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.

Contents

About you

Plan number(s)

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

Yes ☐ No ☐

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.

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	D D M M Y Y Y Y	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 need to contact you about anything you've told us on this form.

Daytime telephone number

Mobile number

Email address

Your personal circumstances

Please tick one box that best describes your personal circumstances	You		You	
	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	☐

Your health & lifestyle

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

Height and weight

	You	Your dependant
Please tell us your height (in feet and inches or centimetres)	☐ ft ☐ in ☐ cm	☐ ft ☐ in ☐ cm
Please tell us your weight (in stones and lbs or kilograms)	☐ st ☐ lb ☐ kg	☐ st ☐ lb ☐ kg
Please tell us your waist measurement (in inches or centimetres)	☐ in or ☐ cm	☐ in or ☐ cm

Smoking

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.

	You	Your dependant
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?	Yes ☐ No ☐	Yes ☐ No ☐

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

	You	Your dependant
Date started	M M Y Y Y Y	M M Y Y Y Y
Date stopped (complete this only if you no longer smoke)	M M Y Y Y Y	M M Y Y Y Y
Amount smoked daily	☐ Cigarettes ☐ Cigars	☐ Cigarettes ☐ Cigars
Amount smoked weekly	☐ g or ☐ oz Rolling Tobacco ☐ g or ☐ oz Pipe Tobacco	☐ g or ☐ oz Rolling Tobacco ☐ g or ☐ oz Pipe Tobacco

Alcohol consumption

	You	Your dependant
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).	☐ Units	☐ Units

Blood pressure

	You	Your dependant
Have you been diagnosed with high blood pressure (hypertension)?	Yes ☐ No ☐	Yes ☐ No ☐
When was this diagnosed?	M M Y Y Y Y	M M Y Y Y Y
Please specify your last 2 blood pressure readings and the dates	☐ over ☐ M M Y Y Y Y	☐ over ☐ M M Y Y Y Y
	☐ over ☐ M M Y Y Y Y	☐ over ☐ M M Y Y Y Y
Do you currently take any medication for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

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

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

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

High cholesterol

	You	Your dependant
Have you been diagnosed with high cholesterol?	Yes ☐ No ☐	Yes ☐ No ☐
When was this diagnosed?	M M Y Y Y Y	M M Y Y Y Y

Please specify your last 2 cholesterol readings and the dates

Reading 1

	You	Your dependant
	HDL ☐ LDL ☐	HDL ☐ LDL ☐
	Total ☐ mmol/l	Total ☐ mmol/l
	Date M M Y Y Y Y	Date M M Y Y Y Y

Reading 2

	You	Your dependant
	HDL ☐ LDL ☐	HDL ☐ LDL ☐
	Total ☐ mmol/l	Total ☐ mmol/l
	Date M M Y Y Y Y	Date M M Y Y Y Y

	You	Your dependant
Do you currently take any medication for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

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

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

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

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. ☐

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

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

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

	Never	Some of the time	Most of the time	Always
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	☐	☐	☐	☐

If surgery has been carried out, please state type of procedure

						Date of most recent procedure
Coronary artery bypass graft (CABG)	☐	Number of arteries	☐	Date		M M Y Y Y Y
Coronary angioplasty/stents	☐	Number of arteries treated	☐	Date		M M Y Y Y Y
Aortic valve replacement	☐	Successful? Yes	☐	No ☐	Date	M M Y Y Y Y
Mitral valve replacement	☐	Successful? Yes	☐	No ☐	Date	M M Y Y Y Y
Tricuspid valve replacement	☐	Successful? Yes	☐	No ☐	Date	M M Y Y Y Y
Pacemaker	☐	Successful? Yes	☐	No ☐	Date	M M Y Y Y Y
Cardioversion/ablation	☐	Successful? Yes	☐	No ☐	Date	M M Y Y Y Y
Aortic aneurysm repair	☐	Successful? Yes	☐	No ☐	Date	M M Y Y Y Y

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 date**
				MM/YYYY
				MM/YYYY
				MM/YYYY
				MM/YYYY
				MM/YYYY

Are you currently under the care of a cardiologist?

