

If you're not ready to take your benefits yet, you don't need to fill in this form, however it's important that you call us to let us know.

Personal information form

Please fill in this form and return it to us. The information you give us may mean you get a higher income in retirement.



We can only give you a personalised quote for an annuity if you give us the information we ask for. This is important because we calculate how much income you'll get from your annuity using the information you give us.

To give you the highest income possible, answer all the relevant questions. This is important because your future income is based on your current health and lifestyle.

If any sections or questions are returned blank, we'll make certain assumptions about your health and lifestyle. These assumptions may give you a lower income than if you tell us the answers.

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Aboutyou

Plan number(s)

Do you want to provide an income for a spouse, civil partner or financial dependant upon your death?

Yes

You

No

١

Your personal details	You	Your dependant
Title	Mr Mrs Miss Ms	Mr Mrs Miss Ms
	Other (Please specify)	Other (Please specify)
Forename		
Surname		
Date of birth	DDMMYYYYY	D D M M Y Y Y Y
Gender	Male Female	Male Female
National insurance number		
Home address		
Postcode		
Please give us some details in case we nee	ed to contact you about anything you've told us on th	is form.

Daytime telephone number

Mobile number

Email address

Your personal circumstances

Please tick one box that best describes your personal circumstances

Single	Separated	
Married	Separated Civil Partnership	
Civil Partnership	Divorced	
Cohabiting	Dissolved Civil Partnership	
Intend to Marry	Widowed	
Intend to form Civil Partnership	Surviving Civil Partnership	

If Yes, you will also need to complete the dependant's

information in the right hand column and any of the

medical forms that are applicable.

16	Ξþ	en	Цс	1111
Y	0	u	r	p

Your health & lifestyle

Height and weight

Please tell us your height (in feet and inches or centimetres)

Please tell us your weight (in stones and lbs or kilograms)

Please tell us your waist measurement (in inches or centimetres)

Smoking

I have never smoked

I am a regular smoker

I used to smoke

Have you been a regular daily smoker for the last 10 years?

Date started

Date stopped (complete this only if you no longer smoke)

Amount smoked daily

Amount smoked weekly

Alcohol consumption

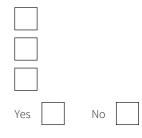
How many units of alcohol do you drink weekly? (A unit of alcohol is equivalent to half a pint of normal strength beer, lager or cider, one standard glass of wine or a single measure of spirit).

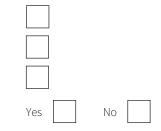
We'll use the information you give us in this form to	provide you with an annuity quote tailored to your
personal circumstances.	

You	Your dependant
ft in	ft in
cm	cm
st lb	st lb
kg	kg
in or cm	in or cm

You

We need to know if you or your dependant smoke and if you do, how often. Please tick one box which describes your smoking habits. If you do not complete this section we will assume you are a non-smoker.





Your dependant

If you are a smoker or used to smoke please answer the following questions

VI	М	Y	Y	Y	Y
VI	М	γ	Y	Y	Y

Cigarettes	
Cigars	
g or	oz Rolling Tobacco
g or	oz Pipe Tobacco

М	M	Y	Y	Y	Y
М	М	Y	Y	Y	Y

Cigarettes
Cigars

			_
g or oz Rolling Tobacco	Ę	g or	oz Rolling Tobacco
g or oz Pipe Tobacco	{	g or	oz Pipe Tobacco

Your dependant

Units

You

Blood pressure

Have you been diagnosed with high blood pressure (hypertension)?

When was this diagnosed?

Please specify your last 2 blood pressure readings and the dates

Do you currently take any medication for this condition?

