HEALTH SHIELD CORPORATE APPLICATION

When completed, please take a picture/scan and return to **paperless@healthshield.co.uk**

Part A (PLEASE USE BLOCK CAPITALS)

1. Your details

I want to become a new Health Shield Corporate member ☐

I want to change my level of contribution ☐

Member number (if known) ☐☐☐☐☐☐☐☐

Title

Surname

Forename(s)

Date of birth DD MM YY

Sex ☐ Male ☐ Female ☐ Prefer not to say

Full postal address

Postcode

Your payroll number ☐☐☐☐☐☐☐☐

Daytime telephone number

Email address

I want to be paperless, please send all my Health Shield membership information by email. Yes ☐ No ☐

2. Please tick the level you have chosen and indicate whether you require cover for you or you and your partner

Access level ☐ Level 1 ☐ Level 2 ☐ You ☐

Level 3 ☐ Level 4 ☐ Prestige ☐ You & partner ☐

3. Your partner's details

'Partner' – anyone who permanently lives with you in a relationship. This could be your husband, wife, civil partner or unmarried partner, regardless of gender.

Title Sex ☐ Male ☐ Female ☐ Prefer not to say

Surname

Forename(s)

Date of birth DD MM YY

4. Dependent children covered by your membership

(If you have more than two children please give their details on a separate sheet and provide it with your application).

Surname

Forename(s)

Date of birth DD MM YY

Sex ☐ Male ☐ Female ☐ Prefer not to say

Surname

Forename(s)

Date of birth DD MM YY

Sex ☐ Male ☐ Female ☐ Prefer not to say

5. Medical history

Health Shield does not cover any pre-existing medical conditions that have arisen before the time of joining or increasing cover.

Examples of pre-existing medical conditions that may lead to the exclusion of certain benefits are as follows: diabetes, epilepsy, respiratory conditions (e.g. asthma), skin disorders (e.g. eczema, psoriasis), arthritis, heart problems (e.g. angina), circulatory problems (e.g. thrombosis), gynaecological disorders, digestive disorders (e.g. liver, bowel or stomach), kidney disorders, cancer, back/neck/shoulder problems, or mental or physical disability.

Have you (or your partner or dependent children where applicable) ever suffered from a medical condition?

YES ☐ If you tick the 'yes' box, we will send you a health declaration form to request further information.

NO ☐ By ticking the 'no' box, you declare that you (or your partner or dependent children where applicable) have not:

– received medication, advice or treatment

– experienced symptoms for any disease, illness or injury, whether the condition has been diagnosed or not before the start of your cover.

6. Declaration

I agree to abide by the rules of membership described in Health Shield's memorandum and rules, the terms and conditions of my membership plan, and with regard to the policy summary document applicable to my scheme. I accept Health Shield's right to vary any of the rules and regulations it considers necessary, and that I will be informed of any changes applicable to my membership. I accept that Health Shield's benefits, benefit levels and contribution rates may also change in future years. I declare that all of the information I have provided is accurate, true and complete to the best of my knowledge and belief.

Your signature

Date DD MM YY

7. Marketing Opt-in

To opt in for marketing communications, please select how we can contact you:

Email ☐ Text Message ☐ Post ☐ Phone ☐

Marketing preferences can be changed at any time in the members area of our website, or by contacting us on the phone. We never share personal information with other organisations for marketing purposes. You can view our Privacy Policy online at www.healthshield.co.uk/privacy-policy or contact us for a paper copy.

Part B (PLEASE USE BLOCK CAPITALS)

1. Your employer's details

Full name of your employer Work location

Full postal address of pay centre

Postcode Telephone number

2. Please tick the level you have chosen and indicate whether you require cover for you or you and your partner

Access level ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Prestige ☐ **You** ☐ **You & partner** ☐

I am paid: Weekly ☐ Four-weekly ☐ Monthly ☐ This is a change to my previous Health Shield deductions Yes ☐ No ☐

Title Surname Forename(s)

Your payroll or employee number

I authorise you to deduct, and pay to Health Shield, the appropriate amount corresponding to my level of cover, or any other contribution that may later apply.

Your signature

Date DD MM YY

VOL

OFFICE USE ONLY Member's payroll number Total amount to be paid Weekly 4-weekly Monthly