yourchoice

Enquiry No (CSH use only):

Registration No (CSH use only):

Full Medical Underwriting & Moratorium Proposal Form

CS healthcare

Proposal Form Please write in BLOCK CAPITALS

Before completing this Proposal Form it is important to understand how your policy will work and what information should be provided to CS Healthcare. To complete the form, you may find it helpful to seek advice from your General Practitioner. Space is provided for any additional medical information required to support your application. All responses to questions should be accurate to the best of your knowledge and belief. Please remember health insurance is designed to work alongside, not to replace all the services offered by the NHS and in all cases members retain their right to use the NHS. If you need help please call us on 020 8410 0400*.

Eligibility

To be eligible for cover with CS Healthcare you and your Spouse/Partner/Dependants on the policy must all: (please tick to confirm)

- ☐ Have been permanent residents in the UK for at least 2 years, and
- ☐ Have been registered with an NHS GP, who is not a family member, for at least 2 years.

Sporting Activity

Has any person named on this proposal ever taken part in a sporting activity, for which they have received monetary re-imbursement (including commercial sponsorship), or for which they have represented their country? ☐ YES ☐ NO

If you have answered yes, please provide details here:

Previous policy information

Has any person named on this proposal had any insurance or an insurance policy declined, cancelled, voided or accepted on special terms? ☐ YES ☐ NO

If you have answered yes, please provide details here:

Once complete, please return this form to the Membership Services Team, CS Healthcare, Princess House, Horace Road, Kingston Upon Thames, Surrey KT1 2SL or using the envelope provided.

CHECKLIST

Please ensure you have completed all relevant sections of this form before submitting. If choosing Moratorium (MOR) underwriting you should complete all sections EXCEPT section 7. If you have selected Full Medical Underwriting (FMU) underwriting you should complete all sections:

- ☐ **Section 1-4** Applicant details, cover required and payment method
- ☐ **Section 5** Access to Medical Reports
- ☐ **Section 6** Underwriting options
- ☐ **Section 7** FMU Underwriting ONLY COMPLETE IF SELECTING FMU
- ☐ **Section 8** Privacy Policy
- ☐ **Section 9** Declaration
- ☐ Have you signed **section 5 & 9?**

Section 1. Applicant Details

Please complete your personal details below:

Title

First Name(s):

Surname:

Gender: ☐ Male ☐ Female

Date of Birth: D D M M Y Y Y Y

Daytime Telephone:

Home Address:

Post Code:

Email:

Occupation (to qualify for membership):

	Tick box	
Civil Service/Public Sector	☐	Department name:
Relative of a Member	☐	Name of member/Relationship:
Charity/Voluntary sector	☐	Organisation name:
Other qualifying organisation	☐	Organisation name:

How did you hear about CS Healthcare?

Requested CS Healthcare policy start date†: D D M M Y Y Y Y

†**Please note:** we require at least 15 working days to assess your application following receipt of this completed Proposal Form. We will confirm your policy start date once your application has been assessed. The assessment is conditional on us receiving all relevant application/medical information and your start date is subject to change if the assessment of your application takes more than 15 days to complete following receipt.

*Your call will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Section 2. Spouse/Partner/Dependant details (if cover is required, if not please leave this section blank)

Please provide details of family members you want included on the policy.

Title	Full name	Relationship to Applicant	Date of Birth

Section 3. Cover required (please tick the boxes which apply)

All people on the policy must be on the same level of cover. Essential cover is compulsory. Full details of all our policy benefits and cover options can be found in the policy summary. Please see hospital list for full details of hospitals covered or visit our website: **cshealthcare.co.uk**

Cover Options

- ✓ Essential
- ☐ Expert Diagnostics Comprehensive
- ☐ Expert Diagnostics 1000
- ☐ Expert Diagnostics 500
- ☐ Heart & Cancer Comprehensive
- ☐ Heart & Cancer Limited
- ☐ Therapy & Care

Choose from:

- ED Comprehensive (inc. up to £1,000 for out-patient psychiatric consultations)
- ED 1000: £1,000 limit (excludes psychiatric cover), saving around 30% over ED Comprehensive
- ED 500: £500 limit (excludes psychiatric cover), saving around 50% over ED Comprehensive

Choose from 2 levels of cover:

- H&C Comprehensive
- H&C Limited: a £50,000 limit for each Heart and each Cancer condition per person for the lifetime of the policy, saving around 25% over Heart & Cancer Comprehensive

Cash Benefits

☐ Level 1 - £50 ☐ Level 2 - £100 ☐ Level 3 - £150 ☐ Level 4 - £200

Hospital Band

☐ Partnership ☐ Extended

Voluntary Excess

☐ No Excess ☐ £100 ☐ £300 ☐ £500 ☐ £1,000 ☐ £2,000

OR

Co-payment option

☐ Maximum £1,000 for each person

☐ Maximum £3,000 for each person

Please note:

- You cannot select an excess AND a co-payment.
- Excess and co-payment options apply per person per policy year.
- You cannot have Expert Diagnostics 500 with a £500, £1000 or £2000 policy excess.
- You cannot have Expert Diagnostics 1000 with a £1000 or £2000 policy excess.

Section 4. Payment Method

Please complete the Direct Debit Instruction at the end of this form OR make cheques payable to CS Healthcare. If you wish to pay annually in advance by Debit or Credit Card please call us on 0800 917 4325*. Alternatively we can call you take payment. We are open 9am to 5pm Monday to Friday please indicate the best time for us to call you.

☐ Monthly Direct Debit

☐ Annual Direct Debit ☐ Annual Cheque ☐ Annual Debit Card ☐ Annual Credit Card

When is the best time for us to call you? ☐ 9am to 11am ☐ 11am - 2pm ☐ 2pm to 5pm

*Your call will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Section 5. Access to Medical Reports

ACCESS TO MEDICAL REPORTS ACT (1988)

If we need to get a medical report from a doctor who has cared for you or a listed family member making a claim, we will need your consent, and while some medical practitioners are happy to accept the patient's verbal consent, some will require a written consent. You also have specific rights under The Access to Medical Reports Act 1988 as detailed below:

- We need your agreement before we can apply for a medical report from your doctor. You can refuse but if you do we will not be able to assess your application/claim.
- You can ask to see the report before your doctor sends it to us, or for up to 6 months after. If you wish to see the report, please tick the box on the declaration below to indicate you want to see the report. This might delay the assessment of your application/claim and your doctor may charge you a fee.
- If you think a part of the report is incorrect or misleading when you see it, you can ask your doctor to have it changed.
- If your doctor will not agree to this, you may wish to attach a statement of your own.
- You will not be entitled to see any part of the report which:
  - The doctor believes could seriously harm your physical or mental health, or that of others.
  - Indicates the doctor's intentions in respect of you.
  - Reveals information about another person, or the identity of someone who has given the doctor information about you (unless that person consents or is a health professional involved in caring for you).

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

☐ Please tick here to confirm you have read the above and disclosed the information to all dependants listed on this form

☐ Please tick if you wish to see your medical report

Signature of main applicant: X Date: / /

Section 6. Underwriting Options

Please choose only ONE option, see below for details. If choosing Moratorium (MOR) underwriting you should **complete all sections EXCEPT section 7**. If choosing Full Medical Underwriting (FMU) underwriting you should **complete all sections**.

MORATORIUM UNDERWRITING (MOR)

If you choose this option you do not need to fill in a health questionnaire. Instead we will automatically exclude the cost of treating any pre-existing conditions for which you (or any spouse/partner/dependant included in your application) have received treatment and/or medication, asked advice on, or had symptoms of (whether diagnosed or otherwise), during the five years immediately before your private medical insurance commences.

If you do not have symptoms, treatment, medication or advice for those pre-existing conditions, and any directly related conditions, for two continuous years after your policy starts, then we will reinstate cover for those conditions.

IMPORTANT NOTES

At the point of **every** claim and before any treatment can be authorised, we will ask you to provide a copy of the GP referral letter so we can assess the claim. This procedure is continuous throughout the life of the policy and may cause a delay in authorising treatment. Your GP may charge you for this service.

We can request a medical report to help us assess claims made against the policy for you and any spouse/partner/dependants, and associated costs will be your responsibility.

You should understand that long-term medical conditions, which are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered by your policy. You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy.

☐ **I wish to select Moratorium Underwriting (MOR),** I have read and understood the information above.

