Freedom Health Insurance

YOUR CHOICE INDIVIDUAL APPLICATION FORM

(Full Medical Underwriting)

Each of the following parts should be completed by you and the completed form returned to: **Freedom Health Insurance, Bourne Gate, 25 Bourne Valley Road, Poole, BH12 1DY.** Please use **BLOCK CAPITALS**.

About you

Title: (Dr/Mr/Mrs/Miss/Ms/Other)

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y Are you a smoker?: ☐ Yes ☐ No

Occupation:

Address:

Postcode:

Telephone numbers: *(inc. area code)* Daytime: Evening: Mobile:

E-mail address:

Are you to be included in the cover under this Policy ☐ Yes ☐ No

About your family

Please insert details of your partner and any unmarried children you want to include in the policy. Children to be included must be under age 21 (or age 25 if in full time education). If there is insufficient room here for all the dependants you wish to include, please provide details on the back page.

	Forename(s)	Surname	Date of Birth	Occupation	Smoker Y/N*
Partner					
Child 1					
Child 2					
Child 3					
Child 4					

About your General Practitioner

Name:

Address:

Postcode:

Date of first registration with your General Practitioner: D D M M Y Y Y Y

If you have been registered with your GP for less than six months, please provide details of your previous GP.

About your existing Private Medical Insurance Cover

Do you have Private Medical Insurance at the moment? Yes ☐ No ☐

If yes, who are the insurers?

Renewal date? D D M M Y Y Y Y

*** Our definition of smoker is someone who smokes or has, within the last 3 years, smoked cigarettes, cigars, tobacco or a pipe.**

The cover you require

A. IN-PATIENT COVER

Freedom level	Annual in-patient limit	Please tick (one box only)
Gold	£30,000	
Platinum	£50,000	
Diamond	£100,000	
Diamond Plus	No annual benefit limit	

B. OUT-PATIENT COVER (OPTIONAL)

If you choose to include this optional benefit, the annual limit of cover will depend on the level of in-patient cover selected, as follows:

In-patient level	Out-patient cover
Gold	£1,000
Platinum	£1,000
Diamond	£1,250
Diamond Plus*	No annual benefit limit

* Please note out-patient cover is automatically included for Diamond Plus policies

Do you want to include out-patient cover? Yes ☐ No ☐

Your Diamond Plus cover can be upgraded to include the following:

In-patient & out-patient cover ☑
A. Alternative therapies ☐
B. Psychiatric care ☐
C. Rehabilitation benefits ☐

VOLUNTARY EXCESS

You can reduce your premiums by agreeing to a voluntary excess when you take out your policy. This will be IN ADDITION TO the compulsory excess of £100 on each claim.

Do you want to accept a voluntary excess? Yes ☐ No ☐

If yes, please indicate below the level you require.

Excess			Premium Reduction	Please tick (one box only)
Voluntary	Compulsory	Total	%	
£100	£100	£200	7.5%	
£250	£100	£350	12.5%	
£500	£100	£600	17.5%	
£1000	£100	£1100	25%	

Please note that the level of cover and any voluntary excess you select will be the same for all dependants included in your policy.

Premium quoted £

When do you want your cover to start? D D M M Y Y Y Y

Note: Backdating of cover is not allowed.

About your health

A: Please provide body mass details for each member:

Forename	Surname	Weight (kg)	Height (cm)

B: In the previous five years have you or any applicant been diagnosed with, treated for or require any ongoing medical medication or tests for the following conditions?

Cancer, tumours, lumps or growths?	Yes ☐	No ☐
Heart disease, rheumatic fever, chest pain or circulatory problems?	Yes ☐	No ☐
Blood disorders?	Yes ☐	No ☐
Respiratory disorders?	Yes ☐	No ☐
Abdominal/Digestive disorders?	Yes ☐	No ☐
Genito/Urinary disorders?	Yes ☐	No ☐
Musculo-skeletal/Nervous system disorders?	Yes ☐	No ☐
Gynaecological disorders?	Yes ☐	No ☐
Ear, nose & throat disorders?	Yes ☐	No ☐
Neurological or mental disorders?	Yes ☐	No ☐
Eye Disorders?	Yes ☐	No ☐
Skin Disorders?	Yes ☐	No ☐
Any operations, special investigations?	Yes ☐	No ☐

C: Have you ever been treated or been recommended for treatment for the use of alcohol or drugs? Been advised to stop/reduce the amount of alcohol intake or ever been convicted of any drug related offences? Yes ☐ No ☐

D: In the previous five years have you been advised to obtain treatment in a hospital or a clinic for any tests, x-rays, treatment or procedures whic are not covered within any other questions on this medical questionnaire? Yes ☐ No ☐

E: Are you aware of any tests, treatment, or specialist consultations that may be necessary within the following two years? Yes ☐ No ☐

F: Do you have any unusual disorders, deformities or disabilities which are not covered within any other questions on this medical questionnaire? Yes ☐ No ☐

G: Have you ever been declined for any life or health insurance products (inc, refusal of a renewal)? Yes ☐ No ☐

H: Have you undergone a surgical operation or have reason to believe that a surgical procedure will be required in the future? Yes ☐ No ☐

If any member to be insured on this application form answers 'Yes' to any of the questions above please give full details.
Please note: You should declare all medical conditions or symptoms even if they do not become apparent in the above questionnaire.

