

## Information for Financial Broker

Please note that **Section A (pages 1-8)** of this form is to be used for data capture with **Section B (pages 9-14)** for signatures and the Direct Debit mandate. You can send us Section B by scanning it and uploading it onto Aviva's WriteNow system. Alternatively you can send it by post. **Please do not upload or post Section A.**

## Section A - On-line Data Capture Form

### Please note carefully

The data entered on this form is a critical part of your application for Protection Cover. Your Financial Broker will keep the form and will enter the data into the Aviva on-line application data capture system.

We will send you a copy of the data entered by your Financial Broker on your behalf. It is your responsibility to ensure the data is correct; you should check it and if you do not agree with any of the data you should make the amendments, sign the document and immediately return it to us at our branch office, Aviva Life & Pensions Ireland, One Park Place, Hatch Street, Dublin 2. We will acknowledge receipt of any amendments within 10 days. If you do not receive this acknowledgement from us within 10 days, please contact us to ensure we have received your amendments.

This data, together with the Customer Application Booklet in Section B that you will sign, will be the basis of your application for Protection Cover.

Material facts are details that we need to know so we can assess applications for cover and claims for benefits. Material facts could include medical history, smoking history and details of occupation, travel and pastimes. If you do not tell us about material facts when you apply for your plan or at the claims stage, this might mean that your contract could be cancelled without premiums being returned, or, that we don't pay a claim.

If you are in any doubt as to whether certain facts are material, you should tell us about them anyway. You must also tell us about any changes to the information you give us up until your policy starts.

In accordance with the Disability Act 2005, you should not tell us the results of any genetic tests which you have had.

Application No.

Agency No.

## 1. Product required

Mortgage Protection Cover *Section 6a*

Flexible Protection Cover *Section 6b*

Mortgage Protection with Accelerated Specified Illness Cover *Section 6a*

## 2. Lives to be insured

### 1st Life to be insured

Title  Surname

Forename(s)

Date of birth

Gender Male  Female

Marital Status

Have you smoked cigarettes, cigars or pipe tobacco in the last 12 months?

Yes  No

Address (for correspondence)

  
  


Contact telephone number

Email address

Occupation (describe type of business and nature of duties)

  


Relationship of Life 2 to Life 1

### 2nd Life to be insured (if applicable)

Title  Surname

Forename(s)

Date of birth

Gender Male  Female

Marital Status

Have you smoked cigarettes, cigars or pipe tobacco in the last 12 months?

Yes  No

Address (for correspondence)

  
  


Contact telephone number

Email address

Occupation (describe type of business and nature of duties)

### 3. Protection Cover Requirements (For full details on all cover types please consult our product brochures).

Purpose of Cover (please select only **ONE** option)

Personal/Family Cover  Personal Borrowing  Inheritance Tax Cover (single life only)   
Business Keyperson Cover  Commercial Borrowing  Partnership / Co-Director's Cover

### 4. Policy Owner Details, if different from the life/lives to be insured

Full name(s) and address(es) of the person(s) or Company owning this policy

  
  

Relationship to life/lives to be insured or details of insurable interest

  

If the policy is to be written in trust please select trust type Sec 72/Sec 60 (single life only)  General Trust

### 5. Policy Details

Premium frequency Monthly  Annually  Policy start date

### 6a. Mortgage Cover (Reducing Cover)

Cover Basis Single Life  Joint Life 1st Death

Term  years

Mortgage Protection Life Cover sum insured €

Do you wish to add Accelerated Specified Illness Cover?\* Yes  No  (If neither box is ticked, we will assume 'No')

\* Applicants for Mortgage Protection with Accelerated Specified Illness Cover should refer to the 'Standard Restrictions' section in their Mortgage Protection Cover brochure for details of the restrictions, conditions and exclusions that apply to this cover. You cannot choose a different sum insured for Accelerated Specified Illness Cover.

