

# Aviva Discounted Gift Trust

## Assessment of life expectancy – underwriting form



### Important Notes

#### Eligibility:

- The bond investment must be £50,000 or more.

Please specify the expected investment amount

- The settlor(s) must be resident in either the UK, Isle of Man or Channel Islands.

#### Application Process:

The trust deed (bare or discretionary) and the appropriate application form must be dated and submitted to Aviva after we inform you of the underwriting decision. Do not submit undated trust deeds and application forms with this underwriting form.

#### Purpose of this form:

When you complete this questionnaire, it will enable Aviva to make an estimate of the possible reduction in Inheritance Tax payable in respect of the gift you make by effecting your Discounted Gift Trust (Discretionary or Bare). This estimate is subject to the agreement of Her Majesty's Revenue & Customs in consultation with your personal representatives after your death. Therefore, it is important to answer every question as fully as you can. If you are not sure of the answer to a particular question, simply state as much as you know and say that you are not sure. All sections of the questionnaire must be completed.

#### The information that you give:

Will be used by our underwriters to make a judgement that you would be classed as in normal health and, consequently, likely to have the typical lifespan of a person of your age and sex, or that you would be expected to have a somewhat shorter span because of certain aspects of your current or previous medical history. This, of course, is similar to the process for underwriting applications for ordinary life insurance.

Any information that you give will be used only for making the assessment described above. It will not be used for any other purpose unless we have your express written consent, and it will be kept securely and in accordance with the Data Protection Act 1998.

#### Genetic test results

In accordance with the Association of British Insurers' policy on genetics and insurance, you do not need to tell us about any genetic test results you have had. However, you must answer the individual application form questions fully and accurately giving details, where appropriate, of any family history, current symptoms or treatment being received in respect of any medical conditions including any genetically inherited condition.

**If you wish to tell us about a negative genetic test result which shows that you have not inherited a genetic disorder we will take this into account when assessing your application.**

#### HIV antibody test results:

We assume that you have not tested positive for HIV/AIDS. If this assumption is incorrect, we regret that we would not be able to provide an assessment within reasonable limits of confidence because of the extreme variability of mortality in persons who have been infected with HIV.

## Data Protection:

Information you supply will be used by Aviva to administer your plan and may be processed by any company within the Aviva Group, by re-insurers and by third parties who provide services to Aviva. It may be transferred to any country, including those outside the European Economic Area, for any of these purposes. Any information may be used for underwriting or claims handling purposes and disclosed in confidence to regulatory bodies, other insurance companies (directly or via shared databases), other Aviva companies and your financial adviser (including third parties providing services to them). We may need to share with your usual doctor any information obtained from any examination or screening.

## Sharing Medical Information:

If we ask you to have a medical examination or screening we will need to share the relevant information from your application with another company we have authorised to arrange such examinations or screenings.

We may need to share with your usual doctor any information we have obtained from a medical examination or screening.

## Consent to obtain a medical report:

We may need to get medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. **Your rights under the act are as follows:**

- You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.
- If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

## The medical report your doctor fills in asks about the following:

- Your current health including any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health including details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
  - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
  - suicidal thoughts or attempts at suicide; or
  - conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years or
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

## We will ask your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health.
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to: Head of Underwriting, Aviva, 2 Rougier Street, York, YO90 1UU

## Settlor 1

### Name of the person whose life is to be underwritten (i.e the trust settlor)

Mr/Mrs/Miss/Ms  Surname

Forenames

Occupation

Date of Birth  /  /

Address

Post Code

Telephone No. (Day)  (Evening)

May we contact you by telephone if we need to clarify any of the information in this form? YES  NO

### Your Doctor's details

Name

Telephone No. (Day)  (Evening)

Address

Post Code

### Smoking

Have you consumed any tobacco within the last 12 months? YES  NO

If "yes" please state type and quantity per day, e.g. cigarettes, cigars, grams of pipe tobacco.

### Alcohol Consumption

What is your usual consumption of alcohol in units per day or week?  ... units per day/week

If it has been higher please state the higher amounts and for how long.  ... units per day/week until...

(A unit of alcohol = 1/2 pint of beer/1 glass of wine/  
1measure of spirits)

What is your Height?  ft.  ins./  M

What is your Weight?  St.  lbs./  Kg.

1. Are you awaiting or currently receiving treatment (tablets, injections, inhalations, radio- or chemotherapy, surgery) for any medical condition? If so, please give details. YES  NO

2. In the last 5 years have you undergone treatment, surgery or investigations? If so, please give details of the condition(s), the treatment, surgery or investigations and dates. YES  NO

3. Do you have, or have you ever undergone treatment, investigations or operations for, the following illnesses or conditions? If so, please state the condition(s) and give details of the treatment, etc. YES  NO

(a) Heart attack, angina, coronary artery bypass grafting?

(b) High blood pressure, stroke, transient ischaemic attack, raised cholesterol or other lipid disorder?

(c) Heart valve disease or surgery/replacement, heart rhythm disorder, palpitations?

(d) Any disorder of the oesophagus, stomach or intestines, ulcerative colitis or Crohn's disease?

(e) Cancer or other growth? Please specify the site(s), the stage and dates when treatment was completed.

(f) Bladder, kidney or other genito-urinary complaints?

(g) Fainting, giddiness, epilepsy or paralysis?

