# Your medical history form

## Bupa By You

Underwritten
To be completed by the customer

BBY/6941/JUN23

**Please use this form to tell us about your medical history, and the medical history for anyone else you want to add to your cover (a dependant).**

**We need this information to confirm your cover, process your claims and pay for any treatment you need that's covered by your policy.**

- You can complete this form on a computer or use a paper copy and write in capital letters and black ink.
- Give as much detail as you can and check all answers are correct to the best of your knowledge.
- If the answers are about a dependant (your partner and any child you or your partner are responsible for and who is covered on your policy and named on your membership certificate), check with them to make sure the information you're providing is correct.
- Read the privacy notice on page 14 to see how we use your information. Please give a copy of this to any dependants covered on your policy.
- Sign and date the form in black ink.
- Return your completed form to us:
  - By email to: **membershipadmin@bupa.com**
  - By post to: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

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 account, go to **switch.egress.com**. You won't have to pay for sending secure emails to a Bupa email address using Egress.

If you have any questions, please call us on **0345 609 0111** between 8am and 8pm Monday to Friday and 8am and 4pm on Saturdays and we'll be happy to help.

We may record or monitor our calls.

**Hearing or speech difficulties?** Please use the Relay UK service on your smartphone or textphone.
Visit **www.relayuk.bt.com** for more information.

**Sight difficulties?** We offer documents in Braille, large print or audio. Please let us know if you'd like us to send you any.

**Need to know**

This policy is fully medically underwritten. This means that any symptoms or conditions you, or your dependant(s), had before the policy started may not be covered.

We may ask you, or your dependant(s), for more medical information when you, or they, claim for up to five years after your policy start date. This is to make sure that a claim doesn't relate to something which isn't covered by your policy.

If there's reasonable evidence that you or a dependant didn't take reasonable care answering our questions, your policy may be cancelled, treated as if it never existed, or your claims may be not be paid.

# 1. Your personal details

| | | | | | |
|---|---|---|---|---|---|
| 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 ☐ |
| If you're already a Bupa policyholder or beneficiary or have been in the past, please give us your membership or registration number. | ☐☐☐☐☐☐☐☐☐☐ | | | | |

**If you'd like to add anyone else to your cover (for example your partner or children) please answer the questions in section 2.**

**If not, go to section 3.**

# 2. Details of anyone else to be covered

**Need to know**

**If you'd like to cover any dependants, please give us their details below. Remember to check with each dependant that you have their correct details and make sure that they're shown our privacy notice on page 14 before sending us their details. You must have their express agreement to send us this form on their behalf, or be their legal representative.**

**Adding people to your policy will affect the price you pay for your cover.**

| | Person 2 | Person 3 | Person 4 | Person 5 |
|---|---|---|---|---|
| Title | | | | |
| First name(s) | | | | |
| Surname | | | | |
| Relationship to you | | | | |
| Date of birth | D D M M<br>Y Y Y Y | D D M M<br>Y Y Y Y | D D M M<br>Y Y Y Y | D D M M<br>Y Y Y Y |
| Sex at birth | Male ☐ Female ☐ | Male ☐ Female ☐ | Male ☐ Female ☐ | Male ☐ Female ☐ |

**Need to add more people?**

**Use a separate piece of paper and attach it with this form when you send it back to us.**

# 3. About you and anyone else to be covered

**Need to know**

**Please answer each question for yourself and for each person named in section 2. If you're an existing policyholder and are only adding dependants, you don't need to complete sections 3 and 4 about yourself, just about your dependants.**

