plutushealth

Health Plan Joining Form

Personal 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	£8.82		
Bronze	£13.45		
Silver	£22.74		
Gold	£32.03		

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:

Hospital In-patient benefit can be paid for your partner and/or dependent children under 16 years of age, living with you. They have to be registered with us to enable you to claim. Please complete their details below.

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.

We have an alternative plan where your partner and dependent children under 16 years of age, living with you, can be enrolled to be covered for most benefit types. If interested please contact our office, details below.

I certify that I am in good health as is my partner and dependent children.

Signature: Date:

Signature of Partner: (if joining) Date:

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