Office use only: Ref

Applying couldn't be easier - Fill in this form and sign the declaration overleaf.

Existing customers can also use this form to change cover level and/or add a family member by filling in the 'Your details' section and the relevant section(s) to amend your policy. To authorise the changes you must sign the declaration overleaf.

Have you been introduced by an existing customer? - If so, please provide their details below.

Title | First name | Surname

Postcode | Policy number

Date of birth D D – M M – Y Y Y Y

Your details - Please make sure you read the policy summary on page 7 and the Insurance Product Information Document provided separately with your policy documents. Please tick the relevant box below to indicate if you want to apply to either join the Morrisons health care cash plan or change an existing policy.

I am: A new customer An existing customer changing cover level and/or adding a family member

Title | First name | Surname

Address

Postcode

Date of birth D D – M M – Y Y Y Y Phone

Email

Pay to cover your partner/family member (optional)

Title | First name | Surname

Address (if different to yours)

Postcode

Date of birth D D – M M – Y Y Y Y Phone

Email

The email address for your partner/family member must be different to yours.

Add up to four dependent children under the age of 18 for free

Dependent 1 Master/Miss*

First name

Surname

Date of birth D D – M M – Y Y Y Y

Dependent 2 Master/Miss*

First name

Surname

Date of birth D D – M M – Y Y Y Y

*Delete as appropriate. Please continue on a separate sheet of paper if you wish to add more than two dependent children.

Choose your level of cover

Please choose your level of cover, and partner/family member cover if needed, by ticking the relevant box(es). 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)	£7.80	£11.76	£15.72	£20.28	£26.52
Your level of cover					
Partner/family member level of cover					

Please continue **overleaf** to complete your application.

Payroll deduction payment instruction

Please fill in this section so we can instruct your payroll department to deduct your premiums from your salary.

Enter your Morrisons location here:

Employee ID number

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

Direct Credit - Fill in this section to have your claims paid into a bank account.

If you do not fill in this section your claims will be paid by cheque. If you are paying for your partner/family member, their claims will be paid by cheque until they provide their claims payment details. To register for direct credit at a later date, simply contact our customer support team or do this online via the secure customer area.

Full name of account holder

Name of bank

Sort code – – Account number

I authorise Sovereign Health Care to pay my claims into this bank account until further notice.

Your marketing contact preferences

We'd like to keep you updated about the latest offers, products and services from Sovereign Health Care and its group companies that may be of interest to you. Please tick the relevant box(es) below to indicate how you would like to be contacted by us. Please be assured that we will never sell your data on to third parties and you can withdraw your consent at any time.

I consent to receiving information by: Post Phone Email Text

Declaration

I want to apply to join the Morrisons health care cash plan provided by Sovereign Health Care or, I am an existing customer and I want to apply to change my policy. I and anyone else detailed on this application apply for cover under the Morrisons health care cash plan and 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 partner/family member cover, I have their 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 amount noted to be deducted from my salary and paid 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 ended. 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 and abide 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 collected by us in line 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, assess and process claims, prevent crime (including fraud and money laundering) and to comply with any legal requirements that apply. We will also need to share your personal information with your employer to deduct your policy premiums from your salary. For more details on how we use your personal information, including sharing it with third parties, how we keep your information secure and your rights relating to the information we hold about you, please see our privacy policy on our website (or contact us if you would like us to send you a copy).

Your application to join or change an existing policy 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 policy will be subject to our terms and conditions, which we will provide to you with your policy documents.

Your signature

Date D D – M M – Y Y Y Y

Please make sure you have filled in all sections and signed the declaration.

Please detach and return in an envelope to: FREEPOST SOVEREIGN HEALTH (no stamp or other address details needed).