

## Who is this form for?

This form is for applicants applying for an EspritHealth policy where the eldest person to be covered is aged over 55 but under 80. There are two ways you can apply for cover. You may EITHER sign a simple moratorium declaration (section 2) OR complete our full medical assessment (section 3). You do not need to do both. These choices are explained in more detail within our brochure, under the section 'Choosing your underwriting.' 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.

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

## 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.

## SECTION 1: ABOUT YOU & YOUR FAMILY

### About you

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

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

Please use **BLOCK CAPITALS**  
to fill in this form.

### 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
1 <sup>st</sup> Child's surname	Forename(s)
Date of birth day / month / year	Relationship to you
2 <sup>nd</sup> Child's surname	Forename(s)
Date of birth day / month / year	Relationship to you
3 <sup>rd</sup> 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**

**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 EspritHealth plan would you like?**

EspritHealth  EspritHealth Saver   
 EspritHealth with 6-week wait  EspritHealth Saver with 6-week wait

**Which excess level would you like?**

No excess  £100  £250  £500

**Which hospital list do you require?**

Countrywide hospital list  Countrywide London upgrade   
 Guided Option\*  Extended London upgrade

*\* Guided Option is not available with EspritHealth Saver or if you choose the 6-week wait option on either plan.*

**Which optional 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Add-on benefits are not available for applicants aged 75 and over.*

**Your premium and payment method**

You may like to refer to 'Your personal quotation' and calculate your premiums here. If the number of claims or number of years covered is different from that on your personal quotation, your starter no-claims discount may be affected. You may call with the new information and we will recalculate your premiums. Or, if you would rather leave your premium blank, we will ensure your policy is started with the correct no-claims discount and premium rate.

**Payment method**

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

**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.

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

## SECTION 2: CHOOSING YOUR UNDERWRITING METHOD

### Underwriting method

There are two ways you can apply for cover. These two options are explained within our brochure, under the section 'Choosing your underwriting.' Once you have chosen the method that is best for you, please tick one of the following:

#### Moratorium

I/we wish to apply for cover by signing the moratorium declaration below as I/we do not wish to have a full medical history assessment.

OR

#### Full medical questionnaire

I/we wish to complete the full medical history questionnaire so Standard Life Healthcare can carry out an assessment of my/our medical history before cover begins.

Please read and sign the moratorium statement below

Please complete the full medical questionnaire overleaf

### Moratorium clause declaration

Please read and sign the following declaration for your EspritHealth application to be underwritten by our moratorium clause.

- 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.
- I have opted not to have a full medical history assessment and understand that pre-existing medical conditions are subject to the terms of the moratorium as defined in the policy.
- I have read the guidance notes in the brochure (under the section 'Choosing your underwriting') which explains how the moratorium works and how it differs from a full medical history assessment.
- I shall read the policy documentation when I receive it and I agree that the terms and conditions of the policy (and any add-on benefits I may have selected) will bind me and any members of my family to be covered.
- 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 1998, 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.

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

Signature

X

Date

X day / month / year

*Please sign and date this declaration if you have chosen the moratorium.*

*You can then skip straight to section 6.*

Please now go straight to **SECTION 6** to choose your start date

## SECTION 3: FULL MEDICAL QUESTIONNAIRE

Sections 3, 4 and 5 are for applicants choosing to complete the full medical questionnaire.

