

Addition of dependants form

Important information

- Eligible dependants are: wife/husband/partners under 65 years of age and children under 21 years of age.
- To include your dependants under your membership simply complete all sections on this form. Please write clearly in BLOCK capitals.
- Once completed you can email your form to bupa@globalcapital.com.mt and post original form to:
GlobalCapital Health Insurance Agency Limited, Testaferrata Street, Ta' Xbiex XBX 1403, Malta.

If you have any questions when completing this form, please call us on 21 342 342 or email us on info@bupamalta.com

1. Principal member's details

Membership number	<input type="text"/>	Group (if applicable)	<input type="text"/>
Name and surname	<input type="text"/>	ID number	<input type="text"/>
Address	<input type="text"/>	Telephone	<input type="text"/>
<input type="text"/>		Mobile	<input type="text"/>
<input type="text"/>		Email	<input type="text"/>

Does any person to be covered, have or had health cover with any other insurer, including Bupa? Y N

If yes, please give details of the cover

Name of insurer Name of plan/cover

2. Additional persons to be covered: personal details

1st additional person	Title	<input type="text"/>	First name	<input type="text"/>	Relationship to you	<input type="text"/>
	Gender	<input type="radio"/> M <input type="radio"/> F	Surname	<input type="text"/>	Nationality	<input type="text"/>
	ID Number	<input type="text"/>	Date of birth	<input type="text"/>	Occupation	<input type="text"/>

2nd additional person	Title	<input type="text"/>	First name	<input type="text"/>	Relationship to you	<input type="text"/>
	Gender	<input type="radio"/> M <input type="radio"/> F	Surname	<input type="text"/>	Nationality	<input type="text"/>
	ID Number	<input type="text"/>	Date of birth	<input type="text"/>	Occupation	<input type="text"/>

3rd additional person	Title	<input type="text"/>	First name	<input type="text"/>	Relationship to you	<input type="text"/>
	Gender	<input type="radio"/> M <input type="radio"/> F	Surname	<input type="text"/>	Nationality	<input type="text"/>
	ID Number	<input type="text"/>	Date of birth	<input type="text"/>	Occupation	<input type="text"/>

4th additional person	Title	<input type="text"/>	First name	<input type="text"/>	Relationship to you	<input type="text"/>
	Gender	<input type="radio"/> M <input type="radio"/> F	Surname	<input type="text"/>	Nationality	<input type="text"/>
	ID Number	<input type="text"/>	Date of birth	<input type="text"/>	Occupation	<input type="text"/>

If any of these additional persons have different home or correspondence addresses to yours, please write their name and address on a separate sheet and confirm you have done so by ticking here

3. Confidential medical history

This section asks for health and medical details, past and present about yourself and each person named in Section 2. Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in Section 4 on the next page. Please ensure you tell us about any known or suspected conditions and symptoms even if professional advice has not yet been sought. If you are applying to increase cover and you are already a Bupa member, you should also include details of any condition for which you have made claims within the last four years. It is important that the information you give in this section matches the correct persons from section 2.

If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

Has anyone to be covered under the membership:

- seen a doctor or other healthcare professional
 - been admitted to hospital, had an operation/procedure or had an investigation (eg a scan/blood tests)
- in the last four years for any of the medical problems listed in questions 1 - 12 below:

	principal member	1st additional person	2nd additional person	3rd additional person	4th additional person
1. Heart or circulatory disorders eg high blood pressure, angina/chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, or varicose veins.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
2. Endocrine (glandular) disorders eg diabetes (Type 1 or Type 2), thyroid problems, or obesity.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
3. Breathing or respiratory disorders eg shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis or allergies (including hayfever and anaphylaxis).	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
4. Stomach, intestines, liver or gall bladder problems eg stomach inflammation/ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
5. Cancer, tumours or growths eg polyps, benign growths, any cancers or pre-cancerous condition.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
6. Skin problems eg eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic conditions.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
7. Brain or nervous system disorders eg stroke, dementia, migraine, repeated headache, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles) or meningitis	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
8. Muscle or skeletal problems eg arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, gout or inflammatory conditions.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
9. Urinary or reproductive system problems eg kidney or bladder problems (including kidney failure), recurrent urinary infections, incontinence, pregnancy/childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, polycystic ovaries, testicular or prostate disorders.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
10. Blood/infective/immune disorders eg abnormal blood tests, high cholesterol, anaemia, hepatitis, HIV, malaria or any autoimmune disorder.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
11. Eye, ear, nose, throat and dental problems eg cataracts, glaucoma, visual impairment, deafness, ear infections, tonsillitis, dental infections, wisdom teeth problems or gingivitis.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
12. Psychiatric/psychological disorders eg schizophrenia, compulsive or eating disorders, depression, stress, anxiety or drug/alcohol dependency.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

Please also answer the following questions:

13. Is anyone to be covered taking any medication, prescribed or otherwise?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
14. Is anyone to be covered receiving any treatment of any kind or required or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in this application?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
15. Has anyone to be covered experienced any signs or symptoms of any medical problems in the last six months, regardless of whether a healthcare professional has been consulted?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

Further details (for over 16s only):

How tall are you? <input type="radio"/> feet/inches <input type="radio"/> metres/centimetres	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How much do you weigh? <input type="radio"/> stones/pounds <input type="radio"/> kilogrammes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Have you used tobacco products within the last seven years?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
If you have indicated 'yes', please state how many a day.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Additional information

This section applies if you have indicated 'Yes' to any questions in Section 3. If you are unsure whether any details are relevant, you must include them.

