

# Lifeline



Joining Bupa Global

[bupaglobal.com](http://bupaglobal.com)

# Lifeline

This form can be completed by **new customers** or **existing Bupa Global customers**.

## Important Information

**YOU CAN TYPE DIRECTLY INTO THIS FORM, SAVE IT AND EMAIL IT TO US.  
ALTERNATIVELY, PLEASE WRITE CLEARLY IN BLOCK CAPITALS USING BLACK INK.**

Once completed, you can email your form to: [Newbusiness.UK@bupaglobal.com](mailto:Newbusiness.UK@bupaglobal.com), fax us on +44 (0) 1273 866 583 or post to Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, United Kingdom.

Please note that we cannot guarantee the security of email as a method of communication. Some companies, employers and/or countries do monitor email traffic, so please bear this in mind when sending us confidential information.

If you have faxed or emailed us then we do not need the original copy of your form.

Please note that the plan you are joining is a fully medical underwritten plan. This means that any symptoms or conditions that have been present prior to the start date of the plan may not be covered.

If you do not take reasonable care to provide full, complete and accurate information for each of the persons to be covered under the policy, it may affect the cover for those people.

Please 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.



## How to use this form

We have split this form into sections to make it easier for you to complete. Each section is numbered with an icon below.



These icons represent the person you are describing on the form.



When you see  you need to fill in information about the **Main Applicant** and this  is referring to the **1st Additional Person**.

## For new customers

Please complete sections 1-10, and section 11 if applicable  
Read, sign and date the declaration in section 12



## For existing customers

There are a number of things you can change on your plan using this form.  
Make sure you read, sign and date the declaration in section 12.

### Changing your address and contact details?

You must notify us of any change of contact details so that we can ensure that correspondence reaches you

The easiest way to change your address and contact details is simply to contact us. You can email us on [info@bupaglobal.com](mailto:info@bupaglobal.com), call us on +44 (0) 1273 323563, or contact us via our secure website at <https://membersworld.bupaglobal.com>.

### Adding additional people to your plan?

- complete sections 1 and 5-9
- complete section 11, if applicable
- **read, sign and date the declaration in section 12**



### Want to change your cover?

- complete sections 1 and 7-9
- complete section 11, if applicable
- **read, sign and date the declaration in section 12**



### Want to change your payment details?

- complete sections 1 and 10
- complete section 11, if applicable
- **read, sign and date the declaration in section 12**





## 5 Your consent to be a paperless customer

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At Bupa we are doing everything we can to reduce our impact on the environment. To help us do this we encourage our customers to be paperless.

- Paperless customer** - view and manage your plan online by registering on MembersWorld. You will receive emails when new documents are available to view (please make sure you have provided us with a valid email address).
- Hard copy** - receive your documents by post.

You can change your mind at any time on MembersWorld (<https://membersworld.bupaglobal.com>) or by contacting us.

You can find out more about the benefits of using MembersWorld in your Membership Guide.

**Please note each dependant over 16 years can select their documents' preference in section 6**

## 6 Additional people to be covered with you

**If any of these additional persons have different residency or correspondence addresses to yours, please write their name and addresses on a separate sheet and confirm you have done so by ticking here:**

Title		Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	1st language	
First name		Middle name					
Family name							
Date of birth	D	D	M	M	Y	Y	Y
Country of nationality							
Country of residency						Relationship to you	
Email							
<b>For over 16s only</b> <input type="checkbox"/> Paperless customer (manage plan online, register on MembersWorld) <input type="checkbox"/> Hard copy (receive documents by post)							
Have you had a previous policy with Bupa? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, membership number							

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Title		Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	1st language	
First name		Middle name					
Family name							
Date of birth	D	D	M	M	Y	Y	Y
Country of nationality							
Country of residency						Relationship to you	
Email							
<b>For over 16s only</b> <input type="checkbox"/> Paperless customer (manage plan online, register on MembersWorld) <input type="checkbox"/> Hard copy (receive documents by post)							
Have you had a previous policy with Bupa? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, membership number							

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Title		Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	1st language	
First name		Middle name					
Family name							
Date of birth	D	D	M	M	Y	Y	Y
Country of nationality							
Country of residency						Relationship to you	
Email							
<b>For over 16s only</b> <input type="checkbox"/> Paperless customer (manage plan online, register on MembersWorld) <input type="checkbox"/> Hard copy (receive documents by post)							
Have you had a previous policy with Bupa? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, membership number							

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## 6 Additional people to be covered with you (continued)

4

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	1st language														
First name						Middle name														
Family name																				
Date of birth	D	D	M	M	Y	Y	Y	Y	Country of nationality											
Country of residency									Relationship to you											
Email																				
<b>For over 16s only</b> <input type="radio"/> Paperless customer (manage plan online, register on MembersWorld) <input type="radio"/> Hard copy (receive documents by post)																				
Have you had a previous policy with Bupa? Yes <input type="radio"/> No <input type="radio"/> If yes, membership number																				

## 7 Medical history

This section asks for health and medical details, past and present about yourself and each person named in Section 6.

Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in Section 8.

**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.**

Whether you are changing your benefits, or a returning Bupa customer, you must complete the medical history section in full so that we have an up to date record of your health.

For any of the medical conditions listed below (questions 1-13), please answer yes if you or anyone to be covered by this plan has:

- Seen a doctor or other healthcare professional in the last three years
- Been admitted to hospital, had an operation or procedure, or had an investigation (e.g. a scan/blood tests) in the last seven years

	M	1	2	3	4
<b>1. Circulatory disorders</b> e.g. high blood pressure, high cholesterol, chest pains, aneurysms, varicose veins or deep vein thrombosis	<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
<b>2. Endocrine (glandular) disorders</b> e.g. diabetes (Type 1 or Type 2), thyroid problems, Addison's disease or obesity	<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
<b>3. Breathing or respiratory disorders</b> e.g. shortness of breath, asthma, chronic obstructive pulmonary disease, chest infections, pneumonia, bronchitis, tuberculosis, emphysema, sleep apnoea or allergies (including hayfever and anaphylaxis)	<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
<b>4. Stomach, intestines, liver or gall bladder problems</b> e.g. stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias	<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
<b>5. Benign tumours, growths or pre-cancerous conditions</b> e.g. polyps, benign growths, non-cystic breast lump, fibrocystic breast disease or lipomas	<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
<b>6. Skin problems</b> e.g. eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic conditions	<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
<b>7. Brain or nervous system disorders</b> e.g. dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles), Parkinson's disease, motor neurone disease, cerebral palsy, encephalitis or meningitis	<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

	M	1	2	3	4
<b>8. Muscle or skeletal problems</b> e.g. arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, fractures, osteoporosis, gout or inflammatory conditions	Y N	Y N	Y N	Y N	Y N
<b>9a. Female urinary or reproductive system problems</b> e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, incontinence, ovarian cysts, polycystic ovaries, pelvic inflammation, cervical disease, endometriosis, dysmenorrhoea, irregular menstruation, fibroids, breast disease or infertility	Y N	Y N	Y N	Y N	Y N
<b>9b. Male urinary or reproductive system problems</b> e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, benign prostate hypertrophy, enlarged prostate or infertility	Y N	Y N	Y N	Y N	Y N
<b>10. Blood/infective/immune disorders</b> e.g. abnormal blood tests, anaemia, hepatitis, HIV, malaria or any autoimmune disorder	Y N	Y N	Y N	Y N	Y N
<b>11. Eye, ear, nose and throat problems</b> e.g. cataracts, glaucoma, visual impairment, detached retina, macular degeneration, deafness, ear infections, glue ear, deviated nasal septum, tonsillitis or gingivitis	Y N	Y N	Y N	Y N	Y N
<b>12. Mental health disorders</b> e.g. schizophrenia, bipolar, compulsive or eating disorders, depression, stress, anxiety or drug/alcohol dependency, panic attacks, paranoia or ADHD	Y N	Y N	Y N	Y N	Y N
<b>13. Congenital/Hereditary conditions</b> e.g. Downs syndrome, spina bifida, cystic fibrosis, cerebral palsy, cleft lip or cleft palate, sickle cell anemia, Huntington's disease, thalassemas or hemochromatosis	Y N	Y N	Y N	Y N	Y N

Please also answer the following questions:

<b>14. Is anyone to be covered taking any medication, prescribed or otherwise?</b>	Y N	Y N	Y N	Y N	Y N
<b>15. Has anyone to be covered ever had a history of the following:</b>					
<input type="radio"/> Cancer	Y N	Y N	Y N	Y N	Y N
<input type="radio"/> Heart condition e.g. angina, heart attack, heart failure, abnormal heartbeat	Y N	Y N	Y N	Y N	Y N
<input type="radio"/> Stroke	Y N	Y N	Y N	Y N	Y N
<input type="radio"/> Prosthetic implants and appliances in his/her body e.g. shunts, pacemakers, joint replacements	Y N	Y N	Y N	Y N	Y N
<b>16. Is anyone to be covered receiving any treatment of any kind or require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in questions 1 - 13?</b>	Y N	Y N	Y N	Y N	Y N
<b>17. In the last 3 months has anyone to be covered experienced any signs or symptoms of any medical problem, illness, or injury not yet diagnosed or treated?</b>	Y N	Y N	Y N	Y N	Y N

Further details (for over 16s only):

<b>How tall are you?</b>	<input type="radio"/> feet/inches	<input type="radio"/> metres/centimetres					
<b>How much do you weigh?</b>	<input type="radio"/> stones/pounds	<input type="radio"/> kilograms					

## 8 Medical questions and history: Additional information

This section applies if you, or anyone to be covered under this plan, have indicated yes to any medical questions in Section 7. If you are unsure whether any details are relevant, you must include them.

