

## **Your Corporate Benefits**



		Level 1	Level 2	Level 3	Level 4	Level 5		
Employee Monthly Premium		Company	£10.00	£20.00	£30.00	£45.00		
Partner Monthly Premium		Funded £10.00	£20.00	£30.00	£40.00	£50.00		
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Benefit	Payback	Level 1	Level 2	Level 3	Level 4	Level 5		
Dental	100%	£80	£110	£150	£200	£275		
Includes check-ups, fillings, hygienist fees, X-Rays and dentures								
<b>Dental Accidents</b> 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%	£80	£110	£150	£200	£275		
Health Screening Includes well man/woman screening and all screening that helps prevent	100%	£100	£130	£150	£200	£300		
an illness	100%			2130		2300		
Specialist Consultation  Covers diagnostic consultations and tests recommended by your GP	100%	£250	£275	£300	£400	£600		
(Also includes - MRI, CT & PET Scanning)	20070			_000		_000		
Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture)	100%	£250	£275	£300	£325	£350		
Covers treatment by a registered practitioner								
Complementary Therapies (Homeopathy/Reflexology/Aromatherapy) Covers treatment by a registered practitioner following CD referred	100%	£150	£200	£250	£300	£350		
Covers treatment by a registered practitioner following GP referral								
Chiropody Covers treatment by a chiropodist or podiatrist	100%	£100	£150	£200	£250	£300		
Accidental Death (adult only)	100%	£1000	£1000	£1000	£1000	£1000		
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 Cover	Up to	Cash	plan bene	fits extenc	l to trips al	oroad		

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 exis	Stillig Cover	LXISti	ng pond	.y 110.								
Please indicate cash pla	ın level:											
Payment per MONTH	Level 1 Company [ Funded	Level2 £10.00		Level : £20.00	_	]	Lev £30			Level 5 £40.67		
Your Details (*mandator	ry field)											
Title	Sur	name*										
First Name (s)*		_										
Date of Birth*												
Address*												
							P	ostco	de*			
Daytime Tel*					Mob	ile						
Email Address*												
Dotoile of regisleration	ild (von) to b	a covered (FD		CLIADO	<b>-</b> \							
Details of resident ch	ilia (ren) to b	e covered (FR	EE OF	СПАКО	<u> </u>							
Full name	full name					Date	Date of Birth					
Full name	Full name					Date	e of Bi	rth				
Details of resident se	cond adult (s	s) to be covere	ed for t	he add	litiona	al prei	mium i	indica	ated			
Full Name								e of Bi				
Full Name								of Bi				
ruii Naiile	1 14								Tui			
Payment per MONTH	Level 1 £10.00	Level2 £20.00		Level 3 £30.00		1	Leve £40			Level 5 £50.00		
Pre-existing condition						J						
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To. The Manager		Ballivibuliding S	ociety	6	9	7	7	6	1			
Address				Reference	<b>&gt;</b> 3					=		
				Instructio	n to you	r bank or	building :	society				
	Postcode			in this instr	uction sub	ject to the	safeguards a	assured by	the Direct	its from the account Debit Guarantee.	I understand	
				will be pass						alth Scheme Ltd an	a, if so details	
Name(s) of account holder(s)				Signature	(s)							
			- 1	Oignature	(3)							
0												
Branch sort code		7										
Branch sort code		]										
Branch sort code  Bank/building society account nu	ımber											



## 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