

Application to join 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)

Scheme 1	Scheme 2	Scheme 3	Scheme 4	Scheme 5	Scheme A	Scheme B	Scheme C	Scheme D
£7	£14	£20	£27	£33	£43	£58	£73	£86

Surname

Forename Other Initials Mr/Mrs/Miss Ms/Other

Address

Postcode

Email Tel: Work

Date of birth Policyholder Day Month Year Tel: Home

Date of birth Spouse/Partner Day Month Year Mobile

Spouse/Partner's Surname

Spouse/Partner's Forename(s)

If already covered by HSF please state:

Amount Paid Registration No. (if known)

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"/>

Claim settlement will normally be made directly to your Bank/Building Society account. If you have your Bank/Building Society account details please enter them here. Alternatively you will be able to advise us of these when you make your first claim.

Name of Account Holder

Sort Code - - Account Number

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, congenital or perinatal conditions which may already exist but which manifest symptoms only after cover commences, and that this application is accepted only on these terms. (Policyholders 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 or my employer. 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 premiums 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 22)

Where did you hear about HSF health plan?

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"/> Clinical Obesity <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 		Date

Instruction to your Bank or Building Society to pay Direct Debits



Originator's Identification Number

Originator's Identification Membership Reference Number

9 4 1 1 4 1

[Empty grid for membership reference number]

Please complete parts 1 to 4 to instruct your bank to take payments directly from your account. Then return the form to: **HSF health plan, FREEPOST SW1062, London SE1 9BR or HSF health plan, FREEPOST RRHG-TLKG-UKTZ, Glasgow G1 3TA**

Please tick your preferred date: Also tick your preferred period:

5th 20th Monthly Quarterly 6 Monthly Annually This is not part of your instruction to your bank

1. Please print the name and full postal address of your bank/building society and branch.

[Three rows of empty grid boxes for address]

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

[Two rows of empty grid boxes for account holder name]

3. Sort Code

Account Number

[Three boxes for Sort Code]

[Eight boxes for Account Number]

Banks may refuse to accept instructions to pay direct debits from some types of account.

4. Your instructions to the bank/building society and signature:

Please pay HSF health plan Direct Debits from the account detailed in this instruction subject to the safeguards assued 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/bulding society.

Signature **X** Date

Banks and building societies may not accept Direct Debit Instructions for 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 accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit HSF health plan will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request HSF health plan to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by HSF health plan or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society
 - If you receive a refund you are not entitled to, you must pay it back when HSF health plan asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

CREDIT/DEBIT CARD PAYMENT FORM ON REVERSE (PAGE 24)

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

£ or such other amount, advised to me in advance for *six months/one year's cover.

Please debit with this amount and the same amount *every six months/annually, (or such future amounts as apply to my cover) until cancelled. *DELETE AS APPROPRIATE

Name

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

Address

PLEASE ENTER THE CARD NUMBER CLEARLY AS INCORRECT NUMBERS CAUSE DELAYS

My Credit/Debit card number is

Valid from Date / Expiry Date / Issue Number (if applicable)

Signature 	Date
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Post Form to:
HSF health plan, FREEPOST SW1062, London SE1 9BR or HSF health plan FREEPOST RRRHG-TLKG-UKTZ, Glasgow G1 3TA

Registration Number (for HSF use)

Head Office

24 Upper Ground, London SE1 9PD
Tel: 020 7928 6662
Fax: 020 7928 0446

Registration enquiries: 020 7202 1380
Email: registration@hsf.eu.com

Claims enquiries: 020 7202 1381
Email: claims@hsf.eu.com

Scotland Office

Suite 1.22, 111 Union Street, Glasgow G1 3TA
Tel: 0141 221 1711
Fax: 0141 248 3992
Email: glasgow@hsf.eu.com

www.hsf.eu.com



INVESTOR IN PEOPLE

