International Statement of Health and Insurability

You may be required to complete this statement of health and insurability for a number of reasons including, but not limited to, a change of insurability status of the life assured and reinstatement of your policy. Please note that only policies that have been lapsed within 12 months will be considered for reinstatement, subject to underwriting and the full payment of the outstanding premiums.

Name | Policy number

Part 1 – Important Information – this form is to be completed by the life to be assured.

It is essential that you read this part before completing the International Statement of Health and Insurability.

If you make any mistakes while completing this Statement, please cross out the error and write the new information clearly. You must initial each correction. Do not use correction fluid or other ways of deleting incorrect information. If you require more space to write your answers, please attach an additional sheet to this Statement.

Additional sheet attached Yes ☐ No ☐

1 Disclosure of all relevant information

- **Help us to assess your International Statement of Health and Insurability by giving us all the information we ask for. All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we will have the legal right to cancel any policy issued as a result of your Statement and to not pay any claim.**
- **IF ANYTHING ABOUT YOUR HEALTH OR CIRCUMSTANCES CHANGES AFTER YOU HAVE COMPLETED THIS STATEMENT AND BEFORE WE ASSUME RISK FOR THE COVER APPLIED FOR YOU MUST LET US KNOW IMMEDIATELY.** We need to know of any changes which would have resulted in different replies to questions asked either: on or resulting from this Statement or other questionnaire; or by any doctor or nurse acting on our behalf.

  Changes would include having, or expecting to have, doctor, hospital or clinic consultations, treatment as an in-patient or out-patient or a blood test for any reason. We also need to know immediately if you change your occupation, country of residence or take up any hazardous sports or pastimes before cover starts.
- If we are advised of any changes we will confirm in writing whether or not any terms quoted will still apply.

2 Terms and conditions

- The plan will not start until we have assessed and accepted your International Statement of Health and Insurability and any other evidence we request, and the first premium has been paid. In the case of a joint life plan, the plan will not start until you have both been assessed and accepted, and the first premium has been paid.
- In most instances your premium will be as we originally quoted. We may offer you revised terms, but occasionally we may not be able to offer any terms

3 Medical evidence

Aviva WILL ONLY PAY FOR MEDICAL INFORMATION WHICH IT HAS SPECIFICALLY REQUESTED.

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 2 – Personal details of life to be assured

The Life Assured is the person on whose life the Policy will be written. Please complete in block capitals.

1 Title e.g. Mr, Mrs, Dr, Miss

2 Last name

3 First name(s)

4 Current residential address (including street name, town and area code if known)

5 Current residential address (if different)

6 Telephone number(s) (mandatory)
- Work
- Home
- Mobile

7 E-mail address

8 ID number (if applicable)

9 Permanent residency visa number (if applicable)

10 Date of birth D D M M Y Y Y Y

11 Marital status

12a Do you have a regular doctor or medical practitioner? Yes ☐ No ☐

If yes, provide **full** name and address of your regular doctor or medical practice/ centre including fax number.

Please note we might not contact your doctor. Even if we do, you must still disclose all facts when completing this statement of health and insurability.

- Telephone
- Fax

b How long has your regular doctor known you? years

c When did you last attend your regular doctor? D D M M Y Y Y Y

d What was the reason for your last visit? Reason

Part 3 – Occupation

1a What is your occupation? (If you have more than one occupation, please provide full details of each one)

b What is the name of your employer and the nature of their business? (e.g. financial services, oil and natural gas, construction)

c Please give details if you work underground, underwater, at heights over 3 metres, offshore or any other hazardous aspects of your occupation

Full details to include percent of working time spent at heights and average and maximum heights worked at (if applicable).

2 Annual earned income

Currency (e.g. USD) Amount

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 4 – Residential and travel details

1 What are your nationalities? Please list all

2 Country of birth

3 Town of birth

4 What is your current country of residence?

5 What is the legal basis of your stay in the current country of residence (e.g. permanent resident visa)?

6a How long have you lived in your current country of residence?

b How long do you intend to stay in your current country of residence?
If you intend to change your country of residence, please provide full details.

7 In which countries have you lived and for how long?

8a Has your occupation involved travel outside your current country of residence in the last two years?

If yes, please give details including **specific countries** visited, dates and duration of stay.

Yes ☐ No ☐

Details (Include countries, dates and durations)

b Do you expect your occupation to involve travel outside your current country of residence in the future?

If Yes, please give details, including **specific countries** to be visited, dates and duration of stay.

Yes ☐ No ☐

Details (including countries, dates and durations)

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Part 5 – Recreation details

To qualify for 'non smoker' status rates you must not have used any form of tobacco or nicotine products within the last 12 months.

1 Have you smoked or used any form of tobacco (for example cigarettes, cigars, pipe tobacco, shisha pipe) or nicotine product (for example nicotine patches, nicotine gum, e-cigarettes) in the last 12 months?

