

# Aviva business protection application and data capture form



## Data capture/application form for Aviva Business Protection

(Business Life Insurance Options and/or Relevant Life Insurance)

### To the adviser: How to use this form

This form mirrors our non-interactive online application so can either be used as a data capture form or an application form. You can apply for up to 6 products per application with a maximum of two lives covered and up to two additional policyholders.

- The **additional health questionnaire** in section **7** should be completed for each condition disclosed in section **6**.
- The **additional family history questionnaire** in section **9** should be completed for each condition disclosed in section **8**.
- The **short financial questionnaire** in section **21** should be completed if overall cover in the market exceeds £1.5m for life insurance or £750,000 for critical illness cover/employee significant illness cover.

If your customer is awaiting the results of medical tests, please be aware that this will automatically result in our online underwriting process postponing the application. It is best to wait to apply until test results are available.

As part of the application process, Aviva asks all customers to give consent for us to request a medical report from their doctor under the Access to Medical Reports Act 1988 (AMRA). We also need your GP details. If you choose not to give consent, or if you're unable to, we will not be able to go ahead with your application. This doesn't stop you from applying to other companies for cover. A report can be sent electronically using secure software or in the post.

Form use:  Application  Data capture

### To the adviser: Important information

Please read the residency eligibility criteria in section 18(a) for Business Life Insurance Options and section 18(b) for Relevant Life Insurance.

### To the customer: Important information

**You must answer all the questions fully, truthfully and accurately. Please remember that the answers you give will be used to assess the terms and the extent of benefits we can offer you. Even if you have already provided us with the information in a previous application you must provide it to us again as our systems may not identify the previous information.**

**In order for us to provide a decision on applications, we will ask questions about build, medical history and other risk factors relevant to the products being applied for. We will use these answers to determine whether we can offer cover and on what basis. This includes questions regarding mental health conditions, where these are relevant to the products being applied for.**

**If you provide incorrect or incomplete information this may result in your policy being amended or cancelled, may reduce the amount payable in the event of a claim, or may result in the non-payment of a claim.**

We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who have a need to see it.

Until we confirm when your cover will start you must notify us immediately of any change in the circumstances relating to the health, activities, occupation or residence of the person(s) covered which would change any of the answers or information provided in this application form.

This includes attending any medical appointment or consultation after submitting the application.

Any changes may affect the terms of extent of cover we can offer you. Aviva reserves the right to offer amended terms or decline cover.

### Contents

1	Account information	13	Doctor's details
2	Personal details	14	Payment details
3	Policyholder details	15	Important information
4	Product details – Business Life Insurance Options Product details – Relevant Life	16	Data protection
5	Lifestyle	17	Medical reports
6	Personal medical history	18(a)	Residency criteria for Business Life Insurance Options
7	Additional health questionnaire (needed for each condition disclosed in section 6)	18(b)	Residency criteria for Relevant Life Insurance
8	Family history	19	Financial Crime
9	Additional family history (needed for each condition disclosed in section 8)	20	Declaration
10	Residency, travel & sports	21	Short financial questionnaire (needed if overall cover in the market exceeds £1,500,000 for life or £750,000 for critical illness/employee significant illness)
11	Occupation	22	AMRA consent form (if required)
12	Overall cover	23	Spare product details, policyholder details and additional health questionnaire pages (if required)

# Section 1 – Account information

**Adviser use – For paper application only – please answer all the questions in full. We cannot work from the quote you sent to the client.**

Account code	<input type="text"/>
Panel ID	<input type="text"/>
Intermediary Case Reference Number	<input type="text"/>
Adviser name	<input type="text"/>
Company name	<input type="text"/>
FCA number	<input type="text"/>
Contact name	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
Was advice given?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Indemnity commission	<input type="checkbox"/> Yes <input type="checkbox"/> No
Commission style	<input type="checkbox"/> Initial <input type="checkbox"/> Initial and renewal <input type="checkbox"/> No commission

## For initial commission only

Commission type	<input type="checkbox"/> Required <input type="checkbox"/> Sacrificed
Commission basis	Lautro points <input type="checkbox"/> Percentage of entitlement <input type="checkbox"/> Enter Lautro points <input type="text"/> Enter percentage of entitlement <input type="text"/> %
Apply these commission details for all	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered no, please complete on separate paper for each policy, with the correct policy reference from section 4 for administration purposes.**

**You can choose to have the policy documents sent to either your client or to you. Please choose where you would like the policy documents to be sent. Please tick one box** Your client  You

**You may also want to send a copy of your quote with this form.**

# Section 2 – Personal details

First life covered

Second life covered

1. Title



2. Name

First name

Middle name

Last name

First name

Middle name

Last name

3. Date of birth

/   /

/   /

4. Gender

Male  Female

Male  Female

5. Occupation



6. Smoking, tobacco and nicotine use  
*We need accurate information about your client's use of cigarettes, cigars, a pipe or any other tobacco or nicotine products including nicotine gums, patches, inhalers, tablets, lozenges, sprays and electronic products, even if only on an occasional basis. It's an important factor in our assessment of terms and payment of claims. We carry out tests to confirm use.*

Never used

Regular, occasional or social use

Completely stopped within last 12 months

Completely stopped more than five years ago

Completely stopped more than three years ago

Completely stopped more than 12 months ago

First life covered	Second life covered
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

7. Address

Address line 1

Address line 2

Town/City

County

Postcode

Address line 1

Address line 2

Town/City

County

Postcode

8. Phone number

Mobile

Home

Mobile

Home

9. Email



10. Pre sale underwriting reference

# Section 3 – Policyholder details

		First policyholder	Second policyholder
1. What is the reason for cover?	<input type="checkbox"/> Key Person Protection <input type="checkbox"/> Business Loan Protection <input type="checkbox"/> Shareholder/Partnership Protection <input type="checkbox"/> Relevant Life	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**For Business Life Insurance Options product applications, go to question 2. For Relevant Life Insurance applications, go to question 3. If you require an additional policyholder form, please go to section 23.**

2. Are the lives covered the same as the policyholders?	<input type="checkbox"/> Yes Fill out question 5 and then go to section 4	<input type="checkbox"/> No Fill out below
---	--	---

3. Is the policyholder a company? <i>For Relevant Life Insurance applications, the policyholder will always be the life covered's employer.</i>	<input type="checkbox"/> Yes Fill out questions 4 – 6 and 10 – 15	<input type="checkbox"/> No Fill out question 5 and questions 7 – 15
--	--	---

4. Type of business of the employer	<input type="checkbox"/> Limited Company	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole trader
	<input type="checkbox"/> Limited liability partnership		<input type="checkbox"/> Charity

	First policyholder	Second policyholder
5. Company/employer name	<input type="text"/>	<input type="text"/>

6. Company or charity number <i>For companies and LLPs, insert your registered company number. For charities, insert your charity number. Otherwise, leave blank.</i>	<input type="text"/>	<input type="text"/>
--	----------------------	----------------------

7. Title	<input type="text"/>	<input type="text"/>
----------	----------------------	----------------------

8. Name	First name	<input type="text"/>	First name	<input type="text"/>
	Middle name	<input type="text"/>	Middle name	<input type="text"/>
	Last name	<input type="text"/>	Last name	<input type="text"/>

9. Date of birth	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
------------------	---	---

## Section 3 – Policyholder details *continued*

	First policyholder	Second policyholder
10. Phone number	Mobile Home	Mobile Home
11. Email <i>Not required if policyholder is a company</i>		
12. Address	Address line 1  Address line 2  Town/City County Postcode	Address line 1  Address line 2  Town/City County Postcode
13. Is this policy to be under trust from the start date?	<i>For Relevant Life Insurance applications, the answer must always be 'Yes'</i>	First policyholder <input type="checkbox"/> Yes <input type="checkbox"/> No Second policyholder <input type="checkbox"/> Yes <input type="checkbox"/> No
14. What is the policyholder's relationship to the first life covered?	Employer (Key Person) Employer (Shareholder Protection) Employer (Business Loan Protection) Employer (Business Partnership) Co-employee (Shareholder Protection) Co-employee (Business Loan Protection) Co-employee (Business Partnership) Employer (Relevant Life)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
15. What is the policyholder's relationship to the second life covered?	Employer (Key Person) Employer (Shareholder Protection) Employer (Business Loan Protection) Employer (Business Partnership) Co-employee (Shareholder Protection) Co-employee (Business Loan Protection) Co-employee (Business Partnership) Employer (Relevant Life)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

# Section 4 – Product details: Business Life Insurance Options

How to use this form: Please number the policies you apply for in the space provided as this may be needed in sections 20 and 23(4). There's an extra form for product details in section 23(4) if you need it.

