

## **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 is 70

About you						
Title:			_			
Forename(s):						
Surname:						
Date of birth:  Maximum age of entry is 70						
Occupation:						
Address:						
Postcode:						
Telephone numbers (inc. area code):	Landline:	Landline: Mobile:				
Email address:						
Are you to be included in the cover under this policy? When would you like your cover to start?	Yes No D D M M Y Y Y					
About your family  If you require further dependants to be	e covered please use a separ	ate sheet. <b>Maximum age</b>	of entry is 70			
Forename(s)	Surname	Date of birth	Occupation			
Partner						
Child 1						
Child 2						
Child 3						
Child 4						
About your General Practition	oner (GP)					
Name:						
Address:						
		Po	ostcode:			
Date of first registration with your General Practitioner:						

About your existing Private Medical Insurance cover									
Who is the insurer?									
Renewal date?									
The cover you require									
Core cover - included as standard									
Please choose from any a	additional op	tions below:							
Outpatient cover									
Limited outpatient cover -	£1,500								
<b>or</b> Full outpatient cover									
·									
Alternative therapies  Alternative therapies - £79	50								
or									
Alternative therapies - £1,	500								
Further cover options:									
Psychiatric care									
	Dental, optical and private GP (£50 compulsory excess applies)								
Hospital list:									
Standard hospital list									
or									
London Plus hospital list e (includes all HCA Healthcare									
Voluntary excess									
Do you require an excess?	?	Yes			No				
If yes, what level of volunt	ary excess do	you require	?						
Excess per year	Premium red	duction %	Please tick	(one bo	ox only)				
£100	10%								
£250	15%								
£500	22.5%					-			
£1,000	35%								
Medical declaration	า								
Please answer the question	ons below for	every applica	ant:						
1: Do you or any applicant have any consultations, investigations or treatment planned or pending in the next 12 months (NHS or Private)?									
2: Have you or any applicant had any consultations, investigations or treatment in the last 12 months (NHS or Private)?									
3: Have you or any applic heart condition, cancer			diagnosed v	vith, or	advised t	they have a		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 and/or your broker have 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 claims being declined, your or any applicant's underwriting terms being changed or the cover being cancelled.

I/We will advise if there are any changes to the information given on this form between the date it is signed and the start date of the Freedom Elite policy cover.

I/We shall read the policy documents when I/we receive them and agree that I/we, 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 policy endorsements 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 Date*	: D D	M	1	Y	Y	Y	Y
signature:							

**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.

datap	rotection@freedomhealthinsurance.co.uk.				
Applicant's signature:		Date: D	М	YYYY	′

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

Annual cheque Please attach the annual cheque payment	Credit card or debit c		Direct Debit Please complete	e section 2 below
Credit card or debit card				
Credit/debit card authorisation form				
Monthly Annually				
Type of card:	Mastercard	Visa		Debit
Name on card:				
Card number:				
Security number:		Expiry date:	MM	YYYY
To Freedom Health Insurance I authorise you, until further notice in wr premiums as and when they become du		/isa account with ur	nspecified amou	nts in respect of
Signed:		Date: D D	M	YYYY
2. Direct Debit  Monthly  Instruction to your bank/building socie Freedom Health Insurance, County Gate Please complete parts 1-5 to instruct you  1. Name and full postal address of you	s House, 300 Poole Road, Poole ur bank/building society to mak		from your accou	Service User Number 9 1 3 0 3 9
To:				Bank/Building Society
Address:				
			Postcode:	
2. Branch sort code:				
3. Account number:				
4. Name of account holder:				
5. Instruction to your bank or building Please pay Freedom Health Insurance, Direct Debit: I understand that this Instruction may remain with F Banks and building societies may not accept Direct	s from the account detailed in this Instructive reedom Health Insurance and, if so, deta	ils will be passed electror	,	
Signed:		Date: D D	ММ	Y   Y   Y   Y   Y
The Direct Debit Guarantee Banks and building societies may not accept Dire	ct Debit Instructions for some types of	account.		DIRECT

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.

Methods of payment