

Personal healthcare Application form



Who is this form for?

This application form is for applicants wishing to apply for a personal healthcare plan on a moratorium or full medical underwriting basis. Your underwriting options are explained in more detail within the 'Choose your underwriting' section of our personal healthcare brochure.

Filling in this form

We've made applying for cover as simple as possible. Please make sure that you complete all the relevant sections before sending us your application. If information is missing or incomplete this will cause a delay in the processing of your application. We want you to be totally confident in the cover you have with us so, if you would like help in completing this form, please call us or speak to your adviser.

Please complete this form in BLOCK CAPITALS using black ink. Please also complete the final checklist on page 10 when you've finished.

Note: You must ensure that you provide full and accurate information in answer to the medical questionnaire. Failure to do so may mean that we cannot cover a claim, or even that your plan is cancelled. If you are unsure whether we would want to know a particular fact, we advise you to tell us about it.

When you have completed your application form, please return it to us or to your adviser.

SECTION 1: ABOUT YOU AND YOUR FAMILY

About you

Title	Full forename(s)	Surname	Gender
			M <input type="checkbox"/> F <input type="checkbox"/>
Date of birth	Occupation		
Address			
Postcode			
Daytime telephone number and area code		Evening telephone number and area code	
Mobile telephone number		Email address	

What type of cover do you require? *(please tick)*

Single Couple Parent & Child Family

For office use only

Quote reference number:

To be completed by adviser

Adviser name:

Agent code:

About your family

Please give details of your partner and any children you wish to be covered. All must be UK residents. Children can be covered up to the age of 25. Please note that all correspondence will be sent to the main planholder. If any family members aged over 18 would prefer us to correspond direct with them, for example when making a claim, they should take out a separate plan in their own name.

Partner's full forename(s)	Surname		
Title	Occupation	Date of birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Child's full forename(s)	Surname	Date of birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Child's full forename(s)	Surname	Date of birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Child's full forename(s)	Surname	Date of birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>

If you wish to cover more than 3 children, please provide their details in the box below. There will be no additional premium as we only charge for the first child.

Do you, or anyone else to be covered on this plan, work in the following occupations:

- a. Emergency services* Yes No
- b. Health industry** Yes No

* *Emergency services includes anyone employed as a paramedic, or working for the coastguard, fire service or in the police force.*

** *Health industry includes those directly involved in the delivery of patient care working in residential / care homes, hospitals, GP & dental surgeries, including doctors, nurses and any other medical staff.*

Please note, we cannot provide cover for anyone working in the armed forces or working offshore in the extraction/refinery of natural/fossil fuels.

If you or anyone to be covered under this plan are engaged in amateur or professional sport (that is any sport for which a salary, sponsorship or benefit in kind is received) please provide full details below. We do not need to be advised of involvement with a sports club on a purely recreational basis.

SECTION 2: YOUR COVER

What date do you want your plan to start?

 / /

If you already have a quote document, please enter your chosen quote reference number here and then go to section 3:

(This can be found at the top of your quote document. The information contained in this quote will form the basis of your personal healthcare plan with us.)

If you do not have a quote document, please choose your cover and plan options below.

Cover options

<i>(Please tick your cover options)</i>	<input type="checkbox"/> Example plan A	<input type="checkbox"/> Example plan B	<input type="checkbox"/> Example plan C	<input type="checkbox"/> Example plan D	<input type="checkbox"/> Pick your own cover options
Core Healthcare	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
GP Consultation Line	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Out-patient Treatment Level 1 - £500		<input checked="" type="checkbox"/>			<input type="checkbox"/>
Out-patient Treatment Level 2 - £1000					<input type="checkbox"/>
Out-patient Treatment Level 3 - Full Cover			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Core Enhancement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Home Care					<input type="checkbox"/>
Additional Therapies Level 1 - £350		<input checked="" type="checkbox"/>			<input type="checkbox"/>
Additional Therapies Level 2 - Full Cover			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Member Assistance Programme				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health Screening				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Private GP				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Maternity Cover					<input type="checkbox"/>
Travel Cover Level 1					<input type="checkbox"/>
Travel Cover Level 2				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dental Cover Level 1				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dental Cover Level 2					<input type="checkbox"/>
Dental Cover Level 3					<input type="checkbox"/>

Plan options

Excess level

£

Excess to be applied: per plan year per claim *(please tick)*

Hospital list

Countrywide Countrywide London upgrade

Extended London upgrade Guided Option *(please tick)*

NHS wait option

(Not available with the Guided Option hospital list)

SECTION 3: CHOOSING YOUR UNDERWRITING BASIS

There are two ways you can apply for cover. These two options are explained within the 'Choose your underwriting' section of our brochure. Once you have chosen the basis that is best for you, please **tick one** of the following:

■ Moratorium

I/We wish to apply for cover by signing the moratorium declaration below as I/we do not wish to have a full medical history assessment.

