

Healthcare Deposit Account



| Your policy explained

Part 1

Policy summary

This is your key facts guide to the Healthcare Deposit Account from National Friendly. It is only a summary of the main features, so to fully understand the Healthcare Deposit Account please read our terms and conditions in Part 2.

Understanding your policy

It's important that you have all the information you need about the Healthcare Deposit Account.

Part 1 Policy Summary gives you the main points about the Healthcare Deposit Account. It does not count as the terms of the policy, these are covered in full in **Part 2 Terms and Conditions**.

If you have any questions about this product, please call us free on **0800 195 9245** (8am–8pm Monday to Thursday, 8am–6pm Friday).

What does the Healthcare Deposit Account offer?

- The Healthcare Deposit Account provides private medical insurance and aims to give you and your family the choice between NHS and private treatment if you become ill or are injured.
- It offers comprehensive cover, including covering the costs of private consultation, surgery, recognised alternative therapies, cancer and heart treatment, hospital fees, and payments for NHS hospital treatments.
- Your monthly premiums will be fixed for 5 years. At the end of each 5 year period your premiums will be reviewed and may increase, see page 6 for more information.
- 75% of each fixed monthly premium goes towards the running of the scheme including paying the majority of each claim. The remainder (or 25%) goes into your personal deposit account.
- Your personal deposit account makes this healthcare different to other providers' healthcare policies. It means you can build up a fund to pay for healthcare cover at your own pace. When you need to claim, your personal deposit account will pay a share of the cost.

Your share will increase as you get older.

The table on page 7 shows you how much this will be.

- The more you have in your personal deposit account, the more of your chosen level of cover you'll be able to claim, please see page 16 for more information.
- To be sure your treatment is paid in full, you will need to have chosen a high enough annual medical limit and have enough in your personal deposit account to pay your share of the claim. Also see the top-up section below.
- For the first ten years your top-up cover will give you immediate extra medical cover in case you don't have enough money in your deposit account to meet your share of a claim. You have the choice of £10, £15 or £20 a month which gives you an extra £30,000, £45,000 or £60,000 to call upon for medical claims. There will be a top-up premium review after 5 years.
- You can boost your personal deposit account balance at any time by paying in extra money. This will increase the amount you can claim in the future from your chosen level of cover.
- You can make withdrawals from your deposit account if you wish, but this will reduce the amount you can claim.



Who can join and for how long?

Each adult has their own policy which will be in their name. You will each choose your own fixed monthly premium, and will have your own individual top-ups too. Child policies can be purchased for individual children or by placing up to 5 children on one policy. In each case, you as an adult will act as the policy holder on their behalf until they each turn 21, at which point we'll invite them to move to an adult policy.

An adult policy is for life with fixed premium review dates. Adult policies begin at age 18 with a maximum age for applicants of 70.

A child policy is until age 21 with fixed premium review dates. The maximum age for child applicants is 17.

Ways to apply

Medical conditions which exist prior to joining may not be covered. This may impact on your choice of application. You have 3 options, which are explained on page 9. They are:

- Full medical underwriting
- Moratorium underwriting, which has a minimum 2 year deferred period on pre-existing conditions.
- Continued personal medical exclusions, sometimes referred to as switch

How much does it cost?

Monthly premiums

You pay monthly premiums by direct debit. The amount will depend on the level of the cover you choose, and your age when you join. You may need to review and update the cover periodically to ensure it remains adequate for your needs.

Reviews will be carried out every five years to establish whether your premium is still sufficient to provide the cover you selected, and your premiums may increase.

We'll assess your premium fairly and will advise you in advance of the 5 year anniversary of your policy whether or not your premium will increase.

Premiums will only increase if claims or other costs across the scheme are higher than were anticipated when priced, or if medical advances specifically merit a change.

Top-up cover

When you join, you have the choice of paying £10pm, £15pm or £20pm over the first 10 years to provide a top-up to the cover afforded by your deposit account.

The extra amounts of medical cover these provide are £30,000, £45,000 and £60,000 respectively.

Please note the top-up cover is for private medical claims only.

Premiums will be reviewed after 5 years and will only increase if claims or other costs across the scheme are higher than were anticipated when priced, or if medical advances specifically merit a change.

After 10 years, we will offer you the chance to extend your top-up cover for a further 10 years, but the premiums and level of cover applicable at that date may be different from those currently available.

NHS payments

If you opt for treatment by the NHS you'll get a simple cash payment as listed on page 6, which will be placed in your bank or personal deposit account.

How do I make a claim?

To make a claim, please call us on **0808 168 2912** (8am to 6pm weekdays) or write to us at Claims Dept, National Friendly, 4-5 Worcester Road, Clifton, Bristol BS8 3JL. More information about claims starts on page 15 of the terms and conditions.

What's not covered

Full details of what's not covered starts on page 12 of the terms and conditions, but here is a summary.

- Conditions specifically excluded on your policy schedule based on health problems disclosed on joining, OR pre-existing conditions which fall within the two year exclusion period for moratorium underwriting.
- Cosmetic treatments.
- Costs already settled as part of another insurance or injury claim.
- Dental and optical claims, though a limited number of oral/optical operations are covered.
- Out-patient drugs and dressings.

What's not covered - continued

- GP charges for signing forms, routine treatments or routine tests.
- Health spas.
- HIV or AIDS related conditions.
- Long term or chronic conditions, although you may be able to claim for acute episodes of a chronic condition.
- Overseas treatment.
- Pregnancy or fertility-related treatments.
- Surgical or medical appliances, unless they are part of another medical procedure covered by your policy.

What else should I know?

Your right to change your mind

You have the right to cancel the Healthcare Deposit Account within 30 days of receiving the welcome pack without giving any reasons. Providing you have not made a claim, we will refund any premiums you have paid. If you have made a claim within the first 30 days we will refund your premiums minus the cost of your claim.

To cancel your Healthcare Deposit Account, please write to us at National Friendly, 4-5 Worcester Road, Clifton, Bristol BS8 3JL.

If you have a complaint

We are a mutual association that exists to support our customers and we aim to provide the highest standards of service. If we fall short at any time and you wish to make a complaint, please contact us by:

Telephone

0808 168 7775 (8am to 6pm weekdays, calls are recorded for quality purposes)

Email

compliance@nationalfriendly.co.uk

Fax

0117 980 9358

Post

Compliance Department National Friendly,
4-5 Worcester Road, Clifton, Bristol BS8 3JL. A copy of our complaints procedure is available on request or from www.nationalfriendly.co.uk.

