

Your Corporate Benefits



		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			
Dental	100%	£60	£110	£150	£200	£275			
Includes check-ups, fillings, hygienist fees, X-Rays and dentures									
Dental Accidents 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			ccess to sp	ecial mem	bership rat	tes			
Savings on holidays, theme parks, retail discounts and attractions Services provided by a third party			ccess to sp	pecial disco	ounted rate	es			
Confidential Counselling Helplines Helpline services provided by a third party				rt for legal ounselling					
Vorldwide Cover Up to 28 days			Cash plan benefits extend to trips abroad						

Immediate cover provided. Pre-existing conditions included.

Benefit levels are annual sums. Dependent children up to age 24 are covered free.



CORPORATE POLICY AMENDMENT FORM



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I WISH to amenu I	iny existing cov		EXISU	ng pon	cy no.					
Please indicate ca	sh plan level:									
Payment per MON	Leve TH Comp Funde	any 🗌	Level2 £7.67		Level 3 £16.67		Level 4 £25.67		Level 5 £40.67	
Your Details (*m	Your Details (*mandatory field)									
Title		Surnam	e*							
First Name (s)*		-								
Date of Birth*										
Address*										
							Postco	ode*		
Daytime Tel*						Mobile				
Email Address*										
Details of resident child (ren) to be covered (FREE OF CHARGE)										
Full name							Date of B	irth		
Full name							Date of B	irth		
Details of resident second adult (s) to be covered for the additional premium indicated										
Full Name							Date of B	irth		
Full Name							Date of B	irth		
Payment per MON	Level TH £5.50	_	Level2 £12.00		Level 3 £21.00		Level 4 £30.00		Level 5 £45.00	
Pre-existing conditions										

Should you decide to upgrade your level of cover, please complete and return this application form within the next 30 days, to guarantee that any pre-existing conditions are covered at the increased benefit levels requested. For applications received after this period our standard terms and conditions will apply, which states that "any medical condition in existence prior to the upgrade, will only be covered at the original level of cover".

♥ UK Healthcare*	your l pay by)ebit				DIF De	REG b	CT it	
Name and full postal address of your bank		Service us	er numbe	er				n i			
To: The Manager	Bank/building society	6	9	7	7	6	1				
Address		Reference						4			
Name(s) of account holder(s)	Postcode	Instruction Please pay V in this instru that this ins will be pass	Vestfield Co Iction subje truction ma	ontributor ect to the s ly remain v	y Health Sc afeguards a with Westfi	heme Ltd E assured by eld Contrib	the Direct outory Hea	Debit Guara	antee. I u	nderst	tand
Branch sort code		Signature	(s)								
Bank/building society account number											
		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