

General Practitioner Aviva Registration Form

For Office Use Only

Registration Number:

Title*:

First Name*:

Second Name:

Surname*:

Name to appear on correspondence*:

PPS Number*:

Irish Medical Council Registration Number*:

Home Address:

Practice Address*:

Contact Telephone Number*:

Contact Fax Number:

Contact E-Mail Address*:

Contact Mobile Number:

Do you wish to be paid electronically directly into your bank account*? Yes No

If yes, we require the following information:

Bank Name:

Bank Address:

Bank Account Name:

Sort Code: - -

Bank Account Number:

If no, and you do not want to be paid directly into your bank account, please insert details of remitting address for payments here:

Member of a Group Practice: Yes No

Name and address of Group Practice:

Will you be (please tick relevant box)*:

Fully accepting Aviva payment rate?

Not accepting Aviva payment rate?

***Mandatory fields**

Please turn over

Data Protection

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

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

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

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

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

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

Declaration

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

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

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

Print name in block capitals:

Your signature:

Date:

We would like to use your details to provide you with information about other financial or insurance products, services and special offers either from us or other Aviva Group companies, or products, services and special offers which any member of the Aviva Group may arrange with a third party. Your details may also be used for this purpose (for up to 12 months) after your policy has ceased. 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.