Main Applicant or Additional Person	The relevant question number from Section 7	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 a separate sheet and indicate that you have done so by ticking here:



Please tick the options you wish to add for you and any additional people.  
(Note: the level of cover you choose will apply to all members detailed on this form)



### Lifeline Essential:

This level concentrates on covering you for in-patient hospital stays. You have the security that you'll be covered for treatment you may receive as an in-patient or as a daycare patient.



### Lifeline Classic:

Our Classic level is designed to cover you and your family for specialist medical treatment or diagnosis. You will be covered for in-patient hospital stays as well as out-patient consultations, treatment such as physiotherapy and a range of preventive health checks.



### Lifeline Gold:

Our top level gives you cover for both in-patient and out-patient care. In addition, Gold also covers family doctor treatment and any prescription medication you may need, as well as accident related dental treatment. Maternity cover, home nursing and a range of four preventive health checks are also included in this comprehensive plan.



### U.S. Cover:

We understand that many people do not need medical insurance for the U.S., so you can choose whether you want to include it. Unfortunately, we cannot offer Bupa Global Lifeline to anyone who is normally resident in the U.S. This cover will increase your premium.



### Choose your Annual Deductible:

If you are paying by Direct Debit or Credit Card, you may choose an annual deductible. This is the amount you would pay towards eligible medical treatment each year.

GBP:	None	<input type="radio"/>	£100	<input type="radio"/>	£250	<input type="radio"/>	£500	<input type="radio"/>	£1000	<input type="radio"/>	£2000	<input type="radio"/>	£5,000	<input type="radio"/>
USD:	None	<input type="radio"/>	\$160	<input type="radio"/>	\$400	<input type="radio"/>	\$800	<input type="radio"/>	\$1600	<input type="radio"/>	\$3200	<input type="radio"/>	\$8,000	<input type="radio"/>
EUR:	None	<input type="radio"/>	€160	<input type="radio"/>	€400	<input type="radio"/>	€800	<input type="radio"/>	€1600	<input type="radio"/>	€3200	<input type="radio"/>	€8,000	<input type="radio"/>

## Your assistance cover options



### Evacuation:

If you are concerned about the quality of local medical care, this is ideal. If the treatment you need is not available locally, we will arrange for you to be evacuated to the nearest centre of medical excellence, no matter where you are in the world.



### Repatriation *(automatically includes Evacuation cover)*:

Our highest level of Assistance cover also gives you the choice of returning to your home country, to be treated in familiar surroundings, near your friends and relatives (if treatment is not available locally). If this happens, you can choose to have someone to accompany you for your visit back home.



Please refer to the membership guide for full details.







### Our complaints procedure

If you have a concern or complaint you can call the Bupa Global service team on +44 (0) 1273 718 379. Alternatively, you can email or write to the team via: Service.UK@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](http://www.financial-ombudsman.org.uk)

### Declaration

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 any cover for the U.S. shall terminate upon informing Bupa Global that I have become a resident of the U.S. (or in the case of an additional person 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 provide complete information, we will not be able to process your application.

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.

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.

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.

### Main Applicant's Signature

M

Print name									
Date	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

## 12 Your membership declaration

### If you have been introduced by an intermediary

You may have received advice from an intermediary. In certain jurisdictions, Bupa Global require your consent to make payment to your intermediary for their part in introducing you to us as a member. Where applicable, we will deduct a fee from each subscription payment received from you and pass this onto your intermediary on your behalf. For the avoidance of doubt, your consent to make payment of intermediary's fees does not affect the amount of any premiums payable by you, which would remain the same whether or not you had approached us directly or not. Upon renewal of your policy, we will continue to pay your intermediary until otherwise notified by you in writing.

### Intermediaries only

Please ensure up to date KYC documents have been provided for the applicant and dependants (aged over 16) where applicable. If clarity is needed on what documents are required; please contact Broker Services on +44 1273 718314. Failure to supply the accurate documents could lead to a delay and cancellation of the member's application.

Intermediary name

Intermediary ID

In case of unsolicited sales, applications will only be accepted for countries that allow unsolicited sales of health insurance contracts - including on a cross-border basis, where this is the case. For more information please refer to your Bupa Global contact.

- Solicited (promoted) sale. Tick the box if this is a Solicited Sale
- Unsolicited sale - I hereby confirm that I neither promoted, sought, approached the customer and the customer neither sought nor required advice

### Intermediary's signature

Print name

Date

**We reserve the right to request further information where appropriate or necessary.**

# NOTES

Identification stamp / Broker name and ID number

## The world of Bupa

Care homes  
Cash plans  
Dental insurance  
Health analytics  
Health assessments  
Health at work services  
Health centres  
Health coaching  
Health information  
Health insurance  
Home healthcare  
Hospitals  
International health insurance  
Personal medical alarms  
Retirement villages  
Travel insurance