



# GLOBAL HEALTH PLANS

## JOINING AND MANAGING YOUR PLAN

Bupa Global is the sole insurer of this plan Bupa Global is a trade name of Bupa, the international health and care company. Bupa is an independent licensee of Blue Cross and Blue Shield Association. Bupa Global is not licensed by Blue Cross and Blue Shield Association to sell Bupa Global/Blue Cross Blue Shield Global co-branded products in Argentina, Canada, Costa Rica, Panama, Uruguay and US Virgin Islands. In Hong Kong, Bupa Global is only licensed to use the Blue Shield marks. Please consult your policy terms and conditions for coverage availability. Blue Cross and Blue Shield Association is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies. Blue Cross Blue Shield Global is a brand owned by Blue Cross and Blue Shield Association. For more information about Bupa Global, visit [bupaglobalaccess.com](http://bupaglobalaccess.com), and for more information about Blue Cross and Blue Shield Association, visit [www.BCBS.com](http://www.BCBS.com).

# GLOBAL HEALTH PLANS

This form can be completed by **new customers** or **existing Bupa Global customers**.



## HOW TO USE THIS FORM

We have split this form into sections to make it easier for you to complete. Each section is numbered with an icon below.



These icons represent the person you are describing on the form.



When you see  you need to fill in information about the **Main Applicant** and this  is referring to the **1st Additional Person**.

## IMPORTANT INFORMATION

YOU CAN TYPE DIRECTLY INTO THIS FORM, SAVE IT AND EMAIL IT TO US.

ALTERNATIVELY, PLEASE WRITE CLEARLY IN BLOCK CAPITALS USING BLACK INK.

Once completed, you can email your form to: [eeadirectsales@bupa.com](mailto:eeadirectsales@bupa.com), fax us on +44 (0) 1273 866 583 or post to Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, United Kingdom.

Please note that we cannot guarantee the security of email as a method of communication. Some companies, employers and/or countries do monitor email traffic, so please bear this in mind when sending us confidential information.

If you have faxed or emailed us then we do not need the original copy of your form.

Please note that the plan you are joining is a fully medical underwritten plan. This means that any symptoms or conditions that have been present prior to the start date of the plan may not be covered.

If you do not take reasonable care to provide full, complete and accurate information for each of the persons to be covered under the policy, it may affect the cover for those people.

Please tell us immediately if you or any additional person to be covered under the policy experience any symptoms between the time you complete this application form and the date the policy starts. Failure to do so may mean we are unable to pay your claims.

The global health plans are not designed to meet specific in-country requirements and are not intended to be used to fulfil visa or compulsory health insurance requirements where they fall due. The plans can be used alongside any locally required health insurance contract. The plans are designed for short term stays in the U.S.

## FOR NEW CUSTOMERS

Please complete sections 1-10, and section 11 if applicable

Read, sign and date the declaration in section 12



## FOR EXISTING CUSTOMERS

There are a number of things you can change on your plan using this form. Make sure you **read, sign and date the declaration in section 12.**

### Changing your address and contact details?

You must notify us of any change of contact details so that we can ensure that correspondence reaches you

The easiest way to change your address and contact details is simply to contact us. You can email us on [info@bupaglobal.com](mailto:info@bupaglobal.com), call us on +44 (0) 1273 323563, or contact us via our secure website at <https://membersworld.bupaglobal.com>.

### Adding additional people to your plan?

- complete sections 1 and 5-8
- complete section 11, if applicable
- **read, sign and date the declaration in section 12**



### Want to change your cover?

- complete sections 1 and 7-9
- complete section 11, if applicable
- **read, sign and date the declaration in section 12**



### Want to change your payment details?

- complete sections 1 and 10
- complete section 11, if applicable
- **read, sign and date the declaration in section 12**



## 1 MAIN APPLICANT: MEMBERSHIP DETAILS

M

Bupa Global membership number

Alternatively, if you have previously had a policy with Bupa, please tick here and provide the membership number above. ☐

## 2 MAIN APPLICANT: YOUR PERSONAL DETAILS

M

The date you want your cover to start: 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 (cannot be between 28th & 31st)

Title 

--	--	--	--

 Male ☐ Female ☐ 1st language 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Middle name 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Family name 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of birth 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Country of nationality 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Occupation 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

## 3 MAIN APPLICANT: YOUR ADDRESS DETAILS

M

### Residency address

(your permanent or usual address in the country where you are resident, on the day you would like the policy to start)

Address line 1 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address line 2 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Town/City 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Country 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Postal/Zip/Area code 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Correspondence address - if your correspondence and residency address are the same please tick here** ☐

Address line 1 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address line 2 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Town/City 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State 

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Country 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Postal/Zip/Area code 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Please check your local rules as to where you are resident. In the UK there are a number of factors which determine whether or not you are a resident. For example, if you have been living in the UK for 183 days or more in the current tax year (since 6 April) you will be deemed a UK resident.

Do you have a residence in the U.S.? Yes ☐ No ☐

## 4 MAIN APPLICANT: YOUR OTHER CONTACT DETAILS

M

(Please include country code, area code and number)

Phone/Mobile 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Email 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

## 5 YOUR CONSENT TO BE A PAPERLESS CUSTOMER

M

At Bupa we are doing everything we can to reduce our impact on the environment. To help us do this we encourage our customers to be paperless.

☐ **Paperless customer** – view and manage your plan online by registering on MembersWorld. You will receive emails when new documents are available to view (please make sure you have provided us with a valid email address).

☐ **Hard copy** – receive your documents by post.

You can change your mind at any time on MembersWorld (<https://membersworld.bupaglobal.com>) or by contacting us.

You can find out more about the benefits of using MembersWorld in your Membership Guide.

**Please note each dependant over the age of 16 can select their documents' preference in section 6**

## 6 ADDITIONAL PEOPLE TO BE COVERED WITH YOU

If any of these additional persons have different residency or correspondence addresses to yours, please write their name and addresses on a separate sheet and confirm you have done so by ticking here: ☐

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	1st language	
First name						Middle name	
Family name							
Date of birth	D	D	M	M	Y	Y	Country of nationality
Country of residency						Relationship to you	
Email							
<b>For over 16s only</b> <input type="radio"/> Paperless customer (manage plan online, register on MembersWorld) <input type="radio"/> Hard copy (receive documents by post)							
Have you had a previous policy with Bupa? Yes <input type="radio"/> No <input type="radio"/> If yes, membership number							

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	1st language	
First name						Middle name	
Family name							
Date of birth	D	D	M	M	Y	Y	Country of nationality
Country of residency						Relationship to you	
Email							
<b>For over 16s only</b> <input type="radio"/> Paperless customer (manage plan online, register on MembersWorld) <input type="radio"/> Hard copy (receive documents by post)							
Have you had a previous policy with Bupa? Yes <input type="radio"/> No <input type="radio"/> If yes, membership number							

Title		Male	<input type="radio"/>	Female	<input type="radio"/>	1st language	
First name						Middle name	
Family name							
Date of birth	D	D	M	M	Y	Y	Country of nationality
Country of residency						Relationship to you	
Email							
<b>For over 16s only</b> <input type="radio"/> Paperless customer (manage plan online, register on MembersWorld) <input type="radio"/> Hard copy (receive documents by post)							
Have you had a previous policy with Bupa? Yes <input type="radio"/> No <input type="radio"/> If yes, membership number							

## 6

## ADDITIONAL PEOPLE TO BE COVERED WITH YOU (CONTINUED)

4

Title					Male	<input type="radio"/>	Female	<input type="radio"/>	1st language											
First name									Middle name											
Family name																				
Date of birth	D	D	M	M	Y	Y	Y	Y	Country of nationality											
Country of residency									Relationship to you											
Email																				
<b>For over 16s only</b> <input type="radio"/> Paperless customer (manage plan online, register on MembersWorld) <input type="radio"/> Hard copy (receive documents by post)																				
Have you had a previous policy with Bupa?										Yes	<input type="radio"/>	No	<input type="radio"/>	If yes, membership number						

## 7

## MEDICAL HISTORY

This section asks for health and medical details, past and present about yourself and each person named in Section 6.

Please tick Yes or No to every question for every person. **If you tick Yes to a question, please give full details in Section 8.**

**If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims and/or cause us to review the terms and conditions of your policy.**

Whether you are changing your benefits, or a returning Bupa customer, you must complete the medical history section in full so that we have an up to date record of your health.

