

# Bupa Select - application form for use when applying to join Bupa from another health insurance company

This application form is for anyone (except professional sportspersons) who is applying to join Bupa Select and who at the time of applying:

- has private medical insurance (PMI) with another insurer and
- has had their PMI cover with that insurer for at least 12 months.

In which case, we may, at our sole discretion, consider your application on a no further underwriting basis. Please note: any dependants you wish to cover who do not currently have PMI cover with another insurer cannot be considered on a no further underwriting basis.

- If we do offer cover on a no further underwriting basis this means that we will not add exclusions to your Bupa cover that are personal to you and/or your dependants other than those personal exclusions that currently apply to you and/or your dependants PMI cover under your current insurer.
- If we do not offer cover on a no further underwriting basis we will tell you what exclusions we will apply to your Bupa cover that are personal to you and/or your dependants (if any) so that you can decide if you want to move to Bupa from your current insurer.
- This application form is designed to ensure we have all the information we need about you and your family in order to make moving to Bupa from your current insurer as straightforward as possible.
- You must provide full details about yourself and any family members you are applying for cover. If you don't provide full details we may terminate your cover or it may prevent us from paying your claims. You must ensure the details about your family members are correct and you should check the information with them before sending it to us.
- If you have any queries while you're completing the questions, please call your Bupa adviser or health care intermediary.

**The Group Secretary must complete the Scheme details and the main applicant must complete Sections A to E using BLOCK CAPITALS and BLACK INK.**

**Please remember to sign and date the application form,** and retain a copy of the completed application form for your records. Your completed form should be returned to us with:

- evidence of current underwriting terms and
- a copy of your current membership certificate held with your current PMI insurer.

Please return to **Bupa, Anchorage Quay, Salford Quays, M50 3XL.**

## Scheme details *to be completed by Group Secretary*

Company name:			
Bupa group number:			
Out-patient benefit (tick one box only)		<b>Please tick</b>	
	£1000 (max. £250 for complementary medical practitioners)		
	Full Refund (no £250 limit for complementary medical practitioners)		
	Full Refund (£1000 out-patient with max. £250 limit for complementary medical practitioners)		
	£1500 (no £250 limit for complementary medical practitioners)		
	£1000 (no £250 limit for complementary medical practitioners)		
	£750 (max. £250 for complementary medical practitioners)		
	£500 (max. £250 for complementary medical practitioners)		
£250 (max. £250 for complementary medical practitioners)			
Cover exclusions	Psychiatric cover excluded		
	Sports club exclusions		
Excess (tick one box only)	£0		
	£100		
	£150		
	£200		
Hospital access (tick one box only)	Partnership Network		
	Participating Network	Scale C	
	Participating Network	Scale B	
	Participating Network	Scale A	
Full refund for surgeons and anaesthetists - This option is only available if full refund out-patient benefit is also chosen			
Optional cash benefits	Optical, dental & prescription cash benefit		
	Family cash benefit		
Island cover	For staff resident in Jersey, Isle of Man and Guernsey		
Preferred start date:   dd   mm   year			
Are dependants eligible under the scheme? Yes / No			



## A Your personal details

Please complete the following details for yourself as the main applicant.

Title: <i>(Mr, Mrs, Miss, Other Title)</i>	
First name(s): <i>(please include all forenames in full)</i>	
Surname:	
Sex at birth: <b>Male / Female</b> (delete as appropriate)	
Address:	
Postcode:	Home telephone no:
Work telephone no:	Mobile telephone no:
Email:	Date of birth: <i>(Day/Month/Year)</i>

## B Your family's details

Please give details of other family members you wish to be covered.

	Title, surname, first name(s) of prospective members	Relationship to you <i>(partner, son, daughter)</i>	Date of birth			Sex at birth	
			Day	Month	Year	Male (M)	Female (F)
2							
3							
4							
5							

Need to add someone else? Please give us their name(s) and the full details for this section and sections D and E on a separate sheet. So that we know you have included additional family members, please tick this circle:

## C Previous insurance details

Name of current insurer:	Existing scheme name:
Date medical insurance was first taken with the current insurer:	
Date existing cover expires/expired:	

This form must be completed in full and returned with:

1. Evidence of current underwriting terms for you and your dependants (if any) (eg letter from previous health insurer showing dates of cover and special conditions applied) or
2. Copy of current registration/membership certificate for you and your dependants (if any) held with previous health insurer(s).

