



CIGNA

SmartHealth Application Form

Employer Name:

For Office Use:

Broker Name:

Agency Number:

New Starters and/or Amendments

This declaration requires a complete answer to all of the questions set out below for every applicant and dependant included in this application.

If this form is being completed by the employee on behalf of adult (over 18) family members, it is done so on the basis that the employee is acting for the adult family members and has their authority to do so. If any adult family members wish to retain confidentiality regarding their sensitive medical information, separate forms are available from your local Human Resources department.

Please state if new application or amendments: **New Application** _____
Amendments _____

Name of employer: _____

This application form must be completed fully using BLOCK CAPITALS.

Name:	Partner/Spouse Name:
Male/Female:	Male/Female:
Address:	Address:
Postcode:	Postcode:
Telephone Number:	Telephone Number:
Email address:	Email address:
Occupation:	Occupation:
Date of Birth:	Date of Birth:
Height and Weight:	Height and Weight:
National Insurance Number:	GP's Name and Address:
Employment Start Date:	
GP's Name and Address:	
Postcode:	Postcode:
Telephone Number:	Telephone Number:
Smoker (if yes how many per day):	Smoker (if yes how many per day):
Units of alcohol consumed per week:	Units of alcohol consumed per week:
1 unit of alcohol is equivalent to ½ pint of beer, lager or cider, 1 glass of wine or 1 measure of spirits.	

Chosen level of excess (please state): £

1. Your dependant's details - Only to be completed for dependants (including spouse/partner) who are to be covered under the scheme.

Surname	Forename	Relationship	Date of Birth	Height/Weight	Occupation if over 18
Dep.1					
Dep.2					
Dep.3					
Dep.4					
Dep. 5					

Access to Medical Reports Act 1988

Medical evidence is crucial to the underwriting of private health insurance cover. We may ask any doctor who has attended you to provide us with a medical report. The production of any such report is subject to the Access to Medical Reports Act 1988. Your summarised statutory rights are that you can: (a) withhold your consent to the obtaining of such medical reports, or (b) request to see any such report before it is sent to us, or during the following six months, or (c) for a charge, obtain a copy of the report from the doctor within six months of it being supplied.

Please note that, although you have the right to withhold your consent, if you do so we may be unable to proceed further with your underwriting. If you request to see reports before they are issued, we will notify you when we apply to the doctor concerned and you will then have twenty-one days in which to contact him/her to arrange to see the report. When you have seen the report it will not be issued without your consent and if you consider any part of it to be incorrect or misleading you may ask the doctor in writing to make an amendment. If the doctor is not prepared to do this you may supply him/her with a written statement of your views, which the doctor will then attach to the report when it is issued. The doctor does not have to let you see any part of a report if, in his/her opinion, you or others may be harmed by it. The same applies if the report discloses confidential information about, or supplied by, another person, unless that person consents to you seeing the report. The doctor must inform you if any part of the report is affected in this way, if the whole report is affected, it still cannot be issued without your consent.

I have read the explanation of my rights under the Access to Medical Reports Act 1988 set out and consent to CIGNA seeking information from any doctor who has at any time attended myself or from any other relevant person or Insurance Office to which I have proposed and I authorise the giving of such information. I also agree that a copy of this consent shall have the validity of the original.

If you wish to see your medical report before it is issued please write your name(s) clearly in the box above.

IMPORTANT: You have an obligation to disclose all material facts which may influence the terms on which CIGNA would accept the proposal, and failure to do so could affect payment of claims under the plan. If you are in any doubt as to whether a fact is material, then you should disclose it. This obligation continues to apply until the commencement of your policy.

Declaration and Consent

I hereby declare that to the best of my knowledge and belief all the information given is true and complete.

I hereby propose to CIGNA for cover to start on the commencement date and agree to abide by the Terms of that Plan.

Data Protection Act 1998 -

CIGNA will act as Data Controller in respect of personal information held.

We will process personal information to allow us to carry out our obligations under the policy and we will share this information with authorised third parties to fulfil the contract. From time to time we may share this information with other insurers to enable us to detect and prevent fraud. Telephone calls to and from our organisation may be recorded for the purposes of quality and training.

If a member or dependant makes a claim under this policy, it may include sensitive medical information. Under the Data Protection Act we are required to obtain their explicit approval before we process this type of information. We will ask for permission to do this.

Members and their dependants have a right to request a copy of any personal information held by us about them. Please note that we may levy a fee to provide this information.

We need your explicit approval to process your data as some of the information contained in the application form may be classified as sensitive data under the Act. Please confirm your agreement by signing below.

- **Please note: dependant(s) only to sign if over 18 years.**

Signature/s

Employee _____

Date _____

Spouse/Partner _____

Date _____

Dependant 1 _____

Date _____

Dependant 2 _____

Date _____

Dependant 3 _____

Date _____

Dependant 4 _____

Date _____

Dependant 5 _____

Date _____

Broker Name (if applicable)

Agency Number