Please read and sign the moratorium statement below

OR

■ Full medical underwriting

I/We wish to complete the full medical history questionnaire so Standard Life Healthcare can carry out an assessment of my/our medical history before cover begins.

Please complete the full medical questionnaire opposite

SECTION 4: MORATORIUM CLAUSE DECLARATION

Please read and sign the following declaration;

I declare that to the best of my knowledge and belief:

- The statements made on this application form, and any additional information supplied as part of this application, are full, true and correct.
- I understand that all correspondence relating to the plan will be addressed to me.
- I have opted not to have a full medical history assessment and understand that pre-existing medical conditions are subject to the terms of the moratorium as defined in the plan.
- I understand that in advance of each annual renewal date Standard Life Healthcare will advise me of my premium for the coming plan year, and of any changes to my plan terms and conditions, and that they will automatically renew my plan on that basis, unless I instruct them to do otherwise.
- I undertake to advise you of any change in the information given in this application which occurs between the date of signing and the date cover commences under this plan.

Data protection consent

- I consent to Standard Life Healthcare and its agents using the information I supply, which may include health information that the Data Protection Act 1998 ("the Act") defines as "sensitive data", for the purposes shown in the data protection notice summary at the back of this form. (Please note that some personal information may be accessed by other parts of the Standard Life group for general administrative purposes, as further detailed in the data protection notice).
- I confirm that, for the purposes of the Act, I have the authority of any of my family named on this application to consent on their behalf to their personal information being processed and by signing this application I agree that Standard Life Healthcare may use their personal information for the purposes described in the data protection notice.

Please read the sections towards the back of this form about acceptance of your application, your cancellation rights and how we use your personal information (data protection notice).

This application form is only valid for a period of 30 days from the date of signing.

Signed by the applicant and on behalf of any other family members named in this application.

Signature

Date day / month / year

We, and any member of the Standard Life group, may use the information you have provided to inform you of other services and products that may be of interest, either through telemarketing or mail, or for general market research.

Please tick this box if you prefer not to be contacted about other products or services.

Please now go straight to section 8 to complete your payment authorisation.

SECTION 5: FULL MEDICAL HISTORY QUESTIONNAIRE

We will not start your cover or collect premiums until your answers to the medical questions have been assessed, and we have decided the basis on which we can offer cover to you and any person to be included in the application. Exclusions will not affect your premium and will be shown on the certificate of insurance.

These questions apply to you and to every person who is applying.

It is important you provide full and accurate information. Leaving out facts or giving inaccurate information may mean we are unable to meet a claim in the future or even that your plan is cancelled. If you are unsure if we need to know a particular fact, please disclose it anyway. If you do not wish to disclose your answers to your adviser, you can provide them on a separate sheet of paper and attach it to this form in a sealed envelope.

Q1. Have you, or any person to be insured, ever suffered from or asked advice about or received treatment for any of the following medical conditions:

- | | | |
|---|------------------------------|-----------------------------|
| a) Cancer, tumours, growths, cysts or moles that have changed in appearance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Heart attack, angina, coronary thrombosis, stroke, chest pain, high blood pressure or any other disorder of the heart or circulatory system? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Depression, anxiety, stress or any psychiatric / psychological disorder? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Gynaecological problems including but not limited to pregnancy or childbirth problems, ovarian cysts, heavy or irregular periods, fibroids, endometriosis, infertility or abnormal smears? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Q2. In the last five years have you, or any person to be insured, suffered from or asked advice about or received treatment for any of the following medical conditions:

- | | | |
|---|------------------------------|-----------------------------|
| a) Any digestive disorder, gastric or duodenal ulcer or any liver or bowel complaint? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Fainting, fits of any kind (including epilepsy), migraines or any other disorder of the nervous system? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) Diabetes, gout or any kidney, urinary tract, bladder or prostate complaint? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d) Asthma, bronchitis, tuberculosis, or any other lung or chest complaint? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e) Bone or muscular problems including but not limited to back complaints, rheumatoid/osteo arthritis, or regular or persistent pain in any joints? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f) Varicose veins? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g) Any skin disorder or allergic skin reaction including but not limited to eczema, acne, psoriasis and dermatitis? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h) Tonsillitis or any other disease or disorder of the ear, nose or throat? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Q3. Is there any other condition not mentioned above which in the last five years you, or any person to be insured, have consulted your doctor or a specialist about, or which has required a visit to a hospital or clinic for any reason including investigations, tests, x-ray, or an operation?

