Application Form

medicash
a positive approach to health

Please complete this form and post to: **Medicash, One Derby Square, Liverpool L2 1AB** or email to: **TechnicalAdmin@medicash.org**

Choose your level

Premiums include Insurance Premium Tax		Level 1	Level 2	Level 3	Level 4
Solo Plan	Price per month	☐ Co. Paid	☐ £9.54	☐ £18.64	☐ £33.37
Dual Plan	Price per month	☐ £7.80	☐ £23.41	☐ £41.60	☐ £71.07

Personal information

Please tick one box only. Please enrol me in the Medicash plan ☐ Please alter my level of cover ☐

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Policy Number (If Known)	
Surname	Address
Forenames	
Date of Birth	
Telephone Number	Postcode

Policy & claims communication preferences

By providing your email address you agree to receiving all policy and claims related communications by email.

Email Address

Your partner's details & dependent children

If you wish your partner and/or children to be covered, you must register their details below. Children must be dependent, in full time education and under the maximum age as shown on your benefit table. On dual plans, your partner must reside permanently with you and also be under the age of 66 at the time of joining.

Partner: Forenames	Surname (if different)	Date of Birth
Child 1: Forenames	Surname (if different)	Date of Birth
Child 2: Forenames	Surname (if different)	Date of Birth
Child 3: Forenames	Surname (if different)	Date of Birth
Child 4: Forenames	Surname (if different)	Date of Birth

I agree that: No advice has been offered to me by Medicash when selecting my level of cover and I accept that additional information is available to me on request. I agree to making an application based on the information I have. The information I have provided is true and complete and I have the explicit consent to provide the information for anyone over the age of 16 being included on my policy as detailed above. I will abide by the terms and conditions in force throughout my policy and pay at the level and frequency indicated or such other amounts as may subsequently apply. The upgraded element of my plan will be automatically renewed on a monthly basis. **I understand that in order to process my application and administer this policy Medicash must process my personal data as supplied here, or any other such information supplied in the future, and that they will do so in line with their Privacy Policy as can be found at www.medicash.org/privacypolicy**

Signature

Date

For office use only

Company Mobile Mini UK Holdings Limikted | Proactive 2019

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Direct Debit Mandate

Instruction to your Bank or Building Society to pay by Direct Debit.

DIRECT Debit

Account details **Service User No. 724706**

Name(s) of Account Holder(s)

Bank/Building Society Account Number ☐☐☐☐☐☐☐☐

Branch Sort Code ☐☐ ☐☐ ☐☐

We will automatically pay claims by direct credit to the account detailed above, unless you submit alternative details on the right.

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

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 Medicash 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 Medicash and, if so, details will be passed electronically to my Bank/Building Society

Signature

Date

Have your claims paid back quicker...

Register for Direct Credit and get your claims paid directly into your bank account

If you wish for your payments to be paid directly into the bank, please enter your bank details below. If you have already provided these details then there is no need to fill them in again unless your details have changed.

Account Holders Name:

Account Number ☐☐☐☐☐☐☐☐

Sort Code ☐☐ ☐☐ ☐☐

How information about you will be used

Medicash and our service partners will use the information supplied here to provide the benefits of this plan, process claims and prevent and detect fraud. This information may be shared with other insurance providers, police and enforcement agencies in the case of fraud. We will always process your personal data in line with our Privacy Policy which can be found at **www.medicash.org/privacypolicy**

Please keep me informed about Medicash's products and offers via:

Email ☐ **SMS** ☐

Please **DO NOT** send me information by **Post** ☐

We may occasionally like to share your information with other similar organisations so that they can send you information about their products and services by post. If you agree to your information being shared in this way, please tick this box ☐

Medicash is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

DIRECT Debit

The Direct Debit Guarantee

THIS GUARANTEE SHOULD BE RETAINED BY THE PAYER

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, Medicash Health Benefits Ltd will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Medicash Health Benefits 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 Medicash Health Benefits 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 Medicash Health Benefits 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.