

Private medical insurance application form.

Employee – Voluntary.

Notes to help you

To apply for PruHealth membership complete sections A to I using BLOCK CAPITALS and black ink.

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.

A – Principal member details

Employer name

Date commenced employment

Date you would like your cover to begin

B – Principal member details

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

Address

 Postcode

Telephone number (home) Telephone number (work)

Telephone number (mobile) Fax number

Date of birth Gender Male Female

E-mail

Staff payroll number

Quote reference number (If applicable) Campaign code (If applicable)

Barcode No: 000000700092018



Class: A0B

2005/12/12 13:31

C – Partner and dependant details

Complete only if there are other people to be covered by this policy. If you have more than four dependants please attach their details on a separate sheet.

Partner

Title Mr Mrs Ms Miss Other

Forename(s) Surname

E-mail

Date of birth Gender Male Female

Dependant 1

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth Gender Male Female

Dependant 2

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth Gender Male Female

Dependant 3

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth Gender Male Female

Dependant 4

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth Gender Male Female

D – Cover choices

Please mark your chosen plan, hospital coverage and excess amount using the table below. You have a choice of four hospital lists which offer different levels of coverage – please check the 'Your choice of hospitals' leaflet to see which list your nearest hospitals are on.

Plan choice:

- **Comprehensive plan** – covers you for extensive hospital care and outpatient cover.
- **Select plan** – covers you for hospital care and most outpatient cover.
- **Core plan** – covers you for hospital care and some outpatient cover.
- **Value plan** – hospital care and outpatient cover attract a member co-payment.

All plans include full access to the Vitality programme.

Hospital choice:

- **Local list** – includes all Spire Healthcare and most BMI Healthcare hospitals (the UK's two largest private hospital groups). 89% of our members have a hospital on this list within 30 minutes of their home. Does not include London hospitals.
- **National list** – extends coverage to over 160 of the UK's private hospitals, including all Nuffield Health hospitals (the UK's third largest private hospital group). Does not include London hospitals.
- **London list** – further extends coverage to Central London, including all remaining BMI Healthcare, and HCA Healthcare hospitals – the largest private hospital provider in London (this list includes over 180 of the UK's private hospitals).
- **Premier list** – offers the widest choice, with access to all the private hospitals and NHS hospitals with private facilities in the UK (over 400 hospitals).

Note: If you choose to receive inpatient treatment or any MRI, CT or PET scan in a hospital outside your hospital list, a 40% co-payment will apply. If you need treatment which is not available in your chosen hospital list, you must contact us and we'll locate a facility and consultant to provide the required treatment.

If you wish to avoid a co-payment this may involve you travelling to a different hospital within your nominated hospital list to receive treatment.

Excess choice:

Choosing an excess can lower the cost of your premiums. PruHealth will then pay any remaining costs up to any applicable limits. Each member on your policy will only have to pay this amount towards the total cost of their treatment within a given year, not for each specific claim. For the Value plan, there is no excess available but you will need to make a co-payment for each admission, consultation, visit or outpatient scan or test.

Plan (choose one plan only)	Excess (mark your choice against chosen plan only)					Hospital (mark your choice against chosen plan only)			
	£0	£100	£250	£500	£1,000	Local	National	London	Premier
Comprehensive plan <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Select plan <input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Core plan <input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value plan <input type="checkbox"/>	No excess available but co-payments will apply.					<input type="checkbox"/>	<input type="checkbox"/>		

E – Previous cover and claims history

1. Have you been covered by health insurance in the past 2 years, whether as an individual or as a member of a company paid scheme? Yes No
2. Have you made any claims on your health insurance in the past 2 years? Yes No

F – Underwriting options

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.

By selecting **full medical underwriting** you will receive a premium discount, you will know exactly what is covered and what conditions are excluded from your cover. You need to provide full medical details on this form.