Please list all medication you currently take for high blood pressure, and how often you take each of them

Yes No						
MMYYYYY						
over	M	М	Y	Y	Y	γ
over	M	М	Y	Y	Y	Y

How often Dose Medication (eg twice (eg 3mg) daily)

Your dependant					
Yes No					
M M Y Y Y Y					
over	M	Y	Y	Y	Y
over	M	Y	Y	Y	Y
Yes No					

Medication	Dose (eg 3mg)	How often (eg twice daily)

Your dependant

No

ΥΤΥΤΥΤΥ

Yes

MIM

HDL

Total

Yes

High cholesterol

Have you been diagnosed with high cholesterol?

When was this diagnosed?

Please specify your last 2 cholesterol readings and the dates

Do you currently take any medication for this condition?

Please list all medication you currently take for high cholesterol, and how often you take each of them

Yes				No		
М	\mathbb{M}	Y	Y	γ	Y	

Reading 1

You

HDL			LDL	
Total			mmol/l	
Date	M	YYY	YY	

Reading 2

Yes

	-			
HDL			LDL	
Total			mmol/l	
Date	MIM	YY	YY	

	LDL	
	mmol/l	
Y	YY	

Date	MMYY	YY	
HDL		LDL	
Total		mmol/l	
Date	MMYY	YY	

No

LDL

mmol/l

No

Medication	Dose (eg 3mg)	How often (eg twice daily)

Medication	Dose (eg 3mg)	How often (eg twice daily)

6

Medical conditions

Please complete a separate questionnaire for each medical condition. One is required for both you and your dependant, so if you need extra questionnaires, please contact us. These forms appear over the following pages:

Please tick the box if you have or have ever had any of the following conditions

You	Your dependant	Form page no.	
I have no other medical conditions	I have no other medical conditions	Please ensure you complete the pension details section on page 17	
Heart	Heart	6	
Diabetes	Diabetes	8	
Respiratory	Respiratory	9	
Stroke	Stroke	10	
Multiple Sclerosis	Multiple Sclerosis	11	
Neurological	Neurological	12	
Cancer	Cancer	13	
Other medical conditions	Other medical conditions	15	

Heart attack, angina and other heart conditions questionnaire

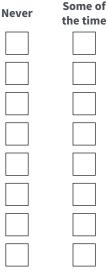
You

Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about your heart condition.

Date of		No. of	Ongoing?	
Diagnosis	diagnosis	occurrences	Yes	No
Heart Attack (myocardial infarction)	ММ/ҮҮҮҮ			
Angina	MM/YYYY			
Heart failure	MM/YYYY			
Aortic aneurysm	MM/YYYY			
Cardiomyopathy	ММ/ҮҮҮҮ			
Heart valve disorders	MM/YYYY			
Atrial fibrillation (AF)	MM/YYYY			
Other irregular heart rhythm	ММ/ҮҮҮҮ			
Other (please specify):	ММ/ҮҮҮҮ			

Symptoms at rest Breathlessness walking from room to room Breathlessness climbing stairs Chest pains on minor to moderate activity Chest pains on severe exertion Swollen ankles Episodes of dizziness Episodes of blackouts



Always

Most of

the time

Date of most recent procedure

If surgery has been carried out, please state type of procedure	Coronary artery bypass graft (CABG)	Number of arteries		Date	MMYYYY
state type of procedure	Coronary angioplasty/stents	Number of arteries	treated	Date	MMYYYY
	Aortic valve replacement	Successful? Yes	No	Date	MMYYYY
	Mitral valve replacement	Successful? Yes	No	Date	MMYYYY
	Tricuspid valve replacement	Successful? Yes	No	Date	MMYYYY
	Pacemaker	Successful? Yes	No	Date	MMYYYY
	Cardioversion/ablation	Successful? Yes	No	Date	MMYYYY
	Aortic aneurysm repair	Successful? Yes	No	Date	MMYYYY

Have you ever been diagnosed with any of the following? Please tick all that apply

How often does your heart condition(s) currently affect you in any of the following ways?

What medication(s) are you currently taking for your heart condition(s)?

