EMPLOYEE APPLICATION FORM

Joining Bupa Global

bupa-intl.com

IMPORTANT INFORMATION

This application form is for employees and eligible dependants who are applying to join Bupa Global on a full medical underwriting (FMU) basis or to amend an existing membership.

The start date will generally be the date on which your completed application form is received and accepted by Bupa Global. If you require a different start date in the future please complete the start date box in section 1.

Please write clearly in BLOCK capitals using black ink.

Please return this form to your company's Bupa Global Group Administrator in a sealed envelope.
If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

Please tell us immediately if you or any additional people to be covered under the plan experience any symptoms before you receive your membership documents. Failure to do so may mean we are unable to pay your claims.

All sections which need to be completed by the main applicant are labelled MA.

We will not be able to process your application if this form is incomplete.

Please be sure to check the entire form

Intermediaries
You may have received advice from an intermediary. In certain jurisdictions, Bupa Global require your consent to payment of your intermediary for their part in introducing you to us as a member. Where, applicable, we will deduct a fee from each subscription payment received from you and pass this onto your intermediary on your behalf. For the avoidance of doubt, consent to payment of your intermediary's fees does not affect the amount of any premiums payable by you which would remain the same whether or not you had approached us directly or not. Upon renewal of your policy, we will continue to pay your intermediary until otherwise notified by you in writing.

If you have any questions when completing this form, please call us on +44 (0) 1273 208 181

CHECKLIST - PLEASE MAKE SURE:

IF THIS IS A NEW GROUP APPLICATION

- your group secretary has completed section 1 ◯
- the information you have given in sections 3-7 is current and complete ◯
- you have read, signed and dated the declaration in section 8 ◯

IF THIS IS A NEW JOINER TO AN EXISTING GROUP PLAN.

- your group secretary has completed section 1 ◯
- the information you have given in section 3-7 is correct and complete ◯
- you have read, signed and dated the declaration in section 8 ◯

IF YOU WANT TO AMEND YOUR EXISTING MEMBERSHIP

- your group secretary has completed section 1 ◯
- the information you have given in section 2 & 7 is correct and complete ◯
- you have read, signed and dated the declaration in section 8

1 TO BE COMPLETED BY THE GROUP SECRETARY

Group name	
Group number	Cover start date* D D M M Y Y Y Y
Product name	
Does an Annual Deductible apply?	Yes ◯ No ◯

***Cover cannot start between 28th and 31st**

The options below will increase your premiums:	MA	1	2	3	4
USA cover	◯	◯	◯	◯	◯
Evacuation	◯	◯	◯	◯	◯
Repatriation (automatically includes Evacuation cover)	◯	◯	◯	◯	◯

GROUP SECRETARY DECLARATION

I confirm that I am authorised to sign on behalf of the company and that all applicants named in this application are eligible to join the plan and do not contribute to the cost, which is borne by the employer.

COMPANY SIGNATURE	DATE
	D D M M Y Y
Print full name	

2 EXISTING MEMBER: MEMBERSHIP DETAILS MA

Bupa Global membership number	BI -	-	-	Date of birth	D D M M Y Y Y Y

3 MAIN APPLICANT: YOUR PERSONAL DETAILS MA

Title	Male ◯	Female ◯	1st language
First name			Other initials
Last name			
Date of birth D D M M Y Y Y Y	Country of nationality		
Occupation			

4 MAIN APPLICANT: YOUR ADDRESS DETAILS MA

Residency address
(your permanent or usual address in the country where you are resident, this should be the country in which you are living on the first day of your current membership year)

Address line 1	
Address line 2	
Town/City	
State/Emirate	
Country	
Postal/Zip/Area code	

Correspondence address
(where membership documents cannot easily be sent to you at your residency address, please supply an alternative address to which they may be sent)

Address line 1	
Address line 2	
Town/City	
State/Emirate	
Country	
Postal/Zip/Area code	

5 MAIN APPLICANT: YOUR OTHER CONTACT DETAILS MA

(Please include country code, area code and number)

Phone / Mobile	
Phone / Mobile	
Email	

6 MAIN APPLICANT: MEDICAL QUESTIONS AND HISTORY

MA

Please answer each of these questions fully and accurately for the person named above. It is important to tell us about any known or suspected medical conditions and symptoms, even if the applicant has not yet consulted a doctor about them. So you should include for example, any varicose vein problems, ear, nose or throat problems and any pains, swellings or lumps. You should also include any symptoms/conditions for which remedies are being taken, whether or not these are prescribed by a medical practitioner.