### 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.

<b>1. Have you, or any person to be insured, ever suffered from or asked advice on any of the following:</b>	<b>YES</b>	<b>NO</b>
a) Fainting, fits of any kind (including epilepsy), migraines or any other disorder of the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
b) Depression, anxiety, stress or any other psychological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c) Diabetes, gout or any kidney, urinary tract, bladder or prostate complaint?	<input type="checkbox"/>	<input type="checkbox"/>
d) Cancer, tumours, growths, cysts or moles that have changed in appearance?	<input type="checkbox"/>	<input type="checkbox"/>
e) Gynaecological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f) Angina, coronary thrombosis, stroke, chest pain, high blood pressure, rheumatic fever or any other disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. In the last five years have you, or any person to be insured, suffered from or asked advice on any of the following:</b>	<b>YES</b>	<b>NO</b>
a) Any digestive disorder, gastric or duodenal ulcer or any liver or bowel complaint?	<input type="checkbox"/>	<input type="checkbox"/>
b) Asthma, bronchitis, tuberculosis or any other lung or chest complaint?	<input type="checkbox"/>	<input type="checkbox"/>
c) Bone or muscular problems including back complaints and arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
d) Varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>
e) Tonsillitis or any other disease or disorder of the ear, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Has any person to be insured:</b>	<b>YES</b>	<b>NO</b>
a) Ever been declined by an insurance company, or accepted with restrictions/premium increases or had their insurance cancelled?	<input type="checkbox"/>	<input type="checkbox"/>
b) Undergone any treatment or taken any drugs or medication within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
d) Ever been admitted to a hospital for an illness or as a result of an accident?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered **NO** to all the questions above then please go straight to **SECTION 5**

If you have answered **YES** to any of the questions above then please provide detailed information in **SECTION 4** opposite



SECTION 4: ANSWERS TO HEALTH QUESTIONS

CONDITION 1

Name of person \_\_\_\_\_

Which question are you referring to from the opposite page? \_\_\_\_\_

The condition \_\_\_\_\_

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

*This page is only to be completed if you have answered YES to one or more of the questions opposite.*

CONDITION 2

Name of person \_\_\_\_\_

Which question are you referring to from the opposite page? \_\_\_\_\_

The condition \_\_\_\_\_

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 the opposite page? \_\_\_\_\_

The condition \_\_\_\_\_

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

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

**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.**

Main applicant's name	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text" value="day / month / year"/>
Partner's name	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text" value="day / month / year"/>
1 <sup>st</sup> child's name	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text" value="day / month / year"/>
2 <sup>nd</sup> child's name	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text" value="day / month / year"/>
3 <sup>rd</sup> child's name	<input type="text"/>	Signature	<input type="text"/>	Date	<input type="text" value="day / month / year"/>

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

**NOW CONTINUE TO SECTION 5**

**SECTION 5: FULL MEDICAL ASSESSMENT 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 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.
- I have read and understood the information about pre-existing conditions and underwriting options in the brochure and have disclosed all information I am required to provide.
- I shall read the policy documentation when I receive it and I agree that the terms and conditions of the policy (and any add-on benefits I may have selected) will bind me and any members of my family to be covered.
- 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 1998, 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.

**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 if you have chosen full medical assessment as your underwriting method*

**SECTION 6: CHOOSING YOUR START DATE**

**When would you like cover to begin?**

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

If you have signed section 2 – the moratorium declaration, your cover will automatically begin on the date you have requested.

If you have completed our full medical assessment (sections 3, 4 & 5), we will not start your cover or collect premiums until your questions have been assessed and you have approved any exclusions we may need to apply. Please note exclusions will not affect your premium. If you prefer, you may call us on **0800 77 99 55** with your completed assessment and our advisers will carry out a telephone assessment.

**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

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

Please complete all sections 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

-    -

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

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)

X

#### Date

X

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

### 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)

X

#### Date

X

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

(office use only)

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

### Final checklist

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 Paying by Direct Debit or credit card? The payment authorisations above are completed, signed and dated.  | <input type="checkbox"/> |
| 2 Moratorium chosen as underwriting method? Declaration in section 2 signed and dated.                      | <input type="checkbox"/> |
| 3 Full medical assessment taken? If any questions are 'YES' then the whole of section 4 has been completed. | <input type="checkbox"/> |
| 4 If full medical assessment taken, the declaration in section 5 is signed and dated.                       | <input type="checkbox"/> |

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

**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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