### 6b. Flexible Protection Cover

Cover Basis Single Life  Dual Life  Joint Life 1st Death

INDEXED COVER - You have the option to increase the benefit payable under the plan by 3% each year with the premiums increasing by 4% each year.

If you wish to include this feature, please tick here

Term  years Conversion Option Yes  No

Please select from the following covers 1st Life Sum Insured 2nd Life Sum Insured (if dual life only)

Life Cover Amount (if any) €  €

Specified Illness Cover<sup>†</sup> Amount (if any) €  €

If you have chosen Specified Illness Cover, which type do you want? Accelerated<sup>††</sup>  Standalone<sup>†††</sup>

† Applicants for Specified Illness Cover should refer to the 'Standard Restrictions' section in their Flexible Protection Cover brochure for details of the restrictions, conditions and exclusions that apply to this cover.

†† Accelerated Specified Illness Cover means we reduce your Life Cover by the amount of the specified illness claim and it cannot be greater than the Life Cover.

††† Standalone Specified Illness Cover means that if you make a specified illness claim, it will not affect any Life Cover.

If you choose Life Cover and Specified Illness Cover and do not choose which type, we will assume the Specified Illness Cover is standalone.

### 7. Payment Method

Direct Debit  Cheque (Annually only)

**AVIVA'S REQUIREMENTS - PERSONAL STATEMENTS - PLEASE COMPLETE PARTS 1, 2 AND 3**

Personal Statements are to be answered by the lives to be insured (please answer carefully giving full details). You may also be required to complete additional Medical, Occupation and Lifestyle questionnaires based on your answers to questions in Parts 1, 2 and 3. Your Financial Broker will provide you with the appropriate questionnaire(s).

**Part 1 Personal statements to be answered by the lives to be insured (Please answer carefully giving full details)**

**1st Life to be insured**

**Your doctor's details**

Name and address of your current medical attendant or family doctor and any other specialist you may have attended


**2nd Life to be insured**


If you have changed your doctor in the **last 18 months**, please give the name and address of your previous doctor



**Your height and weight**

**1st Life to be insured**

**1.1** (a) What is your height?

ft  ins  or mtrs  cms

(b) What is your weight?

st  lbs  or kilos

**2nd Life to be insured**

ft  ins  or mtrs  cms

st  lbs  or kilos

**Your lifestyle**

**1.2** (a) If you have smoked any cigarettes in the last 12 months, please state the average number of cigarettes smoked per day? (If you have not smoked cigarettes within the last 12 months, enter 0)

Number of cigarettes per day

Number of cigarettes per day

(b) Have you used any other tobacco products in the last 12 months?

Yes  No

Yes  No

**1.3** (a) How many units of alcohol do you drink per week? (1 pint of beer = 2 units, 1 glass of wine or 1 measure of spirits = 1 unit) *If you are a non-drinker enter 0 units (n/a or dash not acceptable)*

Number of units per week

Number of units per week

(b) Have you ever been advised by your doctor or other medical practitioner to drink less alcohol?

Yes  No

Yes  No

**1.4** Have you taken any recreational drug(s) in the last 5 years?

Yes  No

Yes  No

**1.5** Do you, or do you intend to, engage in hazardous pursuits?

Yes  No

Yes  No

*(If yes please tick all that apply)*

*(If yes please tick all that apply)*

Aviation

Aviation

*(except as a fare paying commercial passenger)*

*(except as a fare paying commercial passenger)*

Diving

Diving

*(other than holiday diving of less than 20m)*

*(other than holiday diving of less than 20m)*

**1st Life to be insured**

Extreme Sports   
(please specify)

(e.g. bungee or BASE jumping, canyoning, white water rafting)

- Motor Sport
- Mountaineering
- Potholing/caving
- Trans-ocean Sailing

**2nd Life to be insured**

Extreme Sports   
(please specify)

(e.g. bungee or BASE jumping, canyoning, white water rafting)

- Motor Sport
- Mountaineering
- Potholing/caving
- Trans-ocean Sailing

**1.6** During the last 5 years, have you spent more than 90 days in total in Africa, the Caribbean or Thailand?

Yes  No

Yes  No

**1.7** In the next 2 years, apart from holidays amounting to less than 30 days in any year, do you intend to travel, live or work outside of Australia, Canada, the EU, New Zealand, Norway, Switzerland or the United States of America?

