Complete your details

Philip Williams Bupa Healthcare Scheme application/amendment form

Underwritten

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK.

Thank you for choosing Bupa. Please complete this application form as fully as possible.

This form is for new members and existing members wishing to add family members.

- It's important you provide us with your medical history. Please fill in your application form and return it to us as soon as you can. Until you've completed this we won't be able to confirm 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.
- Remember to give us as much detail as you can about yourself and any family members you would like to cover. You must take reasonable care to answer all the questions honestly and to the best of your knowledge. By reasonable care we mean not giving false information or keeping necessary information from us. If you don't take reasonable care, we can end your membership or refuse to pay a claim in full or part if there is reasonable evidence that you or a dependant did not take reasonable care in answering our questions.
- The policy you are joining is a fully medically underwritten policy. This means that any symptoms or conditions that have been present prior to the start date of the policy may not be covered, and we may require further medical information to assess your claim, particularly where claims are made early in your policy. Also where this medical information is not provided, we may not be able to process your claim.
- Please note, you can only claim for eligible private medical costs once. This means if you have two policies that provide private medical cover, the cost of your eligible treatment may be split between Bupa and the other insurance company. You will be asked to provide us with full details of any other insurance policy at the time of claim.

Application type

☐ New application ☐ Amendment only

Where to send your completed form

By post: **Philip Williams & Company Insurance Management, 35 Walton Road, Stockton Heath, Warrington WA4 6NW**

For office use only

MIS number

Date application received D D M M Y Y Y Y

Name of the applicant

1. Your Bupa membership

Are you already a Bupa member? ☐ Yes ☐ No

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

2. Your personal details

Please tell us about yourself here.
(To see how we use your information, please read our privacy notice on page 11 .)

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

Surname

First name(s)

Address

Postcode

Telephone number

Mobile number

Email address

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

Occupation (if retired, please state previous occupation)

Your employer

If you would like any members of your family (partner, children etc) to be included in your membership, please go to section 3. If not, go to section 4.

3. 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. Please note that the inclusion of each family member will impact on the subscription you pay for the cover.

	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 Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y 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 sections 4 and 5 for them.

4. Further details

Please answer each question as it applies for yourself and each person named in section 3.
(If you are an existing member and are only adding family members, you do not need to fill out further details or the medical history relating to your own health, only for your family members.)

	Main applicant		Dependant member 2		Dependant member 3		Dependant member 4		Dependant member 5	
	Name		Name		Name		Name		Name	
Full name of applicant										
(Please tick the 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)?										
Have you smoked any tobacco products in the last two years? (over-18s only)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Your medical history – part one

This section asks for health and medical details, past and present, for you and for each person named in section 3. Please tick 'Yes or No' to every question for each person.

For any of the medical conditions or symptoms listed in questions 1 to 16 please indicate if:

- you or anyone to be covered on your membership has seen a GP or other healthcare professional within the last two years
- you or anyone to be covered on your membership 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 applicant		Dependant member 2		Dependant member 3		Dependant member 4		Dependant member 5	
	Name		Name		Name		Name		Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Heart or cardiovascular disorders *eg coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Glandular disorders *eg diabetes, thyroid, hormonal problems*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Breathing or respiratory disorders *eg asthma, bronchitis, shortness of breath, chest infections, colds, flu*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Ears, nose, throat, or eye problems *eg hayfever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Stomach, intestines, liver or gallbladder *eg ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Cancer, tumours, growths, cysts, or moles that itch or bleed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Skin problems *eg eczema, rashes, psoriasis, acne*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Brain or nervous system disorders *eg stroke, migraines, repeated headaches, MS, epilepsy, nerve pain, fits*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Muscle or skeletal problems *eg arthritis, cartilage and ligament problems, back and neck problems, sprains, joint replacements, gout, sciatica*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Urinary problems *eg bladder, kidney or prostate problems, urinary infections, incontinence*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Your medical history – part one (continued)

