

Your Choice Full Medical Underwriting

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 6 months, please provide details of 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.

About your health

A. Please provide body mass details for each member:

Forename	Surname	Weight (kg)	Height (cm)

B. In the previous five years have you been diagnosed, treated or require any ongoing medical medication or tests for the following conditions?

Cancer tumours, lumps or growths	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart disease, rheumatic fever, chest pain or circulatory problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blood disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Respiratory disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abdominal/Digestive disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Genito/urinary disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Musculo-skeletal/nervous system disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Gynaecological disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ear, nose & throst disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neurological or mental disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Skin disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any operations, special investigations	Yes <input type="checkbox"/>	No <input type="checkbox"/>

C. Have you ever been treated or been recommended for treatment for the use of alcohol or drugs? Been advised to stop/reduce the amount of alcohol intake or ever been convicted of any drug related offences? Yes No

D. In the previous five years have you been advised to obtain treatment in a hospital or a clinic for any tests, x-rays, treatment or procedures which are not covered within any other questions on this medical questionnaire? Yes No

E. Are you aware of any tests, treatment, or specialist consultations that may be necessary within the following two years? Yes No

F. Do you have any unusual disorders, deformities or disabilities which are not covered within any other questions on this medical questionnaire? Yes No

G. Have you ever been declined for any life or health insurance products (inc refusal of a renewal)? Yes No

H. Have you undergone a surgical operation or have reason to believe that a surgical procedure will be required in the future? Yes No

If any member to be insured on this application form answers "Yes" to any of the questions above please give full details.

Please note: You should declare all medical conditions or symptoms even if they do not become apparent in the above questionnaire.

Applicant Name	
Details of condition/symptom, medication and/or treatment received. Please include dates.	
Initial symptom date	
Details of ongoing tests, medication and treatment required. Please include dates.	

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Medical Consent

In order to administer your policy, it may be necessary to request your medical notes, a medical report or any other additional information from your doctor. In order to do this, we need your consent and a signed declaration.

By signing the declaration you and your adult dependents will give us permission to obtain additional information.

The Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 you have specific rights which are outlined below:

- a) You have the right to see the completed report before it is sent to us. If you wish to see the report you have 21 days to arrange this with your doctor. However, please note that we can only authorise treatment once we have received all required information.
- b) You can request that your doctor amends any part of the report that you consider to be incorrect or misleading. If your doctor does not agree to amend certain parts, you may attach your comments.
- c) You may request to see a copy of your report up to six months after we have received it. Your doctor can arrange this for you and may charge a fee to cover the cost.
- d) Your doctor may decide that in the interest of your health, or the health of others, you should not see all or part of the report. If your doctor does not let you see any part of the report, he/she must notify you of the fact.
- e) You have the right to withhold your consent. However, in this case we may not be able to proceed with your claim.

Declaration

I declare to the best of my knowledge and belief the information given on this form is true and correct.

I have been informed and I understand my statutory rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. In connection with the insurance submitted, I hereby consent to Freedom Healthnet seeking medical information from any doctor who at any time, has attended me concerning anything which affects my physical and/or mental health, and that this information shall be passed to Freedom Healthnet's administrators. I agree that a copy of this consent shall have the validity of the original.

I do/do not* wish to see any report before it is sent to Freedom Healthnet Limited (*Delete as appropriate).

Proposer's Signature

Name in Capitals

Date

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/we give consent to you using the health/medical information provided in the "About your health" section, also any other information provided in the course of the application may be used to underwrite and administer my/our policy.

I/we understand that by disclosure of my/our medical history does not guarantee acceptance by Freedom Healthnet and policy endorsements may be necessary to apply special terms and conditions.

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

Freedom Healthnet Ltd, Bourne Gate, 25 Bourne Valley Road, Poole BH12 1DY. Registered Office: Freedom Healthnet Ltd, Bourne Gate, 25 Bourne Valley Road, Poole, BH12 1DY.

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.



Originator's Identification Number

9 4 2 4 6 1

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

1. Full postal address of your branch

To: _____ Bank/Building Society
Address: _____

Postcode: _____

5. Name of Account Holder

2. Branch Sort Code

- -

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.

3. Bank / Building Society Number

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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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.