

For office use only

SR No.

# Health Solutions Application (Moratorium)



**NORWICH  
UNION**

an AVIVA company

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.

If you are unsure of any information requested, please check with the person to whom it relates.

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.

## 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 please state this in the commencement date box in section 2.

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.

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

If selecting the Trust Hospital List,  
please advise your first choice of  
hospital in the event of a claim, in  
the box below.

Reduced out-patient  
cover and selected  
benefit reduction

Six Week Option

**2. Your details** As proposer you are applying to be the policyholder and will be responsible for paying the premium.

Name  Mr, Mrs, Miss, Ms, other  Surname

Forename  Other initials

Sex  Male  Female Date of birth

Address for  
correspondence

Postcode  
(must be completed)

Contact numbers.  Daytime telephone number  
including area code  Evening telephone number  
including area code  Mobile  
telephone no

Occupation  
(please give full details)

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	X	<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			
Sex		<input type="checkbox"/> male <input type="checkbox"/> female	
Date of birth		/ /	/ /
Occupation <i>(Please give full details)</i>			

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	X		
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			
Date of birth	/ /	/ /	/ /
Occupation <i>(Please give full details)</i>			

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    monthly    annual  
 Credit Card    monthly    annual   Mastercard/Visa only  
 Cheque    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. Pre-existing medical conditions

Benefits will not be available for the treatment of any disease, illness or injury (whether or not diagnosed) or of any other disease, illness or injury related to it if:

- the insured person had symptoms of, medication or treatment for, or advice about such a disease, illness or injury within five years before his or her date of entry, and
- there has not been a clear two year period after the date of entry during which the insured person has been free of medication for, treatment for, and advice about such a disease, illness or injury or related condition.



## 6. Declaration

I declare that:

- a. I understand and accept section 5 on pre-existing medical conditions.
- b. 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.
- c. 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).
- d. I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.
- e. I understand that if Norwich Union Healthcare needs to investigate or establish material facts this may delay the claims process.
- f. I have received the ABI Guide to Buying Private Medical Insurance, Direct Debit guarantee (if applicable), 'How you can apply for cover' booklet, the Health Solutions Policy Booklet and the Policy Summary.
- g. I have received and read the Hospital List I have chosen and checked there is a hospital within reasonable distance from my home.
- h. 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

 <p><b>Instruction to your Bank or Building Society to pay by Direct Debit</b></p> <p>Please fill in the whole form <b>including official use only box</b> and send to:</p>	<p><b>Complete this section if paying by Direct Debit from your Bank or Building Society.</b></p> <p>Norwich Union Healthcare Ltd, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY.</p> <p>Originator's identification number 853820</p>	
<p>1. The Manager of <input type="text"/> Bank/Building Society</p> <p>Full address of your Bank/Building Society <input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/> Postcode</p>	<p>For Norwich Union Healthcare Limited official use only</p> <p>This is not part of the instruction to your Bank/Building Society</p> <p>6. Tick your preferred payment option: <input type="checkbox"/> Monthly <input type="checkbox"/> Annually</p>	
<p>2. Name of account holder(s) <input type="text"/></p> <p>3. Sort code <input type="text"/></p> <p>4. Account number (first box to be used for Girobank 9 figure account numbers) <input type="text"/></p> <p>5. Reference number (policy number if known) <input type="text"/></p>	<p>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.</p> <p>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.</p> <p>Signature(s) (in the case of joint accounts, both sign if necessary) <input checked="" type="checkbox"/> <input type="text"/> Date <input type="text"/></p> <p><input checked="" type="checkbox"/> <input type="text"/> <input checked="" type="checkbox"/></p> <p style="font-size: small;">Banks/Building Societies may refuse to accept instructions to pay Direct Debits on some types of account.</p>	

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 Norwich Union Healthcare Ltd.