Please tick either Yes or No to each of these questions		**Yes**	**No**
1	Currently, is this person receiving treatment of any kind, eg receiving physiotherapy or taking medication?		
2	Within the last six months, has this person experienced any signs or symptoms of any medical problem where you have not yet consulted a doctor/health professional?		
3	Within the last four years, have you consulted a doctor/healthcare professional and/or been prescribed any drugs or medication?		
4	Within the last four years, have you required assessment or treatment in a hospital or clinic, as a day case, emergency or in-patient?		
5	Does this person have any medical devices or implants in your body eg heart pacemaker, artificial joint, or any internal fixation such as pins/plates or screws?		
6	Does this person suffer from any chronic/long term medical or dental conditions or have any disability, abnormality, recurrent illness or injury?		
7	Does this person require any consultations with a healthcare professional, tests, medication or treatment for any past or current medical problem?		

This section applies if you have indicated 'Yes' to any medical questions. If you are unsure whether any details are relevant, you must include them.

Question number	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected eg right leg.	When were symptoms first experienced and when was treatment completed (if applicable)?	What was the treatment/ medication (including dates and names)?	What was the outcome of the treatment (eg full recovery, ongoing treatment required, likely to recur or awaiting test results)?

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ◯

Please tell us immediately if you or any additional people to be covered under the plan experience any symptoms before you receive your membership documents. Failure to do so may mean we are unable to pay your claims.

IF YOU HAVE A DOCTOR, PLEASE FILL IN THE DETAILS BELOW

Doctors name

Address

Your consent to your doctor to disclose medical information.

On behalf of myself and each person named on this form, I authorise this doctor to provide Bupa Global with any information it asks for in connection with my membership application and any claims (past, present and future). Please tick here to give your consent: ◯

If any family members included in your application have a different doctor, please give the name and / or address details on a separate sheet - and confirm you have done so by ticking here: ◯

7 ADDITIONAL PERSON: MEDICAL QUESTIONS AND HISTORY

Title		Male ◯	Female ◯	1st language	
First name				Other initials	
Last name					
Date of birth	D D M M Y Y Y Y	Country of nationality			
Occupation					
Relationship to you					

If this additional person has a different home or correspondence address to yours, please write their name and address on a separate sheet and confirm you have done so by ticking here: ◯

Please answer each of these questions fully and accurately for the person named above. It is important to tell us about any known or suspected medical conditions and symptoms, even if the applicant has not yet consulted a doctor about them. So you should include for example, any varicose vein problems, ear, nose or throat problems and any pains, swellings or lumps. You should also include any symptoms/conditions for which remedies are being taken, whether or not these are prescribed by a medical practitioner.

Please tick either Yes or No to each of these questions		**Yes**	**No**
1	Currently, is this person receiving treatment of any kind, eg receiving physiotherapy or taking medication?		
2	Within the last six months, has this person experienced any signs or symptoms of any medical problem where you have not yet consulted a doctor/health professional?		
3	Within the last four years, have you consulted a doctor/healthcare professional and/or been prescribed any drugs or medication?		
4	Within the last four years, have you required assessment or treatment in a hospital or clinic, as a day case, emergency or in-patient?		
5	Does this person have any medical devices or implants in your body eg heart pacemaker, artificial joint, or any internal fixation such as pins/plates or screws?		
6	Does this person suffer from any chronic/long term medical or dental conditions or have any disability, abnormality, recurrent illness or injury?		
7	Does this person require any consultations with a healthcare professional, tests, medication or treatment for any past or current medical problem?		

This section applies if you have indicated 'Yes' to any medical questions. If you are unsure whether any details are relevant, you must include them.

Question number	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected eg right leg.	When were symptoms first experienced and when was treatment completed (if applicable)?	What was the treatment/ medication (including dates and names)?	What was the outcome of the treatment (eg full recovery, ongoing treatment required, likely to recur or awaiting test results)?

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ◯

Please tell us immediately if you or any additional people to be covered under the plan experience any symptoms before you receive your membership documents. Failure to do so may mean we are unable to pay your claims.

7 ADDITIONAL PERSON: MEDICAL QUESTIONS AND HISTORY

Title		Male ◯	Female ◯	1st language	
First name				Other initials	
Last name					
Date of birth	D D M M Y Y Y Y	Country of nationality			
Occupation					
Relationship to you					

If this additional person has a different home or correspondence address to yours, please write their name and address on a separate sheet and confirm you have done so by ticking here: ◯

Please answer each of these questions fully and accurately for the person named above. It is important to tell us about any known or suspected medical conditions and symptoms, even if the applicant has not yet consulted a doctor about them. So you should include for example, any varicose vein problems, ear, nose or throat problems and any pains, swellings or lumps. You should also include any symptoms/conditions for which remedies are being taken, whether or not these are prescribed by a medical practitioner.

