

For office use only

SR No.



**NORWICH  
UNION**  
an AVIVA company

# Health Solutions Application (Full Medical Assessment)

For Internal Use Only

Voluntary scheme name:

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

All information supplied will be treated in strict confidence.

All material facts relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is one which is likely to influence an insurer in the assessment and acceptance of this application. If you are in any doubt as to whether a fact is material then it should be disclosed on this application form.

As proposer you should answer all questions and sign the declaration on behalf of all persons to be insured.

A copy of this application will be supplied to you on request within three months of completion. You should keep a record (including copies of all letters) of all information supplied to us for the purpose of entering into this contract.

Calls may be monitored and/or recorded.

Under the law of England, the parties are free to choose the law which will govern the contract. In the absence of agreement to the contrary, the contract will be subject to the law of England.

**Commencement date.**

The commencement date of this policy will generally be the date on which this application is received and accepted at Norwich Union Healthcare Head Office. However, if you require a commencement date in the future (to take account of the expiry of current contracts elsewhere) you may do so by completing the commencement date box in section 2. Under no circumstances will policies be backdated from the date of receipt.

If you are currently, or have previously been a customer of Norwich Union Healthcare please complete the following:

Policy number

Member number  
(if applicable)

Date previous  
cover ceased

Please note that if you have a previous or current policy with Norwich Union Healthcare you are still required to complete all sections of this application in full, disclosing all material facts.

**1. Benefit Options** You can choose from the following options to either enhance the healthcare benefits provided by Health Solutions, or to help to contain cost. Please refer to the Health Solutions Policy Summary for details of these options. Please indicate which options you require by ticking the appropriate boxes.

Other Treatments  
and Therapies

Dental & Optical  
Benefits

Member excess  
If not selected, member  
excess will be £0

£500

£1,000

Hospital List

If not selected the Hospital List  
will be the Key Hospital List

Extended

Signature

Trust

Reduced out-patient  
cover and selected  
benefit reduction

Six Week Option

**2. Details of proposer** The proposer is applying to be the policyholder and is responsible for paying the premium.

Name

Mr, Mrs, Miss, Ms, other

Surname

Forename

Other initials

Address for  
correspondence

Postcode  
(must be completed)

Contact telephone  
number

Daytime

Evening

Commencement date  
(if applicable see notes above)

Please tick if cover is not required for the proposer

**3. Details of all persons to be covered** If cover is not required for the proposer then the second person will become the main insured person under this policy.

	Proposer	Second person	Third person
Relationship to proposer	If proposer is to be covered then please complete all details below	<input type="checkbox"/> spouse/partner <input type="checkbox"/> son <input type="checkbox"/> daughter	<input type="checkbox"/> son <input type="checkbox"/> daughter
Title		Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
Surname			
Forename			
		Other initials	Other initials
Sex	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female
Date of birth	Age	Age	Age
Occupation	Please give full details	Please give full details	Please give full details

If any of the persons to be covered are usually resident at a different address to that shown overleaf, please give details.

	Proposer	Second person	Third person
Usual place of residence			
Postcode <i>(please ensure postcode is shown)</i>			
Telephone number			

	Fourth person	Fifth person	Sixth person
Relationship to proposer	<input type="checkbox"/> son <input type="checkbox"/> daughter	<input type="checkbox"/> son <input type="checkbox"/> daughter	<input type="checkbox"/> son <input type="checkbox"/> daughter
Title	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other	Mr, Mrs, Miss, Ms, other
Surname			
Forename			
	Other initials	Other initials	Other initials
Sex	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female
Date of birth	Age	Age	Age
Occupation	Please give full details	Please give full details	Please give full details

If any of the persons to be covered are usually resident at a different address to that shown overleaf, please give details.

	Fourth person	Fifth person	Sixth person
Usual place of residence			
Postcode <i>(please ensure postcode is shown)</i>			
Telephone number			

**4. How you wish to pay** Please tick one of the methods listed below.

Please note that if paying monthly, premiums will be requested each month on the same date as the commencement date.

Direct Debit <input type="checkbox"/> monthly <input type="checkbox"/> annual	Credit Card <input type="checkbox"/> monthly <input type="checkbox"/> annual                    Mastercard/Visa only	Cheque <input type="checkbox"/> annual only
If selected, please complete the instructions to your bank on the perforated slip attached to this application.	If selected, please complete the Credit Card authorisation form on the perforated slip attached to this application.	If selected, please make cheque payable to Norwich Union Healthcare Limited, and attach to this application.