Medication	Name of heart condition	Dose (eg 3mg)	How often (eg twice daily)	Start dat
				MM/YYY
				ММ/ҮҮҮ
				MM/YYY
				MM/YYY
				ММ/ҮҮҮ
		Last admissic	on date M M	ΥΥΥΥ
Coronary artery bypass graft (CAB	G)			
Coronary angioplasty/stents				
Aortic valve replacement				
Mitral valve replacement				
Tricuspid valve replacement				
Pacemaker				
Cardioversion/ablation Aortic aneurysm repair				
M M Y Y Y Normal	Abnormal	Other		

Are you currently under the care of a cardiologist?

If yes, name of cardiologist

Name of hospital

How many times have you been admitted to hospital due to your heart condition(s) within the past 10 years?

Is any future treatment planned? Please tick all that apply

Please advise date and result of any stress (exercise) ECG testing eg using a bicycle or treadmill



Please ensure you complete the pension details section on page 19.

Diabetes

ou		
ou		

Type 1

MIM YIYIYI

Your dependant

Type 2

Please tick the box if you have enclosed copies of any hospital letters or reports about your diabetes.

When was your diabetes diagnosed?

Diabetes type

How is your diabetes controlled?

What medication are you currently taking for your diabetes?

Diet only Non Insulin (table	et/injection)	Insulin	
Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date

If this has changed please advise previous treatment regime

Do you have any of the following
diabetes related complications?
Please tick all that apply

Please tell us your last two readings and dates for HbA1c

Have you ever been admitted to hospital as a result of your diabetes?

If yes, when was your last hospital admission date?

	1	1	1
Medication	Dose	How often	End date
	(eg 3mg)	(eg twice daily)	
Heart disease		Kidney disease (prot	ein in urine)
Retinopathy (excluding other eye disease)		Peripheral Vascular of (with Ulceration)	lisease
Neuropathy		Amputation	
Reading 1		ding 2	
DCCT% or IFFC (mr	mol/mol)	DCCT% or	IFFC (mmol/mol)
Date M M Y Y Y Y	Date	MMYYYY	(





Respiratory/lung disease questionnaire

your respiratory/lung disease.

You

Your dependant

Please tick the box if you have enclosed copies of any hospital letters or reports about

Please advise which of the following you have been diagnosed with and when your	Name of condition	Date of diagnosis
condition was diagnosed. Please	Chronic obstructive airways/pulmonary disease (COAD/COPD)	MM/YYYY
tick all that apply	Bronchiectasis	MM/YYYY
	Asbestosis	MM/YYYY
	Pleural plaques	MM/YYYY
	Emphysema	MM/YYYY
	Pneumoconiosis (type of lung disease related to occupation)	MM/YYYY
	Asthma	MM/YYYY
	Sleep apnoea	MM/YYYY
	Other (please specify):	MM/YYYY
How often do any of the following apply?	Nover	lost of Always
	Need for Continuous positive airway pressure (CPAP) breathing machine	
	Signs of cor pulmonale (right heart failure due to lung disease)	
	Breathlessness walking from room to room	
	Breathlessness climbing stairs	
	Breathlessness when lying flat	
	Oral Steroids (tablet form only e.g. prednisolone)	
How many times have you been admitted		

What medication are you currently taking for your respiratory/lung condition(s)?

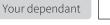
Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
			MM/YYYY
			MM/YYYY
			MM/YYYY



Please ensure you complete the pension details section on page 19.

Stroke questionnaire

You



Please tick the box if you have enclosed copies of any hospital letters or reports about	
your stroke(s).	

CVA (Cerebrovascular Accident - major stroke)

	SAH	Subarachnoid Haemorrhage)
--	-----	--------------------------	---

Cerebral haemorrhage/bleed

JAH	(วินิมิลา	actition	inae	monna	agi

TIA (Transient Ischaemic Attack -
mini-stroke)

Episode/type (eg CVA, TIA)	Date	Part of body affected (speech, arm, memory loss, vision or leg)	Duration of initial symptoms	Fully recovered (yes/no)	If yes, duration it took for full recovery
	ММ/ҮҮҮҮ				
	ММ/ҮҮҮҮ				
	MM/YYYY				

Please advise of any of the following
current and ongoing problems due
to your stroke(s). Please tick all that
apply

What medication are you currently taking for this condition(s)?

