Data Protection

Aviva Health Insurance Ireland Limited ("we", "us" or "our"), as data controller, will keep the information you provide about yourself and about third parties confidential. We may use it to advise on, provide and administer insurance products and financial services provided by us or other Aviva companies and sometimes with our affiliates and/ or commercial partners, in order to comply with legal obligations imposed on us. We may share the information both inside and outside of the European Economic Area, in confidence, for these purposes with agents or service providers we have appointed, private investigators, regulatory organisations, other insurance and financial services companies (directly or via a central register), other Aviva Group companies, those to whom we outsource certain business operations and as required by law. We will process this information and store it on our computer and manual record systems.

To assist in preventing, detecting and/or protecting our customers and ourselves from theft and fraud, we may use your information to make searches of our or other Aviva companies' records, as well as those of other health insurers. If you give us false information or fail to disclose information and we suspect fraud, we will record this. We also participate in industry databases such as those operated by the Irish Insurance Federation for the purpose of sharing of information among insurance companies as a check against non-disclosure.

From time to time, we may record your telephone calls for verification and training purposes.

If you would like a copy of the details we hold about you, please write to: Customer Services Manager, Aviva Health Insurance Ireland Limited, P.O. Box 764, Togher, Cork, Ireland. Please enclose the correct fee (€6.35). You also have the right to correct any errors in the information held about you, block certain uses or object to the processing of your personal data.

Important: Some of the questions on this form may ask for details about your health and convictions and the health and convictions of third parties material to this risk – please do not send us any genetic test results. This information is important for underwriting and claims purposes and will remain confidential. By signing the declaration below, you are giving us permission to process these details for the above purposes, including checking with third parties or accessing State or other official records to verify whether the details you have given are accurate and complete. By signing below, you are confirming that you have fully explained to each person who requires this insurance cover why we asked for this information and what we will use it for. You are also confirming each person has agreed to this.

ONLY SIGN THE FOLLOWING DECLARATION IF YOU FULLY UNDERSTAND, AND HAVE MET, ALL OF THE ABOVE REQUIREMENTS.

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we acknowledge that this proposal will form the basis of my/our membership with Aviva Health Insurance Ireland Limited. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Data Protection section above.

I/we agree to be bound by the terms of the policy including those set out in the relevant handbook**.

**will be sent on registration, but may be obtained on request or may be viewed by logging onto www.aviva.ie/health

Print name in block capitals:

Your signature: Date:

We would like to use your details to provide you with information about other financial or insurance products, services and special offers either from us or other Aviva Group companies, or products, services and special offers which any member of the Aviva Group may arrange with a third party. Your details may also be used for this purpose (for up to 12 months) after your policy has ceased. How would you like to receive such information? (Please tick at least one) ☐ E-mail ☐ Post ☐ Any/All

Please tick here ☐ if you do not wish to receive such information from us.

Your choice will not affect any of the services we provide to you, now or in the future.

Health insurance application form

Aviva Health Insurance Ireland Limited
P.O. Box 764
Togher
Cork

1890 717 717

www.avivahealth.ie

ST-112

AVIVA

A copy of this application form is available on request.

To be completed by the customer

Group name/employer (if applicable):

Intermediary name (if applicable):

Quote number (if applicable):

Personal details

Title: First name: Surname:

Address:

Date of birth:

Home tel. no: Work tel. no:

Mobile tel. no: E-Mail address:

PPS Number[1]:

Date you wish to commence health insurance cover with Aviva (day/mth/yr)

How would you like to receive your documentation? ❑ By Email ❑ By Post

Previous health insurance details

Please complete this section where applicable. This information is used to ensure continuity of cover and prompt claim settlement for you and your dependants.

Previous health insurer: Previous level of cover:

Last renewal date: d m y Previous policy number:

Have you, or any of your dependants, had a break in health insurance cover of more than 13 weeks in the last 10 years? Yes ☐ No ☐

If yes, please include details on a separate sheet of paper.

Please note that if this is the first time you are buying health insurance, or if you are increasing the level of your cover, have had a break in health insurance cover of 13 weeks or more or you have a pre-existing condition, certain exclusion periods may apply before you can make a claim in relation to the pre-existing condition. For more information on waiting periods, please see www.aviva.ie/health.

Method of payment – please tick one box only

Bank Cheque annually ☐ Credit Card annually ☐ Direct Debit monthly ☐ Laser Card annually ☐

Should you wish to avail of salary deduction, please contact us on 1890 721 721 or email corporate.enquiries@avivahealth.ie

1 You must include your PPS number in order to avail of tax relief at source on your premiums.

Level of cover required

Name of plan:

Dependants

1. First Name/Surname:

   Date of birth: d m y — Tick if full-time student and aged 18–22 ☐

   Relationship *(e.g. Spouse/child):* — Place of education:

   PPS Number: — Level of cover required:

   Last renewal date: d m y — Previous policy number:

   Previous insurer: — Previous plan:

2. First Name/Surname:

   Date of birth: d m y — Tick if full-time student and aged 18–22 ☐

   Relationship *(e.g. Spouse/child):* — Place of education:

   PPS Number: — Level of cover required:

   Last renewal date: d m y — Previous policy number:

   Previous insurer: — Previous plan:

3. First Name/Surname:

   Date of birth: d m y — Tick if full-time student and aged 18–22 ❑

   Relationship *(e.g. Spouse/child):* — Place of education:

   PPS Number: — Level of cover required:

   Last renewal date: d m y — Previous policy number:

   Previous insurer: — Previous plan:

4. First Name/Surname:

   Date of birth: d m y — Tick if full-time student and aged 18–22 ❑

   Relationship *(e.g. Spouse/child):* — Place of education:

   PPS Number: — Level of cover required:

   Last renewal date: d m y — Previous policy number:

   Previous insurer: — Previous plan:

Credit Card payment authority

To Aviva Health Insurance Ireland Limited, I authorise you to charge to my credit or debit card account an unspecified amount in respect of subscriptions for health insurance membership.

MasterCard ☐ Visa ☐ Laser ☐

Cardholder's surname, first name, other initials:

Card number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry date: Month ☐☐ Year ☐☐

Cardholder's signature:

Date:

Instruction to your bank to pay Direct Debits

You can choose to pay your insurance by monthly direct debit at no additional cost.

Please complete parts 1–5 to instruct your bank to make payments from your account and then return the form to Aviva Health Insurance Ireland Limited, P.O. Box 764, Togher, Cork.

1. Please write the name and full postal address of your bank and branch:
2. Name of account holder:
3. Sort code: ☐☐ — ☐☐ — ☐☐

   Account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
4. Date that you would like money to be debited from your account (date/mth): ☐☐ / ☐☐
5. Your instructions to the bank and signature:

   I instruct you to pay direct debits from my account at the request of Aviva Health Insurance Ireland Limited. The amounts are variable and may be debited on various dates. I understand that Aviva Health Insurance Ireland Limited may change the amounts and the dates only after giving me prior notice. I will inform the bank in writing if I wish to cancel this instruction. I understand that if any direct debit is paid which breaks the term of this instruction, the bank will make a refund.

Signature 1: Date:

Signature 2: Date:

For office use only:

Health membership number: