

# Your Client's Medical History Form

**Bupa By You**

Underwritten

For the intermediary to complete



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

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

- This form should be completed by you on behalf of your client.
- 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 with your client to make sure they're correct to the best of their knowledge.
- If the answers are about a dependant (their partner and any child they or their partner are responsible for and who is covered on their policy and named on their membership certificate), have your client check with them to make sure the information you're providing is correct.
- Read the privacy notice on page 13 to see how we use your client's information. Please ask your client to give a copy of this to any dependants covered on their policy.
- Sign and date the form in black ink.

**When you have completed this form, please upload it onto the intermediary quote tool or if you are unable to do so, please contact our Consumer Intermediary team on 0800 332 000, option 2.**

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](http://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.

**Once we have received and processed your client's application, we'll send them a welcome pack.**

#### **Need to know**

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

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

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

## **Intermediary details**

Bupa agency number

Intermediary name

Telephone number

Email address

## 1. Your client's personal details

Title <i>(please tick or list title if other)</i> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mx <input type="checkbox"/> Other <input type="checkbox"/>	
First name(s)	Surname
Address	
Postcode	
Home telephone number	Mobile telephone number
Email address	
Date of birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Sex at birth    Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation <i>(please note we may request proof of applicant occupation)</i>	

If your client is already a Bupa policyholder or beneficiary or has been in the past, please give us their membership or registration number.

         

Please tick to confirm your client(s) understand(s) that by joining this scheme they are joining Bupa as a brand new customer(s). Please note that the policy they are joining is a fully medically underwritten policy. 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 to add anyone else to their cover (for example their 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 your client would like to cover any dependants, please give us their details below. Remember to ask your client to check with each dependant that you have their correct details and make sure that everyone to be covered has been shown our privacy notice on page 13 before sending us their details. Your client must have their dependants' express agreement to send us this form on their behalf, or be their legal representative.

Adding people to the policy will affect the price your client pays for their cover.

	Person 2	Person 3	Person 4	Person 5
Title				
First name(s)				
Surname				
Relationship to your client				
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Sex at birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>

### Need to add more people?

Please tick this box and provide their details on a separate sheet of paper. ☐

You'll also need to answer sections 3, 4 and 5 for them.

### 3. Your client's choice of scheme and excess

Please tick the relevant boxes to indicate which options your client requires. Different options can be chosen for each person on the policy.

Please note that the choice of scheme and excess level may impact the subscription your client pays for their cover.

	Main policyholder	Person 2	Person 3	Person 4	Person 5
<b>Core cover</b>					
Treatment and Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive £500	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive £750	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive £1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cover options</b>					
Full cancer cover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No cancer cover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hospital Network options</b>					
Essential Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Choice with Central London	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Essential Access with Guided Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Choice with Guided Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Choice with Central London and Guided Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Excess options</b>					
No excess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£150	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£200	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£250	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£500	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£2,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Add ons</b>					
Dental cover – level 20 (private)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 4. About your client and anyone else to be covered

### Need to know

Please answer each question for your client and for each person named in section 2. If they're an existing policyholder and are only adding dependants, you don't need to complete sections 4 and 5 about your client, just about their dependants.

Please tick 'Yes' or 'No' to every question as it applies to your client and each dependant named in section 2. Remember to ask your client to check with each dependant that you have their correct details and make sure that everyone to be covered has been shown our privacy notice on page 13 before sending us their details.

	Main policyholder	Person 2	Person 3	Person 4	Person 5
	<i>Please tick the relevant box</i>				
Do they live in the UK (including Isle of Man and Channel Islands) for six months or more each year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the person to be covered been registered with a UK GP for at least six months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If not, do they have access to their medical records in English?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Need to know:</b> They'll need to be registered with a GP in the UK - if not, we may be unable to offer them health insurance cover					
Is the person to be covered a professional or semi-professional sports person? By this we mean: are they paid or sponsored to take part in any sport?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'Yes', which sport(s)? Please include the name of the team, if applicable.  <b>Need to know:</b> When we receive your client's application, if we're unable to offer them health insurance cover, we'll let them know as soon as we can					
Has the person to be covered used any tobacco products in the last two years? (Over 18s only)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

## 5. Medical history – part one

### Need to know

This section asks for your client's 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 ask your client to check with each dependant that you have their correct details and make sure that everyone to be covered has been shown our privacy notice on page 13 before sending us their details.

Please answer questions 1 to 16 to indicate if your client or anyone to be covered on their policy has: <ul style="list-style-type: none"> <li>seen a GP or other healthcare professional within the last <b>two years</b> for any of the conditions or symptoms listed</li> <li>OR</li> <li>been admitted to hospital, had an operation or any investigations (for example, scan, X-ray, blood test, biopsy) within the last <b>seven years</b> for any of the conditions or symptoms listed.</li> </ul>	Main policyholder	Person 2	Person 3	Person 4	Person 5
	Please tick the relevant box				
1. Heart or cardiovascular disorders <i>For example: coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Glandular disorders <i>For example: diabetes, thyroid problems, hormonal problems</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Breathing or respiratory disorders <i>For example: asthma, bronchitis, shortness of breath, chest infections</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Ears, nose, throat, or eye problems <i>For example: tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Stomach, intestines, liver or gallbladder <i>For example: ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Cancer, tumours, growths, cysts, or moles that itch or bleed	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Skin problems <i>For example: eczema, rashes, psoriasis, acne</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Brain or nervous system disorders <i>For example: migraines, repeated headaches, MS, epilepsy, nerve pain, fits</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Muscle or bone (musculoskeletal or MSK) problems <i>For example: arthritis, cartilage and ligament problems, back and neck problems, sprains, gout, sciatica</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Urinary problems <i>For example: bladder, kidney or prostate problems, urinary infections, incontinence</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

