

Business Healthcare – employer application form

A – Quote and cover details

By completing this application form, you are applying for the cover and benefits provided in your Business Healthcare quote. This includes the choice of hospital list, excess, cover options and underwriting terms. Please enter the quote reference number below and attach a copy of the relevant quote to this application form. Please complete this form in black ink using BLOCK capitals.

Quote reference number

Start date

D	D	M	M	Y	Y	Y	Y
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B – Employer details

Company name

Legal entity, PLC, Partnership etc Registered number (if applicable)

Is your business a partnership of three partners or less? Yes No

Address*
 Postcode

Industry type

Financial Services <input type="checkbox"/>	Manufacturing <input type="checkbox"/>	Retail <input type="checkbox"/>	Hotel/Leisure/Entertainment <input type="checkbox"/>
Professional Services <input type="checkbox"/>	Construction/Building <input type="checkbox"/>	IT <input type="checkbox"/>	Education <input type="checkbox"/>

Other (Please specify)

* Please note that all communications regarding the Vitality programme will be sent to this address.

To be completed by Adviser

Your FSA number (Registered individuals)

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 Phone number
e.g. A B C 1 2 3 4 5 Email address

Registered individual's first name and last name

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Your PruHealth agency details OR Agency name and address stamp
e.g. 1 2 3 4 5 6 X

Routing of documentation

In line with Data Protection regulations, all information and questions regarding this application that are of a confidential nature will be addressed directly to your customers. We will inform you when this happens. PruHealth will address all non-confidential questions to the Adviser. Please indicate where you would like us to send the following documentation:

Member welcome packs	Member renewal packs	Member mid-term adjustments**	Employer invoices
You* <input type="checkbox"/> Member <input type="checkbox"/>	You* <input type="checkbox"/> Member <input type="checkbox"/>	You* <input type="checkbox"/> Member <input type="checkbox"/>	You* <input type="checkbox"/> Employer <input type="checkbox"/>

IMPORTANT: Only one recipient can be chosen for each document type.

Declaration

I confirm that all material facts regarding the price of this scheme of which I am aware have been passed to PruHealth for consideration. This includes, but is not limited to, information regarding claims performance, ongoing claims or planned changes in the scheme demographics, such as a material change in the make up of the membership of the scheme. If you are not able to sign this document, you should make the same declaration by email to your Account Manager.

* Please note that if you have elected to have member or employer documentation routed to you, it is your responsibility to ensure that the member or employer receives these in a timely way as we will not send any communications to them directly.

** This refers to policy letters and membership certificates sent as a result of changes made to the policy mid-term.

Signature

Date

D	D	M	M	Y	Y	Y	Y
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C – Employer contacts and Employer Zone access

You have the opportunity to nominate three types of employer contact for your organisation. The primary contact is mandatory. Contact types are as follows:

- Primary contact – the main point of contact for the scheme to whom we will send all general correspondence and Vitality information. You must provide a primary contact for your organisation.
- Secondary contact(s) – no documents will be sent to this person, but they will have administrative rights.
- Executive contact(s) – senior contacts requiring an overview of the scheme.

Access to the Employer Zone can be given for each of the contacts. They will still need to register online once contact details have been noted below. Asterisked fields are mandatory so we can provide the most up-to-date information on changes to the Vitality programme. We will not use email addresses to market Vitality products.

NOTE: Please do not enter the Adviser's details on this part of the form. **Advisers who want documentation and notifications sent to them should note that on the front page of this form.**

Primary employer contact*

Title First Name* Last Name*

Job Title Date of birth* Gender M F

Telephone/Mobile* Email address*

Other employer contacts

Contact Type Secondary contact Executive contact

Title First Name* Last Name*

Job Title Date of birth* Gender M F

Telephone/Mobile* Email address*

Contact Type Secondary contact Executive contact

Title First Name* Last Name*

Job Title Date of birth* Gender M F

Telephone/Mobile* Email address*

Contact Type Secondary contact Executive contact

Title First Name* Last Name*

Job Title Date of birth* Gender M F

Telephone/Mobile* Email address*

Note: If you need to add more contacts please attach a separate sheet.

D – Membership details

1. Current medical insurance details. Please provide details of your group's current medical insurance membership (if any).

Current insurer

Date employer joined

D	D	M	M	Y	Y	Y	Y
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Date of termination of scheme

D	D	M	M	Y	Y	Y	Y
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2. Details of your organisation's employee base

a. Total number of staff employed by your organisation

b. Total number of principal members to be covered by PruHealth

c. Will this scheme be compulsory for all employees within a specific group (e.g. directors, managers, administration staff, etc)?

Yes No

If "YES"

(i) Define the compulsory group (e.g. directors etc)

(ii) Will the scheme be compulsory for all future employees within the specified group?

Yes No

3. Is cover being fully paid for by the employer, with no part of the employee's premium (other than, in some cases, the cost for the spouse/partner or dependants) to be recouped in any way from the employee?