## Notes:

Note 1: Premium basis applies to both lives

Note 2: Only available with single life policies

Note 3: Renewal option only available with level life cover, level life & critical illness cover with guaranteed premiums

Note 4: Conversion option only available with level life cover

Note 5: Increasing cover is not available with conversion & renewal option or on decreasing cover

Note 6: Total permanent disability option is only available with critical illness

Note 7: Instalment option is not available with decreasing cover

	No. <input type="text"/>	No. <input type="text"/>
Life covered	<input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both	<input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both
Policyholder	<input type="checkbox"/> As above <input type="checkbox"/> First policyholder <input type="checkbox"/> Second policyholder	<input type="checkbox"/> As above <input type="checkbox"/> First policyholder <input type="checkbox"/> Second policyholder
Cover type	<input type="checkbox"/> Level <input type="checkbox"/> Decreasing Policy interest rate (4-18% to 2 decimal places) <input type="text"/> %	<input type="checkbox"/> Level <input type="checkbox"/> Decreasing Policy interest rate (4-18% to 2 decimal places) <input type="text"/> %
	With critical illness <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both	With critical illness <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both
Life & critical illness premium basis <small>Note 1</small>	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable
Cover	Cover amount <input type="text"/>	Cover amount <input type="text"/>
	OR Premium <input type="text"/>	OR Premium <input type="text"/>
Term	No. of years <input type="text"/> OR Until age <input type="text"/> <small>Note 2</small>	No. of years <input type="text"/> OR Until age <input type="text"/> <small>Note 2</small>
Premium frequency	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
Options	<input type="checkbox"/> Renewal <small>Note 3</small> <input type="checkbox"/> Conversion <small>Note 4</small>	<input type="checkbox"/> Renewal <small>Note 3</small> <input type="checkbox"/> Conversion <small>Note 4</small>
	<input type="checkbox"/> Increasing cover <small>Note 5</small> Increasing cover rate <input type="checkbox"/> 3% <input type="checkbox"/> 5% <input type="checkbox"/> RPI	<input type="checkbox"/> Increasing cover <small>Note 5</small> Increasing cover rate: <input type="checkbox"/> 3% <input type="checkbox"/> 5% <input type="checkbox"/> RPI
	Waiver of premium <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both Deferred period – first life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months Deferred period – second life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months	Waiver of premium <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both Deferred period – first life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months Deferred period – second life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months
	<input type="checkbox"/> Total permanent disability <small>Note 6</small> <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both	<input type="checkbox"/> Total permanent disability <small>Note 6</small> <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both
	Instalment option <small>Note 7</small> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of yearly instalments: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Instalment option <small>Note 7</small> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of yearly instalments: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Will this replace an existing Aviva policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give existing Aviva policy number(s)	<input type="text"/>	<input type="text"/>

# Section 4 – Product details: Relevant Life Insurance

Please number the policies you apply for in the space provided as this may be needed in sections 20 and 23(4).

**Notes:**

Note 1: Total permanent disability option is only available with employee significant illness

	No. <input type="text"/>	No. <input type="text"/>
Life covered	<input type="checkbox"/> First life <input type="checkbox"/> Second life	<input type="checkbox"/> First life <input type="checkbox"/> Second life
Policyholder	<input type="checkbox"/> First policyholder <input type="checkbox"/> Second policyholder	<input type="checkbox"/> First policyholder <input type="checkbox"/> Second policyholder
Cover type	With employee significant illness <input type="checkbox"/> Yes <input type="checkbox"/> No	With employee significant illness <input type="checkbox"/> Yes <input type="checkbox"/> No
Life & employee significant illness premium basis <small>Note 1</small>	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable
Cover	Cover amount <input type="text"/> OR Premium <input type="text"/>	Cover amount <input type="text"/> OR Premium <input type="text"/>
Term	No. of years <input type="text"/> OR Until age <input type="text"/>	No. of years <input type="text"/> OR Until age <input type="text"/>
Premium frequency	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
Options	<input type="checkbox"/> Increasing cover Total permanent disability <small>Note 1</small> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing cover Total permanent disability <small>Note 1</small> <input type="checkbox"/> Yes <input type="checkbox"/> No
Increasing cover rate	<input type="checkbox"/> 3% <input type="checkbox"/> 5% <input type="checkbox"/> RPI	<input type="checkbox"/> 3% <input type="checkbox"/> 5% <input type="checkbox"/> RPI
Will this replace an existing Aviva policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give existing Aviva policy number(s)	<input type="text"/>	<input type="text"/>

# Section 5 – Lifestyle

**IMPORTANT: You must answer all questions fully, truthfully and accurately. Failure to do so may result in your policy being amended or cancelled, may reduce the amount payable in the event of a claim, or may result in the non-payment of a claim. You do not need to tell us about any predictive genetic test results unless this application, together with any existing cover, will total over £500,000 of life insurance. If your cover is over this limit, we only need to know about predictive genetic tests for Huntington’s disease. You can tell us about any negative predictive genetic tests results, because it may help your application.**

Please note: Sections 5 to 13 (inclusive) refer to the lives covered so the questions should be answered by them, not the policyholder.

		First life covered	Second life covered
1. How much alcohol do you drink in an average week? <i>We need you to give us accurate information about your alcohol usage and let us know if you've been advised to reduce it, because it's an important factor in our assessment of terms and payment of claims.</i>	Number of <b>pints</b> of ordinary strength beer, lager or cider (Less than 5% strength)	<input type="text"/>	<input type="text"/>
	Number of <b>pints</b> of strong, premium beer, lager or cider (5% strength or more)	<input type="text"/>	<input type="text"/>
	Number of <b>glasses</b> of wine	<input type="text"/>	<input type="text"/>
	Number of <b>single measures/shots</b> of spirits or <b>bottles</b> of alcopops	<input type="text"/>	<input type="text"/>
	None, I do not drink alcohol	<input type="text"/>	<input type="text"/>

2a. Have you ever attended, or been advised to attend, a support service or had therapy, treatment or counselling with the aim of reducing your alcohol intake?	First life covered <input type="checkbox"/> Yes <input type="checkbox"/> No	Second life covered <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide details of what occurred, when the advice, treatment or support was last given and details of any blood tests or scans you have had due to your alcohol consumption.	
	First life covered <input type="text"/>	Second life covered <input type="text"/>

2b. Has a doctor, or other health or social worker, been concerned about your drinking or suggested that you cut down?  <i>There is no need to tell us about standard advice to reduce your alcohol intake because of pregnancy only.</i>	First life covered <input type="checkbox"/> Yes <input type="checkbox"/> No	Second life covered <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please advise who told you to reduce your alcohol consumption and when this was, the reason for the advice and what your alcohol consumption was at that time.	
	First life covered <input type="text"/>	Second life covered <input type="text"/>

3. If you are a regular, occasional or social smoker, or you have given up in the past 12 months, which of the following tobacco or nicotine products do you currently use?  (If you only use other tobacco or nicotine products, including electronic products, or have given up in the last 12 months, please enter zero)	<input type="checkbox"/> Cigarettes: <input type="text"/> Per day	<input type="checkbox"/> Cigarettes: <input type="text"/> Per day
	<input type="checkbox"/> Small cigars or cigarillos: <input type="text"/> Per day	<input type="checkbox"/> Small cigars or cigarillos: <input type="text"/> Per day
	<input type="checkbox"/> Large cigars including panatelas: <input type="text"/> Per day	<input type="checkbox"/> Large cigars including panatelas: <input type="text"/> Per day
	<input type="checkbox"/> Cigarettes: <input type="text"/> Per day	<input type="checkbox"/> Cigarettes: <input type="text"/> Per day
	<input type="checkbox"/> Small cigars or cigarillos: <input type="text"/> Per day	<input type="checkbox"/> Small cigars or cigarillos: <input type="text"/> Per day
	<input type="checkbox"/> Large cigars including panatelas: <input type="text"/> Per day	<input type="checkbox"/> Large cigars including panatelas: <input type="text"/> Per day



4. During the last ten years, have you used any of the following: *Your answer is confidential and we'll only use it to assess your application and in the event of a claim.*

- Recreational drugs, for example cannabis, cocaine, ecstasy, heroin etc.
- Stimulants, sedatives, tranquillisers or anabolic steroids that have not been prescribed by a doctor
- Methadone

First life covered

Yes  No

Second life covered

Yes  No

If yes, please advise the drug(s) that you used and for each drug advise how long you were taking this for and when you last used the drug.

First life covered

Second life covered

5. Height

Feet Inches

**OR** Metres

Feet Inches

**OR** Metres

6. Weight – *If pregnant, please give weight immediately before pregnancy*

Stones Pounds

**OR** Kilos

Stones Pounds

**OR** Kilos

First life covered

- Up to 34 inches or 86cms
- 36 inches or 91cms
- 38 inches or 97cms
- 40 inches or 102cms
- 42 inches or 107cms
- 44 inches or 112cms
- Over 44 inches or 112cms

Second life covered

- Up to 34 inches or 86cms
- 36 inches or 91cms
- 38 inches or 97cms
- 40 inches or 102cms
- 42 inches or 107cms
- 44 inches or 112cms
- Over 44 inches or 112cms

**Answer only if you are male**

7a. What is your trouser size?

*Please select the nearest size. If you wear more than one size, please choose the size you wear most frequently.*

First life covered

- Up to size 10
- Size 12
- Size 14
- Size 16
- Size 18
- Size 20
- Over size 20

Second life covered

- Up to size 10
- Size 12
- Size 14
- Size 16
- Size 18
- Size 20
- Over size 20

**Answer only if you are female**

7b. What is your dress, skirt, or trouser size?

*If you're pregnant, please give your size immediately before pregnancy. If you wear more than one size, please choose the size you wear most frequently.*

# Section 6 – Personal medical history

If you're using this form as non-interactive data capture or paper application and answer yes to any question in section 6 other than questions for asthma, please fill out section 7. If you have not answered yes to any question in this section, please move to section 8.

