

# Explorer Health Plan

Individual health cover



## For new customers wishing to apply for a policy

Please use this form to tell us about your medical history and the medical history of anyone else you want to add to your cover (dependant). We need this information to confirm your cover, process future claims and pay for treatment.

As the policy you are applying for is a fully medical underwritten, any symptoms or medical conditions that you or any of your dependants had before the start date may not be covered.

You must tell us if you or any dependant to be covered under the policy experience any symptoms between the time you complete this application form and when the policy is issued. This may be different from the requested policy start date on this form. If you do not provide this information you (and your dependants') cover may be affected.

Please provide complete and accurate information. Without it, we may be unable to pay all or part of a claim or need to treat your (and your dependants') policy as if it had not existed.

Start at section 2 and complete all sections after that. Once completed you can send your application to your intermediary, by email directly to us at [advice@bupa-intl.com](mailto:advice@bupa-intl.com) or by post to: Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY United Kingdom.

Please ask your intermediary to complete section 14, if you have one.

## For existing customers wishing to make a change to their policy

Please use this form to make changes to your policy.

**To add dependants:** complete sections

1 3 4 5 6 7 8 12 13

**To change your cover:** complete sections

1 6 7 8 13

**To include US cover:** complete sections

1 11 13

**To change your address or contact details:**

Log into our secure website: <https://membersworld.bupaglobal.com>

Email us: [info@bupaglobal.com](mailto:info@bupaglobal.com)

Call us: [+44 \(0\) 1273 323563](tel:+441273323563)

Remember to quote your membership number when you get in touch with us.

Once completed you can send your application to your intermediary, by email directly to us at [customerengagement@bupa.com](mailto:customerengagement@bupa.com) or by post to: Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY United Kingdom.

Please ask your intermediary to complete section 14, if you have one.

## How to complete this form – all new and existing customers

You can type directly into this form, save it and email it to us. Or please complete it writing clearly in block capitals using black ink.

If you need more space to answer any of the questions, you can use the notes page at the end.

Remember to sign and date the form and check you've completed all relevant sections fully before you return it to us.

Email is not always a secure method of communication. Please bear this in mind when sending us personal or confidential information.

**If you have any questions, please call us on +44 (0) 1273 323563 and we'll be happy to help.**

## 1

## Your personal details – to be completed by existing customers only

Main applicant's membership number	BI	-		-											
Title				Male	<input type="radio"/>	Female	<input type="radio"/>	Date of birth	D	D	M	M	Y	Y	Y
First name															
Family name															
Address															
Town/city															
County/region															
Postal, zip or area code				Country											
Phone/mobile (include country/area code)															
Email															

**Need to know:** Any changes you request on this form will be effective from the date we receive your completed form, unless you provide a date below.

When would you like the change you are requesting to be effective from (this cannot be on or between the 28th and 31st of any month)?	D	D	M	M	Y	Y	Y	Y
--	---	---	---	---	---	---	---	---

## 2

## Your personal details – to be completed by new customers only

## Your personal details

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	Date of birth	D	D	M	M	Y	Y	Y	
First name		Middle name												
Family name														
Nationality				Language										

## Your contact details

Phone/mobile (include country/area code)														
Email														

## Residency address (your permanent or usual address in the country where you are a resident, on the day you would like the policy to start)

Address														
Town/city														
County/region														
Postal, zip or area code				Country										
If you have previously had a policy with Bupa, please provide the membership number														

2

**Your personal details - to be completed by new customers only (continued)**

**Correspondence address** (if your correspondence and residency address are the same please tick here  )

Address																				
Town/city																				
County/region																				
Postal, zip or area code															Country					

Your cover will start on the date we receive your completed application form unless you specify a date in the future.

The date you want your cover to start (cannot be between 28th & 31st of any month)

3

## **Dependants to be covered on your policy – to be completed by existing and new customers**

If any of these dependants have different residency or correspondence addresses to yours, please write their names and addresses on the notes section at the end of this form, and confirm you've done this by ticking here  If not, we understand that they have the same address as you.

