Your client's application/ amendment form

Bupa Healthcare Plan

Underwritten/Moratorium
To be completed by the intermediary

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK

- This form should be completed by you, the intermediary on behalf of your client.
- Please complete this form as fully and accurately as possible.
- This form is for new members and existing members wishing to add their dependants.
- Please note only some products are available for new members.
- If your client has selected Moratorium underwriting, there's no need to complete section 5.

Remember to give us as much detail as you can about your client and any dependants your client would like to cover. Your client must take all reasonable care to answer all the questions honestly and correctly. Your client must check all answers in relation to any dependants with them to make sure that their details are correct. This means they must use reasonable care to not give false information to us or keep necessary information from us. Your client's policy may be cancelled, or treated as if it never existed, or their claim may be rejected or not fully paid, if there is reasonable evidence that your client did not take reasonable care in answering our questions.

Where to send your client's completed form

- By post: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**
- Or by email: **membershipadmin@bupa.com**

  If you need to send us sensitive information you can email us securely using Egress.

  For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

Intermediary details

Bupa agency number
Intermediary name
Telephone number
Email address

1. Your client's personal details

Please tell us about your client here. Please make sure your client reads our privacy notice on page 13, where we outline how we use your client's information.

Title *(please tick or list title if other)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s)	Surname
Address	
	Postcode
Home telephone number	Mobile telephone number
Email address	
Date of birth D D M M Y Y Y Y	Sex at birth Male ☐ Female ☐
Occupation (please note we may request proof of applicant occupation)	
If your client is already a member of Bupa or a beneficiary under a trust, please give us their membership/registration number.	☐☐☐☐☐☐☐☐☐☐

Please tick to confirm that each person joining this scheme is aware that they are joining Bupa as a brand new member. This means that any symptoms or conditions that have been present prior to the start date of this policy may not be covered, and we may require further medical information to assess their claim, particularly where claims are made early in their policy. Please note that where this medical information is not provided, we may not be able to process their claim. ☐

If your client would like any dependants (partner, children etc) to be included in their membership, please go to section 2. If not, go to section 3.

2. Your client's dependants' details

If your client would like to cover their dependants, please give us their details below. Please ask your client to check with each dependant that they have their correct details and make sure you direct them to our privacy notice on page 13 before submitting their details to us. Please note that your client must have their dependants' express agreement to submit this form on their behalf (or be their legal representative). Please note that the inclusion of each dependant will impact the premium your client pays for their cover.

	Member 2	Member 3	Member 4	Member 5
Title				
First name				
Surname				
Relationship to your client				
Date of birth	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Sex at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐

What if your client needs to add more dependants?

If your client would like to cover dependants additional to those listed above, please give us their details on a separate sheet of paper. Your client will also need to answer sections 3, 4 and both parts of section 5 (if your client has chosen Full medical underwriting) for them.

3. Your client's choice of scheme and excess

Please tick the relevant boxes to indicate which options your client requires. Please note that the choice of scheme and excess level may impact the subscription your client pays for their cover.

Products available to new members

BupaCare ☐ LocalCare ☐ Local HospitalCare ☐

EssentialCare ☐

Products available to existing members adding dependants

BupaCare ☐ LocalCare ☐ ClientChoice Essential ☐

Local HospitalCare ☐ ClientChoice ☐ EmployeeChoice ☐

EssentialCare ☐ ClientChoice Plus ☐ EmployeeChoice Essential ☐

Underwriting type (please note, any dependants will have the same underwriting type as the main member)

Full medical underwriting ☐ Moratorium underwriting ☐

Not all product options and underwriting type combinations are available. Please check with your Bupa representative before submitting the form.