**5. GP attendance** Please complete sections 5-7 and sign the declaration. All information will be treated in the strictest confidence.

Has any person named consulted a General Practitioner during the past two years?  
*If yes please give details*

**Proposer** if to be covered

yes	no
-----	----

**Second person**

yes	no
-----	----

**Third person**

yes	no
-----	----

Name of each separate condition requiring consultation


Date(s) of consultation for each condition


Treatment received


Present state of health in relation to each condition


Any foreseeable need for further consultation or treatment of any of these conditions?


Date of last symptoms and treatment

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Has any person named consulted a General Practitioner during the past two years?  
*If yes please give details*

**Fourth person**

yes	no
-----	----

**Fifth person**

yes	no
-----	----

**Sixth person**

yes	no
-----	----

Name of each separate condition requiring consultation


Date(s) of consultation for each condition


Treatment received


Present state of health in relation to each condition


Any foreseeable need for further consultation or treatment of any of these conditions?


Date of last symptoms and treatment

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If you need more room than is available to answer question 5, please complete on a separate sheet of paper, attach to this application and indicate you have done so by ticking this box

**6. Specialist/hospital attendance**

Has any person named consulted a Specialist or been admitted to hospital or a nursing home in the past seven years?  
*If yes please give details*

**Proposer** if to be covered

yes	no
-----	----

**Second person**

yes	no
-----	----

**Third person**

yes	no
-----	----

Name of each separate condition


Dates of consultation(s) for each condition


Treatment received


Present state of health in relation to each condition


Any foreseeable need for further consultation or treatment of any of these conditions?


Date of last symptoms and treatment

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Has any person named consulted a Specialist or been admitted to hospital or a nursing home in the past seven years?  
*If yes please give details*

**Fourth person**

yes	no
-----	----

**Fifth person**

yes	no
-----	----

**Sixth person**

yes	no
-----	----

Name of each separate condition


Dates of consultation(s) for each condition


Treatment received


Present state of health in relation to each condition


Any foreseeable need for further consultation or treatment of any of these conditions?


Date of last symptoms and treatment

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If you need more room than is available to answer question 6, please complete on a separate sheet of paper, attach to this application and indicate you have done so by ticking this box



# Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form including official use only box and send to:

## Complete this section if paying by Direct Debit from your Bank or Building Society.

Norwich Union Healthcare Ltd, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.



Originator's identification number 853820

1. The Manager of

Full address of your Bank/Building Society

2. Name of account holder(s)

3. Sort code

4. Account number (first box to be used for Girobank 9 figure account numbers)

5. Reference number (policy number if known)

Please note that Norwich Union Healthcare Limited may retain the Direct Debit Instruction (DDI) until the policy is activated, at which point the DDI will be processed.

Signature(s) (in the case of joint accounts, both sign if necessary)

Date

For Norwich Union Healthcare Limited official use only

This is not part of the instruction to your Bank/Building Society

6. Tick your preferred payment option:

 Monthly Annually

7. Your instruction to the Bank/Building Society.

Please pay Norwich Union Healthcare 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 Norwich Union Healthcare Limited and, if so, details will be sent electronically to my Bank / Building Society.

Banks/Building Societies may refuse to accept instructions to pay Direct Debits on some types of account.

This guarantee should be detached and retained by the payer



## The Direct Debit Guarantee

- This guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change Norwich Union Healthcare Limited will notify you seven working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Norwich Union Healthcare Limited or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

**Credit card authorisation form**

*Mastercard and Visa only*

Please complete these instructions if you wish to pay your premium by credit card.

*Please tick as appropriate*

Mastercard  Visa  Expiry date

Name as on credit card

Credit card number

To Norwich Union Healthcare Limited

I authorise you, until further notice in writing, to charge my Mastercard/ Visa account with unspecified amounts in respect of premiums as and when they become due.

Signature

Date

**Annual cheque payment**

If you intend to pay by cheque please tick the box below and attach your cheque securely to this application and return it to Norwich Union Healthcare Limited.

Cheque attached  Premium amount   
*Please tick*

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**7. Other conditions** (Whether or not a medical practitioner has been consulted).