Yes  No

Yes  No

Country	Expected number of days in next 2 years

Country	Expected number of days in next 2 years

**Your Occupation**

**1.8** Do you work in any of the following industries?

Yes  No

(If yes please tick all that apply)

- Armed Forces
- Aviation
- Diving
- Fishing
- Mining
- Oil & Gas
- Quarrying / Tunnelling

Yes  No

(If yes please tick all that apply)

- Armed Forces
- Aviation
- Diving
- Fishing
- Mining
- Oil & Gas
- Quarrying / Tunnelling

**1.9** (a) Do you work at heights over 50ft (15m) for more than 10% of your time?

Yes  No

Yes  No

(b) If 'Yes' please state the maximum height you work to.

metres or  feet

metres or  feet

**Previous Applications**

**1.10** Has any application submitted for life or specified illness cover (with Aviva or any other insurance company) ever been declined or postponed?

Yes  No

If yes please give full details

Yes  No

If yes please give full details

**1st Life**

  
  
  


**2nd Life**

**Your family history**

**1.11** Before **the age of 60** have either of your natural parents or any brothers or sisters suffered or died from:

	<b>1st Life to be insured</b>		<b>2nd Life to be insured</b>	
Angina, heart attack, heart disease or hypertrophic cardiomyopathy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer or polyposis of the colon?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes or stroke or multiple sclerosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Huntington's disease, motor neurone disease, muscular dystrophy, polycystic kidney disease, Parkinson's disease or any other hereditary disease or disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

*If yes please give details below*

**1st Life to be insured**

<b>Disease/Disorder</b> (for Cancer, please state site and/or type e.g. Breast Cancer)	<b>Relationship</b> i.e. natural father, natural mother, natural brother, natural sister or identical twin	<b>Age on Diagnosis</b>

**2nd Life to be insured**

<b>Disease/Disorder</b> (for Cancer, please state site and/or type e.g. Breast Cancer)	<b>Relationship</b> i.e. natural father, natural mother, natural brother, natural sister or identical twin	<b>Age on Diagnosis</b>

**Part 2 – Personal Statements**

**Your health history**

Do you currently have or have you ever had any of the following?

	<b>1st life to be insured</b>		<b>2nd Life to be insured</b>	
<b>2.1</b> Cancer (malignant tumour), leukaemia, Hodgkin's disease or lymphoma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.2</b> Heart attack or angina, heart abnormality or heart valve disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.3</b> Stroke, brain haemorrhage, transient ischaemic attack or permanent brain injury through accident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.4</b> Any disease or disorder of the arteries (including disease in the legs or the aorta)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.5</b> Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease or dementia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.6</b> Any other disorder of the central nervous system (brain, spinal cord and nerves) not already mentioned?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.7</b> Diabetes or sugar in the urine? <i>If 'Yes' please complete a Diabetes questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.8</b> Mental illness that has required hospitalisation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2.9</b> Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the result of such a test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## Part 3 – Your health in the last 5 years

### Information for Financial Broker

If the life/lives to be insured answer Yes to any of the questions in Part 3 below, please ask them to complete the relevant medical questionnaire. You should then enter the details online. If a specific medical questionnaire is not available for the condition please ask the life/lives to be insured to complete Part 4. If the life/lives to be insured do not complete the relevant medical questionnaire and/or you do not enter the details online this could cause a delay as we may not be able to process the application until we receive this questionnaire(s).