Please tick either Yes or No to each of these questions		**Yes**	**No**
1	Currently, is this person receiving treatment of any kind, eg receiving physiotherapy or taking medication?		
2	Within the last six months, has this person experienced any signs or symptoms of any medical problem where you have not yet consulted a doctor/health professional?		
3	Within the last four years, have you consulted a doctor/healthcare professional and/or been prescribed any drugs or medication?		
4	Within the last four years, have you required assessment or treatment in a hospital or clinic, as a day case, emergency or in-patient?		
5	Does this person have any medical devices or implants in your body eg heart pacemaker, artificial joint, or any internal fixation such as pins/plates or screws?		
6	Does this person suffer from any chronic/long term medical or dental conditions or have any disability, abnormality, recurrent illness or injury?		
7	Does this person require any consultations with a healthcare professional, tests, medication or treatment for any past or current medical problem?		

This section applies if you have indicated 'Yes' to any medical questions. If you are unsure whether any details are relevant, you must include them.

Question number	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected eg right leg.	When were symptoms first experienced and when was treatment completed (if applicable)?	What was the treatment/ medication (including dates and names)?	What was the outcome of the treatment (eg full recovery, ongoing treatment required, likely to recur or awaiting test results)?

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ◯

Please tell us immediately if you or any additional people to be covered under the plan experience any symptoms before you receive your membership documents. Failure to do so may mean we are unable to pay your claims.

7 ADDITIONAL PERSON: MEDICAL QUESTIONS AND HISTORY

Title		Male ◯	Female ◯	1st language	
First name				Other initials	
Last name					
Date of birth	D D M M Y Y Y Y	Country of nationality			
Occupation					
Relationship to you					

If this additional person has a different home or correspondence address to yours, please write their name and address on a separate sheet and confirm you have done so by ticking here: ◯

Please answer each of these questions fully and accurately for the person named above. It is important to tell us about any known or suspected medical conditions and symptoms, even if the applicant has not yet consulted a doctor about them. So you should include for example, any varicose vein problems, ear, nose or throat problems and any pains, swellings or lumps. You should also include any symptoms/conditions for which remedies are being taken, whether or not these are prescribed by a medical practitioner.

Please tick either Yes or No to each of these questions		**Yes**	**No**
1	Currently, is this person receiving treatment of any kind, eg receiving physiotherapy or taking medication?		
2	Within the last six months, has this person experienced any signs or symptoms of any medical problem where you have not yet consulted a doctor/health professional?		
3	Within the last four years, have you consulted a doctor/healthcare professional and/or been prescribed any drugs or medication?		
4	Within the last four years, have you required assessment or treatment in a hospital or clinic, as a day case, emergency or in-patient?		
5	Does this person have any medical devices or implants in your body eg heart pacemaker, artificial joint, or any internal fixation such as pins/plates or screws?		
6	Does this person suffer from any chronic/long term medical or dental conditions or have any disability, abnormality, recurrent illness or injury?		
7	Does this person require any consultations with a healthcare professional, tests, medication or treatment for any past or current medical problem?		

This section applies if you have indicated 'Yes' to any medical questions. If you are unsure whether any details are relevant, you must include them.

Question number	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected eg right leg.	When were symptoms first experienced and when was treatment completed (if applicable)?	What was the treatment/ medication (including dates and names)?	What was the outcome of the treatment (eg full recovery, ongoing treatment required, likely to recur or awaiting test results)?

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ◯

Please tell us immediately if you or any additional people to be covered under the plan experience any symptoms before you receive your membership documents. Failure to do so may mean we are unable to pay your claims.

7 ADDITIONAL PERSON: MEDICAL QUESTIONS AND HISTORY

Title		Male ◯	Female ◯	1st language	
First name				Other initials	
Last name					
Date of birth	D D M M Y Y Y Y	Country of nationality			
Occupation					
Relationship to you					

If this additional person has a different home or correspondence address to yours, please write their name and address on a separate sheet and confirm you have done so by ticking here: ◯

Please answer each of these questions fully and accurately for the person named above. It is important to tell us about any known or suspected medical conditions and symptoms, even if the applicant has not yet consulted a doctor about them. So you should include for example, any varicose vein problems, ear, nose or throat problems and any pains, swellings or lumps. You should also include any symptoms/conditions for which remedies are being taken, whether or not these are prescribed by a medical practitioner.

