

Your Corporate Benefits



	Level 1	Level 2	Level 3	Level 4	Level 5
Employee Monthly Premium	Company Funded	Company Funded	Company Funded	£9.00	£24
Partner Monthly Premium	£5.50	£12	£21	£30	£45

Partner Monthly Premium			£12	£21	£30	£45								
Benefit	Payback	Level 1	Level 2	Level 3	Level 4	Level 5								
Dental State of the Control of the C	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 Covers diagnostic consultations and tests	100%	£200	£260	£300	£400	£600								
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 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 (excludes annual prescriptions)		1	2	3	4	5								
Discounted Gym / Spa Membership Services provided by a third party			cess to sp	ecial meml	pership rat	es								
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				_	issues, me									
Worldwide Cover	over Up to 28 days					Cash plan benefits extend to trips abroad								





CORPORATE POLICY AMENDMENT FORM Existing policy po

6 9 7 7 6 1	I wish to amend m	y existing cover		Existing	policy r	10:										
Payment per MONTH Company Company E9 £24	Please indicate cas	sh plan level:														
Title Surname* First Name (s)* Date of Birth* Address* Details of resident child (ren) to be covered (FREE OF CHARGE) Full name Date of Birth Details of resident second adult (s) to be covered for the additional premium indicated Full Name Date of Birth Payment per MONTH £5.50	Payment per MONT	H Company	Co	ompany [c	Company				14]				
First Name (s)* Date of Birth* Address* Details of resident child (ren) to be covered (FREE OF CHARGE) Full name Date of Birth Payment per MONTH £5.50	Your Details (*ma	ndatory field)														
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Date of Birth* Address* Daytime Tel* Date of Birth Date of	First Name (s)*															
Address* Daytime Tel* Email Address* Details of resident child (ren) to be covered (FREE OF CHARGE) Full name Date of Birth Full Name Date of Birth Date of Date o																
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Datytime Tel* Email Address* Details of resident child (ren) to be covered (FREE OF CHARGE) Full name Date of Birth Payment per Month Evel 1 Level 2 Level 3 Level 4 Level 5 Payment per Month £5.50 £12.00 £21.00 £30.00 £45.00 Pre-existing conditions Should you decide to upgrade your level of cover, please complete and return this application form within the next 3D 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". Instruction to your bank or building society to pay by Direct Debit WHealthcare* Instruction to your bank or building society Bank/building society to pay by Direct Debit Instruction to your bank or building society Postoode	i								Pc	stc	ode*	k				
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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