Your guide to applying for cover

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This booklet is a general guide only. If you're thinking about buying a policy, it's important that you read the relevant Insurance Product Information Document (IPID) and terms and conditions together with this guide. The IPID provides a short summary of key product information in a standardised format. Whereas the terms and conditions give full details of the cover provided, and any restrictions or exclusions which may apply.

If you go on to buy a policy, you should read all your policy documents so you know the full details, including the underwriting that applies to you, what you're covered for, and any personal medical exclusions that may apply.

If you have any questions or would like any other policy documents, please ask the person arranging your private health insurance cover, or phone our customer helpline on **0800 42 42 42**. Calls may be recorded and/or monitored.

You should take the time to read the terms and conditions before applying for cover.

In any event, you'll have 14 days from the time you purchase your policy, or receive your policy documents, whichever is the later, to cancel your policy, this is called the 'cooling off period'. If, during the cooling off period, you tell us you've changed your mind, we'll send a full refund of any premiums you've paid, provided you've not already made a claim.

Cancellation rights after this 14 day period are explained in the terms and conditions.

The purpose of private health insurance

Insurance policies provide cover against an unexpected event happening during the term of the policy. Private medical insurance (PMI) is designed to pay for the cost of private medical treatment for diseases, illnesses, or injuries which are likely to respond quickly to treatment, commonly known as acute conditions.

Your policy won't cover conditions which you have prior to joining the policy. These are commonly known as pre-existing conditions, and it won't usually cover conditions which are related to pre-existing conditions. Diseases, illnesses or injuries are related if one is a result of the other, or if each is a result of the same disease, illness or injury.

As with most insurance policies, our cover excludes long term treatment and the maintenance of long term conditions, often referred to as chronic conditions, such as epilepsy or Crohn's disease.

This guide explains how we deal with pre-existing conditions and chronic conditions.

The standard industry definitions for an acute condition and a chronic condition can be found on page 10.

Underwriting

Underwriting is the term used to describe the process by which we decide the conditions which may or may not be covered by your policy. There are five types of underwriting for the cover we provide:

1. Full medical underwriting (FMU)

If you choose this option, you'll need to complete an application form detailing your current and previous medical history, and that of any member of your family included in your application. It's important that you answer the questions carefully, including all know medical conditions and treatment details where requested, and in full for each person to be covered this is because we'll use the answers you give to determine what your policy will cover. We'll review this information and if necessary, we'll ask your doctor for any further information.

If you or any members of your family have told us about a pre-existing condition that's likely to need treatment in the future, we'll usually exclude it from cover along with any conditions related to it. If we apply any personal medical exclusions, they'll be available online through MyAviva, or by calling us.

Of course, any new and unexpected acute medical conditions arising after you join the policy will be covered subject to the terms and conditions.

You must answer all the questions in the questionnaire fully, truthfully and accurately. If you don't, this could affect how much we pay if you make a claim, or it could mean we won't pay your claim at all.

2. Moratorium (MORI)

With this option, you don't need to complete an application form. Instead, we automatically exclude any pre-existing or related conditions which you've had:

- symptoms of
- medication for
- treatment for
- diagnostic tests for, or
- advice about

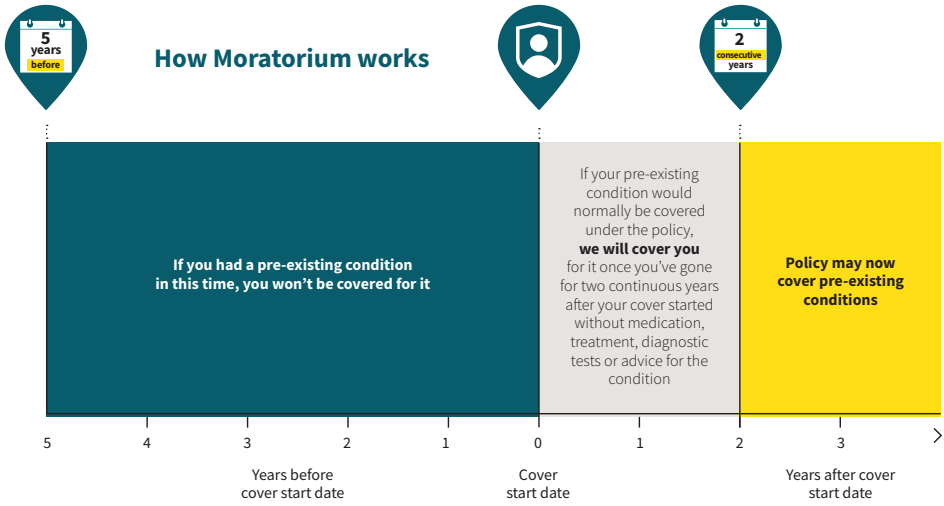
in the five years before you joined the policy.