For any of the medical conditions listed below (questions 1-13), please answer yes if you or anyone to be covered by this plan has:

- Seen a doctor or other healthcare professional in the last three years
- Been admitted to hospital, had an operation or procedure, or had an investigation (e.g. a scan/blood tests) in the last seven years

	M	1	2	3	4
	Y N	Y N	Y N	Y N	Y N
<b>1. Circulatory disorders</b> e.g. high blood pressure, high cholesterol, chest pains, aneurysms, varicose veins or deep vein thrombosis	Y N	Y N	Y N	Y N	Y N
<b>2. Endocrine (glandular) disorders</b> e.g. diabetes (Type 1 or Type 2), thyroid problems, Addison's disease or obesity	Y N	Y N	Y N	Y N	Y N
<b>3. Breathing or respiratory disorders</b> e.g. shortness of breath, asthma, chronic obstructive pulmonary disease, chest infections, pneumonia, bronchitis, tuberculosis, emphysema, sleep apnoea or allergies (including hayfever and anaphylaxis)	Y N	Y N	Y N	Y N	Y N
<b>4. Stomach, intestines, liver or gall bladder problems</b> e.g. stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias	Y N	Y N	Y N	Y N	Y N
<b>5. Benign tumours, growths or pre-cancerous conditions</b> e.g. polyps, benign growths, non-cystic breast lump, fibrocystic breast disease or lipomas	Y N	Y N	Y N	Y N	Y N
<b>6. Skin problems</b> e.g. eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic conditions	Y N	Y N	Y N	Y N	Y N
<b>7. Brain or nervous system disorders</b> e.g. dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles), Parkinson's disease, motor neurone disease, cerebral palsy, encephalitis or meningitis	Y N	Y N	Y N	Y N	Y N
<b>8. Muscle or skeletal problems</b> e.g. arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, fractures, osteoporosis, gout or inflammatory conditions	Y N	Y N	Y N	Y N	Y N



	M	1	2	3	4
<b>9a. Female urinary or reproductive system problems</b> e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, incontinence, ovarian cysts, polycystic ovaries, pelvic inflammation, cervical disease, endometriosis, dysmenorrhoea, irregular menstruation, fibroids, breast disease or infertility	Y N	Y N	Y N	Y N	Y N
<b>9b. Male urinary or reproductive system problems</b> e.g. kidney or bladder problem (including kidney failure), recurrent urinary infection, benign prostate hypertrophy, enlarged prostate or infertility	Y N	Y N	Y N	Y N	Y N
<b>10. Blood/infective/immune disorders</b> e.g. abnormal blood tests, anaemia, hepatitis, HIV, malaria or any autoimmune disorder	Y N	Y N	Y N	Y N	Y N
<b>11. Eye, ear, nose and throat problems</b> e.g. cataracts, glaucoma, visual impairment, detached retina, macular degeneration, deafness, ear infections, glue ear, deviated nasal septum, tonsillitis or gingivitis	Y N	Y N	Y N	Y N	Y N
<b>12. Mental health disorders</b> e.g. schizophrenia, bipolar, compulsive or eating disorders, depression, stress, anxiety or drug/alcohol dependency, panic attacks, paranoia or ADHD	Y N	Y N	Y N	Y N	Y N
<b>13. Congenital/Hereditary conditions</b> e.g. Downs syndrome, spina bifida, cystic fibrosis, cerebral palsy, cleft lip or cleft palate, sickle cell anemia, Huntington's disease, thalassemias or hemochromatosis	Y N	Y N	Y N	Y N	Y N

Please also answer the following questions:

<b>14. Is anyone to be covered taking any medication, prescribed or otherwise?</b>	Y N	Y N	Y N	Y N	Y N
<b>15. Has anyone to be covered ever had a history of the following:</b>					
○ Cancer	Y N	Y N	Y N	Y N	Y N
○ Heart condition e.g. angina, heart attack, heart failure, abnormal heartbeat	Y N	Y N	Y N	Y N	Y N
○ Stroke	Y N	Y N	Y N	Y N	Y N
○ Prosthetic implants and appliances in his/her body e.g. shunts, pacemakers, joint replacements	Y N	Y N	Y N	Y N	Y N
<b>16. Is anyone to be covered receiving any treatment of any kind or require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in questions 1 - 13?</b>	Y N	Y N	Y N	Y N	Y N
<b>17. In the last 3 months has anyone to be covered experienced any signs or symptoms of any medical problem, illness, or injury not yet diagnosed or treated?</b>	Y N	Y N	Y N	Y N	Y N

Further details (for over 16s only):

How tall are you?	<input type="radio"/> feet/inches	<input type="radio"/> metres/centimetres					
How much do you weigh?	<input type="radio"/> stones/pounds	<input type="radio"/> kilograms					

**This section applies if you, or anyone to be covered under this plan, have indicated yes to any medical questions in Section 7. If you are unsure whether any details are relevant, you must include them.**

Main Applicant or Additional Person	The relevant question number from Section 7	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (e.g. right leg, left eye).	When were symptoms first experienced and when was treatment completed (if applicable)?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (e.g. ongoing, complete recovery, recurrent or likely to recur)?
M					
1					
2					
3					
4					






If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ☐













For full details of our health plans, refer to the health plan guides where you can find out what is and isn't covered including any waiting periods and other restrictions. Health plan guides are available on our website [www.bupaglobal.com](http://www.bupaglobal.com).