Yes ☐ No ☐ Last consultation date M M Y Y Y Y

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? ☐ Last admission date M M Y Y Y Y

Is any future treatment planned? Please tick all that apply

- Coronary artery bypass graft (CABG) ☐
- Coronary angioplasty/stents ☐
- Aortic valve replacement ☐
- Mitral valve replacement ☐
- Tricuspid valve replacement ☐
- Pacemaker ☐
- Cardioversion/ablation ☐
- Aortic aneurysm repair ☐

Please advise date and result of any stress (exercise) ECG testing eg using a bicycle or treadmill M M Y Y Y Y Normal ☐ Abnormal ☐ Other ☐

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

Diabetes

You ☐ Your dependant ☐

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

When was your diabetes diagnosed? M M Y Y Y Y

Diabetes type Type 1 ☐ Type 2 ☐

How is your diabetes controlled? Diet only ☐ Non Insulin (tablet/injection) ☐ Insulin ☐

What medication are you currently taking for your diabetes?

Medication	**Dose** (eg 3mg)	**How often** (eg twice daily)	**Start date**

If this has changed please advise previous treatment regime

Medication	**Dose** (eg 3mg)	**How often** (eg twice daily)	**End date**

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

Heart disease ☐
Retinopathy (excluding other eye disease) ☐
Neuropathy ☐
Kidney disease (protein in urine) ☐
Peripheral Vascular disease (with Ulceration) ☐
Amputation ☐

Please tell us your last two readings and dates for HbA1c

Reading 1
☐ DCCT% or ☐ IFFC (mmol/mol)
Date M M Y Y Y Y

Reading 2
☐ DCCT% or ☐ IFFC (mmol/mol)
Date M M Y Y Y Y

Have you ever been admitted to hospital as a result of your diabetes? Yes ☐ No ☐

If yes, when was your last hospital admission date? M M Y Y Y Y

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

Respiratory/lung disease questionnaire

You ☐ Your dependant ☐

Please tick the box if you have enclosed copies of any hospital letters or reports about your respiratory/lung disease. ☐

Please advise which of the following you have been diagnosed with and when your condition was diagnosed. Please tick all that apply

	Name of condition	Date of diagnosis
☐	Chronic obstructive airways/pulmonary disease (COAD/COPD)	MM/YYYY
☐	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

What is your current lung function?

Minimally impaired lung function (FEV1 >70%) ☐ Moderately impaired lung function (FEV1 50–70%) ☐ Severely impaired lung function (FEV1 <50%) ☐

How often do any of the following apply?

	Never	Some of the time	Most of the time	Always
Chest infections	☐	☐	☐	☐
Need for home oxygen	☐	☐	☐	☐
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 to hospital with this condition? ☐

When was your last admission? M M Y Y Y Y

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 ☐ Your dependant ☐

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

Please advise which of the following you have been diagnosed with

CVA (Cerebrovascular Accident – major stroke) ☐

SAH (Subarachnoid Haemorrhage) ☐

Cerebral haemorrhage/bleed ☐

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**
	MM/YYYY				
	MM/YYYY				
	MM/YYYY				

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

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 ☐

Discharged ☐

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**.

Multiple sclerosis questionnaire

You ☐ Your dependant ☐

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

When was your multiple sclerosis diagnosed?

M M Y Y Y Y

Please advise subtype if known

Relapsing remitting ☐ Secondary progressive ☐

Primary progressive ☐ Progressive relapsing ☐

Please advise the number of attacks in the last 5 years ☐

What medication are you currently taking for your multiple sclerosis?

Medication	**Dose** (eg 3mg)	**How often** (eg twice daily)	**Start date**

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

Last admission date M M Y Y Y Y

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 ☐
- 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 ☐ Your dependant ☐

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

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 M M Y Y Y Y

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	Dose (eg 3mg)	How often (eg twice daily)	Start date

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 dependant ☐

If you have a history of more than one different type of cancer please contact us for a separate questionnaire for each.

