

# Private medical insurance – application form for adding dependants.

To apply for PruHealth membership complete SECTIONS A to F. 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 – Principal member details

Title Mr  Mrs  Ms  Miss  Other

First name

Last name

Policy number

### B – Partner and dependant details

If you are adding more than four additional dependants please attach their details on a separate sheet.

Date you would like the cover to begin

**Dependant 1**

Dependant under 21  or Dependant over 21

Partner

Title Mr  Mrs  Ms  Miss  Other

First name

Last name

Gender Male  Female  Date of birth

Relationship to Principal Member

## B – Partner and dependant details – continued

### Dependant 2

Dependant under 21  or Dependant over 21  Partner

Title Mr  Mrs  Ms  Miss  Other

First name  Last name

Date of birth  Gender Male  Female

Relationship to Principal Member

### Dependant 3

Dependant under 21  or Dependant over 21  Partner

Title Mr  Mrs  Ms  Miss  Other

First name  Last name

Date of birth  Gender Male  Female

Relationship to Principal Member

### Dependant 4

Dependant under 21  or Dependant over 21  Partner

Title Mr  Mrs  Ms  Miss  Other

First name  Last name

Date of birth  Gender Male  Female

Relationship to Principal Member

## C – Underwriting

Please note that all additional **dependants** must be underwritten by the same underwriting method originally selected by the principal Member. You can find this information on your membership certificate. Where this underwriting option is not suitable for any of the **dependants** to be added then please complete the Full Medical Underwriting option. If you are unsure of which underwriting option you should select please call 0800 904 7070.

**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.**

### Underwriting options explained

#### 1. Moratorium underwriting

If you choose this option you don't need to give any details of your medical history now. We'll ask you for details of your medical history when you claim.

But, by doing so, you won't be covered for any medical problems you have had in the five years before you apply for PruHealth. However, after two years from when you take out your cover, you will be covered for any medical problems you have – if they are eligible.

#### 2. Underwriting for Members switching from another provider

If you select this option, no medical or underwriting information is required. Any existing exclusions will be carried forward and continued. We may contact you for further information, upon receipt of your current membership certificate, to check appropriateness of any exclusions. You do not have to fill out anything in Section C and should turn to Section D. Please note that this is only available through an Adviser.

#### 3. Full Medical underwriting

If you would like cover that takes into account your medical history, choose this option. We may be able to offer you cover for any existing conditions you have. If we can't cover them, we will exclude them from your policy. Either way you will know what is covered, and what's not covered, from the start. Be aware we may ask for additional information from your GP if necessary.

## 1. Moratorium underwriting

Complete this section if the additional **dependants** are joining a policy underwritten by the moratorium option

I understand and agree that:

- No applicants have ever suffered from heart disease, stroke, cancer or mental illness;
- Any conditions for which any applicant has had symptoms, treatment or advice in the last five years may be excluded from cover for two years from start of cover after which benefits are available for eligible treatments and conditions;
- 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;
- All applicants to be covered are aged 65 or under.

Signature of Principal Member on behalf of all applicants

Date

D	D	M	M	Y	Y	Y	Y
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## C – Underwriting – continued

### 2. Underwriting for members switching from another provider

Complete this section if the additional dependants are joining a policy underwritten by the switching provider option

The switch underwriting option is available to applicants who already have company paid private medical insurance and would like to carry their existing cover (exclusions) across to a new individual policy with PruHealth.

To be eligible, you must be able to answer **NO** to questions 1 and 2. If you answer **YES** to questions 3, 4 or 5, please provide further details on the next page.

1. Is any member to be covered aged over 65? Yes  No
2. Has any member to be covered ever suffered from heart disease, stroke, cancer or mental illness? Yes  No
3. Has any member to be covered made a claim under the existing cover in the last 12 months? Yes  No
4. Has any member to be covered had treatment or seen a consultant in the last 12 months, whether private or NHS? Yes  No
5. Does any member to be covered have any planned or pending treatment, investigations or tests, whether private or NHS? Yes  No

Please confirm your eligibility by signing the switch declaration. Your existing cover will be continued including any exclusions.

Your membership certificate from your current insurer is required along with this application form (a photocopy will suffice).

Signature of Principal Member on behalf of all applicants

X

Date

D D M M Y Y Y Y

If you answered "No" to Q2 or Q3 and "Yes" to any of the other questions, please select Moratorium or Full Medical Underwriting continued below.

