



wpa.org.uk

Employee application form.

Effective from April 2008

Enterprise Flexible Benefits Islander Enterprise Flexible Benefits Corporate Cash Plan

Intermediary/Appointed Representative ID:

Print name:

Office use only

The questions on this form are important. Please take time to answer all of them as fully as possible.

This application form must be completed by both the **Group Co-ordinator** (those sections headed in black) and the **Employee** (those sections headed in blue).

PLEASE COMPLETE ALL SECTIONS IN FULL, IN BLACK INK USING BLOCK CAPITALS. WHERE A CHOICE OF ANSWER IS OFFERED PLEASE TICK THE MOST APPROPRIATE BOX.

Please also ensure that the **Employee** reads the Terms & Conditions in Section 7 and signs the Declaration in Section 8.

Please see the back cover for definitions of phrases used in this application form.

Group Co-ordinator Section

1. TO BE COMPLETED BY THE GROUP CO-ORDINATOR ON BEHALF OF THE COMPANY

Who is the application for Company employee Adding a new family member(s) to an existing employee

When would you like your cover to start **0 1** (mm/yy) **This date cannot be before the date this form is signed or more than 1 month in advance.**

Company name _____

Postcode _____

Group customer number _____ For existing WPA policies only

Signed (Group Co-ordinator on behalf of company) Date (dd/mm/yy) _____

Print name _____

Please note that your company itself must fund premiums for employees from the company accounts and must not seek any reimbursement of this from the employee, except for any premium for family member(s). Any other arrangement will make the policy invalid. When family members are included and the employee agrees to pay for their cover, the company must collect this and send it to WPA with the overall premium. You (the Group Co-ordinator) are also responsible for ensuring that a copy of the brochure and Guide is made available to each employee.

2. POLICY DETAILS

Which product is being applied for

Enterprise Flexible Benefits (EFB)

Islander Enterprise Flexible Benefits (IEFB)

Corporate Cash Plan only

EFB/IEFB & Corporate Cash Plan

POLICY DETAILS CONTINUED OVERLEAF...

2. POLICY DETAILS (CONTINUED)

Select one or more of the cover options below to best suit your requirements.

	EMPLOYEE	2nd FAMILY MEMBER	3rd FAMILY MEMBER	4th FAMILY MEMBER	5th FAMILY MEMBER	6th FAMILY MEMBER
Fully underwritten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WPA Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Re-underwritten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date this cover ceased or will cease _____ (dd/mm/yy)

A copy of your existing Certificate of Registration MUST be enclosed.

The following sections are relevant to all products and must be completed for ALL applicants.

Essential Cover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-patient Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapy Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worldwide Option (35 days or 70 days)	35 <input type="checkbox"/> 70 <input type="checkbox"/>	35 <input type="checkbox"/> 70 <input type="checkbox"/>	35 <input type="checkbox"/> 70 <input type="checkbox"/>	35 <input type="checkbox"/> 70 <input type="checkbox"/>	35 <input type="checkbox"/> 70 <input type="checkbox"/>	35 <input type="checkbox"/> 70 <input type="checkbox"/>
Dental Option*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corporate Cash Plan*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP Fees Full Refund Option (IEFB only)*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP Fees Shared Responsibility Option (IEFB only)*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Shared Responsibility does not apply to Options marked *.

Select an annual maximum level of **Shared Responsibility** for each applicant.

EMPLOYEE	2nd FAMILY MEMBER	3rd FAMILY MEMBER	4th FAMILY MEMBER	5th FAMILY MEMBER	6th FAMILY MEMBER
£250 <input type="checkbox"/>	£250 <input type="checkbox"/>	£250 <input type="checkbox"/>	£250 <input type="checkbox"/>	£250 <input type="checkbox"/>	£250 <input type="checkbox"/>
£500 <input type="checkbox"/>	£500 <input type="checkbox"/>	£500 <input type="checkbox"/>	£500 <input type="checkbox"/>	£500 <input type="checkbox"/>	£500 <input type="checkbox"/>
£1,000 <input type="checkbox"/>	£1,000 <input type="checkbox"/>	£1,000 <input type="checkbox"/>	£1,000 <input type="checkbox"/>	£1,000 <input type="checkbox"/>	£1,000 <input type="checkbox"/>
£3,000 <input type="checkbox"/>	£3,000 <input type="checkbox"/>	£3,000 <input type="checkbox"/>	£3,000 <input type="checkbox"/>	£3,000 <input type="checkbox"/>	£3,000 <input type="checkbox"/>
£5,000 <input type="checkbox"/>	£5,000 <input type="checkbox"/>	£5,000 <input type="checkbox"/>	£5,000 <input type="checkbox"/>	£5,000 <input type="checkbox"/>	£5,000 <input type="checkbox"/>

