

PruHealth private medical insurance application form.

To apply for PruHealth membership complete SECTIONS A to H. Please check all details on the application. If any details are incorrect put a line through them, write in the correct details and initial the change. If you need help completing your application call 0800 904 7070.

Please use BLOCK CAPITALS and black ink when filling in this form.

A – Principal member details

Title Mr Mrs Ms Miss Other

Forename(s)*

Surname*

Address*

Postcode*

Telephone number (home)* Telephone number (work)

Telephone number (mobile) Fax number

Date of birth* Gender Male Female

E-mail*

Date you would like your cover to begin

Quote reference number (If applicable)

Campaign code (If applicable)

* required field

Barcode No: 700015567



B – Partner and dependant details

Complete only if there are other people to be covered by this policy

Partner

Title Mr Mrs Ms Miss Other

Forename(s) Surname

E-mail

Date of birth Gender Male Female

Dependant 1

Dependant under 21 or Dependant over 21

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth

Gender Male Female

Dependant 2

Dependant under 21 or Dependant over 21

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth

Gender Male Female

Dependant 3

Dependant under 21 or Dependant over 21

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth

Gender Male Female

Dependant 4

Dependant under 21 or Dependant over 21

Title Mr Mrs Ms Miss Other

Forename(s)

Surname

E-mail

Date of birth

Gender Male Female

C – Plan choices

Please select your plan, hospital cover and your excess amount

1. Select your plan

| Core Plan <input type="checkbox"/> | Essential Plan <input type="checkbox"/> | Comprehensive Plan <input type="checkbox"/> | Select Plan <input type="checkbox"/> |
|--|---|---|---|
| The Core Plan covers you for hospital care and some out patient cover. No excess is available. | The Essential Plan covers you for hospital care and most out patient cover. | The Comprehensive Plan offers extensive hospital and out patient cover. | The Select Plan offers a greater level of outpatient cover than our Essential Plan but with a fixed excess of £250. |

2. Select your hospital cover

National: Cover at all of our private hospitals outside of London.

London: Cover at all of our private National and London hospitals.

Premier: Cover at all of our private National, London and Premier hospitals.

3. Select your excess amount

Choosing an excess can lower the cost of your premiums. The excess options below show the amount you will need to contribute towards your treatment expenses. PruHealth will then pay any remaining costs up to any applicable limits. Each member on the policy will only have to pay this amount towards the total cost of their treatment within a given year, not for each specific claim. **Please note that all Core Plans must have £0 excess, and all Select Plans must have £250 excess.**

| | | | | | |
|--------------------|-----------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------|
| Core Plan | £0 | | | | |
| Essential Plan | £0 <input type="checkbox"/> | £100 <input type="checkbox"/> | £250 <input type="checkbox"/> | £500 <input type="checkbox"/> | £1000 <input type="checkbox"/> |
| Comprehensive Plan | £0 <input type="checkbox"/> | £100 <input type="checkbox"/> | £250 <input type="checkbox"/> | £500 <input type="checkbox"/> | £1000 <input type="checkbox"/> |
| Select Plan | | | £250 | | |

Section D – Vitality first year discount

The PruHealth plan is designed to reward you for actively seeking to lead a healthier lifestyle. The more you look after yourself the more you can save on your annual premiums. Completing the questions for all applicants could earn you a significant discount on your starter premium.

1. Has any applicant been told by a medical professional that they are obese? Yes No
2. Has any applicant smoked tobacco products in the last 3 years? Yes No
3. Do any of the applicants after management (medication or diet) have high blood pressure? Yes No Don't know
4. Do any of the applicants after management (medication or diet) have high cholesterol? Yes No Don't know
5. How much time do all applicants spend a week participating in exercise or sport?
(a) Less than 1 hour (b) 1 – 3 hours (c) More than 3 hours

Section E – Underwriting

Please help us by completing the underwriting questions honestly and in full. If you give us incorrect information this may mean that we will not pay a future claim.

To ensure you receive the most suitable underwriting for your needs, please complete the following four questions.

