



## Protection Cover Application Form

Application No.

Agency No.

### 1. COVER REQUIRED

Mortgage Protection Cover   
*Section 6a*

Flexible Protection Cover   
*Section 6b*

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

Guaranteed Whole of Life Cover   
*Section 6c*

### 2. LIVES ASSURED

#### 1st Life to be assured

Title  Surname

Forename(s)

Date of birth

Gender Male  Female

Marital Status

Have you smoked any form of tobacco or used nicotine  
replacement products in the last 12 months?  
Yes  No

Address (for correspondence)

  
  
  


Daytime telephone number

Alternative telephone number

Email address

Occupation (describe type of business and nature of duties)

  


Relationship of Life 2 to Life 1

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

Title  Surname

Forename(s)

Date of birth

Gender Male  Female

Marital Status

Have you smoked any form of tobacco or used nicotine  
replacement products in the last 12 months?  
Yes  No

Address (for correspondence)

  
  
  


Daytime telephone number

Alternative 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 Cover:** Personal/Family Protection or Borrowing  Inheritance Tax Liability

**Business Cover:** Commercial Borrowing  Business Keyperson Cover  Partnership/Co-Director's Cover

#### 4. COVER DETAILS

**Cover Basis**Single Life Dual Life   
(not available for  
Mortgage Protection  
Cover)Joint Life 1st Death Joint Life 2nd Death   
(available for Guaranteed  
Whole of Life Cover only)

If the policy owner (grantee) is different from the life/lives assured, please complete the following

Full name(s) and address(es) of the person(s)  
or Company effecting this policy  
Relationship to Life/Lives to be assured  
or details of insurable interest  

If the policy is to be written in trust please select trust type

Sec 72/Sec 60 General Trust 

#### 5. POLICY DETAILS

**Premium frequency**Monthly Annually **Conversion Option**Yes No **Policy start date**

(available for Flexible Protection Cover only)

#### 6a. MORTGAGE COVER (REDUCING COVER)

Term  years

Mortgage Protection Life Cover

**Sum Assured**€ 

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 Protection Cover brochure for details of the restrictions, conditions and exclusions that apply to this cover. You cannot choose a different sum assured for Accelerated Specified Illness Cover.

#### 6b. FLEXIBLE PROTECTION COVER (INDEXED COVER) - The benefit payable under the plan will automatically increase by 5% each year with the premiums increasing by 8% each year, unless otherwise stated below.

**Please choose**Indexation - if you wish to decline this valuable feature, please tick here Term  years**Please select from the following covers****1st Life Sum Assured****2nd Life Sum Assured  
(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> 

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

<sup>††</sup>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.

<sup>†††</sup>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.

#### 6c. GUARANTEED WHOLE OF LIFE

**1st Life Sum Assured****2nd Life Sum Assured  
(if dual life only)**

Guaranteed Whole of Life Cover

€ € 

Guaranteed Increasing Benefit Option

Yes No 

#### 7. PAYMENT METHOD

**Payment method**Direct Debit Cheque (Annually only)

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

Personal Statements to be answered by the lives to be assured (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 and 2. Your Financial Adviser will provide you with the appropriate questionnaire.

**Please note carefully**

Failure to disclose all material facts could render your contract void. Material facts are those which an insurer would regard as likely to influence the assessment and acceptance of an application for insurance. If you are in any doubt as to whether certain facts are material, such facts should be disclosed. Any changes to the answers given before the cover comes into force must be notified to Aviva Life & Pensions Ireland Limited.

In accordance with the Disability Act 2005, you should not disclose the results of any genetic tests undertaken.

**PART 1 PERSONAL STATEMENTS TO BE ANSWERED BY THE LIVES TO BE ASSURED** (Please answer carefully giving full details)

**1st Life to be assured**

**2nd Life to be assured**

**Your doctor's details**

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



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**

1. (a) What is your height?

ft  ins  **or** mtrs  cms

ft  ins  **or** mtrs  cms

(b) What is your weight?

st  lbs  **or** kilos

st  lbs  **or** kilos

**Your lifestyle**

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 (n/a or dash not acceptable))

Number of cigarettes per day

Number of cigarettes per day

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

Yes  No

Yes  No

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 been advised by your doctor or other medical practitioner to drink less alcohol?