### APART FROM CONDITIONS ALREADY MENTIONED IN QUESTIONS

#### 2.1 – 2.9, IN THE LAST 5 YEARS HAVE YOU HAD ANY OF THE FOLLOWING:

	1st life to be insured		2nd Life to be insured	
<b>3.1</b> A lump or growth of any kind, or any mole or freckle that has bled, become painful, changed colour or increased in size? <i>If 'Yes' please complete a Cysts, Growths and Lumps questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.2</b> Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol? <i>If 'Yes' please complete a Chest Pain and/or Raised Blood Pressure &amp; Cholesterol questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.3</b> Asthma, bronchitis or any other respiratory disorder? <i>If 'Yes' please complete an Asthma questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.4</b> Numbness, loss of feeling or tingling of the limbs or face or temporary loss of muscle power? <i>If 'Yes' please complete a Neurological Symptoms &amp; Disorders questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.5</b> Seizure, fits, fainting, dizziness or blackouts? <i>If 'Yes' please complete an Epilepsy questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.6</b> Disorder of the ears or eyes including optic neuritis and blurred or double vision (you can ignore sight problems corrected by glasses or contact lenses)? <i>If 'Yes' please complete Part 4 Supplementary Health Questions</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.7</b> Arthritis, neck, spine or joint disorder (including slipped disc, sciatica, back, knee, shoulder pain or gout)? <i>If 'Yes' please complete a Joint Conditions questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.8</b> Any disorder of the digestive system, liver, stomach, pancreas or bowel (including any ulcer, hepatitis, colitis or Crohn's disease)? <i>If 'Yes' please complete a Digestive Disorders or a Stomach and Intestinal Disorders questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.9</b> Blood disorder or anaemia? <i>If 'Yes' please complete Part 4 Supplementary Health Questions</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.10</b> Thyroid disorder? <i>If 'Yes' please complete a Thyroid questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.11</b> Kidney, bladder or any other disorder of the genito-urinary system (including blood or protein in the urine or urinary tract infection)? <i>If 'Yes' please complete a Kidney Disorders and Urinary Problems questionnaire and/or a Gynaecological Disorders questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.12</b> Any kind of depression, anxiety, stress, nervous breakdown, insomnia or fatigue? <i>If 'Yes' please complete a Mental Health questionnaire</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### APART FROM CONDITIONS ALREADY MENTIONED ABOVE:

<b>3.13</b> Have you sought medical advice, treatment or had investigations for any other condition in the past 5 years? (colds, influenza and hay fever can be omitted) <i>If 'Yes' please complete Part 4 Supplementary Health Questions</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.14</b> Are you awaiting the results of any tests/investigations or referral to any hospital, clinic or doctor? <i>If 'Yes' please complete Part 4 Supplementary Health Questions</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3.15</b> Do you have any medical condition, pain, discomfort or other symptoms for which you have not yet sought medical advice? <i>If 'Yes' please complete Part 4 Supplementary Health Questions</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## Personal Statements – Part 4 Supplementary Health Questions

This section is to be completed only if you have answered Yes to any Question in Part 3 and have NOT already completed a medical questionnaire. Use an extra questionnaire sheet if required.

### 1st Life to be insured

What is the name of the medical condition, illness or injury that you have had or currently have?

Condition 1

Condition 2

Condition 3

a. Please indicate which health question in Part 3 the condition relates to, e.g. 3.6

Question

Question

Question

b. Have you completed a Medical Questionnaire for this condition?

Yes  No

Yes  No

Yes  No

**If Yes,** Which questionnaire?




**Please complete the relevant medical questionnaire(s). Your Financial Broker will enter the details online.**

**If No,** please complete the questions below about each condition. Use an extra questionnaire sheet if required.

c. How many days have you taken off work because of this condition in the last 2 years?

days

days

days

d. When did you last experience symptoms or take treatment for this condition (please give date)? You may provide the approximate month and year.

mm      yyyy

mm      yyyy

mm      yyyy

e. Are you awaiting hospital referral, investigation or surgery for this condition?

