PHILIP WILLIAMS BUPA HEALTHCARE SCHEME

YOUR APPLICATION TO JOIN

Underwritten

Thank you for choosing Bupa. Before we can welcome you as a member, please complete this application form as fully as possible.

bupa.co.uk

FOR OFFICE USE ONLY						
MIS number						
Date application received	D	D	M	M	Y	Y
Name of applicant						

BEFORE YOU BEGIN

Please write in BLOCK CAPITALS and use a black pen.

Remember to give us as much detail as you can about yourself and any family members you would like to cover. You must take good care to answer all the questions honestly and to the best of your knowledge. If you don't, your policy may be cancelled, or treated as if it never existed, or your claim may be rejected or not fully paid.

You must ensure the details of your family members are correct and should check the information with them before sending it to us.

Please remember to sign and date the application form.

Once you have completed the application form, please return it to:

Philip Williams and Company, 35 Walton Road,
Stockton Heath, Warrington WA4 6NW

1. YOUR BUPA MEMBERSHIP

Are you already a Bupa member? Yes ☐ No ☐

If you are already a member of Bupa, or have been in the past, please give us your membership number below.

2. YOUR PERSONAL DETAILS

Please tell us about yourself here.

Mr / Mrs / Miss / Ms / Other (*please circle or list title if other*)

Surname

First name(s)

Address

Postcode

Telephone number

Mobile number

Email address

Your date of birth D D M M Y Y

Occupation (if retired, please state previous occupation)

Your employer

If you would like any members of your family (partner, children etc) to be included in your membership, please go to **section 3**. If not, go to **section 4**.

3. YOUR FAMILY'S DETAILS

If you would like to cover members of your family, please give us their details below. Remember to check with each family member that you have their correct details.

	Member 2	Member 3	Member 4	Member 5
Full name of family member				
Occupation (if retired, please state previous occupation)				
Relationship to you				
Date of birth	D D M M Y Y	D D M M Y Y	D D M M Y Y	D D M M Y Y

What if I need to add more family members?

If you would like to cover family members additional to those listed above, please give us their details on a separate sheet of paper. You will also need to answer both parts of **sections 4 and 5** for them.

4. FURTHER DETAILS

Please answer each question as it applies for yourself and each person named in **section 3**. (If you are an existing member and are only adding family members, you do not need to fill out further details or the medical history relating to your own health, only for your family members.)

	Main member		Member 2		Member 3		Member 4		Member 5	
Full name of family member										
(Please tick the relevant box)	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Have you been a UK resident for more than six months?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Are you registered with a GP/MO in the UK?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Have you been registered with your GP/MO for at least six months?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
If you are not registered with a GP/MO currently or have not been for at least six months, do you have access to your full medical records in English? *(Please note that to continue with your application you must be registered with a UK GP/MO and if under six months, have access to your full medical records in English)*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
If you have answered '**No**' to any questions above please provide details										
Do you play a sport on a professional or semi-professional basis? If '**Yes**', which sport(s)?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Have you smoked any tobacco products in the last two years? (over 18's only)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

5. MEDICAL HISTORY – Part 1

This section asks for health and medical details, past and present, for you and for each person named in **section 3**. Please tick '**Yes**' or '**No**' to every question for each person.

For any of the medical conditions or symptoms listed in questions 1-16 please indicate if:

- **you or anyone to be covered on your membership has seen a GP or other healthcare professional within the last two years**
- **you or anyone to be covered on your membership has been admitted to hospital, had an operation OR any investigations (for example scan, X-ray, blood test, biopsy) within the last seven years**

	Main applicant/ member		Dependant applicant/member							
	Member 2		Member 3		Member 4		Member 5			
	Name		Name		Name		Name			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Heart or cardiovascular disorders *eg coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
2. Glandular disorders *eg diabetes, thyroid, hormonal problems*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
3. Breathing or respiratory disorders *eg asthma, bronchitis, shortness of breath, chest infections, colds, flu*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
4. Ears, nose, throat, or eye problems *eg hayfever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
5. Stomach, intestines, liver or gallbladder *eg ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
6. Cancer, tumours, growths, cysts, or moles that itch or bleed	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
7. Skin problems *eg eczema, rashes, psoriasis, acne*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
8. Brain or nervous system disorders *eg stroke, migraines, repeated headaches, MS, epilepsy, nerve pain, fits*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
9. Muscle or skeletal problems *eg arthritis, cartilage and ligament problems, back and neck problems, sprains, joint replacements, gout, sciatica*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
10. Urinary problems *eg bladder, kidney or prostate problems, urinary infections, incontinence*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
11. Blood disorders *eg anaemia, hepatitis, HIV, abnormal blood tests*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
12. Reproductive system problems *eg pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
13. Dental problems *eg wisdom teeth, abscess, gingivitis*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
14. Allergies	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
15. Psychological disorders *eg depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
16. Undiagnosed symptoms *eg chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding*	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Please also answer the following questions:										
17. Are you or any applicant/member taking any medicines, prescribed or otherwise?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
18. Within the last three months has anyone to be covered experienced symptoms of ANY health problems for which medical advice has not yet been sought?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
19. Has anyone to be covered EVER had any past history of joint replacements, heart conditions, or strokes?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
20. Is there any other information relating to your health that has not yet been prompted by the questions listed 1-19?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

