

Application to be a contributor to HSF health plan

Date Received – HSF use

Registration No. – HSF use

THIS PART MUST BE COMPLETED IN ALL CASES

I apply to join HSF health plan at the monthly rate indicated (PLEASE TICK)

<i>Scheme 1</i>	<i>Scheme 2</i>	<i>Scheme 3</i>	<i>Scheme 4</i>	<i>Scheme 5</i>	<i>Scheme A</i>	<i>Scheme B</i>	<i>Scheme C</i>	<i>Scheme D</i>
£6.00	£12.00	£18.00	£24.00	£30.00	£39.00	£52.00	£65.00	£78.00

Surname

Forename Other Initials Mr/Mrs/Miss Ms/Other

Address

Postcode

Email Tel: Work

Date of birth Contributor Day Month Year Tel: Home

Date of birth Partner Day Month Year Fax

Partner's Surname

Partner's Forename(s)

If already covered by HSF please state:

Contribution	Registration No. (if known)
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Children (*children must be under 18 years of age*)

Child's Surname	Child's Forename(s)	Sex	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

How did you obtain this brochure?

HSF health plan uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF services and those of the Hospital Saturday Fund. Please send details of the HSF MasterCard (PLEASE TICK)

Declaration

I declare that I and all persons covered by this application for whom claims may be submitted are in good health and are not receiving or needing any form of medical treatment and have not had any medical conditions in the past for which treatment is not at present necessary. If this is not the case I have declared all relevant health information on the reverse of this form.

I understand that no claim will be accepted in respect of any conditions which existed or for which symptoms were present before registration or which began during the qualifying periods; nor for any developments of existing conditions; nor for any recurrence of conditions which have existed in the past; nor for any hereditary or congenital conditions which may already exist but which manifest symptoms only after cover commences, and that this application is accepted only on these terms. (Contributors increasing from one scheme to another may be able to receive benefit at their former scheme rate for such conditions and will be advised if this is possible).

I confirm that no advice has been received regarding this application from HSF. I agree to HSF and Chubb holding data relevant to my scheme registration.

I agree to abide by HSF rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or contributions if deemed necessary. I declare that all the information I have given on this application form is true and complete to my knowledge and belief and that if found to the contrary HSF shall be free to cancel cover at any time.

Signature Date

IMPORTANT: PLEASE COMPLETE THE MEDICAL INFORMATION SECTION ON REVERSE (PAGE 18)

TEAR ALONG PERFORATION

Medical information

Your cover has to be based on the information you supply on the whole of this application form. You must be satisfied that it is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and/or treatments of all persons to be covered could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. It could also lead to termination of cover or even be considered a criminal offence.

Please state any long term/chronic/congenital conditions even if at present under control and indicate to whom these apply. PLEASE TICK BOX (if using 'Other' section, please state conditions in full and avoid abbreviations)

Name	Condition/Illness	Date symptoms began
	<input type="checkbox"/> Arthritis PLEASE STATE PART(S) OF BODY AFFECTED BELOW <input type="checkbox"/> Asthma/Chest problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Raised blood pressure/Angina <input type="checkbox"/> Congenital (conditions from birth) PLEASE STATE <input type="checkbox"/> Other PLEASE STATE	

Please list other illnesses/operations, either current or in the past (stating conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition/illness requiring the treatment.

Name	Condition/Illness	Date symptoms began

Signature X	Date
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Instruction to your Bank or Building Society to pay Direct Debits



Please complete parts 1 to 4 using a ball point pen and post it to:

HSF health plan, FREEPOST SW1062, London SE1 9BR or HSF health plan, FREEPOST RRHG-TLKG-UKTZ, Suite 3.5, 111 Union Street, Glasgow G1 3TA

Originator's Identification Number **9 4 1 1 4 1** Reference Number

Please tick your preferred date: 5th 20th Also tick your preferred period: Monthly Quarterly 6 Monthly Annually This is not part of your instruction to your bank

1. Please print the name(s) of the account holder(s)

2. Sort Code - - Bank/Building Society Account Number

3. Please print the name and full postal address of your Bank or Building Society. To the Manager:

Bank/Building Society
Address

 Postcode

4. Instruction to your Bank or Building Society.

Please pay HSF health plan Direct Debits from the account detailed on this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with HSF health plan and if so, details will be passed electronically to my Bank/Building Society.

Signature(s)	Date
<input type="text"/>	<input type="text"/>

Banks and Building Societies may not accept Direct Debit instructions from some types of account.

This guarantee should be detached and retained by the Payer

The Direct Debit Guarantee

- 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 and Building Society.
- If the amounts to be paid or the payment dates change HSF health plan will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by HSF health plan 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 or any time by writing to your Bank or Building Society. Please also send a copy of the letter to us.



CREDIT/DEBIT CARD PAYMENT FORM ON REVERSE (PAGE 20)

TEAR ALONG PERFORATION

Payment by Credit and Debit cards to: HSF health plan



- Please enter the card number clearly as incorrect numbers cause delays.
- If you wish to pay by Maestro/SOLO also complete the Issue Number.
- Maestro/SOLO/DELTA cards also display your account number which is NOT required.

I authorise you, until further notice in writing, to charge my *VISA/MASTERCARD/Maestro/SOLO/DELTA/Electron account the sum of £ for *six months'/one year's contributions.

Please debit with this amount and the same amount *every six months/annually (or such future amounts as apply for my registration), until cancelled.

*DELETE AS APPROPRIATE

Name

(NAME AS IT APPEARS ON YOUR CREDIT/DEBIT CARD, BLOCK CAPITALS PLEASE)

Address

Postcode

Signature 	Date
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My Credit/Debit card number is

Valid from /

Expiry date /

Issue number

Post form to: **HSF health plan**
FREEPOST SW1062
London SE1 9BR

or **HSF health plan**
FREEPOST RRRH-TLGK-UKTZ
Suite 3.5, 111 Union Street
Glasgow G1 3TA

Registration No.