

For office use only

SR No.



Application for Private Medical Insurance Policyholders switching to Healthier Solutions

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

This application form is designed for you if you currently have private medical insurance and want to move to Healthier Solutions:

- on the same underwriting terms as those you currently have with your existing insurer. The option to switch to Healthier Solutions is not available if your current insurer has imposed any premium loadings.
- on the basis of continued moratorium. This option is available if you currently have moratorium underwriting and means that we will apply our moratorium wording with effect from the start date on your existing policy.

You may only switch to Healthier Solutions from your existing policy where your personal medical underwriting remains the same. We may need further medical evidence if the cover you want on Healthier Solutions is more comprehensive than on your existing policy.

The application to switch to Healthier Solutions is subject to your answers to the questions in the declaration section of this form and to you signing the declaration and is only available if you and all persons to be covered by the policy are under 70 years old on the start date of this policy.

To complete the transfer to Healthier Solutions you must supply your current insurance certificate(s) with details of the underwriting on your current policy.

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.

Under the laws of England, the parties are free to change the law which will govern the contract. In the absence of agreement to the contrary, the contract will be subject to the law of England.

1. Details of your existing cover

Current insurer

Product name

Please include a copy of your previous private medical insurance certificate

To enable us to calculate your no claim discount, please answer the following question:

Have you or any person covered by this policy claimed benefit under your existing (or any other PMI) policy:

- A - ever? Yes No
- If yes,
B - in the last five years? Yes No
- C - in the last four years? Yes No
- D - in the last three years? Yes No
- E - in the last two years? Yes No

2. 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 Policy Summary for details of these options. Please indicate which options you require by ticking the appropriate boxes.

Reduced out-patient cover £500 £1,000

Other treatment and therapies

Dental & optical benefits

Psychiatric treatment

Hospital list Extended Trust Signature
If none selected, the hospital list will be the Key hospital list

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

£3,000 £5,000

Six week option

Protected no claim discount

By ticking this box you are confirming that you:

- have not had any form of cancer, heart disease or stroke,
- have not had any consultations, diagnostic tests or treatment in the last two years,
- have no consultations, treatment or diagnostic tests pending with a GP, specialist or hospital, and
- are not aware of any conditions for which you may require diagnostic tests or treatment in the next six months, whether or not a medical practitioner has been consulted.

3. Underwriting options

Please tick one box only

Continued moratorium

This option is only available if you currently have moratorium underwriting.

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, treatment or diagnostic tests for, or advice about such a disease, illness or injury within five years before his or her start date on their existing policy, and
- there has not been a clear two year period after the start date during which the member has been free of medication for, treatment and diagnostic tests for, and advice about such a disease, illness or injury or related condition.

OR

Continued underwriting terms

We will apply the same underwriting terms as those you currently have with your existing insurer.

4. 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	DD / MM / YYYY
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.

5. 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
Forename			
Surname			
Other initials			
Date of birth	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
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: <input type="text"/> 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: <input type="text"/>
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other	
Forename			
Surname			
Other initials			
Date of birth	DD / MM / YYYY	DD / MM / YYYY	

6. Start date

The start date of the policy will generally be the date when this application is accepted by Aviva. However, if you need a start date in the future (to take account of the expiry of your existing policy) please state this here. We will not backdate policies from the date of receipt.

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

Please note that if paying monthly, premiums will be requested each month on the same date as the start date.

Direct Debit monthly annual Credit Card monthly annual MasterCard/Visa only

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

To assist with cardholder data security, we (Aviva) requests 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.

8. Declaration

To apply for cover without further medical underwriting, please answer the questions in Section A below by ticking the appropriate boxes. Please thoroughly read Section B below and only sign and date the application form if you can declare that all the statements in Section B are correct.

Section A

Have you or any person to be covered by this policy had any consultations, diagnostic tests or treatment in the last 12 months or do you currently have appointments planned with a GP, Specialist or a hospital in the future? Yes No

Have you or any person to be covered by this policy received treatment or advice in the last 5 years relating to any:-

- a. type of cancer
- b. form of heart or circulatory condition (if you are taking aspirin or medication to control blood pressure or cholesterol but have not had any treatment for a heart condition, you do not need to tick 'yes' for this question). Yes No
- c. psychiatric or mental illnesses or conditions (only relevant if selecting the psychiatric treatment option)

If you have answered **yes** to any of the above questions, please provide further details below.

Name					
Condition/ Symptoms					
Date(s) of consultation					
Treatment received					
Present state of health					
Any foreseeable need for further consultation or treatment					
Date of last symptoms and treatment					

Section B

I declare that:

- a. I have answered all questions in Section A correctly.
- b. I understand and accept section 3 on underwriting
- c. I have disclosed all material facts on this application form.
- d. 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.
- e. 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).
- f. I confirm that I have checked and found correct any answers or statements on this form that are not in my own handwriting.
- g. I understand that if Aviva needs to investigate or establish material facts this may delay the claims process.
- h. I have received the ABI Guide to Buying Private Medical Insurance, Direct Debit guarantee (if applicable) and the Healthier Solutions policy summary.
- i. For the hospital list that I have chosen I have checked that there is a hospital within reasonable distance from my home.
- j. 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	<input type="text"/>	Date <i>(must be completed)</i>	<input type="text" value="DD / MM / YYYY"/>
Print name	<input type="text"/>		

For agent's use only	<input type="text"/>
Agent's name and address	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Agency ref	<input type="text"/>

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"/>

Direct Debit payment

	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.						
Name and full postal address of your bank/building society		Service User Number <table border="1"><tr><td>8</td><td>5</td><td>3</td><td>8</td><td>2</td><td>0</td></tr></table>	8	5	3	8	2	0
8	5	3	8	2	0			
To: The Manager	Bank/Building Society	<p>For Aviva Health UK Limited official use only This is not part of the instruction to your Bank/Building Society</p> <p>Tick your preferred payment option: <input type="checkbox"/> Monthly <input type="checkbox"/> Annual</p> <p>Please note that we may retain the Direct Debit Instruction until the policy is activated, at which point it will be processed.</p> <p>Instruction to your 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 passed electronically to my bank/building society.</p> <p>Date</p> <table border="1"><tr><td>X</td><td>DD / MM / YYYY</td></tr></table>	X	DD / MM / YYYY				
X	DD / MM / YYYY							
Postcode								
Name of account holder(s)	Signature(s)							
	X							
Branch sort code								
Bank/building society account number								
Reference number								

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



- 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.

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