## 5. Medical history – part one (continued)

	Main policyholder	Person 2	Person 3	Person 4	Person 5
	Please tick the relevant box				
<b>11. Blood disorders</b> <i>For example: anaemia, hepatitis, HIV, abnormal blood tests</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>12. Reproductive system problems</b> <i>For example: pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, low sperm count</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>13. Dental problems</b> <i>For example: wisdom teeth, abscess</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>14. Allergies</b> <i>For example: pet allergies, food allergies</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>15. Psychological disorders</b> <i>For example: depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>16. Undiagnosed symptoms</b> <i>For example: chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please also answer the following questions:

<b>17. Is your client or anyone to be covered currently taking any medicines, prescribed or otherwise?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>18. Within the last three months has anyone to be covered had symptoms of <b>any</b> health problems that they've not talked to a health professional about?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>19. Has anyone to be covered <b>ever</b> had any joint replacements, heart conditions or strokes?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>20. Is there any other information about your client's health that has not yet been included in the answers to questions 1 to 19?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

If they've answered 'No' to all of the above conditions, please go to section 6.

## 5. Medical history – part two

### Need to know

To help us fully understand your client's health and medical history, and the health and medical history of their dependants, please give more details on pages 9 to 11 about any of the conditions they answered 'Yes' to in part one. Please give as much detail as possible. Without this information, their 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 <b>part one</b>	11							
Please describe the illness or medical problem Include which area of the body is affected, if relevant (for example, left, right, upper, lower)	HIGH CHOLESTEROL							
When did the symptoms start and end? If symptoms are ongoing, please leave the end date blank	Started	<div>01012022</div>						
	Ended	<div>DDMMYY</div>						
What treatment have they had?	OVER COUNTER MEDICATION / DIET / PRESCRIBED MEDICATION							
Current state of condition or symptom	Ongoing <input type="checkbox"/> Controlled <input checked="" type="checkbox"/> Recurrent <input type="checkbox"/> Likely to recur <input type="checkbox"/> Fully recovered <input type="checkbox"/>							
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 <b>part one</b>	9							
Please describe the illness or medical problem Include which area of the body is affected, if relevant (for example, left, right, upper, lower)	LEFT KNEE STRAIN							
When did the symptoms start and end? If symptoms are ongoing, please leave the end date blank	Started	<div>05052020</div>						
	Ended	<div>20012021</div>						
What treatment have they had?	PHYSIOTHERAPY							
Current state of condition or symptom	Ongoing <input type="checkbox"/> Controlled <input type="checkbox"/> Recurrent <input type="checkbox"/> Likely to recur <input type="checkbox"/> Fully recovered <input checked="" type="checkbox"/>							
How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?	0							



## 5. 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 the symptoms start and end?

Started

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**If symptoms are ongoing, please leave the end date blank**

Ended

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What treatment have they had?

Current state of 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 the symptoms start and end?

Started

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**If symptoms are ongoing, please leave the end date blank**

Ended

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What treatment have they had?

Current state of 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 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 the symptoms start and end?

Started

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**If symptoms are ongoing, please leave the end date blank**

Ended

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What treatment have they had?

Current state of 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 the symptoms start and end?

Started

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**If symptoms are ongoing, please leave the end date blank**

Ended

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What treatment have they had?

Current state of 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 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 the symptoms start and end?

Started

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**If symptoms are ongoing, please leave the end date blank**

Ended

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What treatment have they had?

Current state of 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 the symptoms start and end?

Started

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

**If symptoms are ongoing, please leave the end date blank**

Ended

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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What treatment have they had?

Current state of 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?

## 6. Your client's payment for their cover

Payment is made by monthly direct debit. Please make sure your client completes the Direct Debit instruction on page 14.

Premium quoted     £

When would your client(s) 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 on the above date, this cannot be guaranteed. Your client's start date will be confirmed on their membership certificate.**

**We won't backdate start dates to a date before we receive 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.
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 everyone to be covered has been shown Bupa's privacy notice.
4. My client has declared they agree to be bound by the terms of this policy's 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's 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 doesn't provide complete information about themselves or any other person covered under the policy, we may have the right to end their policy, or not pay all or part of a claim.

We recommend that you and your client keep a record of all the information you provide 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 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'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 your client what they're covered for until we've verified your signature, and it might take us longer to pay any of their claims.**

# Privacy notice – in brief

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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](https://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](mailto: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](https://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](mailto: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](mailto: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
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## 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 membership or registration 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.<sup>†</sup> You must allow a minimum of seven days before the next payment by Direct Debit is due.**

<sup>†</sup>We may record or monitor our calls.

For those with hearing or speech difficulties you can use the Relay UK service on your smartphone or telephone. For further information visit [www.relayuk.bt.com](http://www.relayuk.bt.com). We also offer documents in Braille, large print or audio.

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## Final checklist

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

- ✓ ticked the cover option in Section 3
- ✓ included full details of everyone your client would like to be covered by the policy
- ✓ checked with your client's dependants that their details are correct and made sure that they were directed to our privacy notice on page 13 before submitting their details to us
- ✓ signed and dated the form
- ✓ made sure you and your client have kept a copy for your own records
- ✓ ensured the direct debit instruction section has been signed by your client.

**When you have completed this form, please upload it onto the intermediary quote tool or if you are unable to do so, please contact our Consumer Intermediary team on 0800 332 000, option 2.**

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](http://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.

### **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 your client 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

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