Bupa Select

Your application form

Applying to join from another insurance company

Before you begin

The Group Secretary must complete the Scheme details and the main applicant must complete Sections 1 to 7 using BLOCK CAPITALS and BLACK INK

This application form is for anyone (except professional sportspersons) who is applying to join Bupa Select and who at the time of applying:

- has health insurance or health trust cover with another insurer and
- has had their health insurance or health trust cover with that insurer for at least 12 months.

In which case, we may, at our sole discretion, consider your application on a no further underwriting basis. Please note: any dependants you wish to cover who do not currently have health cover with another insurer cannot be considered on a no further underwriting basis. They will need to complete a separate application form.

If yes is answered to any of the conditions in section 5 further underwriting may be applied.

- If we do not offer cover on a no further underwriting basis we will tell you what additional exclusions we will apply to your Bupa cover that are personal to you and/or your dependants (if any) so that you can decide if you want to move to Bupa from your current insurer.
- This application form is designed to ensure we have all the information we need about you and your family in order to make moving to Bupa from your current insurer as straightforward as possible.
- You must ensure the details about your family members are correct and you should check the information with them before sending it to us. You must take good care to answer all the questions honestly and to the best of your knowledge. If you don't, your policy may be cancelled, or treated as if it never existed, or your claim may be rejected or not fully paid.
- If you have any queries while you're completing the questions, please call your Bupa adviser or health care intermediary.

Where to send your completed form

By post: **Bupa, Anchorage Quay, Salford Quays M50 3XL**

Or by fax: **0161 254 3713**

Bupa

Scheme details – to be completed by Group Secretary

Company name

Bupa group number

Please tell us which products should be selected for this application.

Preferred start date D D M M Y Y Y Y

Are dependants eligible under the scheme?

☐ Yes ☐ No

Please note: although we will try to start the cover on the date indicated above, this cannot be guaranteed. The beneficiary(ies) start date will be confirmed on the registration certificate.

1. Your personal details

Please tell us about yourself here. (To see how we use your information, please read our privacy notice on page 10).

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other *(please tick or list title if other)*

First name(s) Surname

Address

Postcode

Home telephone number Mobile telephone number

Email address

Your date of birth D D M M Y Y Y Y Sex at birth Male ☐ Female ☐

Occupation and current employer

If you are already a beneficiary of Bupa or insured member, or have been in the past please give us your registration number below.

If you would like any members of your family (partner, children etc) to be included in your registration, please go to section 2. If not, go to section 3.

2. Your family's details

If you would like to cover members of your family, please give us their details below. Remember to check with each family member that you have their correct details.

	Member 2	Member 3	Member 4	Member 5
First name of family member				
Surname of family member				
Relationship to you				
Date of birth	D D M M Y Y	D D M M Y Y	D D M M Y Y	D D M M Y Y
Sex at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐

What if I need to add more family members?

If you would like to cover family members additional to those listed above, please give us their details on a separate sheet of paper. You will also need to answer both parts of section 5 for them.

3. Previous insurance/health trust details

Please tell us about yourself here.

Name of your current insurer/health trust administrator	
Existing scheme name	
Date medical cover was first taken with the current provider	D D M M Y Y Y Y
Date existing cover expires/expired	D D M M Y Y Y Y
Does existing policy cover dependants?	☐ Yes ☐ No

This form must be completed in full and returned with:

1. Evidence of current underwriting terms for you and your dependants (if any) (eg letter from previous health insurer showing dates of cover and special conditions applied) and
2. Copy of current registration/membership certificate for you and your dependants (if any) held with previous health insurer(s)/ health trust administrator.

4. Further details

Please answer each question as it applies to yourself and each person named in section 2. Please tick 'Yes' or 'No' to every question for each person.

	Main beneficiary		Member 2		Member 3		Member 4		Member 5	
Full name of applicant										
(Please tick relevant box)	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Have you been a UK resident for more than six months?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Are you registered with a GP in the UK?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you been registered with a UK GP for six months or more?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
If you are not registered with a GP currently or have not been for at least six months, do you have access to your full medical records in English? *(Please note that to continue with your application you must have been registered continuously with a GP for a period of at least six months, or have access to and be able to provide your full medical records in English)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
If you have answered 'No' to any questions above please provide details										
Do you receive payment for taking part in sports?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
If 'Yes', which sport(s)?										

