HSF health plan for Reed Employees

R1 & R2 Schemes

Helping you and your family cover the cost of everyday healthcare

Who is HSF health plan?
HSF health plan is a health cash plan provider, committed to delivering simple and affordable ways to help you cover the cost of everyday healthcare such as dental, optical and physiotherapy, plus much more. With over 30 health benefits available, it provides an added security for you and your family's health.

The Personal Accident benefits outlined are underwritten for HSF health plan currently by Chubb European Group Limited.The underwriter of the Personal Accident Benefits may be subject to change.

The GP Advice services are currently provided for HSF health plan by Medical Solutions UK Limited.

How does it work?
It's simple. You pay a premium for the scheme that suits you best, then you claim cash back for your treatments as and when you need it. And so your family doesn't feel left out, we also offer to cover the healthcare of your children (up to age of 18, as long as they reside at the same address) at no extra cost. The maximum payable is between all eligible registered persons in any 12 consecutive calendar months.

What am I covered for?
Our R1 and R2 schemes offer a wide range of health categories at affordable prices, and we reimburse you either 50% or 100% of your professional costs up to the maximum shown in the benefits table.

There is a total limit on benefits calculated on a rolling balance over a 12 month basis with a further limit from the start of your policy on some hospital benefits. Please see Policy Terms & Conditions page 11 in this brochure.

All of our schemes include access to our GP Advice Line, Virtual Doctor and Medical Information.

Are there any restrictions?
Most benefits have a three month Qualifying Period (except: 10 months for Infertility, Birth & Adoption and anything related to pregnancy or infertility. 12 months for Eye Laser Treatment and Implantable Contact Lenses).
Full details are shown in the Policy Terms & Conditions, available from page 11 in this brochure.

Making a claim
Claims may be submitted at the conclusion of the qualifying periods stated under each benefit heading in this brochure, as long as all the appropriate premiums are up to date when you make the claim.

There is a qualifying period of 10 months for the Birth and Adoption Grants and this time also applies to other benefit categories if the claim is related to pregnancy or infertility.

To find out more information about HSF health plan, call us on
0800 917 2208
email enquiries@hsf.eu.com

A qualifying period of 12 months applies to Eye Laser Treatment and Implantable Contact Lenses.

All claims must be submitted within six months of the date of treatment/purchase, accident taking place or discharge from a hospital.

Forms are available to download from our website, alternatively they can be provided on request by writing to 24 Upper Ground, London, SE1 9PD, Tel 020 7928 6662. Please quote your policy number which is on your certificate of cover.

Duration of the policy
Your policy is renewed automatically on a monthly basis unless your cover is cancelled or you allow it to lapse.

Can I cancel my policy?
When your application is accepted you will receive a "Welcome Pack" on receipt of this you have 14 days in which to write to us and change your mind; please see "Decreasing or ceasing scheme cover" on page 12.

How to complain
Should you find it necessary to make a complaint, you should in the first instance contact our Customer Services Department at our London address. While we are investigating your complaint, we will keep you regularly updated. If your complaint has not been resolved within 8 weeks, we will explain why it remains unresolved and inform you of your right to refer the matter to the Financial Ombudsman Service at Exchange Tower, London, E14 9SR or telephone them on 0800 023 4567. Their website address is www.financial-ombudsman.org.uk.

HSF health plan and The Hospital Saturday Fund.
HSF health plan is the trading company of the registered charity The Hospital Saturday Fund.
All those who join HSF health plan, just by belonging, are making a contribution to the important work of the charity, not something which usually happens when an insurance policy is taken out.

HSF health plan Limited is an insurance undertaking, and all information is provided in order for applicants to choose the scheme to suit their personal circumstance as HSF health plan is not authorised to provide a professional recommendation.

Statement of demands and needs
This product meets the demands and needs of individuals and families who wish to manage their healthcare expenses such as dental and optical, hospital admissions, consultations and investigations, and personal accident. Advice is not available from HSF health plan and HSF heath plan is not in a position to determine whether the product is appropriate for you. Applicants should choose the scheme to suit their personal circumstances and review in future whether this remains suitable.

Our benefits

Our benefits

Montly cost per adult Dependent children covered at no extra cost*	R1 Scheme £6 a month		R2 Scheme £9 a month	
Benefits	***Claim allowance**		***Claim allowance**	
Dental	£100	100%	£200	100%
Optical	£100	100%	£200	100%
Hospital In-Patient	£25	Per night up to the maximum of 40 nights	£50	Per night up to the maximum of 40 nights
Hospital Day Case	£25	20 days	£50	20 days
Recuperation	£60	Payable after a 15 night hospital stay	£120	Payable after a 15 night hospital stay
Chiropody / Podiatry	£50	50%	£100	50%
Practitioners Physiotherapy, osteopathy, chiropractic, acupuncture, homeopathy	£200	50%	£400	50%
Specialist & Investigations	£150	50%	£300	50%
Health Screening	£100	50%	£200	50%
Birth & Adoption Grant	£100	Payable upon the birth or adoption of a child	£200	Payable upon the birth or adoption of a child
Home help	£175	50%	£325	50%
Prescriptions	1	Payable at the NHS single item rate	2	Payable at the NHS single item rate
Personal Accident				
Permanent disability	£5,000		£10,000	
Accidental death	£2,500		£5,000	
Dental trauma	£250		£500	
GP Advice Services		24/7 access		24/7 access

*Claim allowances are calculated over a rolling 12 month period.
*Children up to age 18 living at same address as policyholder.

Our R1 and R2 Schemes for Reed employees
The advantages of having an HSF health plan

- No medical required before joining and the benefits have no pre-existing health restrictions (apart from Birth & Adoption and any Maternity related claims).
- Flexibility within each benefit category.
- Dependent children under 18 are included for free under the policy.
- Premiums do not increase with age.
- Unlike private medical insurance, the premiums you pay are not based on your age or gender, and once you join you are covered for life.

Both of our schemes include our GP Advice line and Virtual Doctor.

R1 Scheme	R2 Scheme
£6 a month	£9 a month

Dental and Optical

	R1 Scheme		R2 Scheme	
Dental	£100	100%	£200	100%
Optical	£100	100%	£200	100%

Help towards the cost of all dental treatment including check-ups, and the cost of a sight test and optical appliances, up to the maximum shown. It is payable between all eligible registered persons in any 12 consecutive calendar months. **Qualifying period – 3 months.** The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) is included in all Schemes. **Qualifying period – 12 months. We will reimburse you 100% of your professional treatment costs up to the maximum amounts shown for these benefits.**

Dental Trauma
For details on Dental Trauma, please refer to the Personal Accident Section on pages 8, 9,15 and 16.