Yes ☐ No ☐

(Random tests may be carried out to verify non-smoker status)

If yes, what form and how much a day?

e.g. cigarettes, 20 per day

If you have given up, when did you last use tobacco, what form and how much a day did you previously use?

2a Do you drink alcohol?

Yes ☐ No ☐

If yes, how many units a week?

Units per week ☐

(1 unit = a single measure of spirits or 1 glass of wine (125ml) or ½ pint (250ml) of beer).

b Have you ever been advised by a doctor or any other medical practitioner to reduce or stop your alcohol consumption on medical grounds or have you ever taken part in counselling, therapy or a programme with the aim of reducing or stopping your alcohol consumption?

Yes ☐ No ☐

Details

3 In the last 7 years have you taken any non-prescription drugs (for example LSD, ecstasy, cocaine, heroin, cannabis, anabolic steroids etc)?

Yes ☐ No ☐

Details

4 Do you take part in any hazardous sport or pastime or do you intend to start? (Mountaineering, motor sport, sub-aqua diving and private flying are examples but you should include any activity that is hazardous. You do not need to include sports such as horse riding, skiing, football, rugby, hockey, cricket or racquet sports)

Yes ☐ No ☐

Details

Part 6 – Family history

Before the age of 60, have any of your natural parents, brothers or sisters had, or died from, heart disease, stroke, diabetes, cancer, Huntington's disease, polycystic kidney disease, polyposis of the colon, multiple sclerosis, Alzheimer's disease, Parkinson's disease, motor neurone disease, muscular dystrophy or any hereditary disorder not already listed above?

Yes ☐ No ☐

If Yes, please complete the relevant section(s) below with details of any of the conditions listed above. Please state the **age at onset of the medical condition** and in the case of cancer, which part of the body was **first affected**.

Relationship to you of person affected	Medical condition	Age at onset of condition

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 7 – Health questions

All the questions we ask are relevant and important. You must answer them accurately and completely to the best of your knowledge. If you do not, we will have the legal right to cancel any policy issued as a result of your answers and to not pay any claim.
If the answer to any question is 'Yes' please give full details disclosing all facts as they can influence the assessment and acceptance of the statement of health and insurability.

1a What is your height? ☐ cm

b What is your weight? ☐ kg

c Apart from intentional weight loss (e.g. diet) or pregnancy, have you lost more than 6 kilograms in the last six months? Yes ☐ No ☐

2 Do you currently have or have you ever had any of the following:

a Cancer, leukaemia, Hodgkin's disease, lymphoma or a brain or spinal tumour? Yes ☐ No ☐

b Heart disease, angina, a heart attack, heart abnormality or defect, heart valve disorder or an irregular heart beat? Yes ☐ No ☐

c A stroke, mini stroke, transient ischaemic attack (TIA) or a brain or subarachnoid haemorrhage? Yes ☐ No ☐

d Multiple sclerosis, Parkinson's disease, Alzheimer's disease, paralysis or paraplegia? Yes ☐ No ☐

e Visual disturbance, blurred or double vision, optic or retrobulbar neuritis? Yes ☐ No ☐

f Tingling, pins and needles, numbness, a tremor or any loss of feeling, balance or coordination, for which you consulted a doctor or hospital? Yes ☐ No ☐

g Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? Yes ☐ No ☐

(If the result was negative, the fact of having an HIV test will not in itself have any effect on your acceptance terms for insurance)

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

3 In the last 5 years have you had any of the following:

a Any lump that has appeared or grown in size, or a mole or freckle that has bled, caused pain or changed in appearance? Yes ☐ No ☐

b Raised blood pressure or raised cholesterol for which treatment, further readings or a change in diet were advised? Yes ☐ No ☐

c Asthma, bronchitis, tuberculosis, coughing with blood or any chest, lung or breathing disorder? Yes ☐ No ☐

d Recurrent headache for which you have consulted a doctor or any epilepsy, seizure, fit or blackout? Yes ☐ No ☐

e Any impairment of vision or hearing or any disorder of the eyes or ears? (You may ignore sight problems corrected by glasses or contact lenses but you must tell us about all hearing problems, even if corrected by hearing aid(s)) Yes ☐ No ☐

f Back pain, neck pain, sciatica, joint pain, arthritis, repetitive strain injury or any other disorder of the muscles, bones or limbs for which you have consulted a doctor, hospital, physiotherapist, osteopath, chiropractor or any other type of medical practitioner or for which you have taken time off work? Yes ☐ No ☐

g Diabetes, Crohn's disease or colitis? Yes ☐ No ☐

h Any disorder of the kidneys? Yes ☐ No ☐

i Treatment or a positive test for any disease which was transmitted sexually? Yes ☐ No ☐

j (i) Any mental illness or eating disorder or have you attempted self-harm or taken an overdose? Yes ☐ No ☐

