



CORPORATE POLICY AMENDMENT FORM

I wish to amend my exis	ting cover	Existing	g policy r	no:									
Please indicate cash plan	n level:												
Payment per MONTH	Level 1 Company □ Funded	Level2 £7.67		evel 3 16.67			evel 4 25.67			Level 5 £40.67			
Your Details (*mandator	ry field)												
Title	Surnan	ne*											
First Name (s)*													
Date of Birth*													
Address*													
							Postc	ode*					
Daytime Tel*				М	obile								
Email Address*													
Details of resident ch	ild (ren) to be o	overed (FRE	E OF CH	IARGE)									
Full name						Date	Date of Birth						
Full name						Date	Date of Birth						
Details of resident se	cond adult (s) t	o be covered	d for th	e addit	ional	premiu	m ind	icate	d				
Full Name						_	e of Bir			-			
Full Name					Date of Birth								
	Level 1	Level2	Lev	el 3			el 4		Le	vel 5			
Payment per MONTH	£5.50	£12.00	£21	.00 [£30	0.00		£4	5.00			
Pre-existing condition	ıs												
Should you decide to upgrade your l conditions are covered at the increa that "any medical condition in existe	sed benefit levels reques	ted. For application	is received a	fter this per	iod our st		-			_	states		
() UK Healthcare	buildin	nstruction g society	to pay	by D	irect	Debit)	DIF	RECT		
Name and full postal address of you To: The Manager	\$500	e ty Bank/building societ	w I	6 9		7	6	1	1				
Address			_	0 3		30.00	-	,∎,					
			Refe	rence	1 1			ŤŤ	T I	1 1			
			Instr	uction to y	our bank o	or building	society						
	Postcode		in thi	e pay Westfie s instruction s his instruction	ubject to th	e safeguards	assured by	the Direc	t Debit G	uarantee. I	understand		
Name (a) of a count balde (a)				e passed elec					aren sene	inc eta ana,	ii so actalis		
Name(s) of account holder(s)			Sign	ature(s)							2		
Branch sort code													
											5		
Bank/building society account num	ber												
g ettici, account num		, in the second	Date	1									



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 TO EITHER OF THE FOLLOWING E-MAIL ADDRESSES:

S.LEATHLEY@UKHEALTHCARE.ORG.UK

D.GRIMSHAW@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

www.ukhealthcare.org.uk/crossleymillnursery



Your Corporate Benefits



	Level 1	Level 2	Level 3	Level 4	Level 5
Employee Monthly Premium	Company Funded	£7.67	£16.67	£25.67	£40.67
Partner Monthly Premium	£5.50	£12	£21	£30	£45

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 directresult 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	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								
Face to Face Counselling Counselling sessions provided by a third party	6 x Face to Face Counselling Sessions								
Worldwide Cover Up to 28 days			Cash plan benefits extend to trips abroad						