



wpa.org.uk

Application form.

Effective from April 2008

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Intermediary/Adviser ID

Office use only

Flexible Health Flexible Health Freelance

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 625050. Full policy details, including a complete list of general exclusions, can be found in 'A Guide to your Policy', 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.

1. THE COVER YOU WOULD LIKE

Which policy are you joining Flexible Health

or Flexible Health Freelance

Available for those recognised by the Inland Revenue as self-employed and/or operating a franchise business.

Please note that you can join Flexible Health or Flexible Health Freelance as the primary policyholder if you are aged between 18 and 65. Also note that if you would like to join Flexible Health Freelance you must comply with the criteria specified as 'Important – self-employed status (Flexible Health Freelance)' marked in blue in Section 7.

Who is the application for A new policyholder (and family members)

Adding a new member(s) to an existing policy

If you have or have previously had a WPA policy, 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 _____

How would you like to be contacted Standard Post

Notification by E-mail ¹

All communication by E-mail ²

- 1 With this mode of contact we will advise you of correspondence that can be viewed or downloaded from the secure area of our website. The email itself will not contain any personal information or attachments.
- 2 If you select this mode of contact, we will attach all correspondence to the e-mail for you to view or download.

Please note that E-mails are a useful way for us to communicate with you and you to contact us – but please remember that the e-mail address you give us must be secure and not accessible by anyone else (e.g. a work e-mail address). 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 policy.

3. ADD FAMILY MEMBERS TO THE POLICY

To be eligible for inclusion on your policy 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 18 or over; 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 18 or over; 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 18 or over; 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 18 or over; 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 18 or over; if retired please give occupation before retirement)

4. BUILD THE POLICY TO SUIT YOUR NEEDS

Select one or more of the cover options below to best suit your requirements. (Note: Each person must have a base level of cover of either Essential Cover or Essential Plus.)

	YOU	2 nd PERSON	3 rd PERSON	4 th PERSON	5 th PERSON	6 th PERSON
Essential Cover (E) or Essential Plus (EP)	E <input type="checkbox"/> EP <input type="checkbox"/>	E <input type="checkbox"/> EP <input type="checkbox"/>	E <input type="checkbox"/> EP <input type="checkbox"/>	E <input type="checkbox"/> EP <input type="checkbox"/>	E <input type="checkbox"/> EP <input type="checkbox"/>	E <input type="checkbox"/> EP <input type="checkbox"/>
Out-patient Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapy Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worldwide (W) or Worldwide Plus (WP) Option	W <input type="checkbox"/> WP <input type="checkbox"/>	W <input type="checkbox"/> WP <input type="checkbox"/>	W <input type="checkbox"/> WP <input type="checkbox"/>	W <input type="checkbox"/> WP <input type="checkbox"/>	W <input type="checkbox"/> WP <input type="checkbox"/>	W <input type="checkbox"/> WP <input type="checkbox"/>
Dental Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Assist Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Select an annual maximum level of **Shared Responsibility** for each applicant. You do not need to select a Shared Responsibility level for any child under the age of 18. With any eligible claim made by any child, the 25% contribution to their treatment costs will be taken from the annual Shared Responsibility limit of the eldest person. Please note that these Shared Responsibility limits do not apply to the Hospital Assist Option.

	YOU	2 nd PERSON	3 rd PERSON	4 th PERSON	5 th PERSON	6 th PERSON
£500	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£1,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£3,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£5,000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. YOUR HEALTH AND LIFESTYLE

	YOU	2 nd PERSON	3 rd PERSON	4 th PERSON	5 th PERSON	6 th PERSON
How tall are you (for applicants 16+ years of age)	Ft/In <input type="text"/>	Ft/In <input type="text"/>	Ft/In <input type="text"/>	Ft/In <input type="text"/>	Ft/In <input type="text"/>	Ft/In <input type="text"/>
or	Cm <input type="text"/>	Cm <input type="text"/>	Cm <input type="text"/>	Cm <input type="text"/>	Cm <input type="text"/>	Cm <input type="text"/>
How much do you weigh (for applicants 16+ years of age)	St/Lb <input type="text"/>	St/Lb <input type="text"/>	St/Lb <input type="text"/>	St/Lb <input type="text"/>	St/Lb <input type="text"/>	St/Lb <input type="text"/>
or	Kg <input type="text"/>	Kg <input type="text"/>	Kg <input type="text"/>	Kg <input type="text"/>	Kg <input type="text"/>	Kg <input type="text"/>
If you have smoked in the last 12 months please answer 'Yes' to the following question						
Do you smoke (for applicants 18+ years of age)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you smoke, how many do you smoke per day	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you answer YES to any of the following questions please provide more information on the next page.