Practitioner

	R1 Scheme		R2 Scheme	
Practitioners Physiotherapy, osteopathy, chiropractic, acupuncture, homeopathy	£200	50%	£400	50%

Help towards the cost of consultation and treatment (not including medication or appliances) by a qualified and registered practitioner up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible registered persons in any 12 consecutive calendar months. **Qualifying period – 3 months. We will reimburse you 50% of your professional treatment costs up to the maximum amounts shown for this benefit.**

Chiropody / Podiatry

	R1 Scheme		R2 Scheme	
Chiropody / Podiatry	£50	50%	£100	50%

Help towards the cost of chiropody and podiatry treatment (not including medication or appliances) by a qualified and registered practitioner up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible registered persons in any 12 consecutive calendar months. **Qualifying period – 3 months. We will reimburse you 50% of your professional treatment costs up to the maximum amounts shown for this benefit.**

Specialist & Investigations

	R1 Scheme		R2 Scheme	
Specialist & Investigations	£150	50%	£300	50%

Help towards the cost of specialists' consultation fees, allergy testing, vaccination, pathology tests, x-rays, scans, electrocardiograms and other investigations listed in the rules, all undertaken on an outpatient basis, up to the maximum shown. Payable between all eligible registered persons in any 12 consecutive calendar months. **Qualifying period – 3 months. We will reimburse you 50% of your professional treatment costs up to the maximum amounts shown for this benefit.**

Health Screening

	R1 Scheme		R2 Scheme	
Health Screening	£100	50%	£200	50%

Help towards the cost of health screening at a Health Screening Clinic following a recommendation from a General Practitioner. Payable between all eligible registered persons in any 12 consecutive calendar months. **Qualifying period – 3 months. We will reimburse you 50% of your professional treatment costs up to the maximum amounts shown for this benefit.**

Birth & Adoption Grant

	R1 Scheme		R2 Scheme	
Birth & Adoption Grant	£100	Payable upon the birth or adoption of a child	£200	Payable upon the birth or adoption of a child

Payable to the policyholder, whether the mother or father of the baby, for each registered birth in hospital or at home. Hospital benefit is payable for the mother (if she has her own policy) in addition to the grant from the sixth night onwards. The grant is also payable for a registered adoption up to the age of 10.
Qualifying period – 10 months.

Home Help

	R1 Scheme		R2 Scheme	
Home help	£175	50%	£325	50%

Short term assistance towards the cost of Local Authority services and some privately arranged assistance with organisations if supported by a doctor, up to the maximum shown. Payable between all named persons on the policy in any 12 consecutive calendar months.
Qualifying period – 3 months.

Hospital & Day Case

	R1 Scheme		R2 Scheme	
Hospital In-Patient	£25	Per night up to the maximum of 40 nights	£50	Per night up to the maximum of 40 nights
Hospital Day Case	£25	20 days	£50	20 days

General and Hospice: For an inpatient admission to a hospital or hospice to receive medical treatment. Payable to each eligible registered person for up to 40 nights in any 12 consecutive calendar months. (See pages 14 and 15 for full details). **Qualifying period – 3 months.**

Accident: For an inpatient admission to a hospital immediately following an accident. Payable to each eligible registered person for up to 40 nights in any 12 consecutive calendar months. (See pages 14 and 15 for full details). **No qualifying period.**

Elderly and Mental Illness: For an inpatient admission to a hospital for elderly medical care / long stay / rehabilitation / respite / GP care or for a mental illness. Payable to each eligible registered person for up to 50 nights elderly and 50 nights mental illness from first registration, but not for more than 40 nights in a 12 month period. (See pages 14 and 15 for full details).
Qualifying period – 3 months.

Day Case: For a planned admission to occupy a bed for a day in a hospital or clinic to undergo surgery, treatment or a procedure for up to 20 days within a 12 month period. **Qualifying period – 3 months.**

Recuperation

	R1 Scheme		R2 Scheme	
Recuperation	£60	Payable after a 15 night hospital stay	£120	Payable after a 15 night hospital stay

Following each stay in a hospital or hospice for which benefit has been paid for a minimum of 15 nights, a recuperation grant is payable for each eligible registered person.

Prescription

	R1 Scheme		R2 Scheme	
Prescriptions	1	Payable at the NHS single item rate	2	Payable at the NHS single item rate

Help towards the cost of your prescription charges by reimbursement of the current NHS single item prescription rate*. The number of prescriptions you can claim for in any 12 consecutive calendar months are shown against the scheme level. Dependent children are NOT covered under Prescriptions. **Qualifying period – 3 months.**

*Current NHS Prescription rate is £9.15 as per 1st April 2020. This is subject to change.

Personal Accident Benefit

All claims must be submitted within 6 months of the accident occuring.

	R1 Scheme	R2 Scheme
Personal Accident		
Permanent disability	£5,000	£10,000
Accidental death	£2,500	£5,000
Dental trauma	£250	£500

If an Accident results in Permanent Disability or death the financial consequences can be enormous. Even less serious injuries can result in a lengthy period off work or confinement to the house. Whilst you may be able to cope in the short term, a longer period of disability can put severe pressure on your finances. Lump sum cash payments (shown opposite) when they are needed most could ease the financial burden. Policyholders and dependent children are covered 24 hours a day, every day of the year, whether at work, at home or at play.

Permanent Disability: A lump sum cash benefit depending upon the type and degree of permanent disability following an Accident.

Facial Disfigurement: A lump sum payment for Permanent facial disfigurement as a result of an accident.

Accidental Death: A lump sum payment if the accident is fatal.

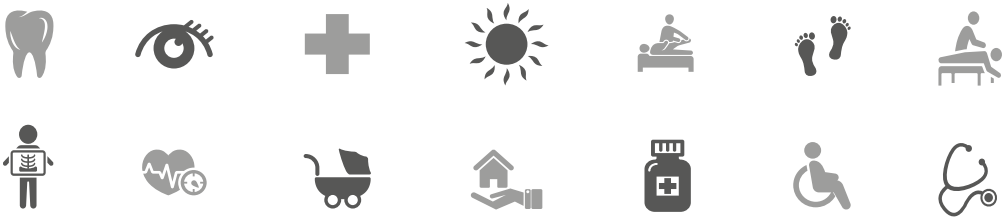
Dental Trauma: A payment for dental treatment required as a direct result of a blow to the head.

Temporary Disability: (not applicable to children under 16 years of age) A weekly sum payable (normally by direct credit, monthly in arrears) if following an Accident, you are:
a) unable to take up your normal paid occupation or any other paid employment; or
b) confined to the home (applicable only if you are not in paid employment at the time of the accident) as certified by a qualified medical practitioner.

Payable from the 31st day of your disability for up to 52 weeks. Odd days will be paid at 1⁄7th of the weekly rate.

Although there is no qualifying period under this section, the Temporary Disability benefit is not payable for the first 30 days (Deferment Period) of each period of temporary disablement.

Fracture Benefit: A lump sum payment for a fracture or fractures to one or more bones of the arm or leg following an Accident.



