

Your Corporate Benefits



		Level 1	Level 2	Level 3	Level 4	Level 5				
Employee Monthly Premium		Council Funded	£10	£20	£30	£40				
Partner Monthly Premium		£5.50	£15	£25	£35	£45				
Benefit	Payback	Level 1	Level 2	Level 3	Level 4	Level 5				
Dental										
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				
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 Covers diagnostic consultations and tests as recommended by your GP	100%	£200	£250	£300	£350	£400				
Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture) Covers treatment by a registered practitioner	100%	£150	£200	£250	£300	£350				
Complementary Therapies (Homeopathy/Reflexology/Aromatherapy/Remedial Massage) Covers treatment by a registered practitioner following GP referral	100%	£50	£100	£150	£200	£250				
Chiropody 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				
Prescriptions The number of standard prescription items that can be claimed		1	2	3	4	5				
Discounted Gym / Spa Membership Services provided by Incorpore Ltd			Access to special membership rates							
Savings on holidays, theme parks, retail discounts and attractions Services provided by Incorpore Ltd		Access to special discounted rates								
Confidential Counselling Helplines + Interactive Counselling App Helpline services provided by Health Assured Limited		Anytime support for legal issues, medical problems, counselling and ID theft								
Worldwide Cover	Up to 28 days	Cash plan benefits extend to trips abroad				proad				

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 cas	h plan level:							
	Level 1 H Council	_	_	2 3	Level 4	Level 5		
Payment per MONT	H Council Funded	⊔ £10	£20		£30 🗌	£40		
Your Details (*ma	ndatory 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				E	Date of Birth			
Details of resider	nt second adu	ilt (s) to be cov	ered for the ac	Iditional prem	ium indicated			
Full Name				[Date of Birth			
Full Name				[Date of Birth			
	Level 1	Level2	Level 3		Level 4	Level 5		
Payment per MONT	H £5.50	£15.00) £25.00		£35.00	£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".

VK Healthcare [*]	Instruction to your bank or building society to pay by Direct Debit								DIF De	RE b	CT it
Name and full postal address of your bank of To: The Manager	br building society Bank/building society	Service us		er —		~	-	1			
		6	9		1	6					
Address		Reference	1								
F Name(s) of account holder(s)	'ostcode	Instruction Please pay V in this instru that this inst will be passe	Vestfield Co ction subje ruction ma	ontributor ect to the s y remain v	y Health Sc afeguards a vith Westfi	heme Ltd D issured by t eld Contrib	the Direct outory Hea	Debit Gua	antee. I u	nderst	and
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

www.ukhealthcare.org.uk/nwldc