Yes No

Q4. Are you, or any person to be insured, currently taking any drugs or medication (whether or not prescribed by a doctor) or receiving any other treatment whether from a doctor, dentist, optician, alternative therapist or any other member of the medical profession?

Yes No

Q5. Do you, or any person to be insured, have any symptoms, long-term or recurrent condition or physical defect not mentioned above which you think we should know about even if no treatment is currently taking place?

Yes No

Q6. Have you, or any person to be insured, ever been refused cover by an insurance company or had your insurance cancelled? If yes, please tell us about the circumstances in the space below.

Yes No

If you have answered NO to all the questions above then please go straight to section 7 to read and sign the full medical underwriting declaration.



If you have answered YES to any of the questions above then please provide detailed information in section 6.



SECTION 6: MEDICAL CONDITIONS

This section is only to be completed if you have answered YES to one or more of the questions in section 5.

Condition 1

Name of person
Which question are you referring to from the previous page?
The condition
Previous treatment received and consultations with dates
What, if any, further treatment or consultations are required?
Present state of health (e.g. full recovery or symptoms still present)

Condition 2

Name of person
Which question are you referring to from the previous page?
The condition
Previous treatment received and consultations with dates
What, if any, further treatment or consultations are required?
Present state of health (e.g. full recovery or symptoms still present)

Condition 3

Name of person
Which question are you referring to from the previous page?
The condition
Previous treatment received and consultations with dates
What, if any, further treatment or consultations are required?
Present state of health (e.g. full recovery or symptoms still present)

If you require more space, please use the additional information box below. If you need more space please continue in the 'ADDITIONAL INFORMATION' section towards the back of this form.

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SECTION 7: FULL MEDICAL UNDERWRITING DECLARATION

Please read and sign the following declaration;

I declare that to the best of my knowledge and belief:

- The statements made on this application form, and any additional information supplied as part of this application, are full, true and correct. Where I have supplied medical information for anyone else included in this application I confirm that, if appropriate, I have checked with them that the information is correct and that I have their consent to provide this information on their behalf.
- I understand that all correspondence relating to the plan will be addressed to me.
- I understand that no cover will apply for treatment of any medical condition or related condition which exists or has existed before the start of this plan unless I have provided Standard Life Healthcare with details and they have agreed to accept it. I also understand that Standard Life Healthcare will advise me of any medical conditions which they specifically exclude from cover because of information that I have given to them.
- I understand that in advance of each annual renewal date Standard Life Healthcare will advise me of my premium for the coming plan year, and of any changes to my plan terms and conditions, and that they will automatically renew my plan on that basis, unless I instruct them to do otherwise.
- I undertake to advise you of any change in the information given in this application which occurs between the date of signing and the date cover commences under this plan.

Data protection consent

- I consent to Standard Life Healthcare and its agents using the information I supply, which may include health information that the Data Protection Act 1998 ("the Act") defines as "sensitive data", for the purposes shown in the data protection notice summary at the back of this form. (Please note that some personal information may be accessed by other parts of the Standard Life group for general administrative purposes, as further detailed in the data protection notice).
- I confirm that, for the purposes of the Act, I have the authority of any of my family named on this application to consent on their behalf to their personal information being processed and by signing this application I agree that Standard Life Healthcare may use their personal information for the purposes described in the data protection notice.

Please read the sections towards the back of this form about acceptance of your application, your cancellation rights and how we use your personal information (data protection notice).

This application form is only valid for a period of 30 days from the date of signing.

Signed by the applicant and on behalf of any other family members named in this application.

Signature	Date	day / month / year
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We, and any member of the Standard Life group, may use the information you have provided to inform you of other services and products that may be of interest, either through telemarketing or mail, or for general market research. Please tick this box if you prefer not to be contacted about other products or services.

SECTION 8: YOUR PAYMENT AUTHORISATION

Please indicate how you would prefer to pay and check the notes for each method below.

	By Direct Debit	By cheque**	By Electronic Funds Transfer**	By credit card**
Annually*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Half yearly*	<input type="checkbox"/>			
Quarterly*	<input type="checkbox"/>			
Monthly	<input type="checkbox"/>			

* Annual, half-yearly and quarterly premium payments attract discounts of 3%, 1% and 0.5% respectively. Your quote will include any relevant discount.

** To cover administration fees, cheque, credit card and Electronic Funds Transfer payments incur a charge of 1.5% of the premium. If applicable, this has already been added to the premium quoted.

Direct Debit: To pay by direct debit, please complete the payment authority below.

Cheque: Cheques should be made payable to Standard Life Healthcare.

Electronic Funds Transfer: You'll receive an invoice in your membership pack with details on how to pay by phone or internet banking.