Has any person to be included on this policy **ever** suffered from any:

- symptoms or conditions not previously disclosed which are long term or recurrent or which may require future investigation or treatment (this should include details of any symptoms recently or currently apparent for which you have not yet sought medical advice) eg: cancer - heart disorders - bone or muscular problems incl. back trouble - joint trouble - insertion of pins, plates or use of other prostheses - complications of pregnancy - gynaecological or menstrual problems - urinary disorders (incl. stress incontinence or stones) - indigestion or irritable bowel - varicose veins - haemorrhoids - skin complaints - dental or optical problems - degenerative, intermittent or chronic conditions, eg: arthritis or 'wear and tear' - asthma - eczema - psoriasis - allergies

yes  no

Please note that the above list is not exhaustive, conditions listed are examples only.

	Proposer if to be covered	Second person	Third person	Fourth person	Fifth person	Sixth person
Condition						
Treatment received (if any)						
Date(s) of symptoms/treatment						

Is any person taking, or have they taken in the past, any regular medication, eg: HRT, inhalers, aspirin? Please give full details including to whom this refers.

If you need more room than is available to answer question 7, please complete on a separate sheet of paper, attach to this application and indicate you have done so by ticking this box

**8. Declaration**

I declare that:

- I understand and accept that benefits will not be available to insured persons (those named in section 3) for the treatment of any disease, illness or injury (whether or not diagnosed) for which the insured person has received medication, advice or treatment or for which the insured person has experienced symptoms prior to the date of acceptance of this application or any related condition unless fully disclosed on this application and accepted by Norwich Union Healthcare Limited. An additional application in our prescribed form will be required for any persons added to the policy in the future.
- I will advise if there are any changes in the information given on this application which occur between the date of signing and the date of commencement of cover under the policy.
- To the best of my knowledge and belief the information given on this application is true and complete. I agree to accept and conform to the terms of the policy when issued. (A specimen copy of the Policy Wording is available on request).
- I have checked and found correct any answers or statements in this application that are not in my own handwriting.
- I understand that if Norwich Union Healthcare needs to investigate or establish material facts this may delay the claims process.
- I have received the ABI Guide to Buying Private Medical Insurance, Direct Debit Guarantee (if applicable), the Health Solutions Policy Booklet and Policy Summary.
- I have received and read the Hospital List I have chosen and checked there is a hospital within reasonable distance from my home.
- On behalf of all persons to be covered I confirm consent to the computer and other processing and use (which may be in any part of the world) of personal and medical details by the data controllers and relevant third parties (which may include disclosure to the Policyholder, relevant intermediaries and medical service providers) for the purposes of this application, policy administration, service provision, reinsurance, claims validation and fraud prevention. The data controllers are Norwich Union Healthcare Limited, Norwich Union Insurance Limited and Norwich Union Life & Pensions Limited. Also, relevant details of persons to be covered may be processed in order to tell them from time to time (by post, telephone, email, fax or other means) about products or services which may be of interest from Aviva Group and connected providers. Any person not wishing to receive such contact may write to Norwich Union, FREEPOST, Mailing Exclusion Team, PO Box 6412, Derby, DE1 1SB.

Proposer's signature

Date (must be completed)

Print name

**Please note for applicants aged 75 or over it is our standard practice to request a medical report.**

For agent's use only	
Agent's name and address	
Agency ref	

For office use only	
Plan code	
Scheme code	
Campaign code	
Coupon code	
Policy number	
Rate key	



**NORWICH  
UNION**

an **AVIVA** company

Norwich Union Healthcare Limited. Registered in England Number 2464270. Registered Office Surrey Street Norwich NR1 3NG.  
This insurance is underwritten by Norwich Union Insurance Limited. Registered in England Number 99122. Registered Office Surrey Street Norwich NR1 3NG.  
Authorised and regulated by the Financial Services Authority. Member of the Association of British Insurers. Member of the Financial Ombudsman Service.

Norwich Union Healthcare Limited is a company in the United Kingdom whose head office is:  
Norwich Union Healthcare Limited Chilworth House Hampshire Corporate Park  
Templars Way Eastleigh Hampshire SO53 3RY

[www.norwichunion.com/healthcare](http://www.norwichunion.com/healthcare)