For office use only
SR No.

AVIVA

Group member application

Small group – full medical underwriting

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

All information supplied will be treated in strict confidence.

It is important that you answer all the questions on this application form fully, truthfully and accurately. 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 a group member you should answer all questions and sign the declaration on behalf of all persons to be insured.

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.

Your start date will be the date we receive and accept your completed application form at our head office. If you would like a start date in the future please advise in this box:

Date / /

We may backdate a member's start date up to a maximum of 30 days from the date we receive the application form if there have been postal errors and/or delays. This may mean that the start specified is before we receive the application, but on or after the date the application has been signed.

A copy of this application will be supplied to you on request within three months of completion. You should keep a record (including copies of all letters) of all information supplied to us for the purpose of joining this policy.

Please indicate which product your company has chosen for you. (If you are unsure please contact your group administrator who will advise you).

Product name

Capital option (Express Care/Six only) ☐ (Please tick if applicable)

1. Company name

Policy number (if known)

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

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

Forename | Other initials

Gender — ☐ Male ☐ Female | Date of birth / /

Home address (your main residence)

Postcode *(must be completed)*

Contact numbers (please include area code) — Daytime | Evening

Mobile | Fax

Employee category *(as detailed on company application)*

3. Details of all persons to be covered (Your group administrator will inform you whether to complete this section.)

	Applicant	Second person	Third person
Relationship to applicant		spouse/partner / son / daughter	son / daughter
Title		Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
Surname			
Forename			
		Other initials	Other initials
Date of birth		/ /	/ /
Occupation *(Please give full details)*			

	Fourth person	Fifth person	Sixth person
Relationship to applicant	son / daughter	son / daughter	son / daughter
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
Surname			
Forename			
	Other initials	Other initials	Other initials
Date of birth	/ /	/ /	/ /
Occupation *(Please give full details)*			

If any of the persons to be covered are usually resident at a different address to that shown overleaf, please give details.

Name			
Usual place of residence			
Postcode *(must be completed)*			
Telephone number			

4. Medical disclosure – The questions in this section apply to everyone 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'. Please note that in most cases we will not approach your GP for this information.

– If you don't answer a question or 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.

4.1 Has anyone had advice from a GP or other medical professional, such as a practice nurse or physiotherapist, in the 2 years prior to the start date? If you are unsure, please check with your GP. 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 advise frequency.)

Member name	Diagnosis (If none made please describe the 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) or for smears frequency (annually, 6 monthly)

4.2 Has anyone consulted a specialist or been admitted to hospital in the past 5 years prior to their start date, (other conditions already listed)? If you have ticked 'Yes', please give us full details. ☐ Yes ☐ No

Member name	Diagnosis (If none made please describe the 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)

4.3 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')

4.4 Has any person named EVER suffered from 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 ☐ Yes ☐ No

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

m) joint and bone problems, fractures, tendon and ligament problems, gout, bunions, osteoporosis ☐ Yes ☐ No

n) joint and spine degeneration, wear & tear, arthritis
– If you have answered 'yes' to question n) above, please specify which type of arthritis you are suffering with e.g. osteo, rheumatoid, reactive <u>also please specify if this affects your left or your right knee, hip etc</u> ☐ Yes ☐ No

o) back / neck problems e.g. sciatica, disc problems, spinal fractures
– 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) ☐ Yes ☐ No

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 the 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)

4.5 Has any person named suffered from any of the following conditions in the past 10 years prior to their start date (other then any 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, kidney, prostate disorder or any other urinary problems, 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 any 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 the 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)

4.6 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 the body including left or right	If no longer present please advise date of removal

4.7 Does anyone named use any orthotics, supports, prosthesis or hearing aids (other than any already listed)? ☐ Yes ☐ No

Member name	Nature of aid/support/implant	Condition necessitating aid, support or implant	Specific location on the body including left or right

4.8 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)

5. Consent to obtain a medical report

In order for us to determine your underwriting terms, we may need to contact your doctor(s) for a medical report. If we do approach your doctor, we will tell you that we have done so. We won't approach your doctor as an alternative to an incomplete form.

