Business Healthcare and Corporate Healthcare
Private medical insurance application form

Full Medical Underwriting (FMU)

For employees (new business and mid-term joiners) and addition of dependants to apply for VitalityHealth membership commencing from 1 October 2024.

To apply for VitalityHealth membership complete Sections A to I as appropriate. Please check all details on the application. If any details are incorrect put a line through them, write in the correct details and initial the change.

- Please ensure you complete all fields unless advised otherwise.
- Please complete this form using black ink in BLOCK CAPITALS.
- Please ensure you're completing the application form which relates to the product and underwriting option selected by your employer and you've read the important information regarding eligibility in section I. If you're unsure as to how to proceed, please refer to your Company Contact.
- The VitalityHealth plan declaration, section J, must be signed and dated by the employee.

A – Who is this application for?

Please tick one box to indicate who this application form has been submitted for:

☐ New company plan – employee (and dependants)

☑ Existing company plan – mid-term employee joiner (and dependants)

☐ Existing employee on cover – addition of dependants

B – Employment details

Employer name

Company plan number 50531610

Date your employment commenced D D M M Y Y Y Y

Date you would like cover to begin* D D M M Y Y Y Y

*If this is a new company plan this will be the date your employer's plan is commencing with us. If you are a new employee this is likely to be the date of your employment. If you are an existing employee, this is likely to be the date you become eligible to join the plan. If required, a date up to 45 days in the future, from the date you have signed and dated this application form, can be requested.

C – Employee details

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ **Gender** Male ☐ Female ☐

First name ☐ **Last name** ☐

Address ☐

Postcode

Please note that we cannot accept 'c/o the company' for a member's address. A full residential address is required.

Telephone number (home) ☐ **Telephone number (mobile)** ☐

Telephone number (work) ☐

Email ☐

Only leave blank if no valid email address exists.

Date of birth D D M M Y Y Y Y

D – Cover details - PLEASE NOTE THAT THIS SECTION DOES NOT NEED TO BE COMPLETED

Your employer has made some cover choices for you which are based on your 'Employee category'. Please tell us in the boxes below which 'Employee category' you are in and also indicate which hospital option applies. If you're not sure of the details, please ask your Company Contact.

Employee category ☐

Hospital option Countrywide ☐ London Care ☐ Consultant Select* ☐

*Consultant Select is not available to applicants who live in the Channel Islands or Isle of Man.

E – Spouse/Partner and child dependant details

Complete only if there are other eligible applicants to be covered by this plan.

If you have more than five dependants, please provide their details on a separate sheet of paper, sign and date it, and attach it to this form, or use the Notes section at the back. Email details are only required for child dependants who are aged 18 or over.

Spouse/Partner/Child (dependant 1)

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

First name ☐ **Last name** ☐

Email ☐

Date of birth D D M M Y Y Y Y **Gender** Male ☐ Female ☐

E – Spouse/Partner and child dependant details (continued)

Child (dependant 2)

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

First name

Last name

Email

Date of birth D D M M Y Y Y Y

Gender Male ☐ Female ☐

Child (dependant 3)

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

First name

Last name

Email

Date of birth D D M M Y Y Y Y

Gender Male ☐ Female ☐

Child (dependant 4)

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

First name

Last name

Email

Date of birth D D M M Y Y Y Y

Gender Male ☐ Female ☐

Child (dependant 5)

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

First name

Last name

Email

Date of birth D D M M Y Y Y Y

Gender Male ☐ Female ☐

Please enter below the names of any applicants who are employed in the occupations listed (leave blank if this doesn't apply to any applicants):

	Name(s) of applicant(s)
Working offshore in the extraction / refinery of natural / fossil fuels.	
Armed forces personnel (including Armed Forces Reservists).	
Professional or semi-professional sports.	

For details of what cover is available for these occupations, please refer to the plan terms and conditions.

F – Full Medical Underwriting

The application process involves answering questions that are designed to capture the information we need to build a clear and accurate picture of your and your dependant's health.