If you make a complaint and are dissatisfied with our response, you can ask the Financial Ombudsman Service for an independent review. You can contact them by:

Telephone

0845 080 1800

Email

complaint.info@financial-ombudsman.org.uk

Website

www.financial-ombudsman.org.uk

Post

Financial Ombudsman Service, South Quay Plaza,
183 Marsh Wall, London E14 9SR.

The Ombudsman Service cannot deal with your complaint until you have first raised it with us. In making any complaint, your right to take legal proceedings is not affected.

The Financial Services Compensation Scheme

The Financial Services Compensation Scheme (FSCS) protects customers of nearly all financial services in the UK, including customers of this policy. Depending on your policy and the circumstances of any claim, you may be entitled to compensation from the FSCS if we can't meet our obligations, for example to pay what we owe.

If you are entitled to a claim, most insurance policies are covered for 90% of the claim with no upper limit. You can ask for more information from the FSCS on 020 7892 7300 or at www.fscs.org.uk.

Part 2

Terms and conditions

This is your complete summary of the Healthcare Deposit Account from National Friendly. Along with your application, it forms the terms and conditions of your policy.

Please let us know as soon as possible if any personal details on your policy change.

Your Healthcare Deposit Account

Providing you are a UK resident you can take out a policy from National Friendly.

You can take out an account for yourself if you are aged 18 - 70. Each adult will have their own policy which will be in their name.

Child policies

You can apply for an account for up to 5 children. You have the choice to cover them all on one policy with one top-up, or on individual policies with their own top-ups. You will be the account holder until they turn 21, at which point we'll invite them to move to an adult policy.

The account holder

The account holder will be responsible for:

- owning the Healthcare Deposit Account
- the personal deposit account and the money in it
- making sure all premiums are paid on time
- making sure a claim is paid if we cannot pay the treatment provider directly (this will be refunded)

How the policy works

Choosing your level of cover

The level of cover for each monthly premium is set out in the table below. These are the maximum levels of cover available each year, but the amount you can claim will also depend on your deposit account balance and your level of top-up cover. You simply choose how much cover you require and this tells you how much your monthly premium will be. Your premiums are fixed for 5 years. Every 5 years there will be a premium review. You will note that the minimum premium increases for older ages, reflecting the increased risk of making claims. It is also our experience that female lives tend to claim more than male lives. You may wish to bear these facts in mind when choosing your premium.

Your premium							Your cover			
5 year fixed monthly premium based on your joining age							10 year top-up premium	Annual cover	10 year top-up cover	NHS payments
Age	0-17	18-29	30-49	50-60	61-64	65-70				
£10	✓	X	X	X	X	X	Either £10, £15 or £20 each month	£5,000	Either £30,000, £45,000 or £60,000	£50 for a child, £150 for an adult. Maximum 10 cash back payments.
£20	✓	X	X	X	X	X		£10,000		
£30	✓	✓	X	X	X	X		£15,000		
£40	✓	✓	✓	X	X	X		£20,000		
£50	✓	✓	✓	✓	X	X		£25,000		
£60	✓	✓	✓	✓	✓	X		£30,000		
£70	✓	✓	✓	✓	✓	✓		£35,000		
£80	✓	✓	✓	✓	✓	✓		£40,000		
£90	✓	✓	✓	✓	✓	✓		£45,000		
£100	✓	✓	✓	✓	✓	✓		£50,000		
£120	✓	✓	✓	✓	✓	✓		£60,000		
£140	✓	✓	✓	✓	✓	✓		£70,000		
£150	✓	✓	✓	✓	✓	✓		£75,000		
£200	✓	✓	✓	✓	✓	✓		£100,000		

Premiums are also available at £10 increments from £100 to £200. Listed premiums inclusive of Insurance Premium Tax at 5%.

Your premiums and reviews

The premium you choose from the table above will be the premium you pay for at least the first five years of your policy. It will be reviewed after five years. The review will look at the claims experience of everyone who has the same policy as you over the past five years. Premiums will only increase if claims or other costs across the scheme are higher than were anticipated when priced, or if medical advances specifically merit a change.

You will be advised of your premium for the next five years of your policy. It may be the same or it may be higher. You will then decide whether you wish to continue on the terms we offer. We will not review your premium for a further five years. Premium reviews will be carried out on each five year anniversary of your policy.

You should also see the section on top-up premiums for details of similar premium reviews on page 7.

How your deposit account works

Your monthly premium is divided with 75% funding the cost of this healthcare scheme. The other 25% goes into your own deposit account. So if you decide on a fixed monthly premium of, say £60, you'll be building your deposit account by £15 a month.

When you need to claim, your personal deposit account will pay part of the cost, but we'll always pay the majority share. The more money you have in your personal deposit account, the more of your chosen level of cover you'll be able to claim. NHS claims will not be funded through your personal deposit account, these are simple cash payments.

Any money used from your personal deposit account to pay your share of a claim will show as a deduction on your annual statement.

Your age	How much can you claim?	How much does your personal deposit account pay?
Under 65	10 x your personal deposit account (+ top-up cover)	10% of each claim
65 or over	4 x your personal deposit account (+ top-up cover)	25% of each claim

For more information on the claims process please see page 15

Own share percentages

The own share percentages are not fixed forever and we reserve the right to change them. However, we will only change them in exceptional circumstances, for example if claims across the scheme turn out to be significantly higher than expected. We will never change the percentage you have to pay just because you have personally made a lot of claims.

Top-up cover

You have the choice of either £10 a month, which provides an extra £30,000 medical cover, £15 a month which provides £45,000 or £20 a month, which gives you £60,000 of additional cover.

Top-up cover is payable in circumstances whereby your deposit account alone is insufficient to fund your treatment, and has been exhausted. Top-up is payable for covered private treatments.

We have set a top-up cover for the first ten years of your policy. The premiums will be reviewed after five years. The review will look at the experience of everyone who has the same policy as you. Premiums will only increase if claims or other costs across the scheme are higher than were anticipated when priced, or if medical advances specifically merit a change.

At the 5 year review, you have three choices

- 1** You can continue with the amount of top-up still remaining on your policy, but at the premium level determined following the review.
- 2** You can apply to reset your top-up to its full amount (e.g. £45,000) and may be able to increase it. The premium will be that which applies at the review plus any additional medical loading. You will be underwritten at this stage and we could apply medical exclusions if deemed necessary.
- 3** You could decline the new terms and cancel the account.

