Your Client's Application/ Amendment Form

Bupa Health

Underwritten/Moratorium

To be completed by the intermediary

PERS/7093/JUL25

Please use this form to tell us about your client's details, and the details 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, the intermediary, on behalf of your client.
- 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 14 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.

Need to know

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.

Application type

☐ New application ☐ Addition of new dependants

Intermediary details

Bupa agency number
Intermediary name
Telephone number
Email address

1. Your client's personal details

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

If your client would like 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 14 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	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Sex at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐

Need to add more people?

Please tick this box and provide their details on a separate piece of paper ☐
You'll also need to answer section 3, 4 and 5 for them.

3. Your client's choice of cover 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
Cover options					
Platinum Plus	☐	☐	☐	☐	☐
Platinum	☐	☐	☐	☐	☐
Classic Plus	☐	☐	☐	☐	☐
Classic	☐	☐	☐	☐	☐
Essentials	☐	☐	☐	☐	☐
Excess options					
No excess	☐	☐	☐	☐	☐
£100	☐	☐	☐	☐	☐
£250	☐	☐	☐	☐	☐
£500	☐	☐	☐	☐	☐
£1,000	☐	☐	☐	☐	☐
£2,000	☐	☐	☐	☐	☐

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

Full medical underwriting ☐ Moratorium underwriting ☐

4. About your client and anyone else to be covered

Need to know

Please answer each question for your client and 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 for your client, just about their new 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 14 before sending us their details.

	Main policyholder	Person 2	Person 3	Person 4	Person 5
	Please tick the relevant box				
Do they 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 ☐
Has the person to be covered been registered with a UK GP for at least six months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If not, do they have access to their medical records in English? **Need to know**: They'll need to be registered with a GP in the UK - if not, we may be unable to offer them health insurance cover	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Is the person to be covered a professional or semi-professional sportsperson? By this we mean: are they 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. **Need to know**: 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 ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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

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 14 before sending us their details.

Please answer questions 1 to 6 to indicate if your client or anyone to be covered on their policy has:

- seen a GP or other healthcare professional within the last two years for any of the conditions or symptoms listed, OR
- 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	
Question 1 – Muscle, bone or joint conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client had any symptoms or a condition affecting their back, neck, joints, muscles, bones, nerves or any other condition that affects normal movement? *(For example: arthritis, cartilage or ligament problems, sprains, joint replacement, gout, sciatica).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 2 – Heart and circulation conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client experienced shortness of breath, heart palpitations, swollen ankles, angina, heart attack, stroke, mini-stroke (also called TIA) or any related symptoms? *(For example: high blood pressure, high cholesterol, atrial fibrillation, heart failure, heart disease, chest pains, coronary artery disease).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 3 – Pelvic conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client had any problems with their bladder, bowels, kidneys or prostate? Do they have heavy or irregular periods? Has your client had a caesarean section? *(For example: urinary tract infections, irritable bowel, incontinence, endometriosis, fibroids, pregnancy or childbirth problems).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 4 – Eye, ear and teeth conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client had any problems with their vision, hearing, balance, an impacted tooth, or retained tooth root? *(For example: cataracts, glaucoma, infections, abscess).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 5 – Mental health conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client talked with a GP, therapist, counsellor or any other health professional about their mental health? *(For example: stress, depression, fatigue, anxiety, anorexia, bulimia, compulsive disorders, schizophrenia, bipolar disorder).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 6 - Lung or other breathing conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client had any problems with breathing or their respiratory system? *(For example: breathlessness, asthma, bronchitis, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, pneumonia or chest infections).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Medical history – part one (continued)

Please also answer the following questions:	Main policyholder		Person 2		Person 3		Person 4		Person 5	
Question 7 – Cancer conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has your client ever been diagnosed with or had treatment for cancer, or had a test that shows they may have cancer? *(For example: tumours, abnormal smears, raised PSA (prostate-specific antigen) levels).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 8 – Any other ongoing conditions	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Does your client have any other symptoms or health conditions for which they need ongoing prescription medication, regular medical tests, examinations or consultations?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Question 9 – Any planned treatment	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Does your client have any other health condition or symptoms for which they intend to seek investigation or treatment in the future or have currently received investigation/treatment for?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If your client has answered 'Yes' to any of the conditions here, please give is 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. If your client would like to add any additional information, please tick this box and use the Notes on page 16. ☐

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

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 us more details on page 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.

