National friendly

One Fund
Your plan explained

Employer

National friendly

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Your plan explained

Changes to plan terms

We are pleased to announce that since the One Fund 'Your plan explained' document was printed, we have changed the minimum scheme size to 10 employees.

This change means that one of the sections within the 'Your plan explained' document's Plan summary will need to be read with the extra information detailed within the table below in mind.

Page	Section on the page	New terms that apply within that section
2	**What does the One Fund plan offer?**	One Fund is a plan which will cover 10 or more employees for six popular treatment types. It provides cash assistance towards some of the bills which your employees may need to pay towards improving their health which can be claimed across the six treatments, subject to payment of an excess.

You should read the full terms and conditions of the plan to make sure you are confident that the cover choices you are making fit in with your healthcare expectations.

Please keep a copy of this document with your plan terms.

Please speak to your healthcare intermediary

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Incorporated and registered friendly society no. 369F. Authorised and regulated by the Financial Services Authority. Register no. 110008.

www.nationalfriendly.co.uk

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Part 1
Plan summary

keyfacts®

This is your key facts guide to the One Fund plan from National Friendly. It is only a summary of the main features, so to fully understand the One Fund plan please read our terms and conditions in part 2.

What does the One Fund plan offer?

One Fund is a plan which will cover 25 or more employees for six popular treatment types. It provides cash assistance towards some of the bills which your employees may need to pay towards improving their health which can be claimed across the six treatments, subject to payment of an excess.

Who can join and for how long?

Employees of the company who are UK residents aged 16 and above can join the One Fund company plan from National Friendly. Partners can be provided with a separate plan at an equivalent premium with benefits that mirror those of your employees. Children under the age of 18 (21 if in full-time education) can be added to plans at no extra cost but will share the annual benefits of a plan holder.

If both an employee and their partner are covered, and they wish to also cover their children, it must be specified at the outset of the plan which parent's allowance each child will share. Children will not be entitled to claim for Health Screening or for Counselling. Once a child reaches age 18 (21 if in full-time education) they will no longer be covered on the plan.

In the first 5 years of the plan, only the company representative can cancel the plan unless the company should breach the terms and conditions through, for example, non-payment of premiums, in which case National Friendly may cancel your plan. If necessary National Friendly can increase premiums or alter benefits at any plan anniversary. See page 8 for further details.

Should an employee leave the company plan, the company will stop paying for the employee, and cover for the employee, their partner and any children will cease.

What else should I know?

Switching Provider

By switching providers, you risk losing benefits not covered or offered on our plan. You should check both sets of terms and conditions to ensure you have the cover you require. You should also check whether you will be surrendering any no-claims discount arrangement by switching to this plan. If you require advice you should contact your healthcare intermediary.

How much does it cost?

Your monthly premium will depend on the level of cover selected, and the number of employees and partners you choose to cover. All premiums will be paid by direct debit. For full details, see page 6.

Premiums and benefits will be reviewable on an annual basis.

How to make a claim?

Anyone on the plan who wishes to make a claim will need to send proof of payment for treatment, in the form of an original receipt, to us at National Friendly PO Box 1362, Liverpool L69 2BF. Please see page 14 for more information. We will ask the employee to fill in a brief claim form with a description of their treatment. We'll make sure they have access to a printed claim form which is available as a download from our website, and we will also supply them to the company representative.

There are annual excesses applicable to this plan. For full details of the excess, and how this affects claims made, see page 7 of the terms and conditions.

If you have any queries about what your employees can claim please call on 08000 147 471 (8am-6pm Mon-Fri, excluding public holidays).

Please note: The company should review the level of cover regularly to make sure it meets the employees' needs – the amount an employee can claim will always depend on the monthly premium. Please see page 6 for more information.