Name of your hospital

Speech difficulties	Vision impairment
Paralysis arm	Paralysis leg
Short-term memory loss	

What medication are you currently taking for this condition(s)?	Medication	Dose (eg 3mg)	How often (eg twice daily)	Start date
				MM/YYYY
				MM/YYYY
				MM/YYYY
Are you under follow-up or have you now been discharged?	Follow-up	Disc	harged	,
Name of your consultant				
Name of your hospital				

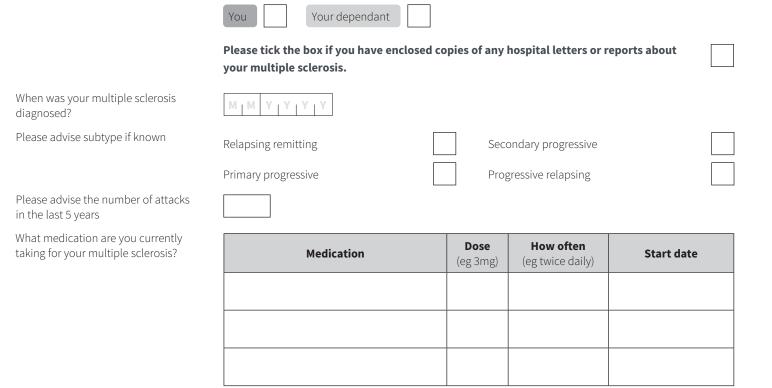


If you have completed the 'Stroke questionnaire' you must complete the Activities of Daily Living questions on page 18.

Please advise which of the following

you have been diagnosed with

Multiple sclerosis questionnaire



How many times have you been
admitted to hospital due to your
multiple sclerosis?

Do you have or have you had any of the following in relation to your multiple sclerosis? Please tick all that apply

Bladder incontinence/self-catheterisation Secondary infection (eg pneumonia) Progressive mental deterioration Impairment of vision Impairment of speech Paralysis of a limb

Last admission date

MIM

 $\mathbf{Y} \mathbf{Y} \mathbf{Y}$

Use of steroids (eg prednisolone) on more than one occasion



If you have completed the 'Multiple sclerosis questionnaire' you must complete the Activities of Daily Living questions on page **18**.

Neurological conditions questionnaire

You

	Please tick the box if you have enclosed copies or neurological condition.	f any hospital letters or rep	ports about your
Have you ever been diagnosed with any of the following? Please tick all that apply	Condition type		Date of diagnosis
	Vascular dementia		MM/YYYY
	Alzheimer's disease or dementia		MM/YYYY
	Parkinson's disease		MM/YYYY
	Motor neurone disease		MM/YYYY
	Other (please specify):		MM/YYYY
How many times have you been admitted to hospital with your neurological condition(s)?		Last admission date	MMYYYY
Have you had any of the following in relation to your neurological condition(s)? Please tick all that apply	Pressure sores Falls Tremors Seizures		
What medication are you currently taking for your neurological condition(s)?	Medication Do (eg 3		Start date
.,			

Your dependant

Please advise last MMSE score if known

/30



If you have completed the 'Neurological conditions questionnaire' you must complete the Activities of Daily Living questions on page **18**.

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

If you're unable to answer all of these questions, please speak to your GP or medical specialist.

