



BUSINESS HEALTH PLANS EMPLOYEE APPLICATION FORM

A COLLABORATION BETWEEN TWO OF THE MOST RESPECTED NAMES IN GLOBAL HEALTHCARE

Bupa Global is the sole insurer of this plan.

Bupa Global is a trade name of Bupa, the international health and care company. Bupa is an independent licensee of Blue Cross and Blue Shield Association. Bupa Global is not licensed by Blue Cross and Blue Shield Association to sell Bupa Global/Blue Cross Blue Shield Global co-branded products in Argentina, Canada, Costa Rica, Panama, Uruguay and US Virgin Islands. In Hong Kong, Bupa Global is only licensed to use the Blue Shield marks. Please consult your policy terms and conditions for coverage availability. Blue Cross and Blue Shield Association is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies. Blue Cross Blue Shield Global is a brand owned by Blue Cross and Blue Shield Association. For more information about Bupa Global, visit bupaglobalaccess.com, and for more information about Blue Cross and Blue Shield Association, visit www.BCBS.com.

IMPORTANT INFORMATION

This application form is for employees and eligible dependants who are applying to join Bupa Global or to amend an existing membership.

The start date will generally be the date on which your completed application form is received and accepted by us. If you require a different start date in the future, please complete the start date box in section 1.

You can type directly into this form, alternatively please write clearly in block capitals using black ink. Please return this form to your company's Group Administrator.

If you do not take reasonable care to provide us with full, complete, and accurate information about yourself or any other person covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

You must tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may mean we are unable to pay your claims.

Please note that **MA** is for the employee and 1,2,3,4 is for dependants.

We will not be able to process your application if this form is incomplete. Please be sure to check the entire form.

If you have any questions when completing this form, please contact your group administrator or call us at 0044 (0) 1273 323 563.

CHECKLIST - PLEASE MAKE SURE:

IF THIS IS A NEW GROUP APPLICATION OR A NEW JOINER TO AN EXISTING GROUP PLAN

- | | |
|---|-----------------------|
| Your Group Secretary has completed section 1 | <input type="radio"/> |
| To add dependants: complete sections 4, 5, 6 and 7 | <input type="radio"/> |
| You have read, signed and dated the declaration in section 10 | <input type="radio"/> |

IF YOU WANT TO AMEND YOUR EXISTING MEMBERSHIP

- | | |
|---|-----------------------|
| Your Group Secretary has completed section 1 | <input type="radio"/> |
| To add dependants: complete sections 4, 5, 6 and 7 | <input type="radio"/> |
| To upgrade your cover: complete sections 5, 6 and 7 | <input type="radio"/> |
| To include US cover: complete section 8 | <input type="radio"/> |
| You have read, signed and dated the declaration in section 10 | <input type="radio"/> |

BRAILLE, LARGE PRINT OR AUDIO

We want to make sure that members with special needs are not excluded in any way. We also offer a choice of Braille, large print or audio for our forms, letters and literature. Please let us know which you would prefer.

Group name

Group number

Cover start date*

D D M M Y Y Y Y

*Cover cannot start between 28th and 31st inclusive

PLAN INFORMATION

Please choose the health plan(s) that you wish to purchase.

Choose Health Plan	Choose Deductible	Choose Optical & Dental	Choose Maternity	Choose U.S. cover
<input type="radio"/> Business Health Select Plan	<input type="radio"/> £0 <input type="radio"/> £250 / \$390 / €325 <input type="radio"/> £500 / \$780 / €650 <input type="radio"/> £1,000 / \$1,550 / €1,300	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<input type="radio"/> Business Health Premier Plan	<input type="radio"/> £0 <input type="radio"/> £250 / \$390 / €325 <input type="radio"/> £500 / \$780 / €650 <input type="radio"/> £1,000 / \$1,550 / €1,300	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<input type="radio"/> Business Health Elite Plan	<input type="radio"/> £0 <input type="radio"/> £250 / \$390 / €325 <input type="radio"/> £500 / \$780 / €650 <input type="radio"/> £1,000 / \$1,550 / €1,300	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<input type="radio"/> Business Health Ultimate Plan	<input type="radio"/> £0 <input type="radio"/> £500 / \$780 / €650 <input type="radio"/> £1,000 / \$1,550 / €1,300 <input type="radio"/> £2,000 / \$3,100 / €2,600	✓ Included	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

UNDERWRITING TERMS

Please tick the underwriting terms to be applied to this application. If you are unsure of the underwriting terms agreed for this group plan please contact us.