Yes  No

Yes  No

**1st Life to be assured**

**2nd Life to be assured**

4. Have you taken any recreational drug(s) in the last 5 years?

Yes  No

If Yes, please give full details


Yes  No


5. Do you or do you intend to engage in any of the following hazardous pursuits?

Yes  No

*(If yes please tick all that apply)*

Aviation   
*(except as a fare paying commercial passenger)*

Diving

Extreme Sports

Motor Sport

Mountaineering

Potholing/caving

Sailing

Yes  No

*(If yes please tick all that apply)*

Aviation   
*(except as a fare paying commercial passenger)*

Diving

Extreme Sports

Motor Sport

Mountaineering

Potholing/caving

Sailing

6. Within the last five years, apart from holidays amounting to less than 30 days in any year, have you:

Travelled, lived or worked outside of Australia, Canada, the EU, New Zealand, Norway, Switzerland or the United States of America

AND/OR

Do you intend to in the next two years?

Yes  No

*If yes please give details below (if not applicable, enter 0)*

**1st Life**

Country	Total number of days in last 5 years	Expected number of days in the next 2 years

Yes  No

*If yes please give details below (if not applicable, enter 0)*

**2nd Life**

Country	Total number of days in last 5 years	Expected number of days in the next 2 years

## Your Occupation

### 1st Life to be assured

7. 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

### 2nd Life to be assured

Yes  No

*(If yes please tick all that apply)*

- 
- 
- 
- 
- 
- 
- 

8. (a) Do you work at heights over 40 feet/15 metres?

Yes  No

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

feet or  metres

Yes  No

feet or  metres

## Your existing cover (if any)

### 1st Life to be assured

9. Does the amount being applied for under this application along with any concurrent applications and/or cover already in force (with Aviva or any other insurance company) exceed €1,000,000 for life cover or €500,000 for specified illness cover?

Yes  No

*If yes please give full details*

1st Life


### 2nd Life to be assured

Yes  No

*If yes please give full details*

2nd Life


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*

1st Life


Yes  No

*If yes please give full details*

2nd Life


## Your family history

11. Before the age of 60 have either of your parents or any brothers or sisters suffered or died from:

Angina, heart attack, heart disease or hypertropic cardiomyopathy?

1st life to be assured

Yes  No

2nd Life to be assured

Yes  No

Cancer or polyposis of the colon?

Yes  No

Yes  No

Diabetes or stroke or multiple sclerosis?

Yes  No

Yes  No

Huntington's disease, motor neurone disease, muscular dystrophy, polycystic kidney disease, Parkinson's disease or any other hereditary disease or disorder?

Yes  No

Yes  No

*If yes please give details below*

### 1st Life

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

### 2nd Life

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

## PERSONAL STATEMENTS - PART 2

If you answer Yes to any question in Part 2, please go to Part 3 to give some details