If you or any other eligible person (Insured Person) suffer Bodily Injury as a direct result of an accident which within 24 months of the Accident results in Permanent Disability, Facial Disfigurement or Death the following will be paid:

Accident benefit	R1 Scheme	R2 Scheme
Permanent Disability A proportion of this sum will be paid depending upon the degree of permanent disability in accordance with the following scale:	Up to £5,000	Up to £10,000
Permanent total disablement	£5,000	£10,000
Loss of sight in one or both eyes	£5,000	£10,000
Loss of hearing in both ears	£3,750	£7,500
Loss of hearing in one ear	£750	£1,500
Loss of the use of an arm, hand or leg above the knee	£5,000	£10,000
Loss of the use of a leg below the knee or a foot	£2,500	£5,000
Loss of the use of a shoulder or elbow	£1,250	£2,500
Loss of the use of a hip, knee, ankle or wrist	£1,000	£2,000
Loss of the use of a thumb	£1,000	£2,000
Loss of the use of any finger or big toe	£500	£1,000
Loss of the use of any other toe	£250	£500
Facial Disfigurement	Not available	£600
Dental Trauma	£250	£500
Accidental Death	£2,500	£5,000

In addition, there are the following payments for temporary disability and a fracture of the specified bone or bones listed below:

Temporary disability	Not available	£30 per week
Fracture grant: only available for these specified bones:		
Leg: ankle, tibia and fibula, kneecap, femur and hip	Not available	£150
Arm: wrist, radius and ulna, humerus and shoulder Fractured fingers/thumbs/toes/hand or foot bones are not covered	Not available	£75
Overall limit per accident	Not availble	£375

For Insured Persons aged 66 to 75 and under 16 years of age the Personal Accident benefits payable shall be reduced by 50%. For Insured Persons aged 76 and over the benefits payable shall be reduced by 75% and the Permanent Total Disablement category shall not apply. See pages 15 and 16 for Definitions and Exclusions.

All claims must be submitted within 6 months of the accident occurring.

GP and health services

Make the most of 24/7 access to our assistance helplines and services which are available to all policyholders and their families.The services available are:

GP telephone advice: 24 hour access to a doctor
Virtual Doctor: A webcam based face-to-face consultation service with a doctor

Our GP services are currently provided for HSF health plan by Medical Solutions UK Limited.

GP Advice Line

This service is available 24 hours a day, 7 days a week and the telephone number will be given to you in your welcome pack. The service allows you to speak with a qualified practising GP free of charge and at a convenient time. After making the initial call the doctor will telephone you. Every call is confidential and your details will not be passed on to anyone without your prior consent.

The GP Advice Line is complementary to your NHS GP. In an emergency situation, you should contact your own NHS GP or the emergency services directly so as not to delay the appropriate treatment.

Virtual Doctor

Now you don't need to leave home or work to see a qualified GP. With HSF Virtual Doctor, the UK's first online webcam GP consultation service, you can arrange an online face-to-face consultation at a time that fits with your busy life, 7 days a week from 8am to 10pm (telephone consultations are available 24/7).

The Virtual Doctor Service is further enhanced by using state of the art explanatory 3D medical images and health information enabling you, the patient, to have a more complete understanding of your condition.

Policy Terms & Conditions (please read carefully)

Becoming a Policyholder

Anyone may join up until their 71st birthday (providing they satisfy health requirements). Cover will continue for life, if the policyholder so wishes, and if premium payments are kept up-to-date and the rules and conditions are adhered to. Cover is provided continuously from month to month until it is cancelled or otherwise comes to an end. You will renew your policy every time your premium is paid, so unless we change the terms and conditions of your policy you will not receive renewal documentation.

The named policyholder must be a parent of the stated children under 18 or be the legal guardian of them. Children in a fostering arrangement are not eligible for inclusion, and neither are children who are on weekend/school holiday stays. Any dependant children must all reside at the same address. Young people aged 16 and 17 may join in their own right but if either parent is a policyholder as well, the young person will cease to be a dependant for cover on the parent's scheme.

Joining online

Join online via a link provided by your employer.

Restrictions

Claims cannot be accepted for: anything related to plastic surgery and consultations / treatment for cosmetic reasons; addictions (e.g. misuse of alcohol or drugs); self-harm or self-inflicted injuries or HIV / AIDS.

Benefits overview

There is a total limit on benefits calculated on a rolling balance over a 12 month basis with a further limit from the start of your policy on some hospital benefits.

The qualifying period shown for each benefit is explained in Rules and further explanations of benefit categories on pages 13, 14, 15, 16 and 17.

See 'Rules and further explanations of benefit categories' and 'Increasing scheme cover' on pages pages 13, 14, 15, 16, and 17.

Switching between schemes is allowed. See 'Increasing scheme cover' and 'Decreasing or ceasing scheme cover' on page 12 for the terms.

Paying premiums and changing your mind

Details of the prices of each scheme are shown in this brochure. Payment can be made by Direct Debit, Credit Card or Debit Card. It is the Policyholders responsibility to check that payments have commenced, by checking their bank statement in order that they are received regularly by HSF health plan.

When your application is accepted you will receive a welcome pack. On receiving your certificate of cover, you have 14 days in which to change your mind and withdraw your application (this must be in writing to the HSF health plan office in London). If any premiums have been paid you will receive a full refund providing no claims have been settled. See 'Decreasing or ceasing scheme cover' on page 12 for cancelling after this period.

If premiums fall into arrears for more than three months, a qualifying period of one month will be imposed from the date of payment before entitlement to claim is resumed. Policyholders who fall into arrears for more than six months will be required to re-join under the usual conditions of enrolment.

Making a claim

Claims may be submitted at the conclusion of the qualifying periods stated under each benefit heading in this brochure, as long as all the appropriate premiums are up to date when you make the claim.

There is a qualifying period of 10 months for the Birth and Adoption Grants and this time also applies to other benefit categories if the claim is related to pregnancy or infertility treatment. A qualifying period of 12 months applies to Eye Laser Treatment and Implantable Contact Lenses.

Forms are available by downloading from our website www.hsf.eu.com or upon request. Please quote your policy number which is on your certificate of cover. Original receipts must be sent with the claim form. Claims will only be accepted where accumulated receipts total £5 or more. Your payment will be made by direct credit payment into your bank account (a current account in your name or joint names).

Claims will not be paid unless the appropriate premiums are up-to-date. Claims must be made within six months from the date of the treatment/purchase or discharge from hospital or the accident taking place. All claims are subject to premium checks and it may be necessary to ask you for additional medical or supporting information in connection with any claims. Please see Paying premiums on page 11.

Reimbursement of most claims is made on a rolling balance principle over any 12 consecutive months. This period starts from the date we pay your claim (not from your joining or scheme increase date or from a calendar year).

