



# Health Plan joining form

To join Plutus Health and pay your membership via **your payroll** please complete this form.

I apply to join the Plutus Health Cash Plan and if accepted, agree to the Terms & Conditions as may apply (subject to my right to give 14 days' notice of withdrawal). **I authorise my payroll to deduct the amount(s) below.**

**Full Name: Mr/Mrs/Miss**

**Date of Birth:**  **Telephone:**

**Address:**

**Postcode:**

**Email:**  **Place of Work:**

**Department:**  **Clock / Payroll Ref:**

**Single Membership**

Foundation	£8.82 PerMonth	<input type="checkbox"/>
Bronze	£13.45 PerMonth	<input type="checkbox"/>
Silver	£22.74 PerMonth	<input type="checkbox"/>
Gold	£32.03 Per Month	<input type="checkbox"/>

**Partner Membership (additional cost)**

Foundation	£8.82 PerMonth	<input type="checkbox"/>
Bronze	£13.45 PerMonth	<input type="checkbox"/>
Silver	£22.74 PerMonth	<input type="checkbox"/>
Gold	£32.03 Per Month	<input type="checkbox"/>

If you have chosen to add a partner membership please complete the following:

**Full Name: Mr/Mrs/Miss**

**Date of Birth:**  **Email:**

**Signature:**  **Date:**

**Partners Signature: (if joining)**  **Date:**

If you would like to add your partner or children under the age of 16 as dependents, in order to claim inpatient benefit on your membership, please contact the office.

### Assessing your Demands & Needs for the Plutus Health Policy

Would you (and your partner, if applying for an additional policy) benefit from financial assistance towards a range of health care costs now and in the future, e.g. costs incurred for optical care, dental treatment, physiotherapy, osteopathy, chiropractic, acupuncture or hospital inpatient treatment?

**No I (we) wouldn't**  **Yes I (we) would**  **Please tick the appropriate box**

Have you (or your partner, if applying for additional policy) an existing policy in place which contributes to the costs of your everyday healthcare needs?

**Yes I (we) have**  **No I (we) don't**  **Please tick the appropriate box**

\*If both **unshaded** boxes are ticked, this product meets your demands and needs.

### Data Protection

Plutus Health are committed to protecting your data, respecting your privacy and complying with data protection legislation. Please refer to the privacy notice on our website [www.plutushealth.co.uk](http://www.plutushealth.co.uk).

Plutus Health may contact you from time to time with marketing offers and information we believe will be of interest to you. To opt in please tick the box(es);

**Email**  **Direct mail**  Remuneration disclosure – Our sales agents receive a salary and may receive a bonus based on sales.





# Health Plan joining form

To join Plutus Health and pay your membership by **direct debit** please complete this form.

I apply to join the Plutus Health Cash Plan and if accepted, agree to the Terms & Conditions as may apply (subject to my right to give 14 days' notice of withdrawal).

**Full Name: Mr/Mrs/Miss**

**Date of Birth:**  **Telephone:**

**Address:**

**Postcode:**

**Email:**

**Single Membership**

<b>Foundation</b>	<b>£8.82 PerMonth</b>	<input type="checkbox"/>
<b>Bronze</b>	<b>£13.45 PerMonth</b>	<input type="checkbox"/>
<b>Silver</b>	<b>£22.74 PerMonth</b>	<input type="checkbox"/>
<b>Gold</b>	<b>£32.03 PerMonth</b>	<input type="checkbox"/>

**Partner Membership (additional cost)**

<b>Foundation</b>	<b>£8.82 PerMonth</b>	<input type="checkbox"/>
<b>Bronze</b>	<b>£13.45 PerMonth</b>	<input type="checkbox"/>
<b>Silver</b>	<b>£22.74 PerMonth</b>	<input type="checkbox"/>
<b>Gold</b>	<b>£32.03 PerMonth</b>	<input type="checkbox"/>

If you have chosen to add a partner membership please complete the following:

**Full Name: Mr/Mrs/Miss**

**Date of Birth:**  **Email:**

**Signature:**  **Date:**

**Partners Signature: (if joining)**  **Date:**

If you would like to add your partner or children under the age of 16 as dependents, in order to claim inpatient benefit on your membership, please contact the office.

### Assessing your Demands & Needs for the Plutus Health Policy

Would you (and your partner, if applying for an additional policy) benefit from financial assistance towards a range of health care costs now and in the future, e.g. costs incurred for optical care, dental treatment, physiotherapy, osteopathy, chiropractic, acupuncture or hospital inpatient treatment?

**No I (we) wouldn't**  **Yes I (we) would**  **Please tick the appropriate box**

Have you (or your partner, if applying for additional policy) an existing policy in place which contributes to the costs of your everyday healthcare needs?

**Yes I (we) have**  **No I (we) don't**  **Please tick the appropriate box**

\*If both **unshaded** boxes are ticked, this product meets your demands and needs.

### Data Protection

Plutus Health are committed to protecting your data, respecting your privacy and complying with data protection legislation. Please refer to the privacy notice on our website [www.plutushealth.co.uk](http://www.plutushealth.co.uk).

Plutus Health may contact you from time to time with marketing offers and information we believe will be of interest to you. To opt in please tick the box(es);

**Email**  **Direct mail**

Remuneration disclosure – Our sales agents receive a salary and may receive a bonus based on sales.





# Direct Debit mandate

## Instructions to your Bank or Building society to pay Direct Debits

Please complete this form and return to: **Plutus Health, 60 Newport Road, Cardiff, CF24 0YG**

### 1. Name and full postal address of your Bank or Building Society Branch

To the Manager:

Bank or Building Society

Address:

Postcode:

### 2. (a) Name(s) of account holder(s)

### (b) Plutus Health Membership No.

### 3. Please tick the appropriate box to indicate frequency of payment:

Monthly Quarterly 1/2 Yearly Annually

### 4. Branchsort code (from the top right hand corner of your cheque)

### Instruction to your Bank or Building Society

Please pay Plutus Health Direct Debits from the account detailed on this Instruction subject to the safeguards assured by The Direct Debit Guarantee.

Signature:

### 5. Bank or Building Society account number

Date:

**Banks and Building Societies may not accept Direct Debit Instructions for some types of account**

### This guarantee should be detached and retained by the Payer

## The Direct Debit Guarantee



- + This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- + If there are any changes to the amount, date or frequency of your Direct Debit Plutus Health will notify you 14 working days in advance of your account being debited or as otherwise agreed. If you request Plutus Health to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- + If an error is made in the payment of your Direct Debit, by Plutus Health or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.
- + If you receive a refund you are not entitled to, you must pay it back when Plutus Health asks you to.
- + You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.