1. In the last 5 years have any applicants been treated for, diagnosed with, or advised that they have the following?

| | |
|--|--|
| Heart condition | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stroke | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer or tumours | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Joint problem for which the applicant may need a joint replacement | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Mental illness | Yes <input type="checkbox"/> No <input type="checkbox"/> |
2. In the last 2 years have any applicants been hospitalised or received surgical treatment (excluding emergencies, pregnancy related treatment, removal of appendix or gall bladder, removal of wisdom teeth, removal of tonsils and sterilisation)? Yes No
3. Does any applicant take ongoing prescribed medication (excluding contraception, hormone replacement therapy, short course of antibiotics, medicine for high blood pressure or high cholesterol where the condition is controlled by the medication, and allergies)? Yes No
4. In the last 2 months have any applicants had any signs or symptoms that may require them to visit a medical professional, or are any applicants awaiting any reviews, treatment or investigation for any current or past medical problems? Yes No

If you answered "NO" to all four questions you are eligible for immediate cover and do not need to answer any more questions in this section. If you answered "NO" to Q1 and "YES" to any of the other questions, please select Moratorium or Full Medical Underwriting continued overleaf. If you answered "YES" to Q1, please select Full Medical Underwriting.

Underwriting options explained

1. **Moratorium Underwriting** – Not disclosing your medical history

- You do not need to give details of any of the applicants' medical history in the application form
- You are comfortable that we will not cover medical conditions for the first two years, that have existed at any time in the five years before your application
- You are comfortable that these conditions will only become eligible for cover after two years (unlike other providers PruHealth does not expect you to be symptom-free for those two years).

2. **Full Medical Underwriting** – Disclosing your full medical history

- You want to know exactly what you and your dependants are covered for
- You are prepared to provide all the requested details of the medical history for all applicants, and are aware that we may ask you to provide additional information from your GP if necessary
- You're comfortable that this information may result in exclusions or loadings on your policy.

NB: For all underwriting options we may contact your GP when a claim is made to confirm that the condition was either disclosed or pre-existing.

1. **Moratorium Underwriting**

Complete this section if you chose the Moratorium Underwriting option, then go to SECTION F

I understand and agree that:

- Any conditions for which any applicant has had symptoms, treatment or advice in the last five years may be excluded from cover for two years from start of cover after which benefits are available for eligible treatments and conditions;
- If any applicant makes a claim PruHealth may have to request information from them or their GP to determine whether the condition was pre-existing or not;
- All members to be covered are under 70.

Signature of Principal
Member on behalf of
all applicants

X

Date

D D M M Y Y Y Y

2. Full medical underwriting

**Only complete this section if you answered "YES" to Q1 or have chosen the Full Medical Underwriting option.
Once completed then go to SECTION F.**

Have any of the applicants, ever experienced or been treated for, or are you currently suffering from any of the following conditions or symptoms?

| | | | |
|--|--|------------------------------|-----------------------------|
| a. Blood disorders | eg; anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, thrombosis (blood clots) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Brain and nerve disorders | eg; stroke, multiple sclerosis, epilepsy, migraine, paralysis, Parkinson's disease, quadriplegia, paraplegia | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Cancer | eg; any form of cancer or pre-cancerous growth | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Cardiac and vascular disorders | eg; angina/heart attack, heart failure, heart murmurs, rheumatic fever, high blood pressure, rhythm disturbance (palpitations), varicose veins, poor circulation, raised cholesterol, heart surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. Connective tissue disorders | eg; systemic lupus erythematosus, scleroderma, dermatomyositis, mixed connective tissue disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Dental disorders | eg; over/underbite problems, missing/skew teeth, false teeth, or ongoing treatment | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Eye, ear and speech disorders | eg; cataracts, glaucoma, retinitis, hearing/visual impairment, disorders of the cornea, blindness, loss of speech | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Gastro-intestinal disorders | eg; peptic ulcer, hiatus hernia, heartburn, changed bowel habits, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i. Gynaecological disorders | eg; ovarian cysts, endometriosis, fibroids, infertility, disorders of the cervix, menstrual disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j. Kidney/Urinary tract disorders | eg; kidney failure, kidney stones, recurrent infections, nephritis, prostate problems, blood/protein in urine, polycystic kidneys | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| k. Liver/Pancreatic disorders | eg; hepatitis, cirrhosis, liver failure, gallstones, pancreatitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| l. Mental health/Psychiatric disorders | eg; depression, anxiety, schizophrenia, eating disorders, Attention deficit hyperactivity disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| m. Metabolic/Endocrine disorders | eg; diabetes, thyroid abnormalities, growth disorder, Cushing's disease, Addison's disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| n. Musculo-skeletal disorders | eg; arthritis, rheumatoid arthritis, crystalline arthritis, myasthenia gravis, muscle weakness, gout, osteoporosis, back problems, eg; slipped disc, backache, sciatica, pinched nerve, loss of limb | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| o. Respiratory disorders | eg; asthma, emphysema, bronchitis, shortness of breath, persistent cough, coughing up blood, cystic fibrosis, sinusitis, allergic rhinitis, chronic obstructive airway disease or any lung surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| p. Skin disorders | eg; eczema, psoriasis, acne, hypertrophic scars (keloid) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| q. Sensory functions | eg; loss or impairment of sense of touch, smell or taste | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

