Complete your details

Bupa By You medical history form

bupa.co.uk

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK.

- It's important you provide us with your medical history. Please fill in your medical history form and return it to us as soon as you can. Until you've completed this we won't be able to confirm exactly what your policy covers you for, meaning your claims might take longer for us to process and we might not be able to pay for treatment you need.
- The policy you're buying is fully medically underwritten. This means that any symptoms or conditions that have been present prior to the start date of the policy may not be covered, and we may require further medical information to assess your claim, particularly where claims are made early in your policy. Also where this medical information is not provided, we may not be able to process your claim.
- Please note, you can only claim for eligible private medical costs once. This means if you have two policies that provide private medical cover, the cost of your eligible treatment may be split between Bupa and the other insurance company. You will be asked to provide us with full details of any other insurance policy at the time of claim.
- You must take reasonable care to answer all the questions honestly and to the best of your knowledge. By reasonable care we mean not giving false information or keeping necessary information from us. If you don't take reasonable care, we can end your membership or refuse to pay a claim in full or part if there is reasonable evidence that you or a dependant did not take reasonable care in answering our questions.
- You must ensure the details of your family members are correct and should check the information with them before sending it to us.
- If you have any queries while you're completing the form, please call us.
- Please remember to sign and date the medical history form.
- Please retain a copy of the completed medical history form for your records.
- Once you have completed the medical history form, please return via one of the following options:

  by post: **Bupa, Anchorage Quay, Salford Quays, Salford M50 3XL**

  or by fax: **0161 254 3713**.

  Documents faxed to this number will only be accessed by the appropriate team.

Bupa

1. Your Bupa membership

Are you already a Bupa member? ☐ Yes ☐ No

If you are already a member of Bupa, or have been in the past, please give us your membership number below.

2. Your personal details

Please tell us about yourself here.
(To see how we use your information, please read our privacy notice on page 11.)

Mr Mrs Miss Ms Other

Surname

First name(s)

Address

Postcode

Telephone number

Mobile number

Email address

Your date of birth D D M M Y Y Y Y Sex at birth Male Female

If you would like any members of your family (partner, children etc) to be included in your membership, please go to section 3. If not, go to section 4.

3. Your family's details

If you would like to cover members of your family, please give us their details below. Remember to check with each family member that you have their correct details. Please note that the inclusion of each family member will impact on the subscription you pay for the cover.

	Member 2	**Member 3**	**Member 4**	**Member 5**
First name of family member				
Surname of family member				
Relationship to you				
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 ☐

What if I need to add more family members?
If you would like to cover family members additional to those listed above, please give us their details on a separate sheet of paper. You will also need to answer sections 4 and 5 for them.

4. Further details

Please answer each question as it applies for yourself and each person named in section 3.
(If you are an existing member and are only adding family members, you do not need to fill out further details or the medical history relating to your own health, only for your family members.)

	Main member		Dependant applicant/member							
			Member 2		Member 3		Member 4		Member 5	
Full name of applicant										
(Please tick the relevant box)	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Have you been a UK resident for more than six months?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Are you registered with a GP in the UK?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Have you been registered with a UK GP for six months or more?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
If you are not registered with a GP currently or have not been for at least six months, do you have access to your full medical records in English? *(Please note that to continue with your application you must have been registered continuously with a GP for a period of at least six months, or have access to and be able to provide your full medical records in English)*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
If you have answered '**No**' to any questions above please provide details										
Do you receive payment for taking part in sports?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
If '**Yes**', which sport(s)?										
Have you smoked any tobacco products in the last two years? (over-18s only)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Your medical history – part one

This section asks for health and medical details, past and present, for you and for each person named in section 3. Please tick 'Yes or No' to every question for each person.

For any of the medical conditions or symptoms listed in questions 1 to 16 please indicate if:

- you or anyone to be covered on your membership has seen a GP or other healthcare professional within the last two years
- you or anyone to be covered on your membership has been admitted to hospital, had an operation OR any investigations (for example scan, X-ray, blood test, biopsy) within the last seven years.

	Main applicant		Dependant member 2		Dependant member 3		Dependant member 4		Dependant member 5	
	Name		Name		Name		Name		Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Heart or cardiovascular disorders *eg coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Glandular disorders *eg diabetes, thyroid, hormonal problems*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Breathing or respiratory disorders *eg asthma, bronchitis, shortness of breath, chest infections, colds, flu*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Ears, nose, throat, or eye problems *eg hayfever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Stomach, intestines, liver or gallbladder *eg ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Cancer, tumours, growths, cysts, or moles that itch or bleed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Skin problems *eg eczema, rashes, psoriasis, acne*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Brain or nervous system disorders *eg stroke, migraines, repeated headaches, MS, epilepsy, nerve pain, fits*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Muscle or skeletal problems *eg arthritis, cartilage and ligament problems, back and neck problems, sprains, joint replacements, gout, sciatica*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Urinary problems *eg bladder, kidney or prostate problems, urinary infections, incontinence*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Your medical history – part one (continued)

