f. 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 named on the form 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. If you do not wish to be contacted please write to Aviva, FREEPOST, Mailing Exclusion Team, PO Box 6412, Derby, DE1 1SB.)

Your signature

Date (must be completed)

DD / MM / YYYY

Print name

For agent's use only

Agent's name

and address

Agency ref

For office use only

Plan code

Scheme code

Campaign code

Coupon code

Policy number

Rate key

Capital Option
district