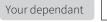
	You Your de	ependant			
	If you have a history of separate questionnaire	more than one different for each.	type of cancer please c	ontact us for a	
		ou have enclosed copies on nfirm the type of cancer, s			
What is the name or type of the tumour/malignant condition?					
Where was the tumour located?					
When was the tumour/condition first diagnosed?	M M Y Y Y Y				
Was the tumour:	Benign Pre-c	ancerous Mal	ignant		
Do you know the staging of the tumour, for example TNM or Duke classification?	Yes No]			
If yes, please enter the letter or number or a combination	Dukes		TNM		
of both in the relevant box:	МАС		FIGO		
	Clark		Breslow Thickness		
	Ann Arbor		Other (eg stage 1)		
Do you know the grading of the tumour?	Yes No]			
If yes, what was the grading of the tumour?	Grade 1 (low)	Grade 2 (intermediate)	Grade 3 (high)		
Please tick the box that most closely describes the nature of the tumour	Carcinoma in situ (stage C), Tis, Ta)	Only local tumour grow	wth	
	Tumour invaded adjacent		Tumour invaded dista	nt lymph nodes	
	Tumour spread to distant (distant metastases)	organs			
Please advise the number of positive lymph nodes affected and location		Head, face and neck	Che	st	
		Abdomen	Arm	pit or arm	
		Groin or leg	Pelv	ic	
		Other			
If your tumour has spread to distant organs (distant metastases), please	Brain and central nervous	s system	Reproductive eg Prost	ate, Uterus	
state where	Urinary eg Kidney		Respiratory eg Lungs		
	Skin		Digestive eg Stomach,	Pancreas	
	Liver		Heart		
	Bones		Other		

Did you have, or are you due to have, any of the following as a result of your	Surgery		Type of sur	gery		Date	of surgery
tumour:						M	IM/YYYY
						N	IM/YYYY
						N	IM/YYYY
	Chemotherapy	Start date:	MMY	YYYY	End date:	M	YYYYY
	Radiotherapy (inc Brachytherapy)	Start date:	MMY	YYYY	End date:	M	YYYYY
	Bone marrow/stem cell transplant	Start date:	MMY	YYY	End date:	M	YYYYY
	Hormone therapy	Start date:	MMY	YYYY	End date:	M	YYYYY
	Other eg BCG, HIFU,	Name	e of therapy		Start da	te	End date
	Immunotherapy				MM/YYY	Y	MM/YYYY
					MM/YYY		MM/YYYY
					MM/YYY	Υ	MM/YYYY
Has there been any recurrence in the same location? What medication are you currently	Yes No		lf yes,	please adv		M	YYYYY
taking for this condition?	Medication		Dose (eg 3mg)	How of twice		Sta	art date
When was your last tumour follow-up appointment with your treating doctor/hospital consultant:	MIMYYYYY						
Have you now been discharged?	Yes No						
In the case of prostate cancer, please advise where known:	Current Prostate Specific Antig	gen (PSA) level: [Dat	e recorded:	MM	YYYYY
	Pre-treatment PSA level:	[Date:	M	YIYIY
	Gleason Score:			Dat	e recorded:	M	YIYIYI
		Ľ				<u> </u>	

Please ensure you complete the pension details section on page **19**.

Other medical conditions

You



Please tick the box if you have enclosed copies of any hospital letters or reports about your other medical conditions.

Please tell us of any other medical conditions you have

Condition		Date of diagnosis	Date you last experienced symptoms
1:		MM/YYYY	MM/YYYY
2:		MM/YYYY	MM/YYYY
3:		MM/YYYY	MM/YYYY

What medication are you currently taking?

	Medication	Dose (eg 3mg)	How often (eg twice daily)
1			
2			
3			



Please ensure you complete the pension details section on page 19.

