Choices
Application form

STANDARD LIFE

Any queries? Call us on ***0800 77 99 55*** *and we'll help you further.*

Who is this form for?

This form is for applicants applying for a Choices policy where the eldest person to be covered is aged under 80. If 'Your personal quotation' does not include the plan or the options you require then please call **0800 77 99 55** for an instant quote.

Filling in this form

Please ensure that you complete all the following sections before sending us your application. We want you to be totally confident in the cover you have with us so if you would like help completing this form, please call one of our healthcare advisers and they will be happy to help.

If joining from another insurer you'll need to enclose a copy of your current certificate of insurance or renewal notice with this application form.

Documents you will need if switching from another insurer

If you are applying on switch terms (joining us from another insurer) you will need to **enclose a copy of your current certificate of insurance or renewal notice** showing all lives to be covered on your new policy. This will state what your current medical exclusions are (if any) and confirm that your policy is still in force.

SECTION 1: ABOUT YOU & YOUR FAMILY

Please use BLOCK CAPITALS to fill in this form.

About you

Please enter the reference number from the top of 'Your personal quotation' E

Title	Forenames	Surname
Address		
		Postcode
Daytime telephone	Evening telephone	
Mobile telephone	Date of birth day / month / year	
Occupation		

What type of cover do you require?

Single ☐ Couple ☐ Family (2 adults & children) ☐ Parent & children ☐

About your family

Please give details of your partner and any unmarried children you wish to be covered. All must be UK residents. Children can be covered up to the age of 21, or 25 while in full-time education. If you wish to cover more than three children your premium will not be affected but you must continue in the additional information box below section 6, giving details as below:

Partner's surname	Forename(s) Mr/Mrs/Miss/Ms
Date of birth day / month / year	Occupation
1st Child's surname	Forename(s)
Date of birth day / month / year	Relationship to you
2nd Child's surname	Forename(s)
Date of birth day / month / year	Relationship to you
3rd Child's surname	Forename(s)
Date of birth day / month / year	Relationship to you

Please note that all correspondence will be sent to the main policyholder. If any family members aged over 18 would prefer us to correspond direct with them, for example when making a claim, they will need to take out a separate policy in their own name.

SECTION 1: Continued overleaf

Sporting activities

Do any of the named applicants participate in sports in order to receive a salary, sponsorship or benefit in kind? YES ☐ NO ☐

If 'Yes', please give details in the additional information box below section 6. Please note, we do not need to be told about involvement with a sports club on a purely recreational basis.

Which excess level would you like?

£1,000 ☐ £2,500 ☐ £5,000 ☐

Which hospital list do you require?

Countrywide hospital list ☐ Countrywide London upgrade ☐

Extended London upgrade ☐

Which add-on benefits would you like to supplement your plan?

COVER REQUIRED FOR	You	You & your partner	Family (2 adults & children)	Parent & children
Major Dental Cash	☐	☐	☐	☐
Hospital Cash	☐	☐	☐	☐
Personal Accident	☐	☐	☐	☐
Critical Illness £5,000 cover	☐	☐		
Critical Illness £10,000 cover	☐	☐		

Add-on benefits are not available for applicants aged 75 and over. Critical Illness applicants must be aged 49 or under.

Your premium and payment method

You may like to refer to 'Your personal quotation' and calculate your premiums here. If you need any help, please call and we will be happy to provide the figures you need.

Payment method

Annually by Direct Debit ☐ Annually by MasterCard/Visa ☐ Annually by cheque ☐
Please make cheque payable to Standard Life Healthcare Limited

Monthly by Direct Debit ☐

The relevant payment authorisations can be found on the back page.

Your premium

Quoted cost of main policy £ .

Plus any add-on benefits £ .

Total premium £ .

Please note: Annual premium payment attracts a discount of 7.5% which has already been deducted from the annual premium quoted.

Please ensure you complete the appropriate payment authorisation on the back page.