## Your health history

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

1st life to be assured

2nd Life to be assured

1. Cancer (malignant tumour), leukaemia, Hodgkin's disease or lymphoma?

Yes  No

Yes  No

2. Heart attack or angina, heart abnormality or heart valve disease?

Yes  No

Yes  No

3. Stroke, brain haemorrhage, transient ischaemic attack or permanent brain injury through accident?

Yes  No

Yes  No

4. Any disease or disorder of the arteries (including disease in the legs or the aorta)?

Yes  No

Yes  No

5. Multiple sclerosis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease or dementia?

Yes  No

Yes  No

6. Any other disorder of the central nervous system (brain, spinal cord and nerves) not already mentioned?

Yes  No

Yes  No

7. Diabetes or sugar in the urine?

Yes  No

Yes  No

8. Mental illness that has required hospitalisation?

Yes  No

Yes  No

**Your health in the last five years**

**1st life to be assured**

**2nd Life to be assured**

**Apart from conditions already mentioned in questions 1-8, in the last 5 years, have you had any of the following;**

- |  |  |  |
|--|--|--|
| 9. A lump, growth of any kind or any mole or freckle that has bled become painful, changed colour or increased in size?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Chest pain, irregular heart beat, raised blood pressure or raised cholesterol?   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Asthma, bronchitis or any other respiratory disorder?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 12. Numbness, loss of feeling or tingling of the limbs or face or temporary loss of muscle power?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Seizure, fits, fainting, dizziness or blackouts?   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 14. 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)? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 15. Arthritis, neck, spine or joint disorder (including slipped disc, sciatica, back, knee, shoulder pain or gout)?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 16. Any disorder of the digestive system, liver, stomach, pancreas or bowel (including any ulcer, hepatitis, colitis or Crohn's disease)?                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 17. Blood disorder or anaemia?   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 18. Thyroid disorder?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 19. Kidney, bladder or any other disorder of the genito-urinary system (including blood or protein in the urine and urinary tract infection)?                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 20. Any kind of medical attention or time off work for depression, anxiety, stress, nervous breakdown, insomnia or tiredness?                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

**Other questions about your health**

**1st life to be assured**

**2nd Life to be assured**

**Apart from conditions already mentioned above,**

- |   |  |  |
|---|--|--|
| 21. Have you received or been advised to have any investigations, scans or blood tests in connection with any medical condition in the past five years? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 22. Have you had a surgical operation or received any medical attention at a hospital or as an in-patient or out-patient in the last five years?        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 23. Have you any expectation of seeking medical treatment or advice in the future?  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 24. Are you currently taking prescribed drugs, medicines, tablets or any other treatment?   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 25. 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"/> |

**If Yes, please provide the name of the condition and the doctor who you attended for treatment.**

*For extra confidentiality, these details can be sent to the Chief Medical Officer at: Aviva Life & Pensions Ireland Limited, One Park Place, Hatch Street, Dublin 2.*

**1st Life to be assured**

**2nd Life to be assured**



**PERSONAL STATEMENTS - PART 3 - SUPPLEMENTARY HEALTH QUESTIONS**

To be completed if you have answered Yes to Questions 1-25 in Part 2.

**First life assured**

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 2 the condition relates to, e.g. 4

Question

Question

Question

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

Yes  No

Yes  No

Yes  No

If Yes, Which questionnaire?




**please enclose the relevant medical questionnaire(s) and submit with this application form.**

If No, please complete the questions below about each condition. Use an extra 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   
Ongoing condition, no restrictions in lifestyle or mobility   
Minor symptoms, some or occasional restriction in activities or pastimes   
More persistent symptoms, some or occasional restriction in activities or pastimes   
Significant restriction in activities or pastimes

Fully recovered   
Ongoing condition, no restrictions in lifestyle or mobility   
Minor symptoms, some or occasional restriction in activities or pastimes   
More persistent symptoms, some or occasional restriction in activities or pastimes   
Significant restriction in activities or pastimes

Fully recovered   
Ongoing condition, no restrictions in lifestyle or mobility   
Minor symptoms, some or occasional restriction in activities or pastimes   
More persistent symptoms, some or occasional restriction in activities or pastimes   
Significant restriction in activities or pastimes

**To be completed if you have answered Yes to Questions 1-25 in Part 2.**

**Second life assured**

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 2 the condition relates to, e.g. 4

Question

Question

Question

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

Yes  No

Yes  No

Yes  No

**If Yes,** Which questionnaire?




**please enclose the relevant medical questionnaire(s) and submit with this application form.**

**If No,** please complete the questions below about each condition. Use an extra 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   
Ongoing condition, no restrictions in lifestyle or mobility   
Minor symptoms, some or occasional restriction in activities or pastimes   
More persistent symptoms, some or occasional restriction in activities or pastimes   
Significant restriction in activities or pastimes

