

Intermediary company application document.

Company No.

Section 1 – Intermediary details

Intermediary Name	Intermediary Ref no:
Do you receive commission from Westfield Health for the sale? Yes No	
Do you charge the client additional commission any other commission in addition to what you receive from Westfield Health?	
Yes No	
If Yes please provide details:	

Section 2 – Company details

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)

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Is the company currently insured with another provider? Yes No

Claims history requested? Yes No

Section 3 – Health Cash Plan product selection

Product name

Start date (1st)

Year

Level of cover (please select) 1

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 3a – 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 3b – 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 4 – 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 5 – 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 6 – 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.

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	



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



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
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Reference

Bank/Building Society account number

Branch sort code

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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

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

THE DIRECT DEBIT GUARANTEE

- 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
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<p>Registered Office. Westfield Health Westfield House 60 Charter Row Sheffield S1 3FZ</p>	<p>Product supplied by Westfield Contributory Health Scheme Ltd. Westfield Contributory Health Scheme Ltd (company number 303523) and Westfield Health & Wellbeing Ltd (company number 9871093) are collectively referred to as Westfield Health and are registered in England & Wales. Our registered office is 60 Charter Row, Sheffield S1 3FZ. Additionally Westfield Contributory Health Scheme Ltd is authorised by the Prudential Regulation Authority (PRA) and regulated by the Financial Conduct Authority (FCA) and the PRA. Details of this registration can be found by accessing the Financial Services Register online at either the PRA or the FCA websites or by contacting the PRA on 020 7601 4878 or the FCA on 0800 111 6768. Our financial services registration number is 202609. Westfield Health is a registered trademark.</p>
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