Application and policy changes form

Individual health cover

Bupa Global
bupaglobal.com

Important information

Please use this form to tell us about your medical history and the medical history of anyone else you want to add to your cover (dependant). We need this information to confirm your cover, process future claims and pay for treatment.

As the policy you are applying for is fully medical underwritten, any symptoms or medical conditions that you or any of your dependants had before the start date may not be covered.

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 provide this information you (and your dependants') cover may be affected.

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

Need to know – If you are a Bupa Global Health Plan (BGHP) France customer and live in France or Monaco, we can give you the following documents in French: Insurance certificate, Membership guide, premium payments and documents about claims and complaints. Alternatively, all documents can be given in English. Please select which language you prefer your documents in section 3.

Note that sometimes we may issue some communications in English.

How to use this form

You can type directly into this form, save it and email it to us. You can also complete it writing clearly in block capitals using black ink.

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

If you are a new customer, start at section 2 and complete all sections after that.

If you are an exising customer, you can use this form to:

- **Add dependants:** complete sections 1 3 4 5 6 7 11
- **Change your level of cover:** complete sections 1 3 6 7 11
- **Include U.S. area of cover:** complete sections 1 9 11

You can make changes to your personal details, like your address, contact number or email on MembersWorld. Log into our secure website: **https://membersworld.bupaglobal.com**

If you need more space to answer any of the questions, you can use the notes page at the end.

Where to send this form

This form can be sent by email and by post;

For new customers, email us at **eeadirectsales@bupa.com**

For existing customers, email us at **eeacustomerengagement@bupa.com**

For new and existing customers, you can send us the application form by post at Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY United Kingdom.

Remember to sign and date the form. Check that all relevant sections have been completed before you return it to us.

If you have any questions, please call us on +44 (0) 1273 323563.

If your policy is managed by an intermediary, please ask them to complete section 12 – Intermediary information.

1 Main applicant: membership details

If you are an existing member wanting to make changes to your policy, please give your membership number

Main applicant's membership number	

2 Your personal details

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

Phone/mobile (include country/area code)	
Email	

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 or area code	Country
If you have previously had a policy with Bupa, please provide the membership number	

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

Address	
Town/city	
County/region	
Postal, zip or area code	Country

3 Your cover

By submitting this application form, you acknowledge that you are applying for / updating your international private medical insurance with Bupa Global.
The details of the insurance can be found in your quotation letter and the full terms and conditions are in the Membership Guide

Quote reference number or product name (if applicable)	

The cover will start on the date we receive your completed application form unless you specify a date in the future.

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

Language preference for documentation *	English ◯	French ◯

*(only for BGHP France customers)

4 Dependants to be covered on your policy

If any of these dependants have different residency or correspondence addresses to yours, please write their names and addresses on the notes section at the end of this form, and confirm you've done this by ticking here ◯ If not, we understand that they have the same address as you.

Dependant 1

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

First name | Middle name

Family name

Nationality | Country of residency

Language | Relationship to you

Phone/mobile (include country/area code)

Email

If they have had a Bupa policy before, please provide the policy number

Dependant 2

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

First name | Middle name

Family name

Nationality | Country of residency

Language | Relationship to you

Phone/mobile (include country/area code)

Email

If they have had a Bupa policy before, please provide the policy number

Dependant 3

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

First name | Middle name

Family name

Nationality | Country of residency

Language | Relationship to you

Phone/mobile (include country/area code)

Email

If they have had a Bupa policy before, please provide the policy number

5 How you'd like to manage your policy

We are working hard to reduce our impact on the environment, and we encourage our customers to help us by managing their plan online.

Please let us know how you would like to receive your and your dependants' (over 16 years old) policy documents.

	Main applicant	Dependant 1	Dependant 2	Dependant 3
To view and manage your policy online, register at **https://membersworld.bupaglobal.com.** We will email you when new documents are available to view	◯	◯	◯	◯
To receive your documents by post	◯	◯	◯	◯

At Bupa, we understand that our members might sometimes need support and we want to make things as easy as possible when they deal with us. To help us do this, please let us know if you or anyone on your policy would like to tell us about a hearing problem, a sight problem, a speech difficulty, a physical disability, or any other communication concerns.

Select this box if you want us to contact you about it ◯

6 Medical history

Please tell us about yours and your dependants' health and medical details, past and present.

If you are an existing customer upgrading your cover you must complete this section in full, so that we have an up to date record of your (and your dependants') health.

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.

If you do not provide us with full details we may lapse 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 dependants experience any symptoms between the time you complete this application form and the date the policy is issued. Failure to do so may also result in cancellation, rejection of claims and/or changes to the terms and conditions of your policy.