You cannot change your top-up cover other than at a five year or ten year review.

Top-up is an integral part of your policy in the first ten years and you cannot stop paying for it without closing the policy itself even if you have exhausted the whole of your top-up cover.

After 10 years, we will offer you the chance to extend your top-up cover for a further 10 years, but the premiums and level of cover applicable at that date may be different from those currently available.

Here's how the top-up cover works

Miss Lane, aged 47, has been a policyholder for 18 months.

Her fixed premiums are £40 per month and she pays £10 per month for the top-up. She's not made any previous claims or any additional deposits. So her deposit account balance is £180 (=£40 per month x 18 months ÷ 4[†]).

Her share of any claim is 10% so each £1 in her account will buy £10 cover. Miss Lane now needs surgery which will cost £5,000 to be done privately. From her Healthcare Deposit account she would be entitled to claim:

- £180 x 10 = £1,800 towards her treatment made up of:
 - £180 from her deposit account and
 - £1,620 from us.

However, because she has the £10 top-up, we can pay the outstanding £3,200 (£5,000 - £1,800) from her top-up cover.

- Miss Lane's surgery bill is paid in full and her £30,000 top-up is reduced by £3,200 to £26,800.
- The top-up is not part of your personal deposit account, so you won't be able to withdraw it in cash.

[†]The sum is divided by 4 as 25% goes into her deposit account, 75% goes into running the scheme.

Boosting your balance

You can make additional deposits at any time for use towards future claims. So, while you're healthy, it might make sense to boost your balance so there is enough in your account when you need it most.

None of these additional deposits go towards the cost of running the scheme; they all go into your personal deposit account.

Please note, you won't be able to use any additional lump sum deposits to cover a claim for a complaint that you knew about when you paid them in. This is to protect the fund that we use to pay all claims and to make sure that all our Healthcare Deposit Account holders are treated fairly and get the cover they are eligible for.

Payment options

You pay monthly premiums by direct debit. Additional lump sums can be paid by direct debit, debit card or cheque.

Distribution of surplus - sharing our profits with our members

The personal deposit account is not a savings account so does not pay interest. However, if the

overall experience for all healthcare contracts is favourable, we expect to distribute a share of any surplus to your policy. The format of any distribution of profits is not fixed but is currently expected to take the form of a discount on the part of your fixed monthly premiums that goes to fund the scheme. This means that less of your monthly premium will fund the scheme and more will go into your personal deposit account. Other forms of distributing surplus may be chosen by the Board, for example, an extension of the benefits that are covered under your policy. Each year, the Board will decide on the amount and format of surplus that is to be distributed. In some years, there may be no share of surplus distributed, and it is not anticipated that any surplus will be distributed in the first 5 years of the policy. Please note that the distribution of surplus will not affect your monthly premium cost.

Keeping track of your personal deposit account

We will send you a statement once a year. You can also ask for your balance over the phone or for an extra statement whenever you wish.

Your healthcare cover in detail

How you can apply for cover

The Healthcare Deposit Account is a private medical insurance (PMI) product. PMI policies provide cover for the cost of private medical treatment for unforeseen medical conditions arising after your policy starts. Your policy is not intended to cover conditions which you already have before your policy starts – these are called ‘pre-existing conditions’. Conditions which are related to pre-existing conditions are also not usually covered. A related condition is one that is caused by, or could be the cause of, another condition. Your policy will not cover all medical treatments.

This chapter explains what is and isn’t covered.

Your underwriting options

Underwriting is the process by which we decide on what terms we will accept a person for cover, based on the information they supply. You have a choice between three ways of applying for a Healthcare Deposit Account from National Friendly. You can decide which best suits your requirements:

■ Full medical underwriting

This is based on you completing a health questionnaire (also called a Medical History Declaration). If you choose this option, you will be asked a number of questions about your health. These will enable us to understand your medical history. It is important that you consider the questions carefully and answer them fully. We will ask if you have had any signs or symptoms of a list of medical complaints.

We will review your details and decide the basis on which we can accept you for cover.

If necessary, we may need to ask your doctor for any further information we need to help us to do this. If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show

any exclusions on the policy schedule you receive from us when we have processed your application.

If we exclude treatment for a pre-existing condition at the time your policy starts we will, in some cases, review the exclusion in future should you wish us to do so.

Of course, any new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

Please note: You must ensure that you provide full and accurate information in answer to the questionnaire. Failure to do so may mean that we cannot cover a claim or even that your policy is void. If you are unsure whether we would want to know about a particular condition, you should tell us about it.

What is the advantage of full medical underwriting?

Although this option involves more of your time when completing your application, it does mean that, when you receive your policy documentation, you will know which pre-existing conditions are excluded from cover.

■ Moratorium

With this option you do not need to fill in a health statement. Instead, we automatically exclude any pre-existing conditions for which you have received treatment and/or medication, or asked advice on, or had signs or symptoms of (whether or not diagnosed), during the five years immediately before your cover started.

However, if you do not have any signs, symptoms, treatment, medication, or advice for those pre-existing conditions, and any directly related conditions, for two continuous years after your policy starts, then we will reinstate cover for those conditions.

You should understand that long-term medical conditions, which are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered by your policy. You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy. Of course, as with full medical underwriting, new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

What is the advantage of moratorium underwriting?

If you choose this option you will only be asked to provide basic information about you and any children you wish to insure. You will not be asked to disclose details of your medical history, but it relies on you to understand that if you have any medical conditions these will be excluded from cover. Also, if you can satisfy the criteria of two years outlined previously

for a pre-existing condition, then treatment for that condition will automatically be covered if it recurs, subject to the policy terms and conditions. This option may be suitable if you're generally well.

If you are switching from another provider. Continued personal medical exclusions.

If you have private medical insurance cover with another insurer and wish to switch to our policy, we will ask you to complete a short application form in which 4 simple questions are asked about your recent health conditions. We will also need to see a healthcare certificate from your current insurer.

If any medical conditions were not covered (excluded) under your previous policy, these exclusions will continue under our policy. Likewise, if any serious condition is ongoing and requires further treatment soon, we may delay or refuse cover.

Example 1: I had an operation on my right knee recently. Will I be covered for any further treatment on it after my policy starts?

■ **Full medical underwriting**

If the operation was recent, there is a chance that we would exclude future claims relating to your right knee. However, we could put a temporary exclusion on claims for the knee, so as long as there are no problems in the two year period after joining, you can apply to us to have the exclusion removed.

