## Saga Health Cash Plan Application Form



Please download this form, complete all the relevant sections in block capitals and sign the declaration. Then return it to us at: Saga Health Cash Plan, Freepost SEA13556, Middelburg Square, Folkestone, Kent CT50 1PD

Alternatively, to take out a Saga Health Cash Plan or for general queries please call 0800 096 4085.

When we receive your application, we will send you the policy documents. Your policy will not commence until 7 days after we receive your application, which should give you time to check the documentation before the policy commences. From the start date of the policy you have 14 days to cancel. Your first Direct Debit payment will also be taken 14 days after the start of the policy.

1 Personal details of those to be covered								
Reference code: ITHCP								
Surname Mr / Mrs / Miss	s / Ms				rename(s)			
Address								
					stcode			
Telephone No.			(We may need to call you to complete the quotation)		Mobile No.			
Date of birth	,		(minimum age 50 years)		Occupation			
e-mail address								
If you have a spouse or partner you wish to include, please give their details:								
	Mr./Mrs./Miss./Ms							
Date of birth	/ Occupation				tial			
Dependent children's details (maximum age 18 years):						Date of birth		
Title Initial Surname								
Title Initial Surname Date of birth / /								
2 Cover details								
What level of cover would you like? Level 1 Level 2 Level 3								
Age	Level 1		Level 2		Level 3			
	Monthly	Annual	Monthly	Annual	Monthly	Annual		
50 to 64*	£16.75	£201	£24.75	£297	£32.50	£390		
65 to 69	£19.75	£237	£31.00	£372	£38.50	£462		
70 +	£22.75	£273	£35.00	£420	£42.00	£504		
*Partners under 50 are charged at the 50 to 64 age rate. Children under 18 are included free of charge. Premiums correct as at November 2011.								
Please insert chosen premium - monthly or annual. Policyholder $\mathfrak E$ : Spouse/Partner $\mathfrak E$ : Total premium $\mathfrak E$ :								
Do you already have Health Cash Plan cover with another insurer? Yes No Current insurer								

## 3 Data protection

Saga Services Limited will keep all the data you supply in connection with this plan, including the medical data, in order to provide the highest standard of service in the administration of your plan. The medical data you provide will be securely stored. It will also be used and shared with the underwriter of the plan, and third parties who need to receive the data, so we can efficiently handle any claims, conduct assessment of our business performance, perform any statistical analysis, cross check any future applications for membership of the scheme and for the detection and prevention of fraud.

By providing us with your personal data, including sensitive data and contact details, you consent to Saga Group using it for administrative purposes and to the Saga and Acromas groups of companies, and their partners, using it in the preparation of quotes and for contacting you by post, telephone, e-mail, SMS or other electronic means, to inform you about any products and services which it considers may be of interest to you. We will do this unless you contact us or you make use of the regular opportunities that we provide you with, to confirm which channels and products you do and do not wish to use or hear about, or unless you tell us you prefer not to receive direct marketing.

If you would prefer to be excluded from further offers for Saga Health Cash Plan, please tick  $\square$ .

4 Declaration statement							
Do you or people to be covered have any pre-existing medical conditions to declare?							
If 'Yes' please provide details of person, and nature of pre-existing medical condition (continue on another sheet if necessary).							
I declare that I, and all persons for whom benefit may be claimed under the terms of my chosen plan, are in good health and not receiving, or been informed of the need for, hospital or medical treatment or any of the services for which Saga provides benefit, other than as disclosed above. Should it be necessary, I authorise my doctor to disclose to the underwriter's Medical Officer any information the underwriter may require. I understand that no claim will be paid for the first two years for any hospital-related benefit, in respect of any medical or other condition of which I am aware or which is being investigated, at the date of application. I agree to abide by the terms and conditions of the policy and I acknowledge the right of Saga to vary them, and the range of rates of benefits and/or premiums, if deemed necessary. I declare that all the information I have given on this Application Form is true and that, if found to the contrary, Saga shall be free to cancel the policy at any time. I understand that Saga's computerised personal information is treated confidentially under the terms of the Data Protection Act.							
Signature							
	Date / / 2 0						
5 Payment method							
Please tick your preferred method of payment:							
Monthly Direct Debit payments Single annual payment by Direct Debit Single annual payment by credit/debit card Single annual payment by cheque							
For credit/debit card or Direct Debit payments - complete and sign the relevant section below. For cheque payments - make your cheque payable to Saga Services Ltd.  Please write your name and address on the reverse and return it with this form.							
Instruction to your Bank or Building Society to pay by Direct Debit  DIRECT Debit							
Please fill in this form and return it to Saga Health Cash Plan, Freepost SEA13556, Middelburg Square, Folkestone, Kent CT50 1PD.	Originator's Identification Number 8 5 4 2 4 8						
To: The Manager	FOR SAGA SERVICES OFFICIAL USE ONLY This is not part of the instruction to your Bank or Building Society						
Bank/Building Society	This is not part of the motivation to your bank of banding coolety						
Address							
Postcode							
Name(s) of account holder(s):	Instruction to your Bank or Building Society Please pay Saga Services Ltd Direct Debits from the account detailed on this instruction, subject to the						
Name (s) of account holder (s).	safeguards assured by The Direct Debit Guarantee. I understand that this instruction may remain with Saga Services Ltd and, if so, details will be passed electronically to my Bank/Building Society.						
Bank/Building Society Account Number:	Signature(s)						
Branch Sort Code:							
Reference Number (for internal use only)	Date / / 2 0						
	Banks and Building Societies may not accept Direct Debit instructions for some types of account.						
Credit or debit card authorisation							
Cardholder name:							
Cardholder address: (if different from overleaf)							
Visa Mastercard Maestro/Switch Visa Delta							
Card number							
Card start date / Issue number (Switch only Month Year	y) Card expiry date / 2 0 Month Year						
I hereby authorise Saga Services Limited to charge this premium to this credit/debit car							
Signature							
	Date / / 2 0						