Full Medical Underwriting:

Unless a pre-existing condition or related condition is fully disclosed on our application form and we have not expressly excluded it, benefit will not be payable. Any specific exclusion(s) will be detailed on the insurance certificate issued in our member welcome pack. Please complete the medical questions and history in section 7.

☐

Continued Personal Medical Exclusions:

This is where underwriting terms from your previous insurer are carried over to your Bupa Global Plan. Please complete the medical questions and history in section 8.

☐

GROUP SECRETARY DECLARATION

I confirm that I am authorised to sign on behalf of the company and that all applicants named in this application are eligible to join the plan and do not contribute to the cost, which is borne by the employer.

GROUP SECRETARY SIGNATURE

DATE

Print full name

Position

Bupa Global membership number BI - - -

(to be completed if you are an existing member)

[illegible]

Your personal details

[illegible]

Your contact details

[illegible]

Residency address (your permanent or usual address in the country where you are a resident, on the day you would like the policy to start)

[illegible]

Correspondence address (if your correspondence and residency address are the same please tick here ☐)

[illegible]

Complete this section if **Full Medical Underwriting** has been selected in section 1 of this form.

If you are upgrading to U.S. cover following the commencement of your policy, please go to section 8.

This section asks for health and medical details, past and present about yourself and each person named in section 4.

Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in section 7.

If you do not provide us with full details, we may terminate your cover, or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

You must also tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may also result in termination, rejection of claims and/or changes to the terms and conditions of your policy.

M	1	2	3	4
---	---	---	---	---

Please tick either Yes or No to each of these questions

1. Within the last 3 years, has any applicant seen a doctor or other healthcare professional for:

☐ any recurrent or persistent medical condition or symptoms?
(Persistent meaning for 2 weeks or more)

Y N

Y N

Y N

Y N

Y N

☐ any abnormal tests or results?

Y N

Y N

Y N

Y N

Y N

2. In the last 7 years, has any applicant been admitted to hospital, had an operation, procedure or investigation (e.g. a scan/blood tests).

Y N

Y N

Y N

Y N

Y N

3. Is any applicant taking any medication, prescribed or otherwise?

Y N

Y N

Y N

Y N

Y N

4. Does any applicant have any medical devices (e.g. shunts for draining fluids from the brain, pins and plates for broken bones) currently in their body?

Y N

Y N

Y N

Y N

Y N

5. Has any applicant (at any time in the past) had a history of:

☐ cancer, including benign brain tumours

Y N

Y N

Y N

Y N

Y N

☐ heart condition

Y N

Y N

Y N

Y N

Y N

☐ stroke

Y N

Y N

Y N

Y N

Y N

☐ joint replacements

Y N

Y N

Y N

Y N

Y N

6. Has any applicant experienced any signs or symptoms of any medical problems, illnesses, or injuries not already disclosed, regardless of whether a doctor or other healthcare professional has been consulted.

Y N

Y N

Y N

Y N

Y N

5

MEDICAL QUESTIONS AND HISTORY – FULL MEDICAL UNDERWRITING (continued)

M

1

2

3

4

Please tick either Yes or No to each of these questions

7. Do you have any planned or pending treatment, investigations or tests?

Y N

Y N

Y N

Y N

Y N

Further details (for over 16s only):

How tall are you?

☐

feet/inches

☐

metres/centimetres

How much do you weigh?

☐

stones/pounds

☐

kilograms

6

MEDICAL QUESTIONS AND HISTORY – CONTINUED PERSONAL MEDICAL EXCLUSIONS

Complete this section if **Continued Personal Medical Exclusions** has been selected in section 1 of this form.

If you are upgrading to U.S. cover following the commencement of your policy, please go to section 8.

This section asks for health and medical details, past and present about yourself and each person named in section 4.

Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in section 7.

If you do not provide us with full details, we may terminate your cover, or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

You must also tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may also result in termination, rejection of claims and/or changes to the terms and conditions of your policy.

M

1

2

3

4

Please tick either Yes or No to each of these questions

1. Have you ever suffered from any form of:

☐ cancer, including benign brain tumours

Y N

Y N

Y N

Y N

Y N

☐ heart condition

Y N

Y N

Y N

Y N

Y N

☐ stroke

Y N

Y N

Y N

Y N

Y N

☐ psychiatric condition

Y N

Y N

Y N

Y N

Y N

2. Have you had a joint replacement or spinal surgery?

Y N

Y N

Y N

Y N

Y N

3. Have you made a claim under your existing insurance in the last 12 months?

Y N

Y N

Y N

Y N

Y N

6

MEDICAL QUESTIONS AND HISTORY – CONTINUED PERSONAL MEDICAL EXCLUSIONS (continued)

4. Do you have any long-term conditions which require regular treatment and reviews with a doctor?

Y N

Y N

Y N

Y N

Y N

5. Do you have any planned or pending treatment, investigations or tests?

Y N

Y N

Y N

Y N

Y N

7

MEDICAL QUESTIONS AND HISTORY: ADDITIONAL INFORMATION

This section applies if you, or anyone to be covered under this plan, has indicated Yes to any medical questions in section 5 or 6. If you are unsure whether any details are relevant, you must include them.