If you have answered '**Yes**' to any of the conditions here, please give us full details in **part 2** on the following pages.
If you have answered '**No**' to all of the above conditions, please go to **section 6**.

5. MEDICAL HISTORY – Part 2

To help us build a more complete picture of your (and your family's) health, please use the space below to expand on any of the conditions you answered '**Yes**' to in **part 1**. Please give as much specific detail as possible.

You

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:	
Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:	
Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:	
Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:	
Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

Name of member:

Question number from **part 1**	
Please describe the illness or medical problem	
When did symptoms begin/end?	
Treatment *(prescribed or otherwise)*	
Outcome of treatment *(eg ongoing, complete, recurrent or likely to recur)*	
How many times have you consulted a healthcare professional in the past two years?	

6. PAYING FOR YOUR COVER

Subscription quoted	£	Payment is made by monthly direct debit. please complete the direct debit instruction on page 13 of this form.

When would you like your cover to start? (This date must be from the 1st of the following month.)

Day	Month	Year

Please note: Although we will try to start your cover on the date indicated above, this cannot be guaranteed. Your start date will be confirmed on your membership certificate.

7. OBTAINING MEDICAL REPORTS FROM A GP

When you need to request a medical report from your/family member's GP, we can do this on your/family member's behalf with your or their consent.

We will always ask for your/family member's consent before requesting a report from your GP on your/family member's behalf and we will ask for your/family members consent on the telephone when we explain to you the need for the report. You can choose from three courses of action.

1. You/they can give consent without asking to see the GP's report before it is sent to us. The GP will send the report directly to us.

   If you/they give consent to us obtaining a report without indicating that you/they wish to see it, you/they can change your/their mind by contacting your/their GP before the report is sent to us. In which case you/they will have the opportunity to see the report and ask the GP to change the report or add your/family member's comments before it is sent to us, or withhold your/family member's consent for its release.

2. You/they can give consent, but ask to see any report before it is sent to us, in which case you/they will have 21 days, after we notify you/them that we have requested a report from the GP, to contact your/family member's GP to make arrangements to see the report.

   If you/they fail to contact the GP within 21 days, we will request they send the report direct to us. If however you/they contact the GP with a view to seeing the report, you/they must give the GP written consent before they can release it to us.

   You/they may ask the GP to change the report if you/they think it is misleading. If your/family member's GP refuses, you/they can insist on adding your/family member's own comment to the report before it is sent to us.

3. You/they can withhold consent, but if you/they do, please bear in mind that we may be unable to progress with your/family member's claim.

Whether or not you/they indicate that you/they wish to see the report before it is sent, you/they have the right to ask your/family member's GP to let you see a copy, provided that you/they ask them within six months of the report having been supplied to us.

Your/family member's GP is entitled to withhold some or all of the information contained in the report if (a) they feel that it may be harmful to you/your family member (b) it would indicate their intentions in respect of you/your family member or (c) would reveal the identity of another person without their consent (other than that of a health professional in relation to your/family member's care).

8. YOUR LEGAL DECLARATION

Important: Please read this declaration carefully before signing and dating the completed form.