	Main applicant	Dependant 1	Dependant 2	Dependant 3
1. In the last 3 years, has any applicant seen a doctor or other healthcare professional for any recurrent or persistent medical condition or symptoms? (persistent means has continued for 2 weeks or more)	Y N	Y N	Y N	Y N
2. In the last 3 years, has any applicant been advised by doctor to take any medications (such as to be taken daily, once per week, as needed as directed by doctor) for a continuous period of more than 1 month?	Y N	Y N	Y N	Y N
3. In the last 3 years, has any applicant to be covered ever had or been advised to have any regular or ongoing follow-up consultations or medical care with a healthcare professional (such as a doctor, physiotherapist, psychiatrist) for any disease or other medical condition?	Y N	Y N	Y N	Y N
4. In the last 7 years, has any applicant ever had or been advised to undergo investigations (such as blood or urine test, colonoscopy, mammogram, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B or Hepatitis C test)?	Y N	Y N	Y N	Y N
5. In the last 7 years, has any applicant been admitted to hospital?	Y N	Y N	Y N	Y N
6. In the last 3 months, has any applicant experienced any signs or symptoms of a medical problem, illness or injury not yet diagnosed or treated?	Y N	Y N	Y N	Y N
7. Does any applicant have any chronic conditions e.g. a disease, illness or injury that has one or more of the below characteristics?				
○ Continues indefinitely, symptoms or condition may recur or likely to recur?	Y N	Y N	Y N	Y N
○ Needs ongoing or long-term monitoring through consultation, examination, check-ups, and tests	Y N	Y N	Y N	Y N
○ Needs ongoing or long-term relief of symptoms	Y N	Y N	Y N	Y N
○ Needs rehabilitation	Y N	Y N	Y N	Y N

6 Medical history (continued)

8. Has any applicant ever had a history of the following?				
○ Cancer, including benign brain tumours	Y N	Y N	Y N	Y N
○ Heart condition e.g. angina, heart attack, heart failure, abnormal heartbeat	Y N	Y N	Y N	Y N
○ Stroke	Y N	Y N	Y N	Y N
○ Prosthetic implants and appliances in their body e.g. shunts, pacemakers, joint replacements	Y N	Y N	Y N	Y N
○ Congenital/hereditary conditions	Y N	Y N	Y N	Y N
9. Does any applicant have any ongoing or planned treatment, investigations or tests?	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				

7 Medical history: additional information

This section applies if any applicant has indicated yes to any medical questions in section 6. If you are unsure whether any details are relevant, you must include them.

Please attach medical reports or test results relating to the medical conditions you have declared if these are available.

Is additional medical information included?	Y N

	The relevant question number from section 6	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (e.g. right leg, left eye).	When were symptoms first experienced and when was treatment completed (if applicable)?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?
Main applicant					
Dependant 1					
Dependant 2					
Dependant 3					

If there is insufficient space, please use the notes page at the end of this form, and indicate that you have done so by ticking here ◯

8 Your payment details

(Contact your Bupa Global representative if payment is to be made by a third party)

Which currency would you like to use to pay for the policy? (please tick one)	GBP £ ◯	USD $ ◯	EUR € ◯
How often would you like to make premium payments?	Monthly ◯	Quarterly ◯	Annually ◯

Payment method

You can pay for your policy by direct debit, credit card, cheque or bankers draft. We're unable to accept cash payments.

Need to know: If you have chosen a deductible, co-insurance and/or to pay your premium each month, you must pay by direct debit or credit card. Please make sure that we always have a valid direct debit agreement or card payment authority. If we don't, it may take us longer to pay claims.

Please choose how you'd like to pay for your policy:

By credit card - now complete the **card payment authority section** below ◯
By direct debit through a UK bank (GBP £ payments only) – now complete the **direct debit section** on the next page ◯
By cheque or bankers draft in the currency you have indicated above. Fill in the name of the person paying the premiums in the box provided below. If the named person is not the policy holder they will be subject to Bupa's KYC (Know Your Customer) checks. ◯

Name

Card payment authority

Visa and Mastercard require Bupa Global to obtain your consent to store your credit card information for future use. This is so that we can take payments from you as agreed in your international private medical insurance contract, such as premiums, deductibles and/or co-insurances. Please refer to your policy documents for details of when payments will be taken and the amounts.

We will also request your consent to store your credit card information if you are using an American Express card.

Your card will remain stored against your policy for transactional purposes until the card expires. For legal and regulatory purposes, we will continue to store records of your transactions in accordance with our Privacy Notice.

If you do not want Bupa Global to store your card details, then we cannot accept payments from your card and you will need to choose a different payment method.

I authorise Bupa Global to charge to my card account when payments become due. I will advise you immediately if the card becomes lost, stolen or if I wish to close my bank account or cancel the card payment authority.

I give my consent to Bupa Global to store my below card details on file and use them to process payments. ◯

Please tick	MasterCard ◯	Visa ◯	American Express ◯

Please note that we do not accept Maestro payments. You will be given 14 days' notice of other unspecified amounts to be collected.

