



wpa.org.uk

Application form.

This application form is effective from February 2006

Application form for:

XS health

Thank you for applying to join WPA. The questions on this form are important, please take your time to answer all of them as fully as possible. Alternatively you can apply online at wpa.org.uk

If you need help to complete this form, please speak to your insurance adviser or WPA on 01823 625175. Full plan details, including a complete list of general exclusions, can be found in 'A Guide to your Plan', available at wpa.org.uk or on request.

PLEASE COMPLETE ALL SECTIONS IN FULL, IN BLACK INK USING BLOCK CAPITALS. WHERE A CHOICE OF ANSWER IS OFFERED PLEASE TICK THE MOST APPROPRIATE BOX.

Please also ensure that you read the Terms & Conditions in Section 7 and sign the declaration in Section 8.

Intermediary/Adviser ID

Medibroker Limited
17 Seatonville Road
Whitley Bay
NE25 9DA

Agency: 2490877

Office use only

1. THE COVER YOU WOULD LIKE

Who is the application for

 A new policyholder (and family members) Adding a new member(s) to an existing plan

If you have or have previously had a WPA plan, what is/was your customer number

When would you like your cover to start

 (dd/mm/yy) This date cannot be before the date this form is signed or more than 1 month in advance

When does your current insurance expire

 (dd/mm/yy)

2. TELL US ABOUT YOU

Title

Male

Female

Date of birth

 (dd/mm/yy)

First name

Middle name

Surname

What is your occupation

(If retired please give occupation before retirement)

Address

Postcode

Home telephone number

Work telephone number

Mobile telephone number

E-mail address

We recognise that communicating by e-mail is quick and efficient but carries no absolute guarantee of confidentiality. By providing your e-mail address on this form you are consenting to its use for services which may include claim and medical information as well as the administration of your plan

Would you rather be contacted via

Letter

E-mail

3. ADD FAMILY MEMBERS TO THE PLAN

To be eligible for inclusion on your plan any additional people must reside at your address unless they are a family member who is under 25 years of age and in full-time education away from home. If you require additional space please continue on a separate sheet of paper.

2nd PERSON TO BE COVERED

Title _____ Male Female _____ Their date of birth _____ (dd/mm/yy)
Their first name _____ Their middle name _____
Their surname _____
Their relationship to you _____
What is their occupation (If retired please give occupation before retirement) _____

3rd PERSON TO BE COVERED

Title _____ Male Female _____ Their date of birth _____ (dd/mm/yy)
Their first name _____ Their middle name _____
Their surname _____
Their relationship to you _____
What is their occupation (If retired please give occupation before retirement) _____

4th PERSON TO BE COVERED

Title _____ Male Female _____ Their date of birth _____ (dd/mm/yy)
Their first name _____ Their middle name _____
Their surname _____
Their relationship to you _____
What is their occupation (If retired please give occupation before retirement) _____

5th PERSON TO BE COVERED

Title _____ Male Female _____ Their date of birth _____ (dd/mm/yy)
Their first name _____ Their middle name _____
Their surname _____
Their relationship to you _____
What is their occupation (If retired please give occupation before retirement) _____

6th PERSON TO BE COVERED

Title _____ Male Female _____ Their date of birth _____ (dd/mm/yy)
Their first name _____ Their middle name _____
Their surname _____
Their relationship to you _____
What is their occupation (If retired please give occupation before retirement) _____

5. YOUR HEALTH AND LIFESTYLE (CONTINUED)

If you have answered YES to any of the previous questions (numbered 1–9), please use the spaces below to provide more information. If you need more space, please use the allocated page at the end of Section 6 or a separate sheet.

Name _____	This information relates to question number _____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number _____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number _____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number _____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number _____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

Name _____	This information relates to question number _____
Details (PLEASE PRINT CLEARLY IN BLOCK CAPITALS)	

	YOU	2 nd PERSON	3 rd PERSON	4 th PERSON	5 th PERSON	6 th PERSON
Is your GP private or NHS	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>	Priv <input type="checkbox"/> NHS <input type="checkbox"/>

We reserve the right to ask your GP for information about your health. Before requesting a medical report we will ask you to sign an ACCESS to MEDICAL REPORTS consent form.

General Practitioner name _____

Address _____

If you have more than one GP for all the people on this application, please list their details in the space provided in Section 6.