■ **Moratorium**

If the operation was performed in the 5 years prior to you taking out the policy you will need to have had a period of two consecutive years after the policy has started where you have not required any treatment, advice or medication for this condition.

■ **Continued personal medical exclusion**

Only if there was an exclusion on claims for your right knee under your previous cover with another insurer or if you had treatment planned when you joined, would we not pay for this.

Example 2: Some time after my cover begins, I go to the doctor for a routine visit. A heart condition is diagnosed and it must have started to develop before my cover began. What is the position?

■ **Full medical underwriting**

If the condition was diagnosed after the start of your policy and if you had not had any signs, symptoms, treatment or advice for this condition before your policy started then cover would be available even if it was proved that the condition existed before you took out the policy.

■ **Moratorium**

If the condition was diagnosed after the start of your policy and if you had not had any signs, symptoms, treatment or advice for this condition in the five years prior to you taking out your policy then cover would be available even if it was proved that the condition existed before you took out the policy.

■ **Continued personal medical exclusion**

As your visit was unplanned and not known about when you applied, we will pay for your treatment.

Example 3: What if I suspect I am suffering from a condition (for example, I have a lump) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts? Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?

■ **Full medical underwriting**

If you had a lump, this could reasonably be considered a sign or symptom of a complaint that you should report on your application. As long as you do so, we will let you know before you join whether an exclusion will apply. So you will know before your treatment whether or not this will be covered.

■ **Moratorium**

As an obvious sign or symptom which existed in the five years prior to taking out the account treatment for the lump would not be covered. We would, as usual, take advice from the GP/ treatment provider as to whether the lump existed prior to you taking out the policy.

■ **Continued personal medical exclusion**

Only if there was an exclusion on claims for the problem under your previous cover with another insurer we will not pay for this.

Example 4: How do regular check-ups affect the moratorium?

■ **Moratorium**

If you have a condition before your policy starts and your doctor or specialist recommends that you continue to have regular check-ups for that condition then we will not cover the cost of the consultations or any treatment received for this condition. Cover for this condition will be available once you have had 2 years where you have not had any signs, symptoms, treatment or advice for this condition.

What we cover

Let's take a look at which treatments we cover and which we don't

Annual Cover	
✓ Included	
Heart surgery.	Oral surgical procedures.
Scans of all types (CT, MRI, etc.).	Private ambulance where medically necessary.
Acupuncture, alternative medicine and homeopathy from accredited providers.	Chiropody and podiatry for acute conditions.
Cancer treatment, including chemotherapy, radiotherapy, oncology and cancer surgery.	In-patient or day-patient treatment of acute conditions.
Operations (including minor ones for ear, nose and throat, carpal tunnel, adenoids and tonsil removal), surgeons' fees, anaesthetic.	Pre-authorised consultations and treatment from a specialist for psychiatric conditions we deem to be acute (curable within 6 outpatient consultations).
Physiotherapy and other manipulative treatments such as chiropractic and osteopathic work by qualified practitioners.	Consultations, diagnosis, pathology and other hospital tests that your GP or other treatment provider has recommended.
Acute medical conditions other than those on the excluded list or conditions that are directly linked to those on that list.	Nursing at home by a qualified nurse, provided this is required as part of your treatment for an acute condition or for treatment of an acute worsening of a chronic condition, that is, one which is long-term with no likely cure, up to a maximum of six weeks a year.
✗ Excluded	
Any costs in connection with childbirth, fertility testing or infertility treatments, or any treatment to help prevent, or help recover from pregnancy.	Residential stays in a hospital, or convalescence of any kind. We will only pay for short-term stays necessary because of an acute medical condition or injury.
Day-patient drugs and dressings.	Gender re-assignment (sex change).
Preventative screening and tests for inherited conditions, cervical smears, mammograms, well-person checks, vaccinations, immunisation and musculoskeletal screenings such as those for osteoporosis.	Cosmetic treatment or plastic surgery, unless this is medically required, while you are an account holder. This extends to any operation to improve physical characteristics which does not benefit your physical health, e.g. breast enlargement.
Any costs that have already been paid from another source, such as another insurer or through another injury claim.	Congenital abnormalities (abnormalities you were born with).
Dental and optical treatments other than for conditions which require surgical intervention.	

Continued ►

Annual Cover - continued

X Excluded

Hormone replacement therapy (HRT).	Organ transplants and donations.
Medical appliances, unless these have been inserted or attached as part of a medical procedure.	Kidney dialysis in either chronic or end stage kidney failure.
Routine testing, treatment or any other service from your GP.	Treatment for any injury deliberately inflicted on yourself.
Treatment from a specialist if your GP does not support your claim.	Treatment such as hydrotherapy and detoxification in health clinics, spas or clinics that promote general health rather than curing specific conditions.
Treatments or remedies carried out by bodies we do not recognise or approve in advance.	Treatments you receive while living abroad or staying overseas.
Treatment for conditions not medically necessary (e.g. for obesity, contraception etc.).	

NHS hospital payments

✓ Included

<p>You can claim a cash payment, £150 for an adult and £50 for a child, for overnight or day case treatment undertaken in an NHS hospital. You can claim ten such payments a year in circumstances where you could have chosen a private hospital (i.e. not A&E admissions).</p> <p>Day case treatments are those which for medical reasons, mean you have to go into a hospital or day patient unit because you need a period of clinically supervised recovery but do not have to stay overnight.</p>	If you have a child policy, you and your child can claim for a stay when your child is in hospital overnight. This counts as two allowances out of the maximum of ten.
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X Excluded

Claims for NHS hospital stays where you have received treatment for which you are not eligible under the terms of your policy e.g. pregnancy, pre-existing conditions, treatment of chronic conditions.	Out-patient treatment including physiotherapy, chiropractic etc.
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General exclusions

- Any condition that has come from being infected by human immunodeficiency virus (HIV) and/or any related illness, including acquired immune deficiency syndrome (AIDS).
- Alcoholism, alcohol abuse, solvent abuse, drug abuse or addictive conditions of any kind or the treatment of any condition developed as a result of such abuse.
- Accident and emergency admissions.
- Injuries or illness arising from war, or war-like operations (civil or otherwise and whether or not war has been declared), military, paramilitary or terrorist activity (including the effects of radiobiological, biological or chemical agents).
- Injuries or illness sustained as a result of your actual involvement in criminal activity and/or public-order offences.
- Injuries or illness sustained or related to taking part in a dangerous sport or activity such as scuba-diving, gliding, parachuting, parascending, paragliding, mountaineering, and motor sports. If you are not sure what we class as a dangerous sport, please contact us.
- Any incapacity sustained while taking part in any professional or semi-professional sport (one you are paid for).
- Learning difficulties, including dyslexia, development problems, or behavioural problems such as attention deficit hyperactivity disorder.
- Treatment of chronic conditions. These are conditions that are long term with no likely cure.
- Sexually transmitted disease or sexual dysfunction.

