Joining Worldwide Health Options
Your Application

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Bupa

IMPORTANT INFORMATION

To join Bupa simply complete the questions on this form. Please write clearly in BLOCK capitals using black ink.
Once completed, you can email your form to newbusiness@bupa-intl.com or fax us on +44 (0) 1273 866 583 or post to Bupa International, Russell House, Russell Mews, Brighton, BN1 2NR, United Kingdom. If you feel that your email is not secure, please send us your application form via post or fax. If you have faxed or emailed us then we do not need the original copy of your form.

We look forward to welcoming you as a member of Bupa.

For full details of terms and conditions, please see a copy of our membership guide available on request.

If you have any questions when completing this form, please contact your broker or call us on +44 (0) 1273 208 181

Checklist - *please make sure:*

- ➥ you have read, signed and dated the declaration in section 13 ◯
- ➥ the information you have given in sections 1-12 is correct and complete ◯
- ➥ for payments by Direct Debit or Credit Card, you have completed the Direct Debit Instruction or the Credit Card Authority ◯

We will not be able to process your application if this form is incomplete.

Please be sure to check the entire form.

(mm) when you see this sign, it is referring to the main member

1 Main member: your personal details

The date you want your cover to start: D D M M Y Y — *Your cover cannot start before the date we receive your completed application form.*

Title		First name	
Other initials		Family name	
Male / Female		Nationality		1st Language	
Occupation		Date of birth	D D M M Y Y

Do you have current health cover with any other insurer, including Bupa? Yes ◯ No ◯
If Yes, please give details of your cover:

Name of other health insurer	
How long have you been with this insurer?	Y Y M M
Name of scheme / cover	Membership number

2 Main member: your address details *(please let us know straightaway about any change of address)*

Residency address *(your permanent or usual address in the country where you are resident. This should be the country in which you are living on the first day of your current membership year.)*	Correspondence address *(where membership documents cannot easily be sent to you at your residency address, please supply an alternative address to which they may be sent)*
Building name / number	Building name / number
Street	Street
Town/City	Town/City
Postal / zip / area code	Postal / zip / area code
Region	Region
Country	Country

If you have been living in the UK for 90 days or more out of the last 120 days at the start of your current membership year, then you are deemed resident in the UK. Does this apply to you? Yes ◯ No ◯ Are you a resident of the USA? Yes ◯ No ◯

3 Main member: your other contact details

Main contact *(home)*				Secondary contact *(work)*			
	Country code	Area code	Number		Country code	Area code	Number
Telephone				Telephone			
Fax				Fax			
Mobile				Mobile			
Email				Email			

4 Additional persons to be covered with you: personal details

1st additional person (1)

Title | First name | Other initials | Family name | Male / Female | Nationality | 1st Language | Occupation | Date of birth (D D M M Y Y) | Relationship to you

2nd additional person (2)

Title | First name | Other initials | Family name | Male / Female | Nationality | 1st Language | Occupation | Date of birth (D D M M Y Y) | Relationship to you

3rd additional person (3)

Title | First name | Other initials | Family name | Male / Female | Nationality | 1st Language | Occupation | Date of birth (D D M M Y Y) | Relationship to you

4th additional person (4)

Title | First name | Other initials | Family name | Male / Female | Nationality | 1st Language | Occupation | Date of birth (D D M M Y Y) | Relationship to you

If any of these additional persons have different home or correspondence addresses to yours, please write their name and addresses on a separate sheet and confirm you have done so by ticking here: ◯

5 Documentation

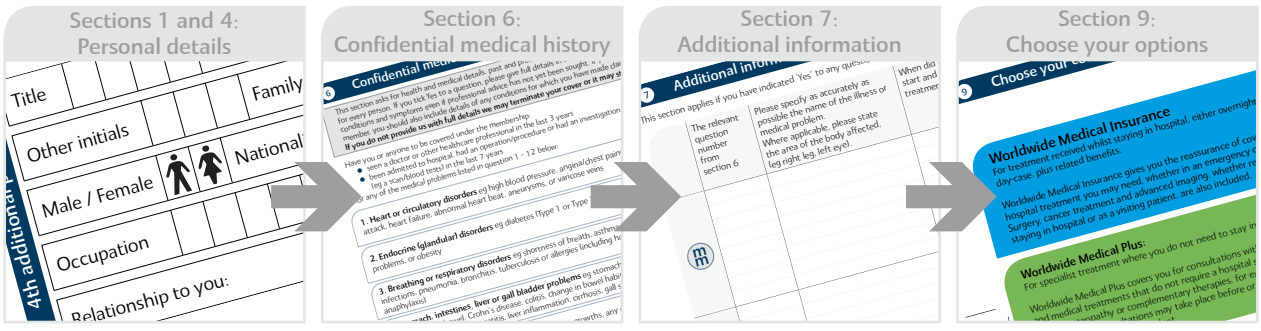
If you would like to view your membership documents online via MembersWorld instead of receiving them in the post, please tell us which email address you would like us to send the link to. Please choose one of the following options:

Main contact *(home)* ◯ Secondary contact *(work)* ◯ Other *(below)* ◯

Email:

IMPORTANT INFORMATION

It is important that the information you give in sections 6, 7 and 9 matches the correct persons from sections 1 and 4.