Taking out cover for the first time?
If you are taking out cover for the first time (i.e. are not transferring directly from another healthcare policy) please complete the full medical history assessment in **SECTION 2A** opposite

Please go to SECTION 2A

OR

Switching from another insurer?
If you are switching from another insurer please complete the short health questionnaire in **SECTION 2B**

Please go to SECTION 2B

SECTION 2A: FULL MEDICAL HISTORY ASSESSMENT

Questions for yourself and every person who is applying

This section is for those taking out cover for the first time.

Please note, it is important you provide full and accurate information. Omitting facts or giving inaccurate information, deliberately or otherwise, may mean we are unable to meet a claim in future or even that your policy is void. If you are unsure if we need to know a particular fact, please disclose it anyway.

1. Have you, or any person to be insured, ever suffered from or asked advice on any of the following:	**YES**	**NO**
a) Fainting, fits of any kind (including epilepsy), migraines or any other disorder of the nervous system?	☐	☐
b) Depression, anxiety, stress or any other psychological disorder?	☐	☐
c) Diabetes, gout or any kidney, urinary tract, bladder or prostate complaint?	☐	☐
d) Cancer, tumours, growths, cysts or moles that have changed in appearance?	☐	☐
e) Gynaecological disorder?	☐	☐
f) Angina, coronary thrombosis, stroke, chest pain, high blood pressure, rheumatic fever or any other disorder of the heart or circulatory system?	☐	☐

2. In the last five years have you, or any person to be insured, suffered from or asked advice on any of the following:	**YES**	**NO**
a) Any digestive disorder, gastric or duodenal ulcer or any liver or bowel complaint?	☐	☐
b) Asthma, bronchitis, tuberculosis or any other lung or chest complaint?	☐	☐
c) Bone or muscular problems including back complaints and arthritis?	☐	☐
d) Varicose veins?	☐	☐
e) Tonsillitis or any other disease or disorder of the ear, nose or throat?	☐	☐

3. Has any person to be insured:	**YES**	**NO**
a) Ever been declined by an insurance company, or accepted with restrictions/premium increases or had their insurance cancelled?	☐	☐
b) Undergone any treatment or taken any drugs or medication within the last five years?	☐	☐
c) Consulted a specialist, or attended a hospital or clinic either as an in-patient, out-patient or day-patient for the purpose of an investigation, test, x-ray, operation or consulted any doctor about any condition in the last five years?	☐	☐
d) Ever been admitted to a hospital for an illness or as a result of an accident?	☐	☐
e) Had any chronic, long-term medical or dental condition, or is there any known disability, physical irregularity or recurrent illness or injury, which you know or suspect exists?	☐	☐

If you have answered **NO** to all the questions above… → **Please go straight to SECTION 5**

If you have answered **YES** to any of the questions above… → **Please go to SECTION 3**

This page is only to be completed if you are switching from another insurer.

Questions for yourself and every person who is applying

Please note, it is important you provide full and accurate information. Omitting facts or giving inaccurate information, deliberately or otherwise, may mean we are unable to meet a claim in future or even that your policy is void. If you are unsure if we need to know a particular fact, please disclose it anyway.

1. During the last 12 months have you or any person to be insured

– claimed under a private medical insurance policy; or

– attended hospital as an in-patient, day-patient or out-patient; or

– been referred for any consultations or investigations or to an alternative therapist?

YES ☐ **NO** ☐

2. Do you or any person to be insured have any medical condition or symptoms for which you are receiving treatment or taking medication (whether prescribed or 'over the counter'), seeing your GP, optician, alternative therapist, attending hospital appointments or where further check-ups are considered necessary or advisable?

YES ☐ **NO** ☐

3. Have you, or any person to be insured, ever had any joint replacement including hip or knee, or ever received treatment for, or diagnosis of, arthritis, cancer, heart condition (including, but not limited to heart attack and angina), or varicose veins, stroke or any psychiatric-related illness?

YES ☐ **NO** ☐

If your answers to questions 1, 2 and 3 are all **NO** we will accept you and any family members included on this application on the same medical underwriting terms that apply with your current insurer.