Group name (if known)

Excess options (please tick) £0 ☐ £100 ☐ £150 ☐ £200 ☐ £250 ☐ £500 ☐ £1,000 ☐ £2,000 ☐

Additional product details including excess and subscriptions

4. Further details

Please answer each question as it applies for your client and each person named in section 2. Please tick 'Yes' or 'No' to every question for each person and provide details where applicable (if your client is an existing member and is only adding dependants, you do not need to fill out further details or the medical history relating to your client's own health, only for your client's dependants). Please ask your client to check with each dependant that they have their correct details and make sure your client directs them to our privacy notice on page 13 before submitting their details to us.

Main member/dependant (as detailed in sections 1 and 2)	Main member	Member 2	Member 3	Member 4	Member 5
(Please tick the relevant box)	Yes No	Yes No	Yes No	Yes No	Yes No
Is the person to be covered a UK resident?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Does the person to be covered/their GP have access to their medical records in English? To be eligible for cover the main member and dependants must have been registered continuously with a UK GP for a period of at least six months, or have access to and be able to provide their full medical records in English *(Please note that for us to appropriately administer your client's policy each person to be covered will need to be registered with a UK GP)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Is the person to be covered a professional or semi-professional sports person? By this we mean: does your client receive payment or sponsorship for taking part in any sport?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
If '**Yes**', which sport(s), including the name of the team, if applicable? *(On receipt of your client's application we will assess each person's eligibility to join the scheme and inform them accordingly)*					
Has the person to be covered used any tobacco products in the last two years? *(Over 18s only)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

5. Medical history – part one (if your client has selected Moratorium underwriting, there's no need to complete this section)

This section asks for health and medical details, past and present, for your client and for each person named in section 2. Please tick 'Yes' or 'No' to every question for each person. Please ask your client to check with each dependant that they have their correct details and make sure that they are directed to our privacy notice on page 13 before submitting their details to us.

For any of the medical conditions or symptoms listed in questions 1 to 16 please indicate if: ▪ your client or anyone to be covered on your client's membership has seen a GP or other healthcare professional within the last two years ▪ your client or anyone to be covered on your client's membership has been admitted to hospital, had an operation OR any investigations (for example scan, X-ray, blood test, biopsy) within the last seven years.	Main member/dependant (as detailed in sections 1 and 2)									
	Main member		Member 2		Member 3		Member 4		Member 5	
(Please tick the relevant box)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Heart or cardiovascular disorders *(For example: coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Glandular disorders *(For example: diabetes, thyroid, hormonal problems)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Breathing or respiratory disorders *(For example: asthma, bronchitis, shortness of breath, chest infections)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Ears, nose, throat, or eye problems *(For example: tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Stomach, intestines, liver or gallbladder *(For example: ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Cancer, tumours, growths, cysts, or moles that itch or bleed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Skin problems *(For example: eczema, rashes, psoriasis, acne)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Brain or nervous system disorders *(For example: migraines, repeated headaches, MS, epilepsy, nerve pain, fits)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Muscle or skeletal problems *(For example: arthritis, cartilage and ligament problems, back and neck problems, sprains, gout, sciatica)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Urinary problems *(For example: bladder, kidney or prostate problems, urinary infections, incontinence)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Medical history – part one (continued)

	Main member/dependant (as detailed in sections 1 and 2)									
	Main member		Member 2		Member 3		Member 4		Member 5	
(Please tick the relevant box)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11. Blood disorders *(For example: anaemia, hepatitis, HIV, abnormal blood tests)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Reproductive system problems *(For example: pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, low sperm count)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Dental problems *(For example: wisdom teeth, abscess)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Allergies *(For example: pet allergies, food allergies)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Psychological disorders *(For example: depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Undiagnosed symptoms *(For example: chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Please also answer the following questions:										
17. Is your client or anyone to be covered taking any medicines, prescribed or otherwise?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Within the last three months has anyone to be covered experienced symptoms of **ANY** health problems for which medical advice has not yet been sought?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Has anyone to be covered **EVER** had any past history of joint replacements, heart conditions, or strokes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Is there any other information relating to your client's health that has not yet been prompted by the questions listed 1 to 19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If your client has answered 'Yes' to any of the conditions here in respect of themselves or anyone to be covered please give us full details in 'Medical history – part two' on the following pages.