Yes No

E – Choice of underwriting

There are four different types of underwriting that we use to assess your employees' medical history and their eligibility for treatment:

1. Switching from an Existing Provider (Continued Personal Medical Exclusions – CPME)

Any special terms or exclusions that apply with your current insurer will continue to apply on your new policy with us. You will need to provide a copy of your current insurance certificates showing the details of all the members who you want to cover on your new policy. Where employees are unable to meet the requirements of the relevant declaration on the next page, or are applying to switch to us mid-term, they will need to complete an Employee Application form. In these circumstances we may need to apply further medical exclusions and in some circumstances we may not be able to offer cover. Until you have received confirmation from us that you can be accepted on those terms we strongly advise you not to cancel your existing health insurance policy. If you switch from another provider's Moratorium underwriting, it is our Moratorium terms and conditions that will apply which may be different from those of your previous insurer.

2. Moratorium

No details of employee medical history are required in the application form. We will not cover any pre-existing conditions which anyone to be covered on the policy has received treatment and/or medication for, or had symptoms of, or asked advice on, or were aware of during the five years before the policy started. However, if they do not have any treatment, medication or advice for those pre-existing conditions (and any directly related conditions) for two continuous years after the policy starts, then after that the conditions may be considered eligible for benefit, subject to the policy terms and conditions.

3. Medical History Disregarded – MHD (schemes of over 50 employees only*)

No medical or underwriting information is required and we will not apply exclusions to your employees. New members joining more than 60 days after they were eligible to join will need to answer two acceptance questions.

4. Full Medical Underwriting

All the details of your employees' medical history are required in the employee application form with this option. Please note that this information may result in an exclusion being placed on their cover. We will show any exclusions that will apply to your employees, or anyone else on their policy, on their membership certificate.

Underwriting type for existing members:

Existing members will be loaded as per the instructions given on the quote.

Underwriting type for new members:

New members will be added under the following underwriting terms:

Continued Personal Medical Exclusions Moratorium
Medical History Disregarded Full Medical Underwriting

Please note that where a selected underwriting option excludes any pre-existing conditions, members may be required to give their permission for PruHealth to gain access to their medical records before any claim is approved.

*Schemes with 20 to 50 members will be evaluated for MHD eligibility.

F – Switching from another private medical insurer (CPME)

If your group is moving to PruHealth under CPME terms, please sign a declaration on behalf of your employees. The declaration you sign will depend upon your scheme size.

Please complete this declaration if your scheme has 3-19 employees.

I declare that to the best of my knowledge:

- No applicants to be covered have had in-patient or day-patient treatment in the last 6 months or have any planned or anticipated, and that they have never suffered from any heart, cancer or psychiatric related conditions.
- All applicants to be covered by this policy will provide certificates of insurance from the previous insurer.

If you cannot meet these conditions, the applicants who need to declare treatment or conditions will need to complete an employee application form giving us more detail on them. We will then decide if we accept with no further exclusions, accept but apply exclusions, or decline to offer cover. 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.

Authorised Signatory(ies) on behalf of all applicants Date

D	D	M	M	Y	Y	Y	Y
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Date

D	D	M	M	Y	Y	Y	Y
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Please complete this declaration if your scheme has 20 or more employees

I declare that to the best of my knowledge:

- No applicants to be covered have any in-patient or day-patient treatment planned or anticipated, and that they have never suffered from any heart, cancer or psychiatric related conditions.
- All applicants to be covered by this plan will provide certificates of insurance from the previous insurer.

If you cannot meet these conditions, the applicants who need to declare treatment or conditions will need to complete an employee application form giving us more detail on them. We will then decide if we accept with no further exclusions, accept but apply exclusions, or decline to offer cover. 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.

Authorised Signatory(ies) on behalf of all applicants Date

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

Date

D	D	M	M	Y	Y	Y	Y
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G – Payment details

You can choose to pay annually, quarterly or monthly. Schemes of 3-19 employees must pay by Direct Debit. Schemes of 20 or more employees may choose to pay by Direct Debit, BACS or Cheque.

How would you like to pay? Annually Monthly Quarterly

Method of payment Direct Debit BACS Cheque

Paying by Direct Debit

Which day of the month would you like the Direct Debit to leave your account? 1st 15th 25th

Paying by BACS or Cheque (schemes of 20 or more only)

If you are paying by cheque or BACS what is your preferred invoice date each month? 1st 11th 17th

Direct Debit instruction

Please fill in the whole form using a ball point pen and send it with the completed application to:

Prudential Health Services Limited
Stirling FK9 4UE

Instruction to your Bank or Building Society to pay by Direct Debit



Name(s) of Account Holder(s)

Service User Number

Reference

Bank or Building Society Account Number

Branch Sort Code

Name and full postal address of your Bank or Building Society

To: The Manager	Bank or Building Society
Address	
<input type="text"/>	
Postcode	

Instructions to your Bank or Building Society.

