

Your Choice Moratorium

INDIVIDUAL APPLICATION

Each of the following parts should be completed by you and the completed form returned to: Freedom Healthnet Ltd, Bourne Gate, 25 Bourne Valley Road, Poole BH12 1DY. Please use BLOCK CAPITALS.

About you

Title (Dr/Mr/Mrs/Miss/Ms/Other)		Forename(s)		Surname	
Date of birth dd/mm/yyyy		Occupation			
Address					
				Postcode	
Telephone numbers <small>(inc. area code)</small>		Daytime		Evening	
				Mobile	
E-mail address			Are you a smoker?*		Yes
					No
Are you to be included in the cover under this Policy?			Yes	No	

About your family

Please insert details of your partner and any unmarried children you want to include in the policy. Children to be included must be under age 21 (or age 25 if in full time education). If there is insufficient room here for all the dependants you wish to include, please provide details on the back page.

	Full forenames	Surname	Male or Female	Date of birth dd/mm/yyyy	Occupation	Smoker?*	
						Yes	No
Partner							
Child 1							
Child 2							
Child 3							
Child 4							

About your general practitioner

Name:

Address:

Date of first registration with your general practitioner:

If you have been registered with your GP for less than six months, please provide details of your previous GP.

About any existing scheme you may have

Please read 'Moratorium Explanatory Note' before cancelling any existing policies.

Have you private medical insurance at the moment? Yes No

If Yes, who are the insurers? Renewal date dd/mm/yyyy

* Our definition of smoker is someone who smokes or has, within the last 3 years, smoked cigarettes, cigars, tobacco or a pipe.

The cover you require

A. IN-PATIENT COVER

Freedom level	Annual in-patient limit	Please tick (one box only)
Gold	£30,000	<input type="checkbox"/>
Platinum	£50,000	<input type="checkbox"/>
Diamond	£100,000	<input type="checkbox"/>
Diamond Plus	No annual benefit limit	<input type="checkbox"/>

B. OUT-PATIENT COVER (OPTIONAL)

If you choose to include this optional benefit, the annual limit of cover will depend on the level of in-patient cover selected, as follows:

In-patient level	Out-patient cover
Gold	£1,000
Platinum	£1,000
Diamond	£1,250
Diamond Plus*	No annual benefit limit

* Please note out-patient cover is automatically included for Diamond Plus policies

Do you want to include out-patient cover? Yes No

Your Diamond Plus cover can be upgraded to include the following:

- In-patient & out-patient cover
- A. Alternative therapies
- B. Psychiatric care
- C. Rehabilitation benefits

VOLUNTARY EXCESS

You can reduce your premiums by agreeing to a voluntary excess when you take out your policy. This will be IN ADDITION TO the compulsory excess of £100 on each course of treatment.

Do you want to accept a voluntary excess? Yes No

If yes, please indicate below the level you require.

Excess		Premium Reduction		Please tick (one box only)
Voluntary	Compulsory	Total	%	
£100	£100	£200	7.5%	<input type="checkbox"/>
£250	£100	£350	12.5%	<input type="checkbox"/>
£500	£100	£600	17.5%	<input type="checkbox"/>
£1000	£100	£1100	25%	<input type="checkbox"/>

Please note that the level of cover and any voluntary excess you select will be the same for all dependants included in your policy.

Premium quoted £

When do you want your cover to start? -

dd/mm/yyyy

Note: Backdating of cover is not allowed.

Declaration

I declare that the statements made on this application form and any additional information supplied as part of this application are to the best of my knowledge and belief, full, true and correct. I shall read the policy documents when I receive them and agree that I, and any other dependants included in this application, will be bound by the terms and conditions of the policy. I understand that pre-existing conditions are subject to the terms of the moratorium as defined in the policy. The "Moratorium Explanatory Note" explains how the moratorium works. I understand that this application is for a new policy and subject to new moratorium underwriting. I understand there is no continuation of underwriting and / or benefits from a previous insurer and the pre-existing condition period of five years commences from the start of the policy.

THIS SECTION MUST BE COMPLETED. FAILURE TO INCLUDE ALL MATERIAL INFORMATION OR PROVIDING FALSE INFORMATION MAY RESULT IN CANCELLATION OF COVER OR DENIAL OF CLAIM PAYMENT AT THE TIME OF CLAIM.

Please check the box if any person for whom this application is being made (including yourself, spouse and dependents):

- (i) has been treated for, diagnosed with, or advised that they have a heart condition, cancer or mental illness
- (ii) has undergone a surgical operation or has reason to believe that a surgical operation will be required in the future

If you have checked either of the above boxes, please provide details on a separate sheet

Proposer's Signature

Date *

* This must be dated: a) prior to the start date of the policy b) not more than 30 days in advance of the start date.

Note: A specimen copy of the policy is available on request. You are advised to keep a record (including copies and letters) of all information supplied to Freedom Healthnet Ltd. A copy of this application will be supplied to you on request within three months of completion. Completion of this form should not be construed as acceptance of risk by Freedom Healthnet Ltd.

Data Protection Act: We, Freedom Healthnet Ltd will use the information you have given to provide and administer the policy you have applied for. The use of personal data and description of the general categories of person and organisations to whom we may disclose it can be found in the Data Protection Register. You are entitled to request a copy of the personal data held in reference to you on our computer, but we reserve the right to charge a small fee.

We, our agents or intermediaries and any member of Freedom Healthnet Ltd, may use the information that you have provided for marketing purposes or for general market research.

We may also use some of the information to advise you of other products and services, offered by Freedom Healthnet. Please tick if you do not wish to receive this information.

(For office use only)

Agency name/number

Consultant Name

Where shall we send the documents?

Direct to client

Direct to you to forward

To you and your client

Methods of payment

(please tick as appropriate)

By Direct Debit Monthly Annually By cheque, annually

Once you have completed this form please return it to: Freedom Healthnet Ltd, Bourne Gate, 25 Bourne Valley Road, Poole BH12 1DY.



Instruction to your Bank / Building Society to pay by Direct Debit
Premium Credit Limited, Premium Credit House, 60 East Street, Epsom KT17 1HB.



Please complete parts 1-5 to insure your Bank / Building Society to make payments directly from your account.

Originator's Identification Number

9 4 2 4 6 1

1. Full postal address of your branch

To: _____ Bank/Building Society

Address: _____

Postcode: _____

2. Branch Sort Code

- -

3. Bank / Building Society Number

5. Name of Account Holder

6. Instruction to your Bank or Building Society

Please pay Premium Credit Limited, 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 Premium Credit Limited and, if so, details will be passed electronically to my Bank/Building Society.

Bank and Building Societies may not accept Direct Debit instructions for some types of accounts.

Signature _____ Date _____

The Direct Debit Guarantee



- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment date change, Premium Credit Limited will notify you 5 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Premium Credit Limited, or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society.
- Please also send a copy of your letter to us.



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25 Bourne Valley Road
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Website: www.freedomhealthnet.com

Registered Office: Freedom Healthnet Ltd, Bourne Gate, 25 Bourne Valley Road, Poole BH12 1DY.
Registered in England No. 4815524.
This Policy is underwritten by Great Lakes Reinsurance (UK) PLC.

Freedom Healthnet Ltd is authorised and regulated by the Financial Services Authority.