UK Healthcare™
Looking after every body

Your Corporate Benefits

My First Five Years™

	Level 1	Level 2	Level 3
Employee Monthly Premium	Company Funded	£10	£15
Partner Monthly Premium	£5	£15	£20

Benefit	Payback	Level 1	Level 2	Level 3
Dental Includes check-ups, fillings, hygienist fees, X-Rays and dentures	100%	£35	£70	£100
Dental Accidents For dental injury as a direct result of accidental impact	100%	£100	£200	£300
Optical Includes eye tests, glasses, contact lenses, repairs and laser eye surgery	100%	£35	£70	£100
Health Screening Includes well man/woman screening and all screening that helps prevent an illness	100%	£50	£100	£150
Specialist Consultation Covers diagnostic consultations and tests	100%	£75	£150	£225
Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture) Covers treatment by a registered practitioner	100%	£75	£150	£225
Chiropody Covers treatment by a chiropodist or podiatrist	100%	£20	£50	£100
Prescriptions The number of standard prescription items that can be claimed (excludes annual prescriptions)		2	3	4
Discounted Gym / Spa Membership Services provided by Incorpore Ltd				
Savings on holidays, theme parks, retail discounts and attractions Services provided by Incorpore Ltd				
Confidential Counselling Helplines Helpline services provided by Health Assured Limited **To speak to a counsellor call 0800 107 6585 quoting reference number 72740**				
Worldwide Cover	Up to 28 days			

Immediate cover provided.

Pre-existing conditions included.

Benefit levels are annual sums.

Dependent children up to age 24 are covered free (in full time education)

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POLICY AMENDMENT FORM

My First Five Years

I wish to amend my existing cover ☐ Existing policy no: ----

Please indicate cash plan level:

	Level 1	Level2	Level 3
Payment per MONTH	Company Funded ☐	£10.00 ☐	£15.00 ☐

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
Payment per MONTH	£5.00 ☐	£15.00 ☐	£20.00 ☐

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".

UK Healthcare

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

DIRECT Debit

Name and full postal address of your bank or building society

To: The Manager — Bank/building society

Address

Postcode

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(s) of account holder(s)

Branch sort code

Bank/building society account number

Signature(s)

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account.

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Corporate plan

DIRECT Debit

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 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/