Please note you will need to **enclose your current certificate of insurance or renewal notice** showing details of each person to be covered and any exclusions that apply to them.

Please go straight to SECTION 5

If you have answered **YES** to questions 1, 2 or 3 and would like us to consider your application to switch to us, we need you to provide additional information which may mean we need to apply additional exclusions. We will send full details on your certificate of insurance along with your policy documentation. You can then decide if these terms are acceptable to you, or if you would prefer to stay with your current insurer. If you prefer, you may call us on **0800 77 99 55** with your completed questionnaire and medical information and our advisers will carry out a telephone assessment before you send your application form to us.

Please note you will need to **enclose your current certificate of insurance or renewal notice** showing details of each person to be covered and any exclusions that apply to them.

Please go to SECTION 3

SECTION 3: ANSWERS TO HEALTH QUESTIONS

CONDITION 1

Name of person

Which question are you referring to from section 2?

The condition

Was the condition covered by your current medical insurance policy (if switching)?

Previous treatment and consultations with dates

Is further treatment or are consultations required or has a full recovery been made?

Present state of health

If you are telling us about high blood pressure, please provide your last three readings and test dates

Test reading day / month / year | Test reading day / month / year | Test reading day / month / year

CONDITION 2

Name of person

Which question are you referring to from section 2?

The condition

Was the condition covered by your current medical insurance policy (if switching)?

Previous treatment and consultations with dates

Is further treatment or are consultations required or has a full recovery been made?

Present state of health

If you are telling us about high blood pressure, please provide your last three readings and test dates

Test reading day / month / year | Test reading day / month / year | Test reading day / month / year

CONDITION 3

Name of person

Which question are you referring to from section 2?

The condition

Was the condition covered by your current medical insurance policy (if switching)?

Previous treatment and consultations with dates

Is further treatment or are consultations required or has a full recovery been made?

Present state of health

If you are telling us about high blood pressure, please provide your last three readings and test dates

Test reading day / month / year | Test reading day / month / year | Test reading day / month / year

Please continue to SECTION 4

This page is only to be completed if you have answered YES to one or more of the health questions in section 2A or section 2B

If you require more space, please use the additional information box below section 6

This page is only to be completed if you have answered YES to one or more of the health questions in section 2A or section 2B

Medical reports consent

As well as reviewing the health questions, we sometimes need to get a medical report from a doctor who has cared for you before we can assess your application.

To avoid delay, it helps to have your permission in advance. For your reassurance, your legal rights are protected under the Access to Medical Reports Act 1988 which is explained in full below.

Please read this before completing your doctor's details:

GP details: Doctor's name	
Address	
	Postcode
Telephone number (inc. code)	Fax number (inc. code)

Access to Medical Reports Act 1988

The Access to Medical Reports Act 1988 gives you certain legal rights. These are:

- we need your agreement before we can apply for a medical report from your doctor. You can refuse, but if you do, we will not be able to assess your application or provide you with any benefit.
- you can ask to see the report before the doctor sends it to us, or for up to six months afterwards.
- if you tell your doctor that you want to see the report, this may delay the assessment of the application, and he or she can charge you a reasonable fee to cover his or her costs.
- if you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your doctor will not agree to do this, you may attach a statement of your own.

You will not be entitled to see any part of the report which:

- the doctor believes could seriously harm your physical or mental health, or that of others;
- indicates the doctor's intentions in respect of you;
- reveals information about another person, or the identity of someone who has given the doctor information about you (unless that person consents or is a health professional involved in caring for you).

We will write and tell you when we have requested the report. If you have asked to see the report before your doctor sends it to us, you will have 21 days from receipt of our letter to contact your doctor. Once you have seen the report, your doctor needs your agreement to send it to us. If you don't arrange to see the report within 21 days, your doctor will be free to send it to us.

Medical reports declaration

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 as explained above and, in connection with my insurance application, I hereby consent to Standard Life Healthcare Limited being provided with medical information from my GP or any doctor/specialist who at any time has attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original.