Yes  No

Yes  No

Yes  No

f. How many times have you experienced symptoms of this condition? (please tick ONE box only)

Once   
More than once   
Continuously   
Never

Once   
More than once   
Continuously   
Never

Once   
More than once   
Continuously   
Never

g. Which of the following best describes the severity of your condition? (please tick ONE box only per condition)

Fully recovered

Fully recovered

Fully recovered

On-going symptoms, no restriction in lifestyle or mobility

On-going symptoms, no restriction in lifestyle or mobility

On-going symptoms, no restriction in lifestyle or mobility

Minor symptoms, some or occasional restriction in activities or pastimes

Minor symptoms, some or occasional restriction in activities or pastimes

Minor symptoms, some or occasional restriction in activities or pastimes

Moderate symptoms, more persistent restrictions in activities or pastimes

Moderate symptoms, more persistent restrictions in activities or pastimes

Moderate symptoms, more persistent restrictions in activities or pastimes

Significant symptoms, with continuous restrictions in activities or pastimes

Significant symptoms, with continuous restrictions in activities or pastimes

Significant symptoms, with continuous restrictions in activities or pastimes

**This section is to be completed only if you have answered 'Yes' to any question in part 3 and have NOT already completed a medical questionnaire. Use an extra questionnaire sheet if required.**

**2nd life to be insured**

What is the name of the medical condition, illness or injury that you have had or currently have?

Condition 1 <input type="text"/>	Condition 2 <input type="text"/>	Condition 3 <input type="text"/>
a. Please indicate which health question in Part 3 the condition relates to, e.g. 3.6 Question <input type="text"/>	Question <input type="text"/>	Question <input type="text"/>
b. Have you completed a Medical Questionnaire for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If Yes, Which questionnaire?</b> <input type="text"/>	<input type="text"/>	<input type="text"/>

**Please complete the relevant medical questionnaire(s). Your Financial Broker will enter the details online.**

**If No**, please complete the questions below about each condition. Use an extra questionnaire sheet if required.

c. How many days have you taken off work because of this condition in the last 2 years? days <input type="text"/>	days <input type="text"/>	days <input type="text"/>
d. When did you last experience symptoms or take treatment for this condition (please give date)? You may provide the approximate month and year. <input type="text"/> <input type="text"/> mm      yyyy	<input type="text"/> <input type="text"/> mm      yyyy	<input type="text"/> <input type="text"/> mm      yyyy
e. Are you awaiting hospital referral, investigation or surgery for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. How many times have you experienced symptoms of this condition? (please tick ONE box only)		
Once <input type="checkbox"/>	Once <input type="checkbox"/>	Once <input type="checkbox"/>
More than once <input type="checkbox"/>	More than once <input type="checkbox"/>	More than once <input type="checkbox"/>
Continuously <input type="checkbox"/>	Continuously <input type="checkbox"/>	Continuously <input type="checkbox"/>
Never <input type="checkbox"/>	Never <input type="checkbox"/>	Never <input type="checkbox"/>
g. Which of the following best describes the severity of your condition? (please tick ONE box only per condition)		
Fully recovered <input type="checkbox"/>	Fully recovered <input type="checkbox"/>	Fully recovered <input type="checkbox"/>
On-going symptoms, no restriction in lifestyle or mobility <input type="checkbox"/>	On-going symptoms, no restriction in lifestyle or mobility <input type="checkbox"/>	On-going symptoms, no restriction in lifestyle or mobility <input type="checkbox"/>
Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/>	Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/>	Minor symptoms, some or occasional restriction in activities or pastimes <input type="checkbox"/>
Moderate symptoms, more persistent restrictions in activities or pastimes <input type="checkbox"/>	Moderate symptoms, more persistent restrictions in activities or pastimes <input type="checkbox"/>	Moderate symptoms, more persistent restrictions in activities or pastimes <input type="checkbox"/>
Significant symptoms, with continuous restrictions in activities or pastimes <input type="checkbox"/>	Significant symptoms, with continuous restrictions in activities or pastimes <input type="checkbox"/>	Significant symptoms, with continuous restrictions in activities or pastimes <input type="checkbox"/>





# Protection Cover

## Information for Financial Broker

When you submit this application electronically, you should only send us this Section B. You can send it to us by scanning it and uploading it onto Aviva's WriteNow system. Alternatively, you can post it. We will acknowledge receipt of any amendments we receive to this form within 10 days.

