HEALTH SHIELD CORPORATE APPLICATION

Please fill in and sign this application form. Once completed please return to:
Health Shield Friendly Society Ltd, Electra Way, Crewe Business Park, Crewe, Cheshire, CW1 6HS.

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
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

(Only fill in section 3 if you want cover for You and Your Partner)
Your husband, wife or any other person who lives with you as if you are married, no matter whether they are male or female.

Title
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

Surname
Forename(s)
Date of birth

Surname
Forename(s)
Date of birth

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?

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

☐ 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

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:
By telephone ☐ By email ☐ By SMS ☐ By post ☐

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

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Member's payroll number

	Weekly	4-weekly	Monthly
Total amount to be paid			