## Dependant 1

Title								Male	<input type="radio"/>	Female	<input type="radio"/>	Date of birth						
First name								Middle name										
Family name																		
Nationality								Country of residency										
Language								Relationship to you										
Phone/mobile (include country/area code)																		
Email																		
If they have had a Bupa policy before, please provide the policy number																		

## Dependant 2

Title								Male	<input type="radio"/>	Female	<input type="radio"/>	Date of birth																
First name								Middle name																				
Family name																												
Nationality								Country of residency																				
Language								Relationship to you																				
Phone/mobile (include country/area code)																												
Email																												
If they have had a Bupa policy before, please provide the policy number																												

## 3

## Dependants to be covered on your policy - to be completed by existing and new customers

(continued)

## Dependant 3

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	Date of birth	D	D	M	M	Y	Y	Y	Y
First name					Middle name									
Family name														
Nationality					Country of residency									
Language					Relationship to you									
Phone/mobile (include country/area code)														
Email														
If they have had a Bupa policy before, please provide the policy number														

## Dependant 4

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	Date of birth	D	D	M	M	Y	Y	Y	Y
First name					Middle name									
Family name														
Nationality					Country of residency									
Language					Relationship to you									
Phone/mobile (include country/area code)														
Email														
If they have had a Bupa policy before, please provide the policy number														

## 4

## How you'd like to manage your policy - to be completed by existing and new customers

We are working hard to reduce our impact on the environment, and we encourage our customers to help us by managing their plan online.

**Please let us know how you would like to receive your and your dependants' (over 16 years old) policy documents.**

	Main applicant	Dependant 1	Dependant 2	Dependant 3	Dependant 4
To view and manage your policy online, register at <a href="https://membersworld.bupaglobal.com">https://membersworld.bupaglobal.com</a> . We will email you when new documents are available to view	<input type="radio"/>				
To receive your documents by post	<input type="radio"/>				

## 5

## Additional information - to be completed by existing and new customers

Fill in this section only if any of the below specific requirements are applicable to you or to your dependants. Otherwise, you can leave it blank.

To help us support you and your dependants' needs, please let us know if you have any specific requirements that affect how we communicate with you and your dependants in relation to your policy with us. We will add a confidential note in our system, so we know about this whenever you contact us.'

	Main applicant	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Low digital skills	<input type="radio"/>				
Low English skills	<input type="radio"/>				
Low literacy skills	<input type="radio"/>				
Low numeracy skills	<input type="radio"/>				
Low knowledge of financial matters	<input type="radio"/>				
Dementia	<input type="radio"/>				
Physical disability	<input type="radio"/>				
Hearing impairment	<input type="radio"/>				
Speech impairment	<input type="radio"/>				
Visual impairment	<input type="radio"/>				

## 6

## Medical history - to be completed by existing and new customers

This section asks for health and medical details, past and present about yourself and each dependant named in section 3. If you are an existing customer upgrading your cover you must complete this section in full so that we have an up to date record of your (and your dependants') health. Please tick yes or no to every question for every person. If you tick yes to a question, please give full details in section 7.

**If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.**

You must also tell us immediately if you or any dependants experience any symptoms between the time you complete this application form and the date the policy is issued. Failure to do so may also result in termination, rejection of claims and/or changes to the terms and conditions of your policy.

	Main applicant	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. Circulatory disorders e.g. high blood pressure, high cholesterol, chest pains, aneurysms, varicose veins or deep vein thrombosis	<input type="radio"/> <input type="radio"/>				
2. Endocrine (glandular) disorders e.g. diabetes (Type 1 or Type 2), thyroid problems, Addison's disease or obesity	<input type="radio"/> <input type="radio"/>				
3. Breathing or respiratory disorders e.g. shortness of breath, asthma, chronic obstructive pulmonary disease, chest infections, pneumonia, bronchitis, tuberculosis, emphysema, sleep apnoea or allergies (including hayfever and anaphylaxis)	<input type="radio"/> <input type="radio"/>				
4. Stomach, intestines, liver or gall bladder problems e.g. stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias	<input type="radio"/> <input type="radio"/>				
5. Benign tumours, growths or pre-cancerous conditions e.g. polyps, benign growths, non-cystic breast lump, fibrocystic breast disease or lipomas 6. Skin problems e.g. eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic conditions	<input type="radio"/> <input type="radio"/>				