As the applicant you have to complete and sign this form on behalf of all people to be insured. If you are unsure about any of the information we ask for, you should check with the person who it relates to or contact your Broker or Sales Agent if you do not understand the question or the nature of the information required.

Duty of disclosure

It is important you take reasonable care to complete all of the health questions honestly and fully for both yourself and other persons to be covered by the plan because we will use the answers you give to determine what medical conditions your plan will cover. Knowing your health status is important to make sure we are treating you, and our other customers, fairly and consistently.

If you do not take reasonable care and the information provided by you is inaccurate or incomplete, this may result in a claim not being paid, your underwriting terms being changed, your cover being cancelled and/or any treatment costs already paid by us being reclaimed.

Please note we may ask you to provide further information and/or documentation to ensure that the information you provided when taking out your plan was accurate and complete.

1. Are any applicants currently: Yes ☐ No ☐

- **a)** taking regular medication (whether prescribed or over the counter, but excluding contraception, hormone replacement therapy or medicines used to treat minor illnesses such as colds and flu)?
- **b)** awaiting any medical test results including blood tests, follow-up consultations, treatment or investigations?
- **c)** experiencing symptoms of any physical or mental health or psychiatric illnesses (or had symptoms in the last three months), whether or not medical advice has been sought?
- **d)** being regularly monitored by a consultant, GP or other healthcare professional, including any mental health professionals e.g. psychologist, therapist, psychiatrist, counsellor?

2. In the last five years, has any applicant attended a hospital, clinic or nursing home as an in-patient, day-patient, out-patient* or had care from a consultant or hospital-based clinician remotely? (excluding midwife-led pregnancy or childbirth which did not lead to complications requiring input or care from an obstetrician). Yes ☐ No ☐

*By out-patient, we mean an attendance to a hospital, consulting room or out-patient clinic and you have not been admitted as either a day-patient or in-patient. By day-patient, we mean an admission to hospital or day-patient unit that required a period of supervised recovery, but did not require an overnight stay. By in-patient, we mean an admission to hospital that required you to stay overnight.

3. Have any applicants ever been treated for, diagnosed with or advised that they may have any of the following: Yes ☐ No ☐

- **a)** heart condition or stroke/transient ischaemic attack (mini-stroke)?
- **b)** cancer?
- **c)** any form of arthritis, or joint or muscular problems that have resulted in regular, recurrent or persistent joint pain?
- **d)** mental health illnesses including mood disorders, behavioural disorders or psychiatric illnesses?**

**You do not need to tell us about a single episode of any anxiety, depression or stress that happened more than 5 years ago and which was only treated by your GP or with a single course of talking therapy. e.g. counselling or Cognitive Behavioural Therapy (CBT).

If ALL applicants have answered 'NO' to all three questions above, you do not need to answer any more questions in this section and you can be accepted on Full Medical Underwriting and no personal medical exclusions.

Please go to section I and continue with the application form.

All applicants answering 'YES' to any question above must now complete the rest of this section and then go to section G.

F – Full Medical Underwriting – Further health questions

Only complete this section for any applicant who answered 'YES' to any of the questions on page 4.

Please ensure you answer 'yes' or 'no' to each question. Where you have ticked 'yes', give full details including date(s) of consultations, investigations and treatment where appropriate, on pages 6 and 7.

If you do not answer a question or you leave it blank, we will assume you have nothing to tell us.

When being asked for date of last symptom / last treatment, please provide whichever date is most recent.

Please be aware the middle column below provides examples only and is not an exhaustive list.

Has any applicant ever experienced or been treated for, or are they currently suffering from, any of the following conditions or symptoms?

