

Business Healthcare – employee application form.

Schemes of 3 to 19 employees

To apply for PruHealth membership complete SECTIONS A to I. Please check all details on the application. If any details are incorrect put a line through them, write in the correct details and initial the change.

Please use BLOCK CAPITALS and black ink when filling in this form.

A – Employment details

Employer name

Date of employment Date you would like your cover to begin (if you are a new employee)

B – Employee details

Title Mr Mrs Ms Miss Other

First name* Last name*

Address*
 Postcode

Telephone number (home) Telephone number (work) Date of birth*

Telephone number (mobile) Fax number Gender Male Female

E-mail*

Job Title* * Denotes a required field.

C – Cover details

Your employer has made some cover choices for you. If you're not sure of the details below, please ask your employer.

Employer group (category)

Please indicate your employer's hospital list and underwriting choice by ticking the appropriate box.

Hospital list Local Countrywide London Premier

Underwriting choice Full medical underwriting Moratorium Continued personal medical exclusions

D – Partner and dependant details

Complete only if there are other people to be covered by this policy

Partner

Title Mr Mrs Ms Miss Other

First name Last name

E-mail

Date of birth Gender Male Female

If you have more than four dependants please attach their details on a separate sheet, or use the notes section at the back of this form, up to a maximum of eight child dependants.

Dependant 1

Title Mr Mrs Ms Miss Other

First name

Last name

E-mail

Date of birth

Gender Male Female

Dependant 2

Title Mr Mrs Ms Miss Other

First name

Last name

E-mail

Date of birth

Gender Male Female

Dependant 3

Title Mr Mrs Ms Miss Other

First name

Last name

E-mail

Date of birth

Gender Male Female

Dependant 4

Title Mr Mrs Ms Miss Other

First name

Last name

E-mail

Date of birth

Gender Male Female

Only complete Sections E and F if you are applying under the Full Medical Underwriting or Switch (CPME) Underwriting options. You do not need to complete Sections E or F if you are applying under Moratorium Underwriting terms.

E – Doctor's details

Please state the name and address of your usual doctor (to whom requests for information are usually made). If you have changed your doctor in the past year, please also give the name and address of your previous doctor on a separate sheet of paper. If the doctor is different for any of the other applicants, please also give details on a separate sheet, or use the notes section at the back of this form.

GP's name

Address*

<input type="text"/>
<input type="text"/>
<input type="text"/>

Postcode*

Telephone number

Fax number

F – Access to Medical Reports Act 1988

Before we can assess your application, we may need to get a medical report from a doctor who has cared for you. The Access to Medical Reports Act 1988 gives you certain legal rights. These are:

- we need your agreement before we can apply for a medical report from your doctor. You can refuse but, if you do, we will not be able to assess your application.
- you can ask to see the report before the doctor sends it to us, or up to six months after.
- if you tick the box below to indicate that you want to see the report, your doctor can charge you a reasonable fee to cover costs.
- if you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your doctor will not agree to do this, you may attach a statement of your own.

You will not be entitled to see any part of the report which:

- the doctor believes could seriously harm your physical or mental health, or that of others.
- indicates the doctor's intentions in respect of you.
- reveals information about another person, or the identity of someone who has given the doctor information about you (unless that person consents or is a health professional involved in caring for you).

We will write and tell you when we have requested the report. If you've asked to see the report before your doctor sends it to us, you will have 21 days from the date of receipt of our letter to contact your doctor. Once you have seen the report, your doctor needs your agreement to send it to us. If you don't arrange to see the report within 21 days, your doctor will be free to send it to us.

Declaration of consent

I have been informed of and understand my statutory rights under the Access to Medical Reports Act 1988, as explained above. In connection with my insurance application I consent to PruHealth being provided with medical information from my GP or any other health professional who at any time has attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original.

I would like to see the report before it is sent to PruHealth

Please tick one box only

I do not need to see the report before it is sent to PruHealth

To avoid delay, each person may choose to give their consent by signing in the box below

Employee's signature	_____	Date	_____
Partner's signature	_____	Date	_____
Parental guardian's signature (for children under 16)	_____	Date	_____
Signature of dependant (aged 16 or over)	_____	Date	_____
Signature of dependant (aged 16 or over)	_____	Date	_____

We may ask you to contact your doctor if we request a medical report and experience delays receiving it.

G – Underwriting options

The underwriting choice is made by your employer. This choice will determine which of the following numbered sections – G1, G2, or G3 – you need to complete. If you are unsure of how to proceed, please contact your employer. **Please only complete one section, then go to section H.**

G1 – Switching from an existing provider (Continued personal medical exclusions – CPME)

If your employer has selected this option, please provide the information below and attach a copy of your most recent membership certificate showing your original medical underwriting terms and any personal medical exclusions that apply.

