

## Switch Proposal Form

Please complete this form using BLOCK CAPITALS and return to CS Healthcare in the pre-paid envelope provided. For assistance, please call our Membership Services Team on 0800 917 4325.

### 1. Applicant details

Title: \_\_\_\_\_ Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Post Code: \_\_\_\_\_

Daytime telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Proposed start date: \_\_\_\_\_ **Occupation (to qualify for membership):**

Name of employer/department: \_\_\_\_\_ Civil/Public Service  Other

Name of previous health insurer: \_\_\_\_\_ Privatised organisation  Relative of member

How did you hear about CS Healthcare? \_\_\_\_\_

### 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 tick all boxes that apply.

<b>Cover options:</b>	Essential <input checked="" type="checkbox"/>	Expert Diagnostics <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"/>	Enhanced <input type="checkbox"/>		
<b>Voluntary excess:</b>	Nil excess <input type="checkbox"/>	£100 <input type="checkbox"/>	£300 <input type="checkbox"/>	£500 <input type="checkbox"/>
<b>Co-payment option:</b>	<input type="checkbox"/> You pay 15% on all approved claims for each insured person each year up to a maximum of £1500 for each person			
<b>NOTE: You cannot select an excess AND a co-payment. The voluntary excess and co-payment options do not apply to Therapy &amp; Care or Cash Benefits option.</b>				

### 3. Spouse/Partner/Dependant details (if covered is required)

Spouse/Partner Title: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Dependant 1 Title: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Dependant 2 Title: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Dependant 3 Title: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

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 in advance 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/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: \_\_\_\_\_

## 6. Choose your underwriting method

If you are switching from an existing health insurance policy or have left a company paid scheme within the last two months you have a choice between two ways of applying for your CS Healthcare health insurance – Continued Personal Medical Exclusions and Continued Moratorium. For more information, and examples of how these different underwriting methods work in practice, please call our Membership Services Team on Freephone 0800 917 4325.

### Continued Personal Medical Exclusions (CPME)

CPME is a method of underwriting where CS Healthcare may continue any personal medical exclusions applied by your previous insurer. This method is designed so that members may not suffer any worse terms from switching insurers. Any disease, condition or symptoms of health which have arisen during your time with your previous insurer will be assessed to decide if there are any specific pre-existing conditions that are likely to need treatment in the future. You may exclude these conditions from cover and clearly show any personal exclusions on the Registration Certificate 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 reviewed if 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.

### Continued Moratorium (CM)

This option is designed to continue the date the original Moratorium period became effective provided no symptoms have occurred or that no treatment, medication or advice has been received during this period.

Please be aware that Continued Moratorium is subject to our underwriting rules therefore any pre-existing conditions that occurred during the last five years prior to the original moratorium start date will be excluded from cover for that condition for a continuous period of two years. After this period the condition will become eligible for benefit subject to the policy rules.

In order to authorise treatment each time, your GP will be required to complete a claim form and 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 CS Healthcare membership will be covered immediately, subject to policy rules.

In order for CS Healthcare to assess as to whether you are able to Switch with no change to your previously insured underwriting terms, you need to answer a series of questions about each of the persons to be insured. Failure to disclose relevant information may result in non-payment of a claim and all cover being cancelled.

**If you require more space for your answers, please continue on a separate sheet and sign and date it.**

### Question 1.

Do you currently hold private medical insurance, or have you left a company private medical insurance plan within the last two months? (Please tick)

Yes  No

If the answer is 'NO' you do not qualify for CPME, please contact our Membership Advisers on Freephone 0800 917 4325  
If the answer to this question is 'YES' please proceed to question 2.

### Question 2.

What Method of Underwriting do you currently have? (Please tick)

**Continued Personal Medical Exclusions (CPME)**

If the answer is CPME please complete the following, by giving full details of any existing exclusions detailed on your current policy. Please refer to your existing certificate of insurance to ensure accuracy. A copy of this certificate will need to be sent with this form. Then complete questions 3 - 6 and proceed to the declaration section for CPME (Section 6a).

Applicant/dependant name	Excluded condition/illness

**Continued Moratorium (CM)**

If the answer is CM please state your original Moratorium dates for those to be insured. Please refer to your existing certificate of insurance to ensure accuracy. A copy of this certificate will need to be sent with this form. Then complete questions 3 - 6 and proceed to the declaration section for CM (Section 6b).

