Intermediary company application document.

Westfield Health

Company No.

Section 1 – Company details

Intermediary Name			Intermediary Ref no:
Full company name			
Address			Postcode
Phone		Fax	
Email		Website	
No. of employees	Nature of business		

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? Yes No

Claims history requested? Yes No

Welcome packs to be sent to:
Home address Company Intermediary

Section 2 – Product selection

Product name

Start date (1st) **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:

FOR KIDS Purchased for: All employees Selected employees
(Please note: For Kids cover is only available with select plans as advised by your Business Development Consultant)

DOCTORLINE™
(Please note: DoctorLine™ must be purchased for the whole workforce)

Section 3 – 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 4 – 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 5 – Hospital treatment insurance

Surgery Choices 1 **Surgery Choices 2**

Purchased for: All employees Selected employees

Please note – Hospital treatment insurance is only available with selected plans as advised by your Business Development Consultant 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 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 current Administration Guide and Group Terms and Conditions and note that this application form is subject to acceptance at the discretion of Westfield Health. The Administration Guide and the Policy Summary & Group Terms and Conditions (corporate paid cover) will have been provided by your Intermediary Healthcare Consultant - additional copies 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.

Section 7 – Payment methods

The payment methods are detailed in your Administration Guide. Please let us know how you wish to pay.

- [ ] **Direct Debit:** please complete the attached Direct Debit mandate
- [ ] **BACS:** please refer to the administration guide for BACS details
- [ ] **Cheque:** please refer to the administration guide for payment details

OFFICE USE ONLY			
	Date	Registered by	Date
SCMS No.	RIT No.	Checked by	Date

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

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

- 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
businessenquiries@westfieldhealth.com

Phone
0845 602 1629

Registered Office.
Westfield Health
Westfield House
60 Charter Row
Sheffield
S1 3FZ

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