I wish to see the report before it is sent to Standard Life Healthcare Limited ☐
I do not wish to see the report before it is sent to Standard Life Healthcare Limited ☐
} Tick one

To be signed by all applicants (or parent/guardian in the case of a child under the age of 16) who have provided medical information. Please print name(s) in BLOCK CAPITALS.

Each person who has provided medical information on the previous three pages needs to sign and date this section.

Main applicant's name		Signature		Date	day / month / year
Partner's name		Signature		Date	day / month / year
1st child's name		Signature		Date	day / month / year
2nd child's name		Signature		Date	day / month / year
3rd child's name		Signature		Date	day / month / year

SECTION 5: DECLARATION

- I declare that to the best of my knowledge and belief the statements made on this application form, and any additional information supplied as part of this application are full, true and correct. Where I have supplied medical information for anyone else included in this application I confirm that, if appropriate, I have checked with them that the information is correct and that I have their consent to provide this information on their behalf.
- I understand that all correspondence relating to the policy will be addressed to me.
- I shall read the policy documentation when I receive it and agree that the terms and conditions of the policy (and any add-on benefits I may have selected), which may be different from those of my current policy, will bind me and any family members included in this application.
- I confirm that Standard Life Healthcare may use personal information to administer my policy, process claims, for underwriting and pricing purposes, to maintain management information for business analysis and may disclose personal information under the protection of a contract to their agents or service providers to administer my policy, to those involved with my treatment or care and to any financial adviser or independent intermediary appointed to act on my behalf. I confirm that my data may be processed by service providers in a country outside the European Economic Area. I am aware that some of the personal data received by Standard Life Healthcare in connection with the policy will also be held centrally on Standard Life group systems. If I am a customer of other companies in the Standard Life group this will enable them to share changes in my personal data, such as address details, with the other companies for administrative purposes. By signing this application, I agree that Standard Life Healthcare and its agents may use the information I supply, which may include health information that the Data Protection Act 1998 defines as 'sensitive data', for the purposes stated.
- I confirm that for the purposes of the Data Protection Act, I have the authority of any of my family named on this policy to consent on their behalf to their personal data being processed and by signing this application I agree that Standard Life Healthcare may use their personal data for the purposes described above. I will give the data protection notice included in my membership pack to any family member included on this application.
- I understand that in advance of each annual renewal date Standard Life Healthcare will advise me each year of my premium for the coming policy year, and of any changes to my policy terms and conditions, and that they will automatically renew my policy on that basis, unless I instruct them to do otherwise.

If you completed section 2A (the full medical history questionnaire):

- I understand that no cover will apply for treatment of any medical condition or related condition which exists or has existed before the start of this policy unless I have provided Standard Life Healthcare with details and they have agreed to accept it. I also understand that Standard Life Healthcare will advise me of any medical conditions which they specifically exclude from cover because of information that I have given to them.

If you completed section 2B (the short health questionnaire):

- I understand that if my answers to the three health questions are all 'No', Standard Life Healthcare will accept me, and any family members included on this application, on the same medical underwriting terms that apply with my current insurer. I agree to supply Standard Life Healthcare with my current certificate of insurance or renewal notice containing details of each person to be covered on this basis and any exclusions that currently apply to each person.

  If I have answered 'Yes' to any of the three health questions, I understand that Standard Life Healthcare will advise me if they need to change the medical underwriting terms for me, or any family members included on this application, from those that apply with my current insurer. I agree to supply Standard Life Healthcare with a copy of my current certificate of insurance or renewal notice so that they can confirm the underwriting terms that will apply.

Signed by the applicant and on behalf of any other family members named in this application

Signature ✗ ____________ **Date** ✗ day / month / year

Please sign and date this declaration.

SECTION 6: CHOOSING YOUR START DATE

When would you like cover to begin?

Enter your start date day / month / year

Start date must be not earlier than today's date and not more than thirty days from today.

If you are joining us from another insurer then you do not need to wait until your renewal date to start your new Standard Life Healthcare policy, but it is **important that your current cover does not lapse before your new policy is in place.**

If joining from another insurer then please make sure you keep your current cover in place until you have accepted and are happy with the new policy we are offering you.

