Solutions application form

AVIVA

Please tick group size appropriate to your policy: ☐ **2-99 group members** ☐ **100-249 group members**

Please read through the following before completing this application in BLOCK CAPITALS and in black ink.

Please complete sections 1-10 and remember if you're going to pay by Direct Debit to complete the Direct Debit instruction.

You'll need to supply us with a membership listing, you can either complete section 11 (for schemes with 2-99 employees) or send us your own listing.

All information supplied will be treated in strict confidence.

Solutions is a private medical insurance product available to companies or business entities with between 2-249 employees.

If you have selected Solutions 2-99, by completing this application you confirm that all persons to be covered permanently live in the UK.

It's important that you answer all the questions on this application form fully, truthfully and accurately. This is so we can determine what your policy will cover and the price. If you don't this could affect how much we pay if a member makes a claim and could mean we won't pay their claim at all.

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

The applicant must answer all questions and sign the declarations on behalf of the company and all persons to be insured. If you would like a copy of the application form please let us know. Please keep a copy of all information supplied to us in connection with this application, including letters and other correspondence, as these may be important contractual documents.

We'll review premium rates and policy terms on an annual basis.

Please contact as straight away if any of the information on this form changes before the policy starts.

Start date

The start date of the policy will be the date we receive and accept the application at Aviva Healthcare Head office. If you would like a specific start date, to coincide with the expiry of an existing contract with another provider, please put this in the date box in section 1.

- If the policy has 100 members or more the policy wording for this product will be written on a Medical History Disregarded basis. Meaning that we do not apply any personal medical exclusions to your policy as a result of pre-exisiting conditions.
- If you have different underwriting this will be shown on your policy statement and in the cover guide included in the member booklets.
- If the policy has between 2 and 99 employees, the product will be written on a Full Medical Underwriting basis.
- If you have different underwriting and any special terms apply these will be shown on your policy statement and the member's policy schedule.

Explanation of underwriting terms and requirements

Full Medical Underwriting (FMU)

We do not cover treatment of any pre-existing condition, or any related condition unless the group member (and their dependants if appropriate) advise us of that condition in writing when they complete their group member application form and we don't apply an exclusion for it.

Any medical exclusions we apply will be shown on their policy schedule.

We may review their personal medical exclusion(s) if they ask us to. If we do apply an exclusion when they join the policy or review a medical exclusion at the renewal date, we will let them know when the medical exclusion may be reviewed again, if they ask us.

We will not alter or remove a medical exclusion if the excluded medical condition (or any related conditions) is likely to need treatment in the future. There are some medical exclusions that we will not review, for example, a chronic condition.

Continued overleaf…

Continued Medical Exclusions (CME) and Continued Moratorium (CMORI)

For both CME and CMORI underwriting we require the members previous insurance certificates so that we can transfer them from their previous scheme. These must confirm the medical exclusions (if any) applicable to each person. These are shown on the member's policy schedule. The terms and conditions of this policy may be different to those of the previous policy. The certificates should also confirm the following information:

Group member's surname, first name, date of birth, gender, home address and the same information for his/her dependants. If not, you must supply us with a full membership listing. For policies with 2-99 employees we have enclosed a form for your use (see section 11).

Please send us the member certificates as soon as possible and if different benefits apply to different categories of employee you must confirm which category is applicable to the group member.

Continued Medical Exclusions (CME)

For members who were fully medically underwritten on another policy and are transferring to Solutions.

For members who supply their previous insurer's medical certificate, benefit under this policy will not be available, for any disease, illness or injury or any related condition excluded on the previous insurer's member certificate. The previous insurer's member certificate must expire no earlier than the member's start date on this policy. Please note if loadings have been applied instead of exclusions, these members will have to complete an application form and may be fully medically underwritten.

Moratorium (Mori)

We do not cover treatment of any pre-existing condition, 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 will cover a pre-existing condition if members do 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.

Continued Moratorium (CMORI)

For members who were insured on a moratorium basis on another policy and are transferring to Solutions.

We do not cover treatment of any pre-existing condition, or any related conditions, if a member had:

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

that condition in the five years before their initial date of cover. Their initial date of cover is the date they started cover with the first insurer (provided there has been no break in cover since then).

However, we will cover a pre-existing condition if they do not have:

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

that condition during a continuous two year period after their initial date of cover.

The terms and conditions of this policy may be different to those of the previous policy.

The previous insurer's member certificate must expire no earlier than the member's start date.

Please note the continued terms described above refer only to the specific medical terms applicable to each individual. Other terms may vary, please refer to the policy wording for full details.

Where CME or CMORI has been selected for 2-99 group members, exclusions from cover section 1a will be amended accordingly.

Medical History Disregarded (MHD - minimum of 15 group members underwritten on this basis)

We do not apply any personal medical exclusions to members as a result of pre-existing conditions.

The terms and conditions of this policy may be different to those of the previous policy.

If your policy has less than 100 group members, the scheme was previously insured and you are choosing MHD underwriting, we require each group member's previous insurance certificate. These must confirm that the group member's cover was Medical History Disregarded. The certificates should also confirm the group member's surname, first name, date of birth, sex, home address and the same information for his/her dependants (if applicable). If not, a full membership listing must be supplied (please use the form in section 11). Where MHD has been selected for a scheme of less than 100 group members, exclusions from cover section 1a is deleted.