## Section B - Customer Application Booklet

Application No.  Agency No.

### Personal Details

#### 1st Life to be insured

Title  Surname   
Forename(s)   
Date of birth

#### 2nd Life to be insured (if applicable)

Title  Surname   
Forename(s)   
Date of birth

## Important Information

### Please note carefully

The On-line Data Capture Form is a critical part of your application for Protection Cover. Your Financial Broker will keep the form and will enter the data into the Aviva on-line system.

We will send you a copy of the data entered by your Financial Broker on your behalf. It is your responsibility to ensure the data is correct; you should check it and if you do not agree with any of the data you should make the amendments, sign the document and immediately return it to us at our branch office, Aviva Life & Pensions Ireland, One Park Place, Hatch Street, Dublin 2. We will acknowledge receipt of any amendments within 10 days. If you do not receive this acknowledgement from us within 10 days, please contact us to ensure we have received your amendments.

This data, together with this Customer Application Booklet that you will sign, will be the basis of your application for Protection Cover.

Material facts are details that we need to know so we can assess applications for cover and claims for benefits. Material facts could include medical history, smoking history and details of occupation, travel and pastimes. If you do not tell us about material facts when you apply for your plan or at the claims stage, this might mean that your contract could be cancelled without premiums being returned, or, that we don't pay a claim.

If you are in any doubt as to whether certain facts are material, you should tell us about them anyway. You must also tell us about any changes to the information you give us up until your policy starts.

In accordance with the Disability Act 2005, you should not tell us the results of any genetic tests which you have had.

## DECLARATIONS

### Declaration of Client(s)

- I/We, the life/lives to be insured, irrevocably authorise and request any doctor or other person who may be in possession of, or hereafter acquire, any information regarding my/our health up to the present time to disclose such information (with the exception of the results of genetic tests) to Aviva Life & Pensions UK Limited.
- I/We agree that this authority shall remain in force after my/our death as well as prior thereto.
- I/We consent to Aviva Life & Pensions UK Limited seeking information from any insurance company to which an application has been made on my/our life/lives for Life, Accident, Specified Illness, Sickness or Disability cover and I/we authorise the giving of such information (with the exception of the results of genetic tests).
- I/We declare that the information on the application form and all other information furnished by me/us and/or on my/our behalf (whether in my/our handwriting, any other hard copy form, by any electronic means or verbally) in relation to my/our application for cover are true and complete.
- I/We understand that:
  1. Aviva will send me a copy of the data entered into the system from the On-line Data Capture Form and I will need to check that the data is correct and immediately inform Aviva of any changes needed.
  2. All parts of this application must be fully completed and any alterations initialled by the signatory/signatories.
  3. Failure to provide true and complete information may mean that the contract could be cancelled without premiums being returned, or, that Aviva don't pay a claim.
  4. Any changes to the answers given, before the policy comes into force, must be notified immediately to Aviva Life & Pensions UK Limited at their branch office, Aviva Life & Pensions Ireland, One Park Place, Hatch Street, Dublin 2.
  5. This application and declaration together with any representations made by the life/lives to be insured to a medical practitioner acting for Aviva will be the basis of the contract.
  6. If a premium is tendered or a direct debit order is signed no binding contract is created until Aviva Life & Pensions UK Limited confirms cover, the policy document is issued and the first premium is paid.
  7. Copies of the application booklet, policy conditions and benefit illustration are available on request.
  8. Any change in address must be notified to Aviva Life & Pensions UK Limited at their branch office, Aviva Life & Pensions Ireland, One Park Place, Hatch Street, Dublin 2, during the policy term.
  9. Aviva's processes may involve electronic means including, but not limited to, data entered on-line, the recording of information provided by me/us during a medical examination or a telephone interview, the capturing of my/our signature(s) on an electronic device or the use of electronic signatures.
- I/We confirm that I/we have received in writing the information specified in the Declaration of Insurer or Intermediary below.
- I/We also agree to the use by Aviva Life & Pensions UK Limited of my/our personal data and where applicable, sensitive personal data, as indicated in the Data Protection Use of Information Notice overleaf.