Ⓜ = Main Member ① = First additional person ② = Second additional person ③ = Third additional person ④ = Fourth additional person

6 Confidential medical history

This section asks for health and medical details, past and present about yourself and each person named in Section 4. 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 on the next page. Please ensure you tell us about any known or suspected conditions and symptoms even if professional advice has not yet been sought. If you are applying to increase cover and you are already a Bupa International member, you should also include details of any conditions for which you have made claims within the last seven years. This information will be passed to our underwriting team who will assess the terms of your plan. **If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.**

Have you or anyone to be covered under the membership:
- seen a doctor or other healthcare professional in the last three years
- been admitted to hospital, had an operation/procedure or had an investigation (eg a scan/blood tests) in the last seven years

for any of the medical problems listed in question 1 - 12 below:

	mm Y N	1 Y N	2 Y N	3 Y N	4 Y N
1. **Heart or circulatory disorders** eg high blood pressure, angina/chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, or varicose veins.	◯◯	◯◯	◯◯	◯◯	◯◯
2. **Endocrine (glandular) disorders** eg diabetes (Type 1 or Type 2), thyroid problems, or obesity.	◯◯	◯◯	◯◯	◯◯	◯◯
3. **Breathing or respiratory disorders** eg shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis or allergies (including hayfever and anaphylaxis).	◯◯	◯◯	◯◯	◯◯	◯◯
4. **Stomach, intestines, liver or gall bladder problems** eg 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.	◯◯	◯◯	◯◯	◯◯	◯◯
5. **Cancer, tumours or growths** eg polyps, benign growths, any cancers or pre-cancerous condition.	◯◯	◯◯	◯◯	◯◯	◯◯
6. **Skin problems** eg eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed, or allergic conditions.	◯◯	◯◯	◯◯	◯◯	◯◯
7. **Brain or nervous system disorders** eg stroke, dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles) or meningitis.	◯◯	◯◯	◯◯	◯◯	◯◯
8. **Muscle or skeletal problems** eg arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, gout or inflammatory conditions.	◯◯	◯◯	◯◯	◯◯	◯◯
9. **Urinary or reproductive system problems** eg kidney or bladder problems (including kidney failure), recurrent urinary infections, incontinence; pregnancy/ childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, polycystic ovaries, testicular or prostate disorders.	◯◯	◯◯	◯◯	◯◯	◯◯
10. **Blood/infective/immune disorders** eg abnormal blood tests, high cholesterol, anaemia; hepatitis, HIV, malaria; or any autoimmune disorder.	◯◯	◯◯	◯◯	◯◯	◯◯
11. **Eye, ear, nose, throat and dental problems** eg cataracts, glaucoma, visual impairment; deafness, ear infections, tonsillitis; dental infections, wisdom teeth problems or gingivitis.	◯◯	◯◯	◯◯	◯◯	◯◯
12. **Psychiatric/psychological disorders** eg schizophrenia, compulsive or eating disorders; depression, stress, anxiety or drug/alcohol dependency.	◯◯	◯◯	◯◯	◯◯	◯◯
Please also answer the following questions:					
13. Is anyone to be covered taking any medication, prescribed or otherwise?	◯◯	◯◯	◯◯	◯◯	◯◯
14. 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 this application?	◯◯	◯◯	◯◯	◯◯	◯◯
15. Has anyone to be covered experienced any signs or symptoms of any medical problem in the last six months, regardless of whether a health care professional has been consulted?	◯◯	◯◯	◯◯	◯◯	◯◯
Further details *(for over 16s only)*:					
How tall are you? feet/inches ◯ metres/centimetres ◯	☐	☐	☐	☐	☐
How much do you weigh? stones/pounds ◯ kilogrammes ◯	☐	☐	☐	☐	☐
Have you used tobacco products within the last seven years?	◯◯	◯◯	◯◯	◯◯	◯◯

7 Additional information

This section applies if you have indicated 'Yes' to any questions in section 6. If you are unsure whether any details are relevant, you must include them.

