TH9 1B

HEALTH SHIELD CORPORATE APPLICATION PLEASE FILL IN AND SIGN THIS APPLICATION FORM

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)

PLEASE CIRCLE MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

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 ☐ LEVEL 3 ☐ LEVEL 4 ☐ PRESTIGE ☐ YOU ☐ YOU & PARTNER ☐

3 (Only fill in section 3 if you want Cover for You and Your Partner) YOUR PARTNER'S DETAILS

Your husband, wife or any other person who lives with you as if you are married, no matter whether they are male or female.

PLEASE CIRCLE MR, MRS, MS, MISS

SURNAME

FORENAME(S)

DATE OF BIRTH

4 DEPENDENT CHILDREN COVERED BY YOUR MEMBERSHIP

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

SURNAME

FORENAME(S)

DATE OF BIRTH MALE ☐ FEMALE ☐

SURNAME

FORENAME(S)

DATE OF BIRTH MALE ☐ FEMALE ☐

SURNAME

FORENAME(S)

DATE OF BIRTH MALE ☐ FEMALE ☐

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

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.

SIGNATURE DATE / /

We'd love to keep you updated and send you more interesting content in the future. Please select your preferences below and if you would like to change your preferences at any point, you can do so on our website. Health Shield will always treat your personal information with the greatest care and never pass it on to other organisations for marketing purposes. For more information on how we process your personal data please refer to our Privacy Policy or contact us for a paper copy.

Please tick the boxes below to tell us how you would prefer to hear from us:

☐ I would like to hear from you by email

☐ I would like to hear from you by telephone

☐ I would like to hear from you by SMS

☐ I would like to hear from you by post

HEALTH SHIELD CORPORATE PAYROLL DEDUCTION AUTHORISATION

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 ☐

PLEASE CIRCLE MR, MRS, MS, MISS

YOUR SURNAME

YOUR FORENAME(S)

YOUR PAY 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.

SIGNATURE DATE / /

OFFICE USE ONLY Member's payroll number

Total amount to be paid: Weekly Four-weekly Monthly

Please return to:

Health Shield Friendly Society Ltd., Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.
Telephone: 01270 588555 Fax: 01270 251366 Opening hours: 8.00am to 6.00pm, Monday to Friday Email: info@healthshield.co.uk Website: www.healthshield.co.uk

Established in 1877. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.
As part of our on-going quality control programme, calls may be monitored or recorded.