If you don't have any medication, treatment, diagnostic tests or advice for those pre-existing conditions, for two continuous years after you join the policy, then we'll cover those conditions, subject to the policy terms and conditions. This two year period is known as the moratorium.

Your policy will probably never cover long term (chronic conditions) or pre-existing medical conditions which are likely to continue to need regular or periodic treatment, medication, medical advice or where you continue to suffer symptoms. This is because each time you need any such treatment, medication, medical advice or suffer any symptoms, the moratorium starts again, so it is unlikely that there would ever be a two year clear period.

Of course, any new and unexpected acute medical conditions arising after you join the policy will be covered subject to the policy terms and conditions.

We strongly advise you against delaying seeking medical advice and treatment during the moratorium for a pre-existing condition simply to try to obtain cover under your policy.



What is a pre-existing condition?

It's when you've had symptoms, medication, advice, treatment or diagnostic tests for a disease, illness or injury before your cover started. For more information on what moratorium and full medical underwriting is visit:
aviva.co.uk/health/health-products/health-insurance/understanding-medical-underwriting-types

3. Continued Medical Exclusions (CME)

This can only be chosen if you're transferring from an existing fully medically underwritten policy. With this option we apply the same personal medical exclusions (if any) to your policy that were applied by your previous insurer. New exclusions may be added to your policy based on the answers you have provided or are required to provide on your application. The terms and conditions of this policy may be different to those of your previous policy.

4. Continued moratorium

This underwriting can be used if you were insured on a moratorium basis on another policy and then transferred to a policy with Aviva.

We don't cover treatment of any pre-existing condition, or any related conditions, if you had symptoms of, medication, diagnostic tests, treatment for or advice about that condition in the five years before your initial date of cover.

Your initial date of cover is the date you started cover with your first insurer (provided there has been no break in cover since then).

However, we'll cover that condition, if you don't have medication, diagnostic tests or treatment for, or advice about that condition during a continuous two year period after your initial date of cover.

The terms and conditions of your new policy may be different to those of your previous policy.

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5. Medical History Disregarded (MHD)

This can only be chosen if you're transferring to our Healthier Solutions product after leaving a company scheme and where you were insured on an MHD basis.

We don't apply any personal medical exclusions to your policy as a result of pre-existing conditions.

However the terms of the Healthier Solutions product may differ from those of your previous company policy.

Which underwriting option should I choose?

Most options have the same outcome, they'll cover you for unexpected acute medical conditions, but they won't cover you for pre-existing medical conditions.

If you're still unsure, the following points may help.

- **Full medical underwriting**

This option involves more of your time when completing your application form. But it does mean that when you receive your policy documents, we'll confirm which conditions and any related conditions we've excluded from cover (if any).

- **Moratorium**

With this option, we only need basic information to set up your policy. We don't ask for any details of your medical history, but we won't cover any pre-existing or related conditions that existed 5 years prior to you taking out the policy.

If you don't have medication, diagnostic tests, treatment or advice for the condition, for two continuous years after you join, then it will be covered within the terms and conditions.

With moratorium underwriting the claims process may take a bit longer because each time you make a claim we'll look at your medical history, and may ask your GP for more information to understand if your symptoms or conditions are new or pre-existing.