The relevant question number from Section 3	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected (leg right leg, left eye)	When did the symptoms start and when was treatment completed?	What treatment did you receive and when (please include dates, names and details of medication)?	What treatment did you receive and when (please include dates, names and details of medication)?
1st additional dependant				
2nd additional dependant				
3rd additional dependant				
4th additional dependant				

If this is insufficient space, please use a separate sheet and indicate that you have done so by ticking this circle

N.B. Please tell us immediately if any additional persons to be covered under the membership, experience any symptoms before you receive your membership documents. Failure to do so may affect your claims. Completion of this application form does not confirm inception of cover. The inception date of membership shall be stipulated on the Membership Certificate which will be sent to you upon approval of addition of dependant form. When a receipt is issued this will only attest that money for premium has been received and not that the insurance cover has commenced.

5. Regular/family doctor details

Family doctor's name

Telephone/mobile number

Full address

6. Direct credit claims payment

(we can now settle eligible, valid claims via direct credit to the principal member's bank account)

All payments in respect of claims for treatment under this membership will be credited to the below mentioned bank account unless otherwise advised by the principal member.

Bank name APS Banif BOV HSBC Lombard Other

(Tick one only)

Account holder's name

Bank account number

Account holder's signature ID number

Preferred payment details notification method Email SMS (Tick one only)

Direct Credit

7. Your membership declaration

In view of the declaration below, it is essential that complete information is supplied.

It is GlobalCapital Health Insurance Agency Limited's (GlobalCapital) intention to provide a first class service to all our members/applicants at all times. However, if you have any cause for dissatisfaction, please write to the Customer Services Manager, GlobalCapital Health Insurance Agency Limited, Testaferrata Street, Ta' Xbiex, XBX 1403. Should you remain dissatisfied, you may submit your complaint to the Head of Legal and Compliance at the same address. Further to the above, if you are not satisfied with the outcome, you may wish to refer the complaint to the Consumer Complaints Manager of the Malta Financial Services Authority.

Unless otherwise agreed by GlobalCapital in writing, Maltese law shall apply to the agreement between yourself and GlobalCapital.

I understand that the benefits may not be payable if I do not fully disclose any material facts which could influence GlobalCapital's assessment and acceptance of my application. I do agree to disclose facts even when I am in doubt as to whether they are material and relevant. I do hereby apply to be enrolled as a member together with the person(s) listed in this Addition of Dependents Form who are to form part of my membership. I declare that, to the best of my knowledge and belief, the information given in this Addition of Dependents Form is true and complete. I agree that all the rules of the GlobalCapital health plan will be binding. I do give explicit and unqualified consent to GlobalCapital and Bupa within the provisions of the Professional Secrecy Act 1994, to obtain and make use of my personal information relating to me and the person(s) listed in this Addition of Dependents Form in order to allow GlobalCapital and Bupa to process this application and any future claims.

Data Protection Notices

Purpose: Personal data collected about you, and where appropriate the person(s) listed in this Addition of Dependents Form, will be used by GlobalCapital and Bupa to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

Confidentiality: The confidentiality of patient and member information is of paramount concern to GlobalCapital and Bupa. To this end GlobalCapital and Bupa fully comply with Data Protection legislation and guidelines and any other legislation concerning client confidentiality.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your Family Doctor / Primary Health Physician, or their agents. If applicable, medical information may be disclosed to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Claims information may be discussed with the GlobalCapital Insurance Intermediary / Advisor where you have requested the Advisor to assist you.

Member details: All membership documents and confirmation of claims assessments will be sent to the principal member.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Keeping you informed: Bupa Malta is brought to you by GlobalCapital Health Insurance Agency Limited. Bupa and GlobalCapital p.l.c. subsidiaries would, on occasion, like to keep you informed of products and services which it considers may be of interest to you.

Contact address: If you do not wish to receive this information, or have any other Data Protection queries please write to the Customer Services Manager, GlobalCapital Health Insurance Agency Limited, Testaferrata Street, Ta' Xbiex XBX 1403, Malta, email bupa@globalcapital.com.mt or Bupa Group Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, United Kingdom, email DataProtection@BUPA.com

Bupa reserves the right to decline any application.

You acknowledge receipt of the relevant details of cover. For further information you may contact us by telephone on 21 342 342 or by email on bupa@globalcapital.com.mt

Important information - your membership declaration

Please be aware that this form must be received by Bupa Malta no more than six weeks after the declaration date. It is advisable that you fill in your form with complete up-to-date medical history before you sign and date this form.

If we receive this form after six weeks from this signed declaration date, or with incomplete information, we will be unable to register your details and enrol you on the plan.

Principal member's signature

Date

If you have any queries regarding your addition of dependant form, please contact our customer services department on 21 342 342.

GlobalCapital Health Insurance Agency Limited (GCHIA) acts as a branch of Bupa Insurance Limited, which has passported its services through the European Passport Rights for Insurance and Reinsurance Undertaking Regulations. GCHIA is registered as an Insurance Agent and is regulated by the Malta Financial Services Authority. Registered office: GlobalCapital p.l.c., Testaferrata Street, Ta' Xbiex XBX 1403, Malta.