Please continue to **section 8** on page 10

FULL MEDICAL UNDERWRITING (FMU)

If you choose this option, you will need to complete a questionnaire (section 7) about the health of all applicants. This will enable us to understand your medical history (and that of any spouse/partner/dependant whom you wish to insure). It is important that you consider the questions carefully, for each person to be covered, and answer them fully. We will review your details and inform you of the terms of insurance we are prepared to offer. If necessary, we may need to ask your doctor for further information to help us to do this, if this is the case you will be liable for any costs associated with obtaining this.

If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show any personal exclusion on the Registration Certificate you receive from us when we have processed your application. The same process will also apply for any spouse/partner/dependants included in your application.

IMPORTANT NOTES

If you or any spouse/partner/dependant covered under the policy make a claim for symptoms that occur within the first year of your policy, we will ask you to provide a copy of the GP referral letter so we can assess the claim. This is to ensure we have received all the correct information regarding the insured individual's state of health when they joined us.

Pre-existing conditions, including symptoms whether diagnosed or not, will not be covered by CS Healthcare, unless they have been fully declared and accepted for cover by CS Healthcare.

☐ **I wish to select Full Medical Underwriting (FMU).** I have read and understood the information above and I understand that I must inform CS Healthcare of any new conditions or symptoms that may arise between submitting this application form and the start of my policy

Please continue to **section 7** on page 6

Section 7. FMU Underwriting section only

MEDICAL QUESTIONS (FOR FMU ONLY)

The following questions apply to all applicants for FMU. Please ensure you answer 'yes' or 'no' to every question. Please check all the information for you and your spouse/partner/dependants to be covered under the policy; if you are not sure of any details it may be useful to discuss this with your GP. Failure to give all the relevant information may lead to a claim being turned down should you choose to go ahead with the policy.

Have you or anyone to be covered under this policy EVER had any of the following:

1. Heart Disease or Heart Condition, for example:
   - Coronary Artery Disease or Ischaemic Heart Disease including Angina, Myocardial Infarction (heart attack)
   - Major Vessel Disease – Aortic conditions affecting your veins or arteries (with the exception of varicose veins, vascular surgery for limbs and lymphatic system, these are covered under Essential)
   - Aortic Aneurysm
   - Cardiac Failure
   - Valve Disease requiring replacement – of the Aortic, Bicuspid (mitral), Tricuspid, Pulmonary valves
   - Conduction/Rhythm Disorders - like Atrial Fibrillation, Syncope, Bradycardia
   - Cardiomyopathy
   - Pericarditis/Endocarditis

   ☐ YES ☐ NO
2. Stroke, Cerebral Vascular Accident (CVA), haemorrhage, Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease, Epilepsy or Transient Ischaemic Attack (TIA) ☐ YES ☐ NO
3. Cancer, Leukaemia, Tumours, Melanomas or Basal Cell Carcinomas ☐ YES ☐ NO
4. Spinal surgery or spinal condition, degenerative joint disease or surgery as a result of joint or bone condition ☐ YES ☐ NO
5. Digestive disorders of the stomach, intestine, liver or bowel such as Crohn's Disease and colitis ☐ YES ☐ NO
6. Diabetes or sugar in the urine ☐ YES ☐ NO
7. Circulatory problems, varicose veins, leg ulcers, poor circulation or peripheral vascular disease ☐ YES ☐ NO
8. HIV or hepatitis B or C ☐ YES ☐ NO
9. Depression, Anxiety or Stress or any other Psychiatric Condition ☐ YES ☐ NO

In the last 5 years have you or anyone to be covered by the policy had:

10. High blood pressure or high cholesterol ☐ YES ☐ NO
11. Nerve pain, muscle, bone or joint pains such as neck, hip or knee problems ☐ YES ☐ NO
12. Breathing or Respiratory Condition such as asthma, bronchitis, shortness of breath or chest infection ☐ YES ☐ NO
13. Any disease or disorders of the eyes, ears, nose or throat such as cataracts, glaucoma, macular degeneration, ear infections, glue ear, deafness, polyps, tonsillitis, sinusitis or rhinitis ☐ YES ☐ NO
14. Endocrine conditions such as thyroid or pituitary/hormone disorders ☐ YES ☐ NO
15. Skin conditions, rashes, eczema, psoriasis, acne, skin lesions or cysts ☐ YES ☐ NO
16. Urinary condition such as bladder or kidney disorders, retention of urine, urinary tract infections, blood in urine and incontinence ☐ YES ☐ NO
17. Blood disorders, clotting disorders, anaemia, abnormal blood results ☐ YES ☐ NO
18. Piles, haemorrhoids, rectal bleeding or blood in stool ☐ YES ☐ NO
19. Any medical conditions or symptoms for which you have received or are receiving treatment, investigations, check-ups or consultations from a doctor or other health professional ☐ YES ☐ NO