Employee Section

Important note: The employee listed in Section 3 must be an employee or active partner of the company detailed in Section 1.

3. EMPLOYEE DETAILS

Title _____ Male Female **Date of birth** _____ (dd/mm/yy)

First name _____ Middle name _____

Surname _____

What is your occupation
(If retired please give occupation before retirement) _____

Home address _____

Postcode _____

Home telephone number _____

Work telephone number _____

Mobile telephone number _____

Fax number _____

3. EMPLOYEE DETAILS (CONTINUED)

E-mail address _____

How would you like to be contacted Standard Post Notification by E-mail ¹ All communication by E-mail ²

- 1 With this mode of contact we will advise you of correspondence that can be viewed or downloaded from the secure area of our website. The e-mail itself will not contain any personal information or attachments.
- 2 If you select this mode of contact, we will attach all correspondence to the e-mail for you to view or download.

Please note that e-mails are a useful way for us to communicate with you and you to contact us – but please remember that the e-mail address you give us must be secure and not accessible by anyone else (e.g. a work e-mail address). By providing your e-mail address you are consenting to its use for services which may include claim and medical information as well as the administration of your policy.

Do you have, or have you previously had, insurance with WPA Yes No

Please give your existing WPA customer number (if you have one) _____ Date this cover ceased or will cease _____ (dd/mm/yy)

4. FAMILY MEMBER(S) DETAILS

To be eligible for inclusion on your policy any additional people must live at your address unless they are a child family member and in full-time education away from home. If you require additional space please continue on a separate sheet of paper.

2nd FAMILY MEMBER TO BE COVERED

Title _____ Male Female Their date of birth _____ (dd/mm/yy)

Their first name _____ Their middle name _____

Their surname _____

Their relationship to you _____

What is their occupation _____

E-mail address _____

3rd FAMILY MEMBER TO BE COVERED

Title _____ Male Female Their date of birth _____ (dd/mm/yy)

Their first name _____ Their middle name _____

Their surname _____

Their relationship to you _____

E-mail address _____

4th FAMILY MEMBER TO BE COVERED

Title _____ Male Female Their date of birth _____ (dd/mm/yy)

Their first name _____ Their middle name _____

Their surname _____

Their relationship to you _____

E-mail address _____

5th FAMILY MEMBER TO BE COVERED

Title _____ Male Female Their date of birth _____ (dd/mm/yy)

Their first name _____ Their middle name _____

Their surname _____

Their relationship to you _____

E-mail address _____

5. HEALTH AND LIFESTYLE (CONTINUED)

If you have answered YES for any member aged 16 or over to any of the previous questions (numbered 1–9), please use the spaces below to provide more information. If you need more space, please use the allocated page at the end of Section 6 or a separate sheet.

Name _____	This information relates to question number ____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number ____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number ____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number ____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number ____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

	EMPLOYEE	2nd FAMILY MEMBER	3rd FAMILY MEMBER	4th FAMILY MEMBER	5th FAMILY MEMBER	6th FAMILY MEMBER
Is your GP private or NHS	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>

We reserve the right to ask your GP for information about your health. Before requesting a medical report we will ask you to sign an ACCESS to MEDICAL REPORTS consent form.

General Practitioner name _____

Address _____

If you have more than one GP for all the people on this application, please list their details in the space provided in Section 6.

How long have you been registered with your GP _____ Months / Years (delete as appropriate)

If under one year please give your previous GP details.