1. Details of company applying to be the policyholder

Applicant - Name of the person who will sign this application form on behalf of the policyholder.

Registered number - You will only have a registered number if you are a PLC, limited company or a LLP.

For other business entities (such as a sole trader or partnership) evidence of your status is required, such as a copy of your letterhead (please attach to this form)

Full business description - ie manufacturer of machine parts.

Start date - It is important you read the section **'Start date'** on the front page.

Full name of applicant — Mr, Mrs, Miss, Ms, other — Surname

Company name

Trading name if different

Registered No. and/or VAT No: *(if applicable , if no VAT/CHN number, please explain the reasons why)*

Business address *(please ensure postcode is shown)*

Postcode: *(must be completed)*

Contact details — Telephone: — Fax:

Email address

Full business description

Start date *(see notes on page 1)*

2. Details of group administrator

Administrator name - Name of the person who will administer the policy on behalf of the company.

All correspondence will be addressed to the group administrator.

Where we consider appropriate and at our discretion we may deal with any person we believe is authorised to represent the company (e.g. a director, partner, officer or senior manager) in addition to/or instead of the person nominated as group administrator.

Name of group administrator — Mr, Mrs, Miss, Ms, other

Position in company

Email address

3. Details of participating companies, include policyholder if policyholder's employees are to be covered by the policy

Participating companies - Names of the companies whose employees (and their dependants) are to be covered by this policy. A participating company can only be the policyholder or a subsidiary of the policyholder.

For Aviva purposes a company is a 'subsidiary' of the policyholder if it is registered as a company at Companies House and the policyholder (or another subsidiary of the policyholder) holds all or most of the issued share capital in it (or as otherwise specifically agreed in writing).

Company name

Registered number

Full business description

Company name

Registered number

Full business description

If more than 2 companies are to be included on this policy, please tick the box and provide details on a separate sheet of paper. ☐

Applicant's declaration

I declare that _____ (name of policyholder)

holds all or most of the issued share capital in all of the other companies named in Section 3 above.

Signature of applicant _____ Date DD / MM / YYYY

Print name _____

4. Previous medical insurance

Please complete this section if you have previously had private medical insurance for your group members. If not go to question 5

Previous medical insurance - Please refer to your previous insurer's policy documents.

Policy number

Date cover expires/ expired — DD / MM / YYYY

Insurer

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

☐ *Yes* ☐ *No* Policy number (if available):

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.

Illustration date - We may have sent you more than one illustration. Please be specific as to which illustration you wish to proceed with.

5. Illustration details

Illustration number

Illustration date (if known) DD / MM / YYYY

Options -

1. Mental health
2. Routine and GP referred services

3a. Extended hospital list
3b. Signature hospital list
3c. Trust hospital list **(not available for policies with more than 99 employees)**

4. Dental & optical
5. Six week option
6. Member excess (£50/£100/£150/£200/£250/£500)
7. Selected benefit reduction
8. Reduced out-patient cover (£0, £1,000, £1,500)

Category name - You may have up to three categories, e.g. director, manager, staff.

Note - For companies with 2-5 group members only 1 category can be chosen.

Number of group members - Write in the total number of group members per category and their breakdown by family status.

6. Benefit options

Details of persons to be covered Define categories of group members to be included. Minimum of three group members each category	Options											Channel Islands	No. of employees in cat.	Please tick if you wish to provide cover for families of group members	
	Core cover	1 (28/45*)	2	3a	3b	3c	4	5	6 (50/100/150/200/250/500*)	7	8 (0/1,000/1,500*)			Spouse	
	✔														
	✔														
	✔														

*Please specify

Total

Category name	No. of group members	Single	Married	Family	Single parent family

Underwriting terms - It is important that you read the section **'Explanation of underwriting terms & requirements'** on the inside front cover page.

7. Underwriting options

Underwriting terms ☐ FMU ☐ CME ☐ Moratorium ☐ Continued Moratorium ☐ MHD

For schemes with 2-99 group members with CME/MHD, Moratorium or Continued Moratorium please complete the membership listing (section 11) if all the group members' certificates are not available.

If more than one form of underwriting, please specify underwriting for each category of group member e.g. Directors MHD, Managers FMU.

Email - Our preferred method is by email.

Membership details - to be completed for schemes with more than 100 group members only

Please indicate format used to provide membership details ☐ email ☐ apps ☐ paper list

Company funded - How much the employer pays for the dependants cover.

The company must fund 100% of the group members' premium.

Dependants' subsidy - to be completed for schemes with more than 100 group members only

Please state % company funding for dependants' premium*
(i.e paid by the company without reimbursement by group members/dependants)

☐ % spouse ☐ % dependants

*If different categories of group members' dependants are to be funded differently please provide details

Schemes with 2-99 group members - For schemes transferring from another private medical insurance company on CME, CMORI or MHD terms, and for new schemes looking for MHD underwriting terms, the declaration must be completed.

