Application form to cover another adult

Sovereign Health Care

MERIT

Please fill in this form (either electronically or by printing a hard copy) and return it to your employer. **Please read the form carefully along with the Insurance Product Information Document and Merit policy terms and conditions**. As the form includes hyperlinks, let us know if you need a hard copy of the linked information. Premiums to cover another adult include insurance premium tax and will be deducted from your regular salary by your employer and paid to Sovereign Health Care.

Section A - Employee's details

Employer/Company name:

Employee name: **Date of birth:** D D – M M – Y Y Y Y

Section B - Cover another adult (please note you can only cover one additional adult and they must be under the age of 75 to be eligible for cover)

To cover another adult on Merit costs £7.70 per month. If you want to cover another adult, please provide their details below.
Please note, additional adult cover automatically ends if your employer cancels the agreement with Sovereign Health Care; if you leave your employer; or if you die. See the section titled 'Leaving Merit' in the Merit policy terms and conditions for full details.

Title: **First name:** **Surname:**

Address:

Postcode:

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

Section C - Authorisation

Statement of demands and needs

Do you require insurance to help cover your everyday, routine health care costs? This policy meets the demands and needs of a person who wants to claim money back towards specified health care items and treatments received during the term of the policy. Sovereign Health Care is the insurer and we do not provide advice, or make any recommendations, about our insurance products however we will provide the information you need to make your own decision. Sovereign Health Care employees who sell this insurance product are remunerated by way of a basic salary and bonus payments linked to their individual performance.

Declaration

I want to cover another adult, as indicated above. I authorise the premium amount noted to be deducted from my salary. If premiums 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 statement of demands and needs and the terms and conditions governing the Merit policy. I understand this insurance will automatically continue as long as premiums continue to be paid or until cover stops for any of the reasons detailed in the Merit terms and conditions. I confirm that the information I have provided on this application form is to the best of my knowledge true and complete. I confirm that where I have provided another adult's information on this form for additional adult cover, I have their permission to provide the information to my employer and Sovereign Health Care, and for it to be used in the same way as my own.
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 Merit 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, and the additional adult's information, with your employer to deduct any 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).

Employee signature: **Date:** D D – M M – Y Y Y Y

Please make sure you have filled in all relevant sections and signed and dated section C before you return this application form to your employer.