1. I am applying for a Bupa healthcare plan. I agree that the terms of cover set out in the current membership guide relating to my cover (which is the cover for which I am now applying) will be binding on me and any dependants covered under my membership, and accept they shall be the basis upon which benefits shall be payable under my cover. (The membership guide for your cover will be posted to you if we accept your application and is available on request.)
2. I declare that all the information given to Bupa on behalf of myself and my dependants for the purposes of receiving my quotation and being covered by Bupa and the information contained in this application for Bupa membership is and remains true and complete, to the best of my knowledge and belief, except to the extent I inform you otherwise when sending you this application for Bupa membership. I have confirmed the details of my dependants with the relevant family member.
3. I agree to inform Bupa if any of the information relating to myself or any dependants I have provided, or provide, changes at any time before cover starts.
4. I understand that if the information I have provided about myself and my dependants in answer to the questions in this application for Bupa membership is inaccurate or misleading, Bupa may terminate my cover or benefits might not be payable.
5. I understand and accept there is no undertaking to cover any medical conditions in existence before the time I, or my dependants, are covered by Bupa.
6. I understand that I will have the option of cancelling my Bupa cover, as long as I do so in writing within 21 days of me receiving my membership certificate and receive a full refund providing no claims have been paid.
7. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any family members specified in this form for Bupa to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.
8. I understand English Law applies to the agreement between me and Bupa, unless otherwise agreed between us in writing.

You are advised to keep a record of all information you supply to us in connection with your Bupa membership, including this application form and any letters. If you would like a copy of this form please ask us.

Obtaining medical reports from your GP:

- I understand that Bupa may need me to provide a medical report from my GP within the first 24 months of my membership before treatment is authorised
- I agree to Bupa obtaining this information from my GP on my behalf and I understand that Bupa will gain verbal confirmation from me prior to any medical report being requested in this way
- I understand the rights I have in relation to such reports as explained on the page overleaf
- I have shown this declaration to the proposed dependants on the policy and confirm that they understand that if they need to claim they will be asked on the telephone to confirm their consent to Bupa requesting a medical report on their behalf

If you do not wish Bupa to request medical reports on your behalf in this way, please tick this box ☐

Signature	Date

BUPA PRIVACY NOTICE

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa Group. To this end, we comply with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be outside of the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security, in addition to the obligations imposed by the Data Protection Act.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care.

Audit of medical and billing information: When we process claims or investigate complaints on your behalf, Bupa may request and obtain further details from your treatment provider. The information may be sought either at the time of processing or subsequently, for the purposes of ensuring the accuracy of information and the quality of treatment and care. You confirm that you consent to Bupa obtaining medical and billing information from your treatment provider relating to claims or complaints you may make.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member. Your membership and contact details may be shared by the companies in the Bupa Group to enable us to manage our relationship with you as a Bupa customer and update and improve our records. Bupa does not share the names, addresses and other contact details of our members with other organisations.

Telephone calls: In the interest of continuously improving our services to members, calls may be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by us, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to detecting and/or preventing fraudulent or improper claims.

Keeping you informed: The Bupa Group would, on occasion, like to keep you informed of the Bupa Group's products and services that we consider may be of interest to you. If you do not wish to receive information about our products and services, or have any other Data Protection queries, please write to: Bupa UK Information Governance Team, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3DZ or contact us via email at: DataProtection@bupa.com

DIRECT DEBIT INSTRUCTION

Instruction to your Bank or Building Society to pay by Direct Debit

Please complete the white areas in **BLOCK CAPITALS** and **BLACK INK** to instruct your bank to make payments directly from your account. Then return the completed form to: **Philip Williams & Co, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW**

DIRECT Debit

Originator Identification Number

7	5	3	2	9	4

1. Name and full postal address of your Bank or Building Society Branch

To: The Manager

Bank or Building Society

Address

Postcode

2. Name(s) of account holder(s)

3. Branch sort code

4. Bank or Building Society account number

5. Bupa Reference/Membership number

FOR Philip Williams & Co OFFICIAL USE ONLY

This is not part of the instruction to your Bank or Building Society

Note to member:

Please complete your member/group name below

6. Instruction to your Bank or Building Society

Please pay Philip Williams & Co Direct Debits from the account detailed in this instruction subject to the safeguards assured by The Direct Debit Guarantee. I understand that this instruction may remain with Philip Williams & Co and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

Bank contact address: Philip Williams & Co, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW

This guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

DIRECT Debit

- 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 Philip Williams & Co will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Bupa 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 Philip Williams & Co 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 Philip Williams & Co 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.

SHOULD YOU WISH TO CANCEL THIS INSTRUCTION THROUGH PHILIP WILLIAMS & CO, PLEASE CALL US ON 0845 230 1654†. YOU MUST ALLOW A MINIMUM OF SEVEN DAYS BEFORE THE NEXT PAYMENT BY DIRECT DEBIT IS DUE.

†Calls to this number may be recorded and may be monitored.

NOTES

FINAL CHECKLIST

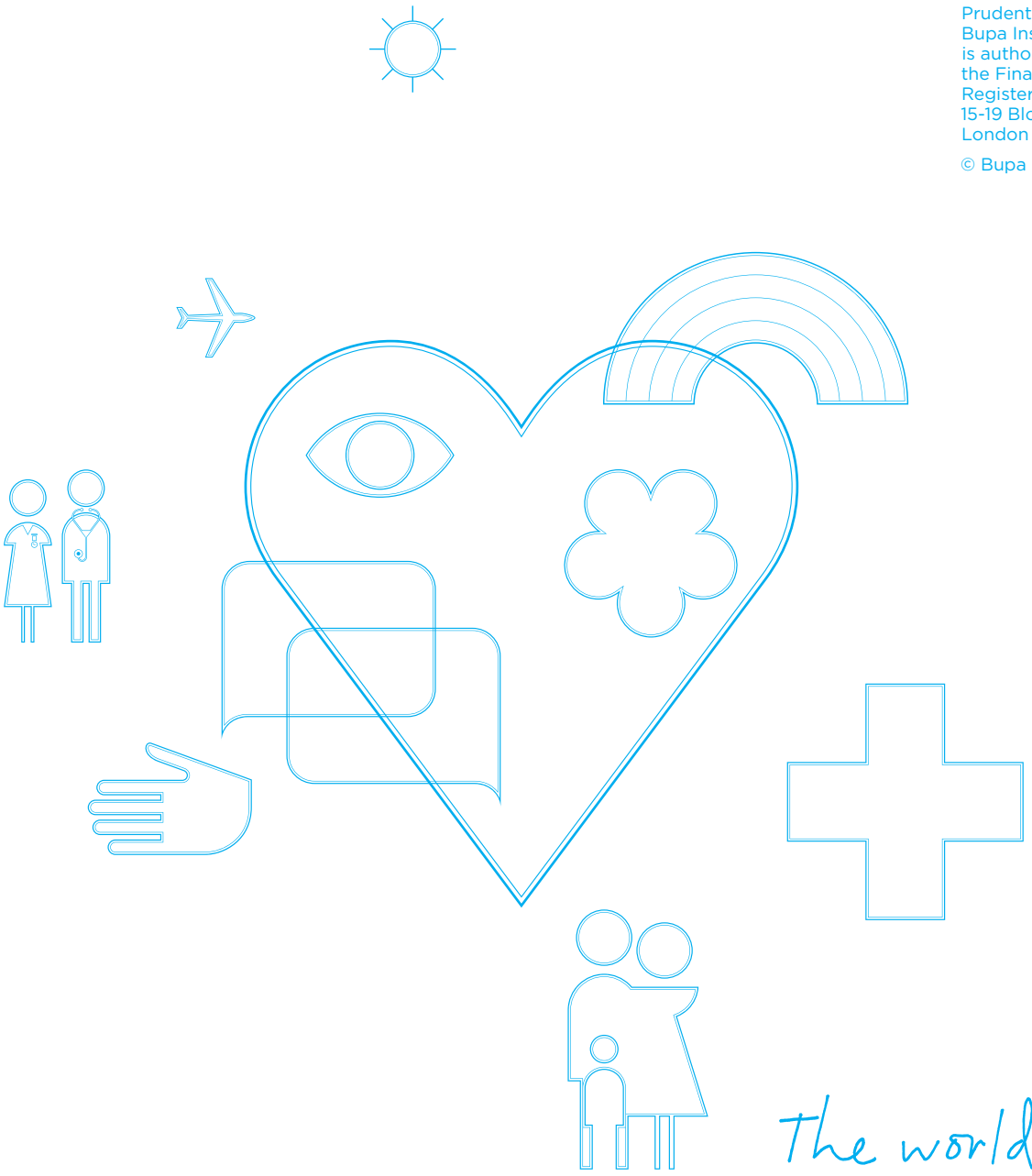
BEFORE YOU RETURN YOUR FORM, HAVE YOU:

- [ ] ticked your choice of scheme
- [ ] included full details of all the family members you would like to cover
- [ ] checked with your family members that their details are correct
- [ ] remembered to sign and date your form
- [ ] kept a copy for your own records

SEND YOUR COMPLETED FORM TO:

Philip Williams and Company, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW

Once we have received and processed your application you will receive a welcome pack in the post.



The world of Bupa

Care homes
Cash plans
Dental insurance
Dental services
Health assessments
Health at work services
Health coaching
Health information
Health insurance
Home healthcare
International health insurance
Travel insurance

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