

EVERYDAY APPLICATION FORM

	policy no:
Please indicate cash plan level:	
Level 4 Payment per MONTH Company Funded	
Your Details (*mandatory field)	
Title Surname*	
First Name (s)*	
Date of Birth*	
Address*	
	Postcode*
Daytime Tel*	Mobile
Email Address*	
Details of resident child (ren) to be covered (FREE	OF CHARGE)
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 Name	Date of Birth
Full Name	Date of Birth
Level 1 Level2	Level 3 Level 4
Payment per MONTH £9.00	£22.50
	od health and not receiving or needing any medical treatment. I ons existing before membership and that I may need to give consent to by. I agree to abide by the terms and conditions of membership and the
right of the company to vary them and the range and rates of benef	
	pay by Direct Debit
building society to Whealthcare Name and full postal address of your bank or building society	pay by Direct Debit Service user number
UK Healthcare building society to	pay by Direct Debit
building society to Whealthcare Name and full postal address of your bank or building society	pay by Direct Debit Service user number
Name and full postal address of your bank or building society To: The Manager Bank/building society	pay by Direct Debit Service user number 6 9 7 7 6 1
Name and full postal address of your bank or building society To: The Manager Bank/building society	pay by Direct Debit Service user number 6 9 7 7 6 1
Name and full postal address of your bank or building society To: The Manager Bank/building society	pay by Direct Debit Service user number 6 9 7 7 6 1 Reference
building society to Name and full postal address of your bank or building society To: The Manager Bank/building society Address	Service user number 6 9 7 7 6 1 Reference 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 and full postal address of your bank or building society To: The Manager Address Postcode Name(s) of account holder(s)	Service user number 6 9 7 7 6 1 Reference 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
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Everyday 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



Everyday Benefits Table

Benefits Table		Level 1	Level 2	Level 3	Level 4
Monthly Premium Employee		Co funded	Co funded	Co funded	Co funded
Benefit	Payback	Level 1	Level 2	Level 3	Level 4
Dental* Includes check-ups, fillings, hygienist fees, X-Rays and dentures	100%	£50	£95	£175	£260
Optical* Includes eye tests, glasses, contact lenses, repairs and laser eye surgery	100%	£80	£120	£200	£330
Health Screening Includes well man/woman screening and all screening that helps prevent an illness	100%	£50	£100	£200	£300
Specialist Consultation* Covers diagnostic consultations and tests recommended by your GP	100%	£60	£110	£200	£425
Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture)* Covers treatment by a registered practitioner up to a max of £20 per visit	100%	£110	£220	£375	£600
Complementary Therapies (Homeopathy/Reflexology/Aromatherapy) Covers treatment by a registered practitioner following GP referral	100%		£110	£200	£350
Chiropody Covers treatment by a chiropodist or podiatrist up to a max of £20 per visit	100%		£110	£200	£350
Hospital In-Patient* A nightly allowance for any NHS or private hospital admission	Up to 25 nts	£20	£30	£50	£75
Day Case A daily allowance for day case admissions	Up to 10 vsts		£30	£50	£75
Hospital Parental Stay A nightly allowance for one parent accompanying a child covered by the policy	Up to 24 nts		£30	£50	£75
Maternity/Paternity/Adoption (one adult only) Single payment per child born or adopted. 12 month qualifying period.		£100	£200	£300	£400
Prescriptions The number of standard prescription items that can be claimed (excludes annual prescriptions)			4	8	12
Accidental Death (adult only)		£2,500	£5,000	£7,500	£10,000
Savings on spas, gyms, holidays, theme parks and attractions Services provided by a third party		Access to special membership rates			
Confidential Counselling Helplines Helpline services provided by a third party		Any time support for legal issues, medical problems, counselling & ID theft			
Worldwide Cover (up to 28 days)		Cash Plan benefits extend to trips abroad			

Benefit levels are annual sums with exclusion of optical which is paid over a 2 year period.

^{*}Children are covered for benefits indicated at 50% of amounts shown.