

# Application Form

CONFIDENTIAL

Medibroker Ltd  
17 Seatonville road  
Whitley Bay  
NE25 9DA

**Exeter**  
Care

Each adult wishing to join must complete a separate application form. Please note that separate Direct Debits are also required for each adult. If you wish to include dependent children, please call 01392 35 35 35 for advice.

Please complete the form in BLOCK CAPITALS using **black ink**, and return to: Exeter Friendly Society Ltd, Lakeside House, Emperor Way, Exeter, EX1 3FD. A copy of this application form will be supplied to you on request within three months of its completion.

If you require any assistance with the completion of this form please telephone us on 01392 35 35 35, or refer to the step by step guide at the back of your brochure.

## A PERSONS TO BE INCLUDED IN THIS APPLICATION

	Applicant Number	Title	Forenames	Surname	Date of Birth	Height	Weight
You	1				/ /		
Child	2				/ /		
Child	3				/ /		
Child	4				/ /		

## B FULL ADDRESS ALL PERSONS INCLUDED IN THIS APPLICATION MUST RESIDE AT THIS ADDRESS

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## C COVER OPTIONS

### PLAN:

**PREFERRED PLAN** (TICK HERE TO SELECT THIS OPTION)

#### DEMANDS AND NEEDS

You should only select this Plan if you are resident in the UK and you wish to insure against the costs of private treatment received on an in-patient, day-patient or out-patient basis, for acute medical conditions originating after the start of your policy.

**LOW COST PLAN** (TICK HERE TO SELECT THIS OPTION)

#### DEMANDS AND NEEDS

You should only select this Plan if you are resident in the UK and you wish to insure against the costs of private treatment received on an in-patient or day-patient basis, for acute medical conditions originating after the start of your policy.

### HOSPITAL COVER:

**LEVEL 1** (TICK HERE TO SELECT THIS OPTION)

#### DEMANDS AND NEEDS

You should tick this box if you wish to be able to use any hospital included on the Hospital Choice List in the event of treatment being required.

**LEVEL 2** (TICK HERE TO SELECT THIS OPTION)

#### DEMANDS AND NEEDS

You should tick this box if you wish to be able to use only those hospitals designated as Level 2 on the Hospital Choice List in the event of treatment being required.

### VOLUNTARY EXCESS:

#### DEMANDS AND NEEDS

You should select an excess only if, in return for the premium discount indicated, you wish to waive entitlement to any benefits to which you would otherwise be entitled up to the value of the excess for each person included on the application in any policy year.

NO EXCESS  £100 (5% DISCOUNT)  £250 (10% DISCOUNT)  £500 (25% DISCOUNT)

£750 (30% DISCOUNT)  £1000 (35% DISCOUNT)

### WHEN DO YOU WISH COVER TO COMMENCE?

On acceptance of my application

Or, on this future date. (This must not more than one calendar month ahead) / /

<b>FOR OFFICE USE ONLY</b>	
Policy Number:	Date of Joining:
Underwritten/Moratorium	Underwriter's Signature:
Date Scrutinised:	Exclusions:
ID(Type/Reference):	
Intermediary/Broker Signature:	Date:

Intermediary Stamp



PLEASE INDICATE WHICH METHOD OF UNDERWRITING YOU WISH THE SOCIETY TO USE FOR THE PERSONS INCLUDED ON THIS APPLICATION (TICK ONE BOX ONLY):

**FULL MEDICAL DECLARATION**

If you select this option, Exeter Friendly Society will not pay benefit for the treatment of any symptoms, illnesses, injuries or conditions which were already in existence, or that arise before the date the policy commences, unless these have been fully disclosed in this application (or subsequently disclosed) and are accepted by Exeter Friendly Society. Any eligible medical conditions arising after the start of the policy will be covered immediately.

IF YOU CHOOSE THIS OPTION PLEASE ENSURE YOU COMPLETE SECTION K 'MEDICAL DECLARATION UNDERWRITING' ON PAGES 4 AND 5 OF THIS APPLICATION FORM IN FULL.

