

Health Plan Joining Form Corporate Membership

FOR DIRECT CONTRIBUTORS: Please complete this page. When received we will send you a direct debit mandate and health declaration form for completion and return. If no bank account is held, please contact our office on Freephone 0808 178 1179 to discuss payment methods available.

FOR PAYROLL DEDUCTION: If offered by your employer please also complete the section at the foot of this page.

I apply to join Plutus Health Cash Plan and if accepted, agree to the terms and conditions applying at the time of this application and other such terms and conditions as may apply later (subject to my right to give 14 days notice of withdrawal)

Please tick against plan and amount required.

Plan Name	Per Month	Member	Partner
Foundation	£9.05	<input type="checkbox"/>	<input type="checkbox"/>
Bronze	£13.69	<input type="checkbox"/>	<input type="checkbox"/>
Silver	£22.98	<input type="checkbox"/>	<input type="checkbox"/>
Gold	£32.24	<input type="checkbox"/>	<input type="checkbox"/>

Title: Full Names:

Date of Birth: Telephone:

Address:

Post Code:

Email:

Employer:

Address:

Postcode: Telephone:

I have previously paid into Plutus Health Yes No if YES through: Direct Employer

Details:

Does your partner currently contribute to Plutus Health? Yes No

Partner's Names:

Your partner and/or dependent children under 18, living with you, may also be enrolled.

Please complete their details below and we will let you know the benefits available and cost.

First Name(s):

Relationship:

Date of Birth:

*If more than 3 dependents, please provide their information by email addressed to: admin@plutushealth.co.uk with a subject line Membership Application, followed by your name.

I certify that I am in good health as is my partner and dependent children (if applying for partner and/or family membership).

Signature:Date:

Signature of Partner:Date:
(if joining)

For online applications please type your names in full.

Terms and conditions apply.

To be completed ONLY if applying for Payroll Deduction

I authorise my employer to deduct the amount of the plan I have ticked above plus any additional amount for my partner and/or dependent children, for credit to my Plutus Health Plan or other contributions as may later apply (subject to my right to give 14 days notice of withdrawal)

Full Names: Date:

Employer: Clock/
Payroll No:

Place of Work & Department:

A copy of your application will be submitted to your employer.

Plutus Health, 13 Cardiff Road, Newport, South Wales, NP20 2EH
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www.plutushealth.co.uk

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