If you do not supply a copy of your most recent membership certificate, we will not be able to accept you on continued personal medical exclusion terms. Instead you will be subject to a new moratorium and cover for pre-existing conditions or ongoing treatment will not be available. Please see section G2 for details of our moratorium clause.

Have you or anyone else to be insured on your policy had in-patient or day-patient treatment in the last 6 months or have any planned or anticipated?

Yes No

Have you or anyone else to be insured on your policy ever suffered from any heart, cancer or psychiatric related conditions?

Yes No

If you have answered yes to either question above, please provide further details below.

1. Name of person to whom the condition(s) apply	
2. Condition/symptom and question(s) it relates to	
3. Details of medication/ treatment/ consultations/investigations (PLEASE INCLUDE ALL DATES)	
4. What, if any, further consultations/ treatment/ investigations are required	
5. Present state of health (eg. Full recovery or symptoms still present)	

Additional information – if you require more space, use the notes section at the back of this form, or continue on a separate sheet of paper and attach it to this form.

Please note:

- Any existing personal medical exclusions will continue with PruHealth. We may also place additional exclusions or in some circumstances we may be unable to offer cover. If you're switching from a moratorium clause, then we'll apply our own moratorium rules but backdated to your cover start date with your current insurer.
- All personal medical exclusions that apply to the policy will be shown on your certificate of insurance.
- Any applicant aged 70 or over will need to complete a special underwriting medical questionnaire, regardless of their ability to meet the above conditions. Please note that non disclosure of relevant information may result in us not being able to pay a future claim or may result in the policy being declared void.

Switch underwriting declaration

Please sign below to confirm that the information provided above is correct to the best of your knowledge.

Signature of employee
on behalf of all
applicants

Date

Please go to section H.

G2 – Moratorium underwriting

Only complete this section if your employer has chosen the moratorium underwriting option, then go to section H.

What is Moratorium Underwriting?:

Under Moratorium Underwriting (Mori), we do not ask you to give details of your medical history or make you undergo a medical examination. Instead, we apply a straightforward exclusion clause (our 'moratorium clause') which says:

We cannot pay claims for the treatment of any medical condition or related condition which you have received medical treatment for, had symptoms of, asked advice on or to the best of your knowledge and belief were aware existed in the five years before the cover start date (a 'pre-existing medical condition').

After two years of continuous insurance cover from the cover start date, all pre-existing medical conditions will become eligible for benefit, subject to the terms and conditions of the policy. However, this only applies if, when you first receive treatment, you have not:

- consulted any doctor for medical treatment or advice (including check-ups), or
- taken medication (including drugs, medicines, special diets or injections), for that medical condition or any related condition for two continuous years after your cover start date.

This clause can easily be broken down into three parts.

- Firstly - Medical conditions that are covered from the first day of your insurance. These are conditions that are new to you after your cover start date.
- Secondly - Pre-existing medical conditions which become eligible for cover after at least two years continuous insurance. We cover them if you have stayed free from receiving any treatment, advice or medication for a continuous period of two years after your cover start date.
- Thirdly – Pre-existing medical conditions which we permanently exclude from cover. We exclude them because you will need regular or periodic treatment, advice or medication and you will never be able to remain free for any continuous two year period.

Your policy will probably never cover any pre-existing long-term medical conditions such as heart problems, cancer and psychiatric conditions, which are likely to require regular or periodic treatment, medication or advice. This is because the moratorium period starts each time you receive such treatment, so it's unlikely you'll ever have two consecutive years free of treatment. Of course, we strongly advise you not to delay seeking medical advice or treatment for a pre-existing condition during the moratorium period.

Moratorium underwriting declaration

I understand and agree that:

- Pre-existing medical conditions are subject to the terms and conditions of the moratorium as defined in the terms and conditions of the policy, and as explained above.
- If any applicant makes a claim, PruHealth will have to request information from them or their GP to determine whether the condition was pre-existing or not.

Signature of employee
on behalf of all
applicants

Date

D	D	M	M	Y	Y	Y	Y
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Please go to section H.

G3 – Full medical underwriting

Only complete this section if your employer has chosen the full medical underwriting option, then go to section H. Please complete the following questions. Should you have any relevant medical reports please attach copies of these to this application. Each person (applicant) to be covered by the policy must provide information where requested. If you are unsure if we need to know a particular fact, please disclose it anyway. Please help us by completing the underwriting questions honestly and in full. If you give us incorrect information this may mean that we will not pay a future claim, or may result in the policy being declared void.

1. Are any applicants currently: Yes No
- a) taking regular medication (whether prescribed or over the counter, but excluding contraception, HRT or medicines used to treat minor illnesses such as colds & flu)?
 - b) awaiting any medical test results, follow-up consultations, treatment or investigations?
 - c) experiencing symptoms of any health problems (or had symptoms in the last 3 months), whether or not medical advice has been sought?
 - d) being regularly monitored by a Consultant, GP or other health professional?
2. In the last five years, has any applicant attended a hospital, clinic or nursing home as an in-patient, day-patient or out-patient? Yes No
3. Have any applicants ever been treated for, diagnosed with or advised that they may have any of the following: Yes No
- a) heart condition or stroke/transient ischaemic attack (mini-stroke)?
 - b) cancer?
 - c) any form of arthritis, or joint or muscular problems that have resulted in regular, recurrent or persistent pain?
 - d) mental health illness (including stress, anxiety and depression)?

If all applicants have answered NO to all 3 questions above you do not need to answer any more questions in this section and you can be accepted on full medical underwriting with no personal medical exclusions. **Please just sign the declaration on page 8.**

Any applicant answering YES to any question above should **complete the rest of this section and then sign the declaration on page 8.** Please see overleaf.

G3 - Full medical underwriting (continued)

Only complete this section for any applicants who answered "Yes" to any of the previous Full Medical Underwriting questions (on page 6). Once completed then go to section H. As stated before, should you have any relevant medical reports, please attach copies of these to this application. Each person (applicant) to be covered by the policy must provide information where requested. If you are unsure if we need to know a particular fact, please disclose it anyway. Please help us by completing the underwriting questions honestly and in full. If you give us incorrect information this may mean that we will not pay a future claim, or may result in the policy being declared void.

Further Health Questions

Has any applicant ever experienced or been treated for, or are they currently suffering from, any of the following conditions or symptoms? (If yes, please provide full details including date(s) of treatment, consultations & investigations where appropriate on page 8)

a. Blood disorders	e.g. anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, thrombosis (blood clots)	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Brain and nerve disorders	e.g. stroke, multiple sclerosis, epilepsy, migraine, paralysis, Parkinson's disease, quadriplegia, paraplegia	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Cancer	e.g. any form of cancer or pre-cancerous growth, tumours or moles that have changed in appearance	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. Cardiac and vascular disorders	e.g. angina/heart attack, heart failure, heart murmurs, rheumatic fever, high blood pressure, rhythm disturbance (palpitations), varicose veins, poor circulation, raised cholesterol, heart surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
e. Connective tissue disorders	e.g. SLE (systemic lupus erythematosus), scleroderma, mixed connective tissue disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Dental disorders	e.g. over/under bite problems, missing/skew teeth, impacted wisdom teeth or ongoing treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
g. Eye, ear and speech disorders	e.g. cataracts, glaucoma, macular degeneration, hearing/visual impairment, loss of speech	Yes <input type="checkbox"/> No <input type="checkbox"/>
h. Gastro-intestinal disorders	e.g. peptic ulcer, hiatus hernia, heartburn, changed bowel habits, rectal bleeding, Crohn's disease, ulcerative colitis, IBS (irritable bowel syndrome)	Yes <input type="checkbox"/> No <input type="checkbox"/>
i. Gynaecological disorders	e.g. ovarian cysts, endometriosis, fibroids, infertility, disorders of the cervix, menstrual disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
j. Kidney/Urinary tract disorders	e.g. kidney failure, kidney stones, recurrent infections, nephritis, prostate problems, blood/protein in urine, polycystic kidneys	Yes <input type="checkbox"/> No <input type="checkbox"/>
k. Liver/Pancreatic disorders	e.g. hepatitis, cirrhosis, liver failure, gallstones, pancreatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
l. Mental health/Psychiatric disorders	e.g. depression, anxiety, schizophrenia, eating disorders, ADHD (attention deficit hyperactivity disorder), autism	Yes <input type="checkbox"/> No <input type="checkbox"/>
m. Metabolic/Endocrine disorders	e.g. diabetes, thyroid abnormalities, growth disorder, Cushing's disease, Addison's disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
n. Musculo-skeletal disorders	e.g. arthritis, rheumatoid arthritis, myasthenia gravis, muscle weakness, gout, osteoporosis, back problems, e.g. slipped disc, backache, sciatica, pinched nerve, loss of limb	Yes <input type="checkbox"/> No <input type="checkbox"/>
o. Respiratory disorders	e.g. asthma, emphysema, bronchitis, shortness of breath, persistent cough, coughing up blood, cystic fibrosis, sinusitis, allergic rhinitis, COAD (chronic obstructive airways disease) or any lung surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
p. Skin disorders	e.g. eczema, psoriasis, acne, hypertrophic scars (keloid)	Yes <input type="checkbox"/> No <input type="checkbox"/>
q. Sensory functions	e.g. loss or impairment of sense of touch, smell or taste	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered "YES" to any of the questions (a – q) on page 7, please supply full details below.

