

Employee Application form



Important information

This application form is for employees and eligible dependants who are applying to join Bupa Global on a full medical underwriting (FMU) basis 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.

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 Bupa Global Group Administrator in a sealed envelope.

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

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 

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 call us on +353 17617331

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
- The information you have given in sections 2-8 is current and complete
- You have read, signed and dated the declaration in section 12

If you want to amend your existing membership (including U.S. upgrades)

- Your Group Secretary has completed section 1
- The information you have given in section 2 is correct
- You have completed the relevant section to reflect the amendment(s) required (for U.S. upgrades this is section 9)
- You have read, signed and dated the declaration in section 12

1 To be completed by the Group Secretary

Group name																																	
Group number																									Cover start date*	D	D	M	M	Y	Y	Y	Y
Product name																																	
Does an Annual Deductible apply?	<input type="radio"/> Y <input type="radio"/> N																																

*Cover cannot start between 28th and 31st inclusive

The options below will increase your premiums:	MA	1	2	3	4
U.S. cover	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Evacuation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repatriation (automatically includes Evacuation cover)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

Authorised signatory	Date								
	<table border="1"> <tr> <td>D</td> <td>D</td> <td>M</td> <td>M</td> <td>Y</td> <td>Y</td> <td>Y</td> <td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
Print name									

2 Main applicant: Membership details MA

Bupa Global membership number																
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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	<input type="radio"/>	Female	<input type="radio"/>	1st language																								
First name																																
Middle name (s)																																
Last name																																
Date of birth	D	D	M	M	Y	Y	Y	Y	Country of nationality																							
Occupation																																

7 Medical questions and history

If you are upgrading to U.S. cover following the commencement of your policy, please go to section 9.

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.

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.

Please tick either Yes or No to each of these questions		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) 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:						
<input type="radio"/> cancer, including benign brain tumours		Y N	Y N	Y N	Y N	Y N
<input type="radio"/> heart condition		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"/> 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 <input type="radio"/>	metres/centimetres <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How much do you weigh?	stones/pounds <input type="radio"/>	kilograms <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8 Medical questions and history: Additional information

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

Main applicant or dependant	The relevant question number from section 7.	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected e.g. right leg.	When were symptoms first experienced and when was treatment completed (if applicable)?	What was the treatment/ medication (including dates and names)?	What was the outcome of the treatment (e.g. full recovery, ongoing treatment required, likely to recur or awaiting test results)?
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 the "Notes" section at the end of this form and indicate that you have done so by ticking here

9 Upgrade cover to include U.S. cover following commencement of the policy

If you are filling out this form to upgrade to U.S. cover following the commencement of the policy, you should complete this section in place of section 7, Medical questions and history. 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

	MA	1	2	3	4
1. Your anticipated length of stay in the U.S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any ongoing or planned treatment? If yes, please provide details below	<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
3. FEMALES ONLY: Are you currently pregnant?	<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

Notes

Notes

General services:

+44 (0) 1273 323 563

Medical related enquiries:

+44 (0) 1273 333 911

Your calls may be recorded or monitored.

Bupa Global

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Bupa Global offers you:

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

bupaglobal.com

Bupa Global is a trading name
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