	YOU	2 nd PERSON	3 rd PERSON	4 th PERSON	5 th PERSON	6 th PERSON
1.....Have you gained or lost more than 2 stone (12 kilograms) in weight in the last 12 months	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2..... Do you wear a knee support when you play sport or exercise	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.... Have you ever professionally been advised to drink less alcohol (for applicants 18+ years)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4... Do you take regular prescription medication (other than for contraception)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.....Are you on any kind of health/screening review programme because of family medical history	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.....Do you have another health policy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7... Have you ever received advice, treatment or medication relating to mental health	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8..... Is there any illness that runs in your family	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9.... Have either of your parents, brothers or sisters suffered or died under the age of 60 as a result of heart disease, cancer or diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you have answered YES to Question 9, please confirm:

a.....The relationship of the family member(s)

b..... If cancer, the type of cancer diagnosed

c..... The age at which they were diagnosed

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 space in 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)	

	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.

How long have you been registered with your GP _____ Months / Years (delete as appropriate)

If under one year please give your previous GP details.

General Practitioner name _____

Address _____

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 Important Information Leaflet (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 policy.**

Please tick YES or NO under each section below if you or anyone else you wish to include on your policy have: a) visited a GP or other healthcare professional for any of the conditions 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/stress 	

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 Knee or hip problems Spinal problems Disc problems Bone, tendon or ligament conditions Gout, rheumatic diseases or fever Arthritis or other joint problems Fracture or injury Other joint problems 	

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 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 	

Please answer the following questions for ALL of 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

WHAT INFORMATION DO WE HOLD AND WHY

Except where stated below, we never disclose any personal information about customers to third parties. 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 (DPA).

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 policy;
- 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 policy 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.

In the course of administering your policy we may disclose:

- Administration and claims data to the staff of WPA and its subsidiaries, FSA registered appointed representatives, agents and medical advisors;
- 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. If you do not wish to receive such information please tick the box below.

No

FRAUD/THEFT/DISHONESTY/JUDGEMENTS

Do you, or any person named on this application form, have any unspent criminal 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 or have a current County Court Judgement (CCJ) or Bankruptcy Order against you or have entered into Individual Voluntary Arrangements (IVA)?

Yes No

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 criminal conviction that may have been acquired, or any such cancellation, while the policy is in force.

IMPORTANT INFORMATION

- The policy will not begin until we have confirmed acceptance of your application.
- If you have not asked us for advice in choosing this policy please give careful attention to the Policy Summary.
- The health information you provide may result in us applying exclusions to your policy 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 policy – these can be requested at any time or can be viewed at wpa.org.uk – and provide the full details of what your policy does and does not cover. You will also be sent a certificate of registration which sets out any personal medical exclusions (exclusions from cover relating to you and any other person on the policy) which will apply.
- Please check all these documents before you cancel any private medical insurance policy you already have. It is important that you understand what the WPA policy you have chosen covers and that it meets your needs.
- 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.
- Unless you tell us that you want to cancel the policy, it will automatically be renewed 12 months from the start date of the contract and each year thereafter, regardless of how you have chosen to pay your premiums. We will notify you 21 days prior to renewal detailing any changes to your policy including premium changes.
- 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.
- If the **Hospital Assist Option** has been chosen: No cover will be provided for any condition or any associated condition existing on or before the date of registration to the policy, irrespective of whether it has been disclosed in this application. Please note that there is a 3 month qualifying period for the Hospital Assist Option for existing customers wishing to upgrade to this Option at renewal.