What's not covered

We don't cover

- Prescription charges
- Dental bills for anything purely cosmetic such as teeth whitening or veneers
- Optical bills for contact lens solutions or cleaning materials of any type. We won't pay for glasses cases or for anything which doesn't directly improve the eyesight of an employee
- Any charges in connection with any other standard dental or optical plan held by the employee
- Missed appointment fees
- Non-prescription lenses or glasses
- Any consultations linked to fertility or infertility or family planning of any type
- Any consultations for cosmetic treatments other than surgical correction for problems which started after joining e.g. as a result of accidents
- Any consultant's fees outside of the consultation/diagnosis itself
- Herbs, supplements or vitamins, unless prescribed by a homeopath
- Spa treatments
- Treatments for obesity or any eating disorder

A full list of what is and isn't covered is included within 'A guide to what your employees can claim for' on pages 10-13.

Membership and voting rights

As this is a group-sponsored scheme for employees, neither the company nor its employees will be members of National Friendly or be entitled to vote on member matters.

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
08000 147 471 (8am to 6pm weekdays, excluding public holidays. Calls are recorded for monitoring and quality purposes)

Email
compliance@nationalfriendly.co.uk

Fax
0117 980 9358

Post
National Friendly, Compliance Department 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
08000 236 567 (free from landlines)
0300 123 9123 (free for mobile users who pay a monthly charge for calls to numbers starting 01 or 02)

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 terms and conditions of the One Fund plan from National Friendly.

You should read this document carefully and keep this information in a safe place with your company policy documents.

Your One Fund plan – who can join?

Provided an employee lives in the UK, the Isle of Man or the Channel Islands they can join the group plan.

You have the option to include an employee's partner at double the cost, so if an employee's premium is £10.00 a month, it will cost £20.00 a month for an employee and their partner. An employee joining the plan must be over the age of 16, as must be their partner. A partner must live with the employee on a permanent basis and will be removed from cover if this ceases to be the case.

Children can be added at no additional cost but they will be able to share the adult cover benefits with some limitations. There is no limit to the number of children that can be added to the plan.

Children can stay on an adult's plan until age 18 (21 if in full-time education) at which point, cover for them will cease.

Children must be born to the employee and/or their partner or be legally adopted by one/both of them.

If both the employee and their partner are covered, and they wish to also cover their children, it must be specified at the outset of the plan which parent's allowance each child will share.

Applying to join the plan

The company representative will sign an application agreeing to the terms of joining.

The application process is very simple, but we do reserve the right not to accept employees or partners if we feel they present an unreasonable risk to the plan. This is to protect the benefits we offer to existing plan holders.

You are free to increase premiums and cover within the maximum limits at your plan anniversary, see page 8 for more information. National Friendly will not give advice as to the level of cover you should have. If you need advice you should contact your healthcare intermediary

Changing the plan details

This plan is designed for all your employees. If you have new employees joining the organisation, you may take a plan out for them when they join.

Subject to your agreement as the employer, a partner and/or any children living at the same address as the employee can be added to the plan. A partner will have their own annual benefit entitlement.

Joiners and leavers will impact upon your direct debit payment so we will need to know by the 10th of the month of any changes. Any employee you wish to remove from cover will keep entitlement to claim for the remainder of the month for which you have paid. If you do not tell us promptly about an employee leaving the scheme, we will only refund a maximum of one month of the overpaid premium for them.

Children will share the benefits of their named parent, other than claims for health screening or counselling, to which they are not entitled.

Cover will start on the date shown on an employee's plan documentation provided the company has paid the premium to cover the plan holder's entry.

The plan cannot be cancelled by National Friendly in the first five years, unless due to fraudulent use of the plan or other breaches of the plan's terms. You are free to cancel it at any time.

Death of a plan holder

If a plan holder dies, all cover will cease and their plan will close.

Any children named on that plan will lose cover unless they are eligible to be transferred to the surviving partner's plan. Contact 08000 147 471 for more details.

Monthly premiums

A choice of monthly premium

Premiums will be paid by direct debit. The amount paid each month will be calculated from the number of plans multiplied by the individual premiums which apply at the time. All employees and partners must be covered at the same premium level.

The benefits shown for each premium level are the maximum levels of cover available in each plan year after payment of a £40 excess for each benefit - see page 7 for details.