- **Continued Medical Exclusions**

With this option you must send us your previous medical insurance certificate which shows any personal medical exclusions that may have been applied. If insufficient information or incomplete documentation is received, you'll be accepted, but all pre-existing conditions will be excluded. It's in your best interest to return the information as soon as possible, as something you could have been covered for may be excluded from cover. This may have an impact on the assessment of any claim you make, and can cause delays. However, if you can provide these documents, we may review the exclusion.

Examples of how full medical underwriting and moratorium underwriting work

Here are some typical questions and answers:

Q **I had an operation on my right knee recently. Will I be covered for any further treatment to it after my policy starts?**

A **Full medical underwriting** - In most circumstances, an exclusion will be applied which will make related future claims to the right knee ineligible. If further information is made available from your GP or specialist regarding the detail of the knee operation or a diagnosis is made, the exclusion may be made more specific. Depending on the diagnosis, you can ask us to review the exclusion after you have been symptom-free for a period of two years after you join the policy.

A **Moratorium** - Treatment to the right knee will be excluded for two years from your joining date. If you receive treatment, diagnostic tests, medication (eg pain relief) or advice during this time, treatment to your right knee will not be covered until you have been free of medication, diagnostic tests, treatment for or advice about the condition for two continuous years. See moratorium diagram on page 4 to see how this works.

Q **Some time after my cover begins, I go to my doctor for a routine visit. A heart condition is diagnosed and it must have started to develop before my policy began. What is the position?**

A **Full medical underwriting** - Provided you were not aware of any symptoms prior to the start date of your policy and had not received any medication, diagnostic tests, treatment or advice. A declaration on the application form wouldn't have been possible and no exclusion would have been applied. If any symptoms had been apparent, such as chest pain, you would have been expected to have provided details of these and an exclusion may have been applied. Further information may be required from your GP.

A **Moratorium** - Provided you were not aware of any symptoms and had not received any medication, diagnostic tests, advice or treatment prior to the start date of your policy it would be unreasonable for the moratorium to be applied to this condition. If it was clear that you'd experienced symptoms, such as chest pain before taking out your policy, then it's likely that cover would be excluded. Further information may be required from your GP.

Q **What if I suspect I'm suffering from a condition (for example, I've pain in my right knee) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts? Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?**

A **Full medical underwriting** - You would be required to disclose details of the symptom, ie the fact you have pain in your right knee, on the medical declaration. An exclusion would be applied to the symptom (and underlying condition). A more specific exclusion could be applied if further information is made available or a diagnosis is made.

A **Moratorium** - As you had symptoms before your cover started, you won't be covered for treatment for that condition until you have been free of medication, diagnostic tests, treatment for or advice about the condition for a continuous period of two years after you join the policy.

For moratorium option only

Q **How do regular check-ups affect the moratorium?**

A

1) If you have a pre-existing condition, (in existence before the start of your policy), that requires regular check-ups we won't cover that condition or any treatment relating to it. Cover will only apply (subject to the policy terms and conditions) once you've been discharged from care and have no further treatment, diagnostic tests, medication or advice for a continuous period of two years.
2) If you have general health check-ups simply in the interests of maintaining good health, and not for any particular condition, we ignore them when applying the moratorium.

We don't pay for check-ups in any of the circumstances described above.

Chronic conditions explained

If you're thinking of buying a private medical insurance policy, or already have a policy, you may have heard the term 'chronic condition'.

Private medical insurance (PMI) products are primarily designed to cover the cost of private medical treatment of 'acute conditions' that start after you join the policy.

The Association of British Insurers (ABI) defines an acute condition as:

A disease, illness or injury that is likely to respond quickly to treatment which aims to return the claimant to the state of health they were in immediately before suffering the disease, illness or injury, or which leads to a full recovery.

There are products that cover some treatment for, or elements of, chronic conditions, but that's not usually the main purpose of a PMI policy.

This section explains how Aviva manages those members whose medical condition becomes a chronic condition.