Please attach medical reports or test results relating to the medical conditions you have declared if these are available.

Is additional medical information included?

Y

N

Main Applicant or dependant	The relevant question number from section 5 or 6	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (e.g., right leg, left eye).	When were symptoms first experienced and when was treatment completed (if applicable)?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?
M					
1					
2					
3					
4					

If there is insufficient space, please use the "Notes" section at the end of this form and indicate that you have done so by ticking here ☐

If you are completing this form to upgrade to U.S. cover after your policy has started, you should complete this section instead of section 5 Medical history – Full Medical Underwriting or section 6 Medical history – Continued Persons Medical Exclusions and section 7 additional information. Medical underwriting will be undertaken at the point of application to upgrade cover to include U.S. Exclusions may be applied to U.S. cover.

Please tick either Yes or No to each of these questions

Your anticipated length of stay in the U.S.

Do you have any ongoing or planned treatment? If yes, please provide details below

FEMALES ONLY: Are you currently pregnant?

M	1	2	3	4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

Last updated: May 2023

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you and how we use and protect it. It also provides information about your rights. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details in our full privacy notice available at: www.bupaglobal.com/privacypolicy. If you do not have access to the internet and would like a paper copy of the full privacy notice, or if you have any questions about how we handle your information, please contact the Bupa Global service team on +44 (0) 1273 323 563. Alternatively, you can email or write to the team via info@bupaglobal.com or Bupa Global, Victory House, Trafalgar Place, Brighton BN1 4FY, United Kingdom.

Information about Bupa Global

In this privacy notice, “we” “us” and “our” means the Bupa companies trading as Bupa Global. For details of these companies visit www.bupaglobal.com/legal-notice

The Bupa companies that process your information will depend on which of our products and services you ask us about, buy or use. For our insurance policies, your information will be processed by the insurer and the lead administrator of your policy who may share it with other Bupa companies as set out in the ‘Sharing your information section’. Please refer to your policy documentation for confirmation of the insurer and lead administrator.

1. What this privacy notice covers

This privacy notice applies to anyone who interacts with us about our products and services (“you”, “your”), in any way (for example email, website, phone, app and so on).

2. How we collect personal information

We collect personal information from you and from other organisations (for example those acting on your behalf, like brokers, healthcare providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

3. Categories of personal information

We process the following categories of personal information about you and, if it applies, your dependants. This is standard personal information (for example information we use to contact you, identify you or manage our relationship with you), special categories of information (for example health information, information about race, ethnic origin and religion

that allows us to tailor your care), and information about any criminal convictions and offences (we may get this information when carrying out anti-fraud or anti-money-laundering checks or other background screening activity).

4. What we use personal information for and our legal reasons for doing so

We process your personal information for the purposes set out in our full privacy notice, including to deal with our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and to protect our rights, property, or safety, or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process. We normally process standard personal information on the basis that it is necessary so we can perform a contract, for our or others’ legitimate interests or it is needed or allowed by law. We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice. We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.

5. Marketing and preferences

We would, on occasion, like to keep you informed of our products and services which we consider may be of interest to you.

- ☐ Please tick if you would like us and other members of the Bupa group to keep you updated about our products and services by post, telephone email and text.

You will be able to opt out of receiving these communications at any time by contacting us.

6. Profiling and automated decision making

Like many businesses, we sometimes use automation to provide you with a quicker, better, more consistent and fair service, as well as with marketing information we think will interest you (including discounts on our products and services). This may involve evaluating information about you and, in limited cases, using technology to provide you with automatic responses or decisions. You can read more about this in our full privacy notice. You have the right to object to direct marketing and profiling relating to direct marketing. You may also have rights to object to other types of profiling and automated decision-making.