Females only

20. Any gynaecological disorders such as fibroids, endometriosis, ovarian cysts, abnormal cervical smear tests or abnormal bleeding ☐ YES ☐ NO

Males only

21. Any prostate conditions, raised PSA or testicular disorders ☐ YES ☐ NO

In the past 12 months have you or anyone to be covered under the policy:

22. Had a consultation, X-ray or scan ☐ YES ☐ NO
23. Taken or been advised to take any medicines or drugs or any other type of treatment ☐ YES ☐ NO

If you have answered 'yes' to any of questions 1-22, please complete the 'Detailed Medical History' on page 7.
If you answered 'yes' to question 23, please also complete 'other medication' on page 8.

Detailed Medical History

Please answer the following supplementary questions as fully as possible. If you wish to provide additional medical documents (e.g. a GP report) you may attach this to your application, but please be aware that any such documents do not take the place of a fully completed medical declaration. **If you need more space to complete the Detailed Medical History please continue on separate sheets.**

MEDICAL QUESTION NUMBER TO WHICH YOU ANSWERED 'YES':

Name of applicant to which this relates?

What is/was the condition/symptom?

When did symptoms first occur?

What medication is taken, if any?

What investigation or treatment has been carried out, what is the current status and what is proposed, including any follow up appointments? Please include dates, Hospital and Practitioner details:

MEDICAL QUESTION NUMBER TO WHICH YOU ANSWERED 'YES':

Name of applicant to which this relates?

What is/was the condition/symptom?

When did symptoms first occur?

What medication is taken, if any?

What investigation or treatment has been carried out, what is the current status and what is proposed, including any follow up appointments? Please include dates, Hospital and Practitioner details:

MEDICAL QUESTION NUMBER TO WHICH YOU ANSWERED 'YES':

Name of applicant to which this relates?

What is/was the condition/symptom?

When did symptoms first occur?

What medication is taken, if any?

What investigation or treatment has been carried out, what is the current status and what is proposed, including any follow up appointments? Please include dates, Hospital and Practitioner details:

MEDICAL QUESTION NUMBER TO WHICH YOU ANSWERED 'YES':

Name of applicant to which this relates?

What is/was the condition/symptom?

When did symptoms first occur?

What medication is taken, if any?

What investigation or treatment has been carried out, what is the current status and what is proposed, including any follow up appointments? Please include dates, Hospital and Practitioner details:

Other Medication

Please complete this section if you are taking any medication not mentioned in 'Detailed Medical History'.
If you need more space to complete this section please continue on separate sheets.

Name of the applicant taking the medication:

☐ Prescribed ☐ Self Prescribed

Name of medication, dosage frequency, and condition/symptom it is used for:

Other Medication

Name of the applicant taking the medication:

☐ Prescribed ☐ Self Prescribed

Name of medication, dosage frequency, and condition/symptom it is used for:

Name of the applicant taking the medication:

☐ Prescribed ☐ Self Prescribed

Name of medication, dosage frequency, and condition/symptom it is used for:

Name of the applicant taking the medication:

☐ Prescribed ☐ Self Prescribed

Name of medication, dosage frequency, and condition/symptom it is used for:

Further Medical Information

If you would like to provide further medical information on a separate piece of paper, or submit a medical report, please indicate below the number of pages and applicants to which the information applies.

Applicant Name	No of extra sheets	Medical Report *(please tick if attached)*
		☐
		☐
		☐
		☐
		☐
		☐

Section 8. Privacy Policy

In becoming the main applicant you have sought and agreed to act on behalf of any other person included within the policy. As such all membership documents and confirmation of how we have dealt with any claim/s under the policy will be sent to you.