For example: a Scheme R1 policyholder, after serving the Qualifying period, who has up to £100.00 to claim for dental expenses in any 12 consecutive months; could have the following claim record:

Date Claim Paid	*Claim Paid Amount*	*Remaining Balance in the Scheme R1 Dental Category*
17 June 2018	£50.00	A balance of £50.00 remains.
5 October 2018	£50.00	Now a nil balance is left. The next available amount will be £50.00 on 17 June 2019.
11 August 2019	£25.00	A balance of £25.00 remains.

Within any consecutive 12 month period, the claim paid amount has not exceeded £100.00. After each claim is paid the amount becomes available again 12 months later.

Balances available in each category can be checked by telephoning the claims department who will give guidance on when to submit a claim.

Benefit payments which relate to amounts paid for a service provided will be 50% or 100% of the cost, depending on the maximum shown in the brochure.

If there are any issues with your claim or premiums paid on your account, this can cause a delay in processing your claim.

The receipts (which will not be returned unless specifically requested) must:

a) be originals, not photocopies;
b) include the practitioner's stamp / name, qualifications and date of issue;
c) include the patient's full name and address;
d) state the type of service and items provided;
e) be for a service for which payment has been met directly by a person registered as a policyholder or dependant;
f) be for a service covered by the HSF health plan categories only and not for any insurance premiums paid to cover that service.

In circumstances where part or all of the amount stated on the receipt has been met by another organisation or insurance company, HSF health plan will limit or decline benefit payment to ensure that overall a policyholder does not receive more than the amount paid as to do so would be an illegal act.

Claims cannot be accepted for purchases or treatment or services provided outside the United Kingdom and Ireland. Claims cannot be accepted for treatment or purchases from service providers who are related to the insured person(s). There are no location restrictions under the Personal Accident categories. Should any overpayment be made in respect of any of the benefits, the amount in question will be set against any future claims, or a repayment may be requested. Any fee paid by a policyholder to a practitioner for any type of medical statement or to a hospital for a statement concerning admission /attendance cannot be reimbursed by HSF health plan.

Payment from Chubb for Personal Accident & Dental Trauma claims

Any money due will be paid to the policyholder, if living, otherwise to his / her personal representative(s) within 21 days of the claim being substantiated to the satisfaction of Chubb. Any receipt which the policyholder or anyone acting on the policyholder's behalf or his / her representative(s) may give to Chubb for benefits payable shall be deemed final and complete discharge of all liability of Chubb in respect of such benefit.

Change of circumstances

When a policyholder wishes to add dependants to the scheme (who are under 18 residing permanently at the same address) a further application form must be completed and submitted to HSF health plan for approval and change to policy. The policy number should be shown and the form marked 'Change of Circumstances'.

Children born in the first 10 months of cover (when it has not been possible to pay a Birth Grant) may be added as dependants on completion of an application form. An application form is also required for children for whom an Adoption Grant has been paid.

A policyholder will be able to make a claim relating to a child when acceptance has been confirmed and the terms and conditions will be as for a new policyholder.

Any change of address must be notified in writing to HSF health plan so that our records remain up-to-date.

Increasing scheme cover

Any existing policyholder is able to apply to increase to a higher scheme up until their 71st birthday by completing an application form. In transfers to any scheme the qualifying periods explained in the 'Rules and further explanations of benefit categories' on pages 13, 14, 15, 16 and 17.

Decreasing or ceasing scheme cover

While it is possible to reduce payments by transferring to a lower scheme, cover at the higher scheme should have been of at least six months' duration before such an application is made. Entitlement at the higher rate then ceases immediately upon transferring. If the maximum has been reached in any category in the higher rate scheme, there will be a qualifying period of six months before claims may be submitted under the new lower rate scheme. Cover at the new lower rate scheme must be of at least 12 months duration before increasing or decreasing again. Policyholders who wish to cease payments should provide written notification to HSF health plan. Past payments will not be refunded. Entitlement to claim will continue throughout any period of time covered by premiums and subject to any qualifying periods or terms and conditions. Any errors in premium payments must be notified to HSF health plan within two years of the occurrence for refunding to be possible.

Any changes to the premium you pay for your policy can take up to 4 to 6 weeks to process, and the policyholder should check their bank statement that the increase/decrease has been applied. If for any reason the increase/decrease has not been applied any claim will be paid at rate applicable to the scheme current at

the time of claim unless a payment is made to bring payments up to date.

Death of a policyholder

When a policyholder dies, any outstanding claims at the time of death will be settled as appropriate, payments being made on production of the required proof of entitlement.

Dental and Optical

Help towards the cost of all dental treatment including check-ups, and the cost of a sight test and optical appliances, up to the maximum shown. It is payable between all eligible named persons on the policy in any 12 consecutive calendar months.
Qualifying period – 3 months.

The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments is included.
Qualifying period – 12 months.

The dentist or optician must be suitably qualified and registered with the General Dental Council or General Optical Council. Sundry items purchased at Dental Surgeries and Opticians premises, eg. solutions, cleaners, contact lens removers, floss, are not covered and prescription charges for any kind of medication are not covered under this category. Claims cannot be accepted for the purchase of spectacles or contact lenses supplied without prescription. Any dental treatment (including teeth whitening) not carried out at a dental surgeon's practice (eg. if undertaken or purchased at a cosmetic/retail outlet) is not covered.

Consultations with Consultant Oral Surgeons, Consultant Facio-Maxillary Surgeons, Consultant Orthodontic Surgeons and Consultant Ophthalmic Surgeons are not covered under this category. These should be claimed under the Specialist and Investigations category. The cost of treatment or operative procedures undertaken by these Consultants is not included in any category. If eye laser treatment or a permanent contact lens implant (to correct long or short sightedness) is carried out by a Consultant Ophthalmic Surgeon or undertaken in hospital as a day case patient or an inpatient, claims cannot be accepted for Specialist and Investigations or for Hospital or Day Case in addition to the Optical category.

Dental Trauma

For details on Dental Trauma, please refer to the Personal Accident Section on pages 8, 9, 15 and 16.

Practitioner: Physiotherapy, Osteopathy, Chiropractic, Acupuncture, Homeopathy, and Chiropody / Podiatry

Help towards the cost of consultation and treatment (not including medication or appliances) by a qualified and registered practitioner up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible named persons on the policy in any 12 consecutive calendar months.
Qualifying period – 3 months.

The maximum payable is between all eligible named persons on the policy. Claims will only be accepted with receipted invoices from qualified practitioners of the six professions above. Policyholders and dependants, in their own interests, should only consult properly qualified practitioners who are registered with that profession's governing body/council e.g. The Health and Care Professions Council - HCPC. The cost of any appliances or medication supplied or prescribed by the practitioners is not included.

NOT covered
Claims will not be accepted for reflexology, reiki healing or hypnotherapy nor for prophylactic/maintenance treatments or sports/general massage or therapy.

Consultations with Consultant Podiatric Surgeons (of hospital consultant status) are not covered under these benefits. These should be claimed under the Specialist and Investigations category. The cost of treatment or operative procedures undertaken by these consultants is not included in any category.