(h) Numbness, blurred vision, multiple sclerosis or other neurological conditions?

(i) Diabetes?

(j) Hepatitis or other liver complaints or disorders?

(k) Asthma, bronchitis, bronchiectasis, emphysema or other respiratory condition or disease?

(l) Any disorder or disease of the skin, tissue, bones, joints or muscles?

(m) Blood disorder?

(n) Any condition, disease or disorder of a disabling nature?

(o) Have any members of your immediate family (parents, brothers or sisters) had or died from, cancer of the bowel or breast, polycystic kidney disease, Huntington's Disease or any other hereditary disease or condition?

(p) Depression, anxiety or other nervous or mental disorder?

## Settlor 2

### Name of the person whose life is to be underwritten (i.e the trust settlor)

Mr/Mrs/Miss/Ms  Surname

Forenames

Occupation

Date of Birth  /  /

Address

Post Code

Telephone No. (Day)  (Evening)

May we contact you by telephone if we need to clarify any of the information in this form? YES  NO

### Your Doctor's details

Name

Telephone No. (Day)  (Evening)

Address

Post Code

### Smoking

Have you consumed any tobacco within the last 12 months? YES  NO

If "yes" please state type and quantity per day, e.g. cigarettes, cigars, grams of pipe tobacco.

### Alcohol Consumption

What is your usual consumption of alcohol in units per day or week?  ... units per day/week

If it has been higher please state the higher amounts and for how long.  ... units per day/week until...

(A unit of alcohol = 1/2 pint of beer/1 glass of wine/  
1 measure of spirits)

What is your Height?  ft.  ins./  M

What is your Weight?  St.  lbs./  Kg.

1. Are you awaiting or currently receiving treatment (tablets, injections, inhalations, radio- or chemotherapy, surgery) for any medical condition? If so, please give details. YES  NO

2. In the last 5 years have you undergone treatment, surgery or investigations? If so, please give details of the condition(s), the treatment, surgery or investigations and dates. YES  NO

3. Do you have, or have you ever undergone treatment, investigations or operations for, the following illnesses or conditions? If so, please state the condition(s) and give details of the treatment, etc. YES  NO

(a) Heart attack, angina, coronary artery bypass grafting?

(b) High blood pressure, stroke, transient ischaemic attack, raised cholesterol or other lipid disorder?

(c) Heart valve disease or surgery/replacement, heart rhythm disorder, palpitations?

(d) Any disorder of the oesophagus, stomach or intestines, ulcerative colitis or Crohn's disease?

(e) Cancer or other growth? Please specify the site(s), the stage and dates when treatment was completed.

(f) Bladder, kidney or other genito-urinary complaints?

(g) Fainting, giddiness, epilepsy or paralysis?

(h) Numbness, blurred vision, multiple sclerosis or other neurological conditions?

(i) Diabetes?

(j) Hepatitis or other liver complaints or disorders?

(k) Asthma, bronchitis, bronchiectasis, emphysema or other respiratory condition or disease?

(l) Any disorder or disease of the skin, tissue, bones, joints or muscles?

(m) Blood disorder?

(n) Any condition, disease or disorder of a disabling nature?

(o) Have any members of your immediate family (parents, brothers or sisters) had or died from, cancer of the bowel or breast, polycystic kidney disease, Huntington's Disease or any other hereditary disease or condition?

(p) Depression, anxiety or other nervous or mental disorder?

### Declaration

All the information provided and questions answered in this application and any attached or associated statements or questionnaires are truthful, accurate and complete.

#### I/We agree:

- To the Company seeking information, including medical reports, from any doctor I have consulted about anything that affects my physical or mental health and I authorise the giving of such information. This consent shall remain valid for a period of up to six months after the start of the contract.
- To authorise those who are asked for such information to provide it on production of a copy of this consent.
- To the Company processing all information associated with this assessment and the associated plan as set out in the Important Notes section of this application under Data Protection.

**I have read and understood the Declaration and Important Notes. I have read the notes relating to my rights of access to medical reports:**

	Settlor 1	Settlor 2
I/We do <b>not</b> want to see the report before it is sent to the Company.	<input type="checkbox"/>	<input type="checkbox"/>
I/We <b>do</b> want to see the report before it is sent to the Company.	<input type="checkbox"/>	<input type="checkbox"/>

### Signature to Declaration and Consent

Signature Settlor 1

Date  /

Signature Settlor 2

Date  /

All references above refer to Aviva and Aviva Life International Limited.

#### For Office Use Only:

Aviva Bare Discounted Gift Trust reference







Aviva Life International Limited is authorised in Ireland by the Financial Regulator and subject to regulation by the Financial Services Authority. Details on the extent of our regulation by the Financial Services Authority are available from us on request. The Financial Services Authority rules and regulations are made under the Financial Services and Markets Act 2000.

If the company should become unable to meet its liabilities, the Financial Services Compensation Scheme will protect the eligible policyholder of an Aviva Life International Limited bond who is habitually UK resident at the time the contract commences. Registered Office: 6 Georges Dock International Financial Services Centre, Dublin 1, Ireland. Registered in Ireland No 303257. Telephone +353 1 802 8494 Fax + 353 1 802 8400 [www.aviva.co.uk/international](http://www.aviva.co.uk/international)