Credit card: If you wish to pay annually by credit card, one of our advisers will contact you to take your credit card details over the phone. For security reasons you will need to provide your credit card details every year at renewal. Please provide your preferred daytime telephone number on which we can contact you.

Contact telephone number

Instruction to your Bank or Building Society to pay by Direct Debit



Name and full postal address of your Bank or Building Society

To: The Manager	Bank/Building Society
Address	
Postcode	

Name(s) of account holder(s)

Branch sort code

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>
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Originator's Identification Number **9 4 0 4 6 0**

Standard Life Healthcare reference 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"/>	<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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Bank/Building Society account 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"/>	<input type="text"/>	<input type="text"/>
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Instruction to your Bank or Building Society

Please pay Standard Life Healthcare Direct Debits from the account detailed on this instruction subject to the safeguards assured by the Direct Debit Guarantee.

I understand that this instruction may remain with Standard Life Healthcare and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)	Date
X	X

Banks or Building Societies may not accept Direct Debits for some types of account.

Your application is now complete. Please return it to us or pass it to your adviser.



Please detach this page and keep it for your records.

Important information about accepting your application

You must advise us if there are any changes in your personal circumstances, including your state of health or that of anyone to be included on your plan, between signing this application form and the start date of your plan with us. We reserve the right to alter your acceptance terms in light of such changes.

You and all other family members to be included in your plan must be resident in the UK for at least 180 days in each plan year and registered with a UK GP.

Once your application has been accepted, we will send you a membership pack which includes the terms and conditions that set out the basis of your plan with us. You and all other family members included in your plan should read these carefully and, if there is anything that you or they do not understand, should contact us to discuss this with one of our advisers.

Completion of this application form should not be taken as acceptance of risk by Standard Life Healthcare. Based on the information you disclose Standard Life Healthcare reserves the right to decline applications.

A specimen copy of the plan terms and conditions is available on request. You are advised to keep a record (including copies of letters) of all information supplied to Standard Life Healthcare. A copy of this application will be supplied to you on request.

Cancelling your plan

Once you've received your membership pack, you will have 14 days in which to check that you are happy with your plan. If for any reason you decide not to continue with your plan within this period, you can cancel it and receive a full refund of any payments you've made, providing you've not claimed in the meantime.

After this period, you can still choose to cancel your plan at any time and we will refund any premiums paid that relate to a period after the date your cover with us ends. No benefits will be payable for any treatment costs incurred after your cancellation date even if you are in the middle of treatment at the time.

Data protection notice – how will we use your personal information?

Data protection notice – You will receive a copy of our full data protection notice in your membership pack, a summary of which is set out below. A copy can be obtained at any time through our website, www.standardlifehealthcare.co.uk, or by phoning us. Please read this notice carefully and show it to any family members on the plan old enough to understand it, as it applies to their personal information as well. Please call us if you have any questions about how we will process your personal information.

Use of personal information – We will use personal information to administer the plan, process claims, for underwriting and pricing purposes and to maintain management information for business analysis.

Some of the personal information we receive in connection with this plan will also be held centrally on Standard Life group systems. If you are a customer of other companies in the Standard Life group this will enable us to share changes in your personal information, such as address details, with them for administrative purposes.

Disclosure – We may disclose personal information, under the protection of a contract, to our agents or service providers to administer the plan, to those involved with your treatment or care, and to any insurance adviser appointed to act on your behalf (although no medical information will be provided to your adviser without your consent).

Your information may also be processed for administration purposes by service providers in a country outside the European Economic Area, which may not have the same standard of data protection as in the UK. We will ensure adequate safeguards are in place to protect your confidentiality at all times.

Claims correspondence – Claims correspondence will be addressed to the planholder. If a family member does not wish us to correspond with the planholder in relation to their claim, and they are aged 18 or over, they should take out a separate plan in their own name.

Telephone calls – To continuously improve our service to members, your calls may be recorded and monitored.

Obtaining a copy of your personal information – If you wish to access your personal information please write to the Data Protection Co-ordinator at Standard Life Healthcare, and ask for a 'Data subject access form'. Please note there is a £10 charge for this service.

This guarantee should be retained by the payer.

The Direct Debit Guarantee



- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Standard Life Healthcare will notify you 3 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Standard Life Healthcare or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

Standard Life Healthcare Limited (02123483) and Standard Life Healthcare Services Limited (06430487) are both registered in England at Marshall Point, 4 Richmond Gardens, Bournemouth BH1 1JD. Standard Life Healthcare Limited is authorised and regulated by the Financial Services Authority. 0845 279 8877. *Calls may be recorded/monitored to help improve customer service. Call charges may vary.*
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Healthcare
FS 34098

