

## Proposal Form

Please complete all sections of this form in BLOCK CAPITALS in black ink and return it to CS Healthcare in the pre-paid envelope provided. For assistance, please call one of our Membership Advisers on Freephone 0800 917 4325.

### 1. Applicant details If any of your details are incorrect, please amend

Title
Forename(s)
Surname

Broker/Agent name:
Proposed start date:
Enquiry No.

Address
Post code

Occupation (to qualify for membership)

Civil/Public Service  Charity/Voluntary

Privatised organisation  Relative of member

If none of the above applies, please provide details below

Name of employer/department

Applicant date of birth (dd-mm-yy)

Name of previous medical insurer (if covered)

Email address

Evening phone

Where did you hear about us?

Daytime phone

### 2. Cover required Please note all persons on the policy must be on the same level of cover and that Essential cover is compulsory. Please cross all boxes that apply.

<b>Cover options</b>	Essential <input checked="" type="checkbox"/>	Expert Diagnostic <input type="checkbox"/>	Heart & Cancer <input type="checkbox"/>	Therapy & Care <input type="checkbox"/>	
<b>Cash Benefits option</b>	Level 1 <input type="checkbox"/>	Level 2 <input type="checkbox"/>	Level 3 <input type="checkbox"/>	Level 4 <input type="checkbox"/>	
<b>Hospital band</b>	Partnership <input type="checkbox"/>	Extended <input type="checkbox"/>			
<b>Voluntary excess</b>	Nil Excess <input checked="" type="checkbox"/>	£100 <input type="checkbox"/>	£300 <input type="checkbox"/>	£500 <input type="checkbox"/>	£1000 <input type="checkbox"/>
<b>Co-payment option</b>	<input type="checkbox"/> 15% on all claims for each insured person each year up to a maximum of £1,500 for each person				

NOTE: You cannot select an excess AND a co-payment. The voluntary excess does not apply to Therapy & Care Benefits option

### 3. Spouse/Partner/Dependant details (If cover is required)

	Title	Full Name	Date of birth (dd-mm-yy)
Spouse/Partner			
Dependant 1			
Dependant 2			
Dependant 3			

If you wish to submit additional dependant information please provide details on a separate sheet.

### 4. Method of payment

Please make cheques payable to CS Healthcare OR complete the Direct Debit instruction.

If you wish to pay annually by Debit or Credit Card please call our Membership Services Team on 0800 917 4325

Monthly Direct Debit  Annual Direct Debit  Annual Cheque  Annual Debit Card  Annual Credit Card

## 5. General Practitioner (GP) Details

Name of Doctor	
Surgery address	
	Post code
Telephone	Fax

GP details of Dependant - if different from Applicant

Name of Dependant	
Name of Doctor	
Surgery address	
	Post code
Telephone	Fax

Do you or any dependants have a **private** GP?      Yes       No       If yes, please provide details on a separate sheet

## 6. Choose your underwriting method

You have a choice between two ways of applying for your health insurance – Full Medical Underwriting or the Moratorium method. Once you have read how these two options work, you will be asked to select **one** of these options. For more information, and examples of how these different underwriting methods work in practice, please refer to the Policy Summary in the **your choice** brochure.

For those considering moving their health insurance from an existing provider we recommend you complete the Full Medical Underwriting option in order for us to confirm if any pre-existing conditions will apply before you transfer to CS Healthcare.

### Option 1 - Full Medical Underwriting

This method of assessment asks you to give details of the medical history for each person to be insured. It is important that you give all the information that you are asked for even if you have not yet consulted your GP. Any disease, condition or symptoms of health which existed before the date of enrolment will not qualify for benefit unless it has been fully disclosed and accepted by us. Failure to disclose relevant information may result in non-payment of a claim and all cover under the policy being cancelled.