Applicant/dependant name	Original date that Moratorium period begins

### Question 3.

- Have you or any dependants within the last three months had a hospital or doctor's appointment or a therapy of any kind?
- Are you or any dependants awaiting investigations or surgery, or intend to have treatment or therapy for a condition/symptom of any sort in the near future?
- Have you been previously diagnosed with or have a symptom or condition for which you may need treatment in the future?
- Are you or any dependants receiving regular medication or under GP supervision? (Please tick)

Yes  No

If the answer is 'NO' please proceed to question 4.  
If the answer to this question is 'YES' for any of the applicants, please complete the following table, giving full details.

Applicant/dependant	Condition/symptoms/injury	Date & time	Current Status

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### Question 4

Have you or any dependants made any health insurance claims or undertaken any NHS Treatment in the last five years? (Please tick)

Yes  No

If the answer to this question is 'YES' please proceed to question 5.  
If the answer to this question is 'NO' please proceed to question 6a or 6b.

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### Question 5

Was/is the claim or treatment related to heart, orthopaedic conditions including joint replacement, neurological conditions or cancer? (Please tick)

Yes  No

If the answer to this question is 'NO' please proceed to question 6a or 6b.  
If the answer is 'YES' you may still qualify subject to completing the table below and submitting a copy of your discharge letter. Then proceed to question 6.

Applicant/dependant	Condition/symptoms/injury	Date & time	Current status

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### Question 6

What treatment did you receive and do you have any related conditions or expect to have more treatment of any sort in the future. **Please provide details of the conditions/treatment procedure below:**

Applicant/dependant	Treatment Received	Treatment received at	Date

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### 6a. Declaration for Continued Personal Medical Exclusions (CPME)

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Please read the following **declaration section for CPME** carefully before signing:

**I apply for membership, along with any dependants listed above**

- I confirm that my current private medical insurance/the company scheme I left within the last 2 months, is U.K. based.
- I declare that the answers and information given by me in this Intermediary Switch Proposal Form are true and complete and that I have not withheld any material information that should be disclosed to CS Healthcare.
- I enclose a copy of my current certificate of insurance showing details of any personal exclusions.
- I understand that without sending in my current certificate of insurance showing details of personal exclusions CS Healthcare will be unable to validate my cover.
- I have received the Policy Summary and recognise that I will receive full documentation about my cover when accepted, 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 agree to inform CS Healthcare of any condition, illness, symptoms 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 form, shall form the basis of the contract between me and CS Healthcare. A copy of this form is available on request.
- I confirm that I give explicit consent for CS Healthcare to process personal information provided in this form and any separate sheet, relating to myself and any dependants to be included in the enrolment, in the manner described under Section 7 "Data Protection" in accordance with the Data Protection Act 1998.

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

Date: \_\_\_\_\_

## 6b. Declaration for Continued Moratorium (CM)

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Please read the following **declaration section for Continued Moratorium** carefully before signing:

### I apply for membership, along with any dependants listed above

- I confirm that I left my current private medical insurance/the company scheme within the last 2 months and that it was a UK based scheme.
- I declare that the answers and information given by me in this Intermediary Switch Proposal Form are true and complete and that I have not withheld any material information that should be disclosed to CS Healthcare.
- I enclose a copy of my current certificate of insurance showing details of the original Moratorium start date.
- I understand that without sending in my current certificate of insurance showing details of the original Moratorium start date CS Healthcare will be unable to validate my cover.
- 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 Continued 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 form, shall form the basis of the contract between me and CS Healthcare. A copy of this form is available on request.
- I confirm that I give explicit consent for CS Healthcare to process personal information provided in this form and any separate sheet, relating to myself and any dependants to be included in the enrolment, in the manner described under section 7 "Data Protection" in accordance with the Data Protection Act 1998.

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

Date: \_\_\_\_\_

## 7. Data Protection

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### Consent:

**In becoming the main applicant 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 how we have dealt with any claim/s under the policy sent will be to you.**

### How we may use your personal information:

- 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 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.
- Medical information or records will only be disclosed to those involved with your treatment or care, including your GP, companies or intermediaries, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses.
- CS Healthcare would like to keep you informed by telephone, post or email of selected 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

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

**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/claim. 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/claim.
- 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 might delay the assessment of your application/claim and your doctor may charge you a fee.
- 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 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 in 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 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.

(Please tick one of the boxes)

**I do not wish to see the report before it is sent to CS Healthcare**

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

**Applicant's name:** \_\_\_\_\_

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

**Spouse/Partner's name:** \_\_\_\_\_

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

**1<sup>st</sup> Dependant's name:** \_\_\_\_\_

\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**2<sup>nd</sup> Dependant's name:** \_\_\_\_\_

\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**3<sup>rd</sup> Dependant's name:** \_\_\_\_\_

\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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