If they have answered 'No' to all of the above conditions, proceed to section 6.

5. Medical history – part two (if your client has selected Moratorium underwriting, there's no need to complete this section)

To help us build a more complete picture of your client's (and your client's dependants') health, please use pages 9 to 11 to expand on any of the conditions your client answered 'Yes' to in part one. Please give as much specific detail as possible. Failure to do so will result in delays processing your client's application. You can use the example below for help when filling out the form.

Definitions

Controlled: Condition/symptom ongoing but controlled by treatment/medication.

Recurrent: Occurring more than once, often or occasionally.

Likely to recur: Symptom free for a period of time but likely to recur.

Fully recovered: Condition fully resolved/cured with no symptoms and no medication.

Example one	
Name of member:	JOHN SMITH
Question number from **part one**	11
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	HIGH CHOLESTEROL
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 1 0 1 2 0 2 0 Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	OVER COUNTER MEDICATION / DIET / PRESCRIBED MEDICATION
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*	CONTROLLED
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?	2

Example two	
Name of member:	JOHN SMITH
Question number from **part one**	9
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	KNEE PAIN
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 5 0 5 2 0 1 8 Ended 2 0 0 1 2 0 1 9
Treatment *(prescribed or otherwise)*	PHYSIOTHERAPY
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*	FULLY RECOVERED
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?	0

EXAMPLE

5. Medical history – part two (continued)

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*		
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*		
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?		

5. Medical history – part two (continued)

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*		
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*		
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?		

5. Medical history – part two (continued)

Name of member:	
Question number from **part one**	
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	
When did symptoms begin/end? **If ongoing please leave end date blank**	Began D D M M Y Y Y Y Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*	
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?	

Name of member:	
Question number from **part one**	
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	
When did symptoms begin/end? **If ongoing please leave end date blank**	Began D D M M Y Y Y Y Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	
Current state of condition/symptom *(eg ongoing, controlled, recurrent, likely to recur, fully recovered)*	
How many times has the person to be covered consulted a healthcare professional about this symptom/condition in the past two years?	

6. Your client's payment for their cover

Subscription quoted	£	Payment is made by monthly Direct Debit. Please ensure your client completes the Direct Debit instruction on page 14.
When would your client like their cover to start?		D D M M Y Y Y Y

Please note: although we will try to start your client's cover (whether for new members or for dependants added to existing membership) on the date indicated above, this cannot be guaranteed. Your client's start date will be confirmed on their membership certificate. We will not backdate start dates to a date prior to receipt of the application.

7. Your legal declaration

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

I confirm the following:

1. My client has declared that to the best of their knowledge and belief the information given in this form is true, accurate and complete. My client understands that Bupa can end a person's policy or refuse to pay a claim in full or part if there is reasonable evidence that they or a dependant did not take reasonable care when providing any information requested in this form.
2. Where my client has provided information on behalf of any other person to be covered by the policy, I have checked with my client that the information about each other person is also correct before completing this form and my client has confirmed that they have express agreement from each individual to submit this form on their behalf or are their legal representative.
3. My client has declared they understand their personal information and that of any other person to be covered by this policy will be processed by Bupa for the purposes set out in Bupa's privacy notice. My client has provided me with confirmation that they have brought Bupa's privacy notice to the attention of any other person who will be covered by the policy.
4. My client has declared they agree to be bound by the policy terms and conditions (including in respect of those terms that apply to any other person to be covered on this policy). My client has confirmed they agree that English law will apply to the policy terms and conditions.

It is essential that your client takes reasonable care to provide full, complete and accurate information when you complete this form. Please be sure to check the entire form.

If your client does not provide complete information about themselves or any other person covered under the policy, we may have the right to end their policy, or to refuse to pay all or part of a claim.

We recommend that you and your client keep a record of all the information you supply to us in connection with this form, including letters.

If you or your client would like a copy of this form, please ask us.

