Esplanade House, 29 Glategny Esplanade, St Peter Port, Guernsey, GY1 1WR

Tel: 01481 728864 Fax: 01481 728705

Email: info@forestershealthcare.co.uk

Court No 8143

Member No.

Sent/Received

Your Application

1. Please complete this form using **Black or Blue Ink** and write within the boxes using **CAPITAL LETTERS.**
2. Please complete all details and answer all questions on this form.
3. Read the declaration carefully and sign to confirm your understanding and acceptance of the terms and conditions.

SECTION A — YOUR DETAILS

Surname

First name(s)

Title

Date of Birth

Are you a permanent resident of Guernsey / Alderney?

Occupation

Name/Practice of your registered doctor

Current health insurer

Guernsey social security number

UK national insurance no. / US Tax no. (if applicable)

Introduced by (if a personal recommendation)

Join to existing member or group (if applicable)

SECTION B — CONTACT DETAILS

Address

Phone number

Mobile number

Post code

Email address

SECTION C — COVER

Please confirm the cover you wish to apply for

Primary Care Scheme

Mandatory Cover— basic level of cover for doctors & nurses consultations, blood tests, consultations at the Emergency Department and essential or emergency ambulance conveyance. For more information please see your brochure. A ***three month deferment applies, this may be reduced at the discretion of the Society or if coming from an existing medical scheme.***

YES

Additional Benefits Scheme

Optional Add-on Scheme—Cover for other treatments such as minor operations, physiotherapy/osteopathy, allergy testing, ECG's and well person checks. For a full list of cover provided please see your brochure. A ***six month deferment applies, this may be reduced at the discretion of the Society or if coming from an existing medical scheme***

Do you require Additional Benefits cover?

If yes, number of Units applying for (maximum 10)

SECTION D — Your Medical History

Are you currently suffering from or have you suffered any serious or ongoing illnesses, conditions or injuries in the last 5 years?

YES NO

If yes, state nature and dates

Are you currently receiving or expecting to undergo treatment in the near future?

YES NO

If yes, give details

SECTION D — Your Medical History (Continued)

Are you currently receiving or expecting to receive physiotherapy, osteopathy or chiropractic treatment in the near future?

YES ☐ NO ☐

If yes, state nature and dates

Have you any prospect of undergoing an operation in the near future?

YES ☐ NO ☐

If yes, give details

On average, how often do you visit your doctor/nurse per year (including home visits)?

SECTION E — Payment Details

Indicate below how you would like to pay your premium to Foresters Healthcare

PAYMENT TYPE

DIRECT DEBIT ☐ CHEQUE ☐ CASH ☐ CREDIT/DEBIT CARD ☐

PAYMENT FREQUENCY

ANNUAL ☐ HALF ANNUAL ☐ QUARTERLY ☐ MONTHLY ☐

We do not issue monthly accounts

SECTION F — OTHER INFORMATION

If there is any other information relevant to your application that you wish to disclose please state below

SECTION G — DECLARATION

Please read carefully and sign below to confirm your understanding and acceptance of following terms and conditions;

The questions in this application must be answered fully and accurately to the best of your knowledge. You must disclose to the Society any material facts or circumstances that would influence the assessment and acceptance of your application. Failure to do so may cause the insurance to be declared void. Premiums are calculated based on an annual review and a standard rate is set for each year.

The Society reserves the right to charge a non-standard premium rate where applicants have pre-existing medical conditions for represent a non-standard risk based on their medical history. The Society also reserves the right to not accept into membership any applicant that represents an unacceptable risk. Should payments not be received by renewal dates medical cover will be suspended until such payment is received.

By signing this form you consent to the Society seeking medical information from any Doctor who at any time has attended you concerning anything which affects your physical or mental health and you authorise the giving of such information. Any costs incurred in the gaining of this information is not payable by the Society. You also consent to the Society providing information to third party companies such as your doctor's surgery, Guernsey Social Services Department and the States of Guernsey Health and Social Care, also any information sought by relevant authorities in the case of a criminal investigation. Information and reports supplied by or to these parties are kept private and confidential and will only be provided to the applicant with prior permission from the party in question.

Signature

Date

PRINT Name

(To be signed by a parent or guardian where the applicant

Is under sixteen years of age)

Please mail your application to:

Foresters Healthcare, Esplanade House, 29 Glategny

Esplanade, St Peter Port, Guernsey, GY1 1WR

OFFICE USE ONLY

Date Received:

Trustee Signature:

Date:

Committee Acceptance:

If you require any assistance please call: