# Business Health Plans

Employee application form

Bupa Insurance Ltd
Switzerland Branch

bupaglobal.com

## Important information

Due to Bupa's global coverage and service delivery, all claims to be processed through the Bupa claims process.
In the context of co-ordination with mandatory health insurance KVG, Bupa is obliged to assess such claims regarding benefit entitlement under KVG.

In this regard and as long as double insurance coverage is in force, you and all of the additional persons named under your plan assign current and future benefit entitlement under KVG to Bupa. You, and any additional persons named under your plan, agree that the KVG insurer pays benefits directly to Bupa and exchanges information pertaining to your claim with Bupa.

## Bupa Global Business Health Plans

You can type directly into this form. Alternatively, please write clearly in block capitals using black ink.

This application form is for employees and their eligible dependants who are applying to join a Bupa Global Business Health Plan 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 Bupa Global. If you require a different start date in the future please complete the start date box in section 1.

Please return this form to your company's Bupa Global Group Administrator in a sealed envelope. Alternatively you may wish to email the completed form to them. If you have any concerns regarding the confidentiality of your medical information in this process, please contact your company's Bupa Global Group Administrator to discuss.

If you do not take reasonable care to provide us with full, complete and accurate information in completing this application form, then we may have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

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

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.

All sections which need to be completed by the main applicant are labelled MA. 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.

We look forward to welcoming you as a Bupa Global customer.

**If you have any questions when completing this form, please call us on +44 (0) 1273 208 181**

## Checklist - please make sure:

- Your Group Secretary has completed section 1 ○
- The information you have given in the applicable sections is correct and complete ○
- You have read, signed and dated the declaration in section 10 ○

## 1 To be completed by the Group Secretary

| Group name | |
|---|---|
| Group number | Cover start date* D D M M Y Y Y Y |

*Cover cannot start between 28th and 31st

### Plan information

**Please tick the plan and any co-insurance, optional modules or U.S. cover which will apply to this application.**

| Choose Plan | Choose Co-insurance | | | Choose Optical & Dental | | Choose U.S. Cover | |
|---|---|---|---|---|---|---|---|
| ◯ Business Select Health Plan | Not available | | | Not available | | Y | N |
| ◯ Business Premier Health Plan | ◯ 0% | ◯ 15% | ◯ 25% | Y | N | Y | N |
| ◯ Business Elite Health Plan | ◯ 0% | ◯ 15% | ◯ 25% | Y | N | Y | N |
| ◯ Business Ultimate Health Plan | Not available | | | ✓ Included | | ✓ Included | |

### Underwriting terms

Please tick the underwriting terms to be applied to this application.

| | |
|---|---|
| Full Medical Underwriting:<br><br>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. | ◯ |
| Continued Personal Medical Exclusions:<br><br>This is where underwriting terms from your previous insurer are carried over to your Bupa Global Plan. | ◯ |

### 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 |
|---|---|
| | D D M M Y Y Y Y |

| Print full name | |
|---|---|
| Position | |

## 2 Main applicant: Membership details MA

| Bupa Global membership number | |
|---|---|

**Alternatively, if you have previously had a policy with Bupa, please tick here and provide the membership number above** ◯

## 3 Main applicant: Your personal details MA

| Title | | Male ◯ | Female ◯ | 1st language | |
|---|---|---|---|---|---|
| First name | | | | Middle name | |
| Last name | | | | | |
| Date of birth | D D M M Y Y Y Y | Country of nationality | | | |
| Occupation | | | | | |

## 4 Main applicant: Your address details

MA

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

| Address line 1 | |
|---|---|
| Address line 2 | |
| Town/City | |
| State/Emirate | |
| Country | |
| Postal/Zip/Area code | |

Are you or any additional persons to be covered with you a U.S. resident? Y N

If yes, will you be resident outside of the U.S. for six months or more in any one year? Y N

**Correspondence address**
(where membership documents cannot easily be sent to you at your residency address, please supply an alternative address to which they may be sent)

| Address line 1 | |
|---|---|
| Address line 2 | |
| Town/City | |
| State/Emirate | |
| Country | |
| Postal/Zip/Area code | |

## 5 Main applicant: Your other contact details

MA

**(Please include country code, area code and number)**

| Phone/Mobile | |
|---|---|
| Email | |

**Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active**

○ **Yes** ○ **No** ○ **Active**

**If yes, please confirm**

| KVG Policy Provider | | | |
|---|---|---|---|
| Membership number | | | |
| Start date | D D M M Y Y Y Y | End date | D D M M Y Y Y Y |
| Supplemental Policy Provider | | | |
| Membership number | | | |
| Start date | D D M M Y Y Y Y | End date | D D M M Y Y Y Y |

## 6 Additional persons 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 ◯

### 1

Title | Male ◯ | Female ◯ | 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

**Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active**

◯ **Yes** ◯ **No** ◯ **Active**

**If yes, please confirm**

KVG Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

Supplemental Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

### 2

Title | Male ◯ | Female ◯ | 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

**Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active**

◯ **Yes** ◯ **No** ◯ **Active**

**If yes, please confirm**

KVG Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

Supplemental Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

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

**3**

Title | Male ◯ | Female ◯ | 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

**Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active**

◯ **Yes** ◯ **No** ◯ **Active**

**If yes, please confirm**

KVG Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

Supplemental Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

**4**

Title | Male ◯ | Female ◯ | 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

**Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active**

◯ **Yes** ◯ **No** ◯ **Active**

**If yes, please confirm**

KVG Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

Supplemental Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

# 7 Medical questions and history – Full medical underwriting

MA

**This section should only be completed if your Group Secretary has ticked 'Full Medical Underwriting' in section 1 of this form.**

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 9. Please answer each of these questions fully and accurately for the person named above.

| 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.<br><br>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. | MA | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **1. Within the last 3 years, has any applicant seen a doctor or other healthcare professional for a) any recurrent or persistent medical condition or symptoms? (persistent meaning for 2 weeks or more)<br>b) 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:**<br>o cancer, including benign brain tumours<br>o heart condition<br>o stroke<br>o joint replacements | Y N | Y N | Y N | Y N | Y N |
| **6. Has anyone to be covered 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 |
| **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 ○ | | | | | | | |

## 8 Medical questions and history – Continued personal medical exclusions (CPME)

**This section should only be completed if your Group Secretary has ticked 'Continued Personal Medical Exclusions' in section 1 of this form.**

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 9. Please answer each of these questions fully and accurately for the person named above.

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.

| | MA | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **1. Has any applicant 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. Has any applicant had a joint replacement or spinal surgery?** | Y N | Y N | Y N | Y N | Y N |
| **3. Has any applicant made a claim under existing insurance in the last 12 months?** | Y N | Y N | Y N | Y N | Y N |
| **4. Has any applicant 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. Has any applicant have any planned or pending treatment, investigations or tests?** | Y N | Y N | Y N | Y N | Y N |

## 9 Medical questions and history: Additional information

**This section applies if you have answered 'Yes' to any of the medical questions in sections 7 or 8.**
**If you are unsure whether any details are relevant, you must include them.**

| Main applicant or dependant | The relevant question number from Section 7 or 8 | 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)? |
|---|---|---|---|---|---|
| MA | | | | | |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |

**If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.**

**If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here:** ○

# 10 Your application declaration

## Privacy Notice

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, 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. If you have any questions about how we handle your information, please contact us at info@bupaglobal.com

**Information about Bupa Global**

In this privacy notice, references to "we" or "us" or "our" are to Bupa Global. For company contact details, visit www.bupaglobal.com/legal-notices

**1 Scope of our privacy notice**

This privacy notice applies to anyone who interacts with us in relation to our products and services ("you", "your"), in any way (for example email, website, telephone, app).

**2 Ways in which we obtain personal information**

We collect personal information from you and from certain third parties (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 Purposes and lawful grounds of our processing personal information**

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 applicable 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 emailing info@bupaglobal.com or by writing to Bupa Global, Victory House, Trafalgar Place, Brighton BN1 4FY, United Kingdom.

**6 Processing for 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 be of interest (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.

**7 Sharing your information**

We share your information within the Bupa Group, 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 accordance with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

**8 Transfers outside of the UK and the European Economic Area (EEA)**

We deal with many international organisations and use global information systems. As a result, we transfer your personal information to countries outside of the UK and the EEA (the EU member states and Norway, Liechtenstein and Iceland), for the purposes set out in this privacy notice.

**9 How long we keep your personal information**

We keep your personal information in line with periods using the criteria shown in the full privacy notice available on our website.

**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.

We are regulated by 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). You have a right to make a complaint to them or to your local privacy supervisory authority.

## 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.

## Declaration

To the best of my knowledge and belief the information given in this application form is true and complete.

I am either the legal representative of the additional persons named in this application form, or I have obtained their prior and express consent to submit this application form, give consent and make declarations on their behalf.

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 any cover for the U.S. shall terminate upon informing Bupa Global that I have become 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).

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. I agree that the laws of Switzerland will apply to the policy.

In view of the declaration above it is essential that complete information is supplied. We will not be able to process your application if this form is incomplete. Please be sure to check the entire form.

If you do not take reasonable care to provide us with full, complete and accurate information in completing this application form, then we may have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

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

Where you hold local health insurance, you, and all persons named under your plan, will submit all claims to Bupa Global, or our regional partners as appropriate.

We will process your claim in accordance with your Bupa Global policy benefits.

We will submit the claim to your local insurer to recover any benefit that is payable by your local insurance.

You, and all persons named under your plan, assign current and future benefit entitlement under your local insurer, to Bupa for as long as you hold your Bupa Global policy.

You, and all persons named under your plan, agree that your local insurer pays benefits directly to Bupa.

You, and all persons named under your plan, will not make any claim against Bupa, where you have claimed against your local insurer.

You, and all persons named under your plan, agree that Bupa and your local insurer, may exchange information about your claim, including information on your health.

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 | Date | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | D | D | M | M | Y | Y | Y | Y |
| Print full name | | | | | | | | |

| For office use only | Identification stamp / broker name and ID number |
|---|---|
| | |

Bupa Global is a trading name of Bupa Insurance Limited and Bupa Insurance Services Limited which are registered in England and Wales at Companies House under numbers 3956433 and 3829851 respectively. The registered offices are 1 Angel Court, London EC2R 7HJ, UK. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Bupa Insurance Services Limited is authorised and regulated by the Financial Conduct Authority. The Financial Registration numbers of Bupa Insurance Limited and Bupa Insurance Services Limited are 203332 and 312526 respectively. The Swiss branch is registered in Switzerland under UID number CHE-473.435.488.  Its registered and reporting address is Dreikoenigstrasse 31a, CH-8002 Zurich, Switzerland

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

BIN-BHPX-APPF-EN-XXXX-2203-0036345