HEALTH SHIELD CORPORATE APPLICATION PLEASE FILL IN AND SIGN THIS APPLICATION FORM

NW3

PART A (PLEASE USE BLOCK CAPITALS)

1 YOUR DETAILS

I WANT TO BECOME A NEW HEALTH SHIELD CORPORATE MEMBER ☐ I WANT TO CHANGE MY LEVEL OF CONTRIBUTION ☐

MEMBER NUMBER (if known)

PLEASE CIRCLE MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

FULL POSTAL ADDRESS

POSTCODE

YOUR PAYROLL NUMBER

DAYTIME TELEPHONE NUMBER

EMAIL ADDRESS

I WANT TO BE PAPERLESS, PLEASE SEND ALL MY HEALTH SHIELD MEMBERSHIP INFORMATION BY EMAIL. YES ☐ NO ☐

2 PLEASE TICK THE LEVEL YOU HAVE CHOSEN AND INDICATE WHETHER YOU REQUIRE COVER FOR YOU OR YOU AND YOUR PARTNER

ACCESS LEVEL	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	PRESTIGE	YOU	YOU & PARTNER
☐	☐	☐	☐	☐	☐	☐	☐

3 YOUR PARTNER'S DETAILS

(Only fill in section 2 if you want Cover for You and Your Partner)

PLEASE CIRCLE MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

4 DEPENDENT CHILDREN COVERED BY YOUR MEMBERSHIP

(If you have more than three children please give their details on a separate sheet and provide it with your application).

SURNAME

FORENAME(S)

DATE OF BIRTH MALE ☐ FEMALE ☐

SURNAME

FORENAME(S)

DATE OF BIRTH MALE ☐ FEMALE ☐

SURNAME

FORENAME(S)

DATE OF BIRTH MALE ☐ FEMALE ☐

5 MEDICAL HISTORY

Health Shield does not cover any pre-existing medical conditions that have arisen before the time of joining or increasing cover.

Examples of pre-existing medical conditions that may lead to the exclusion of certain benefits are as follows: diabetes, epilepsy, respiratory conditions (e.g. asthma), skin disorders (e.g. eczema, psoriasis), arthritis, heart problems (e.g. angina), circulatory problems (e.g. thrombosis), gynaecological disorders, digestive disorders (e.g. liver, bowel or stomach), kidney disorders, cancer, back/neck/shoulder problems, or mental or physical disability.

Have you (or your partner or dependent children where applicable) ever suffered from a medical condition?

YES ☐ If you tick the 'YES' box, we will send you a health declaration form to request further information.

NO ☐ By ticking the 'NO' box, you declare that you (or your partner or dependent children where applicable) have not:

- received medication, advice or treatment
- experienced symptoms

for any disease, illness or injury, whether the condition has been diagnosed or not before the start of your cover.

6

I agree to abide by the rules of membership described in Health Shield's memorandum and rules, the terms and conditions of my membership plan, and with regard to the key facts document applicable to my scheme. I accept Health Shield's right to vary any of the rules and regulations it considers necessary, and that I will be informed of any changes applicable to my membership. I accept that Health Shield's benefits, benefit levels and contribution rates may also change in future years. I give my consent to all processing of personal and sensitive data. I declare that all of the information I have provided is accurate, true and complete to the best of my knowledge and belief.

SIGNATURE

DATE / /

Health Shield can use my details to inform me about new products and services that are available. Please tick box if you do not require further information. ☐

MOISTEN AND SEAL

HEALTH SHIELD CORPORATE PAYROLL DEDUCTION AUTHORISATION

PART B (PLEASE USE BLOCK CAPITALS)

1 YOUR EMPLOYER'S DETAILS

FULL NAME OF YOUR EMPLOYER

WORK LOCATION

FULL POSTAL ADDRESS OF PAY CENTRE

POSTCODE

TELEPHONE NUMBER

2 PLEASE TICK THE LEVEL YOU HAVE CHOSEN AND INDICATE WHETHER YOU REQUIRE COVER FOR YOU OR YOU AND YOUR PARTNER

ACCESS LEVEL	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	PRESTIGE	YOU	YOU & PARTNER
☐	☐	☐	☐	☐	☐	☐	☐

I AM PAID WEEKLY ☐ FOUR-WEEKLY ☐ MONTHLY ☐

THIS IS A CHANGE TO MY PREVIOUS HEALTH SHIELD DEDUCTIONS YES ☐ NO ☐

PLEASE CIRCLE MR, MRS, MS, MISS

YOUR SURNAME

YOUR FORENAME(S)

YOUR PAY OR EMPLOYEE NUMBER

I authorise you to deduct, and pay to Health Shield, the appropriate amount corresponding to my level of cover, or any other contribution that may later apply.

SIGNATURE

DATE / /

OFFICE USE ONLY

Employee's Payroll Number

Total amount to be paid

Weekly

Four-weekly

Monthly

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