5. Medical history – part one

This section asks for health and medical details, past and present, for you and for each person named in section 2. Please tick 'Yes or No' to every question for each person.

For any of the medical conditions or symptoms listed in questions 1 to 6 please indicate if:

- you or anyone to be covered on your registration has seen a GP or other healthcare professional within the last two years
- you or anyone to be covered on your registration has been admitted to hospital, had an operation OR any investigations (for example scan, X-ray, blood test, biopsy) within the last seven years

	Main beneficiary		Dependant/beneficiary							
			Member 2		Member 3		Member 4		Member 5	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. **Heart and stroke conditions** (including hypertension, angina and heart attacks)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. **Any form of cancer**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. **Back or joint problems** (including slipped disc and cartilage problems)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. **Abdominal and stomach or bowel conditions** (including polyps and ulcers)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. **Organ failure or transplants**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. **Psychiatric, mental or nervous conditions** (including stress and depression)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you have answered 'Yes' to any of the conditions here please give us full details in Medical History Part two on the following pages. If you have answered 'No' to all of the above conditions, please continue with the form.

5. Medical history – part two

To help us build a more complete picture of your (and your family's) health, please use pages 6 and 7 to expand on any of the conditions you answered 'Yes' to in part one. Please give as much specific detail as possible. Failure to do so will result in delays processing your application. You can use the example below for help when filling out the form.

Definitions

Controlled: Condition/symptom ongoing but controlled by treatment/medication.
Recurrent: Occurring occasionally, often or repeatedly.
Likely to recur: Symptom free for a period of time but likely to recur.
Fully recovered: Condition fully resolved/cured with no symptoms and no medication.

Example one

Name of beneficiary:	John Smith
Question number from **part one**	11
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	High cholesterol
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 01012016 Ended DDMMYYYY
Treatment *(prescribed or otherwise)*	Over counter medication / Diet / Prescribed medication
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)	Controlled
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	2

Example two

Name of beneficiary:	John Smith
Question number from **part one**	9
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	Knee pain
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 05052013 Ended 20082015
Treatment *(prescribed or otherwise)*	Physiotherapy
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)	Fully recovered
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	0

5. Medical history – part two (continued)

Name of beneficiary:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of beneficiary:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of beneficiary:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

5. Medical history – part two (continued)

Name of beneficiary:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began	D D M M Y Y Y Y
	Ended	D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of beneficiary:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began	D D M M Y Y Y Y
	Ended	D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of beneficiary:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began	D D M M Y Y Y Y
	Ended	D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

6. Obtaining medical reports from a GP

When you need to request a medical report from your/your family member's consultant or general practitioner, we can do this on your/your family member's behalf with your or their consent. We will always ask for your/your family member's consent before requesting a report from your consultant or general practitioner on your/your family member's behalf and we will ask for your/your family member's consent on the telephone when we explain to you the need for the report.

When we ask you for your consent to obtain a medical report from your consultant or general practitioner, you/your family member have certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (NI) Order 1991 (the "Acts"). Your rights under the Acts are summarised below:

Your rights

1. You can authorise the disclosure of the doctor's report without asking to see it. The report will then be sent directly to us by your doctor. Should you give your consent to the disclosure of a report without indicating your wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask your doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.
2. You can give your consent but ask to see the report before it is sent to us. If you do this you should contact your doctor within 21 days of sending the request to him/her. If you do not contact your doctor within the 21-day period you have authorised them to disclose the report to us directly without further notice to you. If you do contact your doctor within the 21-day period you must give them your written consent to disclose the report. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comments to the report before it is sent to us.
3. You can withhold your consent but, if you do, please bear in mind that we may be unable to process your request.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided you ask him/her within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information contained in the report if, in their opinion, this information:

(a) might cause serious harm to your physical or mental health or that of another person, or

(b) it would reveal the identity of another person without their consent (other than that provided by a healthcare professional in their professional capacity in relation to your care).