Please note if you are transferring on a CME basis we reserve the right to exclude additional symptoms or conditions according to the information provided in the declaration.

Transferring cover from another insurer - declaration

Please note: this declaration is very important. Please **answer** the questions carefully. If your scheme has 10-99 group members you need to answer question 1. If your scheme has between 2 and 9 group members you need to answer both questions.

1) Are you aware of any person to be covered by this application who has received treatment or advice relating to:
   - ■ any type of cancer, or ☐ Yes ☐ No
   - ■ any type of heart or circulatory condition ☐ Yes ☐ No

   in the last 2 years?

2) Are you aware of any person to be covered by this application who has received treatment or advice relating to any:
   - ■ psychiatric, or mental, illness or condition in the last 2 years? ☐ Yes ☐ No

   OR
   - ■ knee problems ☐ Yes ☐ No
   - ■ back problems ☐ Yes ☐ No
   - ■ shoulder problems, or ☐ Yes ☐ No
   - ■ arthritis ☐ Yes ☐ No

   in the last 6 months?

If you have ticked 'Yes', please provide details of the condition on a separate sheet. To enable us to make a decision, we need information such as the date of diagnosis, treatment details (dates, treatment received or planned) and the current status regarding the condition (for example, is it cured? Is it controlled?)

Applicant's signature

Date DD / MM / YYYY

Print name

8. How to pay - Payment must be made from the **UK business bank account**.

Please tick one of the methods listed below

Direct Debit ☐ annually ☐ monthly ☐ quarterly

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

Cheque ☐ annually

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

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9. Important notes

Use of personal information

Please note this is a summary of how we will use the personal information you provide in this application form. You should refer to the Use of Personal Information section of your member guide for full details including who we share personal information with, your rights and how to exercise them.

We'll use the personal information you give us to:

- process and underwrite this application
- decide if we can offer cover and on what terms
- administer your company's policy and handle claims
- help prevent and detect fraud
- meet legal and regulatory requirements applicable to us
- conduct research and customer profiling to keep our products and services competitive and suitable for customers' needs

Other companies from across the Aviva Group, or third parties who provide services to us, in any country (including those from outside the European Economic Area) could also use this information in this way. If they do, we'll make sure they agree to treat the information with the same level of protection that we would.

We may share your information with other parties as detailed in your member guide.

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

☐ Post ☐ Email ☐ SMS ☐ Phone

10. Declaration

a) I declare that I will advise if there are any changes in the information given on this application which occur between the date of signing and the date cover starts under the policy.

b) I declare that to the best of my knowledge and belief the information given in this application is true and complete. I have checked any answers or statements on this form that are not in my own handwriting and they are correct.

c) I agree on behalf of the policyholder and the membership of the policy to accept and conform to the terms of the policy when issued (a copy of which is available on request) and in particular (but without limiting the above):

   i) to pay the premium for all persons insured by the policy in accordance with the policy wording;

   ii) that all group members to be covered are either the sole proprietor, a partner, a registered director or an employee of a participating company and that the participating companies will not recover any part of the premium relating to group members from those group members.

   iii) notify Aviva without delay of all changes in membership of the policy.

d) I confirm that I have read page 1 of this form.

e) I agree on behalf of all persons 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.

f) if I have selected Solutions 2-99, I confirm that all persons to be covered permanently live in the UK for 6 months or more of every year.

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

Applicant's signature		Date	DD / MM / YYYY
Print name			
Position held in company			

For agent's use only

Agent's name and address	
Agency reference	

11. Membership listing - Solutions 2-99

CME/MHD/MORI/CMORI. Please state the number of continuation pages accompanying this application form in this box. ☐

Please note: If any dependants are also eligible to be covered as an employee of your company, please complete a new line with their details.

Group member name	Names of dependant(s) to be covered			Home address (main residence)	Underwriting terms: Specify options selected	CME	MHD	Cont. Mora-torium	Mori
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick
Title & Surname First Name Date of Birth Occupation/role within company	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Title & Surname First Name Date of Birth	Postcode	Category:	Please tick	Please tick	Please tick	Please tick

AVIVA

Instruction to your Bank or Building Society to pay by Direct Debit

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.

Service User Number | 8 | 5 | 3 | 8 | 2 | 0 |

Name and full postal address of your bank/building society

To: The Manager — Bank/Building Society

Postcode

Name of account holder(s)

Branch sort code

Bank/building society account number

Reference number

Signature(s)

✗

✗

For Aviva Health UK Limited official use only
This is not part of the instruction to your Bank/Building Society

Tick your preferred payment option: ☐ Monthly ☐ Quarterly ☐ Annual

Please note that we may retain the Direct Debit Instruction until the policy is activated, at which point it will be processed.

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.

Date

✗ DD / MM / YYYY

This guarantee should be detached and retained by the payer

DIRECT Debit

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 Aviva Health UK Limited.

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This insurance is underwritten by Aviva Insurance Limited. Registered in Scotland, No. 2116. Registered Office: Pitheavlis, Perth, PH2 0NH. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Firm reference number 202153. Aviva Health UK Limited, Head Office: Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.
aviva.co.uk/health

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