	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, (eg right leg, left eye).	When did the symptoms start and when was treatment completed?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (eg ongoing, complete recovery, recurrent or likely to recur)?
mm					
1					
2					
3					
4					

N.B. Please tell us immediately if you or any additional persons to be covered under the membership experience any symptoms before you receive your membership documents. Failure to do so may affect your claims.
If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking this box: ◯

8 If you have a regular/family doctor, please fill in the below details

Doctor's name																															

Full postal address																															

Your consent to your doctor to disclose medical information.
On behalf of myself and each person named on this form, I authorise this doctor to provide Bupa International with any information it asks for in connection with my membership application and any claims (past, present and future). Please tick here to give your consent: ◯

If any family members included in your application have a different doctor, please give the name and / or address details on a separate sheet - and confirm you have done so by ticking here: ◯

Choose your cover options

	mm	1	2	3	4
Worldwide Medical Insurance For treatment received whilst staying in hospital, either overnight or as a day-case, plus related benefits. Worldwide Medical Insurance gives you the reassurance of covering essential hospital treatment you may need, whether in an emergency or a planned visit. Surgery, cancer treatment and advanced imaging, whether received whilst staying in hospital or as a visiting patient, are also included.	Each member to be included on this plan automatically receives cover for Worldwide Medical Insurance, our core cover. Please tick the options you wish to add for you and any additional people.				
Worldwide Medical Plus: For specialist treatment where you do not need to stay in hospital. Worldwide Medical Plus covers you for consultations with a doctor or specialist and medical treatments that do not require a hospital stay. These may include osteopathy or complementary therapies, for example. Some of these treatments or consultations may take place before or after a hospital stay, but many will be totally independent.		○	○	○	○
Worldwide Medicines and Equipment: For prescribed medicines and medical equipment. Often, treatment does not end when you leave the hospital or clinic or after you have seen a specialist. This option covers you for prescription medicines and the rental of medical appliances, such as oxygen supplies or wheelchairs. Our unique benefit for long-term prescriptions will also pay for any medicine required to manage chronic conditions such as asthma.		○	○	○	○
Worldwide Wellbeing: For a range of health screenings, vaccinations, dental and optical treatment. Our Wellbeing option is designed to help you protect and maintain your health. It covers medical screenings that can provide valuable early detection of conditions such as cancer. It covers dental and optical treatments, which can play an important role in keeping you healthy by identifying underlying problems such as mouth cancer or diabetes.		○	○	○	○
Worldwide Evacuation: For when you can't get the treatment you need in a local hospital. The Worldwide Evacuation option covers you for reasonable transport costs to the nearest suitable medical centre, when the treatment you need is not available nearby. Repatriation, which is also included, gives you the added option of returning to your home country or specified country of nationality, to be treated in familiar surroundings.		○	○	○	○
Cover for pre-existing conditions: If you have a pre-existing medical condition, this option could provide you with the opportunity to be covered for it. If you would like to find out if we can cover you and to obtain a quote, please tick here. **If your plan includes cover for pre-existing conditions, this cover does not apply in the USA.**	This option will apply to each member to be included on this plan ○				
USA cover: If you spend most of your time in the USA, then you will need to buy USA cover on an annual basis. If you spend most of your time outside the USA, you can choose to add USA cover to your plan by ticking in this section. Please note, we do not cover permanent USA residents. **This cover will increase your premium.** **If your plan includes cover for pre-existing conditions, this cover does not apply in the USA.**		○	○	○	○

Annual Deductible

If you are paying by Direct Debit or Credit Card, you may choose an annual deductible. This is the amount you would pay towards eligible medical treatment each year. If you choose any of the deductible amounts on Worldwide Medical Insurance then a fixed deductible amount of £100 ($170 / €125) is applied to Worldwide Medical Plus and £50 ($80 / €60) fixed deductible amount is applied to Worldwide Medicines and Equipment (if you choose these options).

The deductible you choose will apply to each member on this form.

GBP:	None	○	£250	○	£500	○	£1000	○	£2000	○	£5000	○
USD:	None	○	$425	○	$850	○	$1700	○	$3400	○	$8500	○
EUR:	None	○	€300	○	€625	○	€1250	○	€2500	○	€6250	○

Please refer to the membership guide for full details.

10 Your payment details *(Direct debit, credit card or cheque/bankers draft)*

Your choice of currency for your cover and subscription payments *(please tick one only)*: GBP(£) ◯ USD($) ◯ EUR(€) ◯

How will you make your subscription payments *(please tick one only)*: Monthly ◯ Quarterly ◯ Yearly ◯

You must choose to pay by direct debit or credit card if you have chosen a deductible.