Specialist and Investigations and Health Screening

Help towards the cost of specialists' consultation fees, allergy testing, vaccination, health screening, pathology tests, x-rays, scans, electrocardiograms and other investigations listed below, all undertaken on an outpatient basis, up to the maximum shown. Payable between all eligible named persons on the policy in any 12 consecutive calendar months.
Qualifying period – 3 months.

Claims must be for consultations in a hospital or clinic on an outpatient basis only and carried out by a doctor of consultant status. Treatment (including radiotherapy) and operative procedures (including delivery of a baby) are not covered, neither is any radiography during such treatment/procedures. Reimbursement is only on the initial consultation with a Consultant Psychiatrist, subsequent visits are classified as treatment. Claims cannot be accepted for examinations / investigations carried out while an inpatient or as a day case or for medico-legal reports, possible legal evidence (including paternity testing), or for insurance, employment fitness /occupational assessments or immigration/emigration purposes.

The following are covered under investigations:
Any investigations undertaken, on an outpatient basis only, in a hospital x-ray, scanner, pathology or nuclear medicine / medical physics department (or its equivalent elsewhere); electrocardiogram, electroencephalogram; electromyogram, audiogram and orthoptic investigations. Minor invasive investigations carried out at the same time as an out-patient consultation, and not requiring the use of a separate treatment room, are also covered. Claims are accepted for: visits to health screening clinics if a letter or certificate from the policyholder's/dependant's General Practitioner is provided prior to the appointment and indicates that the screening was on his / her recommendation; the cost of a vaccination administered at a GP surgery or clinic; or the issue of a prescription for a vaccination (which may be in the form of vaccine or medication). For allergy testing the initial consultation and diagnosis of problems by a qualified practitioner with a personal consultation in a clinical environment **(**not a retail outlet or testing that is done by post) is covered but not any subsequent consultation, therapy or treatment.
For Health Screening; Claims are accepted for visits to

health screening clinics if a letter or certificate from the policyholder's/children's General Practitioner is provided prior to the appointment and indicates that the screening was on his/her recommendation.

The following are NOT covered under investigations nor health screening
Invasive investigations, such as endoscopies, carried out with some form of anaesthetic, and requiring the use of an out-patient treatment room (for which the hospital or clinic charges an additional fee) or occupancy of a bed on a day stay basis. The Hospital and Day Case benefit may be claimed in these circumstances if applicable.

Birth & Adoption Grant, Consultation, Investigation and Treatment Associated with Pregnancy.

A Birth or Adoption grant is payable to the policyholder, whether they are mother or father of the baby, for each registered birth in hospital or at home. Hospital benefit is payable for the mother in addition to the grant from the sixth night onwards. The grant is also payable for a registered adoption up to the age of 10.
Hospital benefit relating to the mother or baby is not payable to male policyholders who do not reside at the same address as their partner. The Birth Grant is also paid for a still birth if an official certificate is submitted. Adoption is included in this category, however, a claim under this category may not be submitted until HSF health plan cover has been of at least 10 months' duration. The adoption certificate should be dated after the end of this qualifying period and before the child's 10th birthday. Children already named on the policy may not subsequently be the subject of an Adoption Grant by either parent. Claims for overseas births and adoptions are not covered, but may be considered at our discretion.
Any inpatient treatment and all other categories for consultation, investigation and treatment associated with pregnancy is also subject to the enhanced qualifying period.
Qualifying period – 10 months.

Home Care Assistance and Home Help

Short term assistance towards the cost of Local Authority services and some privately arranged assistance with organisations if supported by a doctor, up to the maximum shown. Payable between all eligible named persons on the policy in any 12 consecutive calendar months.
Qualifying period – 3 months.

This category does not include home nursing and is designed to give short term assistance only (no longer than a period of 6 months) with the costs of housework (cleaning and cooking) for those incapacitated by an illness, and being unable to work, or recuperating at home following a hospital admission. All claims must be submitted with receipts from the Local Authority providing the service. Claims may also be submitted with receipts for home help from private companies or organisations whose businesses provide such services, and these must be accompanied by a letter or certificate from the General Practitioner stating the reason for the assistance and the length of time for which it was required. Claims for child care, shopping or gardening are not covered. We do not accept claims from individual cleaners/service providers paid or employed by you or any insured person.

Hospital and Day Case

General and Hospice: For an inpatient admission to a hospital or hospice to receive medical treatment. Payable to each eligible named person on the policy for up to 20 nights or days in any 12 consecutive calendar months. The hospital or hospice must be in the United Kingdom or Ireland and its name and admission and discharge dates should be clearly stated on the claim form. The amount payable is the stated grant and no direct costs (e.g. Consultants fees, room charges, medication/dressings involved with the hospital admission, including consultants' fees) are covered.
Qualifying period – 3 months.

Accident: For an inpatient admission to a hospital immediately following an accident. Payable to each eligible named person on the policy for up to 40 nights in any 12 consecutive calendar months.
No Qualifying period.

Elderly and Mental Illness: For an inpatient admission to a hospital for elderly medical care / long stay / rehabilitation / respite / GP care or for a mental illness. Payable to each eligible named person on the policy for up to 50 nights elderly and 50 nights mental illness from the start of your policy, but not for more than 40 nights in a 12 month period.
Qualifying period – 3 months.

The hospital or hospice must be in the United Kingdom or Ireland and its name and admission and discharge dates should be clearly stated on the claim form. Benefit is payable to each eligible named person on the policy for up to 40 nights or days in any consecutive 12 calendar months. The amount payable is the stated grant and no direct costs (e.g. Consultants fees, room charges, medication/dressings involved with the hospital admission, including consultants' fees) are covered.

Benefit is restricted to 50 nights in total in a period of continuous cover, regardless of scheme, for each named person on the policy to whom it applies for admissions: for congenital and prematurity disorders in babies and children for whom a Birth Grant has been paid to a parent; to mental illness and geriatric (elderly medical / long stay / rehabilitation / respite care/ General Practitioner care) wards. These 50 nights are counted as part of and not in addition to the ruling in the sentence above eg. within a 12 month period the number of nights for which benefit is payable will not exceed 40 regardless of the reason for admission.

In accordance with the usual practice, the date of admission is counted as the first night but the date of discharge is not counted. Time spent within an Accident and Emergency Department (A&E) is not considered as part of an admission unless the hospital declares it to be so in accordance with their records. Claims must be submitted after each discharge from hospital. Weekend leave or longer periods of home leave do not count as a discharge, although no amounts will be paid for nights spent at home. Transfers from one hospital to another without a period at home in between are counted as a continuous period in hospital.