Premium options – premium increments of £2pm

Maximum total claimable per year

The six benefits of One Fund	£720 annually	£864 annually	£1008 annually	£1152 annually	£1296 annually	£1440 annually
	Pay just £40† excess then claim up to	Pay just £40† excess then claim up to	Pay just £40† excess then claim up to	Pay just £40† excess then claim up to	Pay just £40† excess then claim up to	Pay just £40† excess then claim up to
1 Consultation	£720	£864	£1008	£1152	£1296	£1440
2 Counselling	£720	£864	£1008	£1152	£1296	£1440
3 POCAH*	£720	£864	£1008	£1152	£1296	£1440
4 Dental	£720	£864	£1008	£1152	£1296	£1440
5 Optical	Not more than £120 annually	Not more than £160 annually	Not more than £190 annually	Not more than £220 annually	Not more than £250 annually	Not more than £300 annually
6 Health Screening	Not more than £120 annually	Not more than £160 annually	Not more than £190 annually	Not more than £220 annually	Not more than £250 annually	Not more than £300 annually
Premium level	Pay £10 a month	Pay £12 a month	Pay £14 a month	Pay £16 a month	Pay £18 a month	Pay £20 a month

* POCAH (Physiotherapy, Osteopathy, Chiropractic, Acupuncture, Homeopathy)

† Each benefit is subject to an excess of £40, payable once in each plan year.

Premiums inclusive of insurance premium tax at 5%. Premiums may increase if this rate increases.

Please note

- Partners can be covered on a separate plan by doubling the relevant employee premium.
- Children will share the allowance of the adult on whose plan they are named.
- Children are not entitled to money towards health screening or counselling.

Premium rules

We will not pay claims unless all premiums are paid up to date.

If a payment is missed, we will let you know. A plan holder will lose their entitlement to claim until the payment is made in full.

If premiums are more than three months in arrears at any time, we will cancel the whole plan.

We will take premiums in advance and cover will be purchased for one whole month for each premium paid.

National Friendly review premiums and benefit levels on an annual basis. We may increase the premiums or change the benefit levels at an annual review if, for example, claims across all plans similar to yours are significantly higher than expected, or due to fiscal changes such as a change in insurance premium tax. See page 16 'Alterations to policy terms' for further details.

See 'Changing the plan details' on page 5 for information on premiums for leavers and joiners.

The excess and how it works

When a plan holder needs treatment, they will pay the first £40. The excess is payable per benefit once in each plan year. We will pay any amount above this, up to the maximum shown in the illustration against your chosen premium. Plan holders do not pay an excess for claims against eye tests.

The excess of £40 is not fixed forever, and we reserve the right to change it at an annual review if, for example, claims are considerably higher than predicted. If the excess changes, you can choose to accept, or decline and cancel your company plan.

In such circumstances the excess would change on your plan anniversary.

Example

Dental Treatment

A plan holder goes to the dentist and the bill is £40 for a routine check up. They pay the bill in full and we pay nothing. They would keep their receipt or submit it to us at the address shown in 'How to claim'. However, the dentist tells them that they need a crown fitted on their next visit. When they go back, their bill is £350. We will pay the bill in full, as long as this treatment is received in the same policy year. £350 will be deducted from the total available to claim for the remainder of that plan year.

Example

Physiotherapy Treatment

A plan holder goes to the physiotherapist on the advice of their GP and the bill is £100 for a first consultation and treatment. The physiotherapist says they need 6 sessions of treatment. The bill is £400. They wait until the treatments have been completed and pay the bill in full. They then send the bill to us and we reimburse the plan holder, less the £40 excess, i.e. £360. This example assumes that treatment is received within the same policy year and therefore that one excess only is payable. £360 will be deducted from the total available to claim for the remainder of that plan year.

Changing premium to change cover

You can elect to increase the level of cover each plan holder gets by increasing the monthly premium. An individual plan holder will not be able to pay to increase their own premium and cover on this plan.

The maximum premium is currently £20 a month but we do have other healthcare plans if you or an employee wants to broaden cover.

We reserve the right not to accept an application to increase if we feel this represents an unreasonable risk. But in most circumstances your application will be processed automatically.

Increases/decreases in premiums and cover will be effective from the next plan anniversary date and therefore will be effective for a minimum of one year.