We will use the information provided to decide if there are any specific pre-existing conditions that are likely to need treatment in the future. We will exclude these pre-existing conditions from cover and clearly show any personal exclusions on the Registration Certificate that you will receive along with your policy documents. Personal exclusions may be reviewed at your request after 2 years of membership or earlier if indicated on your Registration Certificate. It is important to understand that some medical conditions may never be cured and they require long-term and continuous care. Any new, unexpected eligible conditions arising after the start of your membership will be covered immediately, subject to the policy rules.

**Option 1** – I/We wish to apply for cover by completing the **Full Medical Underwriting Section**

Please tick and then go to **section 7**

### Option 2 – Moratorium

We will not ask you to give details of your medical history. Instead we will not cover any medical condition (diagnosed or undiagnosed) that existed in the last five years before joining the scheme. However, provided you do not have symptoms, or receive treatment, medication, tests or advice from a GP or a Specialist) for that condition for a continuous period of two years at anytime after the policy starts, then the condition will become eligible for benefit, subject to the policy rules. This two year period is known as the Moratorium.

It is important to understand that you will probably never be covered for long-term medical conditions that are likely to need regular or periodic treatment, medication or advice. This is because each time you need such treatment the Moratorium period starts again, so it is unlikely that there would ever be two clear years during which you do not have any symptoms, treatment, advice or medication. In order to authorise treatment each time, your GP will be required to complete a claim form and a referral letter so that we can confirm if the condition is new or pre-existing. Your GP may charge you for this service. Any new, unexpected eligible conditions arising after the start of your membership will be covered immediately, subject to the policy rules.

**Option 2** – I/We wish to apply for cover by signing the **Moratorium statement & declaration**

Please tick and then go to **section 8**

**Important Notice: You should not delay getting medical advice or treatment, simply to obtain cover.**

## 7. Full Medical Underwriting

**This section must ONLY be fully completed if you select the Full Medical Underwriting as your underwriting option.**

In accordance with the policy any disease, condition, symptom of health or injury, which existed before the date of enrolment, will not qualify for benefit unless it is fully disclosed to and accepted by us. You must, therefore, ensure that each question overleaf is answered clearly and fully and that all material information, including any new disease, condition or symptom of health or any change in state of health, which arises or becomes known to you prior to the date upon which you become enrolled as a member, is given for consideration by us. Failure to disclose relevant information may result in non-payment of a claim and all cover under the policy being cancelled. **Should you require more space for your answers please continue on a separate sheet and sign and date it.**

If you are unsure whether information is material or not it must be disclosed.

## ..../7. Full Medical Underwriting - continued

### Question 1

Have you or any dependants ever suffered from an illness, disease or a condition (including congenital), symptoms or injury requiring hospital treatment, surgery or prolonged supervision by a Hospital Consultant, GP or any other health professional or therapist?

Yes  No  If the answer to this question is 'YES' for any of the applicants, please complete the following, giving full details:  
(please tick)

Applicant/dependant	Conditions/symptoms/injury	Treatment received & date	Current status

### Question 2

Have you or any dependants consulted with a health professional, including GP, Physiotherapist, Sports Therapist, Chiropractor, Osteopath, Homeopath, Dentist or Optician in the last five years for anything? (Please do not list routine dental or eye checks unless there was specific treatment required)

Yes  No  If the answer to this question is 'YES' for any of the applicants, please complete the following, giving full details:  
(please tick)

Applicant/dependant	Conditions/symptoms/injury	Treatment received & date	Current status

### Question 3

Have you or any dependants ever had tests, investigations or health screening from which you have had an abnormal result for which you were advised or required to have medical treatment or further investigation?

Yes  No  If the answer to this question is 'YES' for any of the applicants, please complete the following, giving full details:  
(please tick)

Applicant/dependant	Conditions/symptoms/injury	Treatment received & date	Current status

### Question 4

Do you or any dependants have a hospital/doctor's appointment or therapy booked, or are you on a waiting list awaiting investigations or surgery, or intend to have treatment or therapy for a condition of any sort, or are you suffering from symptoms of any sort?

