

# Full medical underwriting Employee application form



## Filling in this form

You must advise us of any changes in your personal circumstances, including your state of health and that of anyone included on this application form, that take place between signing this application form and the start of your cover with us. We reserve the right to alter your acceptance terms in light of any such changes.

Please complete in BLOCK CAPITALS and answer all questions to allow us to process your application without delay. Based upon the information provided, PruHealth reserves the right to decline this application. Any alterations made to this form must be initialled by the employee.

## Part 1

### About you (to be completed by employee)

Company name		Plan number	
Dr/Mr/Mrs/Ms/Other	Forenames	Surname	
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth	Occupation	
Address			
			Postcode
Evening phone no.			

**Please note:** You and any dependants to be covered must live in the UK for at least 180 days in each year and must be registered with a UK GP who holds your full medical records.

### Your cover

Employee category*			
*If you're not sure what this is, please ask the person administering this plan (the Group Secretary).			
Please choose your hospital list by ticking the appropriate box:			
Countrywide <input type="checkbox"/>	Countrywide London upgrade <input type="checkbox"/>	Extended London upgrade <input type="checkbox"/>	Guided Option <input type="checkbox"/>

### About your family

Please enter details of your partner and children that you wish to cover. Children can be covered up to the age of 25. If any of your family would prefer correspondence to be addressed direct to them when they make a claim, they should take out a plan in their own name.

Partner's full forenames	Surname	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth
Your child's full forenames	Surname	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth
Your child's full forenames	Surname	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth
Your child's full forenames	Surname	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of birth

**IF NECESSARY, PLEASE INCLUDE ADDITIONAL FAMILY MEMBERS TO BE COVERED ON A SEPARATE SHEET OF PAPER.**

## Part 2

### Health statement

Please consider the following questions in relation to you and your family members included on this application form. If you answer "Yes" to any of the following questions, please complete the relevant section in Part 3 of this form, otherwise it will delay your application. If you do not wish to disclose the answers to your adviser or Group Secretary, you can provide the answers on a separate sheet of paper. Please attach it to this form in a sealed envelope.

#### FULL DISCLOSURE

Your answers to the questions on this form provide important information we need to underwrite your insurance. If you answer these questions fully and honestly you will have fulfilled your duty to disclose material facts. Failure to do so may mean that we are unable to pay a claim and, in certain circumstances, it may invalidate your insurance. If you are not sure if we would want to know a particular fact you should disclose it.

#### 1. Have you, or any person to be insured, ever suffered from or asked for advice on any of the following:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a) Fainting, fits of any kind, depression, anxiety or any other nervous disorder?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Diabetes, gout or any kidney, urinary tract or bladder complaint?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Angina, coronary thrombosis, stroke, chest pain, high blood pressure, rheumatic fever or any other disorder of the heart or circulatory system? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Cancer?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) Gynaecological disorders?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

#### 2. In the last 5 years, have you, or any person to be insured, suffered from or asked advice on any of the following:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a) Any digestive disorder, gastric or duodenal ulcer or any liver or bowel complaint? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Asthma, bronchitis, tuberculosis or any other lung or chest complaint?             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Bone or muscular problems including back complaints?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Varicose veins?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) Tonsillitis or any other disease or disorder of the ear, nose or throat?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

#### 3. Have you, or any person to be insured:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a) Ever been rejected by an insurance company, or been accepted with restrictions/premium increases or had their insurance cancelled?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Consulted a doctor or undergone any treatment (including taking drugs or medication) within the last 5 years for any condition not mentioned above?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Consulted a specialist or attended a hospital within the last 5 years, either as an in-patient, day-patient or out-patient, for the purpose of an investigation, test, x-ray or operation for any condition not mentioned above? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Ever been admitted to a hospital for an illness or as a result of an accident?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) Had any chronic, long-term medical or dental condition, or is there any known disability, abnormality or recurrent illness or injury which you know or suspect exists?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

## Part 3

### If you have answered "Yes" to any questions in Part 2, please provide details below

The following details are required:

- |                      |  |  |
|----------------------|--|--|
| 1. Name              | 3. Medical condition/diagnosis                       | 5. Further treatment or consultations required |
| 2. Relevant question | 4. Previous treatment and consultations (with dates) | 6. Present state of health                     |

Note: Failure to provide full details will delay your application.

<hr/> <hr/> <hr/> <hr/> <hr/>	Please continue on a separate sheet if necessary
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## Part 3, continued

### GP's details

Please state the name and address of your usual doctor (to whom requests for information may be made). If you have changed your doctor in the past year, please also give the name and address of your previous doctor on a separate sheet of paper. If the doctor is different for any of the other applicants, please also give details on a separate sheet of paper.

GP's name	Address
	Postcode
Telephone. no.	Fax no.

### Access to Medical Reports Act 1988

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

- we need your agreement before we can apply for a medical report from your doctor. You can refuse but, if you do, we will not be able to assess your application
- you can ask to see the report before the doctor sends it to us, or up to 6 months after
- if you tick the box below to indicate that you want to see the report, your doctor can charge you a reasonable fee to cover costs. This may also delay the assessment of your application
- if you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your doctor will not agree to do this, you may attach a statement of your own

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

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

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

### Access to Medical Reports Act 1988 – declaration and consent

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

I wish to see the report before it is sent to PruHealth  Please tick one box only

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

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

You (employee's signature)	Date
Signature of partner	Date
Parent/guardian (for children under 16)	Date
Signature of child (aged 16 or over)	Date
Signature of child (aged 16 or over)	Date

## Declaration (to be signed by you, the employee)

I declare that, to the best of my knowledge and belief, the statements made on this application form, and any additional information supplied as part of this application, are full, true and correct. Where I have supplied medical information for anyone else included in this application, I confirm that, where appropriate, I have checked with them that the information is correct and that I have their consent to provide this information on their behalf. I agree that the terms and conditions of the plan issued to my employer will bind me, and any of my family members included in this application, and I will read my terms and conditions document when I receive my membership pack.

I understand that no cover will apply for treatment of any medical condition or related condition that exists or has existed before the start of this plan, unless I have provided PruHealth with details and they have agreed to accept it. I also understand that PruHealth will advise me of any medical conditions which they specifically exclude from cover because of information that I have given to them.

I consent to PruHealth and its agents using the information that I supply, which may include health information that is sensitive information under the Data Protection Act 1998, for the purposes shown in the data protection summary below.

I confirm that, for the purposes of the Act, I have the authority of any of my family named on this application to consent on their behalf to their personal data being processed, and by signing this application I agree that PruHealth may use their personal data for the purposes described in the data protection notice. I will give the data protection notice enclosed with my membership pack to any family members included on this application who are old enough to understand it.

Your signature

Date

## Data Protection

**Data Protection Notice** – You will receive a copy of our data protection notice in your membership pack. Please show it to any family members on the plan old enough to understand it, as it applies to their personal data also.

**Use of personal information** – Information we receive in connection with the plan will become part of the data held by PruHealth in accordance with the Data Protection Act 1998. We will handle this information on a confidential basis and use it to administer the plan, process claims, for underwriting and pricing purposes and to maintain management information for business analysis.

**Disclosure** – We may disclose personal information, under the protection of a contract, to our agents or service providers to administer the plan, to those involved with your treatment or care, and to any adviser or independent intermediary appointed to act on your employer's behalf. You may want to ask your employer whether an adviser or an independent intermediary has been appointed. Your data may be processed by service providers in a country outside the European Economic Area.

**Claims correspondence** – Claims correspondence will be addressed to you, the insured employee. If a family member does not wish us to correspond with you in relation to their claim, and they are aged 18 or over, they should take out a separate plan in their own name.

**Telephone calls** – To continuously improve our service to members, your calls may be recorded and monitored.

**Keeping you informed** – PruHealth, our group of companies and our business associates, service providers and agents may use your personal information to inform you of other services and products that may be of interest, either through telemarketing or mail, or for general market research. If you would prefer not to receive details of other products, please either tick this box  or write to the Data Protection Co-ordinator at PruHealth, PO Box 28836, Edinburgh, EH15 1WQ.

**Obtaining a copy of your personal information** – If you would like a copy of the personal information we keep about you, please write to the Data Protection Co-ordinator at PruHealth, and ask for a 'Data subject access form'. Please note there is a £10 charge for this service.

### To be completed by the adviser

Agent code

Consultant's name

For office use only

Main plan no.

Client code