By direct debit through a UK bank. *(This is only an option for GBP(£) payments. Please complete the below Direct Debit Instruction)*: ◯

By credit card *(please complete the below Card Payment Authority)*: ◯

By cheque or bankers draft in the currency you have indicated above: ◯

Please note, when choosing to pay via cheque or bankers draft, you can not pay monthly or have a deductible. Please fill in the name of the person paying the subscription in the box provided below when choosing to pay via cheque or bankers draft.

Name:

A valid Direct Debit agreement or Card Authority is required throughout your membership year. Your cover may be suspended or terminated if you do not have such an agreement or authority in place.

11 Direct Debit *(for GBP (£) payments only - this must come out of a UK bank account)*

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

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

DIRECT Debit

Name(s) of account holder(s):

Bank/Building Society account number:

Branch sort code: - -

Swift code:

Instruction to your Bank or Building Society
Please pay Bupa International 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 International 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:

Account holder's signature

Date

Reference number (for Bupa International use only)

BI - - - -

Originator's ID number 9 8 0 9 3 9

Banks and Building Societies may not accept Direct Debit Instructions for some type of accounts.

As Instruction Form

12 Credit Card authority

Card payment authority

To Bupa International, I authorise you, until further notice in writing, to charge to my card account, subscriptions and other unspecified amounts, as and when payments become due. I will advise you immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

(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: /

Expires/end date: /

Cardholder's signature

Date

The Direct Debit Guarantee

This guarantee should be detached and retained by the payer

DIRECT Debit

- 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 International will notify you 7 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Bupa International 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.

13 Your membership declaration

In view of the declaration below, it is essential that complete information is supplied.

Benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters. If you would like a copy of this application form, please ask us.

It is Bupa International's intention to provide a first class service to our members at all times. However, if you have any comments or complaints, you can call the Bupa International customer helpline on +44 (0)1273 323 563, 24 hours a day, 365 days a year. Alternatively you can email via www.bupa-intl.com/membersworld, or write to us at: Bupa International, Russell House, Russell Mews, Brighton, BN1 2NR, UK. If you have not received a response within 8 weeks or you remain unhappy with our final response, you may refer your complaint to the Financial Ombudsman Service. Their address and contact details are: South Quay Plaza, 183 Marsh Wall, London E14 9SR, telephone: 0845 080 1800 or +44 (0) 207 964 1000 from outside the UK. For hearing or speech impaired members with a textphone, please call +44 (0) 1273 866 557. We also offer a choice of Braille, large print audio for our letters and literature. Please let us know which you would prefer. English Law shall apply to the agreement between you and Bupa International.

I hereby apply to be enrolled as a Member with the Dependants listed above included in my membership. I declare that to the best of my knowledge and belief the information given in this Application is true and complete. I agree that the Rules of the Bupa International scheme will be binding on me and all eligible Dependants included in my membership. I agree that any cover which I may purchase for the USA shall terminate upon informing Bupa International that I have become a resident of the USA.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any family members specified in this form for Bupa International to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

Bupa International Data Protection Notice

Purpose: Personal data collected on you, and where appropriate, your family, will be used by Bupa International to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

Confidentiality: The confidentiality of patient and member information is of paramount concern to Bupa International. To this end, Bupa International fully comply with UK Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may also be shared with appointed third parties involved in the management and handling of your claim. Claims information may be discussed with the Bupa International Agent/Adviser where you have requested the Adviser to assist you.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the principal member.

Telephone calls: In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by Bupa International, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and addresses: Bupa International does not make the names and addresses of members or patients available to other organisations.

Keeping you informed: Bupa International would, on occasion, like to keep you informed of Bupa International products and services which it considers may be of interest to you.

Contact address: If you do not wish to receive information about Bupa International's products and services, or have any other Data Protection queries please write to the Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@Bupa.com.

for office use only	Identification stamp / broker name and ID number
	AOC Insurance Broker **Expat Health & Travel Insurance Comparator** 60 rue de Strasbourg – 92400 Courbevoie – France Tél : +33 970 40 56 52 – Cell : +33 6 09 12 32 89 Orias Member n° 08 045 906 – (www.orias.fr) Website : www.aoc-insurancebroker.com www.assurance-sante-expatrie.eu Email : contact@aoc-insurancebroker.com

IMPORTANT INFORMATION - YOUR MEMBERSHIP DECLARATION

Please be aware that this form must be received by Bupa International no more than six weeks after the declaration date.

It is advisable that you fill in your form with complete up-to-date medical history before you sign and date this form.

If we receive this form after six weeks from this signed declaration date, or with incomplete information, we will be unable to register your details and enrol you on the plan.

Please use the checklist on the front of the form to ensure you have filled everything in completely.

Signature	Date