Making a claim

We aim to make our claims process as simple and quick as possible. Our medical claims team will guide you through the process, making sure that the price of your treatment is fair and reasonable.

Claiming for medical cover

Claims start with a visit to your doctor (GP)

- 1** When your GP makes a referral (recommends you to a specialist), you should let them know that you have a policy with National Friendly. You can then discuss whether the NHS or private sector offers the most suitable source of treatment. You are also welcome to use our claims team to help you.
- 2** After being referred by your GP, call our Claims Helpline first on 0808 168 2912 to check that your condition and any potential treatment are covered and to request a medical consent form (available on our website www.nationalfriendly.co.uk/healthcare). We will ask your doctor to submit a copy of your referral and so will need your permission to view their comments, plus those of any attending practitioner. It is important that our claims team speaks to your treatment provider to negotiate payment terms. If you don't let us know about your treatment and we don't authorise it in advance, you may well have to pay the bill yourself. Once we have confirmed you are covered we can speak directly with your GP or treatment provider.
- 3** Your GP will most likely give you the name of a private specialist. If not, we will let you have the details of someone close to your home or workplace. We don't have preferred lists of hospitals or providers, so we can help you get the quality and convenience you expect from the specialist or provider you want.

4 We will check details of your condition against your application.

5 Our trained staff will make everything as easy as possible for you throughout the process.

We will keep you informed about our discussions with your treatment provider and will authorise payment to them. Please help us by informing them you have cover with us and that we, and not you, will pay for treatment (unless there is a shortfall which we would tell you about well in advance). Plus we'll always try to make sure the price of your treatment is fair and reasonable.

6 We will try to pay your medical provider direct upon receipt of their original invoice without your involvement or expense.

7 If, for any reason, the treatment provider sends the bill to you in error, please forward it to us as soon as possible to avoid penalties for late payment.

Claiming for physiotherapy, chiropractic treatment etc.

If you have chosen private treatment and are likely to need multiple visits to your treatment provider, please call us to check that you're covered. You will need to get a GP referral before each course of treatment.

Once we have given you the go-ahead on your claim and, if the treatment provider is happy for us to do so, we will settle your bill at the end of your treatment. You won't need to contact us about each session of treatment, but we may check with your provider after eight sessions. This is to establish what extra treatment may be necessary to cure you and to ensure that your future needs can be met.

Work out how much you can claim

The amount you can claim depends on:

- How much cover you have chosen
- Your own share of each claim
- How much money you have in your personal deposit account
- How much top-up you have
- Whether you have already been paid, or you're due to be paid, in full by another insurer for the same claim. If this happens, we will not pay the claim.

The own share percentages are not fixed forever and we reserve the right to change them. However, we will only change them in exceptional

circumstances, if claims across the scheme turn out to be significantly higher than expected. We will never change the percentage you have to pay just because you have personally made many claims. We will write to you if any feature of your policy changes so you can assess your options.

Top-up cover lasts for ten years, during which time we hope you will have built up your deposit account balance to help cover the cost of private treatments. There will be an option to take new top-up cover after ten years, terms and conditions of which will be provided at that time.

If you don't have enough in your account for your share of a claim and don't have enough top-up cover in place, we will pay a proportion of the amount you are claiming.

The example below can help you understand how much you can claim.

Mrs Jackson wanted up to £30,000 annual cover and chose to pay £60pm, even though at 55, she could have chosen £50pm. She selected the £10 top-up option to cover medical claims in the first 10 years.

25% of her monthly premium went into her personal deposit account. After 12 months she had £180 in her account.

After 5 years, when Mrs Jackson needed to make her first claim, she had built up £900 in her deposit account.

As Mrs Jackson was under 65, she was required to pay 10% of the claim from her deposit account, and so was entitled to ten times the amount in her deposit account in total.

Mrs J could therefore claim up to £9,000 without dipping into her £30,000 top-up fund.

Mrs J's actual claim was for £8,000, so she paid £800 from her deposit account and we paid the balance of £7,200.

Her claim was paid in full, she had £100 left in her deposit account (£1,000 cover) and still had her £30,000 top-up available.

Claiming for NHS treatment

If you're admitted to an NHS hospital for an overnight stay or having covered day surgery performed, please get an admission or discharge sheet signed by a doctor or senior nurse. You'll need to send this to us with your completed claim form.

- 1 Check you're covered before your visit.
- 2 Complete the patient's section of the NHS claim form.

- 3 Ask your hospital to complete their section of the form.

- 4 Return your form so we can arrange payment.

Claims will be paid in circumstances where you have a choice between NHS and private treatment, so accident and emergency admissions, for example, will not be covered.

We will only pay an NHS allowance for conditions which appear in our covered treatments.

Your age	How much can you claim?	How much does your personal deposit account pay?
Under 65	10 x your personal deposit account + (top-up cover)	10% of each claim
65 or over	4 x your personal deposit account + (top-up cover)	25% of each claim

When we will and won't pay out

Your Healthcare Deposit Account aims to return you to health when you get a condition that will respond quickly to treatment – whether that involves a major operation or a few physiotherapy sessions. These are known as acute conditions. We will pay out for acute conditions covered by your policy.

If an acute condition develops into a chronic condition, we will stop paying the claim. Chronic conditions are diseases, illnesses or injuries that:

- Continue indefinitely and have no known cure.
- Come back or are likely to come back.
- Need ongoing or long-term control or relief of symptoms.
- Need you to have specialist rehabilitation or training, or regular tests, check-ups or consultations to monitor the condition over a long time.

We will always write and let you know if, after getting advice from your specialist, we believe that your acute condition has become chronic.

The Healthcare Deposit Account does not cover you for chronic conditions. We do however view cancer differently from other chronic conditions – please see page 21 for full details. When you make a claim, we decide whether the condition you are claiming for is chronic or acute. If we decide, using the medical information available, that the condition is chronic, we will not pay for its treatment.

