

Complete your details

Bupa By You medical history form

bupa.co.uk

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK.

- It's important you provide us with your medical history. Please fill in your medical history form and return it to us as soon as you can. Until you've completed this we won't be able to confirm exactly what your policy covers you for, meaning your claims might take longer for us to process and we might not be able to pay for treatment you need.
- You must take good care to answer all the questions honestly and to the best of your knowledge. If you don't, your policy may be cancelled, or treated as if it never existed, or your claim may be rejected or not fully paid.
- You must ensure the details of your family members are correct and should check the information with them before sending it to us.
- If you have any queries while you're completing the form, please call us.
- Please remember to sign and date the medical history form.
- Please retain a copy of the completed medical history form for your records.
- Once you have completed the medical history form, please return it to: **Medical Assessment, Bupa UK, 5th Floor, Victoria Harbour City Building, Salford Quays M50 3SP.**



5. Stomach, intestines, liver or gallbladder <i>eg ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Cancer, tumours, growths, cysts, or moles that itch or bleed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Skin problems <i>eg eczema, rashes, psoriasis, acne</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Brain or nervous system disorders <i>eg stroke, migraines, repeated headaches, MS, epilepsy, nerve pain, fits</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle or skeletal problems <i>eg arthritis, cartilage and ligament problems, back and neck problems, sprains, joint replacements, gout, sciatica</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Urinary problems <i>eg bladder, kidney or prostate problems, urinary infections, incontinence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Blood disorders <i>eg anaemia, hepatitis, HIV, abnormal blood tests</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Reproductive system problems <i>eg pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Dental problems <i>eg wisdom teeth, abscess, gingivitis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Psychological disorders <i>eg depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Undiagnosed symptoms <i>eg chest pain, fatigue, weight loss, dizziness, joint pain, change in bowel habit, shortness of breath, abdominal pain, rectal bleeding</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please also answer the following questions:

17. Are you or any applicant/member taking any medicines, prescribed or otherwise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Within the last three months has anyone to be covered experienced symptoms of ANY health problems for which medical advice has not yet been sought?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Has anyone to be covered EVER had any past history of joint replacements, heart conditions, or strokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Is there any other information relating to your health that has not yet been prompted by the questions listed 1 to 19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Additional information

If you have answered Yes to any of the questions in section C, please give full details here. If you need more space please use a separate sheet. If you are unsure whether any details are relevant, you must include them.

Name of applicant/member	When did symptoms start and/or when was treatment completed?
The relevant question number from section C	Treatment (including medication, prescribed or otherwise)
Illness or medical problem	Outcome of treatment (<i>eg ongoing, complete recovery, recurrent, or likely to recur</i>)

Your legal declaration

Important: Please read this declaration carefully before signing and dating the completed form.

1. I declare that all information given to Bupa is true and complete to the best of my knowledge and belief whether given: on my behalf or on behalf of my dependants for the purposes of receiving my quotation or as part of the application process. If there has been any change to the information since it was supplied to you, I declare that I have set out details of that change in this completed form. I declare that I have confirmed the details provided for dependants with my relevant family member.
2. I agree to inform Bupa if any of the information relating to myself or any dependants I have provided, or provide, changes at any time before cover starts.
3. I understand that if the information I have provided about myself and my dependants in answer to the questions in this application for Bupa membership is inaccurate or misleading, Bupa may terminate my cover or benefits might not be payable.
4. I understand and accept there is no undertaking to cover any medical conditions in existence before the time I, or my dependants, are covered by Bupa.
5. I understand that I will have the option of cancelling my Bupa cover and receiving a refund of premiums paid, as long as I do so in writing within 21 days of me receiving my membership certificate and no claims have been paid or claimed.
6. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and any family members specified in this form for Bupa to process our personal information with respect to our membership as set out in the Bupa privacy notice and I confirm that I have brought the Bupa privacy notice to the attention of these family members.
7. I understand English Law applies to the agreement between me and Bupa, unless otherwise agreed between us in writing.

You are advised to keep a record of all information you supply to us in connection with your Bupa membership, including this medical history form and any letters. If you would like a copy of this form please ask us.

Signature

Date

D	D	M	M	Y	Y	Y	Y
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Bupa privacy notice

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa group. To this end, we comply with data protection legislation and medical confidentiality guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be outside of the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security, in addition to the obligations imposed by the Data Protection Act 1998.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care.

Audit of medical and billing information: When we process claims or investigate complaints on your behalf, Bupa may request and obtain further details from your treatment provider. The information may be sought either at the time of processing or subsequently, for the purposes of ensuring the accuracy of information and the quality of treatment and care. You confirm that you consent to Bupa obtaining medical and billing information from your treatment provider relating to claims or complaints you may make.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member. Your membership and contact details may be shared by the companies in the Bupa group to enable us to manage our relationship with you as a Bupa customer and update and improve our records. Depending on how your cover or policy has been funded or introduced, Bupa may share information with your employer and or an appointed intermediary, solely for scheme administration purposes. Bupa does not make the names, addresses and other contact details of our members available to any other organisations to use for their own purposes.

Telephone calls: In the interest of continuously improving our services to members, calls may be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by us, or disclosed to others, for research or statistical purposes.

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

Keeping you informed: The Bupa group would, on occasion, like to keep you informed of the Bupa group's products and services that we consider may be of interest to you. If you do not wish to receive information about our products and services, or have any other data protection queries, please write to: Bupa UK Information Governance Team, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3DZ or contact us via email at: DataProtection@bupa.com