# Your Corporate Benefits

UK Healthcare™
A Westfield Health company

THE GOLDEN HINDE

| | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| Employee Monthly Premium | Company Funded | £7.67 | £16.67 | £25.67 | £40.67 |
| Partner Monthly Premium | £5.50 | £12 | £21 | £30 | £45 |

| Benefit | Payback | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|---|
| **Dental**<br>Includes check-ups, fillings, hygienist fees, X-Rays and dentures | 100% | £60 | £110 | £150 | £200 | £275 |
| **Dental Accidents**<br>For dental injury as a direct result of accidental impact | 100% | £200 | £400 | £600 | £800 | £1,000 |
| **Optical**<br>Includes eye tests, glasses, contact lenses, repairs and laser eye surgery | 100% | £60 | £110 | £150 | £200 | £275 |
| **Health Screening**<br>Includes well man/woman screening and all screening that helps prevent an illness | 100% | £100 | £130 | £150 | £200 | £300 |
| **Specialist Consultation**<br>Covers diagnostic consultations and tests | 100% | £200 | £260 | £300 | £400 | £600 |
| **Wellbeing (Physiotherapy/Osteopathy/Chiropractic/Acupuncture)**<br>Covers treatment by a registered practitioner | 100% | £150 | £280 | £370 | £500 | £750 |
| **Complementary Therapies (Homeopathy/Reflexology/Aromatherapy/Remedial Massage)**<br>Covers treatment by a registered practitioner following GP referral | 100% | £50 | £100 | £150 | £200 | £250 |
| **Chiropody**<br>Covers treatment by a chiropodist or podiatrist | 100% | £20 | £50 | £100 | £150 | £200 |
| **Hospital In-Patient**<br>A nightly allowance for any NHS or private hospital admission | Up to 28 nts | £10 | £15 | £20 | £30 | £50 |
| **Day Case**<br>A daily allowance for day case admissions | Up to 10 vsts | £10 | £15 | £20 | £30 | £50 |
| **Hospital Parental Stay**<br>A nightly allowance for one parent accompanying a child covered by the policy | Up to 28 nts | £10 | £15 | £20 | £30 | £50 |
| **Prescriptions**<br>The number of standard prescription items that can be claimed (excludes annual prescriptions) | | 1 | 2 | 3 | 4 | 5 |
| **Discounted Gym / Spa Membership**<br>Services provided by a third party | | Access to special membership rates | | | | |
| **Savings on holidays, theme parks, retail discounts and attractions**<br>Services provided by a third party | | Access to special discounted rates | | | | |
| **Confidential Counselling Helplines**<br>Helpline services provided by a third party | | Anytime support for legal issues, medical problems, counselling and ID theft | | | | |
| **Worldwide Cover** | Up to 28 days | Cash plan benefits extend to trips abroad | | | | |

Immediate cover provided. Pre-existing conditions included.
Benefit levels are annual sums. Dependent children up to age 24 are covered free.

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# CORPORATE POLICY AMENDMENT FORM

I wish to amend my existing cover ☐ Existing policy no:

## Please indicate cash plan level:

| | Level 1 | Level2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| Payment per MONTH | Company Funded ☐ | £7.67 ☐ | £16.67 ☐ | £25.67 ☐ | £40.67 ☐ |

## Your Details (*mandatory field)

Title | Surname*

First Name (s)*

Date of Birth*

Address*

Postcode*

Daytime Tel* | Mobile

Email Address*

## Details of resident child (ren) to be covered (FREE OF CHARGE)

Full name | Date of Birth

Full name | Date of Birth

## Details of resident second adult (s) to be covered for the additional premium indicated

Full Name | Date of Birth

Full Name | Date of Birth

| | Level 1 | Level2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| Payment per MONTH | £5.50 ☐ | £12.00 ☐ | £21.00 ☐ | £30.00 ☐ | £45.00 ☐ |

## Pre-existing conditions

Should you decide to upgrade your level of cover, please complete and return this application form within the next 30 days, to guarantee that any pre-existing conditions are covered at the increased benefit levels requested. For applications received after this period our standard terms and conditions will apply, which states that "any medical condition in existence prior to the upgrade, will only be covered at the original level of cover".

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

DIRECT Debit

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

To: The Manager — Bank/building society

Address

Postcode

**Service user number**

6 9 7 7 6 1

**Reference**

**Instruction to your bank or building society**

Please pay Westfield Contributory Health Scheme Ltd 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 Contributory Health Scheme Ltd and, if so details will be passed electronically to my bank/building society.

**Name(s) of account holder(s)**

**Branch sort code**

**Bank/building society account number**

Signature(s)

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account.

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# Corporate plan



DIRECT Debit

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 Westfield Contributory Health Scheme Ltd will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Westfield Contributory Health Scheme Ltd 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 Westfield Contributory Health Scheme Ltd or your bank or building society, you are entitled 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 Westfield Contributory Health Scheme Ltd 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.

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**IN ORDER TO UPGRADE, ADD A PARTNER OR INCLUDE YOUR CHILDREN, PLEASE COMPLETE THE FORM ABOVE AND E-MAIL IT BACK THE FOLLOWING E-MAIL ADDRESS:**

**corporate@ukhealthcare.org.uk**

**PICTURE COPIES WILL ALSO BE ACCEPTED AND CAN BE DONE BY TAKING A PHOTOGRAPH OF THE COMPLETED AMENDMENT FORM VIA YOUR MOBILE**