If however, you have a chronic condition and suddenly develop acute symptoms, we may cover you for treatment to return you to a more controlled state of health.

How this works in practice

These examples assume there is enough money in the account holder's personal deposit account to cover their own share of each claim and/or sufficient top-up is in place to supplement your deposit. All payments are subject to the maximum level of cover chosen.

Example 1 - Alan		
Condition	We will pay for	We won't pay for
Alan develops chest pains and is referred by his GP to a specialist. He is diagnosed with angina and placed on medication to control his symptoms.	Investigations leading to the diagnosis of angina.	Ongoing monitoring, medication or routine follow-ups, as this is a chronic condition.
Two years later, Alan's chest pain recurs and his specialist recommends a heart-by-pass operation.	Alan's heart by-pass surgery as it is an acute worsening of his condition.	

Example 2 - Sandra

Condition	We will pay for	We won't pay for
Sandra develops hip pain. Her GP refers her to an osteopath who treats her every other day for two weeks and recommends that she return once a month for additional treatment to prevent a recurrence.	The osteopathy until Sandra's hip pain is cured.	Treatment if her condition is subsequently diagnosed as chronic.

Example 3 - Eve

Condition	We will pay for	We won't pay for
<p>Eve has been with National Friendly for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months, to see if her condition has improved.</p> <p>At that consultation Eve states that her breathing has been much better, so the specialist suggests she has check-ups every four months.</p>	Specialist consultations and tests leading up to the diagnosis of asthma.	As this is a chronic condition, following initial stabilisation, we will not pay for any monitoring, medication, or routine follow-ups for this condition.
Eighteen months later Eve has a bad asthma attack.	As this is an acute worsening of Eve's chronic condition we would pay for the treatment required to return her asthma to a controlled state.	

Example 4 - Deirdre

Condition	We will pay for	We won't pay for
<p>Deirdre has been with National Friendly for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to an endocrinology specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments made to her medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review the condition.</p>	<p>Specialist consultations and tests leading up to the diagnosis of diabetes and would continue cover until the patient was stabilised.</p>	<p>As this is a chronic condition, following initial stabilisation we will not pay for any monitoring, medication or routine follow-ups for this condition.</p>
<p>One year later, Deirdre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.</p>	<p>As this is an acute worsening of Deirdre's chronic condition we would pay for the treatment required to return her diabetes to a controlled state.</p>	

Example 5 - Beverley

Condition	We will pay for	We won't pay for
<p>Beverley has been with National Friendly for five years when she is diagnosed with breast cancer. Following discussions with her specialist she decides to have the breast removed followed by breast reconstruction. Her specialist also recommends a course of radiotherapy and chemotherapy.</p> <p>In addition she is to have hormone therapy tablets for several years. Will her insurance cover this treatment and are there any limits to the cover?</p>	<p>Any private consultations, surgery, radiotherapy and chemotherapy until Beverley has reached remission or is cured.</p>	

Example 6 - Cara

Condition	We will pay for	We won't pay for
Cara has previously had breast cancer which was treated by lumpectomy, radiotherapy and chemotherapy under her existing policy. She now has a recurrence in her other breast and has decided to have a mastectomy, radiotherapy and chemotherapy. Will her insurance cover this treatment and are there any limits to the cover?	This is considered to be a new condition and we would therefore pay for Cara's operation, the radiotherapy and the chemotherapy.	

Example 7 - Sharon

Condition	We will pay for	We won't pay for
Sharon would like to be admitted to a hospice for care aimed solely at relieving symptoms. Will her insurance cover this and are there any limits to the cover?		We do not pay for hospice care.

Example 8 - Monica

Condition	We will pay for	We won't pay for
<p>Monica, who was previously treated for breast cancer under her existing policy, has a recurrence which has unfortunately spread to other parts of her body. Her specialist has recommended the following treatment:</p> <ul style="list-style-type: none"> ■ A course of six cycles of chemotherapy, aimed at destroying cancer cells, to be given over the next six months. ■ Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years). ■ Weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years). <p>Will her insurance cover this treatment plan and are there any limits to the cover?</p>	We will pay for Monica's treatment if its aim is curative or to achieve remission. This would include consultations, chemotherapy, radiotherapy and surgery.	However if at any stage Monica's consultant confirmed that the aim of her treatment became palliative, cover would cease.

Our approach to cancer claims

At National Friendly, we won't treat cancer like other potentially chronic conditions.

We will either pay towards your private treatment, subject to the limits of your policy, or we will pay an allowance for any covered NHS cancer treatment you have, subject to a 10 day maximum.

In general, we will pay towards any treatment you have from your diagnosis until remission or a cure is reached. This is what we will and won't pay for:

Cancer claims	
We will pay for	We won't pay for
Active treatment. This is defined by Cancerbackup as 'treatment intended to affect the growth of the cancer by shrinking the cancer, stabilising it to slow the spread of the disease and not given solely to relieve symptoms'.	Preventative treatment, routine testing or screening.
Consultations, surgery, chemotherapy and/or radiotherapy if you are being investigated or are diagnosed with cancer.	Clinical trials.
Scans and tests required to monitor your condition during active treatment, unless they are part of a screening programme or routine testing.	Experimental treatment not licensed by the EMEA or the MHRA.
Consultations, scans and tests for up to two years following successful treatment or during a period of remission.	Hospice care.
Drugs pre-licenced and recommended by your cancer specialist. Please be aware that some of these treatments are extremely expensive.	
Bills incurred in hospital or at home.	

You must remember

With any medical treatment you have, the amount you receive from us will be determined by:

- The annual medical limit of your policy.
- The amount your personal deposit account will fund.
- The top-up cover you choose.

We will help you manage the cost of your treatment, but you will need to know how much your treatment could cost in total and what your options are at the beginning of your care.

Changing your account

Changing your account details

You can apply at any time to add another child to an existing child account (subject to a maximum of 5 children on the child account). Please contact us on 0808 168 7775 and we'll send you an application form.

Additional children will be covered once:

- You have given us their details
- We have written to you to confirm they are now included on the account
- You have paid the next monthly payment which will include the extra premium.

We'll only decline to add a family member if they don't match our application criteria.

You can also ask to remove a child from a child account at any time.

Changing your level of cover

Each year you can increase your fixed monthly premium by one level of cover without giving us any more information about your health as long as it does not exceed the maximum monthly premium. We reserve the right to refuse an application to increase fixed premiums.