Activities of daily living questionnaire

	You Your dependant		
	Please tick one box from each of the following that most closely reflects your current condition(s).		
If you complete any of the sections on this page please ensure you tell us which medical condition(s) your answer relates to.	Dressing:	Bowels:	
	Dependent, requires full assistance	Incontinent (or requires enema)	
	Needs help, but can do about half unaided	Occasional accident (once a week)	
	Independent (including buttons, zips, laces etc)	Continent	
	Condition:	Condition:	
	Mobility:	Bathing:	
	Bedridden	Dependent	
	In need of daily nursing care	Needs some assistance	
	Wheelchair use – permanent	Independent	
	Wheelchair use – non-permanent	Condition:	
	Walks with assistance (frame/stick etc)		
	Independent (needs no assistance)	Feeding:	
	Condition:	Unable (naso-gastric tube/PEG tube in place)	
		Needs some help (cutting, spreading butter etc)	
	Transferring:	Independent	
	Unable, no sitting balance	Condition:	
	Major help		
	Minor help, can sit unaided	Please advise any progression in the last 5 years:	
	Independent	Stable (no/minimal change)	
	Condition:	Deteriorating (impact 2 or more ADLs above/acute episodes)	
		Rapid deterioration	
	Bladder:	Condition:	
	Incontinent/catheterised/unable to manage alone		
	Occasional accident (once a week)		
	Continent		
	Condition:		



Pension details

Did you know you can bring pensions from lots of companies together in one place and it might increase your retirement income?

If you have other plans and want to find out about bringing them together, please call us and we'll be happy to give you more details.

Pension company

Yes

No

Fund/Transfer	value	(approx)
---------------	-------	----------

If you have other plans please tell us:

,	

Financial adviser details

Do you have a financial adviser who will be giving you advice on your retirement?

If yes, please tell us the following: Name of the firm

Name of adviser

Adviser Postcode

Email address

g.	



Next you need to read and sign the declaration on page **20**.

Important information

Privacy Notice

Aviva Life & Pensions UK Limited is the main company responsible for your Personal Information (known as the controller).

We collect and use Personal Information about you in relation to our retirement and investments products and services. Personal Information means any information relating to you or another living individual who is identifiable by us. The type of Personal Information we collect and use will depend on our relationship with you and may include more general information (e.g. your name, date of birth, contact details) or more sensitive information (e.g. details of your health).

Some of the Personal Information we use may be provided to us by a third party. This may include information already held about you within the Aviva group, information we obtain from publicly available records, third parties and from industry databases, including fraud prevention agencies and databases. Where you are a member of an occupational or workplace pension scheme, or if you join a savings product through your employer, we may obtain information from, and share information with, the employer who set up your pension or savings product, the trustees of the pension and any third parties who are providing services to you or them.

This notice explains the most important aspects of how we use your Personal Information, but you can get more information by viewing our full privacy policy at **aviva.co.uk/privacypolicy** or requesting a copy by writing to us at: The Data Protection Team, Aviva, PO Box 7684, Pitheavlis, Perth PH2 1JR. If you are providing Personal Information about another person you should show them this notice.

We use your Personal Information for a number of purposes including providing our products and services and for fraud prevention.

We also use profiling and other data analysis to understand our customers better (e.g. what kind of content or products would be of most interest) and to predict the likelihood of certain events arising (e.g. to assess risk or the likelihood of fraud).

We may sometimes make decisions using automated decision making. More information about this, including your right to request that certain automated decisions we make have human involvement, can be found in the "Automated Decision Making" section of our full privacy policy.

We may use Personal Information we hold about you across the Aviva group for marketing purposes, including sending marketing communications in accordance with your preferences. If you wish to amend your marketing preferences please contact us at **contactus@aviva.com** or by writing to us at: Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD. More information about this can be found in the "Marketing" section of our full privacy policy.

Your Personal Information may be shared with other Aviva group companies and third parties (including service providers and regulatory and law enforcement bodies). We may transfer your Personal Information to countries outside of the UK but will always ensure appropriate safeguards are in place when doing so.