General Practitioner name _____

Address _____

6. MEDICAL HISTORY

Private Medical Insurance covers policyholders against future illness. It is not intended to provide cover for chronic conditions. Please refer to the Information Leaflet 'Chronic Conditions' (available on request or online at wpa.org.uk/chronic) which explains this in more detail. Existing, or previous, conditions are NOT covered, unless you give us full details and we are satisfied that they are no longer relevant to your future health. **Failure to disclose medical information may result in a rejection of claims in the future, and/or cancellation of your policy.**

Please tick Yes or No under each section below if you or anyone else you wish to include on your policy have: a) visited a GP or other healthcare professional for any of the conditions or symptoms in the past 2 years; b) been treated in hospital, seen a specialist or had any investigation for any of the conditions or symptoms in the past 5 years.

If you or any applicant answers YES to any of the questions in this section, please give full details opposite.

<p>1) NEUROLOGICAL</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Epilepsy • Brain, nerve or muscle problems • Development or behavioural disorders • Psychiatric or nervous problems • Anxiety/depression 	<p>2) DIGESTIVE SYSTEM</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Indigestion • Bowel disturbance • Irritable bowel syndrome • Crohn's disease, colitis • Hiatus and other types of hernia • Conditions of liver, gallbladder or similar • Piles • Other rectal blood loss 	<p>3) JOINTS & BONES</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Back ache or neck ache • Knee or hip problems • Spinal problems • Disc problems • Bone, tendon or ligament conditions • Gout, rheumatic diseases or fever • Arthritis or other joint problems • Fracture or injury • Other joint problems 	<p>4) KIDNEY</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Kidney and bladder conditions • Urinary tract stones • Urinary symptoms, cystitis
<p>5) EYES & EARS</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Glaucoma • Cataracts • Retinal or other eye disorders • Glue ear, hearing problems or other ear problems 	<p>6) SKIN</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Eczema • Psoriasis • Moles, warts or other skin problems • Cysts and benign lumps • Thread Veins 	<p>7) CIRCULATORY</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Blood pressure problems or abnormalities • Angina, heart attack • Other heart or circulatory problems • Blood lipid or cholesterol abnormalities • Varicose Veins • Stroke • Deep Vein Thrombosis 	<p>8) GLANDS</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Diabetes • Thyroid conditions • Other glandular disorders • Breast disorders, including cysts or lumps
<p>9) RESPIRATORY</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Asthma • Bronchitis • Other lung or respiratory tract problems • Nose or throat disorders • Tonsillitis • Sinus problems 		<p>10) MALE</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Conditions of the genital system • Disorders of the prostate • Infertility or fertility problems • Sexually transmitted diseases 	<p>11) FEMALE</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <ul style="list-style-type: none"> • Childbirth or pregnancy problems • Menstrual irregularities or problems • Gynaecological conditions • Problems with menopause • Abnormal smear test • Infertility or fertility problems • Sexually transmitted diseases

Answer the following questions for ALL the people to be covered. If you or any applicant answers YES to any of the questions in this section, please give full details overleaf.

ANY APPLICANT	
12) Have you had any symptoms or conditions in the last 2 years for which a specialist, GP or healthcare professional's opinion has not yet been sought?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13) Are you waiting to see a specialist, GP or a healthcare professional?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14) Have you ever had treatment for arterial or heart disease (including stroke)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15) Have you ever had any malignant condition (eg cancer)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16) Have you ever had any orthopaedic surgery as a result of a bone or joint condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
17) Have you undergone any medical tests in the last 2 years including home testing kits or as part of a national screening programme?	Yes <input type="checkbox"/> No <input type="checkbox"/>
18) Have you had any other condition, symptom or medical history that should be disclosed in the interests of good faith?	Yes <input type="checkbox"/> No <input type="checkbox"/>

6. MEDICAL HISTORY (CONTINUED)

Please tell us about any condition you and others on this application are suffering or have suffered from.

CONDITION 1

This information relates to number _____

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ (dd/mm/yy) The date the condition has been suffered to _____ (dd/mm/yy)

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

CONDITION 2

This information relates to number _____

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ (dd/mm/yy) The date the condition has been suffered to _____ (dd/mm/yy)

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

CONDITION 3

This information relates to number _____

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ (dd/mm/yy) The date the condition has been suffered to _____ (dd/mm/yy)

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

6. MEDICAL HISTORY (CONTINUED)

If you need more space please use the allocated page overleaf or a separate sheet.