If you wish to increase your level of cover by more than one level you will need to provide information about your health. If you have suffered a new condition since joining you may only be able to claim your original level of cover for it.

You can also choose to decrease your monthly premium as long as it doesn't fall below the minimum monthly premium for your age.

Top-up cannot be changed other than through a specific offer made at a review date agreed by us.

The amount you can claim will still be limited by your deposit account balance and any top-up cover you have.

Missing a payment

If you miss a monthly premium, whether for the fixed premium or the top-up cover, your Healthcare Deposit Account will not cover you for any claim until you pay it. We will write to tell you if we have not received your monthly premium.

If you owe three months premiums at any stage, your Healthcare Deposit Account will automatically close and you will not be able to re-open it.

Once your account has been closed, we will write to tell you how to withdraw any money in your deposit account. If you do not claim the balance within 28 days, we will move it to a holding account which does not pay interest.

Withdrawing cash from your personal deposit account

You can withdraw money from your personal deposit account whenever you wish, but please remember that the more money you have in your personal deposit account, the greater the amount you can claim.

The only time you will not be able to withdraw cash is if it reduces the amount of cover you need to pay a pending claim.

If you would like to withdraw cash without closing your Healthcare Deposit Account, please contact us on **0808 168 7775** (8am to 6pm weekdays, calls are recorded for quality purposes) quoting your policy number. Any cash you withdraw will show on your statement as a deduction.

Your right to change your mind

You have the right to cancel the Healthcare Deposit Account within 30 days of receiving the welcome pack without giving any reasons. Provided you have not made a claim, we will refund any premiums you have paid. If you have made a claim within the first 30 days we will refund your premiums minus the cost of your claim.

To cancel your Healthcare Deposit Account, please write to us at National Friendly, 4-5 Worcester Road, Clifton, Bristol BS8 3JL.

Closing your account

We hope you see the benefits of keeping your Healthcare Deposit Account throughout your life, but if at any time you would like to close it, please write to us.

We will return any balance in your deposit account, less any money you owe (such as missing premiums or your own share of any claims).

The account holder

A policy taken out for a child aged under 18 will have a named parent or guardian as account holder until aged 21, when the child will be offered an adult policy.

The account holder will be responsible for:

- Owning the Healthcare Deposit Account.
- The personal deposit account and the money in it.
- Making sure the monthly premiums are paid on time.
- The actions of anyone on the policy.
- Paying a claim if we cannot pay the treatment provider directly (this will be refunded).

If the account holder dies

As soon as we hear from the executors or next of kin, we will explain to them what we will do with the account.

The remaining balance in their personal deposit account can be paid to those entitled to receive it.

The account holder has the right to nominate one or more people to receive the combined value of their National Friendly policies if they die. This is currently limited to a total of £5,000 and would be paid without needing to wait for the Grant of Probate or Letters of Administration. The sum payable on death forms part of the estate for inheritance tax purposes and we will need to see the death certificate and policy schedule for it to be claimed.

Any amount over £5,000 will be paid out once we've received proof of title from the executors or administrators.

For more information, please call us on **0808 168 7775** (calls are recorded for quality purposes).

If we lose contact with you

If we lose contact with an account holder or do not hear from the representatives of an account holder who has died, we will move that person's personal deposit account balance to a non-interest bearing holding account. The account holder or their representatives can claim the money once they give us proof that they are entitled to it.

Transferring or assigning a Healthcare Deposit Account

This Healthcare Deposit Account is a legal contract between us and the account holder. You cannot transfer it or give it to anyone else.

Extra information

Where to get further information

If you have any questions about this Healthcare Deposit Account and would like further information, please call us free on 0800 195 9245 (8am–8pm Monday to Thursday, 8am–6pm Friday). Alternatively, if you require advice about whether it is suitable for you, please contact your healthcare intermediary.

Direct debit guarantee

The direct debit guarantee is offered by all banks and building societies that take part in the direct debit scheme.

- The efficiency and security of the scheme is monitored and protected by your own bank or building society.
- If the amounts to be paid or the payment dates change, National Friendly will notify you ten working days in advance of your account being debited or as otherwise agreed.
- If an error is made by National Friendly or your bank or building society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a direct debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.

Data consent

By opening a Healthcare Deposit Account, you agree to us holding and processing medical and other personal details on our computer system. We may share this data with other relevant organisations so that we can set up and run your Healthcare Deposit Account, validate claims and prevent fraud and money laundering. For the purposes of data protection law, National Friendly is the data controller.

You may receive information on other products or services from our group companies, unless you asked not to on your application form. You may contact us at any time to stop receiving this information.

If you have a complaint

We are a mutual association that exists to support our customers and we aim to provide the highest standards of service. If we fall short at any time and you wish to make a complaint, please contact us by:

Telephone

0808 168 7775 (8am to 6pm weekdays, calls are recorded for quality purposes)

Email

compliance@nationalfriendly.co.uk

Fax

0117 980 9358

Post

Compliance Department National Friendly,
4–5 Worcester Road, Clifton, Bristol BS8 3JL.

A copy of our complaints procedure is available on request or from www.nationalfriendly.co.uk.

If you make a complaint and are dissatisfied with our response, you can ask the Financial Ombudsman Service for an independent review. You can contact them by:

Telephone

0845 080 1800

Email

complaint.info@financial-ombudsman.org.uk

Website

www.financial-ombudsman.org.uk

Post

Financial Ombudsman Service, South Quay Plaza,
183 Marsh Wall, London E14 9SR.

The Financial Ombudsman Service cannot deal with your complaint until you have first raised it with us. In making any complaint, your right to take legal proceedings is not affected.

Our right to cancel your policy or decline your application

We have the right to expel any policy holder who, in connection with this or any other National Friendly policy has:

- Provided false information with the aim of gaining money from us.
- Not acted in a fair and reasonable way.

If we plan to expel a policy holder, we will first explain what will happen and their right to appeal. If a policy holder is expelled, we may end their policy at any date after that and will return all money, less any money obtained fraudulently and all reasonable expenses incurred in expelling the member.

We also reserve the right to decline an application which is made against the spirit of the product, for example from someone deliberately cancelling and re-applying for membership to seek unfair advantage.

Applicable law

If there is a legal dispute, English law will apply.

Language and currency

All correspondence will be in English and all currency will be £ sterling. All literature is available in Braille, large print or audio. To request a copy, please call us on 0808 168 7775 (8am to 6pm weekdays).