1. Name of person to whom the condition(s) apply	
2. Condition(s)	
3. Previous treatment and consultations (with dates)	
4. Further treatment or consultations required	
5. Present state of health	

Please attach any additional medical information. We will review this and contact you regarding your eligibility for switch underwriting.

## C – Underwriting – continued

### 3. Full medical underwriting

Complete this section if the additional **dependants** are joining a policy underwritten by the full medical underwriting option

Please complete this section on behalf of all new **dependants** if Full Medical Underwriting was originally selected or the other underwriting options are not suitable for one or more of the applicants. Should you have any relevant medical reports please attach copies of these to this application. Each person to be covered by the policy must provide information where requested.

#### 1. General health information

1. In the last 5 years have any applicants been treated for, diagnosed with or advised that they have the following:

- a) Heart condition or stroke Yes  No
- b) Cancer or tumours Yes  No
- c) Joint/bone problem for which the applicant has had or may need a joint/bone replacement Yes  No
- d) Mental illness Yes  No

2. In the last 2 years have any applicants been hospitalised overnight or received surgical treatment as a day patient (excluding emergencies, pregnancy related treatment or the removal of appendix or gall bladder, removal of wisdom teeth, removal of tonsils and sterilisation)?

Yes  No

3. Does any applicant take ongoing prescribed medication (excluding contraception or HRT)?

Yes  No

a) If you answered yes to Q3 because you take medication for high blood pressure or high cholesterol please confirm:

i) Blood pressure medication: Your latest systolic blood pressure reading is below 130 mmHg Yes  No

ii) Cholesterol medication: Your serum cholesterol is less than 5 mmol/l Yes  No

4. Have any applicants sought advice or treatment from any medical professional in the past 6 months?

Yes  No

5. Are any applicants awaiting any reviews, treatment or investigation for any current or past medical problems?

Yes  No

If you answered **No** to all five questions, or are controlling your blood pressure or cholesterol below the levels mentioned in Q3a, having answered **No** to all other questions, you are eligible for full medical underwriting and do not need to answer any more questions in this section – please proceed to **section D**. If you answered **Yes** please complete the rest of this section.

## C – Underwriting options – continued

### 3. Full medical underwriting – continued

Please only complete this table if you answered "Yes" to any question in Section 1.

#### 2. Further health questions

Have any of the applicants ever experienced or been treated for or are currently suffering from any of the following conditions or symptoms?

a. Blood disorders	eg; anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, thrombosis (blood clots)	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Brain and nerve disorders	eg; stroke, multiple sclerosis, epilepsy, migraine, paralysis, Parkinson's disease, quadriplegia, paraplegia	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Cancer	eg; any form of cancer or pre-cancerous growth	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. Cardiac and vascular disorders	eg; 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	eg; systemic lupus erythematosus, scleroderma, dermatomyositis, mixed connective tissue disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Dental disorders	eg; over/underbite problems, missing/skew teeth, false teeth, or ongoing treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
g. Eye, ear and speech disorders	eg; cataracts, glaucoma, retinitis, hearing/visual impairment, disorders of the cornea, blindness, loss of speech	Yes <input type="checkbox"/> No <input type="checkbox"/>
h. Gastro-intestinal disorders	eg; peptic ulcer, hiatus hernia, heartburn, changed bowel habits, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome.	Yes <input type="checkbox"/> No <input type="checkbox"/>
i. Gynaecological disorders	eg; ovarian cysts, endometriosis, fibroids, infertility, disorders of the cervix, menstrual disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
j. Kidney/Urinary tract disorders	eg; 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	eg; hepatitis, cirrhosis, liver failure, gallstones, pancreatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
l. Mental health/Psychiatric disorders	eg; depression, anxiety, schizophrenia, eating disorders, attention deficit hyperactivity disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
m. Metabolic/Endocrine disorders	eg; diabetes, thyroid abnormalities, growth disorder, Cushing's disease, Addison's disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
n. Musculo-skeletal disorders	eg; arthritis, rheumatoid arthritis, crystalline arthritis, myasthenia gravis, muscle weakness, gout, osteoporosis, back problems, eg; slipped disc, backache, sciatica, pinched nerve, loss of limb	Yes <input type="checkbox"/> No <input type="checkbox"/>
o. Respiratory disorders	eg; asthma, emphysema, bronchitis, shortness of breath, persistent cough, coughing up blood, cystic fibrosis, sinusitis, allergic rhinitis, chronic obstructive airway disease or any lung surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
p. Skin disorders	eg; eczema, psoriasis, acne, hypertrophic scars (keloid)	Yes <input type="checkbox"/> No <input type="checkbox"/>
q. Sensory functions	eg; loss or impairment of sense of touch, smell or taste	Yes <input type="checkbox"/> No <input type="checkbox"/>

