Your application/ amendment form

Philip Williams
Bupa Healthcare Scheme

Underwritten

Thank you for choosing Bupa

Before we can welcome you and (if applicable) your dependant(s), please complete this application form as fully and accurately as possible.

This form is for new members and existing members wishing to add their dependants.

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK

It's important you provide us with your (and if applicable, your dependants') medical history.

- Please fill in your application form and return it to us as soon as you can. Until we have received this we won't be able to confirm exactly what your policy covers you for, meaning your claims might take longer for us to process and we might not be able to pay for treatment you need.
- Remember to give us as much detail as you can about yourself and any dependants you would like to cover. You must take reasonable care to answer all the questions honestly and to the best of your knowledge. If you are adding any dependants, you must check all answers in relation to any dependants with them to make sure that their details are correct. By reasonable care we mean not giving false information or keeping necessary information from us. If you don't take reasonable care, your policy may be cancelled, or treated as if it never existed, or your claim may be rejected or not fully paid, if there is reasonable evidence that you or a dependant did not take reasonable care in answering our questions.
- Please note that the policy you are joining is a fully medically underwritten policy. This means that any symptoms or conditions that have been present prior to the start date of the policy may not be covered. For a period of up to 60 months after your start date we may require further medical information to assess your claim, particularly where claims are made early in your policy. This is to ensure that the claim does not relate to a pre-existing condition. Where this medical information is not provided, we may not be able to process your claim.
- Please be aware, that you can only claim for eligible private medical costs once. This means if you have two policies that provide private medical cover, the cost of your eligible treatment may be split between Bupa and the other insurance company. You will be asked to provide us with full details of any other insurance policy at the time of claim.

Where to send your completed form

By post: Philip Williams (G Ins) Management Limited, 35 Walton Road, Stockton Heath, Warrington WA4 6NW

For office use only

MIS number	
Date application received	D D M M Y Y Y Y
Name of the applicant	

1. Your Bupa membership

Are you already a Bupa member? Yes ☐ No ☐

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

2. Your personal details

Please tell us about yourself here (to see how we use your information, please read our privacy notice on page 13).

Title *(please tick or list title if other)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s) Surname

Address

Postcode

Home telephone number Mobile telephone number

Email address

Date of birth D D M M Y Y Y Y Sex at birth Male ☐ Female ☐

Occupation (if retired, please state previous occupation)

Your employer

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

3. Your dependants' details

If you would like to cover your dependants, please give us their details below. Remember to check with each dependant that you have their correct details and make sure that they are directed to our privacy notice on page 13 before submitting their details to us. Please note that the inclusion of each dependant will impact the subscription you pay for the cover. You must have your dependants' express agreement to submit this form on their behalf (or be their legal representative).

	Member 2	Member 3	Member 4	Member 5
First name				
Surname				
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
Sex at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐

What if I need to add more dependants?

If you would like to cover dependants additional to those listed above, please give us their details on a separate sheet of paper. You will also need to answer 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 dependants, you do not need to fill out further details or the medical history relating to your own health, only for your dependants. Please tick 'Yes' or 'No' to every question for each person and provide details where applicable. Remember to check with each dependant that you have their correct details and make sure that they are directed to our privacy notice on page 13 before submitting their details to us.

Main member/dependant (as detailed in sections 2 and 3)	**Main member**	**Member 2**	**Member 3**	**Member 4**	**Member 5**
(Please tick the relevant box)	**Yes No**	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Are you a UK resident?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Do you have access to your medical records in English? To be eligible for cover the main member and dependants must have been registered continuously with a GP for a period of at least six months, or have access to and be able to provide their full medical records in English *(Please note that for us to appropriately administer your policy you will need to be registered with a UK GP)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Are you a professional or semi-professional sports person? By this we mean: do you receive payment or sponsorship for taking part in any sport?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
If '**Yes**', which sport(s), including the name of the team, if applicable? *(On receipt of your application we will assess your eligibility to join the scheme and inform you accordingly)*					
Have you smoked any tobacco products in the last two years? (Over 18s only)	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

5. Medical history – part one

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. Remember to check with each dependant that you have their correct details and make sure that they are directed to our privacy notice on page 13 before submitting their details to us.