Please tick either Yes or No to each of these questions		**Yes**	**No**
1	Currently, is this person receiving treatment of any kind, eg receiving physiotherapy or taking medication?		
2	Within the last six months, has this person experienced any signs or symptoms of any medical problem where you have not yet consulted a doctor/health professional?		
3	Within the last four years, have you consulted a doctor/healthcare professional and/or been prescribed any drugs or medication?		
4	Within the last four years, have you required assessment or treatment in a hospital or clinic, as a day case, emergency or in-patient?		
5	Does this person have any medical devices or implants in your body eg heart pacemaker, artificial joint, or any internal fixation such as pins/plates or screws?		
6	Does this person suffer from any chronic/long term medical or dental conditions or have any disability, abnormality, recurrent illness or injury?		
7	Does this person require any consultations with a healthcare professional, tests, medication or treatment for any past or current medical problem?		

This section applies if you have indicated 'Yes' to any medical questions. If you are unsure whether any details are relevant, you must include them.

Question number	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected eg right leg.	When were symptoms first experienced and when was treatment completed (if applicable)?	What was the treatment/ medication (including dates and names)?	What was the outcome of the treatment (eg full recovery, ongoing treatment required, likely to recur or awaiting test results)?

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ◯

Please tell us immediately if you or any additional people to be covered under the plan experience any symptoms before you receive your membership documents. Failure to do so may mean we are unable to pay your claims.

8 YOUR APPLICATION DECLARATION

DATA PROTECTION NOTICE

Purpose:
Personal data collected on you, and where appropriate, your family, will be used by Bupa Global to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

Confidentiality:
The confidentiality of patient and member information is of paramount concern to Bupa Global. To this end, Bupa Global fully comply with UK Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical Information:
Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may also be shared with appointed third parties involved in the management and handling of your claim. Claims information may be discussed with the Bupa Global Agent/Adviser where you have requested the Adviser to assist you.

Member details:
All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.

Telephone calls:
In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

Research:
Anonymised or aggregated data may be used by Bupa Global, or disclosed to others, for research or statistical purposes.

Fraud:
Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and Addresses:
Bupa Global does not make the names and addresses of members or patients available to other organisations.

Keeping you informed:
Bupa Global would, on occasion, like to keep you informed of Bupa Global products and services which it considers may be of interest to you.

Contact Address:
If you do not wish to receive information about Bupa Global's products and services, or have any other Data Protection queries please write to the Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@Bupa.com.

Our complaints procedure:
It is Bupa Global's intention to provide a first class service to our members at all times. However, if you have any comments or complaints, you can call the Bupa Global customer helpline on +44 (0) 1273 323 563, 24 hours a day, 365 days a year. Alternatively you can email via bupa-intl.com/membersworld, or write to us at: Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, UK. If you have not received a response within 8 weeks or you remain unhappy with our final response, you may refer your complaint to the Financial Ombudsman Service. Their address and contact details are: South Quay Plaza, 183 Marsh Wall, London E14 9SR, telephone; 0845 080 1800 or +44 (0) 207 964 1000 from outside the UK.

DECLARATION

I hereby apply to be enrolled under my employers plan with the Dependants listed above included in my membership. I declare that to the best of my knowledge and belief the information given in this Application is true and complete.

I agree that the Rules of the Bupa Global plan will be binding on me and all eligible Dependants included in my membership.

I agree that any cover purchased by my employer for the USA shall terminate upon informing Bupa Global that I have become a resident of the USA.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any Dependants specified in this form, for Bupa Global to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these Dependants.

Where applicable, I hereby consent to your payment of the fees to my intermediary as described in this application.

In view of the declaration above it is essential that complete information is supplied. We will not be able to process your application if this form is incomplete. Please be sure to check the entire form.

Benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters. If you would like a copy of this application form, please ask us.

Please be aware that this form must be received by Bupa Global no more than six weeks after the declaration date. Fill in your form with complete up-to-date medical history before you sign and date it. If we receive this form after six weeks from this declaration date, or with incomplete information, we will be unable to register your details and enrol you on the plan.

MAIN APPLICANT'S SIGNATURE	DATE					
	D	D	M	M	Y	Y
Print full name						

FOR OFFICE USE ONLY	IDENTIFICATION STAMP / BROKER NAME AND ID NUMBER

General services:
+44 (0) 1273 323 563
Medical related enquiries:
+44 (0) 1273 333 911
Your calls will be recorded and may be monitored.

Bupa Global
Victory House
Trafalgar Place
Brighton
BN1 4FY
United Kingdom

Bupa Global offers you:
Global medical plans for individuals and groups
Assistance, repatriation and evacuation cover
24-hour multi-lingual helpline

bupa-intl.com

The world of Bupa

Care homes
Cash plans
Dental insurance
Health analytics
Health assessments
Health at work services
Health centres
Health coaching
Health information
Health insurance
Home healthcare
Hospitals
International health insurance
Personal medical alarms
Retirement villages
Travel insurance

BIN-COMP-APPF-1407v1.2