

**Worldwide Cover** 

## **Your Corporate Benefits**



Cash plan benefits extend to trips abroad

A Westfield Health company	Colosseon Demai						
		Level 1	Level 2	Level 3	Level 4	Level 5	
Employee Monthly Premium			£7.67	£16.67	£25.67	£40.67	
Partner Monthly Premium			£12	£21	£30	£45	
Benefit	Payback	Level 1	Level 2	Level 3	Level 4	Level 5	
<b>Dental</b> Includes check-ups, fillings, hygienist fees, X-Rays and dentures	100%	£60	£110	£150	£200	£275	
<b>Dental Accidents</b> For dental injury as a direct result of accidental impact	100%	£200	£400	£600	£800	£1,000	
Optical Includes eye tests, glasses, contact lenses, repairs and laser eye surgery	100%	£60	£110	£150	£200	£275	
Health Screening Includes well man/woman screening and all screening that helps prevent an illness	100%	£100	£130	£150	£200	£300	
Specialist Consultation Covers diagnostic consultations and tests	100%	£200	£260	£300	£400	£600	
Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture) Covers treatment by a registered practitioner	100%	£150	£280	£370	£500	£750	
Complementary Therapies (Homeopathy/Reflexology/Aromatherapy/Remedial Massage) Covers treatment by a registered practitioner following GP referral	100%	£50	£100	£150	£200	£250	
Chiropody  Covers treatment by a chiropodist or podiatrist	100%	£20	£50	£100	£150	£200	
Hospital In-Patient A nightly allowance for any NHS or private hospital admission	Up to 28 nts	£10	£15	£20	£30	£50	
Day Case A daily allowance for day case admissions	Up to 10 vsts	£10	£15	£20	£30	£50	
Hospital Parental Stay A nightly allowance for one parent accompanying a child covered by the policy	Up to 28 nts	£10	£15	£20	£30	£50	
Prescriptions  The number of standard prescription items that can be claimed (excludes annual prescriptions)		1	2	3	4	5	
Discounted Gym / Spa Membership Services provided by a third party		Access to special membership rates					
Savings on holidays, theme parks, retail discounts and attractions Services provided by a third party		Access to special discounted rates					
Confidential Counselling Helplines Helpline services provided by a third party			Anytime support for legal issues, medical problems, counselling and ID theft				



## CORPORATE POLICY AMENDMENT FORM



I wish to amend my	existing cover	E	xisting pol	icy no:		-			
Please indicate cash	n plan level:								
Payment per MONTH	Level 1 Company Funded	Leve	_	Level 3 £16.67		Level 4 £25.67		Level 5 £40.67	
Your Details (*man	datory field)								
Title	S	urname*							
First Name (s)*									
Date of Birth*									
Address*									
						Postc	ode*		
Daytime Tel*					Mobile				
Email Address*					_	_			
Details of residen	t child (ron) to	ho covered	/EDEE OE	CHARGE	1				
	t ciliu (reii) to	be covered	(FREE OF	CHARGE	1	Data of Div	A la		
Full name						Date of Bir			
Full name						Date of Bir	tn		
Details of residen	t second adult	(s) to be co	vered for	the addi	tional pre	emium indic	ated		
Full Name						Date of Bir	th		
Full Name						Date of Bir	th		
	Level 1	Level	_	Level 3		Level 4		Level 5	
Payment per MONTH	£5.50	£12.0	00 📙	£21.00		£30.00	Ш	£45.00	
Should you decide to upgrade conditions are covered at the that "any medical condition in	increased benefit levels existence prior to the u	requested. For ap pgrade, will only b	plications receive covered at the	yed after this pe original level	eriod our stan of cover".	dard terms and co			RECT
UK Healthcare  Name and full postal address		na society		Service user	number		•		
To: The Manager	.,	Bank/buildi	ng society	6	9 7	7 6	1	6)	
Address							-	15	
				Reference					
				Instruction to	your bank or	building society			
	Postcode			in this instruction that this instruc	on subject to the tion may remain	ory Health Scheme Ltd safeguards assured by with Westfield Contri my bank/building socie	the Direct D butory Healt	ebit Guarantee. I	understand
Name(s) of account holder(s)			1	[a:/\)					
				Signature(s)					
Branch sort code									
Bank/building society accoun	nt number	_	7	Date					
			1	Date					



## Corporate plan





## Direct Debit Guarantee

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 Westfield Contributory Health Scheme Ltd will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Westfield Contributory Health Scheme Ltd 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 Westfield Contributory Health Scheme Ltd 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 Westfield Contributory Health Scheme Ltd 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.

IN ORDER TO UPGRADE, ADD A PARTNER OR INCLUDE YOUR CHILDREN, PLEASE COMPLETE THE FORM ABOVE
AND E-MAIL IT BACK THE FOLLOWING E-MAIL ADDRESS:

corporate@ukhealthcare.org.uk

PICTURE COPIES WILL ALSO BE ACCEPTED AND CAN BE DONE BY TAKING A PHOTOGRAPH OF THE COMPLETED

AMENDMENT FORM VIA YOUR MOBILE