Nuffield Health

Dependants' Medical Declaration form

Nuffield Health Employee Healthcare Scheme

Underwritten (dependant cover)

Provided by

Bupa

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK or you can type directly onto the form.

Before we can welcome your partner and/or child(ren) (referred to as your dependant(s)) to the scheme, you must complete and return this medical declaration form which you, the employee, must declare as being factual and accurate, having made all necessary enquiries of your dependant(s).

Remember to give us as much detail as you can about yourself and any dependants you would like to cover. You must take reasonable care to answer all the questions honestly and to the best of your knowledge. If you are adding any dependants, you must check all answers in relation to any dependants with them to make sure that their details are correct. By reasonable care we mean not giving false information or keeping necessary information from us. If you don't take reasonable care, your policy may be cancelled, or treated as if it never existed, or your claim may be rejected or not fully paid, if there is reasonable evidence that you or a dependant did not take reasonable care in answering our questions.

The scheme you are joining is a fully medically underwritten scheme for dependants. This means that dependants' pre-existing medical conditions/symptoms, whether or not advice has been sought, are excluded from treatment under the scheme for a period of two years. We'll start to cover dependants' pre-existing medical conditions/symptoms two years after the policy start date so long as they are eligible under the policy terms and conditions.

Once your completed form is received, the administrator will review the medical information provided and inform you if there are any medical conditions that are not eligible for benefit under the scheme.

You do not need to provide medical information about yourself, just for your dependants that you wish to add to your scheme.

Where to send your completed form

By post: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

By email to: **nuffieldhealth@bupa.com**

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress.

For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

1. Employee details

Please tell us about yourself here (to see how we use your information, please read our privacy notice on page 12.)

Title *(please tick or list title if other)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s)

Surname

Address

Postcode

Telephone number

Mobile number

Email address

Date of birth D D M M Y Y Y Y Sex at birth Male ☐ Female ☐

Your employee number ☐☐☐☐☐☐☐☐☐☐

If you are already a beneficiary of the scheme, please give us your registration number

☐☐☐☐☐☐☐☐☐☐

2. Your dependants' details

If you are applying to add eligible dependants, please give details below. If your employer requires a contribution from you, for your and/or your dependants' cover, adding dependant beneficiaries may impact the amount you pay. Remember to check with each dependant that you have their correct details and make sure that they are directed to our privacy notice on page 12 before submitting their details to us. Please note that you must have your dependants' express agreement to submit this form on their behalf (or be their legal representative).

	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name				
Surname				
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 dependants?
If you would like to cover any dependants additional to those listed above, please give us their details on a separate sheet of paper.
You will also need to answer sections 3 and 4 for them.

3. Further details

Please answer each question as it applies to each person named in section 2. Please tick 'Yes' or 'No' to every question for each person and provide details where applicable. Remember to check with each dependant that you have their correct details and make sure that they are directed to our privacy notice on page 12 before submitting their details to us.

	Dependant 1	Dependant 2	Dependant 3	Dependant 4
(Please tick the relevant box)	Yes No	Yes No	Yes No	Yes No
Are you a UK resident?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Do you have access to your medical records in English? To be eligible for cover the main member and dependants 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 their full medical records in English *(Please note that for us to appropriately administer your policy you will need to be registered with a UK GP)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Are you a professional or semi-professional sports person? By this we mean: do you receive payment or sponsorship for taking part in any sport?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
If '**Yes**', which sport(s), including the name of the team, if applicable? *(On receipt of your application we will assess your eligibility to join the scheme and inform you accordingly)*				

4. Medical history – part one

This section asks for health and medical details, past and present, for each person named in section 2. Please tick 'Yes' or 'No' to every question for each person. Remember to check with each dependant that you have their correct details and make sure that they are directed to our privacy notice on page 12 before submitting their details to us.

For any of the medical conditions or symptoms listed in questions 1 to 16 please indicate if: ■ any dependant to be covered on your policy has seen a GP or other healthcare professional within the last two years ■ any dependant to be covered on your policy has been admitted to hospital, had an operation OR any investigations (for example scan, X-ray, blood test, biopsy) within the last seven years	Dependant 1	Dependant 2	Dependant 3	Dependant 4
(Please tick the relevant box)	Yes No	Yes No	Yes No	Yes No
1. **Heart or cardiovascular disorders** *(For example coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
2. **Glandular disorders** *(For example diabetes, thyroid, hormonal problems)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
3. **Breathing or respiratory disorders** *(For example asthma, bronchitis, shortness of breath, chest infections)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
4. **Ears, nose, throat, or eye problems** *(For example tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
5. **Stomach, intestines, liver or gallbladder** *(For example 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** *(For example eczema, rashes, psoriasis, acne)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
8. **Brain or nervous system disorders** *(For example migraines, repeated headaches, MS, epilepsy, nerve pain, fits)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
9. **Muscle or skeletal problems** *(For example arthritis, cartilage and ligament problems, back and neck problems, sprains, gout, sciatica)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐
10. **Urinary problems** *(For example bladder, kidney or prostate problems, urinary infections, incontinence)*	☐ ☐	☐ ☐	☐ ☐	☐ ☐