	Main applicant		Dependant member 2		Dependant member 3		Dependant member 4		Dependant member 5	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Please also answer the following questions:										
11. Blood disorders *eg anaemia, hepatitis, HIV, abnormal blood tests*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Reproductive system problems *eg pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, erectile dysfunction, low sperm count*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Dental problems *eg wisdom teeth, abscess, gingivitis*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Allergies *eg hay fever, pet allergies, food allergies*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Psychological disorders *eg depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Undiagnosed symptoms *eg chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17. Are you or any applicant/member taking any medicines, prescribed or otherwise?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Within the last three months has anyone to be covered experienced symptoms of ANY health problems for which medical advice has not yet been sought?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Has anyone to be covered EVER had any past history of joint replacements, heart conditions, or strokes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Is there any other information relating to your health that has not yet been prompted by the questions listed 1 to 19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you have answered 'Yes' to any of the conditions here please give us full details in 'Medical history – part two' on the following pages. If you have answered 'No' to all of the above conditions, please continue with the form.

5. Medical history – part two

To help us build a more complete picture of your (and your family's) health, please use pages 7 and 8 to expand on any of the conditions you answered 'Yes' to in part one. Please give as much specific detail as possible. Failure to do so will result in delays processing your application. You can use the example below for help when filling out the form.

Definitions

Controlled: Condition/symptom ongoing but controlled by treatment/medication.
Recurrent: Occurring occasionally, often or repeatedly.
Likely to recur: Symptom free for a period of time but likely to recur.
Fully recovered: Condition fully resolved/cured with no symptoms and no medication.

Example one

Name of member:	John Smith
Question number from **part one**	11
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	High cholesterol
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 1 0 1 2 0 1 6 Ended D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*	Over counter medication / Diet / Prescribed medication
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)	Controlled
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	2

Example two

Name of member:	John Smith
Question number from **part one**	9
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*	Knee pain
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 5 0 5 2 0 1 3 Ended 2 0 0 8 2 0 1 5
Treatment *(prescribed or otherwise)*	Physiotherapy
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)	Fully recovered
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?	0

5. Medical history – part two (continued)

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

5. Medical history – part two (continued)

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

Name of member:		
Question number from **part one**		
Please describe the illness or medical problem If applicable please specify which area of the body is affected *(eg left, right, upper, lower)*		
When did symptoms begin/end? **If ongoing please leave end date blank**	Began Ended	D D M M Y Y Y Y D D M M Y Y Y Y
Treatment *(prescribed or otherwise)*		
Current state of condition/symptom (eg controlled, recurrent, likely to recur, fully recovered)		
How many times have you consulted a healthcare professional in the past two years about this symptom/condition?		

6. Obtaining medical reports from a GP

When you need to request a medical report from your/family member's General Practitioner/Consultant, we can do this on your/family member's behalf with your or their consent. We will always ask for your/family member's consent before requesting a report from your GP/Consultant on your/family member's behalf and we will ask for your/family members consent on the telephone when we explain to you the need for the report.

When we ask you for your consent to obtain a medical report from your GP/Consultant, you/your family member has certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (NI) Order 1991 (the "Acts"). Your rights under the Acts are summarised below:

Your rights

1. You can authorise the disclosure of the doctor's report without asking to see it. The report will then be sent directly to us by the doctor. Should you give your consent to the disclosure of a report without indicating your wish to see it, you can change your mind by contacting your doctor before the report is sent to us, in which case you will have the opportunity to see the report and ask the doctor to change the report or add your comments before it is sent to us, or withhold your consent for its release.
2. You can give your consent but ask to see the report before it is sent to us. If you do this you should contact your doctor within 21 days of sending the request to him/her. If you do not contact the doctor within the 21-day period you have authorised them to disclose the report to us directly without further notice to you. If you do contact your doctor within the 21-day period you must give them your written consent to disclose the report. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comments to the report before it is sent to us.
3. You can withhold your consent but, if you do, please bear in mind that we may be unable to process your request.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided you ask him/her within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information contained in the report if, in their opinion, this information
(a) might cause serious harm to your physical or mental health or that of another person, or
(b) it would reveal the identity of another person without their consent (other than that provided by a healthcare professional in their professional capacity in relation to your care).

Your doctor may charge a fee for providing a medical report. We may contribute a maximum of £15 (inclusive of VAT) towards the cost of the report. If we do make a contribution, you will be responsible for any amount above this.

Your legal declaration

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

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

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 will 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.

This form must be received by us within six weeks of the date of this declaration. Fill in your form with complete up-to-date medical history before you sign and date it. If we do not receive this form within six weeks of this declaration date, we will require you to submit a new form.