3. If you answered "Yes" to any question in section 2 please supply full details below.

Name of Applicant	Condition/symptom for which medication/treatment was prescribed	Description of medication/treatment including dates	Present state of health

## D – Important information

### General notes

- Cover 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 waiting for reports which we have asked for.
- If we ask you to undergo a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.
- We may need to send your application and relevant medical reports to our reinsurers. You can get details of general reinsurance principles and details of any company we use to assess your application, from our head office.
- We have a Confidentiality Policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.
- You are entitled to ask for a copy of our Standard Terms and Conditions and a copy of your Application Form at any time..

### How we use your personal data

PruHealth & PruProtect, our 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.

You have a right to obtain a copy of your personal information (for which we may charge a fee) and to have any inaccuracies corrected by writing to: The Privacy Manager, Information Risk and Privacy Team, Prudential Assurance Company Ltd, 3 Sheldon Square, London, W2 6PR.

### 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.

## D – Important information – continued

### Access to medical reports consent form

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 proceed with your application or process a claim. 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 may cover the following:

#### Your current health:

- 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:

- details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your doctor or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - (a) malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases
  - (b) Musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles
  - (c) anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
  - (d) 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
- 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; or
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from

#### The information you and your doctor provide about your health may result in us:

- setting premiums at standard rates
- Increasing premiums above standard rates
- refusing to provide insurance

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: The Senior Medical Officer, PruHealth, Stirling FK9 4UE.

I want to see the report before it is sent to PruHealth

Signature of Principal Member on behalf of all applicants.

Date

## E – PruHealth policy declaration to be signed by principal member Member on behalf of additional dependents

- 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 dependants.
- I give consent to PruHealth to contact any doctor I have consulted and to obtain access to the medical records of all applicants on this policy should it be necessary to verify any medical details provided both during and after this application. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for.
- I give permission to the disclosure of the medical information I've provided for risk management and underwriting purposes to any employee in the PruHealth group. This information can also be used to maintain management information for business analysis.
- I declare that no 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 declaration, may result in the contract being declared void and that a claim under the contract may not be paid.
- I will inform you immediately of any changes to the information provided that occur before the policy starts.
- 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.
- I acknowledge that should this application be submitted via the Internet, it is solely for the purposes of convenience and neither I nor PruHealth (subject to its sole and absolute discretion) shall rely on the information contained herein without my providing PruHealth with a signed hard copy of this application. I further agree that the copy submitted pursuant to an Internet application will constitute an offer on my part for membership to the Scheme.
- I have read, understood and consent to the Data Protection Declaration.
- I understand that a completed 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 will be sent out to declare any change in health should the final assessment of your application be older then 30 days from the date that the application was signed.

Signature of Principal Member  
on behalf of all applicants

Date

D	D	M	M	Y	Y	Y	Y
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### APPLICATION CHECK LIST

Before you return this application please ensure you have:

- Entered all personal details for you and your dependants
- Answered all relevant questions, attached membership certificate from previous insurer if applicable or signed the Declaration Statement for your chosen underwriting option
- Signed the Access to Medical Reports Consent Form
- Signed the PruHealth policy declaration on behalf of all applicants

A large, empty rectangular box with a thin black border, occupying most of the page. It is intended for the user to write notes.

## G – only for completion by Advisers where relevant

### 1. Your FSA Number (Registered Individuals)

R.I. Number

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e.g. A B C 1 2 3 4 5

OR

Registered Individual's Forename(s)

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Registered Individual's Surname

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### 2. Your Agency Details

Your PruHealth Agency Number

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e.g. 1 2 3 4 5 6 X

OR Agency Name & Address Stamp

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### 3. 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 customer. We will inform you when this happens.

PruHealth will address all questions to yourself.

Please confirm where welcome packs are to be issued:

Direct to you

Direct to the member

#### FOR OFFICE USE ONLY

CONSULTANT CODE:

Agency code:

CONSULTANT NAME:

MEMBER QUOTE NUMBER: 

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CAMPAIGN CODE: 

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