6. Skin problems e.g. eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic conditions	Y N	Y N	Y N	Y N	Y N
7. Brain or nervous system disorders e.g. dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles), Parkinson's disease, motor neurone disease, cerebral palsy, encephalitis or meningitis	Y N	Y N	Y N	Y N	Y N
8. Muscle or skeletal problems e.g. arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, fractures, osteoporosis, gout or inflammatory conditions	Y N	Y N	Y N	Y N	Y N
9a. Female urinary or reproductive system problems e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, incontinence, ovarian cysts, polycystic ovaries, pelvic inflammation, cervical disease, endometriosis, dysmenorrhoea, irregular menstruation, fibroids, breast disease or infertility	Y N	Y N	Y N	Y N	Y N
9b. Male urinary or reproductive system problems e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, benign prostate hypertrophy, enlarged prostate or infertility	Y N	Y N	Y N	Y N	Y N
10. Blood/infective/immune disorders e.g. abnormal blood tests, anaemia, hepatitis, HIV, malaria or any autoimmune disorder	Y N	Y N	Y N	Y N	Y N
11. Eye, ear, nose and throat problems e.g. cataracts, glaucoma, visual impairment, detached retina, macular degeneration, deafness, ear infections, glue ear, deviated nasal septum, tonsillitis or gingivitis	Y N	Y N	Y N	Y N	Y N
12. Mental health disorders e.g. schizophrenia, bipolar, compulsive or eating disorders, depression, stress, anxiety or drug/alcohol dependency, panic attacks, paranoia or ADHD	Y N	Y N	Y N	Y N	Y N
13. Congenital/Hereditary conditions e.g. Downs syndrome, spina bifida, cystic fibrosis, cerebral palsy, cleft lip or cleft palate, sickle cell anemia, Huntington's disease, thalassemias or hemochromatosis	Y N	Y N	Y N	Y N	Y N
14. Is anyone to be covered taking any medication, prescribed or otherwise?	Y N	Y N	Y N	Y N	Y N
15. Has anyone to be covered ever had a history of the following:					
o Cancer	Y N	Y N	Y N	Y N	Y N
o Heart condition e.g. angina, heart attack, heart failure, abnormal heartbeat	Y N	Y N	Y N	Y N	Y N
o Stroke	Y N	Y N	Y N	Y N	Y N
o Prosthetic implants and appliances in his/her body e.g. shunts, pacemakers, joint replacements	Y N	Y N	Y N	Y N	Y N
16. Is anyone to be covered receiving any treatment of any kind or require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in questions 1 - 13?	Y N	Y N	Y N	Y N	Y N
17. In the last 3 months has anyone to be covered experienced any signs or symptoms of any medical problem, illness, or injury not yet diagnosed or treated?	Y N	Y N	Y N	Y N	Y N

## Further details (for over 16s only):

How tall are you?	<input type="radio"/> feet/inches	<input type="radio"/> metres/centimetres					
How much do you weigh?	<input type="radio"/> stones/pounds	<input type="radio"/> kilograms					

This section applies if any applicant has indicated yes to any medical questions in section 6. If you are unsure whether any details are relevant, you must include them.

Please attach medical reports or test results relating to the medical conditions you have declared if these are available.

Is additional medical information included?	<input checked="" type="radio"/> Y <input type="radio"/> N
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	The relevant question number from section 6	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (e.g. right leg, left eye).	When were symptoms first experienced and when was treatment completed (if applicable)?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?
Main applicant					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

If there is insufficient space, please use the notes page at the end of this form, and indicate that you have done so by ticking here

Please choose the cover that you wish to purchase. If you have any questions or queries please contact your sales advisor or intermediary

	Choose Area of cover	Choose Deductible	Choose Dental & Optical
Explorer Essential Plus	<input type="radio"/> Africa Plus <input type="radio"/> Africa Plus including Europe <input type="radio"/> Worldwide excluding the U.S. <input type="radio"/> Worldwide	<input type="radio"/> \$0 / £0 / € 0 <input type="radio"/> \$200 / £120 / € 160 <input type="radio"/> \$500 / £290 / €400 <input type="radio"/> \$1,000 / £590 / € 800	<input type="radio"/>
Explorer Gold	<input type="radio"/> Africa Plus <input type="radio"/> Africa Plus including Europe <input type="radio"/> Worldwide excluding the U.S. <input type="radio"/> Worldwide	<input type="radio"/> \$0 / £0 / € 0 <input type="radio"/> \$200 / £120 / € 160 <input type="radio"/> \$500 / £290 / €400 <input type="radio"/> \$1,000 / £590 / € 800	<input type="radio"/>

## Your payment details – to be completed by new customers

(Contact your Bupa Global representative if payment is to be made by a third party)

Which currency would you like to use to pay for the policy? (please tick one)

GBP £

USD \$

EUR €

How often would you like to make premium payments?

