

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			£12	£21	£30	£45			
Benefit	Payback	Level 1	Level 2	Level 3	Level 4	Level 5			
Dental	100%	£60	£110	£150	£200	£275			
Includes check-ups, fillings, hygienist fees, X-Rays and dentures									
Dental Accidents For dental injury as a direct result 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	100%	£200	£260	£300	£400	£600			
Covers diagnostic consultations and tests									
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	100%	£20	£50	£100	£150	£200			
Covers treatment by a chiropodist or podiatrist	10070	120	130	1100	1130	1200			
Hospital In-Patient	Up to	£10	£15	£20	£30	£50			
A nightly allowance for any NHS or private hospital admission	28 nts								
Day Case	Up to	£10	£15	£20	£30	£50			
A daily allowance for day case admissions	10 vsts								
Hospital Parental Stay	Up to	£10	C1E	C20	C20	£50			
A nightly allowance for one parent accompanying a child covered by the policy	28 nts	E10	£15	£20	£30	LJU			
Prescriptions									
The number of standard prescription items that can be claimed (excludes annual prescriptions)		1	2	3	4	5			
Discounted Gym / Spa Membership		٨	scoss to sp	ecial meml	horshin rat				
Services provided by a third party			less to sp		bership ta	les			
Savings on holidays, theme parks, retail discounts and attractions Services provided by a third party			ccess to sp	pecial disco	ounted rate	es			
Confidential Counselling Helplines & F2F Sessions			ime suppo	rt for legal	issues, me	edical			
elpline services provided by a third party – Employee only				ounselling					
Worldwide Cover 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



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Please indicate cas	sh plan level:									
Payment per MONT	Level 1 H Company Funded	_	Level2 £7.67		Level 3 £16.67		Level 4 £25.67		Level 5 £40.67	
Your Details (*mandatory field)										
Title		Surname*								
First Name (s)*										
Date of Birth*										
Address*										
							Postco	de*		
Daytime Tel*					[Mobile				
Email Address*										
Details of reside	nt child (ren) t	to be cove	red (FRE	E OF C	HARGE					
Full name							Date of Bi	irth		
Full name							Date of Bi	irth		
Details of reside	nt second adu	lt (s) to be	covered	for t	he addit	ional prem	ium indic	ated		
Full Name							Date of B			
Full Name							Date of B			
	Level 1		Level2		Level 3		Level 4		Level 5	
Payment per MONT			£12.00 [_	£21.00		£30.00		£45.00	
Pre-existing con	ditions									

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)	DIF	RE b	
Name and full postal address of your bank		Service us	ser numbe	er				1			
To: The Manager	Bank/building society	6	9	7	7	6	1				
Address		Reference		1 1				.	T T		
F Name(s) of account holder(s)	Postcode	Instruction Please pay V in this instru- that this inst will be pass	Westfield Co uction subje truction ma	ontributor ect to the s ly remain v	y Health Sc afeguards a vith Westfi	heme Ltd E assured by eld Contrib	the Direct outory Hea	Debit Gua	rantee. I	unders	stand
Branch sort code		Signature	(s)								
Bank/building society account number											
		Date									



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 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