a. Blood disorders	e.g. anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, thrombosis (blood clots).	Yes ☐	No ☐
b. Brain/Nerve disorders	e.g. stroke, multiple sclerosis, epilepsy, migraine, paralysis, Parkinson's disease, quadriplegia, paraplegia.	Yes ☐	No ☐
c. Cancer	e.g. any form of cancer or pre-cancerous growth, tumours or moles that have changed in appearance.	Yes ☐	No ☐
d. Cardiac/Vascular disorders	e.g. angina/heart attack, heart failure, heart murmurs, rheumatic fever, high blood pressure, rhythm disturbance (palpitations), varicose veins (including haemorrhoids/piles), poor circulation, raised cholesterol, heart surgery.	Yes ☐	No ☐
e. Connective tissue disorders	e.g. SLE (systemic lupus erythematosus), scleroderma, mixed connective tissue disorder.	Yes ☐	No ☐
f. Dental disorders	e.g. over/under bite problems, missing/skew teeth, impacted wisdom teeth or ongoing treatment.	Yes ☐	No ☐
g. Ear, nose, throat, eye and speech disorders	e.g. cataracts, glaucoma, macular degeneration, hearing/visual impairment, loss of speech, tonsillitis.	Yes ☐	No ☐
h. Gastro-intestinal disorders	e.g. peptic ulcer, hiatus hernia, heartburn, changed bowel habits, rectal bleeding, Crohn's disease, ulcerative colitis, IBS (irritable bowel syndrome).	Yes ☐	No ☐
i. Female/Male reproductive system disorders	e.g; ovarian cysts, endometriosis, fibroids, infertility, disorders of the cervix, menstrual disorders, penile/testicular disorders, epididymitis, breast lumps/cysts, complications of pregnancy/childbirth.	Yes ☐	No ☐
j. Kidney/Urinary tract disorders	e.g. kidney failure, kidney stones, recurrent infections, nephritis, prostate problems, blood/protein in urine, polycystic kidneys.	Yes ☐	No ☐
k. Liver/Pancreatic disorders	e.g. hepatitis, cirrhosis, liver failure, gallstones, pancreatitis.	Yes ☐	No ☐
l. Mental health illnesses, behavioural disorders or psychiatric illnesses	e.g. anxiety, depression, stress, bipolar affective disorder, personality disorders, ASD (Autism Spectrum Disorders), ADHD (Attention Deficit Hyperactivity Disorder), dementia.	Yes ☐	No ☐
m. Metabolic/Endocrine disorders	e.g. diabetes, thyroid abnormalities, growth disorder, Cushing's disease, Addison's disease.	Yes ☐	No ☐
n. Musculo-skeletal disorders (bone, joint, muscular)	e.g arthritis, rheumatoid arthritis, myasthenia gravis, muscle weakness/ injury, gout, osteoporosis, back problems (e.g slipped disc, backache, sciatica, pinched nerve), loss of limb, breaks/fractures, sports injuries, hernia.	Yes ☐	No ☐
o. Respiratory disorders	e.g. asthma, emphysema, bronchitis, shortness of breath, persistent cough, coughing up blood, cystic fibrosis, sinusitis, allergic rhinitis, COAD/COPD (chronic obstructive airways/pulmonary disease) or any lung surgery.	Yes ☐	No ☐
p. Skin disorders	e.g. eczema, psoriasis, acne, hypertrophic scars (keloid).	Yes ☐	No ☐
q. Sensory functions	e.g. loss or impairment of sense of touch, smell or taste.	Yes ☐	No ☐

F – Full Medical Underwriting – Further information (continued)

If any applicant has answered 'YES' to any of the questions 1-3 on page 4 and/or a-q on page 5, please supply full details below and overleaf.

Name of applicant to whom the condition/ symptom applies				
Condition/symptom (Confirm precise location and always state diagnosis if known. Please also advise what question number / letter it refers to).				
Date when condition/ symptoms first presented				
Please confirm if any consultations have taken place (advise if GP or consultant led and include all dates)				
Please confirm any investigations that have taken place (include all dates)				
Please confirm any medications that have been taken whether prescribed or over the counter (please state if ongoing or alternatively the date it ceased to be taken)				
Please confirm any additional treatment (other than medication) that has taken place (include all dates)				

Please continue to complete this section on page 7

F – Full Medical Underwriting – Further information (continued)

If any applicant has answered 'YES' to any of the questions 1-3 on page 4 and/or a-q on page 5, please supply full details below.