If all people to be covered by the policy are aged 65 or under and none have suffered from heart disease, stroke, cancer or mental illness, you can select **moratorium underwriting**. You will not have to provide full medical details on this form but we may have to request information from your GP when you make a claim to determine whether the condition was pre-existing.

Select one underwriting option:

1. Full medical underwriting

2. Moratorium underwriting

F1 – Full medical underwriting

Only complete this section if you chose the full medical underwriting option, then go to section G.

Please complete the following questions. Should you have any relevant medical reports please attach copies of these to this application. Each person to be covered by the policy (applicant) must be under 80 years of age and must provide information where requested.

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

Yes No

b) If you answered yes to Q3a 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 Don't know

ii) Cholesterol medication: Your serum cholesterol is less than 5 mmol/l Yes No Don't know

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 Q3b, 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 G**. If you answered **Yes** please complete the rest of this section.

F1 – Full medical underwriting (continued)

Only complete this section if you answered "YES" to the previous Full Medical Underwriting questions. Once completed then go to SECTION G. 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.

Further Health Questions

Has any person to be covered by the policy ever experienced or been treated for, or are you 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"/>

F1 – Full medical underwriting (continued)

If you answered "YES" to any of the questions (a – q) on page 5, 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

F2 – Moratorium underwriting

Only complete this section if you chose the moratorium underwriting option, then go to section G.

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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G – How to pay

Payment must be made on a monthly basis by direct debit. We invoice on the 17th of each month and the payment will be debited on the 1st of the following month.

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)

Originator's Identification Number

6	4	8	3	1	6
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Reference

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Bank or Building Society
Account Number

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Branch Sort Code

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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)

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Date

--

Name and full postal address of your Bank or Building Society

To: The Manager

Bank or Building Society

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Address

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Postcode

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 – 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.
- 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.

Data Protection notice

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.

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).

H – 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 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 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:

- refusing to provide insurance
- increasing premiums above standard rates; or
- setting premiums at standard rates

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 do **NOT** want to see the report before it is sent to PruHealth

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

Signature of principal member on behalf of all applicants

Date

I – Policy declaration

- 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 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 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 1988.
- 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 copy submitted pursuant to an internet application will constitute an offer on my part for PruHealth membership.
- I have read, understood and consent to the Data Protection Declaration contained in Section G 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 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 than 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:

- Read the Why you're better off with us brochure.
- Entered and checked all personal details for you and other applicants if applicable.
- Selected your plan type and hospital list.
- Selected your excess level if you have chosen a Comprehensive, Select or Core plan.
- Answered all relevant questions, attached membership certificate from previous insurer if applicable or signed the Declaration Statement for your chosen underwriting option.
- Completed your payment details.
- Signed the PruHealth Policy Declaration on behalf of all applicants.
- Read and keep for your information 'The Direct Debit Guarantee'.

J – Only for completion by Advisers

1. Your FSA number (Registered Individuals) R.I. Number or
 e.g. A B C 1 2 3 4 5

Registered individual's Forename and

Registered individual's Surname

2. Your agency details

Your PruHealth agency number OR Agency name & address stamp

e.g. 1 2 3 4 5 6 X

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 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:

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

	To member	To you*
Member welcome packs	<input type="text"/>	<input type="text"/>
Member renewal packs	<input type="text"/>	<input type="text"/>
Member mid-term adjustments**	<input type="text"/>	<input type="text"/>

* Please note that if you have elected to have member documentation routed to you, it is your responsibility to ensure that the member receives these in a timely way as we will not send any communications to them directly. This is also the case with packs routed to the employer. Please ensure the employer contact is aware of this.

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

I confirm that all material facts regarding the pricing for this individual (and their dependants) for which I am aware, have been passed to PruHealth for consideration.

Name: Date:

Signature:

Please mail this complete application form to: PruHealth, Stirling FK9 4UE.

FOR OFFICE USE ONLY

CONSULTANT CODE: Agency code:

CONSULTANT NAME:

