

# Health Cash Options

## Employee application form



### Filling in this form

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 initialed by the employee.

### 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*
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\*If you're not sure what this is, please ask the person administering this plan (the Group Secretary).

### 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.**

## 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. 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 the members' terms and conditions document when I receive it.

I understand that, with the exception of the dental and optical benefits, there is a one month waiting period before anyone included in this application can claim for benefits under this plan and that, in any event, no benefit is payable for any medical conditions that needed advice, medication or treatment in the 12 months immediately before the start of cover under this plan until I, and any family members included in this application, have been covered for 12 consecutive months.

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