You have certain data rights in relation to your Personal Information, including a right to access Personal Information, a right to correct inaccurate Personal Information and a right to erase or suspend our use of your Personal Information. These rights may also include a right to transfer your Personal Information to another organisation, a right to object to our use of your Personal Information, a right to withdraw consent and a right to complain to the data protection regulator. These rights may only apply in certain circumstances and are subject to certain exemptions. You can find out more about these rights in the "Data Rights" section of our full privacy policy or by contacting us at **dataprt@aviva.com**

The Aviva group and its agents would like to contact you from time to time to provide you with updates and offers for Aviva's products and services tailored to you by direct marketing, by post, phone, email or text.

Tell us if you do not want to hear from us

How we keep you informed

You can tell us below if you would prefer not to hear about Aviva products, services, and promotions. You can always tell us if you change your mind.

Post
Email
Telephone
SMS/Text

Declaration and consent

Notice of statutory rights

Under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Access to Health Records and Reports (Isle of Man) Act 1993, the provider reserves the right to apply for a medical report from any doctor who has at any time attended you. The declaration gives us your consent to apply for such a report if we need to.

Your rights:

- You do not have to give your consent, but, without it, the provider will not be prepared to accept your request.
- If you do give your consent, you can indicate whether or not you wish to see any report before it is sent to us.

If you indicate that you do not wish to see any report:

- The doctor can forward it to us immediately and we should be able to process your proposal without delay.
- You can, however, still change your mind at any time within six months and notify the doctor that you wish to see the report. If the doctor has already forwarded the report to us, he/she will send you a copy and, if not, he/she will give you 21 days to arrange to see it.

If you indicated that you do wish to see any report:

- This may delay the processing of your proposal.
- The doctor is allowed to charge you a fee to cover the cost of supplying you with the report.
- You should follow the procedures outlined below.

Procedures for access to reports

- 1. If you indicate that you do wish to see any report, we will notify you if we apply for one, and will inform the doctor of your wishes. You will then have 21 days to contact the doctor to arrange to see the report.
- 2. If you do see the report, the doctor must obtain your consent before sending it to us.
- 3. You have the right to request that the doctor amends any part of a report you consider incorrect or misleading, and can attach your written views on any part the doctor refuses to amend.
- 4. The doctor does not have to let you see any part of a report that he/she considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his/her intentions towards you. He/she also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report, he/she must notify you of that fact.

Please read, complete and sign this section.

I am completing this declaration to allow Aviva to prepare a quotation for an Aviva Pension Annuity/Enhanced Pension Annuity.

If I choose to accept a quotation prepared on the basis of the information given in this form, this declaration will form part of my application for an Aviva Annuity.

I declare that, to the best of my knowledge and belief, the statements above are true and complete and if I have not provided full information this may result in amendment of the plan. The information I give during this application process will be used to assess the terms and extent of the benefits provided within the plan.

If I apply for an Aviva annuity, I agree that Aviva may obtain medical information from any doctor who, at any time, has attended me, about anything that affects my physical or mental health and/or any insurance office to which a proposal has been made on my life and I authorise the giving of such information. This consent shall remain valid throughout the duration of the insurance and after my death.

If I apply for an Aviva annuity, I agree that Aviva may apply for medical evidence. I authorise Aviva to pass medical information to any medical officer on Aviva's behalf.

I understand that Aviva reserves the right to offer revised policy terms should they issue the policy and subsequently find that I have provided incorrect information.

I agree Aviva may pass the information to third parties for the prevention or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

I agree that a copy of this consent can be treated as the original.

I agree to Aviva processing my medical data. I understand that I must inform Aviva without delay if there is a change to my health or circumstances before the commencement of the policy. I understand that failure to do so may result in amendment of the policy.

I understand that the Aviva Pension Annuity plan conditions will apply to my plan.

	You	Your dependant	
Doctor's Name			
Address			
Telephone number			
Fax number			
report before it is sent to Aviva	I do I do not	I do not	
	I have read the notice regarding Use of personal information.		
Name (BLOCK CAPITALS)			
Signature			
Date	D D M M Y Y Y Y	D D M M Y Y Y Y	



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