MEDICARE

HEALTHCARE AND LEISURE

PLEASE COMPLETE IN BLOCK CAPITALS

Member Details

Title Forename(s) Surname

Home address

Postcode

Daytime Telephone Date of Birth

Email

BAWA Membership Number

Please give details of any individual, other than yourself, that you wish to include in the Medicare scheme

Name

Date of Birth Relationship to Member

Name

Date of Birth Relationship to Member

Name

Date of Birth Relationship to Member

Medicare Rates

	Rates	No. you wish to cover	Total
1 Adult	£83.30 per month		£
1 Child under 21	£30.90 per month		£
1 Adult over 65	£225.00 per month		£
		Grand Total	**£**

Where did you hear about BAWA?

It is the members responsibility to inform BAWA Healthcare & Leisure of any changes to employment, address or other personal details - failure to do this may effect future claims

07.16

Authorised and registered by the Financial Conduct Authority and Prudential Regulation Authority.

HEALTHCARE AND LEISURE

Declaration to the Underwriters

1. I confirm that all statements made in this application are true and complete to the best of my knowledge and belief. I understand that they will form the basis of the proposed contract between myself and the Underwriters based upon the terms and conditions of the BAWA Medicare Scheme (which are available on request).

2. **THE INDIVIDUALS LISTED AGREE TO BE BOUND BY THE TERMS AND CONDITIONS OF THE BAWA MEDICARE SCHEME AND UNDERSTAND THAT, IN ADDITION TO ANY OTHER EXCLUSIONS AND CONDITIONS CONTAINED THEREIN:**

   Membership is on the understanding that if you've had a medical condition in the last five years, you will only be covered for it (and specified related conditions) after:
   - you have been covered with us on the scheme for two consecutive years as a member and;
   - you have been completely free of any form of treatment, medical advice, drugs or medicines or special diets relating to that condition for a consecutive two year period.

   However, please do NOT delay visiting a doctor merely to become eligible to claim for a pre-existing condition, as this may damage your health.

   Please note full medical underwriting is also available, for further information regarding underwriting please read "*Your Guide to Applying for Cover*" and/or contact BAWA.

Data Protection

Please make sure that you either show this statement to anyone covered by this policy, or inform them of its contents before you return this form.

To set up and administer your policy PHC and the underwriters, AXA PPP healthcare limited will hold and use information about you and any family members covered by your policy, supplied by you, those family members, medical providers or your employer. Please ensure that you only provide us with sensitive personal information, such as health information, about other people with their agreement. When you give us this information we will take this as confirmation that you have consent to do so.

Personal and sensitive personal information may be sent in confidence for processing by other companies and intermediaries including those located outside the European Economic Area.

As you act on behalf of any family member covered by this policy, we send correspondence about the policy, including claims correspondence, will be sent to you unless we are advised to do otherwise.

By signing and returning this form you indicate that you have authority to give consent on behalf of any family members covered by your policy and on your own and their behalf you consent to the use of personal information in the ways described above.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crime. Information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including reasonable suspicion about fraud or otherwise improper claims. This may involve adding non-medical information to a database that will be accessible by other insurers and law enforcement agencies. There is a legal obligation to notify the General Medical Council or other relevant regulatory body about any issue where we have reason to believe a medical provider's fitness to practice may be impaired.

PHC would like to use the contact details obtained as a result of this application, to inform you by letter, telephone or email of other products and services. PHC would also like to share these contact details with other PHC Group companies and other carefully selected companies in the European Economic Area so that they can let you know about their products and services By signing and returning this form you will be consenting to these uses to enable you to receive marketing information from PHC unless you tick the box to indicate you do not consent. You may change your mind at any time by writing to the address on the back of the Policy Booklet.

Employee Signature　　　　　Date

JOINING OPTIONS

Please indicate below which joining option you wish to take:

☐ Moratorium - Pre-existing conditions (any medical condition you have suffered in the last 5 years) will not be covered unless you have been in BAWA Medicare for 2 years without medical treatment or consultation.

☐ Transfer - You may transfer any moratorium period you have served for a pre-existing condition whilst in a previous scheme. You will be sent a 'Plan Transfer Application' to complete

☐ Full Medical Underwriting - There will be no moratorium period but it can be expected that any pre-existing conditions will be highlighted as permanent exclusions on your policy. You will be sent a questionnaire to complete and a form to sign that gives PHC permission to consult with your GP.

SETTING UP PAYMENT

Payroll Deductions

I request that the sum indicated above (or such other sum as may be determined by the scheme as qualifying contribution) be deducted from my pay until further notice. This authority may be revoked by me at any time by notice in writing.

Pay Frequency (please tick)　☐ Weekly　☐ 4 Weekly　☐ Monthly　☐ Other

If other please state

Company　　　　　Signed　　　　　Dated