simplyhealth
We can be bothered

Simply Private Health

Application to transfer cover

About this form

- Please complete this form if you wish to transfer your cover from an existing private medical insurance policy and would like us to consider your application without the need for an updated medical assessment.
- If we accept your application without an updated medical assessment we would apply the same personal medical exclusions that you, and any family members you wish to include in the policy, have with your current insurer.
- Please return the completed form accompanied by evidence of the terms of your current policy. You **MUST** include your most recent Policy Schedule/Insurance Certificate. We regret that without this we will be unable to consider your application to transfer. If you do not have your Certificate you can apply for a Simply Private Health Policy by completing an 'Application for cover' form. Please be aware that new medical underwriting terms will apply.
- If you wish to include any family members in your Simply Private Health Policy who are not currently covered by your existing insurance you will need to complete our 'Application for cover' form on their behalf. Please be aware that new medical underwriting terms will apply.
- This form should be completed by the main policyholder, who should sign and date it along with any spouse/partner to be included in the policy.
- We will write to confirm whether we are able to transfer your cover without updating your medical underwriting or, whether we will require you to complete a full medical assessment or agree to the moratorium basis of underwriting. For details please refer to the Underwriting Options section of our policy document.
- Please take time to read this form carefully, making sure you have completed all the sections.
- Please be aware that policies do vary. You should read the enclosed brochure and the Policy Document, together with your quotation, carefully, in conjunction with the comparable information from your current insurer.
- If you need any assistance please call our Helpline on **0800 854 976**. We are here to help. Your calls may be recorded and monitored for training and quality assurance purposes.
- Please write in blue or black ink and use **BLOCK CAPITALS**.

1 About you

To apply for Simply Private Health Cover you must be under the age of 66 and resident in the UK.

Title		Forenames	
Surname		Date of birth	D D M M Y Y Y Y
Occupation			
Address			
		Postcode	
Daytime telephone no.		Mobile telephone no.	
Preferred contact time, between 8am and 6pm			
Email address			

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory)	Choice 1	Choice 2	Choice 3
✔	☐	☐	☐

Have you smoked in the last 12 months? Yes ☐ No ☐

If you, or a member of your family, are already a Simplyhealth member please tell us the registration/policy number

2 About your family and their level of cover

You may include a spouse or partner under the age of 66, and unmarried dependent children under the age of 21, or under 24 if they are in full-time education. Everyone enrolled in the policy must be resident in the UK and reside with you permanently.

Title		Forenames		Surname	
Relationship to you				Date of birth	D D M M Y Y Y Y

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory) ☑ Choice 1 ☐ Choice 2 ☐ Choice 3 ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

Title		Forenames		Surname	
Relationship to you				Date of birth	D D M M Y Y Y Y

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory) ☑ Choice 1 ☐ Choice 2 ☐ Choice 3 ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

Title		Forenames		Surname	
Relationship to you				Date of birth	D D M M Y Y Y Y

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory) ☑ Choice 1 ☐ Choice 2 ☐ Choice 3 ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

Title		Forenames		Surname	
Relationship to you				Date of birth	D D M M Y Y Y Y

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory) ☑ Choice 1 ☐ Choice 2 ☐ Choice 3 ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

Title		Forenames		Surname	
Relationship to you				Date of birth	D D M M Y Y Y Y

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory) ☑ Choice 1 ☐ Choice 2 ☐ Choice 3 ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

Title		Forenames		Surname	
Relationship to you				Date of birth	D D M M Y Y Y Y

Your level of cover

Please refer to the enclosed Policy Document then tick ✔ the boxes to tell us which options you would like to choose. You can change your benefit options at your annual renewal date. If you add an option, new underwriting terms will be added to that option, (see section 5).

Core Cover (mandatory) ✔ Choice 1 ☐ Choice 2 ☐ Choice 3 ☐

Have you smoked in the last 12 months? Yes ☐ No ☐

3 Payment method

Payments are payable by Direct Debit, please complete the attached form.

How would you like to pay? Annually by direct debit ☐ Monthly by direct debit ☐

Quotation

Have you received a quotation? Yes ☐ No ☐

5 How we use information about you

As the Data Controller, we will store and process personal data in accordance with the Data Protection Act 1998 (DPA).

We and other Simplyhealth Group companies will use information to provide our services, for assessment and analysis, for underwriting and claims handling, to improve our services, and to protect our interests.

Unless you ask us not to we may use your information to keep you informed by post, telephone, email or other means about products and services, which may be of interest to you.

We will keep information about you confidential. However we may give information about you and how you use our products to the following:

- Fraud prevention agencies and other organisations who may record, use and give out information to other insurers.
- People who provide a service to us or act as agents on the understanding that they will keep the information confidential.
- Anyone to whom we may transfer our rights and duties under this agreement.
- We may also give out information about you if we have a duty to do so (such as regulatory bodies), or if the law allows us to do so or if the person requesting the information has in our opinion, a legitimate interest in the disclosure.

Sensitive data

In order to assess the terms of the contract of insurance, including any specific medical exclusions or administer claims we may collect data, including medical information, which the DPA defines as sensitive.

Medical information will be kept confidential and only disclosed to those involved in providing the patient’s treatment or care, including their General Practitioner or Dentist, or their agents. Only in exceptional circumstances will we disclose medical information to other third parties or family members, without the patient’s explicit consent.

If you have appointed an insurance broker or intermediary, we may disclose to them the personal information that they need to deal with your cover. Details of medical information will not be disclosed to the intermediary unless we have the specific consent of the patient.

Accuracy of personal information

To help us ensure that your personal information remains accurate and up to date please inform us of any changes.