4. Medical history – part one (continued)

	Dependant 1		Dependant 2		Dependant 3		Dependant 4	
(Please tick the relevant box)	Yes	No	Yes	No	Yes	No	Yes	No
11. **Blood disorders** *(For example anaemia, hepatitis, HIV, abnormal blood tests)*	☐	☐	☐	☐	☐	☐	☐	☐
12. **Reproductive system problems** *(For example pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause, caesarean section, low testosterone, low sperm count)*	☐	☐	☐	☐	☐	☐	☐	☐
13. **Dental problems** *(For example wisdom teeth, abscess, gingivitis)*	☐	☐	☐	☐	☐	☐	☐	☐
14. **Allergies** *(For example pet allergies, food allergies)*	☐	☐	☐	☐	☐	☐	☐	☐
15. **Psychological disorders** *(For example depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety)*	☐	☐	☐	☐	☐	☐	☐	☐
16. **Undiagnosed symptoms** *(For example chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding, lumps)*	☐	☐	☐	☐	☐	☐	☐	☐
Please also answer the following questions:								
17. **Is any dependant to be covered on your membership taking any medicines, prescribed or otherwise?**	☐	☐	☐	☐	☐	☐	☐	☐
18. **Within the last three months has any dependant to be covered experienced symptoms of ANY health problems for which medical advice has not yet been sought?**	☐	☐	☐	☐	☐	☐	☐	☐
19. **Has any dependant to be covered EVER had any past history of joint replacements, heart conditions, or strokes?**	☐	☐	☐	☐	☐	☐	☐	☐
20. **Is there any other information relating to the health of any dependant to be covered 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 go to section 6.

5. Medical history – part two

To help us build a more complete picture of your dependants' 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 more than once, often or occasionally.
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 dependant:	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 8 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 dependant:	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)*	LEFT KNEE PAIN
When did symptoms begin/end? **If ongoing please leave end date blank**	Began 0 5 0 5 2 0 1 6 Ended 2 0 0 1 2 0 1 7
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 dependant:

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 D D M M Y Y Y Y

Ended 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 dependant:

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 D D M M Y Y Y Y

Ended 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 dependant:

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 D D M M Y Y Y Y

Ended 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 dependant:

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 dependant:

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 dependant:

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. Medical reports – when we need more information from your doctor

When we need to ask your doctor for more information about your consultation, tests or treatment, we will need your permission.The **Access to Medical Reports Act 1988** or the **Access to Personal Files and Medical Reports (NI) Order 1991** give you certain rights, which are:

1. You can give permission for your doctor to send us a medical report without asking to see it before they send it to us.
2. You can give permission for your doctor to send us a medical report and ask to see it before they send it to us.
   - You will have 21 days from the date we ask your doctor for your medical report to contact them and arrange to see it.
   - If you don't contact your doctor within 21 days we will 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 insist on adding your own comments to the report before they send it to us.
   - Once you've seen the report, it won't be sent to us unless you give your doctor permission to do so.
3. You can withhold your permission for your doctor to send us a medical report. If you do, we'll be unable to see whether the consultation, test or treatment is eligible under your benefits, and we won't be able to give you a pre-authorisation number or confirm whether we can contribute to the costs.

In any event you also have the right to ask your doctor to let you see a copy of your medical report within six months of it being sent to us.

Your doctor can withhold some or all the information in the report if, in their view, the information:

- might cause physical or mental harm to you or someone else or
- it would reveal someone else's identity without their permission (unless the person is a healthcare professional and the information is about your care provided by that person)

Bupa may contribute to the cost of any medical report that Bupa has requested on your behalf. We will confirm whether you are eligible for a contribution on the telephone. If Bupa does contribute, you will be responsible for any amount above this.

