

CORPORATE POLICY AMENDMENT FORM



I wish to amend my exis	sting cover	Existing po	olicy no:									
Please indicate cash pla	ın level:											
Payment per MONTH	Level 1 Company Funded	Level2 £10	Level 3 £20		Level 4 £30		Level 5 £40					
Your Details (*mandato	ry field)											
Title	Surname	*										
First Name (s)*												
Date of Birth*												
Address*												
					Postco	ode*						
Daytime Tel*			N	∕lobile								
Email Address*												
Details of resident ch	ild (ren) to be cov	ered (FREE C	F CHARGE)									
Full name	ull name						Date of Birth					
Full name					Date of Birt	:h						
Details of resident se	cond adult (s) to b	e covered fo	r the addit	ional pre	mium indic	ated						
Full Name					Date of Birt	th						
Full Name					Date of Birt	th						
	Level 1	Level2	Level 3		Level 4	_	Level 5					
Payment per MONTH	£5.50	£12.00	£21.00		£30.00		£45.00					
Pre-existing condition	ns											
Should you decide to upgrade your le conditions are covered at the increa that "any medical condition in existe the "any medical	ised benefit levels requested ence prior to the upgrade, wi	. For applications rec ill only be covered at	eived after this pe the original level o	eriod our stand of cover".		-	-	tes				
UK Healthcare*	building	struction to society to	pay by E	Direct D	ebit		DIR De	ECT b i t				
Name and full postal address of yo To: The Manager	755 TS	ink/building society	Service user n	9 7	7 6	1						
Address					7 0	_						
			Reference									
			- 400 P		building society	nius de Dalaide	£	4-11-4				
	Postcode		in this instructior that this instructi	n subject to the si ion may remain v	y Health Scheme Ltd E afeguards assured by vith Westfield Contrib	the Direct Do outory Health	ebit Guarantee. I un	derstand				
Name(s) of account holder(s)			will be passed el	ectronically to m	y bank/building socie	ty.						
			Signature(s)									
Branch sort code			<u> </u>									
Bank/building society account num	nber		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 BACK TO THE FOLLOWING E-MAIL ADDRESSES:

D.GRIMSHAW@UKHEALTHCARE.ORG.UK

S.LEATHLEY@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



Your Corporate Benefits



						1877		
		Level 1	Level 2	Level 3	Level 4	Level 5		
Employee Monthly Premium			£10	£20	£30	£40		
Partner Monthly Premium	£5.50	£12	£21	£30	£45			
Benefit	Payback	Level 1	Level 2	Level 3	Level 4	Level 5		
Dental Includes check-ups, fillings, hygienist fees, X-Rays and dentures	100%	£60	£110	£150	£200	£275		
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 as recommended by your GP (PMI Excess included)	100%	£250	£300	£350	£400	£450		
Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture) Covers treatment by a registered practitioner	100%	£150	£200	£250	£300	£350		
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%	£50	£80	£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 Incorpore Ltd			Access to special membership rates					
Savings on holidays, theme parks, retail discounts and attractions Services provided by Incorpore Ltd			Access to special discounted rates					
Confidential Counselling Helplines Helpline services provided by Health Assured Limited			Anytime support for legal issues, medical problems, counselling and ID theft					
Worldwide Cover	Cash plan benefits extend to trips abroad							