How your plan will run

Cover will start on the 1st day of a set month on joining and will run to the end of each month subject to us receiving your premium in advance. Claims entitlement will run on an annual basis from the date the plan is opened so each employee will get a new annual entitlement on each plan anniversary. A new excess will also be payable for each benefit after every plan anniversary.

How much can a plan holder claim?

Claims entitlement

Each premium level entitles the employees to a maximum level of cover which can be claimed in each plan year. Each claim made will reduce the maximum amount of cover available for further claims in that plan year. Limits are detailed in the illustration on page 6.

The overall benefit limit is an annual one. An employee can only claim a set amount of it in any year for optical benefit (glasses, contact lenses etc), and for health screenings.

The other benefits can be claimed to the full annual limit. Limits are subject to the first £40 per benefit being paid by the plan holder per plan year for claims for each benefit type (except eye tests).

The maximum claim depends on:

- Whether the excess is payable
- The annual limit of the plan that has been chosen
- Any separate limit which applies to optical and health screening benefits
- How much an employee has previously claimed in the current plan year

Additionally, if your employee has other insurances, and they have claimed on them for the benefits covered under this plan, we will only pay the proportion not reimbursed by the other insurer, within the limits of the plan, subject to payment of the excess if applicable.

Level of cover

Please see the illustration on page 6 to check the maximum annual allowances for your premium.

The excess of £40 is not fixed forever and we reserve the right to change it at an annual review if, for example, claims are considerably higher than predicted. You can choose whether to accept the change, or decline and cancel your company plan.

In such circumstances the excess would change on your plan anniversary.

A guide to what your employees can claim for

Here's a list of what we do and don't pay for under this plan for each type of claim. You should also check our general exclusions on page 13.

Partners can be provided with a separate plan at an equivalent premium with benefits that mirror those of your employees.

Children can share the cover limits available to their named adult where applicable.

Dental Cover	
✓ **What's covered under the plan?** Plan holders can claim up to the annual limits for their premium for the following:	
Check-ups	Dentures, whether partial, or complete, plus denture repairs
Dental x-rays	Dental implants
Hygienist fees	Dental operations including anaesthetic
Extractions	Crowns, bridges or inlays
Fillings	Dental braces for adults
All treatments to be carried out by a member of the General Dental Council. All bills paid up to the annual limit upon proof of purchase in the form of a receipted account as detailed in the How to Claim section on page 14. **Each claim is paid subject to the claimant having paid the first £40 under this benefit in each plan year.**	
✗ **What's not covered?** Any other dental treatment or expense not listed in 'what's covered' above, including:	
Teeth whitening or any other cosmetic treatment	Treatments for gum disease
Dental veneers	Prescription charges or anything which does not constitute treatment, such as missed appointment fees or purchased items such as, but not limited to, bite guards, floss or brushes
Dental braces for children	We won't pay any amounts which have already been claimed from another source such as another insurance or dental care scheme

Optical Cover

✓ **What's covered under the plan?**

Plan holders can claim up to the specified annual limit for their premium for the following:

Prescription glasses	Eye tests*
Prescription contact lenses, including monthly prescribed	Laser eye treatment – subject to the employee's plan being held and paid for 2 years minimum
Sunglasses or goggles issued under prescription Repairs to, or replacement of, frames or prescription lenses	Other eye operations to improve eyesight, e.g. cataracts, stigmatisms

All treatments to be carried out by, and all purchases made through, a member of the General Optical Council. All treatment paid up to the annual limit upon proof of purchase in the form of a receipted account as detailed in the How to Claim section on page 14.

Each claim is paid subject to the claimant having paid the first £40 under this benefit in each plan year, *with exception of eye tests where no excess applies.

✗ **What's not covered?**

Any other optical treatment not listed above, including:

Any cosmetic eye treatment or operation	Charges for anything which does not directly improve eyesight, such as missed appointment fees, guarantees or purchased items such as lens solutions or other cleaning agents
Non-prescription glasses, sunglasses, contact lenses or goggles	We won't pay any amounts which have already been claimed from another source such as another insurance or optical care scheme

Consultations

✓ **What's covered under the plan?**

Plan holders can claim up to the annual limits for their premium for the following:

Any consultation with a Specialist Consultant, Consultant Physician or Surgeon which is referred by a GP	Medical tests, scans or investigative procedures undertaken as part of the Consultant's diagnosis

All treatment paid up to the annual limit upon proof of purchase in the form of a receipted account as detailed in the How to Claim section on page 14.

