



# Joining BUPA International - Your enrolment

Please write clearly, in BLOCK CAPITALS. Be sure to read, sign and date the declaration on the back page.

Then return the form to your companies BUPA International Group Secretary, in a sealed envelope.

## Pacific Prime International

### 1 To be completed by company

Scheme required	FOR COMPANY USE ONLY	Start date of cover	/	/
Group name		Group number (if known)		

To be completed by the school if joining the BUPA International ECIS scheme				
School name	FOR SCHOOL USE ONLY	Start date of cover	/	/
Scheme required		School number (if known)		

### 2 Main applicant: your personal details

Title	First name	
Other initials	Family name	
Male/Female (please tick): <input type="checkbox"/> <input type="checkbox"/>	Nationality	1st language
Occupation	Date of birth	
Have you had health cover with any other insurer, including BUPA? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please give details		
Name of other health insurer		
Name of scheme / cover	Your membership number	

### 3 Main applicant: your address details (Please let us know straightaway about any change of address)

Residency address (your residency address is your usual address in the country where you are currently living)	Correspondence address (if different)
Building number and/or name	Building number and/or name
Street number and name	Street number and name
Town/City and area postal code	Town/City and area postal code
Region	Region
Country	Country

Do you have a residence in the USA? No  Yes

### 4 Main applicant: your other contact details

Home contact			Work contact			
	Country code	Area code	Number	Country code	Area code	Number
Telephone						
Fax						
Mobile						
Email				Email		



## 8 Confidential medical history

There is no need to complete this section for anyone who is a current BUPA member.

Please answer each of these questions fully and accurately, for each person included on your application. It is important to tell us about any known or suspected medical conditions and symptoms, even if the person concerned has not yet consulted a doctor about them. So you should include, for example, any varicose vein problems, allergies, backache, bunions, piles, gynaecological or menstrual problems, ear, nose or throat problems, and any pains, swellings or lumps. If you do not give us all relevant medical information now, it could affect payment of your claims later on.

8.1 Please tick (✓) Yes or No to each of these questions, for each person to be covered.	Yourself	1st family member	2nd family member	3rd family member	4th family member
	Name	Name	Name	Name	Name
1. Within the last four years, have any of you stayed in a hospital or nursing home as in-patient?	Yes No	Yes No	Yes No	Yes No	Yes No
2. Within the last four years, have any of you consulted a medical specialist or consultant?	Yes No	Yes No	Yes No	Yes No	Yes No
3. Within the last two years, have any of you consulted a doctor and/or been prescribed any drugs or medication?	Yes No	Yes No	Yes No	Yes No	Yes No
4. Do any of you suffer from any chronic or long-term medical or dental condition, or have any other disability, abnormality or recurrent illness or injury?	Yes No	Yes No	Yes No	Yes No	Yes No
5. Is there any known or foreseeable reason why any of you need to consult a doctor or other health professional?	Yes No	Yes No	Yes No	Yes No	Yes No
6. Are any of you taking any medication now, or is there any foreseeable need for you to do so?	Yes No	Yes No	Yes No	Yes No	Yes No

8.2 If you answered Yes to any of the questions in 8.1 please give full and complete details here.

For each person with a Yes tick (✓), please be sure to write in every medical condition and symptom, even undiagnosed ones.

List the condition/symptom in column 3, and give all additional details in columns 4, 5 and 6. Please write clearly, in BLOCK CAPITALS.

1. Person's name	2. Relevant box numbers	3. Medical condition or symptom	4. Consultations and treatment received, with dates	5. Any future consultations or treatment needed	6. The condition/symptoms now

If you need extra space, please go on to a separate sheet - and confirm you have done so by ticking (✓) this box.

## 9 Your doctor

Please give the name and address of your usual doctor / general practitioner.

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. 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

**Please be sure to sign and date the declaration below**

## 10 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's intention to provide a first class service to our members at all times. However, if you do have any cause for dissatisfaction, please write to the Head of Customer Services at BUPA International's Head Office. The address is, BUPA International, Russell Mews, Brighton BN1 2NR, United Kingdom. If you remain dissatisfied you may appeal to the Managing Director by writing to him at the same address. Unless otherwise agreed by BUPA in writing, English Law shall apply to the agreement between you and BUPA.

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 Lifeline 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 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 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.

Signature X

Date X

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### 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.

**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 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.

**Regulation:** BUPA is a member of the General Insurance Standards Council, which regulates the Insurance Activities of its members. Personal data may be disclosed to GISC as part of this system of regulation. Such data will be subject to a duty of confidentiality on the part of GISC.

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

**Names and Addresses:** BUPA does **not** make the names and addresses of members or patients available to other organisations.

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

**Contact Address:** If you do not wish to receive information about BUPA's products and services, or have any other Data Protection queries please write to the BUPA Group Information Protection Manager, at BUPA House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@BUPA.com.