7. Your legal declaration

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

It is Bupa's intention to provide a first class service at all times. If you do have cause for dissatisfaction you may write to the Customer Relations Department at **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP** or phone your helpline on 0800 028 7687*. Lines are open between 8am and 8pm Monday to Friday and between 8am and 4pm on Saturday. They will consider your complaint and can provide you with full details of our internal complaints process.

Your legal declaration

1. I am applying for a Bupa healthcare plan for my dependants. I understand that the terms of cover set out in the current trust guide relating to my cover (which is the cover for which I am now applying) will be binding on me and any dependants covered under my policy, and accept they shall be the basis upon which benefits shall be payable under my cover.
2. I declare that all the information given to Bupa about myself and my dependants is and remains true and complete, to the best of my knowledge and belief, except to the extent I inform you otherwise when sending you this application for Bupa cover. I have confirmed the details of my dependants with the relevant dependant.
3. I agree to inform Bupa if any of the information relating to myself or any dependants I have provided, or provide, changes at any time before cover starts.
4. I understand that if the information I have provided about myself and my dependants in answer to the questions in this application for Bupa cover is inaccurate or misleading, Bupa may terminate my cover or benefits might not be payable.
5. I understand and accept there is no undertaking to cover any medical conditions in existence before the time my dependants are covered by Bupa. Bupa will apply any exclusions which apply under my existing policy, and may also need to exclude additional medical conditions in existence before the time my dependants are covered by Bupa.
6. I confirm that I have read Bupa's Privacy Notice on page 12 of this form and that I have brought it to the attention of any dependants who may also be covered under the health care plan. I agree, on behalf of myself and any dependants, to Bupa processing our personal information, in order to provide my dependants with cover under the terms of this plan. I understand that Bupa cannot provide my dependants with cover under the healthcare plan without our agreement and that if we later withdraw this agreement, Bupa will no longer be able to provide my dependants with cover under this plan.
7. I understand English Law applies to the agreement between me and Bupa, unless otherwise agreed between us in writing.

You are advised to keep a record of all information you supply to us in connection with your Bupa cover, including this application form and any letters. If you would like a copy of this form please ask us.

Obtaining medical reports from your dependants' doctor:

- I understand that Bupa may need my dependants to provide a medical report from their doctor to support their application before treatment is authorised or a claim paid.
- I have shown this declaration to the proposed dependants on the policy. I confirm that they understand that Bupa will gain verbal or written permission from them prior to any medical report being requested in this way.
- I acknowledge the rights I/my dependants have in relation to such reports as explained in section 6.

Signature (Nuffield Health employee)

Date D D M M Y Y Y Y

We'll verify your digital signature if your form is signed using an Adobe Digital ID or Adobe Sign (or equivalent). If you modify your form after digitally signing it, or send us a printed or scanned copy of the form, then we won't be able to verify your digital signature at this point and will need to contact you either by phone or in writing to confirm this is your signature. Until we have verified or confirmed your signature, we won't be able to advise exactly what your policy covers your dependants for, meaning your dependants' claims might take longer for us to process and we might not be able to pay for the treatment they need.

Where to send your completed form

By post: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

By email to: **nuffieldhealth@bupa.com**

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress.

For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

*We may record or monitor our calls.

Bupa 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 and how we use and protect it. It also provides information about your rights. 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 contact the Bupa Privacy team on **+44 (0) 1784 893706**. Or, 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 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, healthcare providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

3. Categories of personal information

We process two 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) and 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, we have your permission or as otherwise described in our full privacy notice.

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, healthcare providers) or who we need information from, to handle or check claims or entitlements (for example, professional associations). We also share your information in line with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

8. Transfers outside of the European Economic Area (EEA)

We deal with many international organisations and use global information systems. As a result, we transfer your personal information to countries outside of the European Economic Area (the EU member states plus Norway, Liechtenstein and Iceland) for the purposes set out in this privacy policy.

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.

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 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).

Final Checklist

Before you return your form, ensure that you have:

- ✔ included full details of all the dependants you would like to cover
- ✔ checked with your dependants that their details are correct and provided the privacy notice on page 12 to each person and confirmed that you have their express agreement to submit this form on their behalf (or you are their legal representative)
- ✔ remembered to sign and date your form
- ✔ kept a copy for your own records.

Where to send your completed form:

By post: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

By email to: **nuffieldhealth@bupa.com**

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress.

For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

Once we have received, approved and processed your application you will receive a welcome pack in the post.

Notes

Notes

Bupa health trusts are administered by:

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

Registered office: 1 Angel Court, London EC2R 7HJ

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