**Please tick 'Yes' or 'No' to every question as it applies to you and each dependant named in section 2. Remember to check with them that you have their correct details and make sure they're shown our privacy notice on page 14 before sending us their details.**

| | Main policyholder | Person 2 | Person 3 | Person 4 | Person 5 |
|---|---|---|---|---|---|
| | *(Please tick the relevant box)* | | | | |
| Are you a UK resident?<br>If you live in the UK (including Isle of Man and Channel Islands) for 183 days or more each year | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| Have you been registered with a UK GP for at least six months? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| If not, do you have access to your medical records in English?<br>**Need to know:** You'll need to be registered with a GP in the UK – if not, we may be unable to offer you health insurance cover | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| Are you a professional or semi-professional sportsperson?<br>By this we mean: are you paid or sponsored to take part in any sport? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| If 'Yes', which sport(s)? Please include the name of the team, if applicable.<br>**Need to know:** When we receive your application, if we're unable to offer you health insurance cover, we'll let you know as soon as we can | | | | | |
| Have you used any tobacco products in the last two years? *(Over 18s only)* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |

# 4. Medical history - part one

**Need to know**

**This section asks for your previous and current health and medical details, and for each dependant named in section 2. Please tick 'Yes' or 'No' to every question for each person. Remember to check with them that you have their correct details and make sure they're shown our privacy notice on page 14 before sending us their details.**

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

# 4. Medical history - part one (continued)

| | Main policyholder | Person 2 | Person 3 | Person 4 | Person 5 |
|---|---|---|---|---|---|
| | *(Please tick the relevant box)* | | | | |
| **11.** Blood disorders<br>*For example: anaemia, hepatitis, HIV, abnormal blood tests* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **12.** Reproductive system problems<br>*For example: pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, low sperm count* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **13.** Dental problems<br>*For example: wisdom teeth, abscess* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **14.** Allergies<br>*For example: pet allergies, food allergies* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **15.** Psychological disorders<br>*For example: depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **16.** Undiagnosed symptoms<br>*For example: chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps* | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **Please also answer the following questions:** | | | | | |
| **17.** Are you currently taking any medicines, prescribed or otherwise? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **18.** Within the last three months have you had symptoms of any health problems that you've not talked to a health professional about? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **19.** Have you ever had any joint replacements, heart conditions, or strokes? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **20.** Is there any other information about your health that has not yet been included in your answers to questions 1 to 19? | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ | Yes ☐ No ☐ |

**If you've answered 'Yes' to any of the conditions here please give us full details on the following pages in 'Medical history – part two'.**

**If you've answered 'No' to all of the above conditions, please go to section 5.**

# 4. Medical history - part two

**Need to know**

**To help us fully understand your health and medical history, and the health and medical history of your dependants, please give more details on pages 8 to 11 about any of the conditions you answered 'Yes' to in part one. Please give as much detail as possible. Without this information, your application for cover may be delayed. Below are some examples to help you.**

## Definitions

**Controlled:** Condition or symptom ongoing but controlled by treatment or medication.

**Recurrent:** Occurring more than once, often or occasionally.

**Likely to recur:** Symptom free for a period of time, but likely to come back or happen again.

**Fully recovered:** Condition fully resolved or cured, with no symptoms and no medication.

**Example one**

| | |
|---|---|
| **Name:** | JOHN SMITH |
| Question number from **part one** | 11 |
| Please describe the illness or medical problem<br>Include which area of the body is affected, if relevant (for example left, right, upper, lower) | HIGH CHOLESTEROL |
| When did symptoms start and end?<br>**If symptoms are ongoing, please leave end date blank** | Started 01 01 2020 (D D M M Y Y Y Y)<br>Ended |
| What treatment have you had? | OVER COUNTER MEDICATION / DIET / PRESCRIBED MEDICATION |
| Current state of the condition or symptom | Ongoing ☐ Controlled ☑ Recurrent ☐<br>Likely to recur ☐ Fully recovered ☐ |
| How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years? | 2 |

**Example two**

| | |
|---|---|
| **Name:** | JOHN SMITH |
| Question number from **part one** | 9 |
| Please describe the illness or medical problem<br>Include which area of the body is affected, if relevant (for example left, right, upper, lower) | LEFT KNEE PAIN |
| When did symptoms start and end?<br>**If symptoms are ongoing, please leave end date blank** | Started 05 05 2020 (D D M M Y Y Y Y)<br>Ended 20 01 2022 |
| What treatment have you had? | PHYSIOTHERAPY |
| Current state of the condition or symptom | Ongoing ☐ Controlled ☐ Recurrent ☐<br>Likely to recur ☐ Fully recovered ☑ |
| How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years? | 5 |

