

This application can only be used to apply to join BUPA via SHS Consulting and must not be used for any other purpose. Please complete all relevant sections on pages 1,2 and 3 of the form in BLOCK CAPITALS, sign, date and return it to **SHS Consulting**.

## Page 1

### 1 Your personal details

Title	Surname
Forename	Initials
Address	
Postcode	Are you a smoker? Yes <input type="checkbox"/> No <input type="checkbox"/>
Tel no. Day	Evening
Date of birth	day     month     year
Occupation	Self-employed <input type="checkbox"/>
BUPA membership number (If existing member)	

If you are eligible to join a BUPA Group please state the name of the organisation

**mystaffbenefits@shsconsulting.com (3188819-1100)**

Preferred start date | | | | Subscription quoted £ | | | |

### 2 Your choice of scheme

SCHEME REQUIRED	COVER/EXCESS OPTIONS (please tick)						
	Scale (A/B/C)	No Excess	£100	£150	£200	£250	£500
BUPACare							

**METHOD OF PAYMENT**

	Monthly	Annually
Card payment*	<input type="checkbox"/>	<input type="checkbox"/>
Variable direct debit*	<input type="checkbox"/>	<input type="checkbox"/>
Cheque (made payable to BUPA)	N/A	<input type="checkbox"/>

\* Please complete the relevant payment authority on page 3.

### 3 Your family's details *Please give details of all other people to be covered - adults first, then children in descending order of age.*

Forename, other initials and surname	Relationship to you (wife/husband, son/daughter etc.)	Date of birth			Does he/she smoke?	
		DAY	MONTH	YEAR	YES	NO
1						
2						
3						
4						

Please include any additional dependants on a separate sheet and indicate that you have done so by ticking this box:

### 4 Confidential medical history

Please complete this section in BLOCK CAPITALS. PART A

Please consider the following five questions as they apply to each of the people named. Answer each question by clearly ticking one of the corresponding numbered boxes shown under the heading "Yes" or "No".	APPLICANT		1ST DEPENDANT		2ND DEPENDANT		3RD DEPENDANT		4TH DEPENDANT	
	Name	Name	Name	Name	Name	Name	Name	Name	Name	Name
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
1. Has any in-patient stay in a hospital or nursing home taken place within the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any consultant been consulted within the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any general practitioner been consulted and/or provided prescriptions for any drugs or medication within the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does any chronic/long-term medical or dental condition exist or is there any other known disability, abnormality, or recurrent illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there any known or foreseeable need to consult any doctor or other health professional (see below*)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Please ensure that you fully disclose any known or suspected conditions and any symptoms experienced by anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, bunions, piles, gynaecological problems (including any irregularities of menstruation), any ear, nose or throat problems, or any pains, swellings or lumps.

I declare that to the best of my knowledge and belief all the information I have given on this page 1 of 2 of the application form is true and complete and I have confirmed the family details with the respective family members and I confirm that I have read and signed section 5 on page 2.

Your Signature  Date

Confidential medical history continued

**PART B**

This part applies if you have indicated any "Yes" replies in PART A on Page 1. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use Column 3 to list them separately and give the further detailed information required by Columns 4 to 6.

1. Name	2. Relevant box nos.	3. Medical condition	4. Previous treatment and consultation (with dates)	5. Needs for any future treatment or consultation	6. Present state of health

If there is insufficient space please use a separate sheet and indicate that you have done so by ticking this box:

**5 Declaration**

**Important:** please read this declaration carefully before signing and dating the completed form.

*In view of this declaration it is essential that complete information is supplied. Benefits may not be payable if you do not fully disclose any material facts. If you are unsure whether any facts are material, you should disclose them. (A material fact is any information about yourself or your family members that might influence our assessment or acceptance of your BUPA membership - such as the terms of cover we offer you, your subscription amount or whether we offer cover at all). You must make sure that any details provided about your family members are correct. You are advised to keep a record of all information you supply to us in connection with this application, including letters. If you would like a copy of this application form please ask us.*

*It is BUPA's intention to provide a first class service to our members at all times. If you do have cause for dissatisfaction you may write to the Head of Customer Relations at BUPA, Staines, TW18 4XF. They will consider your complaint and can provide you with full details of our internal complaints process and details of the independent resolution scheme available to you.*

*Unless otherwise agreed between us in writing English Law shall apply.*

**Your declaration**

I agree that I and my family members specified in this form, and on any separate sheet, will be bound by the rules and table of benefits of the scheme I have indicated in section 2 above and accept they shall be the basis upon which benefits shall be payable under the scheme (a copy of the membership guide is available on request and will be sent to you on joining). I understand and accept that there is no undertaking to cover any medical conditions in existence before the time I, or my family members, are covered by the scheme.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any family members specified in this form, for BUPA to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

I declare that to the best of my knowledge and belief, all the information I have given in this application form is true and complete and that I have confirmed the family details with the respective family member.

I agree that I will inform BUPA if any of the details given in this application form change.

I understand that I will have the option of cancelling the contract as long as I do so in writing within 21 days of me receiving my first membership certificate.

On the basis of this legal declaration I now apply for membership.

Your signature X	Date X
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**BUPA Data Protection Notice**

**Confidentiality:** The confidentiality of patient and member information is of paramount concern to the companies in the BUPA group. To this end, BUPA fully complies with Data Protection Legislation and Medical Confidentiality Guidelines.

**Medical Information:** Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your GP, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents.

**Member details:** All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.

**Telephone calls:** In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

**Research:** Anonymised or aggregated data may be used by BUPA, or disclosed to others, for research or statistical purposes.

**Regulation:** BUPA is a member of the General Insurance Standards Council, which regulates the Insurance Activities of its members. Personal data may be disclosed to GISC as part of this system of regulation. Such data will be subject to a duty of confidentiality on the part of GISC.

**Fraud:** Information may be disclosed to others with a view to preventing fraudulent or improper claims.

**Names and Addresses:** BUPA does **not** make the names and addresses of members or patients available to other organisations.

**Keeping you informed:** BUPA would, on occasion, like to keep you informed of BUPA products and services which it considers may be of interest to you.

**Contact Address:** If you do not wish to receive information about BUPA's products and services, or have any other Data Protection queries please write to the BUPA Group Information Protection Manager, at BUPA House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@BUPA.com.