Obtaining medical reports from your GP:

- I understand that Bupa may need me to provide a medical report from my GP to support my application before treatment is authorised or a claim paid
- I consent to Bupa obtaining this information from my GP on my behalf and I understand that Bupa will gain verbal confirmation from me prior to any medical report being requested in this way
- I have read, understand and accept the rights I have in relation to such reports as explained in section 6
- I have shown this declaration to the proposed family members on the policy and confirm that they understand that if they need to claim they will be asked on the telephone to confirm their consent to Bupa requesting a medical report on their behalf.

Please tick this box if you do **NOT** wish Bupa to request medical reports on your behalf in this way ☐.

Please tick this box if you do **NOT** wish to see the medical report from your doctor before it is supplied to Bupa ☐.

Signature Date D D M M Y Y Y Y

We'll verify your digital signature. If you modify this form after signing it or send us a printed or a scanned copy of this form, we won't be able to verify the signature and will contact you either by phone or in writing to confirm your signature. Until we've confirmed your signature, we won't be able to advise exactly what your policy covers you for, meaning your claims might take longer for us to process and we might not be able to pay for treatment you need.

†We may record or monitor our calls

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 and protect it. It also provides information about your rights. Further details can be found 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 of the Full Privacy Notice, please contact the Bupa Privacy team on **+44 (0) 1784 893706**. Alternatively you can email the team at **dataprotection@bupa.com** or 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 Bupa
In this privacy notice, references to 'we' or 'us' or 'our' are to Bupa. Bupa is registered with the Information Commissioner's Office, registration number Z6831692. Bupa is comprised 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**

Scope of our privacy notice
This privacy notice applies to anyone who interacts with us in relation to our products and services ('you', 'your'), via any channel (eg email, website, telephone, app etc).

Ways in which we obtain personal information
We obtain personal information from you and from certain third parties (eg those acting on your behalf, like brokers, healthcare providers etc). Where you provide us with information about other individuals, you must ensure that they have seen a copy of this privacy notice and are comfortable with you doing this.

Categories of personal information
We process two categories of personal information about you and/or, where applicable, your dependants, namely standard personal information (eg information we use to contact you, identify you or manage our relationship with you); and special categories of information (eg health information, information about race, ethnic origin and religion that allows us to tailor your care, and information about crime in connection with screening).

Purposes and lawful grounds of our processing personal information
We process your personal information for the purposes set out in our Full Privacy Notice, including to administer our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and in order to protect the rights, property, or safety of Bupa, our customers, or others. The legal ground upon which we process personal information depends on what category of personal information we process. Standard personal information is normally processed by us on the basis that it is necessary for the performance of a contract, our or a third parties' legitimate interests or it is required or permitted by applicable law.

Marketing and preferences
We may use your personal information to send you marketing by post, telephone, social media platforms, email and text. We only use your personal information to send you marketing if we have either your consent or a legitimate interest. If you don't want to receive personalised marketing about similar Bupa 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**

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 be of interest (including discounts on our products and services). This may involve evaluating information about you and, in some 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. Further details are available in our Full Privacy Notice.

Sharing your information
We share your information within the Bupa Group, with relevant policyholders (including your employer if you are covered under a group scheme), with funders commissioning services on your behalf, those acting on your behalf (eg brokers and other intermediaries) and with others who help us provide services to you (eg healthcare providers) or from whom we need information to handle or verify claims or entitlements (eg professional associations). We also share your information in accordance with the law. You can read more about what information may be shared in what circumstances in our Full Privacy Notice.

Transfers outside of the European Economic Area (EEA)
Bupa deals with many international organisations and uses global information systems. As a result, Bupa transfers your personal information to countries outside of the European Economic Area ('EEA'), (the EU member states plus Norway, Liechtenstein and Iceland) for the purposes set out in this privacy policy.

How long we retain your personal information
Bupa retains your personal information in accordance with retention periods calculated in accordance with the criteria detailed in the Full Privacy Notice available on our website.

Your rights
You have rights to have access to your information and to ask us to rectify, erase and restrict use of your information. You also have rights to object to your information being used, to ask for the transfer of information you have made available to us, to withdraw consent to the use of your information and not to be subject to automated decision-making which produce legal effects concerning you or similarly significantly affects you.

Data Protection Contacts
If you have any questions, comments, complaints or suggestions in relation to this notice, or any other concerns about the way in which we process information about you, please contact us at **dataprotection@bupa.com**

You also have a right to make a complaint to your local privacy supervisory authority. Bupa's main establishment 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. Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

Bupa health insurance is provided by:

Bupa Insurance Limited. Registered in England and Wales No. 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 No. 3829851.

Registered office: 1 Angel Court, London EC2R 7HJ.

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BBY/6941/MAY18 BHF 06181