PRIVACY NOTICE

7. Sharing your information

We share your information within the Bupa group of companies, with relevant policyholders (including your employer if you are covered under a group scheme), with funders who arrange services on your behalf, those acting on your behalf (for example brokers and other intermediaries) and with others who help us provide services to you (for example healthcare providers) or who we need information from to handle or check claims or entitlements (for example professional associations). We also share your information in line with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

8. International transfers

We work with companies that we partner with, or that provide services to us (such as healthcare providers, other Bupa companies and IT providers) that are located in, or run their services from, countries across the world. As a result, we transfer your personal information to different countries including transfers from within the UK to outside the UK, and from within the EEA (the EU member states plus Norway, Liechtenstein and Iceland) to outside the EEA, for the purposes set out in this privacy notice. We take steps to make sure that when we transfer your personal information to another country, appropriate protection is in place, in line with global data protection laws.

9. How long we keep your personal information

We keep your personal information in line with periods we work out using the criteria shown in the full privacy notice.

10. Your rights

You have rights to have access to your information and to ask us to correct, erase and restrict use of your information. You also have rights to object to your information being used, to ask us to transfer information you have made available to us, to withdraw your permission for us to use your information and to ask us not to make automated decisions which produce legal effects concerning you or significantly affect you. Please contact us if you would like to exercise any of your rights.

11. Data protection contacts

If you have any questions, comments, complaints or suggestions about this notice, or any other concerns about the way in which we process information about you, please contact us at info@bupaglobal.com. You can also use this address to contact our Data Protection Officer.

You also have the right to make a complaint to your local privacy supervisory authority. Our main office is in the UK, where the local supervisory authority is the Information Commissioner's Office (www.ico.org.uk) who can be contacted at, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, United Kingdom. Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

OUR COMPLAINTS PROCEDURE

If you have a concern or complaint you can call the Bupa Global service team on +44 (0) 1273 323 563. Alternatively, you can email or write to the team via: info@bupaglobal.com; or Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, United Kingdom. You can also use these contact details to request a full copy of our complaints procedure. If we can't settle your complaint you may be able to refer your complaint to the Financial Ombudsman Service.

You can write to them at: The Financial Ombudsman Service, Exchange Tower, London E14 9SR; or call them on:

- 0800 023 4 567 – fixed line number (free from most landlines)
- 0300 123 9 123 – charged at the same rate as 01 or 02 numbers on mobile phone tariffs
- +44 20 7964 0500 – from abroad where UK numbers may not be accessible and/or find details at their website: www.financial-ombudsman.org.uk.

To the best of my knowledge and belief the information given in this application form is true, accurate and complete. I understand that benefits may not be payable in full or at all and my policy may be treated as if it had not existed, if I do not take reasonable care when providing any information requested in this application form.

Where I have provided information on behalf of any other person to be covered by the policy, I confirm that I have checked with them that the information is correct before completing this application form and I have their express agreement to submit this application form on their behalf, or I am their legal representative.

I understand that my personal information and that of any other person to be covered by this policy will be processed by Bupa Global for the purposes set out in Bupa Global's privacy notice. I confirm that I have brought Bupa Global's privacy notice to the attention of these covered.

I agree to be bound by the policy terms of my health plan (and for cover provided to any other person to be covered by this policy but under a different health plan, the policy terms of that health plan). I agree that English law will apply to the policy.

I agree that my policy shall terminate upon informing Bupa Global that I have become a permanent resident of the U.S. (or in the case of a dependant becoming a resident of the U.S., their cover under the policy shall terminate).

It is essential that you take reasonable care to provide us with full, complete, and accurate information when you complete this application form. Please be sure to check the entire form.

If you do not take reasonable care to provide us with full, complete, and accurate information about yourself or any other person covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

Fill in your form with complete up-to-date medical history before you sign and date it. If we do not receive this application form within six weeks of this declaration date, or the date of signature expires six weeks before your cover start date we will ask for a declaration of continued good health. Or we may ask you to submit a new form.

We recommend that you keep a record of all the 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.

I affix my signature on this application form with full responsibility on the contents disclosed therewith.

MAIN APPLICANT'S SIGNATURE**DATE OF SIGNATURE**

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Print full name

FOR OFFICE USE ONLY**IDENTIFICATION STAMP / BROKER NAME AND ID NUMBER**

Notes

General services:
+44 (0) 1273 323 563
Medical related enquiries:
+44 (0) 1273 333 911
Your calls will be recorded
and may be monitored.

Bupa Global
Victory House
Trafalgar Place
Brighton
BN1 4FY
United Kingdom

Bupa Global
offers you:
Global medical plans for
individuals and groups
Assistance, repatriation and
evacuation cover
24-hour multi-lingual helpline

bupaglobal.com