Cardholder's name as it appears on the card

Card number

Valid from date M M / Y Y Expiry/end date M M / Y Y

Cardholder's signature	Date of signature
	D D M M Y Y Y Y

Cardholder address (if different from the main applicant's address)

Address

Town/city

County/region

Postal/zip/area code Country

8 Your payment details (continued)

(Contact your Bupa Global representative if payment is to be made by a third party)

Direct Debit

If you are paying by Direct Debit you must complete this section **- for GBP £ payments only**

Instruction to your Bank or Building Society to pay by Direct Debit **- this must come out of a UK bank account**

Name(s) of account holder(s)

Sort code - - Bank/Building Society account number

Swift code

Instruction to your Bank or Building Society

Please pay Bupa Global 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 Bupa Global and, if so, details will be passed electronically to my Bank/Building Society.

Name and full postal address of your Bank/Building Society:

To: The Manager

Address

Postcode

Account holder's signature	Date of signature
	D D M M Y Y Y Y

Membership number (for Bupa Global use only)

BI - - - -

Originator's ID number 1 7 8 0 1 7

Banks and Building Societies may not accept Direct Debit Instructions for some type of accounts.

The Direct Debit Guarantee

This guarantee should be detached and retained by the payer

This Guarantee is offered by all banks and building societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.

If the amounts to be paid or the payment dates change, Bupa Global will notify you 7 working days in advance of your account being debited or as otherwise agreed.

If an error is made by Bupa Global or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.

You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

9 Upgrade to include U.S. cover once the policy has started

Need to know: Cover can only be added to certain health schemes and if you or your dependents are not permanent residents of the U.S. You can find more information in your Membership Guide.

If you are completing this form to upgrade to U.S. cover after your policy has started, you should complete this section instead of sections 6 Medical history and 7 Medical history: additional information. Medical underwriting will be undertaken at the point of application to upgrade cover to include U.S. Exclusions may be applied to U.S. cover.

	Main applicant	Dependant 1	Dependant 2	Dependant 3
1. How long do you plan to stay in the U.S.?				
2. Do you have any ongoing or planned treatment? If yes, please provide details in the box below	Y N	Y N	Y N	Y N
3. Females only: Are you currently pregnant?	Y N	Y N	Y N	Y N

10 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.

11 Privacy notice (continued)

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. We are regulated by the Data Protection Commissioner (**www.dataprotection.ie**) who can be contacted at, 21 Fitzwilliam Square South, Dublin 2, D02 RD28, Ireland.
Tel +353 (0)761 104 800 or +353 (0)57 868 4800

11 Your 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 dependant 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 dependant to be covered by this policy will be processed by Bupa Global for the purposes set out in the privacy notice above. I confirm that I have brought the privacy notice to the attention of the dependants to be covered under this policy.

I understand and accept that some written communications associated with this application including any claims information will be given in English, and some verbal communications may also be in English. I acknowledge that Bupa will try to facilitate verbal communication in an alternative language if possible.

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 Irish law will apply to the policy when purchasing Global Health Plans EEA, BWHO (Bupa Worldwide Health Options) and Lifeline. I agree that French law will apply to the policy when purchasing Global Health Plans France and Monaco.

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).

It is essential that you take reasonable care to provide us with full, complete, and accurate information when you complete this application form. If you do not provide complete information, we will not be able to process your application. Please be sure to check the entire application form.

If you do not take reasonable care to provide us with full, complete, and accurate information about yourself or any dependant covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

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

We recommend that you keep a record of all the information you supply to us in connection with this application form, including letters and any other documents and correspondences exchanged between you and Bupa Global. If you would like a copy of this application form please ask us.

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

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

Print name	

12 Intermediary information

Please ensure up-to-date Know Your Customer (KYC) documents have been provided for the main applicant and dependants (aged over 16) where applicable. If you need information about which documents are required, please contact your Bupa Global sales representative. If we don't receive accurate documents, the application could be delayed or cancelled.

Intermediary name	
Intermediary ID	

In case of unsolicited sales, applications will only be accepted for countries that allow unsolicited sales of international private medical insurance contracts – including on a cross-border basis, where this is the case. For more information please refer to your Bupa Global sales representative.

Solicited (promoted) sale. Tick the box if this is a Solicited sale.	◯
Unsolicited sale. By ticking this box I hereby confirm that I neither promoted, sought, approached the customer and the customer neither sought nor required advice.	◯

Intermediary's signature	Date of signature
	D D M M Y Y Y Y

Print name	

We reserve the right to request further information where appropriate or necessary.

Final checklist

Before you return this form to us, please make sure you have:

- ◯ included full details of everyone you would like to be covered by the policy
- ◯ checked that everyone's details are correct
- ◯ shown each dependant the privacy notice
- ◯ checked you have everyone's agreement to send us this form on their behalf, or you're their legal representative
- ◯ signed and dated the declaration section
- ◯ kept a copy for your own records

What happens next?
We'll review the information you've provided and if we need more details, we'll be in touch. If we don't need to check anything with you, we'll send you a welcome pack.

Notes