Yes  No  If the answer to this question is 'YES' for any of the applicants, please complete the following, giving full details:  
(please tick)

Applicant/dependant	Conditions/symptoms/injury	Treatment received & date	Current status

## ..../7. Full Medical Underwriting - continued

### Question 5

Are you or any dependants currently using any medication, or have a prescription for tablets, inhalers, injections, ointments or creams?

Yes  No  If the answer to this question is 'YES' for any of the applicants, please complete the following, giving full details:  
(please tick)

Applicant/dependant	Conditions/symptoms/injury	Treatment received & date	Current status

If you wish to submit additional information, please provide details on a separate sheet.

### Declaration I apply for membership, along with any dependants listed in Section 3

- I declare that the answers and information given by me in this Proposal Form are true and complete and that I have not withheld any material information that should be disclosed to CS Healthcare.
- I have received the Policy Summary and recognise that if my application is accepted I will receive all documentation about my cover, including the Policy Document and Memorandum of Association and Rules.
- I understand a copy of the Policy Document and Memorandum of Association and Rules are available in advance on request.
- If, for any reason, I wish to cancel my cover I can do so without obligation, provided that I write to CS Healthcare no later than 15 days after receiving my policy documents when I first join the Society. If I do a full refund will be made provided that no claims for benefit have been submitted against the policy.
- I agree to inform CS Healthcare of any condition, illness, symptom or injuries that may occur between completing this form and the start of my policy.
- I agree that this declaration, and the answers given on this Proposal Form shall form the basis of the contract between me and CS Healthcare. A copy of this Proposal Form is available on request.
- I confirm that I give explicit consent for CS Healthcare to process personal information provided in this Proposal Form and any separate sheet, relating to myself and any dependants to be included in the enrolment, in the manner described under section 9 Data Protection.

Signature of applicant

Date dd-mm-yy   -   -

## 8. Moratorium

**This section must ONLY be fully completed if you select Moratorium as your underwriting option.**

Please read and sign the following declaration if you choose to be underwritten by our Moratorium option. CS Healthcare will not cover any condition or symptom for which you, or any eligible dependants, have received advice, medication, tests or treatment, or was aware of, or might reasonably have been aware of during the five years immediately before the commencement of cover. However, provided you, or any eligible dependants, do not have symptoms, or receive treatment, medication, tests or advice (from a GP or a Specialist) for that condition for a continuous period of two years at anytime after the policy starts, then the condition will become eligible for benefit, subject to the policy rules. This two year period is known as the Moratorium. In order to authorise treatment each time, your GP will be required to complete a claim form and a referral letter so that we can confirm if the condition is new or pre-existing. This will continue for all new conditions for the duration of the policy. Your GP may charge you for this service.

## ..../8. Moratorium - continued

### Declaration I apply for membership, along with any dependants listed in Section 3

- I declare that the answers and information given by me in this Proposal Form are true and complete and that I have not withheld any material information that should be disclosed to CS Healthcare.
- I have received the Policy Summary and recognise that if my application is accepted I will receive full documentation about my cover, including the Policy Document and Memorandum of Association and Rules.
- I understand a copy of the Policy Document and Memorandum of Association and Rules are available in advance on request.
- If, for any reason, I wish to cancel my cover I can do so without obligation, provided that I write to CS Healthcare no later than 15 days after receiving my policy documents when I first join the Society. If so, a full refund will be made provided that no claims for benefit have been submitted against the policy.
- I understand that by selecting the Moratorium option a GP will be required to complete a claim form along with a referral letter before any medical treatment or advice under the policy can be authorised.
- I agree that this declaration, and the answers given on this Proposal Form, shall form the basis of the contract between me and CS Healthcare. A copy of this Proposal Form is available on request.
- I confirm that I give explicit consent for CS Healthcare to process personal information provided in this Proposal Form and any separate sheet, relating to myself and any dependants to be included in the enrolment, in the manner described under section 9 Data Protection.