3. Full medical underwriting – continued

If you answered "YES" to any of the above questions (a – q), please supply full details below.

| Name of Applicant | Condition/symptom for which medication/treatment was prescribed | Description of medication/ treatment including dates | Present state of health |
|-------------------|---|--|-------------------------|
| | | | |
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| | | | |

Section F – How to pay

Please complete the relevant section below. You can choose to pay annually by Credit/Debit card or monthly by Direct Debit.

Paying Annually by Credit or Debit Card

If paying annually by credit or Debit Card please select your preferred payment date: 1st 15th 25th

Credit card **Debit card** **Card type:** VISA MASTERCARD MAESTRO SOLO

Name of Card or Account holder

Card number

Sort code (if applicable)

Security number (The last three digits on the reverse side of the card)

Valid from (if applicable)

Valid from (if applicable)

Signature of card holder

Date

The Direct Debit Guarantee

Section F – How to pay – continued

Paying Monthly by Direct Debit

If paying monthly by Direct Debit please select your preferred monthly payment date

1st

15th

25th

Direct Debit Instruction



Please fill in the whole form using a ball point pen and send it with the completed application to:

Prudential Health Limited, Stirling, FK9 4UE

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

Name(s) of Account Holder(s)

Originator's Identification Number

Reference

Bank or Building Society Account Number

Branch Sort Code

Instructions to your Bank or Building Society.

Please pay Prudential Health Limited 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 Prudential Health Limited and if so, details will be passed electronically to my Bank/Building Society.

| |
|----------------------|
| Signature(s) |
| <input type="text"/> |
| Date |

Name and full postal address of your Bank or Building Society

| | |
|----------------------|--------------------------|
| To: The Manager | Bank or Building Society |
| <input type="text"/> | |
| <input type="text"/> | |
| Address | |
| <input type="text"/> | |
| Postcode | |
| <input type="text"/> | |

Banks and Building Societies may not accept Direct Debit instructions for some types of account.

This guarantee should be detached and 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 date changes Prudential Health Ltd will notify you 6 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Prudential Health Ltd 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.

G – Important information

General notes

- The plan will not start until we have accepted your application.
- If you have a birthday while your application is being processed, the terms may differ from those originally quoted. We may offer you revised policy terms, but in certain circumstances we may not be able to offer cover.
- We may ask you to contact your doctor if we are experiencing delays in receiving reports which we have asked for.
- If we ask you to undergo a medical examination, we will need to share the application information with another company we have authorised. They will make the arrangements for the examination to take place.
- We may need to send your application and relevant medical reports to our reinsurers. You can get details of general reinsurance principles and details of any company we use to assess your application from our head office.
- We have a confidentiality policy in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.
- You are entitled to ask for a copy of our standard terms and conditions and a copy of your application form at any time.

Data Protection notice

PruHealth & PruProtect, our group of companies and our business associates, service providers and agents will use your information, together with other information, for administration, customer services, marketing and profiling your purchasing preferences and fraud prevention. We will pass your information to them for these purposes.

We will pass your information to any legal or regulatory body if required to do so.

By submitting this form you consent to us processing your sensitive personal information; such as health data.

For the above purposes it will be necessary to transfer your information to countries that provide a different level of data protection from the UK. We have contracts in place to ensure your information is protected.

You have a right to obtain a copy of your personal information (for which we may charge a fee) and to have any inaccuracies corrected by writing to: The Privacy Manager, Information Risk and Privacy Team, Prudential Assurance Company Ltd, 3 Sheldon Square, London, W2 6PR.

