

Application form for adding dependants.

Age-rated schemes

To apply for PruHealth membership complete SECTIONS A to E. 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

Membership 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

D	D	M	M	Y	Y	Y	Y
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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

D	D	M	M	Y	Y	Y	Y
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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

D	D	M	M	Y	Y	Y	Y
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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

D	D	M	M	Y	Y	Y	Y
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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

D	D	M	M	Y	Y	Y	Y
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Gender Male Female

Relationship to Principal Member

C – Underwriting options

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.

Please only tick and sign one underwriting option.

C1 – Switching from an existing provider (CPME)

If your underwriting choice is CPME, but your dependants have not been covered by private medical insurance previously, please complete either the Moratorium Underwriting section C2 or the Full Medical Underwriting section C4.

If your dependants are moving from an existing private medical insurance policy and are able to complete the declaration below, any existing exclusions will be carried forward and continued. We may contact you for further information, upon receipt of their current membership certificate(s), to check the appropriateness of any exclusions.

Please sign the following declaration on behalf of all applicants:

I declare that to the best of my knowledge, no applicants to be covered by this plan have had any deterioration in health since being underwritten, as a result of any major illness such as heart disease, stroke, cancer or mental illness.

Signature of Principal Member on behalf of all applicants

X

Date

If any applicants do not meet this condition, please complete either the Moratorium Underwriting section C2 or the Full Medical Underwriting section C4.

C2 – Moratorium underwriting

I understand and agree that:

- Any conditions for which any applicant has had symptoms, treatment or advice in the last five years will be excluded from the cover for two years from start of cover after which, eligible conditions and their treatment will be covered.
- If any applicant makes a claim PruHealth may have to request information from the applicant or the applicant's GP to determine whether the condition was pre-existing or not.

Signature of Principal Member on behalf of all applicants

X

Date

C3 – Medical History Disregarded

If you have selected this option, no medical or underwriting information is required and no individual exclusions are applied, subject to your answers to the two questions below.

- C3a) Are all applicants joining the scheme as a result of becoming eligible to join in the last 60 days, through recent employment, length of service, promotion, marriage, adoption, or divorce? Yes No
- C3b) If you answered No to C3a, has any applicant had any signs or symptoms in the last six months for which they have needed to or may need to see a medical professional? Not applicable Yes No

If you have answered Yes to question C3b, please complete the Full Medical Underwriting section C4.

Signature of Principal Member on behalf of all applicants

X

Date

C4. Full medical underwriting

Please complete the following questions if your employer has selected full medical underwriting, or if you are not eligible for the underwriting choice your employer has made. Should you have any relevant medical reports please attach copies of these to this application. It is essential that each person to be covered by the policy provides all relevant information where requested. Failure to do so may mean that we are unable to provide cover. **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.**

C4.1 General health information

- a) Do any applicants take any ongoing prescribed medication (excluding Hormone Replacement Therapy or contraception)? Yes No
- b) Are any of the applicants currently awaiting medical treatment or advice, or planning an operation or an admission to hospital for treatment? Yes No
- c) Have any applicants had an operation or admission to any hospital in the last 3 years (excluding treatment for maternity and emergencies)? Yes No
- d) Have any applicants ever been refused cover for health or life insurance or had special terms applied? Yes No
- e) Have any applicants suffered from any form of the following (please tick yes if any apply, no if none apply): Yes No
Heart disease Stroke Cancer Alcohol or drug problems Arthritis (including back pain)
- f) Are any of the applicants currently experiencing any symptoms that have not been diagnosed by a medical professional? Yes No

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

Signature of Principal Member on behalf of all applicants

Date

C4. Full medical underwriting continued

Please only complete this table if you answered "YES" to any question in section C4.1.

C4.2 Further health questions

Have you, or any of your dependants, ever experienced or been treated for, or are you or any of your dependants 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"/>

continued overleaf

C4. Full medical underwriting continued

If you answered "YES" to any of the questions in section C4.2 please supply full details below.

Name of Applicant	Name of medication, description of treatment	Condition for which medication/ treatment was prescribed	Prescribing doctor's name and telephone number

C4.3 OTHER HEALTH CONDITIONS

Please enter in the table below the details of any condition or symptom that you or your dependants have that the questions in section C4.1 and C4.2 have not covered.

Name of Applicant	Diagnosis	Date first diagnosed	Currently on treatment for this condition?		Date of last consultation, hospitalisation or medication taken for this disorder	Treating practitioner's name and telephone number
			Yes	No		

C4. Full medical underwriting continued

C4.4 Details about your current doctor

Please provide your doctor's details.

Name of doctor	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		Postcode
Telephone number	<input type="text"/>	Years with current doctor	<input type="text"/> years

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

Signature of Principal Member on behalf of all applicants	<input type="text" value="X"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
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D – Important Information

General Notes

- The plan 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.
- 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 reassurers. 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.

Data protection notice

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.

Please note that we may randomly survey members from time to time to assess our service quality, product and processes.

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.

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, e-mail 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).

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
- applying exclusions to your policy
- 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

- 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 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 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 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 my employer or 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 hard 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 contained in Section D of this application form.
- 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 in 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 than 30 days from the date that the application was signed.

Signature of Principal Member
on behalf of all applicants

X

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 PruHealth policy declaration on behalf of all applicants