In cases of long stay admissions a claim may be submitted after 40 nights and an amount will be paid up to the number of nights due within the rules. Recuperation only, as appropriate, will be payable upon discharge. However,

if an admission extends beyond 12 months a further claim may be submitted. There are special rules for these unusual circumstances. If, on the date of admission to hospital, the benefit limit is shown to have been reached in the preceding 12 months then no payment is made for that admission at all unless the current admission is of a duration which takes it past the anniversary of the discharge date 12 months earlier. In these cases the balance of nights due will be paid.

NOT covered
Adults staying with their children at the hospital/hospice are not entitled to Hospital or Day Case benefit; nor are children who are staying with their parents.

Day Case Surgery and Treatment

For a planned admission to occupy a bed for a day in a hospital or clinic to undergo surgery, treatment or a procedure to a maximum of 20 occassions in 12 months.

Qualifying period – 3 months.
The claim form must be signed by an official at the hospital and bear the official stamp to verify the information given by the policyholder. Anyone admitted overnight following a Day Case attendance will be entitled to the Hospital and not the Day Case benefit. The following are not included: Geriatric, psychiatric or rehabilitation day hospitals or units; an unplanned day or period spent in an Accident and Emergency or Casualty Department; minor surgery, treatment or procedures undertaken in outpatient or similar departments. The amount payable is the stated grant and no direct costs, e.g. Consultants fees, room charges, medication/dressings involved with the hospital admission including consultants' fees are covered.

Recuperation

Following each stay in a hospital or hospice for which benefit has been paid for a minimum of 15 nights, a recuperation grant is payable for each eligible named person on the policy. This grant is paid automatically, subject to qualifying for the appropriate number of nights in the hospital categories and actually having been discharged. There is no requirement to make an additional claim. If readmissions occur after less than 15 nights following discharge, and the second or subsequent admissions by virtue of their length would also qualify for a grant, only one such grant will be paid at the rate set for the longest of the admissions.

NOT covered
The grant is not payable when the patient dies in hospital or an admission includes a confinement and qualifies for the Birth Grant.

Prescriptions

We will pay benefit to the policyholder at the appropriate rate and up to the appropriate maximum number of individual prescription items in any 12 consecutive calendar months, for current NHS prescription charges (or the NHS equivalent rate) on the production of a receipted invoice supplied by a Pharmacy (Dispensing Chemist), indicating that a prescription supplied by a General Practitioner has been dispensed. Only one amount is payable on each receipt regardless of the number of items.

The following are covered under Prescriptions:
- NHS standard prescription charges.
- NHS equivalent rate for private prescription charges.

The following are not covered:
- Charges above the current rate set out in the NHS prescription charges.
- Any charges for prescriptions outside the United Kingdom & Northern Ireland.
- Any advance prescription prepayment certificate.

The Prescription benefit is not available for dependent children. The maximum number of prescriptions you can claim are set out in the scheme levels you have chosen.

Personal Accident

If an Accident results in Permanent Disability or death the financial consequences can be enormous. Even less serious injuries can result in a lengthy period off work or confinement to the house. Whilst you may be able to cope in the short term, a longer period of disability can put severe pressure on family finances. Lump sum cash payments when they are needed most could ease the financial burden. Policyholders and dependent children are covered 24 hours a day, every day of the year, whether at work, at home or at play.

Permanent Disability: A lump sum cash benefit depending upon the type and degree of Permanent Disability following an Accident.

Facial Disfigurement: A lump sum payment for Permanent facial disfigurement as a result of an accident.

Accidental Death: A lump sum payment if the Accident is fatal.

Dental Trauma: A payment for dental treatment required as a direct result of a blow to the head. See definitions on pages 15 and 16.

Temporary Disability: Not applicable to children under 16 years of age. A weekly sum payable (normally by direct credit, monthly in arrears) if following an Accident, you are: a) unable to take up your normal paid occupation or any other paid employment; or b) confined to the home (applicable only if you are not in paid employment at the time of the Accident) as certified by a qualified medical practitioner.

Payable from the 31st day of your disability for up to 52 weeks. Odd days will be paid at 1/7th of the weekly rate.
Although there is no qualifying period under this section, the Temporary Disability benefit is not payable for the first 30 days (Deferment Period) of each period of temporary disablement.

Fracture Benefit: A lump sum payment for a fracture or fractures to one or more bones of the arm or leg following an Accident.

1. Payment for any Permanent Disability not shown in the table on page 8 will be based on a medical assessment of the disability in relation to the table and not in relation to the Insured Person's ability to work.
2. If the Insured Person was already disabled before an Accident or already had a condition which is gradually deteriorating, the payment will be reduced. The reduced payment will be based on a medical assessment of the difference between: a) the Permanent Disability after the Accident; and b) the extent to which the Permanent Disability is affected by the disability or condition before the accident.
3. If the Insured Person claims for loss of limb, he / she cannot also claim for parts of that limb.
4. The most an Insured Person can receive for Permanent Disability resulting from any one Accident is the amount specified for Permanent Total Disablement.

Definitions

1. **Accident** means a sudden unforeseen and fortuitous identifiable event and the word accidental shall be construed accordingly.
2. **Bodily Injury** means injury to an Insured Person which solely and independently of any other cause results in the Insured Person's Death, Permanent Disability, Temporary Disability, fracture of a specified bone or bones, or Dental Trauma. Bodily Injury excludes any condition resulting from any gradually operating cause or degenerative process.
3. **Permanent Disability** means disablement which has lasted for at least 12 months and from which it is believed the Insured Person will never recover.
4. **Permanent Total Disablement** means disablement caused other than by loss of limb or Sight which, having lasted for at least 12 months, will in all probability entirely prevent the Insured Person from engaging in or giving attention to a profession or occupation of any and every kind for the remainder of his / her life.
5. **Loss of Sight** means total and irrecoverable loss of sight when an Insured Person's name has been added to the Register of Blind Persons or when the degree of sight remaining after correction is 3/60 or less on the Snellen Scale
6. **Dental Trauma** means Bodily Injury resulting from an Accident which is as a direct result of a blow to the head. Payments will be made only for Dental Treatment required following the Accident. Payment will be up to the amount shown in the Dental Trauma benefit for the scheme chosen. In any case the amount will not exceed 5% of the Permanent Disability Benefit of the cover selected. The Maximum for this on Scheme R1 is £250 and £500 for Scheme R2. The benefit will only be paid in respect of treatment an Insured Person receives within 12 months of the date of the Accident. This benefit covers dental treatment directly relating to an Accident such as a sports injury or a fall and includes anaesthetic fees, Dental crowns, bridges and white fillings, Dental veneers and Replacement dentures or repairs. It is a condition of this policy that the dentist confirms on each receipt that the treatment is only to repair the damage to the Insured Person's teeth as a direct result from a blow to the head. In addition to the Exclusions stated under Personal Accident the following exclusions also apply to this benefit:

I. Cancellation charges made by the dentist (for example, for missed appointments).
II. Damage to dentures when not being worn.
III. Dental consumables (for example, toothbrushes, mouthwash and dental floss).
IIII. Dental prescription charges.
V. Dental insurance, premiums and joining fees for a practice's dental plan.
VI. Any treatment an Insured Person receives 12 months or more after the date of the accident.
VII. Dental treatment an Insured Person receives for an accident which happened before joining the plan.
VIII. Bodily Injury caused by eating and drinking.