*Please sign - Do not use block capitals*

1st life to be insured	<input type="text" value="X"/>	Date	<input type="text" value="D D M M Y Y Y Y"/>
2nd life to be insured	<input type="text" value="X"/>	Date	<input type="text" value="D D M M Y Y Y Y"/>
Signature of Policy Owner(s) if different	<input type="text"/>	Date	<input type="text" value="D D M M Y Y Y Y"/>
	<input type="text"/>	Date	<input type="text" value="D D M M Y Y Y Y"/>

In the case of a corporate owner, state the name of the company that authorised signatory is signing for and on behalf of

**WARNING:** If you propose to take out this policy in complete or partial replacement of an existing policy, please take special care to satisfy yourself that this policy meets your needs. In particular, please make sure that you are aware of the financial consequences of replacing your existing policy. If you are in doubt about this, please contact your insurer or insurance intermediary.

**\* Please note: The references of any Aviva policies being replaced MUST be provided.**

Reference Number(s) of the Aviva policies to be cancelled:

### Declaration of Insurer or Intermediary

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001, the applicant has been provided with the information specified in Schedule 1 to those Regulations and that I have advised the client as to the financial consequences of replacing an existing policy with this policy by cancellation or reduction and of possible financial loss as a result of such replacement.

Name of Insurer or Insurance Intermediary

Date

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## DATA PROTECTION – USE OF INFORMATION NOTICE

The information you provide about yourself and about third parties will be held by Aviva Life & Pensions UK Limited (the data controller) and may be used, stored and processed by Aviva Group companies (together, “we”, “us” or “our”), our commercial partners, authorised agents/service providers and/or successors, on computer systems and/or in paper files for the following purposes: (a) to provide and administer financial services/products requested by you; (b) to comply with applicable legal or regulatory obligations; and (c) for other legitimate business interests of Aviva Life & Pensions UK Limited, including marketing that you have permitted and protection against non-disclosure of material facts and fraud.

In connection with these purposes, information may be shared, both inside and outside the European Economic Area, with our other insurance and financial services companies including those within the Aviva Group and third parties such as reinsurance companies, medical practitioners, Insurance Ireland, trustees/administrators and sponsoring employers of pension plans, other insurance and financial services companies, our service providers such as those to whom we outsource certain business operations, professional advisers, private investigators who may be instructed to investigate a claim, reputable external agencies and as required by law.

To assist in preventing, detecting and/or protecting our customers and ourselves from theft and fraud, we may also use your information to make searches of our records. If you give us false information or fail to disclose information and we suspect fraud, we will record this.

In the event of your application not proceeding or your policy ceasing, information provided in connection with such may be retained for as long as is permitted by law and may be shared as outlined above where applicable.

Where sensitive personal data, for example data relating to your physical or mental health, is provided by you or on your behalf, access to and disclosure of this information will be restricted to that necessary for the purposes set out above, in particular for administering contracts of insurance/products requested by you (including underwriting, processing, claims handling, reinsurance, protection against non-disclosure and fraud prevention).

We may record your telephone calls for quality assurance purposes.

You may request, in writing, a copy of your information held by us. Please write to The Compliance Manager, at our branch office, Aviva Life & Pensions Ireland, One Park Place, Hatch Street, Dublin 2. together with payment of the applicable fee (currently €6.35). You may be asked to prove your identity before your request is met. If you believe there may be inaccuracies identified in the information held about you, then you can contact the Compliance Manager to have such corrected, to block certain uses or object to the processing of your personal data.