For all to answer

## 1. Have you ever had:

	First life covered	Second life covered
1a. Any disease or disorder of the heart, aorta or arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1b. Stroke, transient ischaemic attack, brain haemorrhage, brain aneurysm or brain damage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1c. Diabetes, pre-diabetes, impaired glucose tolerance (IGT) or raised blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1d. Any neurological condition, for example multiple sclerosis, optic neuritis, paralysis, cerebral palsy, Parkinson's disease or any form of dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1e. Cancer, Hodgkin's disease, lymphoma, leukaemia, melanoma, or a cyst or tumour of the brain or spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
1f. A positive test for HIV, hepatitis B or hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 2. Within the last ten years have you:

For all to answer

	First life covered	Second life covered
2a. Required hospital treatment for a mental health condition, been referred to or seen by a psychiatrist, or have you attempted suicide or self-harmed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2b. Been prescribed medication or required surgery or monitoring for ulcerative colitis, Crohn's disease or Barrett's oesophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2c. Had any of these symptoms? <ul style="list-style-type: none"> <li>• Blurred or double vision</li> <li>• Numbness, persistent pins and needles or loss of muscle power</li> <li>• Balance problems or dizziness</li> <li>• Tremor</li> <li>• Facial pain</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section 6 – Personal medical history *continued*

3. **Within the last four years** have you had any of the following or required treatment for any of the following:

For all to answer	First life covered	Second life covered
3a. Any mental health condition including anxiety, stress, depression, insomnia or an eating disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3b. Asthma, chronic obstructive pulmonary disease (COPD), or any other condition affecting your lungs or breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>You don't need to tell us about hay fever or symptoms related to Coronavirus (COVID-19) unless the symptoms have not fully resolved.</i>		
<b>If you have asthma:</b>		
3c. In the last five years, have you been admitted to hospital for more than 24 hours because of asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3d. How many days have you taken oral steroid tablets in the last two years?	<input type="text"/> Days	<input type="text"/> Days
3e. How many days have you taken off work because of asthma in the last two years?	<input type="text"/> Days	<input type="text"/> Days
<b>For all to answer</b>		
3f. Raised blood pressure or raised cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>You don't need to tell us about fully resolved pregnancy related high blood pressure.</i>		
3g. A lump, growth, polyp or tumour?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3h. Chest pain, or an ECG or any other heart investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are applying for critical illness cover or employee significant illness</b>		
3i. A mole or freckle that has bled, itched, become painful, changed colour or increased in size?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are female and applying for critical illness cover or employee significant illness</b>		
3j. An abnormal cervical screen (this includes a positive HPV result) or abnormal mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you're applying for critical illness, employee significant illness or waiver of premium</b>		
3k. Any problems with your eyes or ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>You don't need to tell us about sight problems corrected by glasses or contact lenses, laser eye treatment for short/long sight or cosmetic reasons, simple earache and ear infections that have resolved leaving no continuing hearing loss.</i>		
3l. Lupus, fibromyalgia, gout, any form of arthritis or hypermobility disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are applying for total permanent disability or waiver of premium</b>		
3m. Any pain, restriction in movement or injury to your joints, ligaments, tendons or muscles? (This may include your neck, back or shoulders)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Section 6 – Personal medical history *continued*

## 4. Apart from anything you've already told us about, **within the last two years have you:**

4a. Been prescribed any medication or treatment for a continuous period of four weeks or more, or had any counselling?

Yes  No

Yes  No

*You don't need to tell us about the oral contraceptive pill, medication or treatment for pregnancy, marriage or couples counselling, or minor accidents or injuries providing they have not prevented you from performing your daily activities or kept you off work for two weeks or more).*

4b. Been referred to a medical professional or specialist? (Regardless of whether you attended)

Yes  No

Yes  No

4c. Had, or been advised to have any tests, investigations or follow-up appointments with a medical professional? (Regardless of whether you attended)

Yes  No

Yes  No

### Answer only if you're applying for critical illness cover, employee significant illness or waiver of premium

4d. Been absent from work or unable to perform your daily activities due to illness, disorder or injury for more than two weeks at a time?

Yes  No

Yes  No

First life covered

Second life covered

## 5. Apart from anything you've already told us about:

5a. Are you waiting for the results of any test or investigation?

Yes  No

Yes  No

*You don't need to tell us about routine well man/woman clinic appointments, employment medicals, private health medicals or routine fertility or pregnancy monitoring.*

5b. **In the last 3 months** have you had any of these symptoms, even if you have not consulted a doctor?

- Unexplained weight loss
- A lump, growth or cyst
- Bleeding from the bowels or change in bowel habit
- Blood in your urine
- Persistent tiredness or fatigue
- A persistent cough lasting more than three weeks
- A mole of skin blemish which has changed

Yes  No

Yes  No

5c. **In the last month** have you experienced any symptoms for which you have not yet sought medical advice?

Yes  No

Yes  No

*You don't need to tell us about routine pregnancy or fertility appointments.*

### Answer only if you're applying for total permanent disability or waiver of premium

5d. Are you currently unable to work or do you have any condition that restricts your ability to perform your occupation or your normal daily activities?

Yes  No

Yes  No

# Section 7 – Additional health questionnaire

Only fill out this section if you're using this form as a non-interactive data capture or paper application and have answered yes to any question in section 6 other than questions for asthma. Please complete section 7 for each separate condition and continue on a separate sheet available in section 23(7) if necessary.

You only need to provide details of any condition once, even if it relates to more than one question in section 6.

	First life covered	Second life covered
1. In section 6, which question(s) did you answer yes to? For example 1a, 2b etc	<input type="text"/>	<input type="text"/>
2. Condition	<input type="text"/>	<input type="text"/>
3. Are you currently taking or have you been advised to take any medication for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the medication:   <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the medication:   <input type="text"/>

	First life covered	Second life covered
4. Does this condition restrict you from carrying out any routine daily activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the restrictions:   <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the restrictions:   <input type="text"/>

	First life covered	Second life covered
5. When did you last take any time off due to this condition?	Currently off work Within the last three months Between three months and a year ago More than a year ago No time off work	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	First life covered	Second life covered
6. If you have taken time off, how many days have you taken off work because of this condition in the last two years?	<input type="text"/> Days	<input type="text"/> Days

	First life covered	Second life covered
7. When did you last experience any symptoms of this condition?	Currently experiencing symptoms Within the last six months More than six months ago, but within the last year More than one year ago Never experienced symptoms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

# Section 7 – Additional health questionnaire *continued*

8. If you have experienced symptoms, please give details of the symptoms.

First life covered

Second life covered

9. When were you diagnosed with this condition?

No diagnosis made  
 Within the last three months  
 Between three months and a year ago  
 More than a year ago

First life covered

Second life covered

10. Are you under any form of follow up or awaiting investigations or referral for this condition?.

First life covered

Yes       No

If yes, please provide full details including when and where you were first seen or will be seen, and if applicable, when and where you were last seen, how often you are followed up and the type of investigations awaited:

Second life covered

Yes       No

If yes, please provide full details including when and where you were first seen or will be seen, and if applicable, when and where you were last seen, how often you are followed up and the type of investigations awaited:

11. Is there any further information you would like to provide regarding this condition?

Yes       No

If yes, please provide the further information here:

Yes       No

If yes, please provide the further information here:

Please go to sections 23(7) to complete the information for other conditions. You can click [HERE](#) to take you there if completing electronically.

# Section 8 – Family history

If you are aged 50 or over and are applying for life cover only, please move to Section 10

	First life covered	Second life covered
1. Have any of your natural parents, brothers or sisters been diagnosed with, or died from, any of the following before age 60? (You do not need to tell us about half-brothers or half-sisters)		
<b>Answer only if you are female</b>		
Breast or ovarian cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For all to answer</b>		
Heart attack, angina or stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon or bowel cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are aged 60 or under</b>		
Motor neurone disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are aged 55 or under</b>		
Muscular dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Huntington's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are aged 49 or under</b>		
Polycystic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiomyopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are aged 64 or under and applying for critical illness or employee significant illness cover</b>		
Parkinson's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer of another site (cancer other than of the ovary, breast, colon or bowel) including lymphoma and prostate cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are aged 40 or under and applying for critical illness or employee significant illness cover</b>		
Familial adenomatous polyposis (FAP)/polyposis coli	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are applying for critical illness or employee significant illness cover</b>		
Type 2 Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For all to answer</b>		
Don't know as I have no further contact with family members or don't know as I am adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section 8 – Family history *continued*

First life  
covered

Second life  
covered

2. Apart from anything you've already told us about:

### For all to answer

Have you had or been offered screening for any condition that runs in your family (even if you didn't attend or haven't attended yet)?

Yes

No

Yes

No

If you have answered yes to '**Have you had or been offered screening for any condition that runs in your family (even if you didn't attend or haven't attended yet)?**'

Please confirm the condition that runs in your family and provide details of your screening programme, including the results to date.

Please confirm the condition that runs in your family and provide details of your screening programme, including the results to date.

**For non-interactive data capture or paper application only: If you've answered yes to any of the questions in this section, please fill out section 9. If not, please move to section 10.**



# Section 9 – Additional family history

Only fill out this section if you're using this form as a non-interactive data capture or paper application and have answered yes to any question in section 8.

First life covered

Second life covered

1. Condition		
2. Number of family members affected with this condition	<input type="text"/>	<input type="text"/>
3. Please provide the relationship of the relative(s) affected and their age at diagnosis		

If you are unsure of the exact age at diagnosis, please give the approximate age to the best of your knowledge. If there are more than two family members, please continue on a separate sheet.