Monthly

Quarterly

Annually

### Payment method

You can pay for your policy by direct debit, credit card, cheque or bankers draft. We're unable to accept cash payments.

**Need to know:** If you have chosen a deductible, co-insurance and/or to pay your premium each month, you must pay by direct debit or credit card.

Please make sure that we always have a valid direct debit agreement or card payment authority. If we don't, it may take us longer to pay claims.

Please choose how you'd like to pay for your policy:

By credit card - now complete the **card payment authority section** below

By direct debit through a UK bank (GBP £ payments only) - now complete the **direct debit section** on the next page

By cheque or bankers draft in the currency you have indicated above. Fill in the name of the person paying the premiums in the box provided below and then go to **section 9**. If the named person is not the policy holder they will be subject to Bupa's KYC (Know Your Customer) checks.

Name

### Card payment authority

Visa and Mastercard require Bupa Global to obtain your consent to store your credit card information for future use. This is so that we can take payments from you as agreed in your international private medical insurance contract, such as premiums, deductibles and/or co-insurances. Please refer to your policy documents for details of when payments will be taken and the amounts.

We will also request your consent to store your credit card information if you are using an American Express card.

Your card will remain stored against your policy for transactional purposes until the card expires. For legal and regulatory purposes, we will continue to store records of your transactions in accordance with our Privacy Notice.

If you do not want Bupa Global to store your card details, then we cannot accept payments from your card and you will need to choose a different payment method.

I authorise Bupa Global to charge to my card account when payments become due. I will advise you immediately if the card becomes lost, stolen or if I wish to close my bank account or cancel the card payment authority.

I give my consent to Bupa Global to store my below card details on file and use them to process payments.

Please tick

MasterCard

Visa

American Express

Please note that we do not accept Maestro payments. You will be given 14 days' notice of other unspecified amounts to be collected.

Cardholder's name as it appears on the card

Card number

Valid from date  /  Expiry/end date  /

**Cardholder's signature**

**Date of signature**

**Cardholder address**

Address

Town/city

County/region

Postal/zip/area code  Country

**Direct Debit**

**If you are paying by Direct Debit you must complete this section**

**Instruction to your Bank or Building Society to pay by Direct Debit**

**- for GBP £ payments only**

**- this must come out of a UK bank account**



Name(s) of account holder(s)																															
Sort code			-			-																									
Swift code																															

**Instruction to your Bank or Building Society**

Please pay Bupa Global 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 Bupa Global and, if so, details will be passed electronically to my Bank/Building Society.

**Name and full postal address of your Bank/Building Society:**

To: The Manager																																				
Address																																				
																														Postcode						
<b>Account holder's signature</b>																			<b>Date of signature</b>																	
	D	D	M	M	Y	Y	Y	Y																												

**Membership number (for Bupa Global use only)**

BI	-					-																								Originator's ID number	9	8	0	9	3	9
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Banks and Building Societies may not accept Direct Debit Instructions for some type of accounts.

Do you have a current medical insurance policy?	<input checked="" type="radio"/> Y	<input type="radio"/> N
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If yes, please provide the following information (refer to the policy documents issued by the insurer as required)

Name of Insurer																													
Plan name																													
Policy number																													
Current/ongoing	<input type="radio"/>	Renewal date of the plan	D	D	M	M	Y	Y	Y	Y																			
Expired	<input type="radio"/>	Cover expiry date	D	D	M	M	Y	Y	Y	Y																			

**The Direct Debit Guarantee**

This guarantee should be detached and retained by the payer



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, Bupa Global will notify you 7 working days in advance of your account being debited or as otherwise agreed.

If an error is made by Bupa Global 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.

## Upgrade cover to include U.S. cover once the policy has started – to be completed by existing customers

**Need to know:** Cover can only be provided if you or your dependents are not permanent residents of the U.S. You can find more information in your Membership Guide.