However, before we can apply for a medical report from you/your dependant's doctor(s) we need consent to do so. A declaration for this appears on the next page. You have certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. You've certain rights under this Act in relation to reports requested by us which have been prepared by your doctor(s), which are summarised as follows:

a) if you indicate (in the declaration overleaf) that you do want to see the report, we'll write to you at the same time we contact your doctor. We'll let the doctor know that you'd like to see the report; you then have 21 days to contact your doctor to make arrangements to see it. When you've seen the report your doctor might not send it to us until you've given consent to do so. If you don't contact your doctor within 21 days the report will be sent to us.

b) if you indicate (in the declaration overleaf) that you don't wish to see the report, we will still let you know if we apply for one. If you decide that you want to see the report, before it is sent to us, you can write to your doctor within 21 days to make arrangements to see it.

c) you can ask your doctor if they'll amend any part of the report which you consider to be incorrect or misleading. If your doctor is not in agreement, you may attach your comments.

d) you can ask your doctor to see a copy of the report up to 6 months after we've received it. If you ask for a copy of your report your doctor may charge you a fee to cover the cost.

e) in some circumstances your doctor may decide, in the interest of your health, or to respect the interest of other persons, that you should not see all or part of the report. Your doctor will tell you of this and you'll have the right to see any remaining part of the report. If your doctor decides that you should not see any of the report, they will not give it to us without your consent.

f) you do not have to give us your consent (but without it we may be unable to proceed with your application).

Please read the declaration and complete the boxes below:

Authorisation for the release of medical information

I have read the section about my rights under the Access to Medical Reports Act 1988 (or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991). I agree to the provision of any and/or all of my medical records to Aviva in connection with this application.

By signing below, I give my permission to 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 also give my permission for any medical exclusions that are applied to my policy as a result of information provided on this form or from my medical records, to be disclosed to my insurance intermediary (if I am using one) and my group administrator for the purposes of advising on or administering the policy.

Details are required for each insured person to be covered by the policy.

Insured person's details

Name | Name of doctor

Date / / | Address

Signature

The signature of each insured person is required (or the signature of parent or guardian on behalf of insured person, if they are under 16 years old).

GP telephone number *(please include area code)*

I do/do not wish to see the report *(please delete as appropriate).*

This consent will last until your policy ends. If you wish to specify an expiration date for this consent, please state it here: DD / MM / YYYY

Insured person's details

Name | Name of doctor

Date / / | Address

Signature

The signature of each insured person is required (or the signature of parent or guardian on behalf of insured person, if they are under 16 years old).

GP telephone number *(please include area code)*

I do/do not wish to see the report *(please delete as appropriate).*

This consent will last until your policy ends. If you wish to specify an expiration date for this consent, please state it here: DD / MM / YYYY

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Insured person's details

Name | Name of doctor

Date / / | Address

Signature

The signature of each insured person is required (or the signature of parent or guardian on behalf of insured person, if they are under 16 years old).

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Insured person's details

Name

Date

Signature

The signature of each insured person is required (or the signature of parent or guardian on behalf of insured person, if they are under 16 years old).

Name of doctor

Address

GP telephone number *(please include area code)*

I do/do not wish to see the report *(please delete as appropriate).*

This consent will last until your policy ends. If you wish to specify an expiration date for this consent, please state it here: D D / M M / Y Y Y Y

Insured person's details

Name

Date

Signature

The signature of each insured person is required (or the signature of parent or guardian on behalf of insured person, if they are under 16 years old).

Name of doctor

Address

GP telephone number *(please include area code)*

I do/do not wish to see the report *(please delete as appropriate).*

This consent will last until your policy ends. If you wish to specify an expiration date for this consent, please state it here: D D / M M / Y Y Y Y

6. 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 ☐

7. Declaration

By signing below, I confirm that:

a) I will advise you if there are any changes in the information given on this form between now 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 have checked any answers or statements on this form that are not in my own handwriting and they are correct.

c) 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 from your Group Administrator.)

d) I am aware that benefits will not be available to insured persons (those named in section 3) 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 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 persons added to the policy in the future.

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.

(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).

Group member's signature

Date (***must be completed***) / /

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

GPAP002 04/2018 REG001