If there are any further types of family history from Section 8, please disclose them on a separate sheet

4. If you have answered yes to 'colon or bowel cancer,' are you under any form of follow up or surveillance programme regarding your family history?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give full details including the result of any investigations and dates: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give full details including the result of any investigations and dates: <input type="text"/>
--	--	--

Answer only if you are female

5(a). If you have answered yes to 'breast or ovarian cancer', are you under any form of follow up or screening programme regarding your family history?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give full details including the result of any investigations and dates: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give full details including the result of any investigations and dates: <input type="text"/>
5(b). If you have a family history of breast cancer, have you ever undergone investigations, had treatment for, or been diagnosed with any form of breast lump?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please provide full details about this history, including when this was diagnosed, type of lump (if known), details of any treatment, whether the breast lump(s) is present and whether you are under any review or follow-up. <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No Please provide full details about this history, including when this was diagnosed, type of lump (if known), details of any treatment, whether the breast lump(s) is present and whether you are under any review or follow-up. <input type="text"/>

# Section 9 – Additional family history *continued*

First life covered

Second life covered

5(c). If you have a family history of **breast cancer**, have any of your grandparents or aunts been diagnosed with breast cancer before the age of 60?

Yes  No

Yes  No

**Answer only if you're applying for critical illness, employee significant illness or waiver of premium**

6. If you have answered yes to “**cancer of another site (cancer other than of the ovary, breast, colon or bowel) including lymphoma and prostate cancer**”, please advise the type of cancer each family member suffered from:

7. If you have answered yes to “**Multiple sclerosis**”, have you ever been investigated by a Neurologist or had any visual disturbance, persistent pins and needles, balance problems, facial pain (other than dental pain) or numbness which have led to you seeking medical advice?

Yes  No

If yes, please give full details:

Yes  No

If yes, please give full details:

# Section 10 – Residency, travel & sports

First life covered

Second life covered

1. During the last three years, have you spent more than 90 days in total in Africa, the Caribbean, Russia, Thailand or Ukraine?

*You should add together the days spent in these regions but you can ignore holidays lasting less than 1 month and postings as a member of HM Forces.*

Yes  No

If yes, please detail, countries visited, time spent there and dates of travel:

Yes  No

If yes, please detail, countries visited, time spent there and dates of travel:

2. During the next 12 months, do you intend to spend more than 30 days outside of the UK, EU, other Western European countries, North America, Australia or New Zealand? *You can ignore holidays lasting less than one month, business trips of up to one week provided they do not total more than 12 weeks and postings as a member of HM Forces.*

First life covered

Second life covered

Yes  No

Yes  No

First life covered

Second life covered

3. If you answered **yes** to question 2, in the next 12 months do you expect to spend more than six months outside the UK?

Yes  No

If yes, please detail, countries visited, time spent there and dates of travel:

If no, please tell us the names of the countries you intend to reside in or travel to:

Yes  No

If yes, please detail, countries visited, time spent there and dates of travel:

If no, please tell us the names of the countries you intend to reside in or travel to:

## Section 10 – Residency, travel & sports *continued*

**For all to answer**

	First life covered	Second life covered
4. Do you take part in any of the following activities?		
Underwater diving	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mountaineering or rock climbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flying (other than as a fare paying passenger), hang gliding or paragliding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motorcar or motorcycle sport?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parachuting, skydiving or BASE jumping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Answer only if you're applying for critical illness, employee significant illness or waiver of premium**

Caving or potholing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Powerboat racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trans-ocean sailing or offshore racing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Full contact martial arts, combat sport or boxing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any extreme sport, for example bungee jumping (other than one-off bungee jumps), white water rafting, cliff or free diving etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section 11 – Occupation

Please note, if you are using this form for interactive data capture purposes, not all of these questions may appear when inputting into the interactive online system.

**If you're retired and over 50, please move to section 12.**

**Answer only if you are aged 50 or under**

	First life covered	Second life covered
1. Are you a member of the Armed Forces Reserves or Territorial Army?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**For all to answer**

2. Which industry or service do you work in?		
Armed Forces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flying other than as a fare paying passenger or as a member of the armed forces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Commercial underwater diving	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Working on a fishing vessel or trawler	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tunnelling below ground	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Quarrying	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mining	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Working offshore on an oil or gas platform	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Section 11 – Occupation *continued*

	First life covered	Second life covered
Working outside at heights over 15 metres (50 feet) for more than 25% during a typical week	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Merchant marine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prison service	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Police service	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sports professional	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Answer only if you are aged 60 or under**

<p>3. Are you likely to travel as part of your occupation to countries where there are areas of internal conflict or insecurity (other than as a member of the Armed Forces)?</p>	<p>First life covered</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide full details, including the countries you will be travelling to and the reason for the travel:</p> <div style="border: 1px solid black; height: 100px;"></div>	<p>Second life covered</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide full details, including the countries you will be travelling to and the reason for the travel:</p> <div style="border: 1px solid black; height: 100px;"></div>
---	--	---

If you're unsure about the security situation in a country you may visit, please check on the government website at [gov.uk/foreign-travel-advice](http://gov.uk/foreign-travel-advice) and click on travel advice by country. If the Foreign and Commonwealth Office advises against any travel to any part of the country you should answer the question as 'Yes'.

**Answer only if you are retired and are aged 50 or under**

<p>4. Please confirm when you retired, whether your health influenced your retirement, and if so, please tell us about the medical condition.</p>	<p>First life covered</p> <div style="border: 1px solid black; height: 100px;"></div>	<p>Second life covered</p> <div style="border: 1px solid black; height: 100px;"></div>
---	---	--

**Answer only if you are applying for total permanent disability or waiver of premium**

<p>5. Is your work clerical/administrative and based in an office environment for at least 75% of a typical working day?</p>	<p>First life covered</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Second life covered</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>If no, does your job involve carrying, lifting, working with machinery or tools?</p>	
	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>If yes, please advise what percentage of your normal working day is spent carrying out manual duties:</p> <p style="text-align: center;"> <input type="text"/> %             <span style="margin-left: 200px;"><input type="text"/> %</span> </p>	

## Section 11 – Occupation *continued*

6. Does your occupation require you to drive (other than commuting to and from work)?

Yes  No

Yes  No

If yes, what is your annual business mileage?

Less than 10,000 miles

Less than 10,000 miles

10,001 to 25,000 miles

10,001 to 25,000 miles

25,001 to 40,000 miles

25,001 to 40,000 miles

More than 40,000 miles

More than 40,000 miles

## Section 12 – Overall cover

**Answer only if you're applying for life insurance:**

1. Apart from this application, have you applied to Aviva for life insurance within the last 12 months?

Yes  No

Yes  No

If yes, excluding this application, what is the total amount of life insurance cover that you hold with Aviva?

£

£

2. Including this application, will the total amount of life insurance with Aviva or any other company, be more than £1,500,000 (£750,000 if houseperson, unemployed, student or retired)

Yes  No

Yes  No

If no, go to section 13.

If yes, ignoring any existing insurance plans that will definitely be cancelled or replaced by this application and any other applications currently being made that will definitely be cancelled if this application is put into force, how much life insurance will you have when this cover is put into force?

£

£

You'll need this figure in Section 19

You'll need this figure in Section 19

**Answer only if you're applying for critical illness or employee significant illness cover:**

3. Apart from this application, have you applied to Aviva for critical illness or employee significant illness insurance within the last 12 months?

Yes  No

Yes  No

You can ignore any existing policies or outstanding applications which will definitely be cancelled, or replaced by this application. You should not rely on Aviva making checks about previous applications that you have submitted to Aviva.

Employee significant illness is a benefit only available with an Aviva Relevant Life Insurance policy, it is not a form of employee group insurance or sickness cover.

If yes, excluding this application, what is the total amount of critical illness and/or employee significant illness cover that you hold with Aviva?

£

£

4. Including this application, will the total amount of critical illness and/or employee significant illness with Aviva or any other company, be more than £750,000 (£375,000 if house-person, unemployed, student or retired)

Yes  No

Yes  No

Employee significant illness is a benefit only available with an Aviva Relevant Life Insurance policy, it is not a form of employee group insurance or sickness cover.

If no, go to section 13.

If yes, ignoring any existing critical illness and/or employee significant illness plans that will definitely be cancelled or replaced by this application and any other applications currently being made that will definitely be cancelled if this application is put into force, how much critical illness and/or employee significant illness insurance will you have when this cover is put into force?

£

£

You'll need this figure in Section 19

You'll need this figure in Section 19

# Section 13 – Doctor’s details

Please complete this section so we know who to contact if we need medical information.  
For more details, please refer to section 17.

First life covered

Second life covered

1. Name

Doctor's name

**OR** Surgery name

Doctor's name

**OR** Surgery name

2. Surgery address

Address line 1

Address line 2

Town/City

County

Postcode

Address line 1

Address line 2

Town/City

County

Postcode

3. Phone number

**IMPORTANT: Before going any further, please ensure you have answered all questions in sections 5–13 fully, truthfully and accurately. Failure to do so may result in your policy being amended or cancelled, may reduce the amount payable in the event of a claim, or may result in the non-payment of a claim.**

# Section 14 – Payment details



## INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT



Aviva Life & Pensions UK Limited,  
Wellington Row, York, YO90 1WR

**Please fill in the whole form using a ball point pen and send it to: Aviva Life & Pensions UK Limited, PO Box 520, Norwich, NR1 3WG.**

Name and full postal address of your Bank or Building society

To The Manager	Bank/Building Society
Address	
Postcode	

Service user number

2	9	4	0	1	6
---	---	---	---	---	---

Instruction to your Bank or Building Society

Please pay Aviva Life & Pensions UK Limited Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Aviva Life & Pensions UK Limited and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date

Name(s) of Account Holder(s)


Bank/Building Society account number

--	--	--	--	--	--	--	--

Branch Sort code

--	--	--	--	--	--

Reference

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

**This is not part of the Instruction to your Bank or Building Society and must be detached by Aviva Life & Pensions UK Limited before submission to the Paying Bank.**

Account holders address	Address
Preferred payment day (Between 1st and 28th)	Postcode

**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 Aviva Life & Pensions UK Limited will notify you five working days in advance of your account being debited or as otherwise agreed. If you request Aviva Life & Pensions UK Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Aviva Life & Pensions UK Limited or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society.
  - If you receive a refund you are not entitled to, you must pay it back when Aviva Life & Pensions UK Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.





