

	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

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
<b>Optical</b> Includes eye tests, glasses, contact lenses, repairs and laser eye surgery	100%	£60	£110	£150	£200	£275
<b>Health Screening</b> Includes well man/woman screening and all screening that helps prevent an illness	100%	£100	£130	£150	£200	£300
<b>Specialist Consultation</b> Covers diagnostic consultations and tests as recommended by your GP	100%	£200	£260	£300	£400	£600
<b>Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture)</b> Covers treatment by a registered practitioner	100%	£150	£280	£370	£500	£750
<b>Complementary Therapies (Homeopathy/Reflexology/Aromatherapy/Remedial Massage)</b> Covers treatment by a registered practitioner following GP referral	100%	£50	£100	£150	£200	£250
<b>Chiropody</b> Covers treatment by a chiropodist or podiatrist	100%	£20	£50	£100	£150	£200
<b>Hospital In-Patient</b> A nightly allowance for any NHS or private hospital admission	Up to 28 nts	£10	£15	£20	£30	£50
<b>Day Case</b> A daily allowance for day case admissions	Up to 10 vsts	£10	£15	£20	£30	£50
<b>Hospital Parental Stay</b> A nightly allowance for one parent accompanying a child covered by the policy	Up to 28 nts	£10	£15	£20	£30	£50
<b>Prescriptions</b> The number of standard prescription items that can be claimed (excludes annual prescriptions)		1	2	3	4	5
<b>Confidential Counselling Helplines</b> Helpline services provided by a 3 <sup>rd</sup> party		Anytime support for legal issues, medical problems, counselling and ID theft				
<b>Worldwide Cover</b>	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

I wish to amend my existing cover  Existing policy no:  

**Please indicate cash plan level:**

	Level 1	Level 2	Level 3	Level 4	Level 5
Payment per MONTH	Company <input type="checkbox"/>	£7.67 <input type="checkbox"/>	£16.67 <input type="checkbox"/>	£25.67 <input type="checkbox"/>	£40.67 <input type="checkbox"/>
	Funded				

**Your Details (\*mandatory field)**

Title	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	Surname*	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>
First Name (s)*	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>		
Date of Birth*	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>		
Address*	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>		
	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>		Postcode* <span style="background-color: #cccccc; padding: 2px 20px;"> </span>
Daytime Tel*	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	Mobile	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>
Email Address*	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>		

**Details of resident child (ren) to be covered (FREE OF CHARGE)**

Full name	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	Date of Birth	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>
Full name	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	Date of Birth	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>

**Details of resident second adult (s) to be covered for the additional premium indicated**

Full Name	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	Date of Birth	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>
Full Name	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	Date of Birth	<span style="background-color: #cccccc; padding: 2px 20px;"> </span>
Payment per MONTH	Level 1 <input type="checkbox"/>	Level 2 <input type="checkbox"/>	Level 3 <input type="checkbox"/>
	£5.50	£12.00	£21.00
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Level 4 <input type="checkbox"/>	Level 5 <input type="checkbox"/>	
	£30.00	£45.00	
	<input type="checkbox"/>	<input type="checkbox"/>	

**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".

### Instruction to your bank or building society to pay by Direct Debit



**Name and full postal address of your bank or building society**

To: The Manager	Bank/building society
Address	
<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	
<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	
Postcode	
<span style="background-color: #cccccc; padding: 2px 20px;"> </span>	

**Service user number**

6	9	7	7	6	1
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**Reference**

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**Instruction to your bank or building society**

Please pay Westfield Contributory Health Scheme Ltd Direct Debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Westfield Contributory Health Scheme Ltd and, if so details will be passed electronically to my bank/building society.

**Name(s) of account holder(s)**

**Signature(s)**

**Date**

**Branch sort code**

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**Bank/building society account number**

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**UK Healthcare™**  
A Westfield Health company

# 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.

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**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](mailto:D.GRIMSHAW@UKHEALTHCARE.ORG.UK)**

**[S.LEATHLEY@UKHEALTHCARE.ORG.UK](mailto: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**