You confirm, by signing the declaration on the previous page, that you have fully explained to each person whose information has been provided to us by you in connection with this policy, the purposes and use for which that information has been provided and how the information may be used, in the same detail as set out in this form and that each person has explicitly consented to such.

### Marketing

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.

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.

By submitting this application or if you have any other communication with Aviva Life & Pensions UK Limited through or in relation to its products and services, you acknowledge the foregoing and consent to the processing of the personal data as indicated above. In particular you acknowledge and explicitly consent to the arrangements in relation to sensitive personal data as indicated.

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**FOR FINANCIAL BROKER USE ONLY**

**IMPORTANT:** Please ensure all relevant questions and sections are answered before submitting the application. When keying the data on-line through WriteNow, please ensure that ALL information entered is identical to the information captured in the On-line Data Capture Form.

You are to keep the On-line Data Capture Form and either scan and upload the Customer Application Booklet or post it to Aviva. If you are posting the Booklet we recommend that you retain a copy for your records.

Aviva, as a data controller, will store and destroy the information captured in these documents in accordance with our Data Protection obligations. As a data processor, you also have responsibilities to store and destroy these documents in accordance with your Data Protection Obligations.

**1. Name & Address**


**2. Agency No.**

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**3. Name of Financial Broker/Salesperson**

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**4. Financial Broker's/Salesperson's Email address**

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**5. Financial Broker's/Salesperson's mobile/daytime telephone**

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**6. Special Instructions/Commission Terms**


**For office use only****1. Consultant**

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**2. Branch**

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**Date**

D	D	M	M	Y	Y	Y	Y
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**3. Vetted by**

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**Date**

D	D	M	M	Y	Y	Y	Y
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Application No.

**SEPA DIRECT DEBIT MANDATE**



SEPA Direct Debit Mandate

*Unique Mandate Reference (UMR) – To be completed by Aviva Life & Pensions UK Limited*

By signing this mandate form, you authorise (A) Aviva Life & Pensions UK Limited to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from Aviva Life & Pensions UK Limited.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that can be obtained from your bank.

Please complete all fields marked\*

Name(s) of Account holder(s) \*

Account number – IBAN\*

Bank identifier code – BIC\*

Creditor's name **Aviva Life & Pensions UK Limited**

Creditor identifier **I E 7 4 Z Z Z 9 9 2 9 5 0**

Creditor branch address **One Park Place, Hatch Street, Dublin 2, Ireland.**

This mandate is in respect of a recurring payment.

Signature\*

Signature\*

Date

Location

**Please return this mandate to Aviva Life & Pensions UK Limited trading as Aviva Life & Pensions Ireland, One Park Place, Hatch Street, Dublin 2.**

**Please note:**

Banks may refuse to accept instructions to pay Direct Debits from some types of accounts, usually savings or deposit accounts. If in doubt check with your bank. Aviva Life & Pensions UK Limited may combine the Direct Debits for this mandate with those from any other mandate(s) which you have signed in their favour and which may be payable to them within the same calendar month. Payment amounts may vary from time to time.





**Aviva Life & Pensions UK Limited**, trading as Aviva Life & Pensions Ireland, is authorised by the Prudential Regulation Authority in the UK and is regulated by the Central Bank of Ireland for conduct of business rules.

Aviva Life & Pensions UK Limited, trading as Aviva Life & Pensions Ireland, is also regulated in the UK: by the Prudential Regulation Authority for prudential rules and, to a limited extent, by the Financial Conduct Authority for applicable UK conduct rules. Registered Branch Office in Ireland (No 906464) at One Park Place, Hatch Street, Dublin 2.  
Tel (01) 898 7000 Web [www.aviva.ie](http://www.aviva.ie) Registered in England (3253947) at 2 Rougier Street, York, YO90 1UU.

Telephone calls may be recorded for quality assurance purposes.