Alterations to the policy terms

These terms and conditions may change as a result of a new law or regulation. We also have the right to change the terms and conditions at any time as a result of product or system development, or changes in the cost of providing a service or product to you, or to remove any ambiguities. We will write to you and let you know of any changes. If you do not accept the changes then your policy will be cancelled.

Our regulator

We are authorised and regulated by the Financial Services Authority (FSA). Our FSA register number is 110008. Our permitted business is sickness, medical, income replacement and term assurance, life assurance, investment bonds and personal pension annuities.

You can check this on the FSA's register by visiting www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.

Words & phrases

Words and phrases explained

Accident or Emergency Treatment

If you need to go to hospital immediately because you're suffering acute symptoms from an illness or accident, or if you go to a hospital ward for unplanned urgent treatment.

Acupuncture

A treatment involving inserting needles in the skin or muscle to relieve conditions such as pain, anxiety, allergic reactions, sinus and skin problems.

Acupuncturist

A doctor who is also a Medical Member or an Accredited Member of the British Medical Acupuncturist Society and recognised by us as being fit to carry out such treatment.

Acute condition

A disease, illness or injury that is likely to respond quickly to treatment that aims to return you to the state of health they were in before or which leads to your full recovery.

Cancer

A malignant tumour, tissue or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chiropody

The treatment of feet, nails, corns and bunions.

Chiropractic treatment

A treatment that involves gentle hand movements, known as adjustments, which concentrate on the spine and associated nerves.

Chiropractor

A practitioner on the Register of Chiropractors kept by the General Chiropractic Council as required as part of the Chiropractors Act 1994, and recognised and agreed by us.

Chronic condition

A disease, illness or injury that has at least one of the following characteristics:

- It continues indefinitely and has no known cure.
- It comes back or is likely to come back.
- It needs ongoing or long-term control or relief of symptoms.
- You need to be rehabilitated or specially trained to cope with it.
- It needs long-term monitoring through consultations, check-ups, examinations or tests.

Consultation

A meeting with a medical specialist to find out more about a medical condition and decide how to treat it.

Day case treatment

Treatment which, for medical reasons, means the member has to go into a hospital or day patient unit because they need a period of clinically supervised recovery but do not have to stay overnight.

Day-patient treatment

Treatment for which you have to go into a hospital or day-patient clinic/unit because you need time to recover under medical supervision, but for which you do not need to stay overnight.

Deposit account

See Personal Deposit Account.

Diagnostic tests

Any investigation, such as a blood test or x-ray, which might find or help to find the cause of your symptoms.

EMA

The European Medicines Agency.

Fixed monthly premium

Monthly premium of which 25% goes into a personal deposit account. The premium is fixed for 5 years.

GP

A general medical practitioner (doctor) who has a Certificate of General Practice Training and is registered with the General Medical Council in the UK.

Hospital

- A private hospital in the UK which is registered in accordance with UK law and which has specialist facilities for major surgical operations.
- An NHS pay-bed. This is a bed and treatment in an NHS hospital that you pay for.
- Any hospital or establishment that we agree is appropriate for providing treatment.

Hospital charges

Charges for accommodation, nursing care, drugs and dressings, diagnostic tests, prosthesis and operating costs.

In-patient treatment

Treatment which, for medical reasons, means you have to stay in hospital overnight or longer.

MHRA

The Medicines and Healthcare products Regulatory Agency.

Moratorium

The period during which we will not pay for pre-existing conditions that you knew about when you joined.

Nurse

A nurse on the register of the Nursing and Midwifery Council (NMC) and who holds a valid NMC personal identification number.

Nursing at home

If you have difficulty getting to in-patient or out-patient appointments, you may need to get treatment at home. You are covered to receive treatment at home by a qualified nurse.

Oncology

The field of medicine specialising in the study, diagnosis and treatment of cancer.

Osteopath

A practitioner on the Register of Osteopaths kept by the General Osteopathic Council as required as part of the Osteopaths Act 1993, and recognised and agreed by us.

Out-patient treatment

Treatment given at a hospital, consulting room or out-patient clinic where you do not go in for day-patient or in-patient treatment.

Own share

Your set percentage paid towards each claim from your personal deposit account.

Personal Deposit Account

Your own account that 25% of your fixed monthly premium goes into.

Podiatry

Treatment of lower extremities including foot, ankle, knee and hip.

Physiotherapist

A physiotherapist regulated by and registered as practising with the Health Professions Council and recognised by us.

Policy schedule

The document containing details of the Healthcare Deposit Account. We will give you your policy schedule when you join, and we will update it whenever your account or other details change.

Pre-existing condition

Any disease, illness or injury that you have had medication, advice or treatment for, or that has produced symptoms, whether or not it was diagnosed, in the five years before joining this Healthcare Deposit Account.

Private ambulance

A purpose-built vehicle run by a recognised private ambulance service approved by us.

Sign

Any objective evidence of disease which can reasonably be recognised by a patient, healthcare professional or other.

Specialist

A medical practitioner, under the age of 70, who is registered under the Medical Acts and is a specialist in the treatment you are referred for. They must hold a certificate of Higher Specialist Training in their speciality that is issued by the Higher Specialist Training Committee of the appropriate Royal College or Faculty. They will be or will have been a National Health Service Consultant and must be recognised as a specialist by our claims team.

Symptom

A sensation (e.g. pain) felt by the patient and caused by a disease.


Treatment

Surgical or medical services (including diagnostic tests) to diagnose, relieve or cure a disease, illness or injury.

UK

For the purpose of this policy this means England, Scotland, Wales, Northern Ireland, the Channel Islands and the Isle of Man.

If you have any questions, please:

 **Call 0800 195 9245**
(8am-8pm Monday to Thursday, 8am-6pm Friday)

 **Email enquiries@nationalfriendly.co.uk**

 **Speak to your healthcare intermediary**

Notes

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**To request a copy in Braille, large print or audio
please call us on:**

☎ Call 0800 195 9245 (8am-8pm Monday to Thursday, 8am-6pm Friday)



Registered office: 4-5 Worcester Road, Clifton, Bristol BS8 3JL.
Tel: 0117 973 9003 Fax: 0117 980 9358 Email: enquiries@nationalfriendly.co.uk

National Friendly is the trading name of National Deposit Friendly Society Limited.
Incorporated and registered friendly society no. 369F.
Authorised and regulated by the Financial Services Authority. Registration no. 110008.

www.nationalfriendly.co.uk

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