



# Preferential Private Health Cover

## Application to join a group scheme

### About this form

- Please complete this form if you wish to be added to your employer's Preferential Private Health Cover.
- Please take time to read this form carefully, making sure you have completed all the sections.
- It is important that you select **ONE** method of applying for cover (section 6) and that you sign and date the relevant declaration.
- Please write in blue or black ink and use **BLOCK CAPITALS**.
- If you need any assistance please call our helpline on **0800 197 6997**. We are here to help. Your calls may be recorded and monitored for training and quality assurance purposes.

## 1 About you

To apply for Preferential Private Health Cover you must be resident in the UK, Channel Islands or Isle of Man.

Title	<input type="text"/>	Forenames	<input type="text"/>															
Surname	<input type="text"/>					Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
Occupation	<input type="text"/>																	
Address	<input type="text"/>											Postcode	<input type="text"/>					
Daytime telephone no.	<input type="text"/>	Mobile telephone no.	<input type="text"/>	Preferred contact time, between 8am and 6pm	<input type="text"/>													
Email address	<input type="text"/>																	
If you, or a member of your family, are already a Simplyhealth member please tell us the registration/policy number											<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer's name	<input type="text"/>																	
Employer's address	<input type="text"/>											Postcode	<input type="text"/>					

## 2 About your family

You may include a spouse or partner, and unmarried dependent children under the age of 21, or under 24 if they are in full-time education. Everyone enrolled in the policy must be resident in the UK, Channel Islands or Isle of Man.

Title	Forenames	Surname	Relationship to you	Date of birth									
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 3 Scale of cover

Please refer to our Policy Document and Hospital Directory as well as your Group Secretary, the person in your company responsible for your insurance, then tick  one of the following:

Scale A  Scale B  Scale C  Scale D

### 4 Optional excess

Please refer to our Policy Document and Hospital Directory as well as your Group Secretary, the person in your company responsible for your insurance, then tick  one of the following:

I agree to pay the following optional claims excess  
Level 1:  Level 2:  Level 3:  Level 4:

### 5 How we use information about you

As the Data Controller, we will store and process personal data in accordance with the Data Protection Act 1998 (DPA).

We and other Simplyhealth Group companies will use information to provide our services, for assessment and analysis, for underwriting and claims handling, to improve our services, and to protect our interests.

Unless you ask us not to we may use your information to keep you informed by post, telephone, email or other means about products and services, which may be of interest to you.

We will keep information about you confidential. However we may give information about you and how you use our products to the following:

- Fraud prevention agencies and other organisations who may record, use and give out information to other insurers.
- People who provide a service to us or act as agents on the understanding that they will keep the information confidential.
- Anyone to whom we may transfer our rights and duties under this agreement.
- We may also give out information about you if we have a duty to do so (such as regulatory bodies), or if the law allows us to do so or if the person requesting the information has in our opinion, a legitimate interest in the disclosure.

#### Sensitive data

In order to assess the terms of the contract of insurance, including any specific medical exclusions or administer claims we may collect data, including medical information, which the DPA defines as sensitive.

Medical information will be kept confidential and only disclosed to those involved in providing the patient's treatment or care, including their General Practitioner or Dentist, or their agents. Only in exceptional circumstances will we disclose medical information to other third parties or family members, without the patient's explicit consent.

If your employer has appointed an insurance broker or intermediary, we may disclose to them the personal information that they need to deal with your cover. Details of medical information will not be disclosed to the intermediary unless we have the specific consent of the patient.

#### Accuracy of personal information

To help us ensure that your personal information remains accurate and up to date please inform us of any changes.

You have the right to see personal information, which is held by us. There may be a charge if you want to do this. For more details write to: The Data Protection Co-ordinator, Simplyhealth, James Tudor House, 90 Victoria Street, Bristol BS1 6DF.

Your calls may be recorded and monitored for training and quality assurance purposes.

## 6 Applying for cover

Please read all of the following section carefully before selecting EITHER option 1 or option 2.

You have a choice of two ways of applying for cover, involving different levels of medical information. We have produced a leaflet, **Underwriting Explained**, to help you apply for cover and decide which is the best underwriting option for you. Before deciding which underwriting option you require please read the leaflet. If you do not have a copy or need assistance please call our helpline on 0800 197 6997.

### Option 1 Moratorium - no medical assessment

In choosing this option there is no need to provide any medical history.

Please be aware that we will not be able to cover any pre-existing conditions that have occurred during the last five years. However if you, or your family members, remain free from any symptoms, treatment, medication or advice for a pre-existing condition, or any related condition, for two consecutive years after joining (the Moratorium period) we will reinstate cover, subject to the policy Terms and Conditions.

It is important to realise that you will probably never be covered for conditions requiring regular or periodic treatment. This is because each time you need treatment the Moratorium period starts again. It is therefore unlikely that there will be two consecutive years when you will be free from symptoms, treatment, advice or medication.

Please do not delay in seeking medical advice simply to get cover.