If you are completing this form to upgrade to U.S. cover after your policy has started, you should complete this section instead of sections 6 Medical history and 7 additional information. Medical underwriting will be undertaken at the point of application to upgrade cover to include U.S. Exclusions may be applied to U.S. cover.

Main applicant	Dependant 1	Dependant 2	Dependant 3	Dependant 4
<input type="checkbox"/>				
<input checked="" type="checkbox"/> <input type="checkbox"/>				
<input checked="" type="checkbox"/> <input type="checkbox"/>				

1. How long do you plan to stay in the U.S.?

2. Do you have any ongoing or planned treatment?

If yes, please provide details below

 

3. Females only: Are you currently pregnant?

 

## Privacy notice

**Last updated:** May 2023

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you and how we use and protect it. It also provides information about your rights. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details in our full privacy notice available at: [www.bupaglobal.com/privacypolicy](http://www.bupaglobal.com/privacypolicy). If you do not have access to the internet and would like a paper copy of the full privacy notice, or if you have any questions about how we handle your information, please contact the Bupa Global service team on +44 (0) 1273 323 563. Alternatively, you can email or write to the team via [info@bupaglobal.com](mailto:info@bupaglobal.com) or Bupa Global, Victory House, Trafalgar Place, Brighton BN1 4FY, United Kingdom.

### Information about Bupa Global

In this privacy notice, “we” “us” and “our” means the Bupa companies trading as Bupa Global. For details of these companies visit [www.bupaglobal.com/legal-notices](http://www.bupaglobal.com/legal-notices)

The Bupa companies that process your information will depend on which of our products and services you ask us about, buy or use. For our insurance policies, your information will be processed by the insurer and the lead administrator of your policy who may share it with other Bupa companies as set out in the ‘Sharing your information section’. Please refer to your policy documentation for confirmation of the insurer and lead administrator.

### 1. What this privacy notice covers

This privacy notice applies to anyone who interacts with us about our products and services (“you”, “your”), in any way (for example email, website, phone, app and so on).

### 2. How we collect personal information

We collect personal information from you and from other organisations (for example those acting on your behalf, like brokers, healthcare providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

### 3. Categories of personal information

We process the following categories of personal information about you and, if it applies, your dependants. This is standard personal information (for example information we use to contact you, identify you or manage our relationship with you), special categories of information (for example health information, information about race, ethnic origin and religion that allows us to tailor your care), and information about any criminal convictions and offences (we may get this information when carrying out anti-fraud or anti-money-laundering checks or other background screening activity).

### 4. What we use personal information for and our legal reasons for doing so

We process your personal information for the purposes set out in our full privacy notice, including to deal with our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and to protect our rights, property, or safety, or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process.

We normally process standard personal information on the basis that it is necessary so we can perform a contract, for our or others’ legitimate interests or it is needed or allowed by law. We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice. We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.

### 5. Marketing and preferences

We would, on occasion, like to keep you informed of our products and services which we consider may be of interest to you.

Please tick if you would like us and other members of the Bupa group to keep you updated about our products and services by post, telephone email and text.

You will be able to opt out of receiving these communications at any time by contacting us.

### 6. Profiling and automated decision making

Like many businesses, we sometimes use automation to provide you with a quicker, better, more consistent and fair service, as well as with marketing information we think will interest you (including discounts on our products and services). This may involve evaluating information about you and, in limited cases, using technology to provide you with automatic responses or decisions. You can read more about this in our full privacy notice. You have the right to object to direct marketing and profiling relating to direct marketing. You may also have rights to object to other types of profiling and automated decision-making.

### 7. Sharing your information

We share your information within the Bupa group of companies, with relevant policyholders (including your employer if you are covered under a group scheme), with funders who arrange services on your behalf, those acting on your behalf (for example brokers and other intermediaries) and with others who help us provide services to you (for example healthcare providers) or who we need information from to handle or check claims or entitlements (for example professional associations). We also share your information in line with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

**8. International transfers**

We work with companies that we partner with, or that provide services to us (such as healthcare providers, other Bupa companies and IT providers) that are located in, or run their services from, countries across the world. As a result, we transfer your personal information to different countries including transfers from within the UK to outside the UK, and from within the EEA (the EU member states plus Norway, Liechtenstein and Iceland) to outside the EEA, for the purposes set out in this privacy notice. We take steps to make sure that when we transfer your personal information to another country, appropriate protection is in place, in line with global data protection laws.

