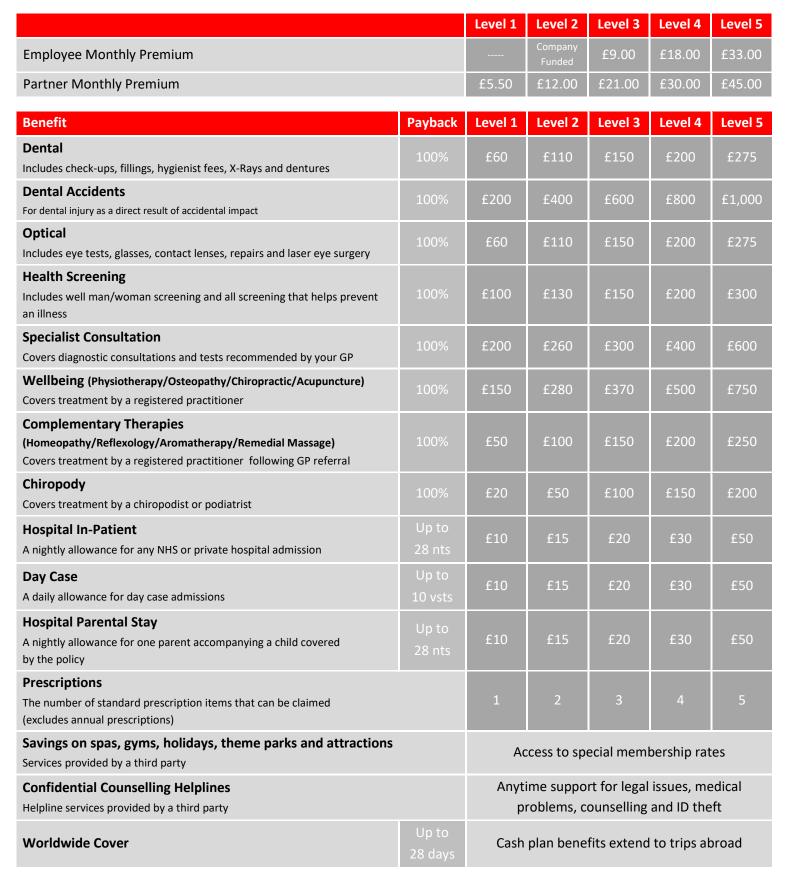


Your Corporate Benefits Plan

medela



Immediate cover provided. Pre-existing conditions included. Benefit levels are annual sums. Dependent children up to age 24 are covered free.

www.ukhealthcare.org.uk/medela



POLICY AMENDMENT FORM



I wish to amend my existing cover Existing policy no:												
Please indicate cash plan	level:											
		Level2	Level 3		Level 4	Level 5						
Payment per MONTH		Company Funded	£9.00		£18.00	£33.00						
Your Details (*mandatory field)												
Title	Surname	2*										
First Name (s)*												
Date of Birth*												
Address*												
					Postcode*							
Daytime Tel*				Mobile								
Email Address*												
Details of resident child	d (ren) to be cov	vered (FREE (OF CHARGE	:)								
Full name					Date of Birth							
Full name					Date of Birth							
Full name					Date of Birth							
Details of resident second adult (s) to be covered for the additional premium indicated												
Full					Date of Birth							
name												
Full					Date of Birth							
name												
Deverent is an MONIT!	Level 1	Level2	Level 3		Level 4	Level 5						
Payment per MONTH	£5.50	£12.00	£21.00		£30.00	£45.00						
e-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".

Payroll Deduction Authority										
Employer's name*	Medela									
Work address*	Unit 3, Huntsman Drive, Northbank Industrial Park, Irlam									
	Manchester									
Postcode*	M44 5EG	Department	Payroll							
Payroll / staff / pension number		I am paid	weekly		monthly					
I hereby authorise the above deduction from my salary/wage/pension (for such future amounts as may be in force throughout my membership)										
and for them to be held in trust and remitted to UK Healthcare. Payroll Department: Please ensure that the application form has been forwarded to										
our office and retain a copy of this section for your records. Please confirm date of 1 st deduction, then scan and email to										
d.grimshaw@ukhealthcare.org.uk or <u>s.leathley@ukhealthcare.org.uk</u> Date of first deduction:										