Freedom Health Insurance

In partnership with Key Health

Elite

Corporate Application Form

(2-member scheme)

Accepted quote reference:

Each of the following parts should be completed by the Group Secretary or other authorised official and the completed form returned to **Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ.** Each employee should also complete a separate Freedom Elite individual application form (either Moratorium/Full Medical Underwriting or Continued Personal Medical Exclusions/Continued Moratorium as appropriate). This should include details of any further options or cover for dependants (including children) at the employee's own expense. **Please use BLOCK CAPITALS.**

Maximum age of entry is 70 unless agreed by Freedom Health Insurance.

About the company

Name of company:

Nature of business:

Address:

Postcode:

Telephone number (inc. area code):

Fax:

Email address:

Name of contact:

When would you like your cover to start? D D M M Y Y Y Y

Declaration

I hereby apply to Freedom Health Insurance for private medical insurance cover on behalf of the employees (and their dependants, where applicable) as shown on the separate individual application forms.

I understand that if this application is for Moratorium Underwriting, pre-existing conditions will be excluded as described in section 11 (Pre-existing medical conditions) of The Group Member's Guide to Cover, which I have read.

I understand that if this application is for Full Medical Underwriting, pre-existing conditions will be excluded from the cover and each employee must complete an Elite Individual Application Form (Moratorium or Full Medical Underwriting). These will be reviewed and personal exclusions for each member may be applied.

I understand that if I am applying to transfer an existing private medical insurance scheme to Freedom Health Insurance, on either Continued Personal Medical Exclusions (CPME) or Continued Moratorium (Switch Moratorium or CM), that each employee must complete a Freedom Elite Individual Application Form (Continued Personal Medical Exclusions (CPME) and Continued Moratorium).

Current certificates of insurance for each eligible employee must be provided to Freedom Health Insurance if you are transferring cover from your current insurer.

I declare that to the best of my knowledge and belief, the information I have provided in this application is full, true and correct.

Signed:

Date: D D M M Y Y Y Y

Name:

Position:

Note: Policy documents are available on request or can be viewed at **www.freedomhealthinsurance.co.uk**. You are advised to keep a record (including copies of letters) of all information supplied to Freedom Health Insurance. A copy of this application will

be supplied to you on request within three months of completion. Completion of this form should not be construed as acceptance of risk by Freedom Health Insurance.

Use of personal information

The personal information you give us on this application form will be used to administer your employees', and their dependants' (if applicable), insurance cover given to them under this group scheme. This includes processing and underwriting each policy to decide if we can offer cover and on what terms, administering each policy and handling any claims, and helping to detect and prevent fraudulent activity.

Personal information may be shared with third parties that help us with the efficient and cost-effective administration of the insurance cover. We may also share personal information with regulatory bodies, other insurers, any broker appointed by the policyholder or third parties appointed by them.

How we use and process personal information is explained in our Privacy Policy which can be found on our website at **freedomhealthinsurance.co.uk/privacy-policy**. Alternatively you can ask us for a copy.

Marketing choices

☐ From time to time, we would like to tell you about products and services that may be of interest to you. If you would like to receive this information, please tick this box. You can unsubscribe at any time by contacting us at **dataprotection@freedomhealthinsurance.co.uk**.

Methods of payment

☐ Annual cheque
Please attach the annual cheque payment

☐ Credit card or debit card
Please complete section 1 below

☐ Direct Debit
Please complete section 2 below

1. Credit card or debit card

Credit/debit card authorisation form

☐ Monthly ☐ Annually

Type of card: ☐ Mastercard ☐ Visa ☐ Debit

Name on card:

Card number:

Security number: Expiry date: M M Y Y Y Y

To Freedom Health Insurance

I authorise you, until further notice in writing, to charge my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed: Date: D D M M Y Y Y Y

2. Direct Debit

☐ Monthly ☐ Annually

DIRECT Debit

Service User Number

9	1	3	0	3	9

Instruction to your bank/building society to pay by Direct Debit to:

Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ.

Please complete parts 1-5 to instruct your bank/building society to make payments directly from your account.

1. Name and full postal address of your branch

To: Bank/Building Society

Address:

Postcode:

2. Branch sort code: - -

3. Account number:

4. Name of account holder:

5. Instruction to your bank or building society

Please pay Freedom Health Insurance, 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 Freedom Health Insurance and, if so, details will be passed electronically to my bank/building society.

Banks and building societies may not accept Direct Debit Instructions for some types of accounts.

Signed: Date: D D M M Y Y Y Y

The Direct Debit Guarantee

DIRECT Debit

Banks and building societies may not accept Direct Debit Instructions for some types of account.
This Guarantee should be detached and retained by the payer.

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Freedom Health Insurance will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Freedom Health Insurance to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by Freedom Health Insurance or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society
  – If you receive a refund you are not entitled to, you must pay it back when Freedom Health Insurance asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.