For office use only
SR No.

International Solutions

Private medical insurance individual application

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

Thank you for choosing Aviva. As part of the process of becoming a member you need to complete this form, which will be treated in the strictest confidence. We need to know all the material facts relating to the questions we ask. If you do not give us all the material facts your policy may be invalid. Any fact that is likely to influence an insurer in the assessment and acceptance of this application is a material fact, and if you are unsure whether or not as fact is material you should tell us about it. As proposer you are required to answer all the questions and sign 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.

A copy of this application will be given to you within three months of completion if you ask for it. We recommend that you keep a record of all the information that you have given us regarding this application. The contract will be subject to English law.

If you need to provide further information on any section of this application, please write on separate paper, indicate the number of sheets here ☐ and attach to this application

Important notes

International Solutions is designed to meet the needs of ex-patriates living and working in another country. We regret that this product is not available to people who live in their home country for six months or more each year. Due to regulatory restrictions, it may not be possible to offer cover to permanent ex-patriates resident in certain countries. Please check with your usual Aviva adviser. We are able to provide information in English only. If you need information in any other language, unfortunately we may not be able to process your application.

1. 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	☐ Male	☐ Female	Date of birth D D / M M / Y Y Y Y
Current residential address			
			Country
	Postcode	Passport nationality	
Contact telephone numbers incl country and area codes	Daytime	Evening	Mobile
Email address			

You can view policy details online or receive them as printed documents. If you wish to view your policy terms, conditions, benefits and limits via the secure area of the International Solutions website (www.aviva.co.uk/internationalhealth), please tick the box. ☐ You must give us your email address to be able to access the site. A policy certificate, personalised member card and details of any endorsements to cover will be posted to the policyholder.

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.

Association or group name (if applicable)

How long each year do you spend at your residential address?

Will everyone covered by the policy spend six months or more of the policy year outside their country of nationality? Yes ☐ No ☐ If no, please state who and why not

Address for correspondence (if different)

Country | Postcode

Contact telephone number: Country code | Area code | Tel no

Fax number

Do you intend to move to another country?	☐ Yes	☐ No	Name of country	
If yes, is this move temporary?	☐ Yes	☐ No	Intended length of stay	
Does this apply to everyone covered by the policy?	☐ Yes	☐ No*		

***If No, please provide full details on a separate sheet of paper and indicate you have done so by ticking this box ☐**

If you are currently a customer of Aviva Health UK Limited, please complete the following:

Policy number

Member number

Renewal date DD/MM/YYYY

2. Details of everyone you want to cover

	Second person	Third person	Fourth person
Relationship to proposer	spouse/partner / 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
	Passport nationality	Passport nationality	Passport nationality
Date of birth	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
Sex	male / female		

	Fifth person	Sixth person
Relationship to proposer	son / daughter	son / daughter
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
Surname		
Forename		
	Other initials	Other initials
	Passport nationality	Passport nationality
Date of birth	DD/MM/YYYY	DD/MM/YYYY

If any person on this application is employed by a foreign embassy or diplomatic service please write their name here:

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:

If anyone lives at a different address to the proposer, please tell us who and write the address here

Country

3a. Benefit options

- you can choose from the following options to either enhance the benefits provided by International Solutions, or to help contain costs. The International Solutions Policy Summary gives details of these options. Please indicate the options you would like by ticking the appropriate boxes.

Wellness	☐						
Dental & optical	☐						
Increased out-patient benefits	☐						
Compassionate travel	☐						
Maternity	☐						
Alternative excess	☐	£0, €0 or $0	☐	£100, €110 or $150	☐	£250, €275 or $375	☐ £500, €550 or $750
Reduced out-patient benefits	☐						
Reduced additional benefits	☐						

- **Please note** - you cannot choose increased out-patient cover with reduced out-patient cover
- If you choose an alternative excess, you cannot choose either the reduced out-patient cover or the reduced additional benefits options.

b. Region options

(for details, see the International Solutions Region Guide in the brochure) Please choose the region you wish to be covered for by writing the number (between 1 and 6) in the box.

If any of the people you want to insure on the policy need a different region to this, please write their names and chosen regions here

c. Currency options

Please tick one box for the currency you would you like to pay your premiums in.