6. YOUR MEDICAL HISTORY

Private Medical Insurance covers policyholders against future illness, it is not intended to provide cover for chronic conditions. Please refer to the Information Leaflet 'Chronic Conditions' (available on request or online at wpa.org.uk/chronic) which explains this in more detail. Existing, or previous, conditions are NOT covered, unless you give us full details and we are satisfied that they are no longer relevant to your future health. **Failure to disclose medical information may result in a rejection of claims in the future, and/or cancellation of your plan.**

Please tick **Yes** or **No** under each section below if you or anyone else you wish to include on your plan have: a) visited a GP or other healthcare professional for any of the conditions or symptoms in the past 2 years; b) been treated in hospital, seen a specialist or had any investigation for any of the conditions or symptoms in the past 5 years.

If you or any applicant answers **YES** to any of the questions in this section, please give full details overleaf.

NEUROLOGICAL	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Epilepsy • Brain, nerve or muscle problems • Development or behavioural disorders • Psychiatric or nervous problems • Anxiety/depression 	

DIGESTIVE SYSTEM	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Indigestion • Bowel disturbance • Irritable bowel syndrome • Crohn's disease, colitis • Hiatus and other types of hernia • Conditions of liver, gallbladder or similar • Piles • Other rectal blood loss 	

JOINTS & BONES	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Back ache or neck ache • Spinal problems • Disc problems • Bone, tendon or ligament conditions • Gout, rheumatic diseases or fever • Arthritis or other joint problems • Fracture or injury 	

KIDNEY	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Kidney and bladder conditions • Urinary tract stones • Urinary symptoms, cystitis 	

EYES & EARS	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Glaucoma • Cataracts • Retinal or other eye disorders • Glue ear, hearing problems or other ear problems 	

SKIN	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Eczema • Psoriasis • Moles, warts or other skin problems • Cysts and benign lumps • Thread/Varicose Veins 	

CIRCULATORY	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Blood pressure problems or abnormalities • Angina, heart attack • Other heart or circulatory problems • Blood lipid or cholesterol abnormalities • Varicose Veins • Stroke • Deep Vein Thrombosis 	

GLANDS	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Diabetes • Thyroid conditions • Other glandular disorders • Breast disorders, including cysts or lumps 	

RESPIRATORY	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Asthma • Bronchitis • Other lung or respiratory tract problems • Nose or throat disorders • Tonsillitis • Sinus problems 	

MALE	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Conditions of the genital system • Infertility or fertility problems • Sexually transmitted diseases • Disorders of the prostate 	

FEMALE	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • Childbirth or pregnancy problems • Menstrual irregularities or problems • Gynaecological conditions • Infertility or fertility problems • Problems with menopause • Abnormal smear test • Sexually transmitted diseases 	

Answer the following questions for ALL the people to be covered. If you or any applicant answers **YES** to any of the questions in this section, please give full details overleaf.

ANY APPLICANT	
1) Have you had any symptoms or conditions in the last 2 years for which a specialist, GP or healthcare professional's opinion has not yet been sought?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2) Are you waiting to see a specialist, GP or a healthcare professional?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3) Have you ever had treatment for arterial or heart disease (including stroke)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4) Have you ever had any malignant condition (eg cancer)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5) Have you ever had any orthopaedic surgery as a result of a bone or joint condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6) Have you undergone any medical tests in the last 2 years including home testing kits?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7) Have you had any other condition, symptom or medical history that should be disclosed in the interests of good faith?	Yes <input type="checkbox"/> No <input type="checkbox"/>

6. YOUR MEDICAL HISTORY (CONTINUED)

Please tell us about any condition you and others on this application are suffering or have suffered from.

CONDITION 1

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ dd/mm/yy The date the condition has been suffered to _____ dd/mm/yy

Does the condition still exist Yes No

Is any medication still being taken for this condition Yes No

CONDITION 2

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ dd/mm/yy The date the condition has been suffered to _____ dd/mm/yy

Does the condition still exist Yes No

Is any medication still being taken for this condition Yes No

CONDITION 3

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ dd/mm/yy The date the condition has been suffered to _____ dd/mm/yy

Does the condition still exist Yes No

Is any medication still being taken for this condition Yes No

6. YOUR MEDICAL HISTORY (CONTINUED)

If you need more space please use the allocated page overleaf or a separate sheet.