Please pay Prudential Health Services Limited Direct Debits from the account detailed on this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Prudential Health Services Limited and if so, details will be passed electronically to my Bank/ Building Society.

Signature(s)
<input type="text"/>
Date

Banks and Building Societies may not accept Direct Debit instructions for some types of account.

THIS GUARANTEE SHOULD BE DETACHED AND RETAINED BY THE PAYER

The Direct Debit Guarantee



- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit, Prudential Health Services Limited will notify you 3 working days in advance of your account being debited or as otherwise agreed. If you request Prudential Health Services Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit by Prudential Health Services Limited or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society - If you receive a refund you are not entitled to, you must pay it back when Prudential Health Services Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

H – PruHealth Policy Declaration to be signed by Employer

- We understand that this Private Medical Insurance is for 12 months. The renewal will be assumed, unless PruHealth is advised in writing that the contract must be terminated before the anniversary date.
- As a participating employer we hereby apply for membership for our employees to the Business Healthcare policy.
- We acknowledge that the terms and conditions of the policy are set out in the document titled 'Your policy terms and conditions - Business and Corporate Healthcare'.
- We acknowledge that this is a 12 month contract and understand that if we cancel our policy, regardless of whether we pay monthly premiums, we will be required to pay the full annual premium. This does not apply to participating employers comprising a partnership of three partners or less.
- We understand that this application is subject to written acceptance by PruHealth. We understand that by signing this declaration we are applying on behalf of all applicants to be covered by this policy.
- We declare that nothing material has been withheld and that the information given on this form is true. We understand that failure to disclose any material fact, being a fact that may influence the assessment and acceptance of this application, may result in the contract being declared void and that any claim under the contract may not be paid. We acknowledge that PruHealth will be relying on such information when agreeing to accept this application. PruHealth reserves the right to investigate where uncertainty exists about the validity of information provided.
- We consent to our employees and their listed dependants, subject to their consent, who participate in the contracts to which this proposal relates, being called upon to submit to such medical examinations and tests as PruHealth deems necessary, during the currency of the said contracts and of PruHealth addressing such requests directly to our employees or their dependants, with the same legal consequences as if such requests had been addressed to us.
- We acknowledge that all information pertaining to our employees is confidential and we undertake to respect confidentiality (and comply with all applicable data protection legislation) in so far as this confidentiality is determined by PruHealth in its sole discretion at all times.
- We acknowledge that should PruHealth, at its sole discretion, disclose any information (subject to data protection legislation) to us regarding our employees – including general or medical information – that this information will be kept confidential at all times.
- We acknowledge that PruHealth reserves the right to cancel membership if any amount is due and is not paid on the due date, and that PruHealth may recover any unpaid premium(s) up until the end of the contract year. Any participating employer comprising a partnership of three partners or less shall not be liable to pay premiums from the date of cancellation of their policy up until the end of the contract year.
- We understand that PruHealth assumes no liability in respect of any employee until such time as notice of acceptance of the risk is given by PruHealth.
- We undertake to give PruHealth immediate written notice should any changes material to the assessment of this application occur before the date upon which PruHealth grants written acceptance. This will enable PruHealth to reconsider the terms of acceptance.
- We accept that we will notify our employees about receiving 'servicing updates' from PruHealth in relation to this product. PruHealth will approach employees' to obtain marketing rights separately.
- We understand that PruHealth may randomly survey members, by phone, face to face or online, from time to time to assess their service quality, product and processes.
- We agree that, if a cheque for payment is sent to PruHealth by mail, the Post Office shall become our agent and that we are liable for the consequences of late or non-receipt of payment by Prudential Health Services Limited.
- We warrant that the signatories to this declaration are fully authorised and entitled to sign this declaration on behalf of the employer and to bind the employer to the terms of the Business Healthcare policy.

Note:

Principal members must be employed on the commencement date of this contract. Where this is not the case, confirmation of cover will be deferred until such time as the applicants are employed.

Cover under your previous healthcare policy (if applicable) must have ended before commencement of your PruHealth membership.

Authorised Signatory(ies)

Date

D	D	M	M	Y	Y	Y	Y
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Name(s)

Job title(s)

Application checklist

- Before you return this application please ensure you have confirmed the quotation number on page 1

Application has been completed in full:

- Employer details
- Employer contact details
- Payment details
- Signed PruHealth policy declaration
- Member pack and invoice distribution instructions (completed by Adviser)

Member data: Please provide the following:

- Certificates of insurance from previous provider, if switching to PruHealth on CPME underwriting terms
- Completed employee application forms if you've selected FMU underwriting or are unable to sign the Switch (CPME) underwriting declaration
- If not submitting employee application forms, provide a full member listing including employee first name, last name, postal address, email address, date of birth, and dependants' first names, last names and dates of birth.