### SELECT GLOBAL HEALTH PLAN:

A mandatory 15% co-insurance for out-patient treatment applies to the Select Health Plan. You can increase this to 25% by ticking the associated boxes below.





				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CO-INSURANCE:

 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>	 <input type="radio"/>
15%	25%	15%	25%	15%	25%	15%	25%	15%	25%

### PREMIER GLOBAL HEALTH PLAN:

An optional co-insurance of 15% or 25% for out-patient treatment is available on the Premier Health Plan. If you would like to add a co-insurance, please tick the associated boxes below.

				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CO-INSURANCE:

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15%	25%	15%	25%	15%	25%	15%	25%	15%	25%






**ELITE GLOBAL HEALTH PLAN:**

An optional co-insurance of 15% or 25% for out-patient treatment is available on the Elite Global Health Plan. If you would like to add a co-insurance, please tick the associated boxes below.

**Children covered at no additional cost**

With your Elite Global Health Plan up to two children under 10 years of age, per paying parent or insured legal guardian, can be insured at no additional cost\*. The child being added must reside at the same address as the parent who is insured and who has legal custody of the child.

\*Any medical loadings following underwriting will be charged.






				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CO-INSURANCE:

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15%	25%	15%	25%	15%	25%	15%	25%	15%	25%

**MAJOR MEDICAL GLOBAL HEALTH PLAN:**

A mandatory deductible of £5,000 per person per policy year applies to the Major Medical Global Health Plan.

				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A valid Direct Debit agreement or Credit Card Authority is required throughout your policy year. We may delay paying claims until you have such an agreement or authority in place.

Your choice of currency for the policy and premium payments (please tick one only): GBP £ ☐ USD \$ ☐ EUR € ☐

How will you make your premium payments (please tick one only): Monthly ☐ Quarterly ☐ Annually ☐

By Direct Debit through a UK bank. (This is only an option for GBP (£) payments. Please complete the below Direct Debit Instruction): ☐

By Credit Card (please complete the below Card Payment Authority): ☐

### CARD PAYMENT AUTHORITY

In order to take payments from your credit card, Bupa Global needs to store your card details on file.

☐ I give my consent to Bupa Global storing card details on file and using them to process payments.

Visa & Mastercard's terms and conditions require Bupa Global to obtain your consent to store your credit card information for future use. This is to enable us to take payments from you as agreed in your insurance contract, i.e.; subscriptions, deductibles and/or co-insurances. Please refer to your membership documents for details of when payments will be taken and the amounts.

We will also request your consent to store your credit card information if you are using an American Express card.

Your card will remain stored against your plan for transactional purposes until the card expires. For legal and regulatory purposes, we will continue to store records of your transactions in accordance with our Privacy Notice.

By cheque or bankers draft in the currency you have indicated above:

If you do not want Bupa Global to store your card details, then we cannot accept payments from your card and you will need to choose a different payment method.

To Bupa Global, I authorise you until further notice in writing, to charge to my card account when payments become due. I will advise you immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

(please tick) ☐ MasterCard ☐ Visa ☐ American Express

Please note that we do not accept Maestro payments. You will be given 14 days notice of other unspecified amounts to be collected.

Cardholder's name as it appears on the card

Card number

Valid from

M

M

Y

Y

Expiry date

M

M

Y

Y

CARD HOLDER'S SIGNATURE

DATE

#### Cardholder address

Address line 1

Address line 2

Town/City

Country

Postal/Zip/Area code

## DIRECT DEBIT

**If you are paying by Direct Debit you must complete this section**

- for GBP (£) payments only

Instruction to your Bank or Building Society to pay by Direct Debit

- this must come out of a UK bank account



Name(s) of account holder(s):

[illegible]

Sort code:

Bank/Building Society account number:

[illegible]

Swift code:

[illegible]

Name and full postal address of your Bank/Building Society:

To: The Manager

[illegible]

Address

																				Postcode							
--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	----------	--	--	--	--	--	--	--

Postcode

ACCOUNT HOLDER'S SIGNATURE

DATE \_\_\_\_\_

--	--

Reference number (for Bupa Global use only)

BI	-					-						-					
----	---	--	--	--	--	---	--	--	--	--	--	---	--	--	--	--	--

Originator's ID number

1	7	8	0	1	7
---	---	---	---	---	---

Banks and Building Societies may not accept Direct Debit Instructions for some type of accounts.