CONDITION 4

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ dd/mm/yy The date the condition has been suffered to _____ dd/mm/yy

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

CONDITION 5

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ dd/mm/yy The date the condition has been suffered to _____ dd/mm/yy

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

CONDITION 6

Patient's name _____

Condition suffered _____

Diagnosis made by whom _____

Tests performed _____

Results _____

Treatment _____

The date the condition has been suffered from _____ dd/mm/yy The date the condition has been suffered to _____ dd/mm/yy

Does the condition still exist Yes No Is any medication still being taken for this condition Yes No

7. TERMS & CONDITIONS – PLEASE READ CAREFULLY

DPA: WHAT INFORMATION DO WE HOLD AND WHY

We never disclose any information to third parties for sales, marketing or similar purposes. We take our responsibility regarding the confidentiality of our customers' personal information very seriously. Any information you give to us on this application form (your name, address, bank details and medical history) will be processed accurately and held securely in accordance with the Data Protection Act 1998.

By signing this form you are giving your consent for us to use your data as set out below.

How we may use your personal data or disclose it to third parties

- To process your claims and administer your plan;
- To liaise with your treatment provider regarding treatment details and costs;
- To process claims that are also covered by another insurer or other party;
- To help us develop services that we think may be in your interest;
- For statistical analysis to help us to assess how the plan you belong to is used;
- To detect and prevent fraud or improper claims. We may check your details with a fraud prevention agency/agencies and if you give us false or inaccurate information and we suspect fraud, we will record and investigate this. Please note that WPA works with other organisations to pool information about applications or claims which are believed to be fraudulent. Where potential fraud is notified to us, or identified by us, we will investigate this. For more information about our fraud prevention policy contact riskreviewteam@wpa.org.uk

In the course of administering your policy we may disclose data to countries outside the EEA which may not have data protection legislation in place. However, a contract will be held to ensure that your information is protected and we will remain bound by our obligations under the Data Protection Act.

We at WPA may advise you by letter, telephone, electronic mail or otherwise of other services or products which we believe that you may be interested in. This may involve an analysis of any information that you have provided. Would you like to receive such information?

Yes	No
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FRAUD/THEFT/DISHONESTY

Do you, or any person named on this application form, have any unspent conviction evidencing fraud, theft or dishonesty or have you, or any person named on this application form, ever had an insurance policy declined or cancelled by an insurer?

Yes	No
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If you have replied YES to the above question, please provide full details in Section 9 or on a separate sheet. NB: You have a continuing duty to tell us of any unspent conviction that may have been acquired, or any such cancellation, while the plan is in force.

IMPORTANT INFORMATION

- The plan will not begin until we have confirmed acceptance of your application.
- If you have not asked us for advice in choosing this plan please give careful attention to the Key Facts Section of the plan brochure.
- The health information you provide may result in us applying exclusions to your plan or declining your application.
- Before you sign the declaration, please check that the information you have given is complete and accurate, especially the details of your medical histories. Please then ensure that you accept these Terms & Conditions by signing the Declaration in Section 8. WPA reserves the right to request you undergo a medical examination prior to our confirming cover.
- When your application is accepted, WPA will send you the rules of the plan – these can be requested at any time or can be viewed at wpa.org.uk – and provide the full details of what your plan does and does not cover. You will also be sent a certificate of registration which sets out any special terms (exclusions from cover relating to you and any other person on the plan) which will apply.
- Please check all these documents before you cancel any private medical insurance plan you already have to be sure that you understand what the WPA plan you have chosen covers and that it meets your needs.
- If you visit a doctor after the time of completing this application, or prior to our accepting your application in writing, it is your duty to tell us.
- If you are not satisfied with your plan and the benefits it provides you have the right to cancel your plan provided you notify us within fourteen (14) days of receiving your policy documents. If you do not exercise this right within the 14 day period then you are committed to the cover and premium for the rest of the cover period. Should you wish to cancel during the notice period please write to Western Provident Association Limited, Private Client Division, Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE or e-mail pcd@wpa.org.uk. Please return the Certificate of Registration with your notice to cancel.
- Please note we can NOT accept your application if the start date is more than 1 month in advance. You must let us know if you suffer any symptoms, have any treatment or see a GP, specialist or other healthcare professional for a condition between filling in this form and the date your cover starts.

- Cover cannot be backdated.
- We carry out random quality checks on applications. This involves asking your GP for a medical report. WPA will pay any reasonable fee for this.