# Section 14 – Payment details



## INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT



Aviva Life & Pensions UK Limited,  
Wellington Row, York, YO90 1WR

**Please fill in the whole form using a ball point pen and send it to: Aviva Life & Pensions UK Limited, PO Box 520, Norwich, NR1 3WG.**

Name and full postal address of your Bank or Building society

To The Manager	Bank/Building Society
Address	
Postcode	

Service user number

2	9	4	0	1	6
---	---	---	---	---	---

Instruction to your Bank or Building Society

Please pay Aviva Life & Pensions UK Limited Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Aviva Life & Pensions UK Limited and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date

Name(s) of Account Holder(s)


Bank/Building Society account number

--	--	--	--	--	--	--	--

Branch Sort code

--	--	--	--	--	--

Reference

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

**This is not part of the Instruction to your Bank or Building Society and must be detached by Aviva Life & Pensions UK Limited before submission to the Paying Bank.**

Account holders address	Address
Preferred payment day (Between 1st and 28th)	Postcode

**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 Aviva Life & Pensions UK Limited will notify you five working days in advance of your account being debited or as otherwise agreed. If you request Aviva Life & Pensions UK Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Aviva Life & Pensions UK Limited or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society.
  - If you receive a refund you are not entitled to, you must pay it back when Aviva Life & Pensions UK Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.



## Section 15 – Important information

The policy conditions and policy summary for the product(s) you are applying for are important and you should take time to read them. You should have already received these documents but if you have not please ask your Financial Adviser for a copy.

If there are any terms that you don't understand then you should ask for further information.

## Section 16 – Data protection

### 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 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 or criminal convictions).

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.

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](https://www.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 insurance risk or the likelihood of fraud).

We may carry out automated decision making to decide on what terms we can provide products and services, deal with claims and carry out fraud checks. 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](mailto: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 our suppliers such as those who provide claims services 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](mailto:dataprt@aviva.com)

## Section 17 – Medical reports

Please read this section carefully as it tells you how we'll obtain your medical information if we need it.

As part of the application process, Aviva asks all customers to give consent for us to request a medical report from their doctor under the Access to Medical Reports Act 1988 (AMRA). We also need your GP details. If you choose not to give consent, or if you're unable to, we will not be able to go ahead with your application. This doesn't stop you from applying to other companies for cover. A report can be sent electronically using secure software or in the post.

A report may be needed to help Aviva make a decision about the insurance you've applied for or within 12 months of your policy starting to help Aviva monitor the quality of customer information provided.

Aviva accepts the vast majority of applications based on customer information alone without obtaining upfront medical evidence. After the policy has started, we will obtain a doctor's report for a selection of these customers, to ensure the application questions have been answered accurately. We call this post-issue sampling, and the possible outcomes of this are:

- The policy will remain in force on the original terms.
- If evidence is received showing that the policy would have been offered on different terms, the policy will be amended to reflect this.
- If evidence shows information that means we wouldn't have offered a policy, the policy will be cancelled, and premiums refunded.

Aviva will tell you if it needs to ask your doctor to prepare a medical report and will use the consent you give to do this. Your doctor will use your medical records to complete a medical report. Usually the report will be sent directly to us. However, you can ask to see it before it's sent to us. We'll use the report to assess your application, for audit purposes or in the event of a claim.

### What we'll ask for

We'll ask your doctor:

- for information about your medical history, including details of any relevant illnesses, trauma, hospital admissions, medical consultations, referrals, tests or investigations and treatments you may have had
- about your current health including any care, medication or treatment you're receiving and the results of any referrals or tests you're waiting for.

We won't ask your doctor:

- for information about any negative tests for HIV, hepatitis B or C, or any sexually-transmitted diseases unless there could be long term effects on your health
- about any predictive genetic test results unless this application, together with any existing cover, will total over £500,000 of life insurance. If your cover is over this limit, we only need to know about predictive tests for Huntington's disease. You can tell us about any negative predictive test results, because it may help your application.

You can find two copies of the Aviva Access to Medical Reports Declaration in Section 22.

## Section 18 (a) – Residency criteria for Business Life Insurance Options

Please read this section carefully as it tells you the residency criteria that you need to fulfil in order to apply for the policy.

At the time you complete the application, both you and the life covered must:

1. be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
2. consider your main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.

Companies must be incorporated and registered in the UK.

You need to tell us if you move outside of the UK, the Channel Islands, Isle of Man or Gibraltar, and your main residence is in another

territory, or if your business ceases to be incorporated and registered in the UK. Laws in the territory you become resident in may affect your ability to continue to benefit fully from the features of your policy. We may need to change, reduce or remove any of your policy terms. We'll give you details once you've told us. You should seek your own independent advice to consider your options if you move to another territory.

Regardless of what is set out elsewhere in the policy terms we will not be obliged to exercise any of our rights and/or comply with any of our obligations under this policy, if to do so would cause, or be reasonably likely to cause, us to breach any law or regulation in any territory.

## Section 18 (b) – Residency criteria for Relevant Life Insurance

Please read this section carefully as it tells you the residency criteria that you need to fulfil in order to apply for the policy.

At the time of application both you and the life covered must:

1. be in the UK, with a legal right to live in that jurisdiction, and
2. consider your main home as being in the UK and have no current intention of moving anywhere else permanently, and
3. be a UK taxpayer.

Companies must be incorporated and registered in the UK.

You need to tell us if you move outside of the UK, or if your business ceases to be incorporated and registered in the UK. Laws in the

territory you become resident in may affect your ability to continue to benefit fully from the features of your policy. We may need to change, reduce or remove any of your policy terms. We'll give you details once you've told us. You should seek your own independent advice to consider your options if you move to another territory.

Regardless of what is set out elsewhere in the policy terms we will not be obliged to exercise any of our rights, and/or comply with any of our obligations under this policy, if to do so would cause, or be reasonably likely to cause, us to breach any law or regulation in any territory.

## Section 19 – Financial Crime

To verify your identity and prevent financial crime, your information may be used by any company within the Aviva group. It may also be shared with third parties who provide services to us, and any other organisations, where required to by law and regulation.

We may record any searches carried out. These, and any suspicion of financial crime, may be used to help other companies with verification and identification. The search isn't a credit check and your credit rating shouldn't be affected.

# Section 20 – Declaration to Aviva Life & Pensions UK Limited ('Aviva')

Policy numbers:

1.	2.	3.
4.	4.	6.

## For use with Relevant Life Insurance and Business Life Insurance Options only.

To continue with your application, you will need to read and sign this declaration:

### For Relevant Life Insurance:

- **If you're the employee** - you should read part 1 of the declaration then sign and date as the first life covered.
- **If you're the employer** - you should read part 3 of the declaration (over the page) then sign and date as the policyholder.

Once the declaration has been signed and dated by both the employee and employer, return it to us.

**Important: For Relevant Life Insurance both the employer and employee must be incorporated and registered/resident in the UK.**

### For Business Life Insurance Options:

- **If you're a life covered and a policyholder** – you should read part 1 and part 2 of the declaration. Unless you're applying online, please sign and date the declaration and return it to us.
- **If you're a life covered only** – you should read part 1 of the declaration then sign, date and return it to us.
- **If you're a policyholder only** – you should read part 3 of the declaration (over the page) then sign, date and return it to us.

#### Part 1 – If you're a life covered please read this section.

I confirm:

- The answers I've provided about my health and lifestyle are truthful, accurate and complete.
- I'm aware that if any of the information I have provided is not truthful, accurate or complete, and this might have reasonably affected their decision to provide cover, Aviva may amend or cancel the policy, may reduce the amount payable in the event of a claim, or may not pay a claim.
- I'll check my answers to the health and lifestyle questions in the Personal details confirmation form sent to me, and will let Aviva know within 14 days if anything is incorrect. If I don't receive this document within 10 days then I'll contact Aviva so that they can send me another one.
- I'll let Aviva know if any of my answers to the health and lifestyle questions change before they confirm when cover will start. I'm aware that any changes may result in alterations to the cover, premium or benefits offered.
- I've read the important information about how medical information can be obtained from my doctor, either for the purposes of assessing my application, or for audit purposes, and I agree to give my written consent to such information being obtained, if required.
- I'm aware that Aviva may need to seek medical information in the event of a claim and I also agree to provide my authority for this.
- I give my authority for Aviva, and any company within the Aviva group, to seek relevant information from other insurers if I have applied, or am currently applying, for a policy with them.
- I've read the data protection statement section, which explains how my personal data will be held and used, and am happy to continue with this application.
- **For Business Life Insurance Options only:** I'm currently living in the UK, The Channel Islands, the Isle of Man or Gibraltar and meet the residency criteria as confirmed in section 18(a).
- **For Relevant Life Insurance only:** I'm currently living in the UK and meet the residency criteria as confirmed in section 18(b).

#### Part 2 – If you're a policyholder and a life covered, please read this section (in addition to Part 1 above).

I confirm:

- I'm aware of the importance of reading the Policy conditions and Policy summary for the policy or policies I am applying for and that these documents, together with my Policy schedule, the Personal details confirmation, this Declaration and any information given in the application process will apply to my policy.
- I understand that the Policy conditions are written subject to the laws of England.
- **For Business Life Insurance Options only:** I'm currently living in the UK, The Channel Islands, the Isle of Man or Gibraltar and meet the residency criteria as confirmed in section 18(a).
- I've read the Financial Crime section and understand Aviva, or a company within the Aviva group of companies, may need to verify my identity and address using the services of a third party company.
- I understand that it may be necessary to assess my application and that cover will not start until Aviva has accepted my application, received a Direct Debit mandate and confirmed when cover will start.