How we may use your personal information:

- CS Healthcare sometimes uses third parties to process data on its behalf (if you would like further information as to these third parties please write to the Data Protection Officer).
- To aid CS Healthcare in detection and prevention of fraudulent claims we may disclose personal information about you to fraud prevention agencies that in turn may record, use and distribute this personal information to other organisations. In addition we work collectively with other organisations to share information relating to fraudulent/ suspicious claims.
- Medical information or records will only be disclosed to those involved with your treatment or care, including your GP, companies or intermediaries, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses.
- Under the terms of the General Data Protection Regulation (2016/679), you have the right to:
  - Be Informed about the collection and use of your personal data.
  - Access your personal data.
  - Recitfy any inaccurate personal data or complete if it is incomplete.
  - To have your personal data erased.
  - Restrict or supress the processing of your personal data.
  - Obtain and reuse your personal data for use across different services
  - Object to the processing of your personal data, in certain circumstances.
  - Request contest or human intervention for any automated decision making.

  If you wish to invoke any of these rights, please contact CS Healthcare's Data Protection Officer either verbally or in writing.

  Further information about these rights can be found on the ICO website https://ico.org.uk/
- CS Healthcare will use your personal data in order to administer your policy. This will involve contacting you via email and post about key events and information integral to the ongoing maintenance of your policy. In addition, your medical information will be needed to be processed in order to manage any claims you have with the society
- For all Data Protection queries please write to the Data Protection Officer at: Civil Service Healthcare Society Limited, Princess House, Horace Road, Kingston Upon Thames, Surrey KT1 2SL

Telephone calls:

In the interest of continuously improving our service to members, calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

CS Healthcare would like to keep you updated in regards to products and services that we believe may be of interest to you. We will only do this if you are happy to receive such information.

Please tick below which methods you would like to be contacted by:

☐ Email ☐ Post ☐ Telephone ☐ SMS

☐ **Consent:** I understand that by completing this proposal I give explicit consent on behalf of myself and listed family members for CS Healthcare to process our personal information with respect to our membership.

Section 9. Declaration

I have read the Policy Summary (this can be found in the resources area of the website www.cshealthcare.co.uk) and recognise that if my application is accepted I will receive full documentation about my cover, including the Policy Document.

If, for any reason, I wish to cancel my cover I can do so without obligation, provided that I write to CS Healthcare no later than 15 days after the policy documents are sent to me when I first join the Society. If so, a full refund will be made provided that no claims for benefit have been submitted against the policy.

I, on behalf of any spouse/partner/dependants, apply for cover and agree to be bound by the Policy terms and conditions of the plan for which I am applying. I understand English Law applies to the agreement between CS Healthcare and I, unless otherwise agreed between us in writing.

☐ I have read and understood this declaration.

I declare that all the information given to CS Healthcare is true and complete to the best of my knowledge and belief whether given: on my behalf or on behalf of my spouse/partner/ dependants for the purposes of receiving my quotation or as part of the application process.

If there has been any change to the information since it was supplied to you I declare that I have set out details of that change in this completed form.

I understand that if any of the information provided by me is incorrect or incomplete, CS Healthcare may be entitled to decline my claim, refuse to pay benefit and/or cancel my policy.

Signature of main applicant: X Date: / /

Please ensure you have completed the checklist on page 2 before returning the form.
Once complete, please return this form to the Membership Services Team, using the envelope provided or E-mail: membership@cshealthcare.co.uk

Please fill the whole form including official use box using a ball point pen and send it to:

CS Healthcare
Princess House
Horace Road
Kingston Upon Thames
Surrey
KT1 2SL

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager Bank/building society

Address:

Post Code:

Reference

Instruction to your bank or building society to pay by Direct Debit

Originator's Identification Number

9	5	4	3	4	3

For CS Healthcare OFFICIAL USE ONLY
This is not part of the instruction to your bank or building society

Do you wish to pay your premium annually or monthly by Direct Debit

☐ Annually ☐ Monthly

Instructions to your bank or building society
Please pay CS Healthcare Direct Debits from the account details in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with CS Healthcare and, if so, details will be passed electronically to my bank/building society.

Signature X

Signature X

Date: / /

Bank and building society 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 CS Healthcare will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request CS Healthcare 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 CS Healthcare or your bank or building society, you are entitles 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 CS Healthcare 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.