

Application for registration with Aviva



Aviva Health UK Limited Department 10,
Chilworth House, Hampshire Corporate Park,
Templars Way, Eastleigh, Hants SO53 3RY.
Fax 023 8035 4678 (Recognition Requests Only)

Please fully complete the relevant sections of the form and return it to the address above to enable us to consider your request for registration. Issue of this form does not constitute acceptance of your registration or liability for any costs arising from your services. If your registration request is accepted by us you will be notified in writing by Aviva. **Please note incomplete application forms or applications without supporting documentation will be returned.**

Section 1 - MUST BE COMPLETED FOR ALL APPLICATIONS

Surname _____ Forename(s) _____
Title _____ Sex M / F Date of Birth ____/____/____
e.g. Dr, Mr, Mrs etc
Email _____

Payment and Correspondence Details

Payee Name _____ Payee Name _____
Address for payments _____ Additional Address _____
and correspondence _____ (if applicable) _____
Postcode _____ Postcode _____
Telephone Number _____ Telephone Number _____
Fax Number _____ Fax Number _____

In the event that your employment or personal details change, please advise us in writing, this will enable us to maintain accurate provider records. Failure to do so may affect or delay payment for services.

In order to deal with your request for registration and to meet our obligations under the Data Protection Act 1998; we would be grateful if you would complete the following declaration:

I confirm my consent to the computer and other processing and use (which may be in any part of the World) of personal details, including sensitive data by the data controller and relevant third parties for the purposes of the registration of my services with the data controllers and associated administration, policy and claims administration, fraud prevention, payment for my services and enquiries into my professional practice in connection with my registration by the data controllers. The data controllers are Aviva Health UK Limited, Aviva Insurance UK Limited and Aviva Life & Pensions UK Limited.

I will inform Aviva immediately if my employment with the NHS or any other employer is suspended or terminated for whatever reason and/or if my GMC/or appropriate governing bodies' registration is modified, suspended or withdrawn, for whatever reason.

I agree that Aviva has the right to suspend or withdraw a provider's recognition where my employment with the NHS or other employer is suspended, terminated or conditions placed on my registration with the governing body applicable to my speciality. I agree that withdrawal of recognition is at the discretion of Aviva when they consider the welfare of their policyholders is at risk.

Signed _____ Date _____

Section 2 - Medical Practitioners registered with the GMC

If this section does not apply, please continue to Section 3.

Hospital at which NHS consultant post is held _____

Effective date _____ Grade of post _____

Speciality _____ GMC registration number _____

Are you entered on the GMC specialist register

Yes

No If no, please give further information _____

Area of Practice/ Clinical Interests _____

COPY OF YOUR CERTIFICATE OF COMPLETION OF SPECIALIST TRAINING IS REQUIRED

Do you have personal / professional indemnity cover Yes No

If yes, please give further information _____

Are you a member of a Chambers, Partnership or Practice Group? Yes No

If yes please provide details _____

Section 3 - Other Practitioners

Field of Speciality _____

Details of membership with your relevant professional/regulatory body must be provided

Professional/regulatory Body	Level/grade of membership (if applicable)	Current registration Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

COPY OF CURRENT REGISTRATION CERTIFICATE/RELEVANT SUPPORTING DOCUMENTS MUST BE ATTACHED

Do you have personal / professional indemnity cover Yes No

If yes, please give further information _____

For security and administration, calls and emails to and from Aviva may be monitored and/or recorded.

We act in good faith on the basis of information that the policyholders, providers (including hospitals and specialists) provide. We take a very serious view of fraud or misrepresentation in any claim. As a matter of policy we will investigate fully any instance of suspected fraud or misrepresentation whether by customers or providers of healthcare. We will report any cases of fraud or suspected fraud by providers to the appropriate authority. In addition we reserve the right to withdraw our recognition of providers who have submitted fraudulent claims or misrepresented the circumstances of a claim so as to obtain or facilitate benefit that would not otherwise be eligible under the terms of our policyholder's policy.

Preferred Method of Payment (please tick as appropriate)

BACS

Cheque

Cheque Payment

Cheque Payee Name

Bank Details for BACS Payments

Account Name

Sort Code (6 digits)

Account Number
(8 digits)

Bank Name

Bank Address

Payment Frequency Preference (please tick as appropriate)

Monthly

Weekly

Declaration

I confirm and agree that:

- a) Aviva may at its discretion make payments for my services in to the nominated bank account by BACS payment;
- b) I will promptly repay any monies to Aviva that are incorrectly paid into my account by them.

Provider signature

Date

Please print name

Office use only

ACM updated by

Checked by

Date

GMS updated by

Checked by

Date