CONDITION 4

This information relates to number

Patient's name

Condition suffered

Diagnosis made by whom

Tests performed

Results

Treatment

The date the condition has been suffered from (dd/mm/yy) The date the condition has been suffered to (dd/mm/yy)

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

CONDITION 5

This information relates to number

Patient's name

Condition suffered

Diagnosis made by whom

Tests performed

Results

Treatment

The date the condition has been suffered from (dd/mm/yy) The date the condition has been suffered to (dd/mm/yy)

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

CONDITION 6

This information relates to number

Patient's name

Condition suffered

Diagnosis made by whom

Tests performed

Results

Treatment

The date the condition has been suffered from (dd/mm/yy) The date the condition has been suffered to (dd/mm/yy)

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

7. TERMS & CONDITIONS – PLEASE READ CAREFULLY

WHAT INFORMATION DO WE HOLD AND WHY

Except where stated below, we never disclose any personal information about customers to third parties. We take our responsibility regarding the confidentiality of our customers' personal information very seriously. Any information you give to us on this application form (your name, address and medical history) will be processed accurately and held securely in accordance with the Data Protection Act 1998 (DPA).

By signing this form you are giving your consent for us to use your data as set out below.

How we may use your personal data or disclose it to third parties

- To process your claims and administer your policy;
- To liaise with your treatment provider regarding treatment details and costs;
- To process claims that are also covered by another insurer or other party;
- To help us develop services that we think may be in your interest;
- For statistical analysis to help us assess how the policy you belong to is used;
- To detect and prevent fraud or improper claims. We may check your details with a fraud prevention agency/agencies and if you give us false or inaccurate information and we suspect fraud, we will record and investigate this.

In the course of administering our policy we may disclose:

- Administration and claims data to the staff of WPA and its subsidiaries, FSA registered appointed representatives, agents and medical advisors;
- Data to countries outside the EEA which may not have data protection legislation in place. However a contract will be held to ensure that your information is protected and we will remain bound by our obligations under the Data Protection Act.

We at WPA may advise you by letter, telephone, electronic mail or otherwise of other services or products which we believe you may be interested in. If you do not wish to receive such information please tick the box below.

Yes No

IMPORTANT INFORMATION

- The policy will not begin until we have confirmed acceptance of your application.
- The health information you provide may result in us applying exclusions to your policy or declining your application.
- When your application is accepted, WPA will send you the rules of the policy – these can be requested at any time or can be viewed at wpa.org.uk – and provide the full details of what your policy does and does not cover. You will also be sent a certificate of registration which sets out any personal medical exclusions (exclusions from cover relating to you and any other person on the policy) which will apply.
- Please check all these documents before you cancel any private medical insurance policy you already have to be sure that you understand what the WPA policy you have chosen covers and that it meets your needs.
- If you visit a doctor after the time of completing this application, or prior to our accepting your application in writing, it is your duty to tell us.
- **Please note we can NOT accept your application if the start date is more than 1 month in advance.** You must let us know if you suffer any symptoms, have any treatment or see a GP, specialist or other healthcare professional for a condition between filling in this form and the date your cover starts.
- **To ensure that you have had the opportunity to fully understand the terms of your cover, cover cannot be backdated to a period before you signed this form.** Once you receive the Certificate of Registration setting out your personal exclusions you have a fourteen (14) day cooling off period.

- We carry out random quality checks on applications. This involves asking your GP for a medical report. WPA will pay any reasonable fee for this. Only applicable to Enterprise Flexible Benefits and Islander Enterprise Flexible Benefits;
- If the Corporate Cash Plan Option has been chosen: No cover will be provided for any condition or any associated condition existing on or before the date of registration to the policy, irrespective of whether it has been disclosed in this application. You must not hold a cash plan with any other insurer after the qualifying period. Please note that there is a 6 month qualifying period for this Option, for all benefits except Attendance to Accident & Emergency which can be claimed immediately, and Maternity/Paternity Benefit for which the qualifying period is 10 months.
- If the Dental Option has been chosen: Emergency benefit applies only to treatment received for the relief of acute pain, swelling or haemorrhaging associated with the teeth, jaws or soft tissues of the mouth. Please note that there is a 3 month qualifying period for General Dental Treatment, and a 14 day qualifying period for Dental Emergencies. If you choose the Dental Option you must not hold a dental plan with any other insurer after the qualifying period.