- **Dental Option only:** Emergency benefit applies only to treatment received for the relief of acute pain, swelling or haemorrhaging associated with the teeth, jaws or soft tissues of the mouth. Please note that there is a 3 month qualifying period for General Dental Treatment, and a 14 day qualifying period for Dental Emergencies.

CANCELLATION

- If you are not satisfied with your policy and the benefits it provides you have the right to cancel your policy provided you notify us within 14 days (28 days if purchased online) of receiving your policy documents. If you do not exercise this right within this notice period then you are committed to the cover and premium for the rest of the cover period. Should you wish to cancel during this 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.

DECLARATION – FOR ALL APPLICANTS

- I wish to apply for the cover indicated on behalf of myself and/or the other people listed on this form.
- 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 and lifestyle is correct and complete and understand that you also take other risk factors such as body mass index, lifestyle and family history into consideration when underwriting this application.
- I agree that you may approach my GP for more information if you need this to make an accurate decision about my application.
- I undertake to keep to the rules of the policy.
- I undertake to pay the premiums and have completed the necessary form of authority.
- I have read and understood the Important Information above.
- I understand that I will not be covered for treatment of any illness or injury which started on or before the date the policy starts, even if the reason for any symptoms has not yet been diagnosed, with the exception of General Dental Treatment and Optical Treatment where applicable unless declared or subsequently disclosed and accepted by WPA.
- I understand by buying this policy I am consenting on behalf of myself and any other people listed on this form to relevant policy and claims data being disclosed to WPA staff and subsidiaries, FSA regulated appointed representatives, agents and medical advisors.
- If I have chosen the Dental or Essential Plus Option** I confirm that I will not hold a dental plan with any other insurer after the qualifying period.
- Dental Option only:** I confirm on behalf of myself and each family member that we have visited a UK registered dentist for either a dental check-up or dental treatment within the 18 month period to the application to join the policy.
- I agree to credit checks being undertaken upon my application.
- I declare that I and other people listed on this form reside in the UK for at least 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 6 months a year.
- 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 Policy'). I understand that WPA will normally write to the policyholder. I agree that if a family member does not wish WPA to correspond with the policyholder and they are aged 18 or over, they will take out an individual policy in their own right. I am aware that copies of this leaflet are available by visiting wpa.org.uk/importantinfo

Important – self-employed status (Flexible Health Freelance)

The Inland Revenue recognises individuals as self-employed where they meet certain criteria regardless of whether the individual works on his/her own or in a partnership. If you meet the Inland Revenue criteria you are eligible to join this policy. You are also eligible to join this policy if you are the holder of a recognised franchise agreement. We reserve the right to request written confirmation of your tax status or your agreement.

- I confirm that I meet one of the following criteria to subscribe to the Flexible Health Freelance Policy. Please tick as appropriate.
 - I am a director of a private limited company which employs no more than 5 additional salaried member of staff

Yes	No
-----	----
 - I am a partner within a partnership of not more than 2 partners that employs no more than 5 salaried staff

Yes	No
-----	----
 - I confirm that I am currently self-employed

Yes	No
-----	----
 - I confirm that I am the holder of a recognised franchise agreement

Yes	No
-----	----
- I will inform WPA immediately in the event that the above statement ceases to apply and that I will not be eligible for policy cover. I am aware that alternative cover can then be arranged.
- I also agree that if required by WPA now, at renewal or at the point of claim, I will supply evidence of my status as above.
- I understand that a change in status may render this policy void.

8. DECLARATION – I ACCEPT THE TERMS & CONDITIONS

Please make sure you have ticked all the boxes below before signing the Declaration:

You have included all persons to be covered on the policy and selected their cover options (where applicable):

I have read and understood the above Terms & Conditions:

All persons to be included on the policy have read and understood the Terms & Conditions:

Your signature

Date
(dd/mm/yy)

We reserve the right to ask you for proof of your identity when you apply for a WPA policy and at any time thereafter when appropriate.

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 policy 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

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

WPA 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.



WPA 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.



EMS 505226

WPA is one of the first UK companies to achieve the environmental quality standard.

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) 623050 E-mail: pcd@wpa.org.uk

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