Each claim is paid subject to the claimant having paid the first £40 under this benefit in each plan year.

✗ **What's not covered?**

Consultations not directly linked to improved general health such as, but not limited to:

Vasectomy, sterilisation or other fertility/infertility treatments or family planning Consultations or treatments for obesity or eating disorder	Other charges for anything which does not directly improve the claimant's health, such as missed appointment fees or sundry fees for staffing or room hire passed on by a consultant
Health screening – see separate allowance on page 6	Costs associated with medical reports for work
Cosmetic treatments, surgery or advice other than in respect of problems which started after joining e.g. as a result of an accident	

Treatments – Physiotherapy, Osteopathy, Chiropractic, Acupuncture and Homeopathy

✓ **What's covered under the plan?**

Plan holders can claim up to the annual limits for their premium for the following:

Treatments received and paid for from registered practitioners of the above – see Glossary for definitions of registered practitioners	

All treatment paid up to the annual limit upon proof of purchase in the form of a receipted account as detailed in the How to Claim section on page 14.

Each claim is paid subject to the claimant having paid the first £40 under this benefit in each plan year.

✗ **What's not covered?**

Any treatment not listed above including:

Any medical appliances or pharmacy items, other than those prescribed by a homeopath	Treatment which falls outside of the named categories even if they are of a similar nature
Scans or x-rays (these may be available under Consultations allowance)	Treatment administered by members not affiliated to bodies recognised by the Society
Other charges for anything which does not directly improve the claimant's health, such as missed appointment fees or sundry fees for staffing or room hire passed on by the treatment provider	Medicines other than homeopathic medicines prescribed by a homeopath and purchased through him or her
Spa treatments	

Health Screening

✓ **What's covered under the plan?**

Plan holders can claim up to the specified annual limit for their premium for the following:

Full health screens, well man and well woman screens, plus heart, breast & bone density screening recommended by a GP as part of a general health check

These should be carried out by medically qualified staff at a recognised hospital or clinic

If you are unsure what qualifies as a health screen please contact us in advance of your appointment

Each claim is paid subject to the claimant having paid the first £40 under this benefit in each plan year.

✗ **What's not covered?**

Any treatment not listed above including:

Any other screenings for specific complaints, e.g. genetic disorders	Any supplementary charges not directly linked to improved health, such as missed appointment fees
Routine screenings requested by outside sources such as the employer, the courts or an insurance company	Children are not covered for this benefit

Counselling

✓ **What's covered under the plan?**

Plan holders can claim up to the specified annual limit for their premium for the following:

Plan holders will have access to fully-trained providers of telephone and face-to-face counselling. If they require professional help they can call free on 08000 277 844. They will be asked a few details about their plan by the counsellor, including their plan number and their call will be totally confidential. They can call anytime day or night

The cover will include any required face to face sessions up to the annual limit for the premium that is being paid

Each claim is paid subject to the claimant having paid the first £40 under this benefit in each plan year.

✗ **What's not covered?**

Any treatment not listed above	Children are not covered for this benefit

General Exclusions

We won't pay a claim if we don't receive the information we ask for

We won't pay a claim for treatment administered, or for items purchased, outside of the United Kingdom

We won't pay a claim if plan holder ceases to be a UK resident

We won't pay a claim if the company has unpaid premiums outstanding

We won't pay any amounts which have already been claimed from another source such as another insurance or optical/dental care sheme

We won't pay a claim for injuries sustained as a result of reckless endangerment either through participation in dangerous sports, professional sports (in which the claimant is being paid or compensated for playing) or through their involvement in criminal activity in which they are not an innocent victim

We won't pay a claim if treatment is needed as a result of abuse of, or dependency upon, drugs, alcohol, solvents or other addictive substances

We think these exclusions are reasonable. If you have concerns about any of these please do not hesitate to contact us on 08000 147 471 and we will talk them through with you

How to claim

Where a plan holder has paid for treatment and wants to claim money back through this plan, they will need to send us original, dated receipts, and let us have the address and telephone number of the treatment provider.