Fully recovered   
Ongoing condition, no restrictions in lifestyle or mobility   
Minor symptoms, some or occasional restriction in activities or pastimes   
More persistent symptoms, some or occasional restriction in activities or pastimes   
Significant restriction in activities or pastimes

Fully recovered   
Ongoing condition, no restrictions in lifestyle or mobility   
Minor symptoms, some or occasional restriction in activities or pastimes   
More persistent symptoms, some or occasional restriction in activities or pastimes   
Significant restriction in activities or pastimes

## YOUR APPLICATION MAY BE SELECTED FOR THE TELEUNDERWRITING PROCESS

### What is teleunderwriting?

Teleunderwriting is the use of short telephone interviews as the primary means of gathering risk-related information to assess a customer's application for life assurance.

The interviews may be carried out instead of obtaining a report from a doctor or to clarify some details disclosed on the application form. The teleunderwriting process allows for immediate clarification of any medical questions and for a speedier decision-making process.

The interview is carried out by an experienced nurse on behalf of Aviva Life & Pensions Ireland Limited. All interviews are recorded and the information collected will form part of the application process. On completion of the interview, a report will be sent to you to be read, agreed, signed and returned to Aviva Life & Pensions Ireland Limited.

### How long do teleunderwriting interviews take?

Typically a teleunderwriting interview will last 20 - 30 minutes.

### When will the telephone call be made?

You will be contacted a few days after Aviva Life & Pensions Ireland Limited receives your application to arrange a convenient date and time for the interview.

### Is there any preparation needed for the teleunderwriting interview?

To make sure you get the most from the interview and to help speed it up, take a couple of minutes to remind yourself of:

- Any medication you are taking, or have taken; the name of the medication, the dose and why you are taking it.
- Details of any past or present medical conditions suffered; any visits to a doctor, the reason for the visit and what medication you received (other than very minor ailments such as a common cold).
- Names and addresses of your doctors and specialists.
- Any family history of medical conditions.
- Your accurate height and weight.

### Duty of Disclosure

The same obligation to disclose all material facts applies during the teleunderwriting process as when you are completing the application form. The interviewing nurse will explain clearly what information is required, and why.

## DECLARATIONS (must be completed for all Covers)

### Declaration of Client(s)

I/We, the life/lives to be assured, 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 Ireland Limited and 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 Ireland 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 answers to the questions on the application (including, if applicable, any information given on extra sheets), whether in my/our handwriting or written by another are strictly true and complete and that this application and Declaration together with any representations made by the life/lives to be assured to a medical practitioner acting for Aviva Life & Pensions Ireland Limited, shall be the basis of the contract and I/we understand that if a premium is tendered or a direct debit order signed no binding contract is created until Aviva Life & Pensions Ireland Limited confirms cover, the policy document is issued and the first premium is paid. I/We understand that copies of the application form, policy conditions and benefit illustration are available on request.

Any change in address must be notified to Aviva Life & Pensions Ireland Limited during the policy term. This is a legal document and forms part of the basis of the contract. All sections must be fully completed and any alterations initialled by the signatory/signatories. Failure to provide true and complete information may render the contract void.

If your application for insurance is declined or accepted subject to special terms, then that fact may be noted on a registry administered by the Irish Insurance Federation and may be shared with other offices as a protection against non-disclosure of material facts. Any changes to the answers given, before the policy comes into force, must be notified to Aviva Life & Pensions Ireland Limited.

I/We agree to the use by Aviva Life & Pensions Ireland 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 assured X Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

2nd life to be assured X Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Signature of Grantee(s) /Policy Owner(s) if different X Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

In the case of a corporate grantee state name of company that authorised signatory is signing for and on behalf of \_\_\_\_\_

## DECLARATIONS Continued

**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 policy number of the policy being replaced MUST be provided.**

**Reference Number(s) of policies to be cancelled:**

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### 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*

Signed  \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

I/We confirm that I/we have received in writing the information specified in the above Insurer or Intermediary declaration.