Signature

Date D D M M Y Y Y Y

We'll verify your digital signature if this form is signed using an Adobe Digital ID or Adobe Sign (or equivalent). If you modify this form after digitally signing it, or send us a printed or scanned copy of the form, then we won't be able to verify your digital signature at this point and will need to contact you either by phone or in writing to confirm this is your signature. Until we have verified or confirmed your signature, we won't be able to advise exactly what your client's policy covers them for, meaning your client's claims might take longer for us to process and we might not be able to pay for treatment they need.

Privacy notice – in brief

Please make sure that your client (and their dependants, if applicable) are aware of this 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, how we use it and how we 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 **bupa.co.uk/privacy**. If you do not have access to the internet and would like a paper copy, please write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, Middlesex TW18 3DZ**. If you have any questions about how we handle your information, please contact us at **dataprotection@bupa.com**

Information about us

In this privacy notice, references to 'we', 'us' or 'our' are to Bupa. Bupa is registered with the Information Commissioner's Office, registration number Z6831692. Bupa is made up of a number of trading companies, many of which also have their own data-protection registrations. For company contact details, visit **bupa.co.uk/legal-notices**

1. Scope of our privacy notice

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 certain other organisations (those acting on your behalf, for example, brokers, health-care 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 legal grounds for 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 handling complaints), 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 may use your personal information to send you marketing by post, phone, social media, email and text. We only use your personal information to send you marketing if we have either your permission or a legitimate interest. If you don't want to receive personalised marketing about similar products and services that we think are relevant to you, please contact us at **optmeout@bupa.com** or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, Middlesex TW18 3DZ**

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 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.

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, health-care 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 health-care 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 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 **dataprotection@bupa.com**. You can also use this address to contact our Data Protection Officer.

You also have a 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, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, United Kingdom.

Phone: 0303 123 1113 (local rate).

Direct Debit instruction

Instruction to your Bank or Building Society to pay by Direct Debit
Please complete the white areas in BLOCK CAPITALS and BLACK INK to instruct your bank to make payments directly from your account. Then return the completed form to: BUPA, Bupa Place, 102 The Quays, Salford M50 3SP

Service User Number

9	9	1	3	6	4

1. Name and full postal address of your Bank or Building Society branch

To: The Manager

Bank or Building Society

Address

Postcode

2. Name(s) of account holder(s)

3. Branch sort code

4. Bank or Building Society account number

5. BUPA reference/membership number

For BUPA official use only

This is not part of the instruction to your Bank or Building Society

Note to member: Please complete your member/group name below (if applicable)

6. Instruction to your Bank or Building Society

Please pay BUPA Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with BUPA and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s)

Date D D M M Y Y Y Y

Banks and Building Societies may not accept Direct Debit instructions for some types of account.

This guarantee should be detached and retained by the Payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit BUPA will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request BUPA to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit by BUPA or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society. If you receive a refund you are not entitled to, you must pay it back when BUPA asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

Should you wish to cancel this instruction through BUPA, please call us on 0345 609 0111*. You must allow a minimum of seven days before the next payment by Direct Debit is due.

†We may record or monitor our calls. For people with hearing or speech difficulties you can use the Relay UK service on your smartphone or textphone. For further information visit **www.relayuk.bt.com**. We also offer documents in Braille, large print or audio.

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Final checklist

Before you return this form, ensure that you have:

- ticked the cover option in Section 3
- included full details of all the dependants your client would like to cover
- asked your client to check that their dependants' details are correct and made sure that they were directed to our privacy notice on page 13 before submitting their details to us
- remembered to sign and date the form
- made sure you and your client have a copy of this form for your own records
- ensured the direct debit instruction section has been signed by your client.

Where to send your client's completed form

- By post: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**
- Or by email: **membershipadmin@bupa.com**

  If you need to send us sensitive information you can email us securely using Egress.

  For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

Once we have received and processed your client's application they will receive a welcome pack in the post.

Bupa health insurance is provided by:

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