

Transfer Criteria Form

About this form

- We shall be pleased to consider transfer without further medical underwriting for existing scheme members upon receipt of the following information which should be supplied to the best of your knowledge and belief.
- 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

Your name	<input type="text"/>	Company name	<input type="text"/>
Telephone no.	<input type="text"/>	Fax no.	<input type="text"/>
Broker Name	<input type="text"/>		

2. Information

1. Are you aware of any group members or dependants to be covered who have planned in-patient or day-patient treatment, or have received such treatment in the **last three months**? (Tick box) Yes No
 If **yes**, please provide details, including dates, in the box below.

2. Are you aware of any ongoing or planned treatment in respect of cancer, heart and psychiatric conditions? (Tick box) Yes No
 If **yes**, please provide details, including dates, in the box below.

3. Do you know if the claims cost in the current year is 70% or less of your annual premium? Could you please provide any details of claims cost of the scheme for the year. (Tick box) Yes No
 If **yes**, please provide details, including dates, in the box below.

3. Signature

Signature	<input type="text" value="X"/>	Today's date	<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"/>
Name	<input type="text"/>	Position	<input type="text"/>

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