The plan holder will need to complete our claim form. These are available by:-

- Calling on **08000 147 471**
- Downloading a copy from www.onefundplan.co.uk
- e-mailing at onefundclaims@nationalfriendly.co.uk

We will also leave a supply with your company representative.

National Friendly will never pay a treatment provider directly. We will only reimburse a paid receipt.

When we receive a claim, we will do a number of checks.

- That the receipt tells us everything we need to know to pay the claim.
- That the treatment is covered under the plan.
- The claimed amount does not exceed the annual limit for this type of claim.
- That the appropriate excess has been paid.

We will keep hold of any receipts so the claimant should take a copy if for any reason they need a record of the details.

All receipts sent to National Friendly should clearly show full details (name, address and qualifications) of the treatment provider, so we could contact them if required.

The receipt should also show details of the plan holder's name, or that of a covered family member, being the person who received the treatment.

The receipt should be itemised, or if this is not possible, a separate breakdown should be provided by the practitioner.

We will be unable to pay any claim which does not have sufficient supporting evidence as listed above.

All receipts must be original. We will not accept amended receipts, photocopies, credit or debit card receipts or estimated bills.

Receipts in respect of claims should be submitted **within 3 months** of the treatment being administered. Receipts relating to payment of the excess only can be submitted to support a claim at any time during the plan year – an employee may wish to hold on to these receipts until they make a claim, to save postage.

The date treatment was received will determine which plan year we use to calculate the benefit allowance to pay the claim.

We will always request the bank details of the claimant so we can pay money straight into their account, which will remove any need for them to bank a cheque. This will ensure that money reaches their account much quicker, usually within 3 working days of us paying it.

If you have any queries about how to make a claim, please call on **08000 147 471**.

We will pay claims in accordance with the terms and conditions. We regret we cannot pay for charges incurred in claiming.

Completed claim forms should be sent to National Friendly PO Box 1362, Liverpool L69 2BF.

Integrity

We trust that employees will operate within the spirit of the plan and will make claims for genuine dental, optical and medical benefits. Should we discover, upon checking with treatment providers, that they have made a claim which is fraudulent or otherwise lacks integrity, we reserve the right not only to decline the claim, but also to cancel their plan. See page 16 for more information.

Extra information

Where to get further information

If you have any questions about the One Fund plan and would like further information, please call us free on **08000 147 471** (8am-6pm weekdays, except public holidays).

Alternatively, if you require advice about whether it is suitable for your company, please contact your healthcare intermediary.

Membership and voting rights

As this is a group-sponsored scheme for employees, neither the company nor its employees will be members of National Friendly or be entitled to vote on member matters.

Direct debit guarantee

This guarantee is offered by all banks and building societies that accept instructions to pay direct debits.

- If there are any changes to the amount, date or frequency of your direct debit National Friendly will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request National Friendly to collect payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your direct debit by National Friendly or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.

  – If you receive a refund you are not entitled to, you must pay it back when National Friendly asks you to.
- You can cancel a direct debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

Data consent

By opening a One Fund plan, you agree to us holding and processing medical and other personal details on our computer system and paper records.

We may share this data with other relevant organisations so that we can set up and run your One Fund plan, validate claims and prevent fraud and money laundering. For the purposes of data protection law, National Friendly is the data controller.

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
08000 147 471 (8am to 6pm weekdays, excluding public holidays. Calls are recorded for monitoring and quality purposes)

Email
compliance@nationalfriendly.co.uk

Fax
0117 980 9358

Post
National Friendly, Compliance Department
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
08000 234 567 (free from landlines)
0300 123 9123 (free for mobile phone users who pay a monthly charge for calls to numbers starting 01 or 02).

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.

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

Our right to cancel your plan or decline your application

We have the right to cancel a plan, in connection with this or any other National Friendly plan if a plan holder has:

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

If we feel we have to cancel a plan, we will first explain what will happen and a plan holders right to appeal. If a plan is cancelled we reserve the right to recoup all reasonable expenses incurred.

