Tel: 01481 728864
Fax: 01481 728705
Email: info@forestershealthcare.co.uk
Esplanade House, 29 Glategny Esplanade, St Peter Port, Guernsey, GY1 1WR

Court No 8143

Member No.

Your Application

1. Please complete this form using **Black or Blue Ink** and write within the boxes using **CAPITAL LETTERS**.
2. Please complete all details and answer all questions on this form.
3. Read the declaration carefully and sign to confirm your understanding and acceptance of the terms and conditions.

Section A - Your Details

Surname

First Name(s)

Title

Date of Birth

Are you a permanent resident of Guernsey / Alderney?

If yes, how long have you been a resident?

Occupation

Current health insurer

Name/Practice of your registered doctor

Guernsey Social Security number

Introduced by (if a personal recommendation)

Join to existing member or group (if applicable)

Section B - Contact Details

Home Phone Number

Email Address

Mobile Number

Address

Daytime Work Phone Number

Postcode

Section C - Cover

Please confirm the cover you wish to apply for

Primary Care Scheme

Mandatory Cover - basic level of cover for doctors & nurses consultations, blood tests, consultations at the Emergency Department and essential or emergency ambulance conveyance. For more information please see your brochure.

YES

Additional Benefits Scheme

Optional Add-on Scheme - Cover for other treatments such as minor operations, physiotherapy/osteopathy, allergy testing, ECG's and well person checks. For a full list of cover provided please see your brochure.

Do you require Additional Benefits cover?

Please tick the appropriate box **YES** ☐ **NO** ☐

If yes, please tick the level you require

BRONZE ☐ **SILVER** ☐ **GOLD** ☐

Major and Critical Care Scheme

Optional "Add-on" Scheme—Cover for Major and Critical Category treatment within the Accident and Emergency Department of the Princess Elizabeth Hospital. Please see your brochure for full details.

Please indicate if you wish to purchase the "Major and Critical" Care Scheme

Section D - Your Medical History

Are you currently suffering from or have you suffered any serious or ongoing illnesses, conditions or injuries in the last 5 years?

YES ☐

NO ☐

If yes, state nature and dates

Are you currently receiving or expecting to undergo treatment in the near future?

YES ☐

NO ☐

If yes, give details

Section D - Your Medical History (Continued)

Are you currently receiving or expecting to receive physiotherapy, osteopathy or chiropractic treatment in the near future?

YES ☐

NO ☐

If yes, state nature and dates

Have you any prospect of undergoing an operation in the near future?

YES ☐

NO ☐

If yes, give details

On average, how often do you visit your doctor/nurse per year (including home visits)?

Section E - Payment Details

Indicate below how you would like to pay your premium to Foresters Healthcare.

Payment Type

☐ DIRECT DEBIT ☐ CHEQUE ☐ CASH ☐ CREDIT/DEBIT CARD

Payment Frequency

☐ ANNUAL ☐ HALF ANNUAL ☐ QUARTERLY ☐ MONTHLY

We do not issue monthly accounts

Section F - Other Information

If there is any other information relevant to your application that you wish to disclose please state below.

Section G - Declaration

Please read carefully and sign below to confirm your understanding and acceptance of following terms and conditions;

The questions in this application must be answered fully and accurately to the best of your knowledge. You must disclose to the Society any material facts or circumstances that would influence the assessment and acceptance of your application. Failure to do so may cause the insurance to be declared void. Premiums are calculated based on an annual review and a standard rate is set for each year.

The Society reserves the right to charge a non-standard premium rate where applicants have pre-existing medical conditions for represent a non-standard risk based on their medical history. The Society also reserves the right to not accept into membership any applicant that represents an unacceptable risk. Should payments not be received by renewal dates medical cover will be suspended until such payment is received.

By signing this form you consent to the Society seeking medical information from any Doctor who at any time has attended you concerning anything which affects your physical or mental health and you authorise the giving of such information. Any costs incurred in the gaining of this information is not payable by the Society. You also consent to the Society providing information to third party companies such as your doctor's surgery, Guernsey Social Services Department and the States of Guernsey Health and Social Care, also any information sought by relevant authorities in the case of a criminal investigation. Information and reports supplied by or to these parties are kept private and confidential and will only be provided to the applicant with prior permission from the party in question.

Signature

Print Name

Date

(To be signed by a parent or guardian where the applicant is under sixteen years of age)

Please mail your application to:
Foresters Healthcare, Esplanade House, 29 Glategny Esplanade, St Peter Port, Guernsey, GY1 1WR

If you require any assistance please call us on 01481 728864.

OFFICE USE ONLY

Date Received

Trustee Signature

Date

Commitee Acceptance

Sent/Received