

CORPORATE POLICY AMENDMENT FORM



I wish to amend my existing cover Existing policy no:							
Please indicate cash plan	level:						
Payment per MONTH	Level 1 Company 🗌 Funded	Level2 £7.67	Level 3 £16.67	_	Level 4 £25.67	Level 5	
Your Details (*mandatory	field)						
Title	Surnam	e*					
First Name (s)*							
Date of Birth*							
Address*							
					Postcod	e*	
Daytime Tel*				Mobile			
Email Address*							
Details of resident child	d (ren) to be co	vered (FREE C	OF CHARGI	E)			
Full name					Date of Birth		
Full name					Date of Birth		
Details of resident seco	ond adult (s) to	be covered fo	or the add	itional pre	mium indicat	ed.	
Full Name					Date of Birth		
Full Name					Date of Birth		
	Level 1	Level2	Level 3		Level 4	Level 5	
Payment per MONTH	£5.50	£12.00	£21.00		£30.00	£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".

Instruction to your bank or UK Healthcare <sup>*</sup> building society to pay by Direct Debi					ebit	DIREC					
Name and full postal address of your bank or building so To: The Manager	Bank/building society	6	9	<sup>er</sup> 7	7	6	1	1			
Address	R	Reference						•			
Postcode Name(s) of account holder(s)	P ir tł	nstruction lease pay We n this instruc hat this instru vill be passed	estfield Co tion subje uction may	ontributor ct to the s y remain w	y Health Scl afeguards a vith Westfie	neme Ltd D ssured by 1 eld Contrib	the Direct utory Hea	Debit Guar	antee. I	unders	tand
Branch sort code	5	Signature(s	)								
Bank/building society account number											
		Date									



## **Corporate plan**





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 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

www.ukhealthcare.org.uk



## 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		Funded £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		
Dental Accidents 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		
Health Screening 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		
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		
<b>Chiropody</b> 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		
<b>Prescriptions</b> 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					
Worldwide CoverUp 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.