**MORATORIUM**

If you select this option, Exeter Friendly Society will not cover any medical condition for which you, or any included children, have received advice, medication, tests or treatment, or were aware of, or might reasonably have been aware of, during the five years immediately before the policy starts. However, if you, or any included children, do not experience any further symptoms or require any advice, medication, tests or treatment (from a General Practitioner or any specialist) for those conditions or any related conditions for two continuous years after the policy starts, the Society will offer cover for those conditions. This two-year period is known as the moratorium. Long-term medical conditions are never likely to be covered because each time symptoms recur, or advice, medication, tests or treatment are required, the moratorium period of two years starts again. It is therefore unlikely that there would be a two year period free of all advice, medication, tests or treatment. Any eligible medical conditions arising after the start of the policy will be covered immediately.

**We strongly advise against delay in seeking medical advice and treatment for a pre-existing condition during the moratorium period simply to obtain cover under a policy.**

IF YOU CHOOSE THIS OPTION PLEASE DISCARD SECTION K 'MEDICAL DECLARATION UNDERWRITING' ON PAGES 4 AND 5 AS YOU DO NOT NEED TO COMPLETE THIS.

Exeter Friendly Society considers the lawful and correct treatment of personal information as being important to our relationship with customers. All the information that you provide to us will be dealt with in accordance with the requirements of the Data Protection Act 1998.

By signing this form you are giving us consent to use the information you provide to set up and administer your policy. Your personal information will be treated in confidence and will only be used by the Society for the following purposes:

- The assessment and management of your medical insurance, including contacting you on an annual basis regarding the renewal of your policy and processing claims.
- Transmission to those involved in your treatment or care.
- Retaining cancelled policies and associated details indefinitely to assist us in determining future applications for insurance that you may wish to make.
- Transmission to carefully selected third parties (including the intermediary who arranged your policy, if any) as part of our administrative operations.
- Transmission to carefully selected third parties for the purpose of research, advertising, marketing or selling (for example to develop and advise you of new products).
- As may be required or permitted by law or as appropriate to detect and prevent fraud and improper claims.

Our purposes for holding, and our uses of, personal information are listed in the Register of Data Controllers. You may inspect this, or obtain a copy of the relevant entry from the Office of the Information Commissioner (and at its website: [www.informationcommissioner.gov.uk](http://www.informationcommissioner.gov.uk)).

In order to provide you with cover we will need to process sensitive information (such as medical information) about you and the others named on your application. Please get consent from the people named on your policy before sharing their sensitive information with us.

Under the terms of the Data Protection Act 1998, you may request a copy of the details we hold about you. We reserve the right to charge a fee for this service, up to the maximum allowed by the Act. If you require a copy of such information, you should write to the Compliance Director, at the address shown on the reverse of this form.

We have a responsible mailing policy, and we may wish to contact you from time to time to inform you of other products or services that we provide, or we may pass limited personal information to other carefully selected organisations whose products and services we think may be of interest to you.

If you are happy to receive such information, please tick this box

I, ON BEHALF OF ANY INCLUDED CHILDREN AND MYSELF, APPLY FOR PRIVATE MEDICAL INSURANCE COVER AND AGREE TO BE BOUND BY THE RULES OF EXETER FRIENDLY SOCIETY (THE SOCIETY) AND THE PLAN FOR WHICH I AM APPLYING.

I DECLARE THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF THE ANSWERS AND INFORMATION THAT I HAVE GIVEN ARE TRUE, ACCURATE AND COMPLETE AND THAT I HAVE NOT WITHHELD ANY INFORMATION IN REGARD TO THIS APPLICATION THAT OUGHT TO BE DISCLOSED TO THE SOCIETY. I UNDERSTAND THAT IF ANY OF THE INFORMATION PROVIDED BY ME IS INCORRECT OR INCOMPLETE, THE SOCIETY WILL BE ENTITLED TO REFUSE TO PAY MY BENEFITS AND/OR CANCEL MY POLICY.

I CONFIRM THAT MY DEMANDS AND NEEDS ARE MET BY THE COVER OPTIONS I HAVE SELECTED AS DESCRIBED AGAINST THOSE OPTIONS IN SECTION C OF THIS APPLICATION FORM

I HAVE READ AND UNDERSTAND THE BASIS ON WHICH THE SOCIETY WILL UNDERWRITE MY POLICY AS DETAILED AGAINST MY CHOSEN OPTION IN SECTION D OF THIS APPLICATION FORM.