1st Grantee/Policy Owner  \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

2nd Grantee/Policy Owner  \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

*(if applicable)*

## DATA PROTECTION - USE OF INFORMATION NOTICE

The information you provide about yourself and about third parties will be held by Aviva Life & Pensions Ireland 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 Ireland 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, the Irish Insurance Federation, 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. We also participate in the Life Assurance Registry, which is operated by The Irish Insurance Federation for the purpose of sharing of information among insurance companies as a check against non-disclosure.

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, are 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).

From time to time, 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 The Compliance Manager, Aviva Life & Pensions Ireland Limited, 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 opposite, 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 Ireland 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.

**FOR FINANCIAL ADVISER USE ONLY**

**NB** Please ensure all relevant questions are answered before submitting the application form. If keying this application online through WriteNow, please ensure that ALL information inputted online is identical to the information captured on this application form.

1. Name & Address

  


2. Agency No.

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3. Name of Financial Adviser/Salesperson

4. Financial Adviser's/Salesperson's Email address

5. Please indicate the Commission Terms  
If not completed we will assume standard terms.

Please tick:

Standard  Or Other Initial  Renewal

6. Special Instructions/Commission Terms

  
  


**\* Please note: The policy number of the policy being replaced MUST be provided (see declaration). If it is not provided the existing policy will remain in force.**

**For office use only**

1. Consultant

2. Branch

Date

D		M		Y		Y	
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3. Vetted by

Date

D		M		Y		Y	
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**Direct Debit Mandate**

Please complete parts A to E to instruct your bank to make payments directly from your account.

**Your instructions to your bank.** I/We instruct you to pay direct debits from my/our account at the request of Aviva Life & Pensions Ireland Limited. The amounts are variable and may be debited on various dates. I/We understand that Aviva Life & Pensions Ireland Limited may change the amounts and dates only after giving me prior notice. I/We will inform the bank in writing or Aviva Life & Pensions Ireland Limited if I/we wish to cancel this instruction. I/We understand that if any Direct Debit is paid which breaks the terms of this instruction, the bank will make a refund.

A. Please complete full postal address of your Bank Branch

To: The Manager

  
  


**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 Ireland Limited may amalgamate Direct Debits under this mandate with any other mandates payable by Direct Debit which may be due to them within the same calendar month under other mandates expressed in their favour and signed by me/us.

Aviva Life & Pensions Ireland Limited  
ID number **99-29-50**

Reference number *office use only*

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B. Account name

C. Account number

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D. Bank sort code

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E. Signature(s)

X

X

Date

Application Number

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**The Direct Debit Guarantee**

- This is a guarantee provided by your own Bank as a member of the Direct Debit Scheme, in which Banks and Originators of Direct Debits participate
- If you authorise payment by Direct Debit, then:
  - Your Direct Debit Originator will notify you in advance of the amounts to be debited to your account
  - Your Bank will accept and pay such debits, provided that your account has sufficient available funds
- If it is established that an unauthorised Direct Debit was charged to your account, you are guaranteed a prompt refund by your Bank of the amount so charged
- You can cancel the Direct Debit in good time by writing to your Bank

**Aviva Life & Pensions Ireland Limited.** A private company limited by shares.

Registered in Ireland No. 252737 **Registered Office** One Park Place, Hatch Street, Dublin 2.

Member of the Irish Insurance Federation. Aviva Life & Pensions Ireland Limited is regulated by the Financial Regulator.

Aviva Life & Pensions Ireland Limited is a subsidiary of Aviva Life Holdings Ireland Limited, a joint venture company between Aviva Group Ireland plc and Allied Irish Banks, p.l.c.

**Life & Pensions** One Park Place, Hatch Street, Dublin 2. Phone (01) 898 7000 Fax (01) 898 7329

www.aviva.ie

Telephone calls may be recorded for quality assurance purposes.