There are benefit limits and exclusions on all our PMI products and you should check your policy wording and contact us before incurring any costs.

What is a chronic condition?

A chronic condition is defined as a disease, illness or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

At Aviva we cover the cost of treatment for acute conditions, subject to the terms of your policy wording. An acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery. Chronic conditions are generally excluded. Some examples of chronic conditions are given on the next page.

If you have symptoms which need investigating, we'll pay for eligible diagnostic tests, subject to your policy terms and conditions. If, as a result of the tests, you're diagnosed as suffering with a chronic condition your policy won't cover you for treatment of that condition.

What does this mean in practice?

If we think that your condition may have become chronic we'll review your claim, including any medical information provided by your GP or the specialist in charge of your care.

We'll always consider your individual situation and particular circumstances, and we may consult our in-house medical advisers if we need to.

If we feel your condition has become chronic, we'll contact you to explain why. We'll give you time to make other arrangements for your continued treatment, such as asking your doctor to transfer you to NHS care.

If we establish that your condition isn't currently a chronic condition, we may still need to review it again in the future. If so we'll tell you and indicate when we'll need an update.

Our cancer pledge provides extensive cover and support at every stage of cancer treatment and we don't apply the chronic condition exclusion to treatment for cancer. But we do apply the chronic condition exclusion to consequences of, or conditions related to, cancer treatment. The examples on the next pages explain what cover may be available.

What if my condition gets worse?

If you experience an unexpected acute flare-up of your condition with new symptoms, we'll pay for investigations to find the underlying cause. We'll also pay for treatment that's likely to permanently resolve or cure the underlying condition. This doesn't apply to mental health conditions, please refer to your terms and conditions for more details.

Although it's likely that we'll withdraw cover if your condition has become chronic, this doesn't necessarily mean that cover is permanently withdrawn.

Examples of chronic conditions

These examples help to show the cover you could have from Aviva if you develop a medical condition that becomes a chronic condition. Please bear in mind that these are only examples and are specific to the circumstances described. You should always contact us before you have any treatment to ensure that you don't incur any costs which you can't recover from us.

These examples are based on a policy which includes full cover for in-patient, day-patient and out-patient treatment. If the policy you select does not have full out-patient cover you may not be covered for consultations, diagnostic tests, or follow-up consultations.

Example A

Alan has been with Aviva for many years. He develops chest pain and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as suffering from a heart condition called angina. Alan is placed on medication to control his symptoms.

We'll pay for the diagnostic tests needed to find out the cause of Alan's chest pain. We'll also pay for one follow-up consultation with his specialist. We wouldn't pay for any medication.

Two years later Alan's chest pain recurs more severely and his specialist recommends that he has a heart by-pass operation.

We'll pay for the heart by-pass operation. We'll also pay for:

- a pre-operative consultation and diagnostic tests, and
- a post-operative follow-up consultation that Alan's specialist needs to do to ensure that the operation has been successful.

Example B

Eve has been with Aviva for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she has check-ups every four months.

We'll pay for the diagnostic tests and consultations until the diagnosis is made. We'll pay for the first follow-up consultation to allow Eve to make alternative arrangements (for example using the NHS) if she needs to, but we won't pay for further consultations because these are regular check-ups, and so aren't covered by the policy.

Eighteen months later, Eve has a bad asthma attack.

If this is an unexpected acute flare-up we'll pay for the cost of the hospital treatment. We'll also pay for one follow-up consultation with the specialist.

Example C

Deirdre has been with Aviva for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to a specialist who organises a series of investigations to confirm the diagnosis. She then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review her condition.

We'll pay for the diagnostic tests and consultations until Deirdre's condition is more stable and she is comfortable managing it. We'll pay for the first follow-up consultation to allow Deirdre to make alternative arrangements (for example using the NHS) if she needs to, but we won't pay for further consultations because these are regular check-ups of a chronic condition, and so aren't covered by the policy.

One year later, Deirdre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.

As this is an unexpected acute flare-up we'll pay for the cost of the hospital treatment. We'll also pay for one follow-up consultation with the specialist.