	Main applicant		Dependant member 2		Dependant member 3		Dependant member 4		Dependant member 5	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Please also answer the following questions:										
11. Blood disorders *eg anaemia, hepatitis, HIV, abnormal blood tests*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Reproductive system problems *eg pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, erectile dysfunction, low sperm count*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Dental problems *eg wisdom teeth, abscess, gingivitis*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Allergies *eg hay fever, pet allergies, food allergies*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Psychological disorders *eg depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Undiagnosed symptoms *eg chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17. Are you or any applicant/member taking any medicines, prescribed or otherwise?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Within the last three months has anyone to be covered experienced symptoms of ANY health problems for which medical advice has not yet been sought?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Has anyone to be covered EVER had any past history of joint replacements, heart conditions, or strokes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Is there any other information relating to your health that has not yet been prompted by the questions listed 1 to 19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 7 and 8 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 member:	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 0 1 0 1 2 0 1 6 Ended D D M M Y Y Y Y
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 (including a GP) in the past two years about this symptom/condition?	2

Example two

Name of member:	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 0 5 0 5 2 0 1 3 Ended 2 0 0 8 2 0 1 5
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 (including a GP) in the past two years about this symptom/condition?	0

5. Medical history – part two (continued)

Name of member:		
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 (including a GP) in the past two years about this symptom/condition?		

Name of member:		
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 (including a GP) in the past two years about this symptom/condition?		

Name of member:		
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 (including a GP) in the past two years about this symptom/condition?		

5. Medical history – part two (continued)

Name of member:		
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 (including a GP) in the past two years about this symptom/condition?		

Name of member:		
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 (including a GP) in the past two years about this symptom/condition?		

Name of member:		
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 (including a GP) in the past two years about this symptom/condition?		

6. Paying for your cover

Subscription quoted	£	Payment is made by monthly/annual direct debit. Please complete the Direct Debit instruction on page 12 of this form.

When would you like your cover to start? (Applications cannot be back dated).

Day	Month	Year

Payment to be taken: ☐ Monthly ☐ Annually

Please note: Although we will try to start your cover on the date indicated above, this cannot be guaranteed. Your start date will be confirmed on your membership certificate.

7. Obtaining medical reports from a GP

When we ask you for your consent to obtain a Medical report from your GP, you/your family member has 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 the 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 the 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 the 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:

(a) it 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.

8. 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 membership 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 membership, and I accept that 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 dependants for the purposes of receiving my quotation and being covered by Bupa and the information contained in this application for Bupa membership 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 membership. I have confirmed the details of my dependants 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 I have not taken reasonable care to answer all the questions in this application for Bupa membership honestly and to the best of my knowledge, Bupa can end my membership or refuse to pay a claim in full or part.
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.
6. I understand that I may cancel my membership for any reason by calling Bupa on **0345 609 0777**† or writing to **Bupa, Anchorage Quay, Salford Quays, Salford M50 3XL** within 21 days of receipt of my policy documents (including membership certificate) confirming my cover, or the start date of my policy whichever is the later. During this period, if you have not made any claims we will refund all of your subscriptions. After this period of time you can cancel your cover at anytime, we will refund any subscriptions you have paid relating to the period after your cover ends.
7. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any family members specified in this form, and on any separate sheet for Bupa to process our personal information with respect to our membership 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 membership, including this medical history 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 within the first 60 months of my membership to support my application and before my 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 and accept the rights I have in relation to reports under the Acts as explained in section 7
- I have shown this declaration to the proposed dependants 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.

† We may record or monitor our calls

Privacy notice – in brief

This privacy notice should be read alongside our full privacy notice. The full notice and a list of the trading companies that make up the Bupa group, can be found at **bupa.co.uk/privacy**. By providing your information, you consent to the use of your data and information as described in the full privacy notice and cookie policy. If we make a change to any of the ways in which we process personal information, we will update this notice on **bupa.co.uk/privacy** so please check back regularly for updates. You can also email **dataprotection@bupa.com** and ask us to send you the latest version at any time.

Personal information

In providing you with our services, Bupa may handle your personal information, which may include sensitive personal information such as medical information. We are very aware that you trust us to keep this information confidential and that is why we comply with UK data protection law and follow medical confidentiality guidelines issued by professional bodies.

Securing information

We are committed to keeping your personal information secure. We have put in place physical, electronic and operational procedures intended to safeguard and secure the information we collect.

Information we may hold about you

The information we hold about you may include personal and sensitive personal information. We may collect this information during contacts we have with you or with third parties who provide information about you, and from other sources including from your use of websites and other digital platforms.

When we collect your information

Information about you is collected when you engage with Bupa or the Bupa group of companies either by entering into a contract with Bupa, submitting a query or enquiry, applying for a quote or policy or participating in marketing activity.