### Option 2 Full medical assessment

Alternatively, you can choose to complete the medical assessment. With this option you, and any family members you wish to include in the policy, will need to complete the full medical questionnaire overleaf. It is important that you give all the information you are asked for as any disease or condition of health, which existed before the start of your policy will not qualify for benefit unless it has been fully disclosed and accepted by us. We will use the information provided to decide if there are any pre-existing conditions that are likely to need treatment in the future. We will write to you with details of any specific medical conditions that are excluded from the policy due to personal medical history. These will be detailed on your Membership Certificate.

Please indicate your choice by selecting **ONE** of the following:

I/We wish to apply for cover by signing the Moratorium statement and declaration (tick  box)  Please read and complete the declaration in section 6.1.

OR

I/We wish to apply for cover by completing the full medical assessment (tick  box)  Please read and complete the declaration in section 6.2.

### Section 6.1 Moratorium - no medical assessment

#### Declaration

Please only complete this section if you have chosen to be underwritten using our **moratorium** option. Please read the following declaration carefully then sign and date it below.

- I have received and read the leaflet **Underwriting Explained**. I understand that Simplyhealth will not cover any condition for which I, or my family members, have received advice, medication, tests or treatment, or was aware of, or might reasonably have been aware of during the five years immediately before the commencement of cover.  
However, provided I, or my family members included in the policy, do not have symptoms, or receive treatment, medication, tests and advice (from a GP or a Specialist) for that condition for a continuous period of two years after the policy starts, then the condition will become eligible for benefit subject to the terms and benefits of Preferential Private Health Cover. This two year period is known as the Moratorium.
- I apply for Preferential Private Health Cover together with any family members detailed in section 2.
- I have received a copy of the careform Policy Document and have read or had read to me and agree to be bound by the Terms and Conditions of Preferential Private Health Cover.
- I declare that I have authority to give Simplyhealth information about my family members referred to in this application and where necessary, I have checked with them that the information I have provided is correct.
- I declare that, to the best of my knowledge, the information I have provided on this form is complete and accurate and that it contains all the information required for the underwriting option I have selected.
- By agreeing to the Preferential Private Health Cover terms and conditions I consent to any personal data, including medical information about myself and my family members, being processed by Simplyhealth. Where I am applying for cover for unmarried dependent children aged 16 or over I confirm I have their authority to consent to their personal data being processed by Simplyhealth on their behalf.
- We may use your information to keep you informed by post, telephone, email or other means about products and services, which may be of interest to you. If you do not wish your information to be used for these purposes please tick  box.
- I understand that this declaration and the answers given on this application form shall form the basis of my cover within the contract of insurance between my employer and Simplyhealth.

Your signature

X

Today's date

D	D	M	M	Y	Y	Y	Y
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## Section 6.2 Full medical assessment

Please only complete this section if you have chosen to apply using our **full medical assessment** option.

Please help us by answering all the following four questions fully, accurately and honestly, for yourself and each family member you wish to include in your policy. If you are unsure whether something is relevant please tell us anyway.

**It is important that you inform us, before your policy starts, of any existing medical conditions. Under the Terms and Conditions of the policy you will not qualify for benefit unless you have informed us of any such conditions and we have agreed to cover them. If anyone to be insured experiences any change in the state of their health, or have any new disease or medical condition diagnosed before the policy starts then again, you must tell us.**

You must tick **Yes** or **No** to each of the following questions. Should you answer **Yes** to any of them please provide full details on the form below, using a **continuation sheet** if necessary. If there are any other conditions you believe we should be aware of please provide details separately. You do not need to inform us about genetic tests.

### 1. GP visits in the last year

In the last year has anyone to be insured visited a GP for any reason? (Tick  box) Yes  No

Please detail each specific medical condition/symptom as we are unable to accept generic terms such as “minor or general ailments” or “normal childhood illnesses” etc. You may need to give us further information in the next section of this form if your GP has referred you for treatment/consultation.

Patient's name		Patient's name	
Describe the symptoms/medical condition		Describe the symptoms/medical condition	
When were symptoms first experienced?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	When were symptoms first experienced?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
When was medical advice first sought?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	When was medical advice first sought?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
What diagnosis was given?		What diagnosis was given?	
What treatment or advice was received and when?		What treatment or advice was received and when?	
Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is further treatment, consultation or monitoring required? Please give details.		Is further treatment, consultation or monitoring required? Please give details.	
Patient's name		Patient's name	
Describe the symptoms/medical condition		Describe the symptoms/medical condition	
When were symptoms first experienced?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	When were symptoms first experienced?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
When was medical advice first sought?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	When was medical advice first sought?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
What diagnosis was given?		What diagnosis was given?	
What treatment or advice was received and when?		What treatment or advice was received and when?	
Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is further treatment, consultation or monitoring required? Please give details.		Is further treatment, consultation or monitoring required? Please give details.	