(You may pay policy premiums in Pounds Sterling, Euros or US Dollars. Please see section 8 for information about how to pay. Benefit limits apply in the currency in which you pay the premium. Settlement of valid claims costs in currencies other than your chosen premium currency may attract an administration charge)

☐ £ Sterling ☐ € Euro ☐ $ US Dollar

d. Start date

The start date of the policy will normally be the date when Aviva accepts this application. However, if you need a start date in the future, please state this here:

DD/MM/YYYY

4. Switching from another insurer

If you have a policy with another insurer on full medical underwriting (FMU) or continued medical exclusions (CME) terms, you may be able to switch to International Solutions on the same underwriting terms by answering these questions (if you have a policy with Moratorium underwriting you will need to complete section 5 'Medical disclosure' for everyone that you want to insure on this policy):

Do you, or any person you want to cover on this policy, have any appointments, tests or treatment planned or booked with either a family doctor, medical practitioner, Specialist or a hospital? Yes ☐ No ☐

Have you, or any person you want to cover on this policy, received treatment or advice in the last two years relating to any:

1. type of cancer, or Yes ☐ No ☐
2. 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), or Yes ☐ No ☐
3. psychiatric or mental illnesses or conditions Yes ☐ No ☐

If you have answered '**Yes**' to any of these three questions, please provide full details.These should include:

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

If everyone that you want to insure was on the previous policy, you do not need to complete section 5 'Medical disclosure'. Please go to section 6 'Consent to obtain a medical report'.

5. Medical disclosure

Please ensure that for questions 5a - 5d there is a tick in either the 'Yes' or 'No' box. Please note that we will not request information from a family doctor or medical practitioner if you have not fully completed this form. If both boxes are left blank, or you have ticked yes and not provided further details, we will be unable to complete your underwriting and will return the form to you.

When completing sections 5a and 5b details of any check-ups should be included, along with any results. Please include details of any examinations undertaken, such as blood tests or smear tests, along with the frequency of the tests and reason for undertaking these.

5a. Has any person named sought advice from a family doctor or other medical professional, such as a nurse or physiotherapist during the past 2 years? If you have ticked yes, please provide full details in the boxes below.

☐ Yes ☐ No

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

5b. Has any person named consulted a Specialist or been admitted to hospital in the past 5 years?
If you have ticked yes, please provide full details in the boxes below.

☐ Yes ☐ No

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

5c. Other than conditions already listed:

☐ Yes ☐ No

- **is any person named taking, or have they taken regularly in the past 5 years, any medication?**

  or
- **has any person named suffered any ongoing, long-term or recurrent medical condition?**

If you have ticked yes for either point, full details should be given of the conditions/symptom requiring treatment, including any medicines that you take (whether prescribed 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?

5d. Other than conditions already listed has any person named EVER suffered from, or received treatment or advice for the following (please note: this includes any consultations with a specialist and/or complementary therapist such as a physiotherapist, optician, herbalist or acupuncturist):

a) **Heart and cardiovascular disorders**
for example high blood pressure, angina, high cholesterol, heart rhythm disorders
☐ Yes ☐ No

b) **Blood / blood vessel and circulatory disorders**
for example anaemia, haemophilia, varicose veins, deep vein thrombosis, narrowing of the blood vessels
☐ Yes ☐ No

c) **Glandular disorders**
for example diabetes, thyroid conditions, hormonal problems
☐ Yes ☐ No

d) **Urinary problems**
for example bladder, kidney or urinary infections, kidney stones, incontinence, cystitis, urinary frequency problems
☐ Yes ☐ No

e) **Gastric / digestive disorders**
for example repeated indigestion, irritable bowel syndrome, haemorrhoids, change in bowel habit, hernia, gallbladder or liver problems, hepatitis, ulcers
☐ Yes ☐ No

f) **Respiratory disorders**
for example asthma, bronchitis, pneumonia, lung or respiratory tract problems
☐ Yes ☐ No