Name of Applicant	Condition/symptom (and question number/letter(s) it refers to)	Description of medication/ treatment/consultations/ investigations (PLEASE INCLUDE ALL DATES)	What, if any, further consultations/treatment/ investigations are required.	Present state of health (eg. Full recovery or symptoms still present)

Additional information – if you require more space, please use the notes pages or continue on a separate sheet of paper and attach it to this form.

Full medical underwriting declaration.

Please sign below to confirm the above details are accurate, if you have selected Full Medical Underwriting:

Signature of employee on behalf of all applicants

Date

Please go to section H.

H – Important Information

General notes

- The policy will not start until we have accepted your application.
- If you have a birthday while your application is being processed, the terms may differ from those originally quoted. We may offer you revised policy terms, but in certain circumstances we may not be able to offer cover.
- We may ask you to contact your doctor if we are experiencing delays in receiving reports which we have asked for.
- You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

Data protection notice

PruHealth & PruProtect, the Prudential group of companies and our business associates, service providers and agents will use your information, together with other information, for administration, customer services, marketing and profiling your purchasing preferences and fraud prevention. We will pass your information to them for these purposes.

We will pass your information to any legal or regulatory body if required to do so.

By submitting this form you consent to us processing your sensitive personal information; such as health data.

For the above purposes it will be necessary to transfer your information to countries that provide a different level of data protection from the UK. We have contracts in place to ensure your information is protected.

Acting On Someone's Behalf?

When giving us information about another person, you confirm that they have appointed you to act on their behalf. This includes providing consent to process the personal data, receive this data protection notice on their behalf and receive marketing information.

Marketing Choice

We would like to keep you updated with information on our and other carefully selected providers' products and services which we think might interest you by telephone, post, email or text.

If you would prefer not to receive this information please tick this box.

* The Prudential group of companies at the time of printing includes Prudential UK & Europe, the M&G Investments Group, Prudential Corporation Asia, Jackson National Life, and PPM America Inc (indirect wholly owned subsidiary).

I - PruHealth policy declaration to be signed by employee

- I understand that this application is subject to written acceptance by PruHealth.
- I understand that by signing this declaration I am applying on behalf of all applicants to be covered by this policy and am doing so with their full consent. I also agree to receive all policy-related documentation on behalf of all applicants.
- I give permission for the medical information I've provided to be disclosed to any employee in the PruHealth group for risk management and underwriting purposes. This information can also be used to maintain management information for business analysis.
- I declare that nothing material has been withheld and that the information given on this form is true. If I am in doubt about whether certain facts are material, these will be disclosed. I understand that failure to disclose a material fact, which is a fact that may influence the assessment and acceptance of this application, may result in a claim not being paid and/or the policy being declared void.
- I will advise you of any change to the information given in this application which occurs between the date of signing and the cover start date (including changes to any applicants' state of health).
- I understand that no cover will apply for investigations or treatment of any medical condition or related condition which exists or has existed before the start date of this policy unless I have provided PruHealth with details and they have agreed to accept it. I also understand that PruHealth will detail any personal medical conditions, which they have specifically excluded from cover (due to information I have provided), on their certificate of insurance. I also understand that in certain circumstances PruHealth maybe unable to offer cover.
- I agree to PruHealth accepting medical reports faxed directly to PruHealth from the doctor's surgery of any applicant to be covered by this policy. I do not object to copies of the report being faxed to any other company that I have applied to at their request.
- I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act 1988.
- I consent to PruHealth using the information that I supply for the purposes shown in the data protection notice in Section H of this application form.
- I understand that a copy of the application and the policy terms and conditions are available on request.

This application and the medical information disclosed on it is valid for 30 days from the date the application is signed (date recorded below). A declaration of health may be sent out to declare any change in health should the final assessment of your application be older than 30 days from the date that the application was signed.

Signature of employee
on behalf of all
applicants

Date

D	D	M	M	Y	Y	Y	Y
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