

# Full medical underwriting application form

## Healthcare Deposit Account

**Full medical underwriting cover is for people who want to be sure whether or not they are covered for any past or current conditions from the outset.**

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- You can use this form to apply for a Healthcare Deposit Account if you're between 18-70.
- There is room for 2 adults to apply, but each adult will have their own individual plan.
- You can include up to 5 of your children on this form. You have the choice to cover them all on one policy, or on individual policies.
- You'll need to tell us your full medical history and if we are not able to cover a pre-existing condition, either for a fixed period or indefinitely, we will list it on your personal policy schedule.
- Alternatively, if you are generally well and have no pre-existing conditions you may prefer to apply using the shorter Moratorium application form. For more information please speak to your healthcare intermediary.

**Please complete this application form in BLOCK CAPITALS and either return it in the freepost envelope provided or send to: National Friendly, Freepost (SW 3073), Bristol BS8 3BR.**

**If you have any questions or require an alternative or additional application form call us on:**

**☎ Call 0800 195 9245** (8am-6pm weekdays, calls are recorded for quality purposes)

# Healthcare Deposit Account

## Full medical underwriting application form

### 1 1st adult applicant

Title	Full name
Address	
Postcode	
Daytime tel.	Email
Date of birth	Male <input checked="" type="checkbox"/> Female <input checked="" type="checkbox"/>

#### Choice of cover

Monthly premium £

When completing this section, you may find it helpful to refer to the premium table on the back page.

Payments will be taken on the 1<sup>st</sup> of each month and you will be covered as soon as we have processed your application.

Alternatively, please provide your preferred cover date.

#### Top-up cover

Our compulsory top-up gives you immediate cover from day one. This allows you to make a claim early on, when your balance is too low to cover your share of each claim.

Please choose which level you'd like: £10 a month  £15 a month  £20 a month

#### Additional monthly deposits

To boost your personal deposit account balance, you can set up an extra monthly direct debit or make a lump sum payment at any time. To set up an extra direct debit from the moment your policy starts, please enter the amount you'd like to add each month.

£

### 2 Instruction to your bank or building society to pay by direct debit



#### Name and full postal address of your bank or building society

To: The manager	Bank/building society
Address	
Postcode	

Please provide your details if you are not the Healthcare Deposit Account holder.

Relationship to applicant

Date of birth

Address

Postcode

#### Full name(s) of account holder(s)

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Please pay National Friendly direct debits from the account detailed in this instruction subject to the safeguards assured by the direct debit guarantee.

I understand that this instruction may remain with National Friendly and, if so, details will be passed electronically to my bank or building society.

#### Bank/building society account number

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

#### Branch sort code

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

#### Originator's identification number

6	7	7	9	0	2
---	---	---	---	---	---

#### Account holder's signature

X

Date

--

#### Account holder's signature\*

X

Date

--

\*This only needs to be completed if your account requires two signatures

### 3 2nd adult applicant (if applicable)

Title	Full name
Address (if different to 1st applicant)	
Postcode	
Daytime tel.	Email
Date of birth	Male <input checked="" type="checkbox"/> Female <input checked="" type="checkbox"/>

#### Choice of cover

Monthly premium £

When completing this section, you may find it helpful to refer to the premium table on the back page.

Payments will be taken on the 1<sup>st</sup> of each month and you will be covered as soon as we have processed your application.

Alternatively, please provide your preferred cover date. DDMMYY

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Please choose which level you'd like: £10 a month  £15 a month  £20 a month

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#### Name and full postal address of your bank or building society

To: The manager	Bank/building society
Address	
Postcode	

Please provide your details if you are not the Healthcare Deposit Account holder.

Relationship to applicant

Date of birth DDMMYY

Address Postcode

#### Full name(s) of account holder(s)

Full name(s) of account holder(s)
-----------------------------------

Please pay National Friendly direct debits from the account detailed in this instruction subject to the safeguards assured by the direct debit guarantee.

I understand that this instruction may remain with National Friendly and, if so, details will be passed electronically to my bank or building society.

#### Bank/building society account number

Bank/building society account number
--------------------------------------

#### Branch sort code

Branch sort code
------------------

#### Account holder's signature

Account holder's signature
----------------------------

#### Date

Date
------

#### Originator's identification number

Originator's identification number
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#### Account holder's signature\*

Account holder's signature*
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#### Date

Date
------

\*This only needs to be completed if your account requires two signatures

**5 Children under 18 years living with adult applicant (if applicable)** **Adult account holder**

Full name

Date of birth  Male  Female

Please indicate the adult applicant acting as the account holder

1st  2nd

Full name

Date of birth  Male  Female

Please indicate the adult applicant acting as the account holder

1st  2nd

Full name

Date of birth  Male  Female

Please indicate the adult applicant acting as the account holder

1st  2nd

Full name

Date of birth  Male  Female

Please indicate the adult applicant acting as the account holder

1st  2nd

Full name

Date of birth  Male  Female

Please indicate the adult applicant acting as the account holder

1st  2nd

**I wish to cover each of my children on:**

separate plans       one plan      at the following monthly premium **£**

**Top-up cover**      **£10 a month**       **£15 a month**       **£20 a month**       **Additional monthly deposits** **£**

**6 Your medical details**

**Has anyone on this form been aware of, or had any signs, medical symptoms, consultations, investigations, medication, monitoring, advice or treatment for any of the following in the last five years? You should answer all questions honestly. Failure to disclose relevant information may result in non-payment of a claim and all cover under the policy being cancelled.**

**Heart and circulatory problems**      Yes  No   
 e.g. heart disease, heart attack, angina, high/low blood pressure, embolisms/thrombosis, stroke, murmur, irregular heartbeat, chest pains, varicose veins, haemorrhoids (piles).

