

Application and policy change form

Select Healthcare Plan

Transfer from another insurance company

To be completed by the member



This application form is for anyone (except professional sportspeople) who is applying to join Bupa Select and who at the time of applying:

- has health insurance with another insurer and
- has had their health insurance cover with that insurer for at least six months if the underwriting terms were Medical History Disregarded.

In which case, we may, at our sole discretion, consider your application on a No Further Underwriting basis. Applicants who have had their health insurance with another insurer for less than six months where the underwriting terms were Medical History Disregarded cannot be considered on a No Further Underwriting basis. They will need to complete a fully underwritten application form. Please note: any dependants you wish to cover who do not currently have health insurance cover with another insurer cannot be considered to join on a No Further Underwriting basis. They will need to complete a fully underwritten application form. If they do currently have cover, you can include them in this application form.

If yes is answered to any of the conditions in section 5 further underwriting may be applied.

- If we do not offer cover on a No Further Underwriting basis we will tell you what additional exclusions we will apply to your Bupa cover that are personal to you and/or your dependants (if any). If your previous policy was Moratorium, please contact us to find out if any additional exclusions apply.
- This application form is designed to ensure we have all the information we need about you and your dependants in order to make moving to Bupa from your current insurer as straightforward as possible.
- 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), 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 to be covered on your policy.
- Sign and date the form in black ink.

This form must be completed in full and returned with:

1. **evidence of current underwriting terms for you and your dependants (if any) (e.g. letter from previous health insurer showing dates of cover and special conditions applied) and**
2. **copy of current registration/membership certificate for you and your dependants (if any) held with previous health insurer(s).**

- Return your completed form to us - use the checklist on page 15 to make sure you send us everything we need.

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 600 1167** between 8am and 5pm Monday to Friday 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.

Scheme details – please speak to your Group Secretary for these details

Company name

Bupa group number

Please tell us which products should be selected for this application.

Preferred cover start date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Are dependants eligible under the scheme?

Yes

No

Need to know: we'll try to start the cover (for the new application or change, whichever applies) on the above date. We'll confirm your start date on your membership certificate.

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 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.
 Need to know: 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	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
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? Use a separate piece of paper and attach it to this form when you send it back to us.

3. Previous insurance details

Please tell us about your insurance here.

Name of your current insurer

Existing scheme name

Date your insurance started

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Date your insurance ends/ended

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Does your existing policy cover dependants?

Yes No

4. 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, 4 and 5 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
<i>Please tick the relevant box</i>					
Are you a UK resident? You are if you live in the UK (including Isle of Man and Channel Islands) for 183 days or more each year	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Have you been registered with a UK GP for at least six months?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If not, do you have access to your medical records in English? 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 <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Are you a professional or semi-professional sportsperson? By this we mean: are you paid or sponsored to take part in any sport?	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If 'Yes', which sport(s)? Please include the name of the team, if applicable? 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					

5. 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 tick either yes or no to show if you, or anyone to be covered on your policy, has seen a GP or other healthcare professional in the last two years for the following medical conditions or symptoms:	Main policyholder	Person 2	Person 3	Person 4	Person 5
<i>Please tick the relevant box</i>					
1. Heart and stroke conditions <i>For example: uncontrolled hypertension, angina, heart attacks</i>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
2. Any form of cancer	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
3. Back or spinal conditions, arthritic conditions and or joint replacements	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
4. Any mental health conditions <i>For example: stress, depression</i>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>

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 6.

5. 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 9 to 12 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	1								
Please describe the illness or medical problem Include which area of the body is affected, if relevant (for example left, right, upper, lower)	ANGINA								
When did the symptoms start and end? If symptoms are ongoing, please leave the end date blank	Began	0	1	0	1	2	0	2	3
	Ended								
What treatment have you had?	PRESCRIBED MEDICATION								
Current state of the condition or symptom	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	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?	2								

Example two

Name	JOHN SMITH								
Question number from part one	3								
Please describe the illness or medical problem Include which area of the body is affected, if relevant (for example left, right, upper, lower)	LOWER BACK PAIN								
When did the symptoms start and end? If symptoms are ongoing, please leave the end date blank	Began	0	5	0	5	2	0	2	1
	Ended	2	0	0	8	2	0	2	1
What treatment have you had?	PHYSIOTHERAPY								
Current state of the condition or symptom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
	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?	7								

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

Began

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 the symptoms start and end?

If symptoms are ongoing, please leave the end date blank

Began

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 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

Began

Ended

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 the symptoms start and end?

If symptoms are ongoing, please leave the end date blank

Began

Ended

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 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**

Began
Ended

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

Began
Ended

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 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**

Began
Ended

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

Began
Ended

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?

6. 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](#).

7. 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 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.

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
- ✓ included evidence of current underwriting terms
- ✓ included a copy of your current membership certificate held with your current health insurance insurer
- ✓ signed and dated your form
- ✓ kept a copy for your own records.

You can send us this form by:

- Email: membershipadmin@bupa.com or
- 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 account, go to switch.egress.com. You won't have to pay for sending secure emails to a Bupa email address using Egress.

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.

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

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