#### First life covered

Name

Signature

Date

#### Second life covered (if any)

Name

Signature

Date

# Section 20 – Declaration to Aviva Life & Pensions UK Limited ('Aviva') *continued*

**Part 3 – If you're a policyholder only please read this section.**

I confirm:

- I'm aware of the importance of reading the Policy conditions and Policy summary for the policy or policies I am applying for and that these documents, together with my Policy schedule, the Personal details confirmation, this Declaration and any information given in the application process will apply to my policy.
- I understand that the Policy conditions are written subject to the laws of England.
- I've read the Financial Crime section and understand Aviva, or a company within the Aviva group of companies, may need to verify my identity and address using the services of a third party company.
- I've read the data protection statement section, which explains how my personal data will be held and used, and am happy to continue with this application.
- I'm aware it may be necessary to assess my application and that cover will not start until Aviva has accepted my application, received a Direct Debit mandate and confirmed when cover will start.
- I understand cover is provided on the basis that the answers provided by the life or lives covered are truthful, accurate and complete.
- I'm aware that if any of the information the life or lives covered have provided is not truthful, accurate or complete, and this might have reasonably affected their decision to provide cover, Aviva may amend or cancel the policy, may reduce the amount payable in the event of a claim, or may not pay a claim.
- **For Business Life Insurance Options only:** I'm currently living in the UK, The Channel Islands, the Isle of Man or Gibraltar and meet the residency criteria as confirmed in section 18(a).
- **For Relevant Life Insurance only:** I'm currently living in the UK and meet the residency criteria as confirmed in section 18(b). Or where the policyholder is an organisation, I confirm the company is registered and incorporated in the UK.

**If the policyholder is an individual, please sign below.**

**First Policyholder**

Name

Signature

Date

**Second Policyholder (if any)**

Name

Signature

Date

**If the policyholder is an organisation, please sign below.**

**First Authorised Signatory**

Position

Name

Signature

Date

**Second Authorised Signatory (if any)**

Position

Name

Signature

Date

## Confidential financial questionnaire

**IMPORTANT: You must answer all questions fully, truthfully and accurately. Failure to do so may result in your policy being amended or cancelled, may reduce the amount payable in the event of a claim, or may result in the non-payment of a claim.**

# Section 21 – Financial information section

Only fill out this section if you need to give us financial information. The financial information we require depends on the cover amount(s) you provided in Section 12 (Questions 2 & 4):

Up to £1,500,000 life insurance

Up to £750,000  
critical illness and/or employee significant  
illness cover

No financial information is routinely required.

For housepersons and non-earners (eg student, retired, unemployed), we'll need our full financial questionnaire if the overall cover exceeds £750,000 life insurance or £375,000 critical illness and/or employee significant illness cover.

£1,500,001 to £2,500,000  
life insurance

£750,001 to £1,000,000  
critical illness and/or employee significant  
illness cover

Please complete the short financial questionnaire that follows.

>£2,500,000 life insurance

>£1,000,000 critical illness and/or employee  
significant illness cover

Please complete our separate Full Financial Questionnaire - which can be downloaded from:  
<http://www.aviva-for-advisers.co.uk/adviser/site/public/contact-us/protection>

(We will consider a copy of the fact find instead, for overall cover up to £3m life insurance and £1.5m critical illness and/or employee significant illness cover)

Where the total cover with Aviva exceeds  
£4m life insurance or £2m critical illness  
and/or employee significant illness cover

Full financial questionnaire and appropriate supporting evidence:

- Copy of P60 (or equivalent) if application is for relevant life.
- Loan offer letters if related to new loans, or latest statements for existing loans.
- Last 2 years accounts for key person, shareholder/partnership, private equity, venture capital, management buy out/in. (If you don't have these accounts, we'll try and get them from Companies House.)

Are you able to provide this information now?  Yes  No

If **no**, please either post the short or full financial questionnaire to Aviva,  
PO Box 520, Norwich, NR1 3WG or e-mail it to [protection@aviva.com](mailto:protection@aviva.com),  
in which case please add application number:

# Section 21 – Short financial questionnaire

Please complete this section and the questions & declaration(s) that follow.

Reason for the application(s)  
(complete for all that apply)

If you answer **"yes"** to any of the questions asked in this short questionnaire, then you will also need to complete our full financial questionnaire.

First life  
covered

Second life  
covered (if any)

Key person

Based on the last 12 months audited accounts, what was the Net Profit Before Tax?

£

£

Will the total amount of cover between all key persons for this business exceed Net Profit Before Tax x 5 Life, or x 3 CI?

Yes  No

Yes  No

Business loan

What is the amount of the business loan?

£

£

Will the amount of cover or expiry date exceed the loan amount this person is responsible for, or repayment date?

Yes  No

Yes  No

## Section 21 – Short financial questionnaire *continued*

If you answer “**yes**” to any of the questions asked in this short questionnaire, then you will also need to complete our full financial questionnaire.

		First life covered	Second life covered (if any)
Shareholder/Partnership	Based on the last 12 months audited accounts, what was the Net Profit After Tax?	£ <input type="text"/>	£ <input type="text"/>
	Does the valuation of the business exceed 8 x Net Profit After Tax?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relating to private equity, venture capital, management buy out/in		Complete our full financial questionnaire	Complete our full financial questionnaire
Relevant life	What is the gross annual earned income for tax purposes for the last 12 months ( <b>excluding</b> unearned income such as investment income)?	£ <input type="text"/>	£ <input type="text"/>
	Is the overall amount of personal cover more than the earned income in the last 12 months x multiple for age? (See help box *)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other reason?		Complete our full financial questionnaire	Complete our full financial questionnaire

### \*Help box: Multiples of earned income for age & benefit

These multiples are the maximum for this short questionnaire. Higher multiples may be available but you'll need to complete the full financial questionnaire.

Age range	Multiple of earned income for life insurance	Multiple of earned income for critical illness and/or employee significant illness cover
Up to 35	27	10
36-45	21	8
46-55	15	6
56-65	9	4
66 up	6	n/a



# Section 21 – Short financial questionnaire *continued*

		First life covered	Second life covered
<p>1. Financial related crime</p>	<p>Has the life covered been investigated, arrested, charged, convicted or have a prosecution pending for any of the following: Bribery, corruption, embezzlement, fraud, money laundering or tax evasion?</p> <p>Please ignore any conviction that is spent under the Rehabilitation of Offenders Act.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		(If yes, please answer question 2)	

<p>2. If yes, please give their name and the type of offence(s), the date of the conviction(s) and length of sentence(s), and the current position of any pending prosecution.</p>	
--	--

**Declaration & signatures (To be completed if this form is sent to us after the application is submitted).**

**IMPORTANT: You must answer all questions fully, truthfully and accurately. Failure to do so may result in your policy being amended or cancelled, may reduce the amount payable in the event of a claim, or may result in the non-payment of a claim.**

Declaration: All the information on this questionnaire, and all other declarations relating to it, is truthful, accurate and complete.

Additional declaration by each policyholder wishing to insure the life of another person - I agree that this questionnaire, and all other declarations relating to it, will form the basis of the contract with Aviva.

<p><b>Signature of first life covered</b></p> <p>Name <input style="width: 100%;" type="text"/></p> <p>Signature <input style="width: 100%;" type="text"/></p> <p>Date <input style="width: 100%;" type="text"/></p>	<p><b>Signature of second life covered (if any)</b></p> <p>Name <input style="width: 100%;" type="text"/></p> <p>Signature <input style="width: 100%;" type="text"/></p> <p>Date <input style="width: 100%;" type="text"/></p>
<p><b>Additional signature required if the policyholder is not the life covered, or the life covered is not an authorised signatory for the policyholder</b></p> <p>Name <input style="width: 100%;" type="text"/></p> <p>Signature <input style="width: 100%;" type="text"/></p> <p>Date <input style="width: 100%;" type="text"/></p>	<p><b>Details of person signing as policyholder</b></p> <p>Name <input style="width: 100%;" type="text"/></p> <p>Signature <input style="width: 100%;" type="text"/></p> <p>Date <input style="width: 100%;" type="text"/></p>

**IMPORTANT: Before going any further, please ensure you have answered all questions in Section 19 fully, truthfully and accurately. Failure to do so may result in your policy being amended or cancelled, may reduce the amount payable in the event of a claim, or may result in the non-payment of a claim.**



# Section 22 – Aviva Access to Medical Reports declaration

## FOR FINANCIAL ADVISER USE ONLY

Application reference

B	A	P							
---	---	---	--	--	--	--	--	--	--

### Authority for Aviva to approach your doctor to obtain medical information in connection with your application.

#### What you need to do

Please read the following information (in particular, **Your rights under the Access to Medical Reports Act 1988** section on the back of this form before signing as it contains details of your rights and what information we will and will not request.

You should complete sections 1 and 2 of this form and send back to us as quickly as possible to ensure we can make a decision on your application.