g) **Ear, nose, throat and eye disorders**
for example deafness or hearing problems, ear infections, cataracts, tonsillitis, sinusitis, wisdom teeth.
If you have declared problems with wisdom teeth, please advise whether all have been removed and if not, have any remaining wisdom teeth emerged fully with no further problems.
☐ Yes ☐ No

h) **Back / neck disorders**
for example sciatica, arthritis or degenerative changes, disc problems, fractures. If possible, please advise which area of the spine was affected ie cervical (neck), thoracic (upper back), lumbar (lower back) or sacral (bottom of the spine)
☐ Yes ☐ No

i) **Joints and bones**
for example bone, tendon or ligament problems, bunions, gout, fractures, arthritis, sprains and strains
If possible please advise the specific location, for example left knee / right elbow
☐ Yes ☐ No

j) **Male**
for example prostate problems, prolapse, fertility problems
☐ Yes ☐ No

k) **Female**
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 advise the current frequency of your smear tests
☐ Yes ☐ No

l) **Cancer**
if applicable please advise the date you were discharged from follow-up
☐ Yes ☐ No

m) **Cysts / polyps**
for example cysts, polyps, lumps, moles, lesions, nodules, abnormal growths. Please advise the specific location and was this benign (non-cancerous) or malignant (cancerous). Please also advise if this condition is still present
☐ Yes ☐ No

n) **Skin disorders and allergies**
for example hay fever, eczema, acne, psoriasis, rashes, alopecia, keloid scars
☐ Yes ☐ No

o) **Psychological or sleep disorders**
for example depression, stress, anxiety, behavioural disorders – (eating/compulsive disorders), schizophrenia, bipolar disorder, insomnia
☐ Yes ☐ 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
☐ Yes ☐ No

q) **Implants, prostheses or cosmetic surgery**
for example pins, plates, screws, medical or cosmetic implants, orthotics or supports. If you declare that you have had pins, plates or screws, please advise if they are still present
☐ Yes ☐ No

r) **Autoimmune disorders**
for example systemic lupus erythmatosis, HIV, rheumatoid arthritis,
☐ Yes ☐ No

s) **Congenital disorders**
for example autism, cystic fibrosis, Down's syndrome, spina bifida
☐ Yes ☐ No

If you have ticked yes to any of the above, please provide full details in the boxes below (put the appropriate letter next to each answer in the second column, for example k) fainting episodes).

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

Checklist - have you:

☐ ticked either 'yes' or 'no' for section 5a?
☐ ticked either 'yes' or 'no' for section 5b?
☐ ticked either 'yes' or 'no' for section 5c?
☐ ticked either 'yes' or 'no' for **every** part of section 5d?

6. Consent to obtain a medical report

In order to enable 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 shall advise you that we have done so. We will not 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 overleaf.
You should be aware that 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 (these acts only apply to UK medical records). The main points of the Act are as follows:

a) If you indicate (in the declaration) that you do not wish to see the report we will not notify you if we apply for one. However, if before such a report is sent to us you write to your doctor requesting to see it, you will have 21 days to contact your doctor about arrangements for you to see the report.

b) If you indicate (in the declaration) that you wish to see the report, we will write to you at the same time as we contact your doctor. We will indicate that you have asked to see the report and that you have 21 days to contact your doctor to make arrangements to do so. When you have seen the report the doctor may not send it to us until you have given your consent to do so.

   If you do not contact your doctor within 21 days the report will be sent to us.

c) You can ask your doctor if he/she will 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) During the six months after we have received your report you may ask your doctor for a copy. Should you ask for a personal copy of the report the doctor can charge you a reasonable fee to cover the cost.

e) In some circumstances the 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. The doctor will notify you of this and you will have the right to see any remaining part of the report. If it is the whole of the report which is affected, this will not be given to us without your consent.

f) **You can withhold your consent (in which case we may be unable to proceed with your proposal)**.

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, Aviva Life and Pensions UK Limited.
Details are required for each person to be insured by the policy.

