Applying to upgrade your cover and/or join an additional adult.

Health Cash Plan

When applying for cover, please read the Insurance Product Information Document and the full terms and conditions at the back of your plan guide. These are available to view and download online at My Westfield.

Simply visit **www.westfieldhealth.com** and register/log in to the My Westfield area.

Your upgrade and additional adult premiums can be found in your welcome/renewal letter. You can only apply for cover for one additional adult, subject to Terms & Conditions.

Simply complete the application form (we will require an electronic signature on both parts of the form) and pass it to your employer for them to complete their sections.

Alternatively, you can print out the form and use a pen to sign your signature. You will then need to pass/email both parts of the form to your employer. We will accept a scan of these forms or a photograph taken on a smartphone. Your employer then returns the application form to us at **membership@westfieldhealth.com**

Westfield Health

Upgrade and additional adult application form: through your payroll

Please complete using block capitals and black ink

Section A – Employee Details

This section must be completed

Title (Mr/Mrs/Miss/Ms/Other)	Tel work
Forename(s)	Tel home
Surname	Tel mobile
Date of birth (DD/MM/YY) / /	Email
Address	
	Postcode
Westfield Health policy number	

Section B – Employee Cover

Please tick as applicable

I wish to:	Remain on level	Change level to
Level 1	☐	
Level 2	☐	☐
Level 3	☐	☐
Level 4	☐	☐

Employment Details

Name of employer

Payroll number

Pay frequency

☐ Weekly ☐ Monthly ☐ Other

Other – Please specify

Section C – Dependent Children Details

Forename(s)	Surname	M/F	Date of birth (DD/MM/YY)	Forename(s)	Surname	M/F	Date of birth (DD/MM/YY)

Section D – Additional Adult Cover

Title	Forename(s)	Surname	Date of birth (DD/MM/YY)	House number	Postcode	Apply	Remain	Change	Level of cover L1	L2	L3	L4
						☐	☐	☐	☐	☐	☐	☐

Section E – Payment of Claims

Name of Account Holder	Bank/Building Society Name
Sort Code	Account Number

Claims can be paid into my Bank/Building Society account: Employee ☐ Additional Adult ☐ (Please tick as applicable)

Section F – Declaration

This section must be completed and signed by the employee

I declare that the information I have given on this form is true and complete and that I have received full details of the policy, which I have read or have had read to me and agree to be bound by the Terms and Conditions and Benefit Rules of the plan.

Marketing Preferences:

We'd love to keep you up to date with all things health and wellbeing.

Please tell us what you'd like to hear about: ☐ Health & Wellbeing Information ☐ Special Offers ☐ Westfield Insiders ☐ Products

Please tell us how you would like us to communicate with you for the above purposes: ☐ Email ☐ Text ☐ Telephone ☐ Post ☐ Social Media ☐ Web

You're always in control. You can update your choices at any time. Simply visit **westfieldhealth.com** and register or log in to My Westfield.

We'd like to bring to your attention our Privacy Promise in your plan guide which details how your data is used, stored, and how to exercise your privacy rights.

Employee Signature	Date

Section G – To be completed by your employer

Date deductions commence	
Westfield Health company registration number	
Level provided by company (if applicable) L1☐ L2☐ L3☐ L4☐	

Westfield Health Office use only

Policy number	
Event ID	

Health Cash Plan
Payroll deduction authority

Please complete using block capitals and black ink

Employer please detach and retain for your records

Section H – To be completed by you	This section must be completed
Title (Mr/Mrs/Miss/Ms/Other)	Tel work
Forename(s)	Tel home
Surname	Tel mobile
Date of birth (DD/MM/YY)	Email
Payroll number	
Westfield Health policy number	

Please tick box as applicable

I wish to:	Remain on level	Change level to
Level 1	R ☐	
Level 2	R ☐	C ☐
Level 3	R ☐	C ☐
Level 4	R ☐	C ☐
		A

Your upgrade and additional adult premiums can be found in your welcome/renewal letter.

Section I – Additional Adult Cover

Title	Forename(s)	Surname	Date of birth (DD/MM/YY)	House number	Postcode	Apply	Remain	Change	Level of cover L1	L2	L3	L4
						☐	☐	☐	☐	☐	☐	☐

Section J – Authority for deduction from payroll — Must be completed and signed by the employee

Please read carefully before signing

I hereby authorise to have the premiums as shown above, or any increased premiums as may be notified from time to time to secure plan benefits, deducted from my wages or salary for myself or the above named person. Please remit the total premium to Westfield Health on my behalf at the agreed intervals until further notice.

Signature	Date

Section K – To be completed by your employer

Date deductions commence
Westfield Health company registration number

Employee:
After you have completed sections A,B,C,D,E,F,H,I and J please pass the form to your employer to complete sections G and K.

Payroll:
An employee could have either printed the application form and passed it to Payroll or emailed it. Once processed, please print out the application form and separate both parts of the form.

Please retain the payroll deduction authority form and forward the application form to Westfield Health by emailing membership@westfieldhealth.com. We will accept a scan of the form or a photograph taken on a smartphone.

Westfield Health

Clear | E-Mail | Print

Remember, our friendly Customer Care Team is here to help.

Online
westfieldhealth.com

Email
enquiries@westfieldhealth.com

Phone
0114 250 2000
8am-6pm, Mon-Fri (except Christmas Eve and public holidays)

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