Your doctor may charge a fee for providing a medical report. We may contribute a maximum of £15 (inclusive of VAT) towards the cost of the report. If we do make a contribution, you will be responsible for any amount above this.

7. Your legal declaration

Important: Please read this declaration carefully before signing and dating the completed form.

1. I am applying for a Bupa healthcare plan. I agree that the terms of cover set out in the current trust guide relating to my cover (which is the cover for which I am now applying) will be binding on me and any dependants covered under my policy, and accept they shall be the basis upon which benefits shall be payable under my cover.
2. I declare that all the information given to Bupa on behalf of myself and my family members is and remains true and complete, to the best of my knowledge and belief, except to the extent I inform you otherwise when sending you this application for Bupa cover. I have confirmed the details of my family members with the relevant family member.
3. I agree to inform Bupa if any of the information relating to myself or any dependants I have provided, or provide, changes at any time before cover starts.
4. I understand that if the information I have provided about myself and my dependants in answer to the questions in this application for Bupa cover is inaccurate or misleading, Bupa may terminate my cover or benefits might not be payable.
5. I understand and accept there is no undertaking to cover any medical conditions in existence before the time I, or my dependants, are covered by Bupa. Bupa will apply any exclusions which apply under my existing policy, and may also need to exclude additional medical conditions in existence before the time I, or my dependants, are covered by Bupa.
6. I understand that I will have the option of cancelling my Bupa cover, as long as I do so in writing within 21 days of me receiving my registration certificate and receive a full refund providing no claims have been paid.
7. I confirm that I give explicit consent, within the provisions of the Data Protection Act, on behalf of myself and any family members specified in this form, and any separate sheet for Bupa to process our personal information with respect to our cover and I confirm that I have brought the Bupa privacy notice to the attention of these family members.
8. I understand English Law applies to the agreement between me and Bupa, unless otherwise agreed between us in writing.

You are advised to keep a record of all information you supply to us in connection with your Bupa cover, including this application form and any letters. If you would like a copy of this form please ask us.

Obtaining medical reports from your GP

- I understand that Bupa may need me to provide a medical report from my GP to support my application before treatment is authorised or a claim paid.
- I consent to Bupa obtaining this information from my GP on my behalf and I understand that Bupa will gain verbal confirmation from me prior to any medical report being requested in this way.
- I have read, understand and accept the rights I have in relation to such reports as explained in section 6.
- I have shown this declaration to the proposed family members on the policy and confirm that they understand that if they need to claim they will be asked on the telephone to confirm their consent to Bupa requesting a medical report on their behalf.

Please tick this box if you do **NOT** wish Bupa to request medical reports on your behalf in this way ☐.

Please tick this box if you do **NOT** wish to see the medical report from your doctor before it is supplied to Bupa ☐.

Signature

Date D D M M Y Y Y Y

We'll verify your digital signature. If you modify this form after signing it or send us a printed or a scanned copy of this form, we won't be able to verify the signature and will contact you either by phone or in writing to confirm your signature. Until we've confirmed your signature, we won't be able to advise exactly what your policy covers you for, meaning your claims might take longer for us to process and we might not be able to pay for treatment you need.

Privacy notice – in brief

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you, how we use and protect it. It also provides information about your rights. Further details can be found in our Full Privacy Notice available at **bupa.co.uk/privacy**. If you do not have access to the internet and would like a paper copy of the Full Privacy Notice, please contact the Bupa Privacy team on **+44 (0) 1784 893706**. Alternatively you can email the team at **dataprotection@bupa.com** or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-Upon-Thames, Middlesex TW18 3DZ**. If you have any questions about how we handle your information, please contact us at **dataprotection@bupa.com**

Information about Bupa

In this privacy notice, references to 'we' or 'us' or 'our' are to Bupa. Bupa is registered with the Information Commissioner's Office, registration number Z6831692. Bupa is comprised of a number of trading companies, many of which also have their own data protection registrations. For company contact details, visit **bupa.co.uk/legal-notices**

Scope of our privacy notice

This privacy notice applies to anyone who interacts with us in relation to our products and services ('you', 'your'), via any channel (eg email, website, telephone, app etc).