Name | Family doctor or medical practitioner's name
Signature | Date DD / MM / YYYY
(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 | Family doctor or medical practitioner's name
Signature | Date DD / MM / YYYY
(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 | Family doctor or medical practitioner's name
Signature | Date DD / MM / YYYY
(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 | Family doctor or medical practitioner's name
Signature | Date DD / MM / YYYY
(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 | Family doctor or medical practitioner's name
Signature | Date DD / MM / YYYY
(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 | Family doctor or medical practitioner's name
Signature | Date DD / MM / YYYY
(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 family doctors or medical practitioners for everyone covered by the policy. If there are more than 2 family doctors or medical practitioners, please use a separate piece of paper

Family doctor or medical practitioner's name	Address	Tel (incl STD code)	Fax

Checklist - have you:

- ☐ fully completed the personal details for everyone on the policy?
- ☐ fully completed section 4 if you already have private medical insurance?
- ☐ fully completed section 5 for those people who you want to insure that don't already have private medical insurance?
- ☐ fully completed section 6 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.

7. Declaration

I declare that:

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

b) I understand and accept that benefits will not be available to insured persons (those named in section 2) for the treatment of any illness or injury which originated prior to their date of joining the policy 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.

c) to the best of my knowledge and belief the information given on this application is true and complete. I agree to accept and conform to the terms of the policy when issued. (A specimen copy of the policy is available on request).

d) I have checked and found correct any answers or statements in this application that are not in my own handwriting.

e) I understand that if Aviva needs to investigate or establish any material facts this may delay the claims process.

f) the contract will be subject to the law of England and the exclusive jurisdiction of the English courts

For agent use only

Agency ref.

For office use only

Campaign code

Coupon code

Policy number

g) 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 and to relevant intermediaries and medical service providers) for the purposes of this application, policy administration, service provision, reinsurance, claims assessment/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 of English law apply. The data controllers are Aviva Health UK Limited, Aviva Insurance UK Limited, Aviva Life and 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)

*If within UK

Proposer's signature

Date
(must be completed) D D / M M / Y Y Y Y

Proposer's name
(Print name)

Please do not forget to complete the payment details on the next page

8. Payment - please complete one of the sections a, b or c below

Premiums paid in Pounds Sterling can be made by annual cheque or banker's draft, annual credit card, annual or monthly Direct Debit from a UK Bank or Building Society account. Euro and US Dollar premium payments can be by annual cheque/draft or annual bank transfer. If you wish to pay by bank transfer, please contact us for more information.

a) Annual credit card payment authorisation (Sterling only)

Please note that we cannot accept payment by American Express or Diners Club.

Credit Card payment

We only accept MasterCard or Visa.

To assist with cardholder data security, Aviva requests that you do not record credit card details on this form.

If you wish to pay by credit card, please tick here ☐

When we (Aviva) 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.

b) Cheque/Banker's draft payment

Annual cheque payment Cheque attached ☐ Premium amount (delete as applicable) £/€ /$

If you intend to pay by cheque please tick the box and attach your cheque securely to this application and return it to Aviva Health UK Limited, International Team 14, Chilworth House, Hampshire Corporate Park, Templar's Way, Eastleigh, SO53 3RY. **Please make cheque payable to: AVIVA**

Annual Banker's draft payment Banker's draft attached ☐ Premium amount (delete as applicable) £/€ /$

c) Direct Debit payment (Sterling only)

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, International Team 14, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.

Service User Number 9 1 2 3 9 8

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 ☐ 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 Sword UK Ltd re: International Health from Aviva 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 Sword UK Ltd re: International Health from Aviva and, if so, details will be passed electronically to my bank/building society.

Date

✗ DD / MM / YYYY

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, Sword UK Ltd re: International health from Aviva will notify you 7 working days in advance of your account being debited or as otherwise agreed. If you request Sword UK Ltd re: International health from Aviva 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 Sword UK Ltd re: International health from Aviva 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 Sword UK Ltd re: International health from Aviva 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. Private Medical Insurance is underwritten by Aviva Insurance UK Limited.
Registered in England Number 99122. Registered Offices 8 Surrey Street Norwich NR1 3NG.
Authorised and regulated by the Financial Services Authority. Members of the Association of British Insurers.
Members of the Financial Ombudsman Service.
Aviva Health UK Limited International Team 14 Chilworth House Hampshire Corporate Park Templar's Way Eastleigh SO53 3RY

AVIVA

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