7 .**Permanent facial disfigurement** means to the extent of not less than one square centimetre of scar tissue or a scar of not less than two centimetres in length in each case in the area from the hairline to and including the lower jaw and ears.
8. **Temporary Disability** means disablement which prevents the Insured Person from engaging in or giving attention to his / her normal, gainful occupation or which confines the Insured Person to his / her home on medical grounds.
9. **Benefit Period** means the total period (but not necessarily consecutive period) for which the Temporary Disability Benefit is payable in respect of any one Accident to any Insured Person. Note: Odd days will be paid at 1⁄7th of the specified weekly rate.
10. **Deferment Period** means a period of temporary disablement during which the Temporary Disability Benefit shall not be payable.

Exclusions

No Benefits will be payable:

1. 1. If the Bodily Injury is caused by: war or any act of war; the Insured Person serving full-time in the armed forces of any country or international organisation; suicide, attempted suicide or deliberate self-inflicted injury by the Insured Person (even if they are insane); the Insured Person taking part in air sport or air travel, unless as a passenger; a sickness or disease; Repetitive Stress (Strain) Injury or Syndrome or any other condition or injury which develops over a period of time.
2. For any disabilities caused by or arising from Post Traumatic Stress Disorder or related syndromes or any psychological or psychiatric condition.

The Personal Accident categories are underwritten on behalf of HSF health plan by Chubb European Group Limited whose registered office is at 100 Leadenhall Street, London, EC3A 3BP and is a European Company incorporated in England & Wales under Company number 1112892, which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority for the conduct of business in the UK. HSF health plan is an intermediary acting on behalf of the policyholder dealing exclusively with Chubb European Group Limited. The entire administration of the Personal Accident benefits, which may include medical and other enquiries, is carried out by Chubb as soon as receipt of your claim has been acknowledged. The address and contact telephone number will be indicated in the acknowledgement letter.

HSF GP Services

There are no additional charges to use the GP Advice services (except for the cost of the phone call to the service). There is no limit on how many times you use the services.

General Conditions

Regardless of any amendments, the Birth and Adoption Grant will remain available to all policyholders in the form outlined in the brochure for a minimum of 13 calendar months from the date of joining or changing schemes. This applies to all existing policyholders.

In the interest of the majority of the policyholders, the Board of Directors of HSF health plan reserve the right to:

a) vary the premium rates by giving at least 28 days' notice to the policyholder's last known email or home address;
b) vary the range and rates of benefit and the conditions and terms relating thereto;
c) restrict or decline further payments;
d) refuse a new application or refuse to increase or defer increase to a higher premium without giving reasons for doing so;

e) terminate the cover of any policyholder who is in breach of the rules and conditions, has refused to cooperate in the process of settling a claim or whose conduct has, in the opinion of the Board, been unacceptable;
f) take legal action against anyone who makes a fraudulent claim and terminate cover immediately;
g) use information provided on application and claim forms for the prevention and detection of crime;
h) make amendments to these rules with such changes applying at the time of start of the policy or from any subsequent written notification to the policyholder.

Regulatory Information

Regulation and Compensation

HSF health plan Limited (No 202182) and Chubb European Group Limited (No 1112892) are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. (This may be checked on the Financial Services Register by visiting the FCA website).

The GP services are currently provided for HSF health plan by Medical Solutions UK Limited whose doctors are experienced GPs who are GMC registered, licensed, on the NHS Performers list, GP Register and have full Medical Council of Ireland registration, qualifying them as "fit to practise".

In the unlikely event of our going out of business, the Company is covered by the Financial Services Compensation Scheme. The Group Policyholder or Insured Person may be entitled to compensation should the Company be unable to meet its financial obligations. You can obtain further information from the Company at 24 Upper Ground, London, SE1 9PD or from the Financial Services Compensation Scheme at the following address: Financial Services Compensation Scheme, 10th Floor, Beaufort House, 15 St Botolph Street, London EC3A 7QU.

Advice and Reviews

HSF health plan is not authorised to provide advice and our Account Executives are only allowed to provide factual information on our products. They are not in a position to determine whether the product is appropriate for you.
Applicants should carefully consider the schemes available to them and choose the scheme to suit their personal circumstances. Policyholders should regularly review their policy documents to ensure the scheme remains suitable for their circumstances.

Remuneration of our Account Executives

Our Account Executives receive a salary and also receive a bonus based on sales and on meeting certain quality thresholds.

Compliments and Complaints

We endeavour to provide a high standard of service to our Policyholders and welcome comments and suggestions. Should you find it necessary to make a complaint, you should in the first instance contact our Customer Services Department at our London address.

While we are investigating your complaint, we will keep you regularly updated. If your complaint has not been resolved within 8 weeks, we will explain why it remains unresolved and inform you of your right to refer the matter to the Financial Ombudsman Service at Exchange Tower, London E14 9SR or telephone them on 0800 023 4567. Their website address is www.financial-ombudsman.org.uk. Full details of our complaints procedures are automatically sent on receipt of a complaint and at each stage relevant addresses are provided. Such details are available on request at all time.

Governing Law

Cover in your scheme within this HSF health plan will be governed by and interpreted in accordance with English Law.

Data protection laws that affect you

This section informs you of the information we record about you. It sets out the conditions under which we may process any information that we collect from you, or that you provide to us. It covers information that could identify you ("personal information") and information that could not. In the context of the law and this notice, "process" means collect, store, transfer, use or otherwise act on information. We take seriously the protection of your privacy and confidentiality.

Our policy complies with the EU General Data Protection Regulation (GDPR).
The law requires us to tell you about your rights and our obligations to you in regards to the processing and control of your personal data.

Data Privacy Policy
What is GDPR?

The General Data Protection Regulation (GDPR) is an EU regulation. This piece of legislation replaces the Data Protection Act 1998 and places a greater accountability on organisations when using personal information and in turn give customers more rights. The GDPR applies to all organisations that offer products or services to customers that reside in the EU as well as those that collect data from customers based in the EU.

What does this mean to you?

Under the GDPR, we have a legal duty to protect any information we collect from you. We use leading technologies to safeguard your data, and keep strict security standards to prevent any unauthorised access to it. Upon the demonstration of satisfactory identification evidence, you may request a copy of the information we hold about you.

What information do we collect?

Health cash plan applications

If you make an application for a health cash plan, we collect three types of information: your personal details (including those of your dependent children), your medical details (including those of your dependent children) and payment details.

Personal details

The personal details we collect are: your personal and contact details including name, address, date of birth, company name and address (if applicable), email address and telephone numbers. We also collect the name and date of birth of (if applicable) any dependants (if applicable).