Now complete your payment authorisation on the back page

Additional information

Please use this space to provide any further information. If you need more space please continue on a separate sheet of paper and attach it to this form.

If there is anything else you wish to advise us of then please use this space.

Your payment authorisation

Don't forget to complete, sign and date the Direct Debit if paying by this method.

Instruction to your Bank or Building Society to pay by Direct Debit

Please complete and return to Standard Life Healthcare Limited, Marshall Point, 4 Richmond Gardens, Bournemouth BH1 1JD.

Name and full postal address of your Bank or Building Society

To: The Manager Bank/Building Society

Address

Postcode

Name(s) of account holder(s)

Branch sort code

Originator's Identification Number 9 4 0 4 6 0

Bank/Building Society account number

Standard Life Healthcare reference number

Instruction to your Bank or Building Society

Please pay Standard Life Healthcare Limited Direct Debits from the account detailed on this instruction subject to the safeguards assured by the Direct Debit guarantee. I understand that this instruction may remain with Standard Life Healthcare and if so, details will be passed electronically to my Bank/Building Society.

Signature(s) ✗ Date ✗

Banks or Building Societies may not accept Direct Debit instructions for some types of account

Complete, sign and date this section if you are paying by credit card.

Credit card authorisation form

I authorise you, until further notice in writing, to charge to my MasterCard/Visa Account unspecified amounts in respect of premiums until this instruction is countermanded by my giving notice to Standard Life Healthcare Limited. I understand that I will be given one month's notice of any premium increase.

Please insert your credit card number

Please tick your card type

Expiry date /

Name(s) of account holder(s)

Surname Mr/Mrs/Miss/Ms

Forename(s)

Address

Postcode

Signature(s) ✗ Date ✗

Originator's reference: Please note this reference will be your policy number

(office use only)

Final checklist

Please take a moment to look through this checklist to ensure that your application is completed correctly.

It is vital that all relevant sections of this form are completed fully. If information is missing or incomplete this will cause a delay in the processing of your application. If you require any help, or if any aspect is unclear, please call our healthcare advisers on **0800 77 99 55**.

		Tick to confirm
1	If joining from another insurer, copy of current certificate of insurance or renewal notice showing details of all persons to be covered enclosed.	☐
2	Paying by Direct Debit or credit card? The payment authorisation above is completed, signed and dated.	☐
3	If answers to any questions in section 2a or 2b are 'Yes' then sections 3 & 4 have been completed.	☐
4	Section 5 on previous page is signed and dated.	☐

Your application is now complete. Please return in the enclosed FREEPOST envelope

Important information about accepting your application

You must advise us if there are any changes in your personal circumstances, including your state of health or that of anyone to be included on your policy, between signing this application form and the start date of your policy with us. We reserve the right to alter your acceptance terms in light of such changes.

Completion of this application form should not be construed as acceptance of risk by Standard Life Healthcare. Based on the information you have disclosed Standard Life Healthcare reserves the right to decline applications.

If you wish to access your personal information please write to the Data Protection Co-ordinator at Standard Life Healthcare, and ask for a 'Data Subject Access Form'. There is a £10 charge for this service.

A specimen copy of the policy is available on request. You are advised to keep a record (including copies of letters) of all information supplied to Standard Life Healthcare Limited. A copy of this application will be supplied to you on request.

The companies of the Standard Life group may use your personal information to inform you of other services and products that may be of interest. Please tick this box ☐ if you would prefer not to receive this information or write to the Data Protection Co-ordinator at the address below..

Standard Life Healthcare Limited (02123483) and Standard Life Healthcare Services Limited (06430487) are both registered in England at Marshall Point, 4 Richmond Gardens, Bournemouth BH1 1JD. Standard Life Healthcare Limited is authorised and regulated by the Financial Services Authority.
0845 279 8877. *Calls may be recorded/monitored to help improve customer service. Call charges may vary.*
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