**Genito-urinary problems**      Yes  No   
 e.g. kidney stones/infections, cystitis, urgency or frequency of urination, prostate/bladder problems, urethritis, penis/testicular problems, prolapse.

**Cancer**      Yes  No   
 e.g. breast cancer, lung cancer, bowel cancer, tumours, leukaemia, melanomas, lymphomas, Hodgkin's disease.

**Eye disorders**      Yes  No   
 e.g. cataract, glaucoma, reducing vision, detached retina.

**Respiratory problems**      Yes  No   
 e.g. asthma, bronchitis, emphysema.

**Gynaecological and breast problems**      Yes  No   
 e.g. heavy or irregular periods, fibroids, ovarian cysts, abnormal smears, endometriosis, menopausal symptoms, breast lumps/cysts.

**Bone, joint and muscular problems**      Yes  No   
 e.g. fracture, strain, joint pain, arthritis/rheumatism, backache, sciatica, disc problem, bunions, tennis elbow, frozen shoulder, cartilage problems.

**Ear, nose and throat problems**      Yes  No   
 e.g. glue ear infections, hearing difficulties, throat/tonsil infections, adenoid problems, blocked nose, snoring, sinusitis, allergies.

**Abdominal and digestive problems**      Yes  No   
 e.g. irritable bowel syndrome, Crohn's, colitis, gallstones, stomach ulcer, appendicitis, indigestion, liver problems, diarrhoea, hernia.

Continued ►

## 6 Your medical details (continued)

**Has anyone on this form been aware of, or had any signs, medical symptoms, consultations, investigations, medication, monitoring, advice or treatment for any of the following in the last five years? You should answer all questions honestly. Failure to disclose relevant information may result in non-payment of a claim and all cover under the policy being cancelled.**

**Neurological and mental disorders** Yes  No   
 e.g. epilepsy, Parkinson's disease, headaches, migraine, paralysis, multiple sclerosis, depression, anxiety, stress, phobias, myalgic encephalomyelitis (ME).

**Dermatological conditions** Yes  No   
 e.g. eczema, dermatitis, skin cysts or lumps, psoriasis, unusual moles, hair disorders, toe or finger nail disorders.

**Endocrine and blood disorders** Yes  No   
 e.g. diabetes, thyroid problems, overweight/obesity, anaemia, raised cholesterol, factor deficiencies.

**Any other medical conditions or injuries** Yes  No   
 e.g. congenital growth or development, wisdom teeth, sleep disturbance, pregnancy or childbirth complications.

If the answer is 'Yes' to any of these questions, please give full details below. Please note the examples provided are not a complete list – you should tell us about all medical conditions or symptoms even if they are not listed above.

Name	Height	Weight
Condition/symptom		
Investigations/treatment		
Date they became aware of the condition/symptom	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Date of last visit
<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
Present state of health/details of ongoing treatment		
<input type="text"/>		

Name	Height	Weight
Condition/symptom		
Investigations/treatment		
Date they became aware of the condition/symptom	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Date of last visit
<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>		
Present state of health/details of ongoing treatment		
<input type="text"/>		

Please enclose extra pages if you need more room to write. Number of extra pages

## 7 Consent to obtain a medical report

We may need to request medical reports to process your application. Before we can ask any doctor you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988.

### Your rights under the Act:

- You do not need to give permission, but if you don't we may not be able to process your application. This doesn't stop you from applying to other companies for insurance.
- You can ask to see the report before the doctor gives it to us. If you do this we will tell the doctor to keep the report for 21 days so you can arrange to see it. If you haven't arranged to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you can ask the doctor for a copy within six months of it being sent to us. If you ask to see it after this date we can send a copy of the report to your doctor.
- If you think that anything in the report is not correct or is misleading, you can ask the doctor to change it. If your doctor refuses, you can ask him or her to write a statement explaining your views to go with the report.
- Your doctor can refuse to let you see the report if he or she feels that this would cause physical or mental harm to you or others.

Continued ►

## 7 Consent to obtain a medical report (continued)

### The medical report will ask your doctor about:

- Your current health.
- Any care, medication or treatment you are receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
- Any relevant illness, trauma or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor.

### We will ask your doctor not to give us any information about:

- Negative tests for HIV, hepatitis B or C.
- Any sexually transmitted diseases, unless there could be long term effects on your health.
- Genetic test results that predict certain medical conditions, unless it shows you have not inherited a condition your family suffers from.

