FREEDOM ELITE CORPORATE APPLICATION FORM
(for groups of 10 or more)

ACCEPTED QUOTE REFERENCE:

Each of the following parts should be completed by the Group Secretary or other authorised official and the completed form returned to **Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ**. Any employee wishing to include, at their own expense, further options or cover for dependants (including children) must complete a separate individual application form. Please use **BLOCK CAPITALS**.

About the company

Name of company:

Nature of business:

Address:

Postcode:

Telephone number: (inc. area code)

Fax number:

Email address:

Name of contact:

When would you like your cover to start? D D M M Y Y Y Y

Medical declaration

If you are applying to transfer an existing private medical insurance scheme to Freedom Health Insurance on either Continued Personal Medical Exclusions (CPME) Continued Moratorium (Switch Moratorium or CM) or Medical History Disregarded (MHD), you must confirm and provide us with the following information:

To the best of your knowledge, in the last 3 years have any employees or their dependants to be included had:

1) Any treatment or consultations in relation to any type of cancer **Yes** ☐ **No** ☐

2) Any type of heart or circulatory conditions **Yes** ☐ **No** ☐

3) Any type of psychiatric or mental illness **Yes** ☐ **No** ☐

or

4) Been advised that in the next 12 months they will need, or may need an operation, treatment, tests or investigations as an in/day patient. **Yes** ☐ **No** ☐

If you have answered **yes** to any of the above questions, full details of these conditions must be provided to us on a separate sheet prior to the acceptance of this application.

Declaration

I hereby apply to Freedom Health Insurance for private medical insurance cover, as requested per the quote reference above, on behalf of the employees and their dependants as listed in 'Employees and their dependants to be included' and any continuation pages.

I understand that if this application is for Moratorium Underwriting, pre-existing conditions will be excluded, as appropriate, as described in section 11 (Pre-existing medical conditions) of The Group Member's Guide to Cover, which I have read.

I understand that if this application is for Full Medical Underwriting, pre-existing conditions will be excluded from the cover and each member must complete an Individual Application Form (Moratorium or Full Medical Underwriting) and these will be reviewed and personal exclusions for each member may be applied.

It is accepted that failure to fully disclose shall absolve the Insurer from any future claim liability in respect of the affected member(s).

Current certificates of insurance for each eligible employee must be provided to Freedom Health Insurance.

I declare that to the best of my knowledge and belief the information I have provided in this application is full, true and correct.

Signed: | Date: D D M M Y Y Y Y

Name: | Position:

Note: Policy documents are available on request or can be viewed at **www.freedomhealthinsurance.co.uk**. You are advised to keep a record (including copies of letters) of all information supplied to Freedom Health Insurance. A copy of this application will be supplied to you on request within three months of completion. Completion of this form should not be construed as acceptance of risk by Freedom Health Insurance.

Use of personal information

The personal information you give us on this application form will be used to administer your employees', and their dependants' (if applicable), insurance cover given to them under this group scheme. This includes processing and underwriting each policy to decide if we can offer cover and on what terms, administering each policy and handling any claims, and helping to detect and prevent fraudulent activity.

Personal information may be shared with third parties that help us with the efficient and cost-effective administration of the insurance cover. We may also share personal information with regulatory bodies, other insurers, any broker appointed by the policyholder or third parties appointed by them.

How we use and process personal information is explained in our Privacy Policy which can be found on our website at **freedomhealthinsurance.co.uk/privacy-policy**. Alternatively you can ask us for a copy.

Employees and their dependants to be included

Dependant children to be included must be under 30. Please keep family groups together.

Maximum age of entry is 70 unless agreed by Freedom Health Insurance.

Name	Home Address	Smoker Y / N	Date of Birth	RELATION E – Employee P – Partner D – Dependant	Category 1/2/3

Methods of Payment

Annual Cheque ☐
Please attach the annual cheque payment

Annual Credit Card or Debit Card ☐
Please complete section 1

Direct Debit
Monthly or Annually ☐
Please complete section 2 below

1. Annual Credit Card or Debit Card

Credit/Debit Card authorisation form

Type of card: ☐ Mastercard ☐ Visa ☐ Debit

Name on card:

Card number:

Security number: Expiry date: M M Y Y Y Y

To Freedom Health Insurance
I authorise you, until further notice in writing, to charge my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed: Date: D D M M Y Y Y Y

2. Direct Debit

Monthly ☐ Annually ☐

DIRECT Debit
Originator's Identification Number
9 1 3 0 3 9

Instruction to your Bank / Building Society to pay by Direct Debit to:
Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ.
Please complete parts 1-5 to instruct your Bank / Building Society to make payments directly from your account.

1. Full postal address of your branch

To: Bank/Building Society

Address: Postcode:

2. Bank Sort Code – –

3. Account No.

4. Name of Account Holder

5. Instruction to your Bank or Building Society

Please pay Freedom Health Insurance, 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 Freedom Health Insurance and, if so, details will be passed electronically to my Bank/ Building Society.
Banks and Building Societies may not accept Direct Debit instructions for some types of accounts.

Signed: Date: D D M M Y Y Y Y

The Direct Debit Guarantee

DIRECT Debit

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.

- 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 Freedom Health Insurance will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Freedom Health Insurance 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 Freedom Health Insurance 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 Freedom Health Insurance 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.