Signature of applicant

Date dd-mm-yy   -   -

## 9. Data Protection

### Consent:

In becoming the main policyholder you have sought and agreed to act on behalf of any other person included within the policy. As such all membership documents and confirmation of cover we have dealt with any claim/s under the policy will be sent to you.

### How we may use your personal information

- Medical information or records will only be disclosed to those involved with your treatment or care, including your GP, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents.
- CS Healthcare sometimes uses third parties to process data on its behalf (if you would like further information as to these third parties please write to the Data Protection Officer).
- To aid CS Healthcare in the detection and prevention of fraudulent claims we may disclose personal information about you to fraud prevention agencies that in turn may record, use and distribute this personal information to other organisations. In addition we work collectively with other organisations to share information relating to fraudulent / suspicious claims. If you would like further information as to these third parties please write to the Data Protection Officer.
- CS Healthcare would like to keep you informed by telephone, post or email of future products, services and special offers available from us. If you don't wish us to do so, please tick here
- CS Healthcare would like to keep you informed by telephone, post or email of selected products, services and special offers available from carefully selected third parties. We may also share your information with other carefully selected third parties for business analysis and market research purposes. If you don't wish us to do so, please tick here
- Under the terms of the Data Protection Act 1998 you are entitled to request a copy of the information we hold about you. We reserve the right to charge an administrative fee for supplying this service up to the maximum that the Data Protection Act 1998 permits. If you would like to make a request to receive a copy of such information please write to the Data Protection Officer.
- For all data protection queries please write to the Data Protection Officer at Civil Service Healthcare Society Limited, Princess House, Horace Road, Kingston upon Thames, Surrey, KT1 2SL.

### Telephone calls:

In the interest of continuously improving our service to members, your call will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

## 10. Access to Medical Reports Act (1988)

As well as receiving the health questionnaire, sometimes we need to get a medical report from a doctor who has cared for you before we can make a decision on your application. To avoid delay, it helps to have your permission in advance. The Access to Medical Reports Act 1988 gives you certain legal rights which are:

- We need your agreement before we can apply for a medical report from your doctor. You can refuse but if you do we will not be able to assess your application.
- You can ask to see the report before your doctor sends it to us, or for up to 6 months after. If you wish to see the report, please tick the box on the declaration below to indicate you want to see the report. This may delay the assessment of your application and your doctor can charge you a fee to cover costs.
- If you think a part of the report is incorrect or misleading when you see it, you can ask your doctor to have it changed.
- If your doctor will not agree to do this, you may wish to attach a statement of your own.

### You will not be entitled to see any part of the report which:

- The doctor believes could seriously harm your physical or mental health, or that of others
- Indicates the doctor's intentions in respect of you
- Reveals information about another person, or the identity of someone who has given the doctor information about you (unless that person consents or is a health professional involved in caring for you)

We will write to you when we request the report. If you've asked to see the report before your doctor sends it to us, you will have 21 days from the receipt of our letter to contact your doctor. Once you have seen the report, your doctor needs your agreement to send it to us. If you don't arrange to see the report within 21 days, your doctor will be free to send it to us.

### Medical Report Declaration

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 and in connection to my health insurance application I hereby consent to CS Healthcare being provided with medical information from any doctor who at any time has attended me concerning any matter which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original. I consent CS Healthcare seeking medical information in respect of myself from my GP or any other doctor/specialist who has attended me.

I do not wish to see the report before it is sent to CS Healthcare  (Please tick one of the boxes)

I wish to see the report before it is sent to CS Healthcare

Applicant's name

Date dd-mm-yy   -   -   Signature

Spouse/Partner's name

Date dd-mm-yy   -   -   Signature

1st dependant's name

Date dd-mm-yy   -   -   \*Signature

2nd dependant's name

Date dd-mm-yy   -   -   \*Signature

3rd dependant's name

Date dd-mm-yy   -   -   \*Signature

\* For children aged 16 or under, a parent/guardian's signature is required