### The information you and your doctor provide about your health may result in us:

- Not insuring you for certain medical conditions.
- Refusing to insure you.

### I give National Friendly permission to request medical information from any doctor I have consulted about anything which affects my physical or mental health. I agree that a copy of this original consent will also be valid.

- I do not wish to see the report before it is sent to National Friendly – please underwrite my application immediately.
- I wish to see the report before it is sent to National Friendly. I understand that this may delay my application by up to 21 days.

### GP contact details

Doctor's name	Surgery
Address	
Postcode	
Tel.	Fax.

Has any person named on this form seen, or are they likely to see a GP (doctor) privately? Yes  No

If 'Yes' please give their names


## 8 Data protection and confidentiality

National Friendly complies with the 1998 Data Protection Act, 1988 Access to Medical Reports Act and the 1990 Access to Health Records Act. We will treat the information you provide as confidential and hold it on computer, paper or any other appropriate form for as long as your application is being considered, the policy is in force and for an appropriate time after.

We may share this data with other relevant organisations so that we can set up and run your Healthcare Deposit Account, validate claims and prevent fraud and money laundering. We will not disclose it unless it is lawful to do so. For the purposes of data protection law, National Friendly is the data controller. If you would like a copy of the personal data we hold, please write to the Compliance Department at National Friendly, 4-5 Worcester Road, Clifton, Bristol BS8 3JL. We may charge a small fee for providing this information.

Please tick this box if you do not wish to receive information from National Friendly or its subsidiary companies on products and services that may be of interest to you.

**9 Declaration**

As the Account holder I would like to apply for a National Friendly Healthcare Deposit Account and declare that:

- I have read the 'Your policy explained' and agree to the terms & conditions.
- Anyone covered on this policy(ies) is a UK resident.
- I will be the owner of the Healthcare Deposit Account(s) and responsible for the actions of anyone on the policy(ies).
- I agree to National Friendly using any medical and health information provided, for each of the names on this application, to underwrite and administer this policy.
- I, and anyone else on this application, am/is prepared to attend a medical examination paid for by National Friendly if needed.
- I understand the importance of making additional payments into my personal deposit account.
- I understand that National Friendly will contact my GP and/or any medical treatment provider to process any claims I make.
- I agree that to the best of my knowledge and belief the information provided is true and complete and I will let you know of any changes to this information, in writing.
- I confirm that if this application has been completed by someone else, it was done so at my request.
- I understand that if I fail to provide any relevant information National Friendly may cancel the policy(ies).
- I understand that my policy(ies) will begin when this application is accepted and issued by National Friendly.

Signature of 1st applicant

X

Date

DD / MM / YY

Signature of 2nd applicant

X

Date

DD / MM / YY

**BROKER USE ONLY**

Company

FSA Reference # (FRN)

Individual Reference # (IRN)

Advised Sale

YES

NO

## Your monthly premium

You may find it helpful to refer to this table when completing your application.

Your premium							Your cover			
5 year fixed monthly premium based on your joining age						10 year top-up premium	Annual cover	10 year top-up cover	NHS payments	
Age	0-17	18-29	30-49	50-60	61-64	65-70				
£10	✓	X	X	X	X	X	Either £10, £15 or £20 each month	£5,000	Either £30,000, £45,000 or £60,000	£50 for a child, £150 for an adult. Maximum 10 cash back payments.
£20	✓	X	X	X	X	X		£10,000		
£30	✓	✓	X	X	X	X		£15,000		
£40	✓	✓	✓	X	X	X		£20,000		
£50	✓	✓	✓	✓	X	X		£25,000		
£60	✓	✓	✓	✓	✓	X		£30,000		
£70	✓	✓	✓	✓	✓	✓		£35,000		
£80	✓	✓	✓	✓	✓	✓		£40,000		
£90	✓	✓	✓	✓	✓	✓		£45,000		
£100	✓	✓	✓	✓	✓	✓		£50,000		
£120	✓	✓	✓	✓	✓	✓		£60,000		
£140	✓	✓	✓	✓	✓	✓		£70,000		
£150	✓	✓	✓	✓	✓	✓		£75,000		
£200	✓	✓	✓	✓	✓	✓		£100,000		

Premiums are also available at £10 increments from £100 to £200. Listed premiums inclusive of Insurance Premium Tax at 5%.

**For extra information on this product or to request a copy in Braille, large print or audio please call us on:**

**☎ Call 0800 195 9245 (8am-6pm weekdays, calls are recorded for quality purposes)**



Registered office: 4-5 Worcester Road, Clifton, Bristol BS8 3JL.  
Tel: 0117 973 9003 Fax: 0117 980 9358 Email: enquiries@nationalfriendly.co.uk

National Friendly is the trading name of National Deposit Friendly Society Limited.  
Incorporated and registered friendly society no. 369F.  
Authorised and regulated by the Financial Services Authority. Registration no. 110008.

[www.nationalfriendly.co.uk](http://www.nationalfriendly.co.uk)

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INVESTOR IN PEOPLE