Application form.

Westfield Mosaic Health Cash Plan – through payroll

When applying to upgrade your corporate paid cover or applying for cover for an additional adult, please read the full terms and conditions at the back of your Westfield Mosaic Health Cash Plan guide. If you need a new plan guide, please let us know before you complete this application form.

Premiums will be collected by payroll deduction from the employee's wages/salary. We implement stringent credit control procedures for employers operating payroll deduction facilities, however it ultimately remains your responsibility to ensure that premiums for your employee upgrade option or additional adult cover policy are remitted to Westfield Health.

Simply return your completed application form to your employer's HR/Payroll department.

Westfield Health

Westfield Mosaic Health Cash Plan: Application Form

Please complete using block capitals and black ink

Section A – Employee details	
Title (Mr/Mrs/Miss/Ms/Other)	Tel work
Forename(s)	Tel home
Surname	Tel mobile
Date of birth (DD/MM/YY)	Email
Address	
	Postcode
Westfield Health policy number (if applicable)	

Section B – Employee Cover (Please tick as applicable)		
I wish to:	Remain on level	Upgrade to level
Level 1	☐	
Level 2	☐	☐
Level 3	☐	☐

Employment Details
Name of employer
Payroll number
Pay frequency ☐ Monthly
Other – Please specify

Section C – Additional Adult Cover	
Title (Mr/Mrs/Miss/Ms/Other)	Tel work
Forename(s)	Tel home
Surname	Email
Date of birth (DD/MM/YY)	Tel mobile
Additional Adult Level of Cover Required: (please tick)	Level 1 ☐ Level 2 ☐ Level 3 ☐

Section D – Payment of Claims	
Name of Account Holder	Bank/Building Society Name
Sort Code	Account Number
Claims can be paid into my Bank/Building Society account: Employee ☐ Additional Adult ☐ (Please tick as applicable)	

Section E – Declaration This section must be completed and signed by the employee

I declare that the information I have given on this form is true and complete and that I have received full details of the policy, which I have read or have had read to me and agree to be bound by the Terms and Conditions and Benefit Rules of the plan.

I understand that all future benefit claims will be reimbursed to the bank/building society account as detailed in Section D. I can confirm that I am one of the account holders. Once your claim has been processed, confirmation of the payment will be forwarded to you. If an additional adult takes out a policy they can have their claims paid into this account too, providing they are a named account holder.

If the additional adult's claims are to be credited to a different account please request a direct credit instruction form by emailing enquiries@westfieldhealth.com or calling 0114 250 2000.

Marketing Preferences:

We'd love to keep you up to date with all things health and wellbeing.

Please tell us what you'd like to hear about:

Employee

☐ Health & Wellbeing Information ☐ Special Offers ☐ Westfield Insiders ☐ Products

Please tell us how you would like us to communicate with you for the above purposes:

☐ Email ☐ Text ☐ Telephone ☐ Post ☐ Social Media ☐ Web

You're always in control. You can update your choices at any time. Once your application is complete, simply visit **westfieldhealth.com** and register or log in to My Westfield.

We'd like to bring to your attention our Privacy Promise on page 8 in your full plan guide which details how your data is used, stored, and how to exercise your privacy rights.

Employee Signature	Date

Section F – To be completed by your employer	Westfield Health Office use only
Date deductions commence	Policy number
Westfield Health company registration number	Event ID

PAYAPPV3

Westfield Mosaic Health Cash Plan Payroll deduction authority

Please complete using block capitals and black ink

Employer please detach and retain for your records

Section G – To be completed by you	This section must be completed
Title (Mr/Mrs/Miss/Ms/Other)	Tel work
Forename(s)	Tel home
Surname	Tel mobile
Date of birth (DD/MM/YY)	Email
Payroll number	
Westfield Health policy number (if applicable)	

	Please tick box as applicable	
I wish to:	Remain on level	Upgrade to level
Level 1	☐	
Level 2	☐	☐
Level 3	☐	☐

Section H – Additional Adult Cover

Title	Forename(s)	Surname	Date of birth (DD/MM/YY)	House number	Postcode	Additional Adult Level of Cover Required: (please tick one box only) L1 L2 L3
						☐ ☐ ☐

Section I – Authority for deduction from payroll — **Must be completed and signed by the employee**

Please read carefully before signing

I hereby authorise to have the premiums as shown above, or any increased premiums as may be notified from time to time to secure plan benefits, deducted from my wages or salary for myself or the above named person. Please remit the total premium to Westfield Health on my behalf at the agreed intervals until further notice.

Signature	Date

Section J – To be completed by your employer

Date deductions commence
Westfield Health company registration number

Employee:
After you have completed sections A,B,C,D,E,F,H and I please pass the form to your employer to complete sections F and J.

Payroll:
Please retain the payroll deduction authority form and forward the application form to Westfield Health. As the application form will contain bank or building society details please send this to us in a secure way.

Westfield Health

Who are we?

Westfield Health is an insurance provider.

The services you will receive

We will only provide you with information about our plans so that you can make an informed choice. We will not provide you with any advice or recommendation about the plans or range of options available from Westfield Health. You will need to make your own decision as to the suitability of the product for your own circumstances.

Complaints

You can contact us with your concerns by phone, email, post or directly to your sales consultant. If you're not satisfied with our response, you may be able to refer your complaint to the Financial Ombudsman Service. You will have 6 months from the date of our response letter to refer your complaint to the Ombudsman or you may lose your right to have the complaint investigated. You can find the contact details for the Ombudsman as well as further information regarding their service, by visiting the following website: www.financial-ombudsman.org.uk.

The Financial Services Compensation Scheme

If we cannot pay claims, the Financial Services Compensation Scheme (FSCS) protects you. If the FSCS is satisfied that we are unable to pay claims, any valid outstanding claims you have at that point would be paid by the scheme. For more details please visit www.fscs.org.uk or contact the FSCS directly on 0800 678 1100 or 020 7741 4100.

Remuneration

Our sales agents/staff receive a salary and also receive a bonus based on sales and meeting certain quality thresholds.

Multiple policies

If you can claim part or all of your costs under another Westfield Health plan, or from any other source, you are not entitled to receive more than the total amount that you have paid. If you are claiming from another insurer we will pay our proportionate share of the cost, subject to benefit being available and the terms and conditions of your plan.

Statement of Demands and Needs

This product is generally suitable for customers who are looking to cover the cost of a selected range of everyday healthcare expenses.

Cooling Off Period

If you are not completely satisfied with the policy, simply notify us within 14 days of the date you receive your welcome pack and we will cancel it. Provided a claim has not been paid, we will refund any premium collected. Please refer to full terms and conditions in your plan guide.

Remember, our friendly Customer Care Team is here to help.

Online
westfieldhealth.com

Email
enquiries@westfieldhealth.com

Phone
0114 250 2000
8:30am - 5:30pm, Mon-Fri (except Christmas Eve and public holidays)

Postal address
Westfield Health
PO Box 340
Sheffield
S98 1XB