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

Example one

Name:	JOHN SMITH
Question number from **part one**	2
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 01 01 2020 (D D M M Y Y Y Y) Ended
What treatment have they had?	OVER COUNTER MEDICATION / DIET / PRESCRIBED MEDICATION
Current state of the condition or symptom	Ongoing ☐ Controlled ☐ Recurrent ☑ Fully recovered ☐
How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?	2
If your client would like to declare another symptom or condition for this question, please tick this box ☐	

Example two

Name:	JOHN SMITH
Question number from **part one**	1
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 05 05 2020 (D D M M Y Y Y Y) Ended 20 01 2021 (D D M M Y Y Y Y)
What treatment have they had?	PHYSIOTHERAPY
Current state of the condition or symptom	Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☑
How many times has this person spoken to a healthcare professional about this symptom or condition in the last two years?	0
If your client would like to declare another symptom or condition for this question, please tick this box ☑	

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?

If symptoms are ongoing, please leave the end date blank

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have they had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☐

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

If your client would like to declare another symptom or condition for this question, please tick this box ☐

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?

If symptoms are ongoing, please leave the end date blank

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have they had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☐

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

If your client would like to declare another symptom or condition for this question, please tick this box ☐

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?

If symptoms are ongoing, please leave the end date blank

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have they had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☐

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

If your client would like to declare another symptom or condition for this question, please tick this box ☐

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?

If symptoms are ongoing, please leave the end date blank

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have they had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☐

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

If your client would like to declare another symptom or condition for this question, please tick this box ☐

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?

If symptoms are ongoing, please leave the end date blank

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have they had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☐

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

If your client would like to declare another symptom or condition for this question, please tick this box ☐

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?

If symptoms are ongoing, please leave the end date blank

Started D D M M Y Y Y Y

Ended D D M M Y Y Y Y

What treatment have they had?

Current state of the condition or symptom

Ongoing ☐ Controlled ☐ Recurrent ☐ Fully recovered ☐

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

If your client would like to declare another symptom or condition for this question, please tick this box ☐

6. Paying for your client's cover

Premium quoted £	Payment is made by monthly Direct Debit. Please ensure your client completes the Direct Debit instruction on page 13.
When would your client like their cover to start? D D M M Y Y Y Y	

Please note: although we will try to start your client's cover (whether for new members or for dependants added to existing membership) on the 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.

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

DIRECT Debit

Service User Number

9	9	1	3	6	4

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

To: The Manager

Bank or Building Society

Address

Postcode

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

3. Branch sort code

☐☐ - ☐☐ - ☐☐

4. Bank or Building Society account number

☐☐☐☐☐☐☐☐

5. BUPA 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.

DIRECT Debit

The Direct Debit Guarantee

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

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

Privacy notice

Our privacy notice explains how we take care of your personal information and how we use it to provide your cover. A brief version of the notice can be found in your policy guide or the full version is online at **bupa.co.uk/privacy**

†We may record or monitor phone calls.

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

7. Privacy notice – in brief

Please make sure that your client (and their dependants, if applicable) are aware of this privacy notice.

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you, how we use it and how we protect it. It also provides information about your rights. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details in our full privacy notice, which is 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 Privacy Team, Bupa, 1 Angel Court, London EC2R 7HJ**. 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 is for anyone who buys, uses, or contacts 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 when you get in touch with us and from certain other organisations (those acting on your behalf, for example, brokers, healthcare 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. What personal information we collect

We process the following categories of personal information about you and, if it applies, your dependents. 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. How we use the personal information we collect

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, 1 Angel Court, London, EC2R 7HJ**

6. AI, 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, healthcare 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. Cookies

When you use our websites and apps, we and third-party companies use cookies and similar technologies to collect information.

9. Transferring your personal information abroad

We work with companies that we partner with, or that provide services to us (such as healthcare 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.

10. How long we keep your information for

We keep your personal information in line with set periods. We typically keep personal information for seven years after you stop being a customer.

11. 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.

12. 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's Office, who can be contacted via **ico.org.uk/make-a-complaint** or **0303 123 1113**.

8. 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 everyone to be covered has been shown Bupa's privacy notice.
3. My client has declared they understand their personal information and that of any other person to be covered by this policy will be processed by Bupa for the purposes set out in Bupa's privacy notice. My client has provided me with confirmation that they have brought Bupa's privacy notice to the attention of any other person who will be covered by the policy.
4. My client has declared they agree to be bound by the 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 anyone else 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.

9. Notes

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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