Please confirm if any further consultations/ investigations/treatment are required (include details and any dates that are known)				
Date (month and year) when condition/ symptoms ceased, if applicable				
Please confirm the present state of health i.e. full recovery, ongoing symptoms etc.				

Additional information - if there are more than four applicants, or if you require more space, please continue on a separate sheet of paper, sign and date it, and attach it to this form, or use the Notes section at the back.

G – GP's details

Please state the name and address of your usual GP (to whom requests for information are usually made). If you have changed your GP in the past year, or if the GP is different for any of the other applicants, provide the GP name(s) and address(es) on a separate sheet of paper, sign and date it and attach it to this form, or use the Notes section at the back.

GP's first name **GP's last name**

Address

Telephone number

Email address

H – Access to Medical Reports Act 1988

Before we can assess your application, we may need to get a medical report from a GP who has cared for you. The Access to Medical Reports Act 1988 gives you certain legal rights. These are:

- We need your agreement before we can apply for a medical report from your GP. You can refuse but, if you do, we may not be able to assess your application.
- You can ask to see the report before the GP sends it to us, or up to six months after.
- If you tick the box below to indicate that you want to see the report, your GP can charge you a reasonable fee to cover costs.
- If you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your GP will not agree to do this, you may attach a statement of your own.

You will not be entitled to see any part of the report which:

- The GP believes could seriously harm your physical or mental health, or that of others.
- Indicates the GP's intentions in respect of you.
- Reveals information about another person, or the identity of someone who has given the GP information about you (unless that person consents or is a health professional involved in caring for you).

We will write and tell you when we have requested the report. If you've asked to see the report before your GP sends it to us, you will have 21 days from the date of receipt of our letter to contact your GP. Once you have seen the report, your GP needs your agreement to send it to us. If you don't arrange to see the report within 21 days, your GP will be free to send it to us.

Declaration of consent

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, as explained above. In connection with my insurance application I consent to VitalityHealth being provided with medical information from my GP or any other health professional who at any time has attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original and is valid for 12 months.

Please tick one box only.

I would like to see the report before it is sent to VitalityHealth. ☐

I do not need to see the report before it is sent to VitalityHealth. ☐

To avoid delay, each person may choose to give their consent by signing in the box below. If additional signature space is required, please use the Notes section at the back of this form, stating the signatures apply to section H.

Employee's signature.

Date. D D M M Y Y Y Y

Spouse's/Partner's signature.

Date. D D M M Y Y Y Y

Parental guardian's signature (for children under 16).

Date. D D M M Y Y Y Y

Signature of dependant (aged 16 or over).

Date. D D M M Y Y Y Y

Signature of dependant (aged 16 or over).

Date. D D M M Y Y Y Y

Please be aware that we rarely contact GP's as we assess your application based on all of the health questions being completed honestly and fully. If we do ask your GP for information we will keep you advised and we may ask you to contact your GP if we request a medical report and experience delays in receiving it.

I – Important information

General notes and eligibility

- Your cover will not start until we have accepted your application.
- Please check with your Company Contact that you can apply to include your dependant(s) on cover, if applicable.
- You and all applicants must live in the UK (Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man) for at least 180 days in each plan year.
- You must be aged 16 or over at your cover start date.
- Your wife / husband / partner must live at the same address as you and be aged 16 or over at their cover start date.
- On Business Healthcare plans your children, including step-children and adopted children, must be aged 25 or under at their cover start date.
- Business Healthcare applicants only: Children aged 21 or over at their cover start date, or the plan renewal date, whichever is sooner, will be charged at an adult rate.
- On Corporate Healthcare plans your children, including step-children and adopted children, must be aged 24 or under at their cover start date. For mid-term joiners, your children, including step-children and adopted children, must have been aged 24 or under at the last annual renewal date.
- On Corporate Healthcare plans, dependent children will be removed from cover at the first annual renewal date on or after their 25th birthday.
- Our Worldwide Travel and Emergency Medical Expenses Cover is only available to applicants / existing members providing everyone is aged 79 or under at the plan start date / when the benefit is included to cover.
- If an applicant has a birthday while your application is being processed, the terms may differ from those originally quoted. We may offer revised plan terms, but in certain circumstances we may not be able to offer cover.
- You should ensure that all applicants are registered with a UK GP and Dentist and that they have your full medical and dental records, if you haven't already done so. This will help avoid delay in getting authorisation for an eligible claim by us.
- You are entitled to ask for a copy of the applicable terms and conditions and a copy of your application form at any time.