Ways in which we obtain personal information

We obtain personal information from you and from certain third parties (eg those acting on your behalf, like brokers, healthcare providers etc). Where you provide us with information about other individuals, you must ensure that they have seen a copy of this privacy notice and are comfortable with you doing this.

Categories of personal information

We process two categories of personal information about you and/or, where applicable, your dependants, namely standard personal information (eg information we use to contact you, identify you or manage our relationship with you); and special categories of information (eg health information, information about race, ethnic origin and religion that allows us to tailor your care, and information about crime in connection with screening).

Purposes and lawful grounds of our processing personal information

We process your personal information for the purposes set out in our Full Privacy Notice, including to administer our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and in order to protect the rights, property, or safety of Bupa, our customers, or others. The legal ground upon which we process personal information depends on what category of personal information we process. Standard personal information is normally processed by us on the basis that it is necessary for the performance of a contract, our or a third parties' legitimate interests or it is required or permitted by applicable law.

Marketing and preferences

We may use your personal information to send you marketing by post, telephone, social media platforms, email and text. We only use your personal information to send you marketing if we have either your consent or a legitimate interest. If you don't want to receive personalised marketing about similar Bupa products and services that we think are relevant to you, please contact us at **optmeout@bupa.com** or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-Upon-Thames, Middlesex TW18 3DZ**

Processing for Profiling and Automated Decision Making

Like many businesses, we sometimes use automation to provide you with a quicker, better, more consistent and fair service, as well as with marketing information we think will be of interest (including discounts on our products and services). This may involve evaluating information about you and, in some limited cases, using technology to provide you with automatic responses or decisions. You can read more about this in our Full Privacy Notice. You have the right to object to direct marketing and profiling relating to direct marketing. You may also have rights to object to other types of profiling and automated decision-making. Further details are available in our Full Privacy Notice.

Privacy notice – in brief (continued)

Sharing your information

We share your information within the Bupa Group, with relevant policyholders (including your employer if you are covered under a group scheme), with funders commissioning services on your behalf, those acting on your behalf (eg brokers and other intermediaries) and with others who help us provide services to you (eg healthcare providers) or from whom we need information to handle or verify claims or entitlements (eg professional associations). We also share your information in accordance with the law. You can read more about what information may be shared in what circumstances in our Full Privacy Notice.

Transfers outside of the European Economic Area (EEA)

Bupa deals with many international organisations and uses global information systems. As a result, Bupa transfers your personal information to countries outside of the European Economic Area ('EEA'), (the EU member states plus Norway, Liechtenstein and Iceland) for the purposes set out in this privacy policy.

How long we retain your personal information

Bupa retains your personal information in accordance with retention periods calculated in accordance with the criteria detailed in the Full Privacy Notice available on our website.

Your rights

You have rights to have access to your information and to ask us to rectify, erase and restrict use of your information. You also have rights to object to your information being used, to ask for the transfer of information you have made available to us, to withdraw consent to the use of your information and not to be subject to automated decision-making which produce legal effects concerning you or similarly significantly affects you.

Data Protection Contacts

If you have any questions, comments, complaints or suggestions in relation to this notice, or any other concerns about the way in which we process information about you, please contact us at **dataprotection@bupa.com**

You also have a right to make a complaint to your local privacy supervisory authority. Bupa's main establishment is in the UK, where the local supervisory authority is the Information Commissioner, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, United Kingdom. Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

Notes

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Final Checklist

Before you return your form, ensure that you have:

- ✔ included evidence of current underwriting terms
- ✔ included a copy of your current registration certificate held with your current health insurance insurer
- ✔ remembered to sign and date your form
- ✔ kept a copy for your own records.

Send your completed form to.

By post: **Bupa, Anchorage Quay, Salford Quays M50 3XL**

Or by fax: **0161 254 3713**

Once we have received and processed your application you will receive a welcome pack in the post.

Bupa health trusts are administered by:

Bupa Insurance Services Limited. Registered in England and Wales No. 3829851.

Registered office: 1 Angel Court, London EC2R 7HJ

bupa.co.uk

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