For any of the medical conditions or symptoms listed in questions 1 to 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 member/dependant (as detailed in sections 2 and 3)**									
	Main member		**Member 2**		**Member 3**		**Member 4**		**Member 5**	
(Please tick the relevant box)	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1. Heart or cardiovascular disorders *(For example: coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Glandular disorders *(For example: diabetes, thyroid, hormonal problems)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Breathing or respiratory disorders *(For example: asthma, bronchitis, shortness of breath, chest infections)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Ears, nose, throat, or eye problems *(For example: tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Stomach, intestines, liver or gallbladder *(For example: 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 *(For example: eczema, rashes, psoriasis, acne)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Brain or nervous system disorders *(For example: migraines, repeated headaches, MS, epilepsy, nerve pain, fits)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Muscle or skeletal problems *(For example: arthritis, cartilage and ligament problems, back and neck problems, sprains, gout, sciatica)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Urinary problems *(For example: bladder, kidney or prostate problems, urinary infections, incontinence)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Medical history – part one (continued)

	Main member/dependant (as detailed in sections 2 and 3)									
	Main member		Member 2		Member 3		Member 4		Member 5	
(Please tick the relevant box)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11. Blood disorders *(For example: anaemia, hepatitis, HIV, abnormal blood tests)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Reproductive system problems *(For example: pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, low sperm count)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Dental problems *(For example: wisdom teeth, abscess, gingivitis)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Allergies *(For example: pet allergies, food allergies)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Psychological disorders *(For example: depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Undiagnosed symptoms *(For example: chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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 to 19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you have answered 'Yes' to any of the conditions here please give us full details in 'Medical history – part two' on the following pages. If you have answered 'No' to all of the above conditions, please continue with the form.

5. Medical history – part two

To help us build a more complete picture of your (and your dependants') health, please use pages 8 to 10 to expand on any of the conditions you answered 'Yes' to in part one. Please give as much specific detail as possible. Failure to do so will result in delays processing your application. You can use the example below for help when filling out the form.

Definitions

Controlled: Condition/symptom ongoing but controlled by treatment/medication.

Recurrent: Occurring more than once, often or occasionally.

Likely to recur: Symptom free for a period of time but likely to recur.

Fully recovered: Condition fully resolved/cured with no symptoms and no medication.

Example one

Name of member:	JOHN SMITH
Question number from **part one**	11
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	HIGH CHOLESTEROL
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 1 0 1 2 0 1 8 Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	OVER COUNTER MEDICATION / DIET / PRESCRIBED MEDICATION
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*	CONTROLLED
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	2

Example two

Name of member:	JOHN SMITH
Question number from **part one**	9
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	LEFT KNEE PAIN
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 5 0 5 2 0 1 6 Ended 2 0 0 1 2 0 1 7
Treatment *(prescribed or otherwise)*	PHYSIOTHERAPY
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*	FULLY RECOVERED
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	0

5. Medical history – part two (continued)

Name of member:	
Question number from **part one**	
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	
When did symptoms begin/end? **If ongoing please leave end date blank**	Began D D M M Y Y Y Y Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*	
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	

Name of member:	
Question number from **part one**	
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	
When did symptoms begin/end? **If ongoing please leave end date blank**	Began D D M M Y Y Y Y Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*	
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	

Name of member:	
Question number from **part one**	
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	
When did symptoms begin/end? **If ongoing please leave end date blank**	Began D D M M Y Y Y Y Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*	
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	

5. Medical history – part two (continued)

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

5. Medical history – part two (continued)

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg controlled, recurrent, likely to recur, fully recovered)*		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

6. Paying for your cover

Subscription quoted £	Payment is made by monthly/annual direct debit. Please complete the Direct Debit instruction on page 14 of this form.

When would you like your cover to start? (Applications cannot be back dated). D D M M Y Y Y Y

Payment to be taken: Monthly ☐ Annually ☐

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 your doctor

When you or your dependant needs to request a medical report from your/your dependant's doctor, we can do this on your/your dependant's behalf with your or their consent. We will always ask for your/your dependant's consent before requesting a report from your/your dependant's doctor on your/your dependant's behalf and we will ask for your/your dependant's consent on the telephone when we explain to you/your dependant the need for the report.

When we ask you/your dependant for your/your dependant's consent to obtain a medical report from your/your dependant's doctor, you/your dependants have certain rights under the **Access to Medical Reports Act 1988** or the **Access to Personal Files and Medical Reports (NI) Order 1991** (the "Acts"). The section below summarises your/your dependant's rights under the Acts.

You and your dependants should read this section carefully and if you/your dependants don't understand any point, you/your dependants should ask for further information.