DECLARATION – FOR ALL APPLICANTS

1. I wish to apply for the cover indicated on behalf of myself and/or the other people listed on this form.
2. I and they have checked that the information given is correct and complete, especially if I have not filled in the form myself. In particular, I have personally confirmed with family members that the information on their health and lifestyle is correct and complete and understand that you also take other risk factors such as body mass index, lifestyle and family history into consideration when underwriting this application.
3. Please note that it may be necessary to request a medical report from your GP and if one is needed we will write to you telling you why.
4. I undertake to keep to the rules of the policy.
5. I have read and understood the Important Information above.
6. I understand that I will not be covered for treatment of any illness or injury which started on or before the date the policy starts, even if the reason for any symptoms has not yet been diagnosed, with the exception of General Dental Treatment and Optical Treatment where applicable unless declared or subsequently disclosed and accepted by WPA.
7. I understand that I am consenting on behalf of myself and any other people listed on this form to relevant policy and claims data being disclosed to WPA staff and subsidiaries, FSA registered appointed representatives and medical advisors.
8. I understand the criteria for transferring my membership to WPA which have been fully explained to me and I understand that my group policy membership will be subject to the rules of the WPA policy and not those of my previous insurer.
9. I agree to any applicable credit checks being undertaken.
10. If I have chosen the Dental Option and/or the Corporate Cash Plan Option I confirm that I will not hold a dental plan or a cash plan with any other insurer after the qualifying period.
11. I declare that I and other people listed on this form reside in the UK for at least six (6) months a year and I understand that cover will automatically become void for individuals who leave the UK to live elsewhere for more than six (6) months a year.
12. I understand that WPA will normally write to the employee. I agree that if a family member does not wish WPA to correspond with the employee and they are aged 18 or over they will take out an individual policy in their own right.
13. I declare that I am an employee or partner of the company and that the company pays the premium without recovery from me.

8. DECLARATION – I ACCEPT THE TERMS & CONDITIONS

FRAUD/THEFT/DISHONESTY/JUDGEMENTS

Do you, or any person named on this application form, have any unspent criminal conviction evidencing fraud, theft or dishonesty or have you, or any person named on this application form, ever had an insurance policy declined or cancelled by an insurer or have a current County Court Judgement (CCJ) or Bankruptcy Order against you or have entered into Individual Voluntary Arrangements (IVA)?

Yes No

If you have replied YES to the above question, please provide full details in Section 9 or on a separate sheet. NB: You have a continuing duty to tell us of any unspent criminal conviction that may have been acquired, or any such cancellation, while the policy is in force.

Please make sure you have ticked all the boxes below before signing the Declaration:

You have included all persons to be covered on the policy and selected their level of cover (where applicable):

You have read and understood the Terms & Conditions:

All persons to be included on the policy have read and understood the Terms & Conditions:

Your signature

Date

(dd/mm/yy)

We reserve the right to ask you for proof of your identity when you apply for a WPA policy and at any time thereafter when appropriate.



WPA is authorised and regulated by the Financial Services Authority (FSA). The FSA website may be checked at www.fsa.gov.uk/register for WPA number 202608.



FS 28452

WPA is one of very few insurance companies worldwide to have been certified to the ISO 9001:2000 Quality Standard. In addition, Western Provident was awarded the British Standard Institute's 'Gold Standard' of Company Wide registration in May 1997 — the 24th company in the world to achieve this accolade. So the standards of service that you can expect are truly world class.



WPA is a member of the Financial Ombudsman Service, so you can be assured that any complaints are addressed seriously and objectively. Details of WPA's commitment to resolving customer complaints are included in your scheme literature.



EMS 505226

WPA is one of the first UK companies to achieve the environmental quality standard.

WPA customers are covered by the Financial Services Compensation Scheme (FSCS) which can entitle customers to compensation should an insurer become insolvent. Further information can be found at www.fscs.org.uk



wpa.org.uk

Enjoy life. Insure health.

Western Provident Association Limited

Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE.

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