## D Your medical history

This section asks for health and medical details, past and present, about yourself and for each person named in section B. Please tick **Yes** or **No** to every question for each person. If you tick **Yes** to a question, please give full details in section E. If you are unsure whether any details are relevant, you must include them.

Within the last four years, have you or anyone to be covered under the membership: <ul style="list-style-type: none"> <li>• seen a GP or other health care professional</li> <li>• received treatment</li> <li>• experienced symptoms</li> </ul> for any of the medical problems listed in questions 1-6:	Applicant		Prospective member 2		Prospective member 3		Prospective member 4		Prospective member 5	
	Name		Name		Name		Name		Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
<b>1. Heart and stroke conditions</b> (including hypertension, angina and heart attacks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>2. Any form of cancer</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>3. Back or joint problems</b> (including slipped disc and cartilage problems)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>4. Abdominal and stomach or bowel conditions</b> including polyps and ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>5. Organ failure or transplants</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>6. Psychiatric, mental or nervous conditions</b> (including stress and depression)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## E Additional information

If you have answered **Yes** to any of the questions in section D, please give full details here. If you need more space please use a separate sheet. If you are unsure whether any details are relevant, you must include them.

Name of prospective member	The relevant question number from section D	Illness or medical problem	When did symptoms start and/or when was treatment completed?	Treatment (including medication, prescribed or otherwise)	Outcome of treatment (eg. ongoing, complete recovery, recurrent, or likely to recur)

## F Your legal declaration

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

In view of this declaration it is essential that complete information is supplied. Benefits may not be payable if you do not fully disclose any material facts. You do not have to provide any details not requested on this form, but if you are unsure whether any facts are required or are material, you should disclose them. (A material fact is any information about yourself or your family members that might influence our assessment or acceptance of your Bupa membership – such as the terms of cover, subscription rate or whether cover is provided at all). You must make sure that any details provided about your family members are correct. You are advised to keep a record of all information you supply to us in connection with this application, including letters. If you would like a copy of this application form please ask us.

It is Bupa's intention to provide a first class service to our members at all times. If you do have cause for dissatisfaction you may write to the Customer Relations Department at Bupa, Anchorage Quay, Salford Quays, Manchester M50 3XL or phone them on 0845 606 6739\* 8am to 5pm Monday to Friday.

They will consider your complaint and can provide you with full details of our internal complaints process and details of the independent resolution scheme available to you.

It's very rare that we can't settle a complaint but if we tell you we can do no more and we have been unable to resolve your complaint to your satisfaction, you may refer your complaint to the Financial Ombudsman Service at South Quay Plaza, 183 Marsh Wall, London E14 9SR or call them on 0845 080 1800.

Unless otherwise agreed between us in writing English Law shall apply.

\* BT landline calls to 0845 numbers will cost no more than 3.95 pence per minute. Charges from other providers may vary and calls made from mobiles usually cost more. Calls may be recorded and may be monitored

### Your declaration

I agree that I and my family members specified in this form (and on any separate sheet) will be bound by the terms and conditions of the agreement between Bupa and the company, firm or individual with whom Bupa has agreed to operate a group insurance scheme and under which I am applying for cover. I accept that the terms and conditions of the agreement shall be the basis upon which benefits shall be payable under the agreement. I acknowledge that, unless Bupa agrees otherwise, there is no undertaking to cover any medical conditions in existence at the time I, or any of my family members, join the scheme.

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 (and on any separate sheet), 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.

I declare that to the best of my knowledge and belief, all the information I have given in this application form is true and complete and that I have confirmed the family details with the respective family member. I agree that I will inform Bupa if any of the details given in this application form change.

On the basis of this legal declaration I now apply for membership.

Signature 

Date 

## Bupa Data Protection Notice

**Confidentiality:** The confidentiality of patient and member information is of paramount concern to the companies in the Bupa group. To this end, Bupa fully complies 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, including your GP or to their agents and if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents.

**Member details:** All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main applicant.

**Telephone calls:** In the interest of continuously improving our service to members, your call may be recorded and may be monitored.

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

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

**Names and addresses:** Bupa does **not** make the names and addresses of members or patients available to other organisations.

**Keeping you informed:** Bupa would, on occasion, like to keep you informed of Bupa products and services which it considers may be of interest to you.

**Contact address:** If you do not wish to receive information about Bupa's products and services, or have any other Data Protection queries please write to the Bupa Group Information Protection Manager, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at [DataProtection@Bupa.com](mailto:DataProtection@Bupa.com).

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[www.bupa.co.uk](http://www.bupa.co.uk)