Acting on someone's behalf?

When giving us information about another person, you confirm that they have appointed you to act on their behalf. This includes providing consent to process the personal data, receive this data protection notice on their behalf and receive marketing information.

Marketing choice

We would like to keep you updated with information on our and other carefully selected providers, products and services which we think might interest you by telephone, post, email or text. If you would prefer not to receive this information please tick this box.

* The Prudential group of companies at the time of printing includes Prudential UK & Europe, the M&G Investments Group, Prudential Corporation Asia, Jackson National Life, and PPM America Inc (indirect wholly owned subsidiary).

G – Important information – continued

Access to medical reports consent form

We may need to get medical reports to support your application. Before we can ask any doctor that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the act are as follows.

You do not need to give your permission, but if you do not, we may not be able to go ahead with your application. This does not prevent you from applying to other companies for insurance.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

Your current health.

- any care, medication or treatment you are currently receiving.
- the results of referrals or tests you are waiting for.
- any time off work in the last three years.

Your past health.

- details of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
- malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases;
- musculo-skeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles;
- anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue;
- suicidal thoughts or attempts at suicide; or
- conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- any blood pressure readings in the last three years.
- any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C;
- any sexually-transmitted diseases unless there could be long-term effects on your health; or
- predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from.

The information you and your doctor provide about your health may result in us:

- refusing to provide insurance;
- increasing premiums above standard rates; or
- setting premiums at standard rates.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information please write to: The Senior Medical Officer, Prudential, Stirling FK9 4UE.

I do **NOT** want to see the report before it is sent to PruHealth.

I do want to see the report before it is sent to PruHealth.

Signature of Principal Member
on behalf of all applicants

X

Date

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Section H – PruHealth policy Declaration to be signed by Principal Member

- I understand that this Application is subject to written acceptance by PruHealth.
- I understand that by signing this declaration I am applying on behalf of all applicants to be covered by this policy and am doing so with their full consent. I also agree to receive all policy related documentation on behalf of all applicants.
- I give consent to PruHealth to contact any doctor I have consulted and to obtain access to the medical records of all applicants on this policy should it be necessary to verify any medical details provided both during and after this application. You may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance that I have applied for.
- I give permission to the disclosure of the medical information I've provided for risk management and underwriting purposes to any employee in the PruHealth group. This information can also be used to maintain management information for business analysis.
- I declare that nothing material has been withheld and that the information given on this form is true. If I am in doubt about whether certain facts are material, these will be disclosed. I understand that failure to disclose a material fact, which is a fact that may influence the assessment and acceptance of this declaration, may result in the contract being declared void and that a claim under the contract may not be paid.
- I will inform you immediately of any changes to the information provided that occur before the policy starts.
- I agree to PruHealth accepting medical reports faxed directly to PruHealth from the doctor's surgery of any applicant to be covered by this policy. I do not object to copies of the report being faxed to any other company that I have applied to at their request.
- I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.
- I acknowledge that should this application be submitted via the Internet, it is solely for the purposes of convenience and neither I nor my employer or PruHealth (subject to its sole and absolute discretion) shall rely on the information contained herein without my providing PruHealth with a signed hard copy of this application. I further agree that the copy submitted pursuant to an Internet application will constitute an offer on my part for membership to the Scheme.
- I have read, understood and consent to the Data Protection Declaration contained in Section G of this application form.
- I understand that a completed copy of the application and the policy terms and conditions are available on request.

Signature of Principal Member
on behalf of all applicants

X

Date

APPLICATION CHECK LIST

Before you return this application please ensure you have:

- Read the product brochure sent to you with this application form
- Entered and checked all personal details for you and other applicants if applicable
- Selected your plan type and hospital network coverage
- Selected your excess level if you have chosen a Comprehensive or Essential plan
- Completed the First Year Discount questions
- Answered all relevant questions, attached membership certificate from previous insurer if applicable or signed the Declaration Statement for your chosen underwriting option
- Completed your payment details
- Signed the PruHealth Policy Declaration on behalf of all applicants
- Read and keep for your information 'The Direct Debit Guarantee'

FOR OFFICE USE ONLY

CONSULTANT CODE:

AGENCY CODE:

CONSULTANT NAME:

