Intermediary company application document.

Westfield Health

Company No.

Section 1 – Company details

Intermediary Name | Intermediary Ref no:

Full company name

Sole Trader ☐ | Unincorporated Partnership ☐ | Limited Company (Ltd) ☐ | Limited Liability Partnership (LLP) ☐

Public Limited Company ☐ | Other – please state

Address | Postcode

Phone | Fax

Email | Website

No. of employees | Nature of business / SIC code

Primary contact

Title | Forename | Surname

Job title

Phone | Email

Invoice/Payroll contact (if different to address above)

Title | Forename | Surname

Job title

Phone | Email

Invoice/Payroll address (if different to address above)

Is the company currently insured with another provider? ☐ Yes ☐ No

Claims history requested? ☐ Yes ☐ No

Section 2 – Health Cash Plan product selection

Product name

Start date (1st) -SELECT MONTH - **Year** **Level of cover** (please select) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Please complete the following if applicable

Concession date (Advantage Voluntary) **Mosaic quote number**

Additional modules: Can only be added at the anniversary of the plan

Optional Scanning Service - MRI, CT and PET scans ☐

Applies to Foresight Level 1 and must be purchased for all employees

Section 2a – Flex payment options

Please select one payment option:

☐ Voluntary (level chosen by employee / salary sacrifice / company funded pot)

☐ Company paid (level of cover selected by employer)

Section 2b – Voluntary upgrade & additional policyholder payment

Please select one payment option:

☐ Employees will be allowed to pay additional premiums **via Direct Debit**

☐ Employees will be allowed to pay additional premiums **via payroll deduction**

Section 3 – Private Health Insurance product selection

☐ **Surgery Choices 1** ☐ **Surgery Choices 2**

Purchased for: ☐ All employees ☐ Selected employees

Please note – Private Health insurance is only available with selected plans as advised by your Intermediary and must be purchased for a minimum of 5 people.

Underwriting option ☐ Moratorium ☐ CPME* ☐ MHD ☐ MHD with evidence*

*Excluding planned and ongoing inpatient/daycare treatment being received at the time of the transfer

Please confirm: NHS benefit, if applicable, should be paid to **you the employer** ☐ **your employees** ☐

Your choice, once made, **will remain in force for 12 months**, but can be changed annually at the anniversary of the plan.

Section 4 – Marketing preferences (for Sole Traders & Unincorporated Partnerships only)

We'd love to send you the occasional email about all things health and wellbeing.

If you would like to receive these emails, please tick the box below:

Yes ☐

From time to time, we will also contact you by telephone and post with health and wellbeing information we feel may benefit you. You'll always be in control and you can update your choices at any time. If you would like to know more about how we process your personal data and how to exercise your rights, you can view our Privacy Notice, available on our website.

Section 5 – Declaration

Must be signed on behalf of the company by the primary contact
Please check that all information contained in this document is correct before signing.

We confirm that the details provided are correct and that we will operate the Westfield Plan in accordance with the Group Terms and Conditions and note that this application form is subject to acceptance at the discretion of Westfield Health. The Policy Summary & Group Terms and Conditions (corporate paid cover) will have been provided by your Intermediary. An additional copy will be provided with your welcome email.

TO BE COMPLETED IN BLOCK CAPITALS

Name		Position held	
Signature		Date	

Provision of an electronic signature is permissible. The owner of this signature should ensure that it is only provided with their full authority.

OFFICE USE ONLY			
Health & Wellbeing Consultant	Date	Registered by	Date
SCMS No.	RIT No.	Checked by	Date

Westfield Health

THIS IS NOT PART OF THE INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY

Name and full address

Company name:		Company a/c no:	
Company address			
		Postcode	

Westfield Health

Please fill in the whole form including official use box and return to:
Westfield Contributory Health Scheme Ltd.
REGISTERED OFFICE: Westfield House,
60 Charter Row, Sheffield, South Yorkshire, S1 3FZ

DIRECT Debit

INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT

Name(s) of account holder(s)

Service user number

9	4	1	1	1	0

Reference

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			
		Postcode	

Instruction to your Bank or Building Society

Please pay Westfield Health 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 Westfield Health and if so, details will be passed electronically to my Bank/Building Society.

Signature(s):

Date:

For (Westfield Health) official use only:
This is not part of the instruction to your Bank or Building Society

Please indicate your chosen payment collection date:

Originator's Reference Number

Banks and Building Societies may not accept Direct Debit Instructions for some types of account.

THE DIRECT DEBIT GUARANTEE

DIRECT Debit

- This Guarantee is offered by 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 amount to be paid or the payment dates change, Westfield Contributory Health Scheme Limited will notify you 10 working days in advance of your account being debited as otherwise agreed.
- If an error is made by Westfield Contributory Health Scheme Limited 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 friendly Customer Care Team is here to help

Online
westfieldhealth.com

Email
intermediarysupport@westfieldhealth.com

Phone
0114 250 2321

Registered Office.
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