Please tick the box if you have enclosed copies of any hospital letters or reports about your cancer to confirm the type of cancer, stage, grade and treatment received. ☐

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-cancerous ☐ Malignant ☐

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 of both in the relevant box:

Dukes		TNM	
MAC		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 0, Tis, Ta)	☐	Only local tumour growth	☐
Tumour invaded adjacent lymph nodes	☐	Tumour invaded distant lymph nodes	☐
Tumour spread to distant organs (distant metastases)	☐		

Please advise the number of positive lymph nodes affected and location ☐

Head, face and neck	☐	Chest	☐
Abdomen	☐	Armpit or arm	☐
Groin or leg	☐	Pelvic	☐
Other	☐		

If your tumour has spread to distant organs (distant metastases), please state where

Brain and central nervous system	☐	Reproductive eg Prostate, Uterus	☐
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 tumour:

☐ Surgery

Type of surgery	Date of surgery
	MM/YYYY
	MM/YYYY
	MM/YYYY

☐ Chemotherapy Start date: M M Y Y Y Y End date: M M Y Y Y Y

☐ Radiotherapy (inc Brachytherapy) Start date: M M Y Y Y Y End date: M M Y Y Y Y

☐ Bone marrow/stem cell transplant Start date: M M Y Y Y Y End date: M M Y Y Y Y

☐ Hormone therapy Start date: M M Y Y Y Y End date: M M Y Y Y Y

☐ Other eg BCG, HIFU, Immunotherapy

Name of therapy	Start date	End date
	MM/YYYY	MM/YYYY
	MM/YYYY	MM/YYYY
	MM/YYYY	MM/YYYY

Has there been any recurrence in the same location?

Yes ☐ No ☐ If yes, please advise date M M Y Y Y Y

What medication are you currently taking for this condition?

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

When was your last tumour follow-up appointment with your treating doctor/hospital consultant: M M Y Y Y Y

Have you now been discharged?

Yes ☐ No ☐

In the case of prostate cancer, please advise where known:

Current Prostate Specific Antigen (PSA) level: ☐ Date recorded: M M Y Y Y Y

Pre-treatment PSA level: ☐ Date: M M Y Y Y Y

Gleason Score: ☐ Date recorded: M M Y Y Y Y

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

Other medical conditions

You ☐ Your dependant ☐

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:

- ☐ Dependent, requires full assistance
- ☐ Needs help, but can do about half unaided
- ☐ Independent (including buttons, zips, laces etc)

Condition:

Mobility:

- ☐ Bedridden
- ☐ In need of daily nursing care
- ☐ Wheelchair use – permanent
- ☐ Wheelchair use – non-permanent
- ☐ Walks with assistance (frame/stick etc)
- ☐ Independent (needs no assistance)

Condition:

Transferring:

- ☐ Unable, no sitting balance
- ☐ Major help
- ☐ Minor help, can sit unaided
- ☐ Independent

Condition:

Bladder:

- ☐ Incontinent/catheterised/unable to manage alone
- ☐ Occasional accident (once a week)
- ☐ Continent

Condition:

Bowels:

- ☐ Incontinent (or requires enema)
- ☐ Occasional accident (once a week)
- ☐ Continent

Condition:

Bathing:

- ☐ Dependent
- ☐ Needs some assistance
- ☐ Independent

Condition:

Feeding:

- ☐ Unable (naso-gastric tube/PEG tube in place)
- ☐ Needs some help (cutting, spreading butter etc)
- ☐ Independent

Condition:

Please advise any progression in the last 5 years:

- ☐ Stable (no/minimal change)
- ☐ Deteriorating (impact 2 or more ADLs above/acute episodes)
- ☐ Rapid deterioration

Condition:

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

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.

If you have other plans please tell us:

Pension company	**Fund/Transfer value (approx)**

Financial adviser details

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

Yes ☐ No ☐

If yes, please tell us the following:

Name of the firm

Name of adviser

Adviser Postcode

Email address

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		

I do/do not wish to see the medical report before it is sent to Aviva

I do ☐ I do not ☐ (You)

I do ☐ I do not ☐ (Your dependant)

Aviva reserves the right to decline any requests.

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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