As Instruction Form

## The Direct Debit Guarantee

**The Direct Debit Guarantee**  
This guarantee should be detached and retained by the payer



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 or Building Society.

If the amounts to be paid or the payment dates change, Bupa Global will notify you 7 working days in advance of your account being debited or as otherwise agreed.

If an error is made by Bupa Global 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 at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.



## OUR COMPLAINTS PROCEDURE

If you have a concern or complaint you can call the Bupa Global service team on +44 (0) 1273 718 379. Alternatively, you can email or write to the team via: [Service.UK@bupaglobal.com](mailto:Service.UK@bupaglobal.com); or Bupa Global, Victory House, Trafalgar Place, Brighton, BN1 4FY, United Kingdom. You can also use these contact details to request a full copy of our complaints procedure. If we can't settle your complaint you may be able to refer your complaint to the Financial Services and Pensions Ombudsman. You can write to them at: Lincoln House, Lincoln Place, Dublin 2; or call them on +353 1 567 7000. Alternatively, you can find further details at their website: [www.fspo.ie](http://www.fspo.ie)

## INTERMEDIARIES ONLY

Please ensure up to date KYC documents have been provided for the applicant and dependants (aged over 16) where applicable. If clarity is needed on what documents are required, please contact Broker Services on +44 (0) 1273 718314. Failure to supply the accurate documents could lead to a delay and cancellation of the member's application.

[illegible][illegible]

In case of unsolicited sales, applications will only be accepted for countries that allow unsolicited sales of health insurance contracts – including on a cross-border basis, where this is the case. For more information please refer to your Bupa Global contact.

- ☐ Solicited (promoted) sale. Tick the box if this is a Solicited Sale
- ☐ Unsolicited sale - I hereby confirm that I neither promoted, sought, approached the customer and the customer neither sought nor required advice

## INTERMEDIARY'S SIGNATURE

\_\_\_\_\_

[illegible]

Date	D	D	M	M	Y	Y	Y	Y
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**We reserve the right to request further information where appropriate or necessary.**

## DECLARATION

To the best of my knowledge and belief the information given in this application form is true, accurate and complete. I understand that benefits may not be payable in full or at all and my policy may be treated as if it had not existed, if I do not take reasonable care when providing any information requested in this application form.

Where I have provided information on behalf of any other person to be covered by the policy, I confirm that I have checked with them that the information is correct before completing this application form and I have their express agreement to submit this application form on their behalf, or I am their legal representative.

I understand that my personal information and that of any other person to be covered by this policy will be processed by Bupa Global for the purposes set out in Bupa Global's privacy notice. I confirm that I have brought Bupa Global's privacy notice to the attention of these covered.

I understand and accept that all policy documentation and other written communications associated with this application including any claims information will be provided in English. I acknowledge that Bupa will endeavour to facilitate verbal communication in an alternative language insofar as is possible however I understand and accept that some verbal communications may also be in English.

I agree to be bound by the policy terms of my health plan (and for cover provided to any other person to be covered by this policy but under a different health plan, the policy terms of that health plan). I agree that Irish law will apply to the policy.

I agree that any cover for the U.S. shall terminate upon informing Bupa Global that I have become a resident of the U.S. (or in the case of an additional person becoming a resident of the U.S., their cover under the policy shall terminate).

**It is essential that you take reasonable care to provide us with full, complete and accurate information when you complete this application form. Please be sure to check the entire form.**

If you do not provide complete information, we will not be able to process your application.

If you do not take reasonable care to provide us with full, complete and accurate information about yourself or any other person covered under the policy, we will have the right to treat your policy as if it had not existed, or to refuse to pay all or part of a claim.

We recommend that you keep a record of all the 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.

Fill in your form with complete up-to-date medical history before you sign and date it. If we do not receive this application form within six weeks of this declaration date, or the date of signature expires six weeks before your cover start date we will ask for a declaration of continued good health. Or we may ask you to submit a new form.

## MAIN APPLICANT'S SIGNATURE

M

Print name

Date

D

D

M

M

Y

Y

Y

Y



IDENTIFICATION STAMP / BROKER NAME AND ID NUMBER

## The world of Bupa

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