DECLARATION – FOR ALL APPLICANTS

1. I wish to apply for the cover indicated on behalf of myself and/or the other people listed on this form.
2. I and they have checked that the information given is correct and complete, especially if I have not filled in the form myself. In particular, I have personally confirmed with family members that the information on their health, lifestyle and medical history is correct and complete.
3. I agree that you may approach my GP for more information if you need this to make an accurate decision about my application.
4. I undertake to keep to the rules of the plan.
5. I undertake to pay the premiums and have completed the necessary form of authority.
6. I have read and understood the Important Information above.
7. I understand that I will not be covered for treatment of any illness or injury which started on or before the date the plan starts, even if the reason for any symptoms has not yet been diagnosed, unless I have given details of it on this form or subsequently declared to WPA and you have decided not to exclude it from cover.
8. I consent to the processing of my personal data and that of my family members in accordance with the DPA notification above.
9. I agree to credit checks being undertaken in the unlikely event fraud enquiries are instigated.
10. I declare that I and other people listed on this form reside in the UK for at least six (6) months a year and I understand that cover will automatically become void for individuals who leave the UK to live elsewhere for more than six (6) months a year.
11. As the policyholder I am responsible for ensuring that I have shown the leaflet entitled 'Important Information About Our Insurance Services' to each applicant listed on this form to ensure consent is given for WPA to use and disclose personal data in accordance with the terms set out above (and in full in 'A Guide to Your Plan'). I must also ensure that the applicants are aware that all correspondence will be directed to the policyholder, to ensure compliance with current legislation. I am aware that copies of this leaflet are available by visiting wpa.org.uk/importantinfo



8. DECLARATION – I ACCEPT THE TERMS & CONDITIONS

You should only sign this form when you and the other applicants have read, and agreed, that the answers to the questions are accurate and complete.

Your signature  

Date (dd/mm/yyyy) _____

12. CREDIT CARD CONTINUOUS AUTHORITY & CARD DETAILS

To: Western Provident Association Limited. I authorise you, until further notice in writing, to charge my MasterCard/Visa account (not applicable to Maestro) unspecified amounts in respect of my plan premiums when they become due. A 1.5% surcharge applies to credit card payments (not Maestro).

Please charge my MASTERCARD VISA MAESTRO

Card number _____

Expiry date _____ (mm/yy) Issue No. _____ Maestro Card Only

Name (as on card) _____

Address _____

Postcode _____

Telephone number _____

Card Holder's Signature Date (dd/mm/yy) _____

13. DIRECT DEBIT INSTRUCTION



wpa.org.uk

Instruction to your Bank or Building Society to pay Direct Debits

Please fill in the whole form and send it to:
**Private Client Division, WPA, Rivergate House,
 Blackbrook Park, Taunton, Somerset, TA1 2PE**



Originator's Identification Number 7 6 8 1 9 8

Name and full postal address of your Bank or Building Society

To: The Manager	Bank/Building Society
Address	
Postcode	

Branch Sort Code

WPA reference number (FOR WPA OFFICIAL USE ONLY)

Instruction to your Bank or Building Society

Please pay Western Provident Association Limited 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 Western Provident Association Ltd and, if so, details will be passed electronically to my Bank/Building Society.

Name(s) of Account Holder(s)

Signature(s)

Date

X

X

Bank or Building Society Account Number

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

14. DIRECT DEBIT GUARANTEE – PLEASE RETAIN FOR YOUR RECORDS



- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change WPA will notify you 5 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by WPA or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

WPA is authorised and regulated by the Financial Services Authority (FSA). The FSA website may be checked at www.fsa.gov.uk/register for WPA number 202608.



FS 28452

Western Provident Association is one of very few insurance companies worldwide to have been certified to the ISO 9001:2000 Quality Standard. In addition, Western Provident was awarded the British Standard Institute's 'Gold Standard' of Company Wide registration in May 1997 — the 24th company in the world to achieve this accolade. So the standards of service that you can expect are truly world class.



Western Provident Association is a member of the Financial Ombudsman Service, so you can be assured that any complaints are addressed seriously and objectively. Details of WPA's commitment to resolving customer complaints are included in your scheme literature.

WPA customers are covered by the Financial Services Compensation Scheme (FSCS) which can entitle customers to compensation should an insurer become insolvent. Further information can be found at www.fscs.org.uk



wpa.org.uk

Enjoy life. Insure health.

Western Provident Association Limited

Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE.

Tel: (01823) 625230 Fax: (01823) 625050 E-mail: pcd@wpa.org.uk

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