You have the right to see personal information, which is held by us. There may be a charge if you want to do this. For more details write to: The Data Protection Co-ordinator, Simplyhealth, Hambleden House, Waterloo Court, Andover, Hampshire, SP10 1LQ.

Your calls may be recorded and monitored for training and quality assurance purposes.

6 Applying for cover

Please help us by answering the questions below fully, accurately and honestly, for yourself and each family member you wish to include in your policy. If you are unsure whether something is relevant please tell us anyway.

You must tick Yes or No to each of the following questions. Should you answer Yes to any of them please provide full details on the form below, using a continuation sheet if necessary.

1. Have you or any family member to be included in your policy visited a GP in the last six months? (Tick ✔ box) Yes ☐ No ☐

If yes please give details below, using a continuation sheet if necessary:

Name		Name	
Please explain the reason for the visit/s and any treatment planned.		Please explain the reason for the visit/s and any treatment planned.	
Please give dates	D D M M Y Y Y Y	Please give dates	D D M M Y Y Y Y
Name		Name	
Please explain the reason for the visit/s and any treatment planned.		Please explain the reason for the visit/s and any treatment planned.	
Please give dates	D D M M Y Y Y Y	Please give dates	D D M M Y Y Y Y

2. Have you or any family member to be included in your policy had any hospital treatment whether as an in-patient or an out-patient in the last six months, or is any treatment planned? (Tick ✔ box) Yes ☐ No ☐

If yes please give details below, using a continuation sheet if necessary:

Name		Name	
Please explain the reason for the visit/s and any treatment planned.		Please explain the reason for the visit/s and any treatment planned.	
Please give dates	D D M M Y Y Y Y	Please give dates	D D M M Y Y Y Y
Name		Name	
Please explain the reason for the visit/s and any treatment planned.		Please explain the reason for the visit/s and any treatment planned.	
Please give dates	D D M M Y Y Y Y	Please give dates	D D M M Y Y Y Y

3. Have you or any family member to be included in your policy had any treatment or consultations with a specialist in the last 12 months, or are any specialist appointments planned or booked? (Tick ✔ box)

Yes ☐ No ☐

If yes please give details below, using a continuation sheet if necessary:

Name		Name	
Please explain the reason for the visit/s and any treatment planned.		Please explain the reason for the visit/s and any treatment planned.	
Please give dates	D D M M Y Y Y Y	Please give dates	D D M M Y Y Y Y

Name		Name	
Please explain the reason for the visit/s and any treatment planned.		Please explain the reason for the visit/s and any treatment planned.	
Please give dates	D D M M Y Y Y Y	Please give dates	D D M M Y Y Y Y

4. Is there any other information about you or any family member, to be included in your policy, which you believe we should be made aware of with regard to your general state of health, including symptoms of any medical condition, for which you have not yet consulted a GP? (Tick ✔ box)

Yes ☐ No ☐

If yes please give details below, using a continuation sheet if necessary:

Name		Name	
Please give details:		Please give details:	

Name		Name	
Please give details:		Please give details:	

Name		Name	
Please give details:		Please give details:	

7 Declaration

Please read the following declaration carefully, both you and any spouse/partner included in the application should sign and date it below.

- I apply for Simply Private Health Policy together with any family members detailed in section 2.
- I have received a copy of the Policy Document and have read or had read to me and agree to be bound by the terms and conditions of Simply Private Health Policy.
- I declare that I have authority to give Simplyhealth information about my family members referred to in this application and where necessary, I have checked with them that the information I have provided is correct.
- I declare that, to the best of my knowledge, the information I have provided on this form is complete and accurate and that it contains all the information supplied.
- I understand that the Membership Certificate, which I will receive from Simplyhealth, will advise me of any medical conditions specifically excluded from my cover because of the information requested.
- By agreeing to the Simply Private Health terms and conditions I consent to any personal data, including medical information about myself and my family members, being processed by Simplyhealth. Where I am applying for cover for unmarried dependent children aged 16 or over I confirm I have their authority to consent to their personal data being processed by Simplyhealth on their behalf.
- We may use your information to keep you informed by post, telephone, email or other means about products and services, which may be of interest to you. If you do not wish your information to be used for these purposes please tick ✔ box. ☐
- I agree that this declaration, and the answers given on this application form, shall form the basis of the contract of insurance between me and Simplyhealth.
- I attach my current Membership Certificate from my current insurer please tick ✔ box. ☐

Your signature	✗	Today's date	D D M M Y Y Y Y
Signature of spouse/partner if they are to be included	✗	Today's date	D D M M Y Y Y Y

Please complete the direct debit form opposite

DIRECT Debit

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form including official use box using a ball point pen and send it to:

Medical Underwriting Team
Simplyhealth
James Tudor House
90 Victoria Street
Bristol
BS1 6DF

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To the Manager Bank/Building Society

Address

Postcode

Reference

Bank and Building Societies may not accept Direct Debit instructions from some types of account.

Service user number

6	9	0	1	1	9

Simplyhealth official use only. This is not part of the Instruction to your Bank or Building Society. Please complete all relevant sections.

Day of the month on which you'd like the Direct Debit to be collected from your account

If premiums are to be paid by a party other than the policy holder please complete the boxes below. This information will only be used by Simplyhealth.

Name

Address

Telephone no.

Instruction to your bank or building society

Please pay Simplyhealth 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 Simplyhealth and, if so, details will be passed electronically to my Bank or Building Society.

Signatures

Date

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

DIRECT Debit

- 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 Simplyhealth will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Simplyhealth 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 Simplyhealth 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 Simplyhealth 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.

Simplyhealth, Hambleden House, Waterloo Court, Andover, Hampshire, SP10 1LQ

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