# 4. Medical history - part two (continued)

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

# 4. Medical history - part two (continued)

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

# 4. Medical history - part two (continued)

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

# 4. Medical history - part two (continued)

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

**Name:**

Question number from **part one**

Please describe the illness or medical problem

Include which area of the body is affected, if relevant (for example left, right, upper, lower)

When did symptoms start and end?
**If symptoms are ongoing, please leave end date blank**

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have you had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐

Likely to recur ☐ Fully recovered ☐

How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?

# 5. Medical reports – when we need more information from your doctor

- we may need to ask your doctor for information about your consultation, tests, or treatment to see if your policy covers these - we'll need your permission to do this, and you have certain rights when it comes to your personal and medical information
- you can give your doctor permission to send us a medical report without you seeing it first or ask to see it before they send it to us
- you can ask your doctor to show you the medical report before they send it to us so long as you do this within 21 days from the date we ask them for it
- if you don't contact your doctor within 21 days, we'll ask them to send the report straight to us
- you can ask your doctor to change the report if you think it's inaccurate or misleading - if they refuse, you can add your own comments to it before they send it to us
- once you've seen the report, your doctor can't send it to us unless you give them permission to do so
- you can ask your doctor not to send us the medical report - if this happens, we may be unable to tell you whether your consultation, test or treatment is covered, and we may be unable to pay your claim
- you can ask your doctor to let you see a copy of your medical report within 6 months of it being sent to us
- your doctor can withhold some or all the information in the report if they believe the information:
  - might cause you or someone else physical or mental harm, or
  - would reveal someone else's identity without their permission (unless the person is a healthcare professional, and they provide is about your care)
- your doctor may charge you for a medical report - we'll let you know if we'll cover some of this cost - if not, you'll need to pay for it yourself.

There's more detail about your rights in **The Access to Medical Reports Act 1988** and **The Access to Personal Files and Medical Reports (NI) Order 1991.**

# 6. Your legal declaration

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

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

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

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

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

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

**Obtaining medical reports from your doctor**

- I understand that Bupa may need me to provide a medical report from my doctor to support my application, before treatment is authorised or a claim paid.
- I understand that Bupa will gain verbal or written permission from me prior to any medical report being requested in this way.
- I have shown this declaration to the proposed dependants on the policy. I confirm that they understand that Bupa will gain verbal or written permission from them prior to any medical report being requested in this way.
- I acknowledge the rights I have in relation to such reports as explained in section 5.

Signature

Date D D M M Y Y Y Y

**We'll verify your digital signature if you sign your form using an Adobe Digital ID or Adobe Sign (or similar). If you change your form after digitally signing it or send us a printed or scanned copy, then we we'll be unable to do this. We'll call or write to you to confirm this is your signature instead. We'll be unable to tell you what you're covered for until we've verified your signature, and it might take us longer to pay any claims.**

# Privacy notice – in brief

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).

# Final checklist

**Before you return this form to us, please make sure you've:**

- ✔ included full details of everyone you would like to be covered by the policy
- ✔ checked that everyone's details are correct
- ✔ shown each dependant the privacy notice on page 14
- ✔ checked you have everyone's agreement to send us this form on their behalf, or you're their legal representative
- ✔ signed and dated your form
- ✔ kept a copy for your own records.

# You can send us this form by:

- Email: **membershipadmin@bupa.com**
- Post: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

  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.

# What happens next?

We'll review the information you've included in our form and if we need more details, we'll be in touch. If we don't need to check anything with you, we'll send you a welcome pack.

Bupa health insurance is provided by:

Bupa Insurance Limited. Registered in England and Wales with registration number 3956433.

Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

Arranged and administered by: Bupa Insurance Services Limited, which is authorised and regulated by the Financial Conduct Authority. Registered in England and Wales with registration number 3829851.

Registered office: 1 Angel Court, London EC2R 7HJ



**bupa.co.uk**

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