Your/your dependants' rights

1. You can authorise the disclosure of your doctor's report without asking to see it. The report will then be sent directly to us by your doctor. Should you give your consent to the disclosure of a report without indicating your wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask your doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.
2. You can give your consent but ask to see the report before it is sent to us. If you do this you should contact your doctor within 21 days of sending the request to them. If you do not contact your doctor within the 21 day period you have authorised them to disclose the report to us directly without further notice to you. If you do contact your doctor within the 21 day period you must give them your written consent to disclose the report. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comments to the report before it is sent to us or withhold your consent for its release.
3. You can withhold your consent but, if you do, please bear in mind that we may be unable to process your request.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided you ask them within six months of the report having been supplied to us. Your doctor is entitled to withhold some or all of the information contained in the report if in their opinion, this information:

(a) might cause serious harm to your physical or mental health or that of another person, or
(b) would reveal the identity of another person without their consent (other than that provided by a healthcare professional in their professional capacity in relation to your care).

We may make a contribution to the costs of any medical report that we have requested on your behalf. This will be confirmed at point of telephone consent. If we do make a contribution, you will be responsible for any amount above this.

8. Your legal declaration

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

1. To the best of my knowledge and belief the information given in this form is true, accurate and complete. I understand that Bupa can end a person's policy or refuse to pay a claim in full or part if there is reasonable evidence that I or a dependant did not take reasonable care when providing any information requested in this form.
2. Where I have provided information on behalf of any other person to be covered on the policy, I confirm that I have checked with them that the information is correct before completing this form and I have their express agreement to submit this form on their behalf, or I am their legal representative.
3. I understand that my personal information and that of any other person to be covered on this policy will be processed by Bupa for the purposes set out in Bupa's privacy notice. I confirm that I have brought Bupa's privacy notice to the attention of the persons covered.
4. I agree to be bound by the policy terms and conditions (including in respect of those terms that apply to any other person to be covered on this policy). I agree that English law will apply to the policy terms and conditions.

It is essential that you take reasonable care to provide us with full, complete and accurate information when you complete this form. Please be sure to check the entire form.

If you do not provide complete information about yourself or any other person covered under the policy, we may have the right to end your policy, or to refuse to pay all or part of a claim.

We recommend that you keep a record of all the information you supply to us in connection with this form, including letters.

If you would like a copy of this form, please ask us.

Obtaining medical reports from your doctor:

- I have shown this declaration to the proposed dependants on the policy and confirm that they understand and accept that if they need to claim they may be asked on the telephone to confirm their consent to Bupa requesting a medical report on their behalf.
- I understand that Bupa may need me to provide a medical report from my doctor to support my application before treatment is authorised or a claim paid.
- I consent to Bupa obtaining this information from my doctor 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 acknowledge the rights I have in relation to such reports as explained in section 7.

Please tick this box if you do **NOT** wish Bupa to request medical reports on your behalf in this way ☐.

Please tick this box if you do **NOT** wish to see the medical report from your doctor before it is supplied to Bupa ☐.

Signature

Date D D M M Y Y Y Y

We'll verify your digital signature if your form is signed using an Adobe Digital ID or Adobe Sign (or equivalent). If you modify your form after digitally signing it, or send us a printed or scanned copy of the form, then we won't be able to verify your digital signature at this point and will need to contact you either by phone or in writing to confirm this is your signature. Until we have verified or confirmed your signature, we won't be able to advise exactly what your policy covers you for, meaning your claims might take longer for us to process and we might not be able to pay for treatment you need.

Privacy notice – in brief

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you and how we use and protect it. It also provides information about your rights. You can find more details in our full privacy notice available at **bupa.co.uk/privacy**. If you do not have access to the internet and would like a paper copy, please contact the Bupa Privacy team on **+44 (0) 1784 893706**. Or, you can email the team at **dataprotection@bupa.com** or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, Middlesex TW18 3DZ**. If you have any questions about how we handle your information, please contact us at **dataprotection@bupa.com**

Information about us

In this privacy notice, references to 'we', 'us' or 'our' are to Bupa. Bupa is registered with the Information Commissioner's Office, registration number Z6831692. Bupa is made up of a number of trading companies, many of which also have their own data-protection registrations. For company contact details, visit **bupa.co.uk/legal-notices**

1. Scope of our privacy notice

This privacy notice applies to anyone who interacts with us about our products and services ('you', 'your'), in any way (for example, email, website, phone, app and so on).

2. How we collect personal information

We collect personal information from you and from certain other organisations (those acting on your behalf, for example, brokers, healthcare providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

3. Categories of personal information

We process two categories of personal information about you and, if it applies, your dependants. This is standard personal information (for example, information we use to contact you, identify you or manage our relationship with you) and special categories of information (for example, health information, information about race, ethnic origin and religion that allows us to tailor your care), and information about any criminal convictions and offences (we may get this information when carrying out anti-fraud or anti-money-laundering checks, or other background screening activity).

4. Purposes and legal grounds for processing personal information

We process your personal information for the purposes set out in our full privacy notice, including to deal with our relationship with you (including for claims and handling complaints), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and to protect our rights, property, or safety, or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process. We normally process standard personal information on the basis that it is necessary, so we can perform a contract, for our or others' legitimate interests or it is needed or allowed by law. We process special categories of information, because it is necessary for an insurance purpose, we have your permission or as otherwise described in our full privacy notice.

5. Marketing and preferences

We may use your personal information to send you marketing by post, phone, social media, email and text. We only use your personal information to send you marketing if we have either your permission or a legitimate interest. If you don't want to receive personalised marketing about similar products and services that we think are relevant to you, please contact us at **optmeout@bupa.com** or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, Middlesex TW18 3DZ**

6. Processing for profiling and automated decision making

Like many businesses, we sometimes use automation to provide you with a quicker, better, more consistent and fair service, as well as with marketing information we think will interest you (including discounts on our products and services). This may involve evaluating information about you and, in limited cases, using technology to provide you with automatic responses or decisions. You can read more about this in our full privacy notice. You have the right to object to direct marketing and profiling relating to direct marketing. You may also have rights to object to other types of profiling and automated decision making.

7. Sharing your information

We share your information within the Bupa group of companies, with relevant policyholders (including your employer if you are covered under a group scheme), with funders who arrange services on your behalf, those acting on your behalf (for example, brokers and other intermediaries) and with others who help us provide services to you (for example, healthcare providers) or who we need information from, to handle or check claims or entitlements (for example, professional associations). We also share your information in line with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

8. Transfers outside of the European Economic Area (EEA)

We deal with many international organisations and use global information systems. As a result, we transfer your personal information to countries outside of the European Economic Area (the EU member states plus Norway, Liechtenstein and Iceland) for the purposes set out in this privacy policy.

9. How long we keep your personal information

We keep your personal information in line with periods we work out using the criteria shown in the full privacy notice available on our website.

10. Your rights

You have rights to have access to your information and to ask us to correct, erase and restrict use of your information. You also have rights to object to your information being used; to ask us to transfer information you have made available to us; to withdraw your permission for us to use your information; and to ask us not to make automated decisions, which produce legal effects concerning you or significantly affect you.

11. Data protection contacts

If you have any questions, comments, complaints or suggestions about this notice, or any other concerns about the way in which we process information about you, please contact us at **dataprotection@bupa.com**

You also have a right to make a complaint to your local privacy supervisory authority. Our main office is in the UK, where the local supervisory authority is the Information Commissioner, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, United Kingdom.

Phone: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

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 (G Ins) Management Limited, 35 Walton Road, Stockton Heath, Warrington WA4 6NW

DIRECT Debit

Service User 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 (G Ins) Management Limited 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 (if applicable)

6. Instruction to your Bank or Building Society

Please pay Philip Williams (G Ins) Management Limited 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 (G Ins) Management Limited and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date D D M M Y Y Y Y

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

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 (G Ins) Management Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Philip Williams (G Ins) Management 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 Philip Williams (G Ins) Management 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 Philip Williams (G Ins) Management 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.

Should you wish to cancel this instruction through Philip Williams (G Ins) Management Limited, please call them on 01925 604421†. You must allow a minimum of seven days before the next payment by Direct Debit is due.

†Philip Williams may record or monitor their calls.

Final checklist

Before you return your form, ensure that you have:

- included full details of all the dependants you would like to cover
- checked with your dependants that their details are correct and provided the privacy notice on page 13 to each person and that you have their express agreement to submit this form on their behalf (or you are their legal representative)
- remembered to sign and date your form
- kept a copy for your own records.

Where to send your completed form:

Philip Williams (G Ins) Management Limited, 35 Walton Road, Stockton Health, Warrington WA4 6NW

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

Bupa health insurance is provided by:

Bupa Insurance Limited. Registered in England and Wales No. 3956433. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

Arranged and administered by:

Bupa Insurance Services Limited, which is authorised and regulated by the Financial Conduct Authority. Registered in England and Wales No. 3829851.

Registered office: 1 Angel Court, London EC2R 7HJ

bupa.co.uk

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