freedom health insurance

FREEDOM ELITE INDIVIDUAL APPLICATION FORM

(Continued Personal Medical Exclusions (CPME) & Continued Moratorium)

Each of the following parts should be completed by you and the completed form returned to: Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ. Please use BLOCK CAPITALS.

Maximum age of entry 70

About you

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

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y

Occupation:

Address:

Postcode:

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

Mobile number:

Email address:

Are you a smoker? ☐ Yes ☐ No

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

Start date: D D M M Y Y Y Y

About your family

	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

About your existing Private Medical Insurance Cover

Who are the insurers?

Renewal date? D D M M Y Y Y Y

The cover you require Please select only one option in each section.

Core Benefits	☑
Limited outpatient cover – £1,500	☐
Full outpatient cover	☐
Alternative therapies – £750	☐
Alternative therapies – £1,500	☐
Psychiatric care	☐
Dental, optical and private GP (£50 excess)	☐

Hospital List

Standard List	☐
London Plus Hospital List	☐

Voluntary Excess

Do you require an excess?

Yes ☐ No ☐

If Yes, please choose appropriate selection from the table:

Excess Per Year	Premium Reduction %	Please Select
£100	10%	
£250	15%	
£500	22.5%	
£1,000	35%	

Medical Declaration

Please answer the questions below for every applicant:

1) Do you or any applicant have any consultations, investigations or treatment planned or pending in the next 12 months (NHS or Private)? Yes ☐ No ☐

2) Have you or any applicant had any consultations, investigations or treatment in the last 12 months (NHS or Private)? Yes ☐ No ☐

3) Have you or any applicant ever been treated for, diagnosed with, or advised they have a heart condition, cancer or mental illness? Yes ☐ No ☐

If you have been able to answer 'no' to all of these questions, we will offer cover on a continuation basis from your previous insurer. If your current cover is on a Moratorium basis, we will transfer the start date of your previous Moratorium to your new Freedom Elite policy. If your current cover is on a Full Medical Underwriting basis, we will transfer any personal exclusions applied by your previous insurer and will not add further personal exclusions to the Freedom Elite plan.

If you have answered 'yes' to any of the questions, we may not be able to offer cover on a continuation basis from your previous insurer without applying new or additional exclusions to your Freedom Elite policy. Please contact us to discuss your application. If you, or your broker, has already been provided with an underwriting reference number, please enter it here: MUR

Declaration

I/We hereby apply to be covered under the selected Freedom Health Insurance Elite 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 claim being declined, your or any applicant's 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 section 11 (Pre-existing medical conditions) of The Policyholder's Guide to Cover.

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

Please provide your previous Certificate of Insurance including endorsements.

Proposer's Signature: ____________

Date*: D D M M Y Y Y Y

* 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: 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

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.

Methods of Payment

Annual Cheque	☐	Please attach the annual cheque payment
Annual Credit Card or Debit Card	☐	Please complete section 1 below
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

Originator's Identification Number

9	1	3	0	3	9

Monthly ☐ Annually ☐

Instruction to your Bank / Building Society to pay by Direct Debit
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. 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.

Freedom Health Insurance is a trading name of Freedom Healthnet Limited.
Freedom Healthnet Limited is authorised and regulated by the Financial Conduct Authority with the registration number 312282.
Registered address: County Gates House, 300 Poole Road, Poole, BH12 1AZ. Company registration number: 04815524.