Medical details

The medical details we collect are: any conditions or illness you or your dependants may have had (or have) and the date any of the symptoms began. The medical details we collect are: any conditions or illness you, and any dependants may have had (or have) and the date any symptoms began. A copy of this information is kept securely by HSF health plan and our technology suppliers, Microsoft Azure.

Payment details

The payment details we collect are Direct Debit or Credit Card information. Direct Debit or Credit Card information will be used for automatic payments to be made from the account you provide. Confirmation of premium deductions from your employer (where applicable). A copy of this information may be kept securely by HSF health plan (and temporarily by our technology suppliers Microsoft Azure).

Information about your Direct Debit

When you agree to set up a Direct Debit arrangement, the information you give to us is passed to our own bank HSBC UK for processing according to our instructions. We do keep a copy.

Sending a message to our support team

When you contact us, whether by telephone, through our website or by e-mail, we collect the data you have given to us in order to reply with the information you need.
We record your request and our reply in order to increase the efficiency of our business.

How we use your information and the legal basis

When you make an application for a Health Cash Plan or otherwise agree to our terms and conditions, a contract is formed between you and us.
In order to carry out our obligations under that contract we must process the information you give us. Some of this information may be personal information.
We may use it in order to:

- verify your identity for security purposes
- sell products to you
- provide you with our services
- provide you with suggestions and advice on products, services and how to obtain the most from using our website.

We process this information on the basis there is a contract between us, or that you have requested we use the information before we enter into a legal contract.
Additionally, we may aggregate this information in a general way and use it to provide class information, for example to monitor our performance with respect to a particular service we provide. If we use it for this purpose, you as an individual will not be personally identifiable.

Who we share your information with

HSF health plan may share your data with regulatory bodies when it is a legal requirement to do so for the purpose of monitoring and enforcing compliances:

- Financial Ombudsman Services
- Information Commissioners Office
- Fraud Prevention Agencies

We may also share aspects of your information on occasion with organisations to enable continuity of service; these include:

- Your employer
- Organisations that pay premiums on your behalf in line with the policy contract (if applicable).
- IT Support

We may pass information to our service providers to assist in the continuity and provision of benefits. At the time of writing, the providers are Chubb European Group Limited & Medical Solutions UK LTD, however this is subject to change.

How long we hold your data for?

Except as otherwise mentioned in this privacy notice, we keep your personal information only for as long as required by us:

- to provide you with the services you have requested;
- to comply with other law, including for the period demanded by our tax authorities;
- to support a claim or defence in court.

In line with our current retention policy we retain your personal data for at least 6 years but no more than 7 years after the health plan policy has ceased

Where is your information stored?

All of your data is located in the EU.

Implications of not providing data

If you do not provide information we may not be able to:

- provide requested services to you;
- continue to provide and/or renew existing products or services

We will tell you when we ask for information which is not a contractual requirement or is not needed to comply with our legal obligations.

How to exercise your information rights including the right to object

Access to your Data

You have the right to request a copy of all information about you held by HSF health plan.

Data Portability

You have the right to exercise your right to data portability in certain circumstances.

What if you want us to stop using your personal information?

You have the right to object to our use of your personal information, or to ask us to delete, remove, or stop using your personal information if there is no need for us to keep it. Please note our policy is to only keep personal information for as long as is reasonably required for the purpose(s) for which it was collected. We are required to keep certain transactional records – which does include personal information – for more extended periods to meet legal, regulatory, tax or accounting needs. We are also required to retain an accurate record of dealings with us for at least six years after your last interaction with us, so we can respond to any complaints or challenges you or others might raise later.

We may sometimes be able to restrict the use of your data. This means that it can only be used for certain things; if this is the case we would not use or share your information in other ways whilst it is restricted. You can ask us to restrict the use of your personal information if:

- It has been used unlawfully but you don't want us to delete it.
- You have already asked us to stop using your data but you are waiting for us to tell you if we can keep on using it.

If you wish to exercise any of your above rights you can do so by contacting the Data Protection Officer.

Verification of your information

When we receive any request to access, edit or delete personal identifiable information we shall first take reasonable steps to verify your identity before granting you access or otherwise taking any action. This is important to safeguard your information.

Right to complain

Should you not be happy with the way we handle your personal data, you have the right to complain. You can do so by contacting the Data Protection Officer.

If your complaint reasonably requires us to contact a third party, we may decide to give to that third party some of the information contained in your complaint. We do this as infrequently as possible, however it is a matter for our sole discretion as to whether we do give information, and if we do, what that information is.

You also have a right to lodge a complaint with the supervisory: Information Commissioners Office.

Data Protection Officer contact details

The Data Controller is HSF health plan.
You can contact the Data Protection Officer of HSF health plan by telephone on 020 7928 6662 or in writing at:
HSF health plan,
24 Upper Ground,
London,
SE1 9PD.

Visit www.hsf.co.uk to see full details.

Our Charity, The Hospital Saturday Fund

The Hospital Saturday Fund

All those who join HSF health plan, just by belonging, are making a contribution to the important work of the charity. That's not something which usually happens when an insurance policy is taken out.

Paul Jackson, Chief Executive
The Hospital Saturday Fund

100% of all surplus goes to worth while causes.

Get social with us and find out how by being an HSF health plan policyholder, you are making a difference to people's lives.

@hsfcharity

@hsfcharity

@hsfcharity

The Hospital Saturday Fund

Your questions, answered

Q Can I join at any age?
A Anyone between the ages of 16 and 71 may join.

Q Do I have to have a medical to join?
A No.

Q Do older people pay higher rates?
A No, all ages pay the same rates.

Q How do I pay?
A By direct debit from your bank account.

Q Can I get cover for my children?
A Yes. Give details of your children on your application and they will be included for free on your policy.

Q Are benefits taxable?
A No. You keep all you receive from HSF.

Q How do I make a claim?
A Claim forms are available on request by telephoning the number indicated on the reverse of your certificate of cover or from our website, www.hsf.co.uk.

Q How do I receive my money?
A By direct credit into your Bank account.

Q When does my cover begin?
A Cover begins on the date printed on your policy certificate for some benefits and qualifying periods begin on that date as well.

Q Are my existing health conditions covered?
A Yes except for Birth & Adoption benefit or any maternity related claims.

Q Can I change my mind?
A You may cancel cover at any time, and if within 14 days of registration, premiums will be refunded.

Q Are there qualifying periods?
A All benefit categories carry a qualifying period of 3 months except Birth & Adoption which has a qualifying period of 10 months and Eye Laser Treatment which has a qualifying period of 12 months. See our Terms & Conditions for full details.

Any other questions about your plan?

If you have a question about a claim or about your cover you can call HSF health plan on

020 7928 6662

or email

claims@hsf.eu.com

Head Office
24 Upper Ground, London SE1 9PD
Tel: 020 7928 6662
Fax: 020 7928 0446

HSF health plan®