Business Health Plans

Employee application form

Bupa Insurance Ltd
Switzerland Branch

bupaglobal.com

Important information

This application form is for employees and their eligible dependants who are applying to join a Bupa Global Business Health Plan 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.

You must tell us if you or any dependant to be covered under the policy experience any symptoms between the time you complete this application form and when the policy is issued. This may be different from the requested policy start date on this form. If you do not give this information you (and your dependants') cover may be affected.

Please give complete and accurate information. Without it, we may not be able to pay all or part of a claim or need to treat your (and your dependants') policy as if it had not existed.

Please note that 

is for the employee and 1,2,3,4 is for dependants.

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

How to use this form

You can type directly into this form, or write clearly in block capitals using black ink. Once completed, return this form to your company's Group Administrator.

This form can be used for new customers wanting to join Bupa Global Business Health Plan and existing customers wanting to make changes to their policy.

For new customers, please make sure:	
Your Group Secretary has completed section 1	◯
The information in sections 3-7 is current and complete	◯
You have read, signed and dated the declaration in section 9	◯
For existing customers, please make sure:	
Your Group Secretary has completed section 1	◯
The information you have given in section 2 is correct	◯
You have completed the relevant section to reflect the amendment(s) required	◯
You have read, signed and dated the declaration in section 9	◯

1 To be completed by the Group Secretary

Group name																															
Group number											Starting date (cannot be between 28th & 31st of any month)								D	D	M	M	Y	Y	Y	Y

Plan information

Please tick the plan and any co-insurance, optional modules or U.S. cover which will apply to this application.

Choose Plan	Choose Co-insurance			Choose Optical & Dental	Choose U.S. Cover
◯ Business Select Health Plan	Not available			Not available	(Y) (N)
◯ Business Premier Health Plan	◯ 0%	◯ 15%	◯ 25%	(Y) (N)	(Y) (N)
◯ Business Elite Health Plan	◯ 0%	◯ 15%	◯ 25%	(Y) (N)	(Y) (N)
◯ Business Ultimate Health Plan	Not available			✓ Included	✓ Included

Underwriting terms

Please select the underwriting terms to be applied to this application.

Full Medical Underwriting: If you have a pre-existing condition, which is any symptom or medical condition that you had before the start date, you must tell us on the application form. The treatment for pre-existing conditions will generally not be covered. Any specific exclusion(s) will be included on the insurance certificate issued in the member welcome pack.	◯
Continued Personal Medical Exclusions: This is where underwriting terms from your previous insurer are carried over to your Bupa Global Plan.	◯

Group Secretary declaration

I confirm that I am authorised to sign on behalf of the company and that all members named in this application can join the plan and do not make premium payment, which is the company's responsability.

Authorised signatory	Date
	D D M M Y Y Y Y

Print name																															

2 Main applicant: membership details

MA

Bupa Global membership number	BI	-					-					-				

(to be completed if you are an existing member)

3 Main applicant: Your personal details

MA

If you have previously had a policy with Bupa, please provide the membership number

Your personal details

Title | Male ◯ | Female ◯ | Date of birth D D M M Y Y Y Y

First name | Middle name

Family name

Nationality | Language

Your contact details

Email

Phone/mobile (include country/area code)

Residency address (your permanent or usual address in the country where you are a resident, on the day you would like the policy to start)

Address

Town/city

County/region

Postal/zip/area code | Country

Correspondence address (if your correspondence and residency address are the same please tick here ◯)

Address

Town/city

County/region

Postal/zip/area code | Country

Have you had KVG or Supplemental health cover in the last 2 years? Y N

If yes, please tell us if this cover is still active and give details below: Y N

KVG Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

Supplemental Policy Provider

Membership number

Start date D D M M Y Y Y Y | End date D D M M Y Y Y Y

4 Dependants to be covered with you

If any of these additional persons have different residency or correspondence addresses to yours, please write their name and addresses on a separate sheet and confirm you have done so by ticking here ◯