We may collect personal information about you from other people when you are named in an application form or as a dependant under a scheme, when we process an application or claim or when we obtain medical reports, or when we liaise with your family, employer, health professional or other treatment or benefit provider. You confirm that you consent to Bupa obtaining medical and billing information from your treatment provider relating to claims or complaints you may make.

Using your information

We use your personal information to provide you with our services, and to improve and extend our services.

Sharing information

Information about you may be shared by the companies in the Bupa group to enable us to manage our relationship with you as a Bupa customer and update and improve our records. Bupa works with other individuals and organisations to provide our services to you. This may involve them handling your personal information, which may be done outside of the European Economic Area. We ensure that the confidentiality and security of your personal information is protected by contractual restrictions and service monitoring.

You may receive Bupa private medical services where another member of your family is the main member of the scheme or services. In that case we send all membership documents and confirmation of how we have dealt with any claim you make to the main member. You may receive Bupa services where your employer, or the employer of another member of your family, is the policyholder or pays for the scheme or services. In that case, we may share your information with the employer, the employer's insurance broker, or the trustees of your scheme. This will be explained in your policy documents.

In order to detect, prevent and help with the prosecution of financial crime, we may share information with law enforcement agencies and other organisations.

Keeping information

We will only keep your personal information for as long as is necessary and in accordance with UK law.

Keeping you informed

The Bupa group would like to let you know more about our products and services. From time to time we might contact you (by post, email, phone or SMS text) with information we think might interest you. If you do not wish to receive marketing information, or at any time you change your mind about receiving these messages, please contact the Bupa UK Information Governance Team, their contact details can be found below.

Accessing information

If you have any data protection queries, please contact the Bupa UK Information Governance team on **dataprotection@bupa.com** or write to **4 Pine Trees, Chertsey Lane, Staines-upon-Thames TW18 3DZ**.

You should also contact the team if you would like a copy of the personal information we hold about you and to ask us to correct or remove (where justified) any inaccurate information.

Direct Debit instruction

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

Please complete the white areas in BLOCK CAPITALS and BLACK INK to instruct your bank to make payments directly from your account. Then return the completed form to: Philip Williams & Company Insurance Management, 35 Walton Road, Stockton Heath, Warrington WA4 6NW

DIRECT Debit

Originator Identification Number

7	5	3	2	9	4

1. Name and full postal address of your Bank or Building Society branch

To: The Manager

Bank or Building Society

Address

Postcode

2. Name(s) of account holder(s)

3. Branch sort code

– –

4. Bank or Building Society account number

5. Bupa reference/membership number

For Philip Williams & Company Insurance Management OFFICIAL USE ONLY

This is not part of the instruction to your Bank or Building Society

Note to member: Please complete your member/group name below (if applicable)

6. Instruction to your Bank or Building Society

Please pay Philip Williams & Company Insurance Management Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Philip Williams & Co and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date D D M M Y Y Y Y

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

Bank contact address: Philip Williams & Company Insurance Management, 35 Walton Road, Stockton Heath, Warrington WA4 6NW

This guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

DIRECT Debit

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit Philip Williams & Company Insurance Management will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Bupa Insurance Services Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit by Philip Williams & Company Insurance Management or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society. If you receive a refund you are not entitled to, you must pay it back when Philip Williams & Company Insurance Management asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

Should you wish to cancel this instruction through Philip Williams & Company Insurance Management, please call us on 01925 604421†. You must allow a minimum of seven days before the next payment by Direct Debit is due.

†Calls to this number may be recorded and may be monitored.

Final Checklist

Before you return your form, ensure that you have:

- ✔ included full details of all the family members you would like to cover
- ✔ checked with your family members that their details are correct
- ✔ remembered to sign and date your form
- ✔ kept a copy for your own records.

SEND YOUR COMPLETED FORM TO:

Philip Williams & Company Insurance Management,
35 Walton Road, Stockton Health, Warrington WA4 6NW

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

Notes

Notes

Bupa health insurance is provided by:

Bupa Insurance Limited. Registered in England and Wales No. 3956433. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

Arranged and administered by:

Bupa Insurance Services Limited, which is authorised and regulated by the Financial Conduct Authority. Registered in England and Wales No. 3829851.

Registered office: 1 Angel Court, London EC2R 7HJ

bupa.co.uk

FF/5943/FEB18 BUPA 2382