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 cover to seek unfair advantage.

Cancellations and terminations

If you decide that this plan is not suitable or does not meet your needs, let us know and we will cancel it. If you cancel within 30 days of taking out a plan, and providing no claims have been made, we will refund all of the premium that you have paid.

If you change your mind after electing to increase the premium for the plan, and you do so within 30 days, we will refund any increased premium payment, but only if no claims have been made at the higher level.

You may cancel your plan at any time. You must give us notification in writing or by telephone on **08000 147 471**. We will cancel your plan with effect from the last day of the month in which you notify us.

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 **08000 147 471** (8am to 6pm weekdays, except public holidays).

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, 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, personal pension annuities and health cash plans.

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.

Glossary

Words and phrases explained

Acupuncture/chiropractic/homeopathy/osteopathy/physiotherapy

Treatment given by a practitioner who is qualified, and registered with an approved professional organisation recognised by us in the appropriate field.

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.

Annual entitlement/Claims entitlement/Annual limit/Annual allowance

The maximum amount which can be claimed on a One Fund plan in a plan year.

Children

Born to an employee or their partner, or legally adopted by one or both of them, and under the age of 18 years (21 if in full-time education) and residing with the employee.

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.

Company

The organisation which pays the premiums for the One Fund plan.

Company Representative

The person within the company responsible for signing the application form on behalf of the company, and acting as the named contact for the company's One Fund plan

Consultation

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

Cosmetic treatment

Treatment received to change appearance and not to cure or alleviate a medical condition.

Dangerous or hazardous sports/pursuits

Dangerous (hazardous) pursuits and sports include, but are not limited to, canyoning, gorge walking, hang-gliding, high diving, horse jumping, microlighting, mountain boarding, parasailing and rock climbing.

Employee

Any person employed by, or working in some capacity for, the company which pays the premiums for the One Fund plan.

Excess

A fixed contribution that must be paid by the plan holder per benefit in each plan year if a claim is made.

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.

Homeopath

A practitioner whose name appears on the register of the Homeopathic Medical Association, The Society of Homeopathy, The Faculty of Homeopathy or The Alliance of Registered Homeopaths.

Hospital

- A private hospital in the UK which is registered in accordance with UK law and which has specialist facilities for major surgical operations.
- Any facility or establishment that we agree is appropriate for providing treatment.

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.

Our/Us/We/The Society

National Friendly, PO Box 1362,
Liverpool L69 2BF.

National Friendly is a trading name of National Deposit Friendly Society Limited which is authorised and regulated by the Financial Services Authority.

Partner

A person who lives with an employee on a permanent basis, as a domestic partner.

Physiotherapist

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

Plan anniversary

The anniversary of the date on which the plan started.

Plan Holder

The first named person on the policy schedule, who will receive benefits paid under the One Fund plan.

Plan/policy schedule

The document containing details of an individual plan holder's limits of cover at the start of their plan. If the details change or are amended, we will issue an amended schedule.

Plan year

The annual period commencing on the start date, or the anniversary of the start date as shown on your employees' plan schedules.

Specialist

A medical practitioner, who is registered under the Medical Acts and is a specialist in the treatment referred for. Registered as a specialist under the General Medical Council. They will be or will have been, a National Health Service Consultant and must be recognised as a specialist by our claims team.

Treatment

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

UK

This means England, Scotland, Wales, and Northern Ireland, plus the Channel Islands and the Isle of Man.

UK resident

A person who is ordinarily resident in the UK.

You

The company responsible for this plan.

Notes

If you have any questions, please:

Call **08000 147 471**
(8am-6pm weekdays, excluding public holidays.
Calls are recorded for quality purposes)

Email **onefundenquiries@nationalfriendly.co.uk**
or contact your healthcare intermediary if you require advice

www **onefundplan.co.uk**

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

Call 08000 147 471 (8am-6pm Monday to Friday, except public holidays)

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

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Authorised and regulated by the Financial Services Authority. Registration no. 110008.

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