**9. How long we keep your personal information**

We keep your personal information in line with periods we work out using the criteria shown in the full privacy notice.

**10. Your rights**

You have rights to have access to your information and to ask us to correct, erase and restrict use of your information. You also have rights to object to your information being used, to ask us to transfer information you have made available to us, to withdraw your permission for us to use your information and to ask us not to make automated decisions which produce legal effects concerning you or significantly affect you.

Please contact us if you would like to exercise any of your rights.

**11. Data protection contacts**

If you have any questions, comments, complaints or suggestions about this notice, or any other concerns about the way in which we process information about you, please contact us at [info@bupaglobal.com](mailto:info@bupaglobal.com). You can also use this address to contact our Data Protection Officer.

You also have the right to make a complaint to your local privacy supervisory authority. Our main office is in the UK, where the local supervisory authority is the Information Commissioner's Office ([www.ico.org.uk](http://www.ico.org.uk)) who can be contacted at, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, United Kingdom. Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

To the best of my knowledge and belief the information given in this application form is true, accurate and complete. I understand that benefits may not be payable in full or at all and my policy may be treated as if it had not existed, if I do not take reasonable care when providing any information requested in this application form.

Where I have provided information on behalf of any dependant to be covered by the policy, I confirm that I have checked with them that the information is correct before completing this application form and I have their express agreement to submit this application form on their behalf, or I am their legal representative.

I understand that my personal information and that of any dependant to be covered by this policy will be processed by Bupa Global for the purposes set out in the privacy notice above. I confirm that I have brought the privacy notice to the attention of the dependants to be covered under this policy.

I agree to be bound by the policy terms of my plan (and for cover provided to any dependant to be covered by this policy but under a different health plan, the policy terms of that health plan). I agree that English law will apply to the policy.

I agree that my policy shall terminate upon informing Bupa Global that I have become a permanent resident of the U.S. (or in the case of a dependant becoming a resident of the U.S., their cover under the policy shall terminate).

**It is essential that you take reasonable care to provide us with full, complete, and accurate information when you complete this application form.**

If you do not provide complete information, we will not be able to process your application. Please be sure to check the entire application form.

If you do not take reasonable care to provide us with full, complete, and accurate information about yourself or any dependant covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

Fill in your form with complete up-to-date medical history before you sign and date it. We may ask you for a declaration of continued good health or to submit a new application form if:

- o we do not receive this application form within six weeks of this declaration date, or,
- o the declaration date is more than six weeks before your cover start date

We recommend that you keep a record of all the information you supply to us in connection with this application form, including letters and any other documents and correspondences exchanged between you and Bupa Global. If you would like a copy of this application form please ask us.

**I sign this application form confirming that its contents are accurate and true.**

<b>Main applicant's signature</b>								<b>Date of signature</b>							
								D	D	M	M	Y	Y	Y	Y
Print name															

Please ensure up-to-date Know Your Customer (KYC) documents have been provided for the main applicant and dependants (aged over 16) where applicable. If you need information about which documents are required, please contact your Bupa Global sales representative. If we don't receive accurate documents, the application could be delayed or cancelled.

Intermediary name																													
Intermediary ID																													

In case of unsolicited sales, applications will only be accepted for countries that allow unsolicited sales of international private medical insurance contracts – including on a cross-border basis, where this is the case. For more information please refer to your Bupa Global contact.

Solicited (promoted) sale. Tick the box if this is a Solicited sale.	<input type="checkbox"/>
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Unsolicited sale. By ticking this box I hereby confirm that I neither promoted, sought, approached the customer and the customer neither sought nor required advice.	<input type="checkbox"/>
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<b>Intermediary's signature</b>	<b>Date of signature</b>							
	D	D	M	M	Y	Y	Y	Y

Print name																											
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**We reserve the right to request further information where appropriate or necessary.**

### Final checklist

**Before you return this form to us, please make sure you have:**

- included full details of everyone you would like to be covered by the policy
- checked that everyone's details are correct
- shown each dependant the privacy notice
- checked you have everyone's agreement to send us this form on their behalf, or you're their legal representative
- signed and dated the declaration section
- kept a copy for your own records

#### What happens next?

We'll review the information you've provided and if we need more details, we'll be in touch. If we don't need to check anything with you, we'll send you a welcome pack.