### 2. Hospital visits/specialist consultations in the last five years

In the last five years has anyone to be insured been in hospital or other medical establishment (either as an in-patient or an out-patient), had an operation or surgery, had tests such as x-rays or scans, or consulted a specialist, physiotherapist or other form of therapist? (Tick  box)

Yes  No

Patient's name	<input type="text"/>	Patient's name	<input type="text"/>
Describe the symptoms/medical condition	<input type="text"/>	Describe the symptoms/medical condition	<input type="text"/>
When were symptoms first experienced?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	When were symptoms first experienced?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
When was medical advice first sought?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	When was medical advice first sought?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
What diagnosis was given?	<input type="text"/>	What diagnosis was given?	<input type="text"/>
What treatment or advice was received and when?	<input type="text"/>	What treatment or advice was received and when?	<input type="text"/>
Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is further treatment, consultation or monitoring required? Please give details.	<input type="text"/>	Is further treatment, consultation or monitoring required? Please give details.	<input type="text"/>

### 3. Other medical conditions

Please advise us if anyone to be insured has ever suffered from any psychiatric disorders, cancer, heart or orthopaedic conditions? (Tick  box)

Yes  No

Is anyone to be insured aware of any medical condition, symptom or physical defect they have for which medical advice has not been sought or any other medical condition which you consider we should be made aware of? (Tick  box)

Yes  No

Patient's name	<input type="text"/>	Patient's name	<input type="text"/>
Describe the symptoms/medical condition	<input type="text"/>	Describe the symptoms/medical condition	<input type="text"/>
When were symptoms first experienced?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	When were symptoms first experienced?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
When was medical advice first sought?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	When was medical advice first sought?	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
What diagnosis was given?	<input type="text"/>	What diagnosis was given?	<input type="text"/>
What treatment or advice was received and when?	<input type="text"/>	What treatment or advice was received and when?	<input type="text"/>
Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is further treatment, consultation or monitoring required? Please give details.	<input type="text"/>	Is further treatment, consultation or monitoring required? Please give details.	<input type="text"/>

4. Dental treatment			
In the last year has anyone to be insured received treatment from a dentist/hygienist other than for routine appointments or routine treatment such as fillings, extractions or scale and polish? (Tick <input checked="" type="checkbox"/> box)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
In addition, in the last five years has anyone to be insured had any wisdom teeth problems? (Tick <input checked="" type="checkbox"/> box)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Patient's name	<input type="text"/>	Patient's name	<input type="text"/>
Describe the symptoms/dental condition	<input type="text"/>	Describe the symptoms/dental condition	<input type="text"/>
When were symptoms first experienced?	<input type="text" value="D D M M Y Y Y Y"/>	When were symptoms first experienced?	<input type="text" value="D D M M Y Y Y Y"/>
When was medical advice first sought?	<input type="text" value="D D M M Y Y Y Y"/>	When was medical advice first sought?	<input type="text" value="D D M M Y Y Y Y"/>
What diagnosis was given?	<input type="text"/>	What diagnosis was given?	<input type="text"/>
What treatment or advice was received and when?	<input type="text"/>	What treatment or advice was received and when?	<input type="text"/>
If wisdom teeth problems have been experienced, have all four wisdom teeth been removed? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>	If wisdom teeth problems have been experienced, have all four wisdom teeth been removed? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is recovery complete? (tick <input checked="" type="checkbox"/> box)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is further treatment, consultation or monitoring required? Please give details.	<input type="text"/>	Is further treatment, consultation or monitoring required? Please give details.	<input type="text"/>

**Declaration**

Please only complete this section if you have chosen to be underwritten using our full **medical assessment** option. Please read the following declaration carefully, both you and any spouse/partner included in the application should sign and date it below.

- I have received and read the leaflet **Underwriting Explained**.
  - I apply for Preferential Private Health Cover together with any family members detailed in section 2.
  - I have received a copy of the careforme Policy Document and have read or had read to me and agree to be bound by the Terms and Conditions of Preferential Private Health Cover.
  - I declare that I have authority to give Simplyhealth information about my family members referred to in this application and where necessary, I have checked with them that the information I have provided is correct.
  - I declare that, to the best of my knowledge, the information I have provided on this form is complete and accurate and that it contains all the information required for the underwriting option I have selected.
  - I understand that the Membership Certificate, which I will receive from Simplyhealth, will advise me of any medical conditions specifically excluded from my cover because of the information I have supplied.
  - By agreeing to the Preferential Private Health Cover terms and conditions I consent to any personal data, including medical information about myself and my family members, being processed by Simplyhealth. Where I am applying for cover for unmarried dependent children aged 16 or over I confirm I have their authority to consent to their personal data being processed by Simplyhealth on their behalf.
- We may use your information to keep you informed by post, telephone, email or other means about products and services, which may be of interest to you. If you do not wish your information to be used for these purposes please tick  box.
- I understand that this declaration and the answers given on this application form shall form the basis of my cover within the contract of insurance between my employer and Simplyhealth.

Your signature	<input type="text" value="X"/>	Today's date	<input type="text" value="D D M M Y Y Y Y"/>
Signature of spouse/partner if they are to be included	<input type="text" value="X"/>	Today's date	<input type="text" value="D D M M Y Y Y Y"/>

Simplyhealth, James Tudor House, 90 Victoria Street, Bristol BS1 6DF

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