

Bupa Cash Plan. Claim form.



Before you begin

Please complete this claim form in **BLUE** or **BLACK INK**.

To make a claim you can use our online claims portal at bupa.co.uk/cashplanclaim. Or you can submit a claim form to us by post to **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

Before you send the form to us please make sure that all relevant sections have been completed, any copies of receipts should contain the name and contact details of the practitioner, date of the treatment and the name of the person receiving the treatment – this will help us to deal with your claim as quickly as possible. Please ensure you sign the relevant sections to avoid delays in processing your claim.

If you have any queries when claiming, please call us on **0345 606 6003**. We may record or monitor our calls. Lines are open 8am to 6pm Monday to Friday and 8am to 1pm on Saturdays.

For people with hearing or speech difficulties you can use the Relay UK service on your smartphone or telephone. For further information visit www.relayuk.bt.com

We also offer documents in Braille, large print or audio.

A. Main member personal details

To see how we use your information, please read our [privacy notice](#) section at the end of this document.

Membership number

Title (please tick, or provide title if other) Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s) Surname

Address

Postcode

Date of birth

Telephone number Mobile telephone number

Email address

Please tell us about who the claim is for here.

Main member ☐

Partner ☐ Date of birth

Child dependant ☐ Date of birth

Name of child dependant

Is this claim as a result of a third party accident or injury? (please tick) Yes ☐ No ☐

B. Cash Plan claim details

1. Receipted claims

Please complete this claim form by listing the relevant letter reference for each benefit you're claiming for, after referring to your table of cover and membership guide for the full terms and conditions of your cover. Copies of receipts should contain the name and contact details of the practitioner, date of the treatment and the name of the person receiving the treatment.

Letter reference	Benefit type
A	Birth and adoption (Please submit a full copy of the birth or adoption certificate(s) with your name on the certificate)
B	Chiropody/podiatry
C	Consultation and diagnostic tests or scans
D	Dental (for your cash plan policy only)
E	Dental injury (for your cash plan policy only. You will also need to complete section 2)
F	Flu jab
G	Health assessment/screening
H	Home help
I	Medical devices
J	Optical
K	Physiotherapy, osteopathy, chiropractic, acupuncture, homeopathy, reflexology
L	Prescriptions

Letter reference	Treatment dates	Amount of claim
A	2 1 0 5 2 0 2 1 EXAMPLE	£ 30
	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	£
	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	£
	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	£

B. Cash Plan claim details (continued)

2. Dental injury

Please include the details of your accident and enclose a copy of your fully paid receipt from the dental professional confirming your treatment.

Date of treatment	<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"/>	Official stamp of dentist
Cause of accident		
Signature of dentist		

3. Funeral grant

In order for us to process the Funeral Grant we will require:

A certified* copy (not original) of the death certificate and one of the following:

- if there has been a grant of representation, either the grant of probate together with a letter signed by all the executors, or the letter of administration together with a letter signed by all the administrators. In each case the letter needs to confirm the name of the person to whom a payment should be made payable, and the address to send it to
- if there has been no grant of representation, a certified* copy of the main member's will together with the name and address of the named beneficiary.

*Please refer to the membership guide for full details of the requirements.

4. Hospital in-patient/hospital day-case (see section 'D. For hospital use only')

I authorise the hospital to disclose the reason for my admission.

Patient's signature (or signature of legal guardian if the patient is under 16)

C. Payment details

If you pay via Direct Debit, all claims will be paid into the nominated bank account. All claims will be paid to the main member and not your named dependants. If you do not pay via Direct Debit, or have not already provided nominated bank account details, then please provide your nominated details below.

Main member account holder name		
Bank/building society name		
Sort code	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>	Account number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

D. For hospital use only

Full name of patient	Official hospital stamp
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Please state the condition for which the patient
was admitted

I certify that the patient above was admitted to the
establishment named below:

Hospital name

As a day-patient,
admission on

D

D

M

M

Y

Y

Y

Y

Or

As an in-patient,
admitted on

D

D

M

M

Y

Y

Y

Y

and discharged on

D

D

M

M

Y

Y

Y

Y

If during the above period the patient was away from hospital for one or more nights please give dates.

From

D

D

M

M

Y

Y

Y

Y

To

D

D

M

M

Y

Y

Y

Y

Signature of authorising officer

Position held

Parental stay if the main member or their partner (if covered) stays overnight in hospital with a child dependant,
under age 16

I confirm that (name of parent)

stayed overnight with the patient.

From

D

D

M

M

Y

Y

Y

Y

To

D

D

M

M

Y

Y

Y

Y

Signature of authorising officer

E. Member declaration

Please read the following carefully before signing the declaration

- I declare that I am not claiming for treatments, goods or services under another health insurance policy.
- I understand that any fraudulent or misleading information may result in action being taken and immediate cancellation of my policy.
- I authorise any medical practitioner or other person(s) concerned with providing health care to give you any information relevant to this claim.
- Unless being signed by the main member, by submitting this information I confirm that I am doing so with the knowledge and permission of the main member.
- I declare the information shown on this form and any accompanying documentation is true and complete.

Signature (please ensure you sign here to avoid delays in processing your claim)

Claimant name

Date of signature

D	D	M	M	Y	Y	Y	Y
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Terms and conditions including limitations, exclusions and qualifying periods apply, which can be found in your membership guide and table of cover. Benefit limits are shown in your table of cover.

F. Checklist

Please ensure a copy of your receipt(s) clearly shows the following:

- ☐ The name and contact details of the practitioner, date of the treatment and the name of the person receiving the treatment

To help speed up the processing of claim(s), please ensure the name of the practitioner's relevant body that they are registered with is provided with your claim so we can verify this accordingly

- ☐ Details of the treatment, including the cost of treatment, goods or services received

Before you submit your claim form, please be sure you have:

- ☐ Completed sections A, B, C and D (if applicable)
- ☐ Signed and dated section E
- ☐ Attached relevant copy of named receipt(s)

If relevant:

- ☐ For funeral claims, have you enclosed a certified copy of the death certificate and supporting documents
- ☐ For birth/adoption claims, have you enclosed a copy of the birth/adoption certificate
- ☐ For hospital claims, has the hospital fully completed, stamped and signed the hospital benefit section
- ☐ For prescription claims we require proof of payment, prescription prepayment certificate and an FP57 or a copy of your named prescription(s)

Terms and conditions:

- ☐ Terms and conditions including limitations, exclusions and qualifying periods apply, which can be found in your membership guide and table of cover. Benefit limits are shown in your table of cover

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-notice

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) or 01625 545 745 (national rate).