(ii) Any other feeling of depression, anxiety, stress or fatigue that you have reported to a doctor, hospital, nurse, psychologist or psychiatrist or any other type of medical practitioner? Yes ☐ No ☐

k Within the last 5 years have you been exposed to the risk of HIV infection?
(HIV can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the European Union)

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

FAILURE TO GIVE ACCURATE AND COMPLETE ANSWERS MAY RESULT IN NON PAYMENT OF A CLAIM

Part 7 – Health questions

4 In the last 2 years, other than for those conditions you have already mentioned:

a Have you had any medical consultation (for example with a doctor, consultant, psychiatrist, clinic, physiotherapist or any other type of medical practitioner) or attendance at a hospital as an inpatient or outpatient? Yes ☐ No ☐

b Have you had, or been advised to have, any medical investigation, x-ray, scan or test? (For this question, you do not need to give details of occasional consultations with your regular doctor for colds, flu, or consultations for oral contraceptive pills, smear tests, well man/woman check-ups where the results are known and were normal) Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

5 In the last 12 months have you been prescribed any drug, medicine or tablet, or have you had any other form of medical treatment (for example physiotherapy, psychotherapy)? Yes ☐ No ☐

6 In the last 6 months have you had any medical symptom, change in your physical or mental health or change in your physical or mental ability for which you have not consulted a doctor, hospital or medical practitioner? (For this question, you do not need to give details of colds and flu which have lasted less than 2 weeks in total) Yes ☐ No ☐

7 In the next 12 months are you due to have any consultation or check-up in connection with any medical symptom or condition, or are you waiting for the result of any medical investigation? Yes ☐ No ☐

8 Other than the information you have already provided, have you ever had an illness or medical condition that has lasted more than 3 months and which affected your ability to study or perform normal daily activities or for which you took more than 2 weeks off work? Yes ☐ No ☐

Question Reference	Please list in this box the disorder(s), date of disorder(s) and duration, treatment, result of investigations, time off work and when. Continue in the box at the end of this section if necessary.	Name, address, tel/fax of doctor or clinic/hospital attended.

Additional information

Part 8 – Access to Existing Medical Reports

Please note we might not contact your doctor. Even if we do, you must still disclose all the facts when completing this Statement of Health and Insurability form.

We may need to get medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission.

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

We ask your doctor not to reveal information about:

- Negative tests for HIV, hepatitis B or C; or
- Any sexually-transmitted diseases unless there could be long-term effects on your health.

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

- Refusing to provide insurance;
- Increasing premiums above standard rates;
- Applying an exclusion to the cover; or
- Setting premiums at standard rates.

If you have any questions relating to the process of getting, assessing or storing medical information, please write to:

The Chief Medical Officer
Aviva
PO Box 1550
Salisbury
Wiltshire
SP1 2TW

Part 9 – Declaration

1 - I have read Part 1, Important Information, and my answers to the questions in this International Statement of Health and Insurability and declare that, to the best of my knowledge and belief, all the information I have given is true and that no fact has been withheld. I understand I must ensure that all facts I disclosed to my Independent Financial Adviser in answer to the questions in this Statement are accurately recorded in this form. I understand and accept that failure to disclose a fact or the giving of false information will give Aviva the right to cancel from inception any policy issued as a result of this Statement and may invalidate any future claim.

- **I understand that I must tell Aviva without delay if my health or circumstances change before Aviva assumes risk for the Policy applied for.**

2 - I understand and accept Aviva may require sight of my medical records to consider a claim.

- I understand that information given to Aviva in connection with this Statement may be used by Aviva in its consideration of any claim in future and may be shared with a third party e.g. medical examiner, to help in the assessment of a claim.
- I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual organisation or government office that has any records or knowledge of me or my health to disclose to Aviva any information for the purpose of considering a claim. This authorisation shall irrevocably bind my successors and assigns and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

3 - I agree Aviva will use the information I give (as well as information about me relating to any existing policy I may have with Aviva) for administration, underwriting, claims, research and statistical purposes. I authorise Aviva to pass information including medical information to medical examiners and practitioners, underwriters, claims investigation companies, life insurance or reinsurance companies, data processors and to any company or agency appointed for these purposes. (These companies or agencies may be located in countries that do not have laws to protect your information. Aviva will remain responsible for making sure that the information is held securely).

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

4 - I understand and accept that the terms and conditions and a copy of this completed Statement are available on request.

- I accept that if I am required to have a medical examination, the replies to the medical examiner's questions will form part of this Statement.
- **I have read Part 8 relating to Access to Existing Medical Reports.**

5 - **I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess this Statement.** You may gather relevant information from other insurers about any other Applications for life, critical illness, sickness, disability, accident or private medical insurance on my life that I have applied for. I authorise those asked to provide medical and policy information when they see a copy of this consent form.

Life Assured

Signature

Date D D M M Y Y Y Y

This International Statement of Health and Insurability must be received within 30 days of the date of signing.

| Retirement | Investments | Insurance | Health |

Aviva Life & Pensions UK Limited

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