1

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency

Relationship to you

Email

Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active (Y) (N) ◯ **Active**

If yes, please confirm

KVG Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

Supplemental Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

2

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency

Relationship to you

Email

Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active (Y) (N) ◯ **Active**

If yes, please confirm

KVG Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

Supplemental Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

4 Dependants to be covered with you (continued)

3

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency

Relationship to you

Email

Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active (Y) (N) ◯ **Active**

If yes, please confirm

KVG Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

Supplemental Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

4

Title | Male ◯ | Female ◯ | 1st language

First name | Middle name

Family name

Date of birth (D D M M Y Y Y Y) | Country of nationality

Country of residency

Relationship to you

Email

Has this additional person held KVG or Supplemental cover in the last 2 years? Please indicate if this cover is still active (Y) (N) ◯ **Active**

If yes, please confirm

KVG Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

Supplemental Policy Provider

Membership number

Start date (D D M M Y Y Y Y) | End date (D D M M Y Y Y Y)

5 Medical history – Full Medical Underwriting (FMU)

MA

This section should only be completed if your Group Secretary has ticked 'Full Medical Underwriting' in section 1 of this form.

This section asks for health and medical details, past and present about yourself and each person named in section 4. Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in section 7. Please answer each of these questions fully and accurately for the person named above.

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

You must also tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may also result in termination, rejection of claims and/or changes to the terms and conditions of your policy.

	M	1	2	3	4
1. Within the last 3 years, has any applicant seen a doctor or other healthcare professional for a) any recurrent or persistent medical condition or symptoms? (persistent meaning for 2 weeks or more) b) any abnormal tests or results?	Y N	Y N	Y N	Y N	Y N
2. In the last 7 years, has any applicant been admitted to hospital, had an operation, procedure or investigation (e.g. a scan/blood tests)?	Y N	Y N	Y N	Y N	Y N
3. Is any applicant taking any medication, prescribed or otherwise?	Y N	Y N	Y N	Y N	Y N
4. Does any applicant have any medical devices (e.g. shunts for draining fluids from the brain, pins and plates for broken bones) currently in their body?	Y N	Y N	Y N	Y N	Y N
5. Has any applicant (at any time in the past) had a history of:					
○ cancer, including benign brain tumours	Y N	Y N	Y N	Y N	Y N
○ heart condition	Y N	Y N	Y N	Y N	Y N
○ stroke	Y N	Y N	Y N	Y N	Y N
○ joint replacements	Y N	Y N	Y N	Y N	Y N
6. Has anyone to be covered experienced any signs or symptoms of any medical problems, illnesses, or injuries not already disclosed regardless of whether a doctor or other healthcare professional has been consulted?	Y N	Y N	Y N	Y N	Y N
7. Do you have any planned or pending treatment, investigations or tests?	Y N	Y N	Y N	Y N	Y N

Further details (for over 16s only):

How tall are you?	feet/inches	○	metres/centimetres	○					
How much do you weigh?	stones/pounds	○	kilograms	○					

6 Medical questions – Continued Personal Medical Exclusions (CPME)

This section should only be completed if your Group Secretary has ticked 'Continued Personal Medical Exclusions' in section 1 of this form.

This section asks for health and medical details, past and present about yourself and each person named in section 4. Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in section 7. Please answer each of these questions fully and accurately for the person named above.

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.

You must also tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may also result in termination, rejection of claims and/or changes to the terms and conditions of your policy.

	M	1	2	3	4
1. Has any applicant suffered from any form of:					
○ cancer, including benign brain tumours	Y N	Y N	Y N	Y N	Y N
○ heart condition	Y N	Y N	Y N	Y N	Y N
○ stroke	Y N	Y N	Y N	Y N	Y N
○ psychiatric condition	Y N	Y N	Y N	Y N	Y N
2. Has any applicant had a joint replacement or spinal surgery?	Y N	Y N	Y N	Y N	Y N
3. Has any applicant made a claim under existing insurance in the last 12 months?	Y N	Y N	Y N	Y N	Y N
4. Has any applicant have any long-term conditions which require regular treatment and reviews with a doctor?	Y N	Y N	Y N	Y N	Y N
5. Has any applicant have any planned or pending treatment, investigations or tests?	Y N	Y N	Y N	Y N	Y N

7 Medical questions: Additional information

This section applies if you have answered 'Yes' to any of the medical questions in sections 5 or 6.
If you are unsure whether any details are relevant, you must include them.