Please return the form to:

The Chief Medical Officer

Aviva

PO Box 520

Norwich

NR1 3WG

### Section 1 – Your details

Your full name

Your date of birth

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

### Section 2 – Declaration

#### I confirm that:

- I've read the contents of this consent form, including **Your rights under the Access to Medical Reports Act 1988** section. I know what information Aviva needs, and why.
- I give my consent to Aviva seeking (i) a medical report from any doctor I've consulted under AMRA and/or (ii) any other information which is relevant to the assessment of my application.
- I give my consent to any doctor I've consulted to release and provide to Aviva any information concerning my physical and/or mental health which Aviva considers is relevant to the assessment of my application. Aviva will use this form as proof that I've given them my consent to request other relevant information from my doctor.
- My consent is valid for 12 months from the date of this consent form, or until the assessment of my application has been completed.

#### Please confirm whether you want to see the report before it is sent to us.

Yes I want to see the report

No I don't want to see the report

Signature

Today's Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

# Section 22 – Aviva Access to Medical Reports declaration

*continued*

## **Your rights under the Access to Medical Reports Act 1988:**

Before we can ask a doctor to give us a medical report, you need to give your consent under the Access to Medical Reports Act 1988 (or if you live in Northern Ireland or the Isle of Man, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Isle of Man Access to Health Records and Reports Act 1993 respectively) (collectively referred to as “AMRA”).

This is specific legislation which allows insurers, like Aviva, to obtain a medical report with your consent.

We may need to ask for additional information (such as specialist letters or test results) from your doctor to give us the information we need to fully assess the application.

Please be assured that we'll only ask for, and take into account, the medical information that we need to in relation to your application. We respect the confidentiality and privacy of your information and will ensure that your medical information isn't kept for longer than is necessary and is safe in our hands. We may also need to send it to other third parties, such as reinsurers, to help assess your application.

## **Your rights under this Act are as follows:**

You can change your mind at any time before your doctor sends the medical report to us. Just contact the team on **0800 2851 098/+44 1603 603 479** or your doctor directly. However, if you do withhold/withdraw your consent, we may not be able to go ahead with your application. Where your policy has already been set up, withholding/withdrawing your consent may result in your policy being cancelled and premiums refunded.

You can ask to see the report before your doctor sends it to us. If this is the case, we'll tell the doctor you wish to see the report. Your doctor will keep the report for 21 days so you can arrange to see it. If you've not made arrangements to see the report within this time, your doctor will send it to us, unless you withdraw consent for us to access the report.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. If you ask to see a copy of the report at a later date, you can speak to your doctor, or ask us. If you ask us, we may need to consult with your doctor before providing a copy of the report.

If you think any part of the report isn't correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report. Or, you can withdraw your consent and ask your doctor not to send your medical report to us.

In some circumstances the doctor may decide, in the interests of your health, or to respect the interests of other persons, that you should not see all or part of the medical report. The doctor will tell you of this and you will have the right to see any remaining part of the report. If the doctor decides that you should not see any of the report, it may be that they will not give it to us without your consent.

## **Detail about the type of information that will be provided in the GP's medical report:**

Our preference is to request an electronic report using secure software. Electronic reports are more comprehensive and can be requested and returned to us more quickly. We would request a manual (paper) report if your GP doesn't have the software to produce an electronic report.

### **For electronic reports:**

The medical report your doctor completes will contain the following, where applicable:

- Details of major conditions which impact on your long-term health, for example:
  - Malignancy (cancer), cardiovascular (heart) disease and diabetes.
  - Neurological conditions, such as Multiple Sclerosis or Alzheimer's Disease.
  - Suicidal thoughts or attempts at suicide.
  - Conditions related to drug or alcohol misuse or smoking.
- Details of referrals from the last 10 years, for example a referral to a specialist at a hospital.
- Details of relevant medical consultations you have had over the last 10 years. (Information from consultations not considered relevant to your application, for example details regarding uncomplicated pregnancy, or minor conditions such as acne or chicken pox, will not be included in the report).
- Details of investigations such as biopsies, blood tests, electrocardiograms (heart tests), urinalyses (tests on urine), x-rays or other investigations from the last 10 years.
- Copies of any hospital letters from the last 5 years.
- Medication prescribed within the last 5 years.
- Details of blood pressure, cholesterol and height/weight recordings in the last 3 years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

### **For manual reports:**

The medical report your doctor fills in asks about the following:

- Your current health including any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health including details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your doctor or any other medical adviser, therapist or counsellor, in particular if you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;

## Section 22 – Aviva Access to Medical Reports declaration

*continued*

- musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
  - suicidal thoughts or attempts at suicide; or – conditions related to drug or alcohol misuse or smoking or chewing tobacco
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
  - Any blood pressure readings in the last three years or
  - Any history of disease among your parents or brothers or sisters that you have told your doctor about.

### **In both reports we will not ask your doctor to reveal information about:**

- Negative tests for HIV, hepatitis B or C;
- Any sexually-transmitted diseases unless there could be long-term effects on your health.
- Any predictive genetic test results (except genetic tests for Huntington's disease, but only when the total amount of your life cover is more than £500,000.)

If this information is included, we'll disregard it. If your doctor does include reference to other unfavourable predictive genetic test results, we will not take these into account when assessing your application or considering a claim.

If your doctor includes reference to favourable genetic test results, we can take these into account if they show that you haven't inherited a condition your family suffers from.

If you have any questions about your rights under the Act or the process of getting, assessing or storing medical information, please write to: **Chief Medical Underwriter, Aviva, Wellington Row, York, YO90 1WR.**

### **The information you and your doctor provide about your health may result in us:**

- Setting premiums at standard rates
- Increasing premiums above standard rates,
- Applying exclusions, or
- Refusing to provide insurance or, where insurance has already been provided, cancelling your policy.

# Section 22 – Aviva Access to Medical Reports declaration

## FOR FINANCIAL ADVISER USE ONLY

Application reference

B

A

P

## Authority for Aviva to approach your doctor to obtain medical information in connection with your application.

### What you need to do

Please read the following information (in particular, **Your rights under the Access to Medical Reports Act 1988** section on the back of this form before signing as it contains details of your rights and what information we will and will not request.

You should complete sections 1 and 2 of this form and send back to us as quickly as possible to ensure we can make a decision on your application.

Please return the form to:

The Chief Medical Officer

Aviva

PO Box 520

Norwich

NR1 3WG

## Section 1 – Your details

Your full name

Your date of birth

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

## Section 2 – Declaration

### I confirm that:

- I've read the contents of this consent form, including **Your rights under the Access to Medical Reports Act 1988** section. I know what information Aviva needs, and why.
- I give my consent to Aviva seeking (i) a medical report from any doctor I've consulted under AMRA and/or (ii) any other information which is relevant to the assessment of my application.
- I give my consent to any doctor I've consulted to release and provide to Aviva any information concerning my physical and/or mental health which Aviva considers is relevant to the assessment of my application. Aviva will use this form as proof that I've given them my consent to request other relevant information from my doctor.
- My consent is valid for 12 months from the data of this consent form, or until the assessment of my application has been completed.

### Please confirm whether you want to see the report before it is sent to us.

Yes I want to see the report

No I don't want to see the report

Signature

Today's Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

# Section 22 – Aviva Access to Medical Reports declaration

*continued*

## **Your rights under the Access to Medical Reports Act 1988:**

Before we can ask a doctor to give us a medical report, you need to give your consent under the Access to Medical Reports Act 1988 (or if you live in Northern Ireland or the Isle of Man, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Isle of Man Access to Health Records and Reports Act 1993 respectively) (collectively referred to as “AMRA”).

This is specific legislation which allows insurers, like Aviva, to obtain a medical report with your consent.

We may need to ask for additional information (such as specialist letters or test results) from your doctor to give us the information we need to fully assess the application.

Please be assured that we'll only ask for, and take into account, the medical information that we need to in relation to your application. We respect the confidentiality and privacy of your information and will ensure that your medical information isn't kept for longer than is necessary and is safe in our hands. We may also need to send it to other third parties, such as reinsurers, to help assess your application.

## **Your rights under this Act are as follows:**

You can change your mind at any time before your doctor sends the medical report to us. Just contact the team on **0800 2851 098/+44 1603 603 479** or your doctor directly. However, if you do withhold/withdraw your consent, we may not be able to go ahead with your application. Where your policy has already been set up, withholding/withdrawing your consent may result in your policy being cancelled and premiums refunded.

You can ask to see the report before your doctor sends it to us. If this is the case, we'll tell the doctor you wish to see the report. Your doctor will keep the report for 21 days so you can arrange to see it. If you've not made arrangements to see the report within this time, your doctor will send it to us, unless you withdraw consent for us to access the report.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. If you ask to see a copy of the report at a later date, you can speak to your doctor, or ask us. If you ask us, we may need to consult with your doctor before providing a copy of the report.

If you think any part of the report isn't correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report. Or, you can withdraw your consent and ask your doctor not to send your medical report to us.

In some circumstances the doctor may decide, in the interests of your health, or to respect the interests of other persons, that you should not see all or part of the medical report. The doctor will tell you of this and you will have the right to see any remaining part of the report. If the doctor decides that you should not see any of the report, it may be that they will not give it to us without your consent.

## **Detail about the type of information that will be provided in the GP's medical report:**

Our preference is to request an electronic report using secure software. Electronic reports are more comprehensive and can be requested and returned to us more quickly. We would request a manual (paper) report if your GP doesn't have the software to produce an electronic report.

