Office use only: Ref

# Morrisons health care cash plan

## Application form - pay to cover your family member

**Use this application form to cover your family member on the Morrisons health care cash plan. Simply complete all sections of the form below and overleaf. Please be aware their policy premium will be deducted from your salary every four weeks, but you will each have a separate policy.**

### Your details

Policy number

Title | First name | Surname

Address

Postcode

Date of birth D D – M M – Y Y Y Y | Telephone

Email

### Your family member's details

**Please ensure you and your family member read the policy summary on page 7 of the leaflet and the Insurance Product Information Document provided separately in their welcome pack.** I wish to pay to cover my family member on the Morrisons health care cash plan provided by Sovereign Health Care and we agree to abide by the terms and conditions.

Title | First name | Surname

Address (if different to yours)

Postcode

Date of birth D D – M M – Y Y Y Y | Telephone

Email

**Please choose their level of cover by ticking the appropriate box below.**

Premiums include Insurance Premium Tax (IPT) and are deducted from your salary.

| Cover level | Level 2 | Level 3 | Level 4 | Level 5 | Level 6 |
|---|---|---|---|---|---|
| Four weekly premium (per person) | £7.44 | £11.16 | £14.88 | £18.60 | £22.32 |
| Family member level of cover | ☐ | ☐ | ☐ | ☐ | ☐ |

Please continue **overleaf** to complete your application

## Payroll deduction payment instruction

Please complete this section so we can instruct your payroll department to deduct the additional premium for your family member from your salary. Please be aware this amount is in addition to the premium you already pay for the existing policy/policies you have.

Please enter the additional premium to be deducted from your pay £

## Declaration

I am an existing customer and I wish to apply to cover my family member on the Morrisons health care cash plan provided by Sovereign Health Care. I declare that any information contained on this application is to the best of my knowledge true and complete. I confirm that where I have provided information about another person within this form for family member cover, I have that person's permission to provide the information to Sovereign Health Care, and for it to be used in the same way as my own.

I authorise the additional amount noted to be deducted from my salary and remitted to Sovereign Health and Insurance Services Ltd. If premium rates change, subject to Sovereign Health Care giving me 30 days notice, the revised amount may also be deducted from my salary. I understand and accept the policy summary, including the key limitations and exclusions and the statement of demands and needs. I understand that this insurance will automatically renew each month until it is cancelled or I allow it to lapse. I/We understand that certain benefits have a qualifying period, or a qualifying period for pre-existing conditions, and that I/we will not be able to claim for these benefits until the relevant qualifying period has expired. I/We agree that Sovereign Health Care may request a medical report from a GP or health care provider/practitioner to verify future claims. I/We agree to be bound by the policy terms and conditions.

**Data Protection** Sovereign Health Care and its group companies comply with the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal information (**'Data Protection Legislation'**) and we will store and process any personal information we collect in accordance with Data Protection Legislation. We will use your personal information to set up and manage your policy, take payments for premiums payable, comply with our contractual obligations, undertake claims assessments, prevent crime (including fraud and money laundering) and comply with our legal requirements. We will also need to share your personal information with your employer to deduct your policy premiums from your salary. For further information on how your personal information is used, including disclosure to third parties, how we maintain security of your information and your rights in relation to the information we hold about you, please see our privacy policy available on our website or contact us if you require a hard copy.

**Your application to cover your family member is subject to acceptance by Sovereign Health Care and we reserve the right to refuse your application for any reason without providing an explanation. Your family member's policy will be subject to our terms and conditions, a copy of which we will send to them with their welcome pack. This should be read carefully by them.**

**Your signature** **Date** D D – M M – Y Y Y Y

Please ensure you have completed all sections and signed the declaration.

**Please return in an envelope to: FREEPOST SOVEREIGN HEALTH (no stamp or other address details required).**

If you have any questions please call the Sovereign Health Care team on:

# 01274 841 130

Lines are open Monday to Thursday 9am to 5pm and Friday 9am to 4pm.