Main applicant or dependant	The relevant question number from section 5 or 6	What was the condition (or symptom if not yet diagnosed)? If applicable, state the area affected e.g. 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 (e.g. full recovery, ongoing treatment required, likely to recur or awaiting test results)?
M					
1					
2					
3					
4					

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: ◯

8 Privacy Notice

Last updated: September 2023

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. 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: www.bupaglobal.com/privacypolicy. If you do not have access to the internet and would like a paper copy of the full privacy notice, or if you have any questions about how we handle your information, please contact the Bupa Global service team on +44 (0) 1273 323 563. Alternatively, you can email or write to the team via info@bupaglobal.com or Bupa Global, Victory House, Trafalgar Place, Brighton BN1 4FY, United Kingdom.

Information about Bupa Global

In this privacy notice, "we" "us" and "our" means the Bupa companies trading as Bupa Global. For details of these companies visit www.bupaglobal.com/legal-notices

The Bupa companies that process your information will depend on which of our products and services you ask us about, buy or use. For our insurance policies, your information will be processed by the insurer and the lead administrator of your policy who may share it with other Bupa companies as set out in the 'Sharing your information section'. Please refer to your policy documentation for confirmation of the insurer and lead administrator.

1. What this privacy notice covers

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 other organisations (for example those acting on your behalf, like 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 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. What we use personal information for and our legal reasons for doing so

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 complaints handling), 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 would, on occasion, like to keep you informed of our products and services which we consider may be of interest to you.

Please tick if you would like us and other members of the Bupa group to keep you updated about our products and services by post, telephone email and text.

You will be able to opt out of receiving these communications at any time by contacting us.

6. 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. International transfers

We work with companies that we partner with, or that provide services to us (such as healthcare 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.

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 info@bupaglobal.com. You can also use this address to contact our Data Protection Officer.

You also have the 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's Office (www.ico.org.uk) who can be contacted at, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, United Kingdom. Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

9 Declaration

To the best of my knowledge and belief the information given in this application form is true, accurate and complete. I understand that benefits may not be payable in full or at all and my policy may be treated as if it had not existed, if I do not take reasonable care when providing any information requested in this application form.

Where I have provided information on behalf of any other person to be covered by the policy, I confirm that I have checked with them that the information is correct before completing this application form and I have their express agreement to submit this application form on their behalf, or I am their legal representative.

I understand that my personal information and that of any other person to be covered by this policy will be processed by Bupa Global for the purposes set out in Bupa Global's privacy notice. I confirm that I have brought Bupa Global's privacy notice to the attention of these covered.

I agree to be bound by the policy terms of my health plan (and for cover provided to any other person to be covered by this policy but under a different health plan, the policy terms of that health plan). I agree that Switzerland law will apply to the policy.

I agree that my policy shall terminate upon informing Bupa Global that I have become a permanent resident of the U.S. (or in the case of a dependant becoming a resident of the U.S., their cover under the policy shall terminate).

Where you have local health insurance, you, and all persons named under your plan, will submit all claims to Bupa Global, or our regional partners as appropriate. We will process your claim in accordance with your Bupa Global policy benefits. We will process your claim in accordance with your Bupa Global policy benefits. We will submit the claim to your local insurer to recover any benefit that is payable by your local insurance.

You, and all persons named under your plan, agree that your local insurer pays benefits directly to Bupa.

You, and all persons named under your plan, will not make any claim against Bupa, where you have claimed against your local insurer.

You, and all persons named under your plan, agree that Bupa and your local insurer, may exchange information about your claim, including information on your health.

We recommend that you keep a record of all the 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.

Fill in your form with complete up-to-date medical history before you sign and date it. We may ask you for a declaration of continued good health or to submit a new application form if:

- we do not receive this application form within six weeks of this declaration date, or,
- the declaration date is more than six weeks before your cover start date

I sign this application form confirming that its contents are accurate and true.

Main applicant's signature	Date
	D D M M Y Y Y Y

Print name	

Notes

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

bupaglobal.com

BIN-BHPX-APPF-EN-XXXX-2402-0049127