Data Protection Notice

Vitality will only collect information that is necessary to provide you with the services we offer, or an associated or required service. The security of and appropriate use and disclosure of your health and medical information is of paramount importance to Vitality. Full details of how Vitality uses, collects, stores and processes your personal and medical information can be found in our Privacy Notice at **vitality.co.uk/privacy**.

The Vitality group consists of Vitality Corporate Services Limited, Vitality Health Limited, Vitality Life Limited and Vitality Healthy Workplace Limited. Visit Visit **vitality.co.uk/legal** to find out more about the companies that handle your information based on the products and services you access or use.

Keeping you up to date with our latest product offers

We'll send you updates about our new Vitality products and offers by email and text message. You can opt-out at any time and we'll never share your personal data with other companies for marketing purposes.

When your plan starts you will be provided with access to Member Zone where you can manage your marketing choices.

Please go to section J and read, sign and date the plan declaration on behalf of all applicants.

J – VitalityHealth plan declaration to be signed by the employee

By submitting this application you confirm your understanding of the following:

- That this application is subject to written acceptance by VitalityHealth.
- That by completing this application you are applying on behalf of all applicants to be covered on this plan and are doing so with their full consent. You also agree to receive all plan-related documentation on behalf of all applicants.
- That the information given on this application form must be full and accurate. That failure to take reasonable care in answering any questions may result in a claim not being paid, your underwriting terms being changed, your cover being cancelled, and / or any treatment costs already paid by us being reclaimed.
- That you must advise us of any change to the information given in this application which occurs between the date of signing the plan declaration below and the cover start date, including changes to any applicants' state of health.
- That no cover will apply for investigations or treatment of any medical condition or related condition which exists or has existed before the cover start date unless, where requested within this application form, you have provided VitalityHealth with full details and they have agreed to accept it.
- That VitalityHealth will detail on your membership certificate any personal medical exclusion(s) that they've applied due to the information you have provided.
- That you understand that in certain circumstances VitalityHealth may be unable to offer cover.
- That you consent to VitalityHealth using the information supplied for the purposes shown in the data protection notice in section I.
- That a copy of your application form and the applicable plan terms and conditions are available on request.
- If any applicant has answered 'YES' to any health questions, you also confirm that all applicants have read the information relating to their rights under the Access to Medical Reports Act 1988 and completed the declaration.

This application and the medical information disclosed on it is valid for 45 days from the date the application form is signed and dated (date recorded below). We may need you to confirm that there has been no change in health since you signed this form if the final assessment of this application takes longer than 45 days from the date the application form was signed, or in the event we require further medical information from you or your dependant(s).
In some circumstances a new application form will be required.

Signature of employee on behalf of all applicants

Date

D D M M Y Y Y Y

Print full name

K – Application checklist

Before you return this application, please use this checklist to confirm that you have:

- ☐ Acknowledged that your consent is valid for 12months from date of signature or decision on application, whichever is longer.
- ☐ Completed section A to confirm the basis of your application.
- ☐ Provided your employment, employee, cover details and, if applicable, your dependants details.
- ☐ Answered 'YES' or 'NO' to all the health history questions asked in section F.
- ☐ Provided a medical disclosure on pages 6 and 7 in relation to each question that's been answered 'YES' in section F.
- ☐ Completed the GP details and Access to Medical Reports Act 1988 consent form if any applicants have answered 'YES' to any questions in section F. Please also indicate whether or not you wish to see the medical report if VitalityHealth request one.
- ☐ Read the 'Important information' in section I.
- ☐ Read, signed and dated the VitalityHealth plan declaration in section J.

NOTES

VHF0165 0824 BHC_CHC EMP FMU APP_J8740