I CONFIRM THAT I GIVE EXPLICIT CONSENT FOR THE SOCIETY TO PROCESS MY PERSONAL DATA AND THAT OF ANY INCLUDED CHILDREN IN ACCORDANCE WITH THE DATA PROTECTION NOTICE DETAILED IN SECTION E OF THIS APPLICATION FORM. I WILL INFORM ANY INCLUDED CHILD WHO IS OLD ENOUGH TO UNDERSTAND OF THIS CONSENT.

SIGNATURE OF APPLICANT: ..... DATE: .....

## G

## ADDITIONAL INFORMATION

Your occupation: \_\_\_\_\_ If retired, your previous occupation: \_\_\_\_\_

Are you changing from another insurer? \_\_\_\_\_ Yes No

If Yes, name of insurer: \_\_\_\_\_ Renewal date: / /

For security reasons, please provide answers to the following, which will be used to verify your identity when you telephone the Society:

1. Your mother's maiden name: \_\_\_\_\_

2. The name of the first school you attended: \_\_\_\_\_

## H

## PAYMENT OPTIONS

<b>MONTHLY</b>	Direct Debit (no discount available)	Complete section J	<input type="checkbox"/>
<b>ANNUALLY</b>	Direct Debit (5% discount)	Complete section J	<input type="checkbox"/>
	Credit Card (no discount available)	Complete section L	<input type="checkbox"/>
	Cheque (no discount available)	PLEASE ATTACH TO THIS FORM	<input type="checkbox"/>

Direct Debit and credit card payments will not be debited until at least 21 days after acceptance terms have been issued.

## I

## BENEFIT PAYMENT DETAILS

We will normally pay benefits directly to the hospital or specialist that treated you. However, if you need these benefits to be paid to you instead, we will usually pay them by direct credit transfer to the bank account from which we collect your premium. If you are **not** paying your premium by Direct Debit, please fill in your bank account details here:

Your name: \_\_\_\_\_ Bank name & address: \_\_\_\_\_

Bank account number: \_\_\_\_\_ Bank sort code: \_\_\_\_\_

Completed by: Name: \_\_\_\_\_

Signature: \_\_\_\_\_

## J

## INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

**Please fill in the whole form and send it complete with your application to: Exeter Friendly Society Ltd, Lakeside House, Emperor Way, Exeter, EX1 3FD**

1. Name(s) of account holder(s) \_\_\_\_\_

2. Branch Sort Code \_\_\_\_\_  
(from the top right corner of your cheque)

3. Name and full postal address of your Bank or Building Society

The Manager \_\_\_\_\_ Bank or Building Society \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

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

ORIGINATOR'S IDENTIFICATION NUMBER

9 3 0 4 2 0



4. Bank or Building Society account number \_\_\_\_\_

5. Exeter Friendly Society reference number (office use only) \_\_\_\_\_

6. Instruction to your Bank or Building Society

Please pay Exeter Friendly Society Direct Debits from the account detailed on this instruction subject to the safeguards assured by the Direct Debit Guarantee.

I understand that the Instruction may remain with Exeter Friendly Society Ltd and, if so, details will be passed electronically to my Bank/Building Society.

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_

## THE DIRECT DEBIT GUARANTEE

- 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 and Building Society.
- If the amounts to be paid or the payment dates change, Exeter Friendly Society Ltd will notify you twelve working days in advance of your account being debited or as otherwise agreed.

- If an error is made by Exeter Friendly Society Ltd or your Bank or Building Society, you are guaranteed a full 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.



**THIS GUARANTEE SHOULD BE DETACHED AND RETAINED BY THE PAYER**



Exeter Friendly Society Limited  
Lakeside House Emperor Way Exeter EX1 3FD UK  
Website: www.exeterfriendly.co.uk

Exeter Friendly Society Limited is incorporated under the Friendly Societies Act 1992, registered number 91F, registered address as above.  
Authorised and regulated by the Financial Services Authority, registered number 205309.



Telephone calls may be recorded and monitored for quality assurance and training purposes.



INVESTOR IN PEOPLE  
ECA/07/2005/web

**L CREDIT CARD PAYMENT AUTHORITY**

To Exeter Friendly Society Limited, I authorise you to charge my:

 Visa   Master Card

Credit Card Number  
□□□□□□□□□□□□□□□□

Card Expiry Date  
□□□□

With £ \_\_\_\_\_  
(As Payment Of My Initial Premium)

Card Holder's Address  
\_\_\_\_\_  
\_\_\_\_\_

Postcode  
\_\_\_\_\_

Card Holder's Name  
\_\_\_\_\_

Card Holder's Signature  
\_\_\_\_\_

Please ensure that you have fully completed this application form, signed and dated it, and that you have attached your cheque (if applicable).

