medicash active

Membership Application Form

Please complete the application form and payroll deduction form in BLOCK CAPITALS. Sign both forms and send them to: **Medicash, One Derby Square, Liverpool, L2 1AB**

Choose your plan

Premiums include Insurance Premium Tax		Bronze	Silver	Gold	Platinum	Platinum Plus
Solo Plan	£ per month	£6.95 ☐	£13.90 ☐	£22.25 ☐	£33.40 ☐	£41.75 ☐
Cover for you and up to 4 dependent children	£ per week	£1.60	£3.21	£5.13	£7.71	£9.63
Dual Plan	£ per month	£12.85 ☐	£25.70 ☐	£41.05 ☐	£61.20 ☐	£76.50 ☐
Cover for you, your partner and up to 4 dependent children	£ per week	£2.97	£5.93	£9.47	£14.12	£17.65

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, under the age of 16 or 19 if in full-time education. 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 or provided to me by Medicash. Additional information is available to me on request, but I agree to making an application for cover based on the information contained in this leaflet. The plan will be automatically renewed on a monthly basis. The information I have provided is true and complete. 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 membership and pay at the level and frequency indicated or such other amounts as may subsequently apply. Qualifying periods apply to the birth/adoption of a child benefit and to claims for hospital benefits that relate to a pre-existing condition. You will send me full terms and conditions with my welcome pack after joining. **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 UK Greetings

S Nathan Moore nathan.moore@medicash.org

Payroll Deduction Authority

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

Payroll details

Employer / Pension Company

Medicash Group Ref. No.

Pension or Payroll No.

National Insurance No.

Deductions from payroll are to be made

Weekly ☐ 4 Weekly ☐ Monthly ☐

When will my policy start?

In the majority of cases your policy will start from the 1st of the following month from the date that Medicash receives your application. Occasionally, due to how your payroll is processed, this may not be the case. Please speak to your Medicash representative or payroll department if you have any questions regarding this.

I hereby authorise deductions by my employer or pension scheme of the amounts and frequency indicated above or such other amounts as may subsequently apply.

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 ☐

MED2516/JUL20