Applicant Name:	
Details of condition/symptom, medication and/or treatment received. Please Include dates	
Initial Symptom Date	
Details of ongoing tests, medication and treatment required. Please Include dates	

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Medical Consent

In order to administer your policy, it may be necessary to request your medical notes, a medical report or any other additional information from your doctor. In order to do this, we need your consent and a signed declaration.

By signing the declaration you and your adult dependents will give us permission to obtain additional information.

The Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 you have specific rights which are outlined below:

a) You have the right to see the completed report before it is sent to us. If you wish to see the report you have 21 days to arrange this with your doctor. However, please note that we can only authorise treatment once we have received all required information.

b) You can request that your doctor amends any part of the report that you consider to be incorrect or misleading. If your doctor does not agree to amend certain parts, you may attach your comments.

c) You may request to see a copy of your report up to six months after we have received it. Your doctor can arrange this for you and may charge a fee to cover the cost.

d) Your doctor may decide that in the interest of your health, or the health of others, you should not see all or part of the report. If your doctor does not let you see any part of the report, he/she must notify you of the fact.

e) You have the right to withhold your consent. However, in this case we may not be able to proceed with your claim.

Declaration

I declare to the best of my knowledge and belief the information given on this form is true and correct.

I have been informed and I understand my statutory rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. In connection with the insurance submitted, I hereby consent to Freedom Health Insurance seeking medical information from any doctor who at any time, has attended me concerning anything which affects my physical and/or mental health, and that this information shall be passed to Freedom Health Insurance administrators. I agree that a copy of this consent shall have the validity of the original.

I do/do not* wish to see any report before it is sent to Freedom Health Insurance (*Delete as appropriate).

Proposers Signature:

Date: D D M M Y Y Y Y

Name in capitals:

Declaration

I/We hereby apply to be covered under the selected Freedom Health Insurance Your Choice Policy together with the dependants listed in this application.

I/We declare that the statements made on this application form and any additional information supplied as part of this application is full and accurate. Failure to take reasonable care in answering any questions may result in a claims being declined, your or any applicants underwriting terms being changed or the cover being cancelled.

I/We shall read the Policy documents when I receive them and agree that I, and any other dependants included in this application, will be bound exclusively by the terms and conditions of the Policy. This agreement shall constitute the entire agreement between the parties.

I/We understand and accept the information provided in the underwriting section of the Your Choice brochure.

I/We understand that this application is subject to acceptance by Freedom Health Insurance and the medical information provided may result in a Policy endorsements being applied or in some circumstances Freedom Health Insurance being unable to offer cover.

Proposers Signature:

Date: D D M M Y Y Y Y

Name in capitals:

* This must be dated: a) prior to the start date of the policy b) not more than 30 days in advance of the start date.

Note: A specimen copy of the policy is available on request. You are advised to keep a record (including copies and 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

Personal information given on this application form will be used to administer your insurance policy. This includes underwriting your policy to decide what cover we can offer, administering your policy and handling claims, and helping to detect and prevent fraud.

Personal information may be shared with third parties that help us administer your policy. We may also share personal information with regulatory bodies, medical professionals involved in your treatment, and any broker acting on your behalf.

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

Marketing choices

☐ From time to time, we would like to tell you about products and services that may be of interest to you. If you would like to receive this information, please tick this box. You can unsubscribe at any time by contacting us at dataprotection@freedomhealthinsurance.co.uk.

(For office use only)

Agency name/number

Consultant Name

Where shall we send the documents? Direct to client ☐ Direct to you to forward ☐ To you and your client ☐

Methods of payment

Annual Cheque	☐	Please attach the annual cheque payment
Direct Debit - Monthly or Annually	☐	Please complete a separate direct debit mandate

2. Direct Debit

Monthly ☐ Annually ☐

Originator's Identification Number

9	1	3	0	3	9

Instruction to your Bank / Building Society to pay by Direct Debit Freedom Health Insurance, Bourne Gate, 25 Bourne Valley Road, Poole BH12 1DY.

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. Bank/Building Society 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.

Bank 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

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.