### **For electronic reports:**

The medical report your doctor completes will contain the following, where applicable:

- Details of major conditions which impact on your long-term health, for example:
  - Malignancy (cancer), cardiovascular (heart) disease and diabetes.
  - Neurological conditions, such as Multiple Sclerosis or Alzheimer's Disease.
  - Suicidal thoughts or attempts at suicide.
  - Conditions related to drug or alcohol misuse or smoking.
- Details of referrals from the last 10 years, for example a referral to a specialist at a hospital.
- Details of relevant medical consultations you have had over the last 10 years. (Information from consultations not considered relevant to your application, for example details regarding uncomplicated pregnancy, or minor conditions such as acne or chicken pox, will not be included in the report).
- Details of investigations such as biopsies, blood tests, electrocardiograms (heart tests), urinalyses (tests on urine), x-rays or other investigations from the last 10 years.
- Copies of any hospital letters from the last 5 years.
- Medication prescribed within the last 5 years.
- Details of blood pressure, cholesterol and height/weight recordings in the last 3 years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

### **For manual reports:**

The medical report your doctor fills in asks about the following:

- Your current health including any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health including details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your doctor or any other medical adviser, therapist or counsellor, in particular if you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;

## Section 22 – Aviva Access to Medical Reports declaration

*continued*

- musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
  - suicidal thoughts or attempts at suicide; or – conditions related to drug or alcohol misuse or smoking or chewing tobacco
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
  - Any blood pressure readings in the last three years or
  - Any history of disease among your parents or brothers or sisters that you have told your doctor about.

### **In both reports we will not ask your doctor to reveal information about:**

- Negative tests for HIV, hepatitis B or C;
- Any sexually-transmitted diseases unless there could be long-term effects on your health.
- Any predictive genetic test results (except genetic tests for Huntington's disease, but only when the total amount of your life cover is more than £500,000.)

If this information is included, we'll disregard it. If your doctor does include reference to other unfavourable predictive genetic test results, we will not take these into account when assessing your application or considering a claim.

If your doctor includes reference to favourable genetic test results, we can take these into account if they show that you haven't inherited a condition your family suffers from.

If you have any questions about your rights under the Act or the process of getting, assessing or storing medical information, please write to: **Chief Medical Underwriter, Aviva, Wellington Row, York, YO90 1WR.**

### **The information you and your doctor provide about your health may result in us:**

- Setting premiums at standard rates
- Increasing premiums above standard rates,
- Applying exclusions, or
- Refusing to provide insurance or, where insurance has already been provided, cancelling your policy.

# Section 23 (4) – Additional product details: Business Life Insurance Options

How to use this form: Please number the policies you apply for in the space provided as this will be needed later in the form.

**Notes:**

Note 1: Premium basis applies to both lives

Note 2: Only available with single life policies

Note 3: Renewal option only available with level life cover, level life & critical illness cover with guaranteed premiums

Note 4: Conversion option only available with level life cover

Note 5: Increasing cover is not available with conversion & renewal option or on decreasing cover

Note 6: Total permanent disability option is only available with critical illness

Note 7: Instalment option is not available with decreasing cover

	No. <input type="text"/>	No. <input type="text"/>
Life covered	<input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both	<input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both
Policyholder	<input type="checkbox"/> As above <input type="checkbox"/> First policyholder <input type="checkbox"/> Second policyholder	<input type="checkbox"/> As above <input type="checkbox"/> First policyholder <input type="checkbox"/> Second policyholder
Cover type	<input type="checkbox"/> Level <input type="checkbox"/> Decreasing Policy interest rate (4-18% to 2 decimal places) <input type="text"/> %	<input type="checkbox"/> Level <input type="checkbox"/> Decreasing Policy interest rate (4-18% to 2 decimal places) <input type="text"/> %
	With critical illness <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both	With critical illness <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both
Life & critical illness premium basis <small>Note 1</small>	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable	<input type="checkbox"/> Guaranteed <input type="checkbox"/> Reviewable
Cover	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Term	No. of years <input type="text"/> <u>OR</u> Until age <input type="text"/> <small>Note 2</small>	No. of years <input type="text"/> <u>OR</u> Until age <input type="text"/> <small>Note 2</small>
Premium frequency	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
Options	<input type="checkbox"/> Renewal <small>Note 3</small> <input type="checkbox"/> Conversion <small>Note 4</small>	<input type="checkbox"/> Renewal <small>Note 3</small> <input type="checkbox"/> Conversion <small>Note 4</small>
	<input type="checkbox"/> Increasing cover <small>Note 5</small> Increasing cover rate <input type="checkbox"/> 3% <input type="checkbox"/> 5% <input type="checkbox"/> RPI	<input type="checkbox"/> Increasing cover <small>Note 5</small> Increasing cover rate: <input type="checkbox"/> 3% <input type="checkbox"/> 5% <input type="checkbox"/> RPI
	Waiver of premium <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both Deferred period – first life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months Deferred period – second life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months	Waiver of premium <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both Deferred period – first life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months Deferred period – second life <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months
	<input type="checkbox"/> Total permanent disability <small>Note 6</small> <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both	<input type="checkbox"/> Total permanent disability <small>Note 6</small> <input type="checkbox"/> First life <input type="checkbox"/> Second life <input type="checkbox"/> Both
	Instalment option <small>Note 7</small> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of yearly instalments: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	Instalment option <small>Note 7</small> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of yearly instalments: <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
	Will this replace an existing Aviva policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give existing Aviva policy number(s)	<input type="text"/>	<input type="text"/>



# Section 23 (3) – Additional Policyholder details

For the Business Life Insurance Options product applications, start at question 1. For Relevant Life Insurance applications, start at question 2.

1. Are the lives covered the same as the policyholders?	<input type="checkbox"/> Yes Go to Section 23 (4)	<input type="checkbox"/> No Fill out below
---	--	---

2. Is the policyholder a company?	<input type="checkbox"/> Yes Fill out question 3 and questions 7 – 13	<input type="checkbox"/> No Fill out questions 4 – 13
-----------------------------------	--	--

First policyholder

Second policyholder

3. Company/employer name. <i>For Relevant Life Insurance applications, the policyholder will always be the life covered's employer.</i>		
--	--	--

4. Title		
----------	--	--

5. Name	First name	First name
	Middle name	Middle name
	Last name	Last name

6. Date of birth	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
------------------	---	---

7. Phone number	Home	Home
	Mobile	Mobile

8. Email <i>Not required if policyholder is a company</i>		
--	--	--

9. Address	Address line 1	Address line 1
	Address line 2	Address line 2
	Town/City	Town/City
	County	County
	Postcode	Postcode



## Section 23 (3) – Additional Policyholder details *continued*

		First policyholder	Second policyholder
10. What is the reason for cover?	Key Person Protection Business Loan Protection Shareholder/Partnership Protection Relevant Life	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11. Is this policy to be under trust from the start date?	<i>For Relevant Life Insurance applications, the answer must always be 'Yes'</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. What is the policyholder's relationship to the second life covered?	Employer (Key Person) Employer (Shareholder Protection) Employer (Business Loan Protection) Employer (Business Partnership) Co-employee (Shareholder Protection) Co-employee (Business Loan Protection) Co-employee (Business Partnership) Employer (Relevant Life)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13. What is the policyholder's relationship to the first life covered?	Employer (Key Person) Employer (Shareholder Protection) Employer (Business Loan Protection) Employer (Business Partnership) Co-employee (Shareholder Protection) Co-employee (Business Loan Protection) Co-employee (Business Partnership) Employer (Relevant Life)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

# Section 23 (7) – Additional health questionnaire

Only complete this section if you've more conditions to tell us about, as per the notes in section 7.

Please print extra copies of section 23 (7) if required.

	First life covered	Second life covered
1. In Section 6, which question did you answer yes to?	<input type="text"/>	<input type="text"/>
2. Condition	<input type="text"/>	<input type="text"/>
3. Are you currently taking or have you been advised to take any medication for this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the medication:   <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the medication:   <input type="text"/>
4. Does this condition restrict you from carrying out any routine daily activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the restrictions:   <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details of the restrictions:   <input type="text"/>

		First life covered	Second life covered
5. When did you last take any time off due to this condition?	Currently off work Within the last three months Between three months and a year ago More than a year ago No time off work	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6. If you have taken time off, how many days have you taken off work because of this condition in the last two years?		<input type="text"/> Days	<input type="text"/> Days
7. When did you last experience any symptoms of this condition?	Currently experiencing symptoms Within the last six months More than six months ago, but within the last year More than one year ago Never experienced symptoms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>



## Section 23 (7) – Additional health questionnaire *continued*

8. If you have experienced symptoms, please give details of the symptoms.

First life covered

Second life covered

9. When were you diagnosed with this condition?

No diagnosis made  
 Within the last three months  
 Between three months and a year ago  
 More than a year ago

First life covered





Second life covered





10. Are you under any form of follow up or awaiting investigations or referral for this condition?

First life covered

Yes  No

If yes, please provide full details including when and where you were first seen or will be seen, and if applicable, when and where you were last seen, how often you are followed up and the type of investigations awaited:

Second life covered

Yes  No

If yes, please provide full details including when and where you were first seen or will be seen, and if applicable, when and where you were last seen, how often you are followed up and the type of investigations awaited:

11. Is there any further information you would like to provide regarding this condition?

First life covered

Yes  No

If yes, please provide the further information here:

Second life covered

Yes  No

If yes, please provide the further information here:

**If you have any more conditions please complete them on extra printed copies of section 23 (7). Once you've completed your additional conditions, please go to section 8 to carry on with the application. You can click [HERE](#) to take you there if completing electronically.**

| Retirement | Investments | Insurance | Health |

**Aviva Life & Pensions UK Limited.** Registered in England No 3253947. Aviva, Wellington Row, York, YO90 1WR. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Firm Reference Number 185896. Member of the Association of British Insurers.

[aviva.co.uk](https://www.aviva.co.uk)

AL99017 06/2023 © Aviva