Example D

Bob has been with Aviva for three years when he develops hip pain. His GP refers him to an osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional treatment to prevent a recurrence of his original symptoms.

We'd pay for the initial acute phase of treatment while Bob is seeing the osteopath every other day for two weeks, within the limits of his policy. After this there will be no cover for further management or monitoring to prevent a recurrence of his original symptoms. However, if his symptoms worsen, and he needs a hip replacement, we'd pay for this as the intention would be to cure him.

Example E

Beverley has been with Aviva for five years when she is diagnosed with breast cancer. Following discussion with her specialist she decides:

- **to have the tumour removed by surgery. As well as removing the tumour, Beverley's treatment will include a reconstruction operation**
- **to undergo a course of radiotherapy and chemotherapy, and**
- **to take hormone therapy tablets for several years after the chemotherapy has finished.**

We'd pay for the surgery to remove the tumour and surgery to reconstruct the breast. We'd also pay for radiotherapy and licensed chemotherapy. We'll only pay for hormone therapy if it's needed to shrink a tumour before surgery or radiotherapy.

As Beverley's hormone treatment is not being used for this purpose we wouldn't provide cover. Beverley's GP will be able to prescribe the tablets.

During the course of chemotherapy Beverley suffers from anaemia. Her resistance to infection is also greatly reduced. Her specialist:

- **admits her to hospital for a blood transfusion to treat her anaemia, and**
- **prescribes a course of injections to boost her immune system.**

We'd pay for the blood transfusion which is intended to treat the anaemia and also the injections to boost her immune system.

Despite the injections to boost her immune system, Beverley develops an infection and is admitted to hospital for a course of antibiotics.

We'd pay for the admission to hospital and the course of antibiotics which is intended to treat the infection.

Five years after Beverley's treatment finishes the cancer returns. Unfortunately, it has spread to other parts of her body. Her specialist recommends a treatment plan:

- **a course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months**
- **monthly infusions of a drug to help protect the bones against pain and fracture which is to be given for as long as it continues to work (hopefully years), and**
- **weekly infusions of a drug to suppress the growth of the cancer which is to be given for as long as it continues to work (hopefully years).**

We'd pay for licensed chemotherapy drugs recommended by Beverley's specialist. We'll pay for monthly infusions of a drug to help protect the bones against pain and fracture (bone strengthening drugs, such as bisphosphonates). We'd also pay for the weekly infusions of the drug used to suppress the growth of the cancer, for as long as her specialist recommends them.

Example F

David has been with Aviva for two years when he is diagnosed with cancer. Following a discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a "bone marrow") transplant.

We'd pay for the licensed chemotherapy drugs. We'd also pay for the stem cell transplant. This includes the collection, storage and implantation of the stem cells. We wouldn't pay for search costs, including compatibility testing, to find a donor for a transplant, and we wouldn't pay for courier charges. We'll pay for drugs David needs to take home at the time he is discharged from hospital following the stem cell transplant but he may need to take certain drugs (for example immunosuppressants, antibiotics, steroids) for a long period of time in order to prevent complications. We won't pay for these drugs.

When his treatment is finished David's specialist tells him that the cancer is in remission but he would like him to have regular check-ups for the next five years to see whether the cancer has returned.

We don't place a time limit on cancer monitoring, so we'll pay for these check-ups for as long as his specialist recommends them.

Example G

Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms.

If Eric is suffering from cancer and is admitted to a hospice for end of life care, we'll make a donation to the hospice of £100 per night, up to a maximum limit of £10,000.

If Eric is admitted to a hospice with a condition other than cancer and we've previously covered treatment for that condition, we'll pay a donation to the hospice of £70 per day for up to 10 days.

This has been produced to help you understand how Aviva may handle a claim involving a chronic condition. The examples given are for illustrative purposes only.

Please refer to your policy documents for details of your cover and contact the customer service helpline before receiving treatment.

Any questions?

Call us on **0800 42 42 42**

Calls may be monitored and recorded

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