Please continue on a separate sheet if necessary.

**K MEDICAL DECLARATION UNDERWRITING**

1. Is anyone included in this application currently being treated for any conditions by their GP (primary care physician)? Yes  No   
 If yes, please give details:

Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms:	/ /
What investigations were performed?		Date of diagnosis:	/ /
Current treatment:			
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Current treatment:			
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms:	/ /
What investigations were performed?		Date of diagnosis:	/ /
Current treatment:			

2. Has a GP (primary care physician) advised anyone included in this application to see a specialist, or has anyone included in this application been admitted into hospital over the past 10 years? Yes  No  If yes, please give details:

Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms:	/ /
What investigations were performed?		Date of diagnosis:	/ /
Treatment received:		Date of treatment:	/ /
Are you still receiving treatment or follow-up appointments?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms:	/ /
What investigations were performed?		Date of diagnosis:	/ /
Treatment received:		Date of treatment:	/ /
Are you still receiving treatment or follow-up appointments?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms:	/ /
What investigations were performed?		Date of diagnosis:	/ /
Treatment received:		Date of treatment:	/ /
Are you still receiving treatment or follow-up appointments?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms:	/ /
What investigations were performed?		Date of diagnosis:	/ /
Treatment received:		Date of treatment:	/ /
Are you still receiving treatment or follow-up appointments?		Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. Has anyone included in this application been to see a physiotherapist, chiropractor or other complementary therapist in the last 10 years? Yes  No  If yes, please give details:

Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms: / /
Date of diagnosis: / /		Are you still attending? Yes <input type="checkbox"/> No <input type="checkbox"/>
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms: / /
Date of diagnosis: / /		Are you still attending? Yes <input type="checkbox"/> No <input type="checkbox"/>
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms: / /
Date of diagnosis: / /		Are you still attending? Yes <input type="checkbox"/> No <input type="checkbox"/>
Applicant number:	Condition/confirmed diagnosis:	Date of first symptoms: / /
Date of diagnosis: / /		Are you still attending? Yes <input type="checkbox"/> No <input type="checkbox"/>

4. Does anyone included in this application smoke, or have they ever smoked? Yes  No  If yes, please give details:

Applicant number:	Dates: from: / / to: / /	How many per day?
Applicant number:	Dates: from: / / to: / /	How many per day?
Applicant number:	Dates: from: / / to: / /	How many per day?
Applicant number:	Dates: from: / / to: / /	How many per day?

5. Does anyone included in this application drink alcohol? Yes  No  If yes, how much?  
Please note: 1 unit = 1/2 pint beer/lager, 1 glass wine, 1 spirit measure.

Applicant number:	Amount per week: (units)
Applicant number:	Amount per week: (units)
Applicant number:	Amount per week: (units)
Applicant number:	Amount per week: (units)

6. Has anyone included in this application ever had a serious accident or injury? Yes  No  If yes, please give details:

Applicant number:	Details: Date: / /
Applicant number:	Details: Date: / /
Applicant number:	Details: Date: / /
Applicant number:	Details: Date: / /

7. Has anyone included in this application had or do they currently have any symptoms or conditions that may or may not require treatment in the future, which have not been detailed elsewhere on this application form? Yes  No   
If yes, please give details:

Applicant number:	Symptoms/condition:	Details:
Applicant number:	Symptoms/condition:	Details:
Applicant number:	Symptoms/condition:	Details:
Applicant number:	Symptoms/condition:	Details:

8. Have you attended a well man, well woman or private health check in the last 10 years? Yes  No   
If yes, please attach a copy of the report.

PLEASE NOTE: YOU MUST INFORM THE SOCIETY IMMEDIATELY IF ANY CHANGES OCCUR IN THE FACTS THAT YOU HAVE PROVIDED ON THIS APPLICATION FORM BETWEEN NOW AND THE DATE UPON WHICH YOUR POLICY STARTS.

Please continue on a separate sheet if you need more space, or if you are aware of any other medical details that you think the Society would want to know about.