Key Features of the Assisted Living Insurance

Introduction

The Financial Conduct Authority is a financial services regulator. It requires us, National Friendly, to give you this important information to help you to decide whether our Assisted Living Insurance policy is right for you. You should read this document carefully so that you understand what you are buying, and then keep it safe for future reference.

It provides a summary of the cover provided by the policy and how we deal with claims in order to help you decide if the policy is right for you. Full details of the policy benefits and exclusions are provided in the Terms and Conditions and Policy Schedule which we provide to you once you have taken out the policy. A copy of the Terms and Conditions can be obtained on request before you take out the policy.

As with all insurance products, we recommend you review your cover periodically to ensure it remains adequate for your needs.

Assisted Living Insurance is provided by National Friendly, a trading name of National Deposit Friendly Society Ltd.

1. Its aims

Assisted Living Insurance is a long-term care insurance policy designed to extend independent living in your home, should you be unable to perform two or more activities of daily living or suffer from severe cognitive impairment. It provides care benefits in addition to any benefits provided by the state.

This policy does not aim to meet all your care costs but does aim to make a contribution towards the cost of care services and assistive devices in your home and to provide support services to help you make informed choices about your choice of care provider.

The policy aims to offset some of the effect of inflation by increasing the remaining cover level each year.

2. Your commitment

Assisted Living Insurance has no fixed end date and can be held for your lifetime.

You must pay your premiums throughout the lifetime of the policy, except for when you qualify to receive the Assisted Living Allowance.

If you stop paying the premiums then cover will cease after one month and the policy will end after three months' missed premiums.

3. Risks

Our initial expectation is that your premium will increase each year by 2%, however there is a risk that the increase may be higher than 2%.

Depending on how long the policy runs, the total amount you pay in premiums over the lifetime of the policy may be more than the total amount of cover available.

Over time inflation may reduce the buying power of the benefits available from this policy.

If the government changes the way this policy is treated for tax purposes this may reduce the value of benefits available to you from this policy and/or increase any tax payable.

If the government changes the way this policy is assessed for means-tested state benefits this may affect the value of any of those benefits for which you might be eligible.

4. Who might it be suitable for?

This policy might be suitable for someone who:

- ✓ Wants to contribute towards their future care needs, in addition to the care and support services provided by the state;
- ✓ Wants to receive professional care in their own home;
- ✓ Wants access to care advice providing information and support tailored to their care needs;
- ✓ Currently has no immediate care needs but wants peace of mind via an insurance policy should their care needs change in the future;
- ✓ Expects to be able to afford the monthly premiums over the lifetime of the policy.

5. Who might it not be suitable for?

This policy might not be suitable for someone who:

- × Wants it to provide for all later life care costs including long-term residential care;
- × Wishes to rely solely on the care services available from the state;
- × Has sufficient assets to pay for their desired levels of care in their own home and is happy to use them for this purpose;
- × Would prefer to receive long-term care in a registered care facility rather than receive care in their own home;
- × Has a current or imminent need for care;
- × Does not expect to be able to afford the monthly premiums over the lifetime of the policy.

6. Questions and answers

What's covered?

Assisted Living Insurance provides four elements of cover should you be medically assessed as being unable to perform two or more activities of daily living or have a severe cognitive impairment. These four elements are:

1. Assisted Living Allowance;
2. Assistive Devices Allowance;
3. Respite Care Allowance;
4. Care Advice Benefit.

The Assisted Living Allowance, Assistive Devices Allowance and the Respite Care Allowance provide financial assistance.

The Care Advice Benefit is an advisory service.

The following table is a summary of the benefits provided by the Assisted Living Insurance policy. Full details are set out in the Terms and Conditions.

Cover	Limitations of cover
Assisted Living Allowance This provides a regular financial contribution towards professional care services that you receive in your home that help you perform an activity of daily living. This can be in the form of: 1. Professional nursing care; 2. Domiciliary care; 3. Therapy, and is in addition to any allowances and benefits provided by the state. Although the policy is intended to provide professional care in your home, if your circumstances require that you should move into a nursing or care home, it will pay the allowance towards care delivered there, too.	
Assistive Devices Allowance This provides a financial contribution towards: 1. the purchase or rental of equipment which helps you to carry out activities of daily living, that you have been assessed as being unable to perform, such as: ■ chair raisers; ■ handrails; ■ long-handled shoehorns; ■ personal mobility hoists; ■ ramps; ■ shower stools; ■ stair lifts; ■ toilet frames; ■ walking frames or rollators. We will pay for repeat purchases or rentals of an assistive device as described in 1. above only where they have a new medically required specification. 2. the fitting of equipment we have authorised payment for in your home; 3. modifications to your home to the extent of fitting or accommodating an assistive device, such as: ■ installing a walk-in shower; ■ widening of doorways to accommodate a wheelchair.	Please note that the following are not covered: ■ clothing; ■ drugs or dressings; ■ food or drink items; ■ sanitary equipment; ■ general building work which is not directly attributable to the installation of assistive devices; ■ building repairs or renovations.

Cover	Limitations of cover
Respite Care Allowance This provides payment for, or a financial contribution towards, temporary respite care should your regular unpaid carer take a short break. This can be for: ■ day care; ■ replacement care at home; ■ short-term residential care.	
Care Advice Benefit This gives you telephone access to care advisers throughout the lifetime of your policy for you to discuss your care needs. The care advisers will: 1. provide you with information about available care services in your local area and explain your care options, helping you to choose a relevant care provider. 2. help you make the best use of the benefits available to you from the state, your local authority and your policy. 3. provide information: i. on which state benefits are means-tested, discounted or available for free; and ii. other sources of funding (e.g. charitable) for which you may be eligible.	■ this service does not provide regulated financial advice on how to fund your care and does not make any personal recommendation about the suitability of any long-term care arrangements you might make; ■ we will not advise you on which care option you should take and will not make the care arrangements for you.

What's not covered?

This is a summary of the general exclusions from cover. Full details will be provided in your policy Terms and Conditions document.

We will not pay for any claims as a direct or indirect result of:

- functional mental illness, such as, but not limited to depression, anxiety, mood disorders or schizophrenia;
- the effects of the use of alcohol, other intoxicants or drugs unless taken in accordance with a prescription from a registered medical practitioner;
- intentional self-inflicted injury or illness;
- failure to seek or follow medical advice.

We will not pay a claim where costs are incurred outside of the UK.

When can I claim?

You can make a claim on this policy where you have been assessed by a relevant medical professional as:

- being unable to perform two or more activities of daily living; or
- having a severe cognitive impairment.

which are defined as follows:

Activities of daily living

Washing

The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means, with the use of assistive devices* where appropriate.

Dressing

The ability to put on, take off, secure and unfasten all necessary garments, with the use of assistive devices* where appropriate and, if relevant, the ability to put on, take off, secure and unfasten braces, artificial limbs or other surgical appliances.

Feeding

The ability to feed oneself once food has been prepared and made available.

Mobility

The ability to move indoors from room to room on level surfaces within the front and rear entrances of your main dwelling.

Transferring

The ability to move from a bed to an upright chair or wheelchair and vice versa.

Continence

The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.

* For the purposes of assessing an Assistive Devices Allowance claim, the device being claimed for will not be taken into account.

Severe cognitive impairment

Severe cognitive impairment means the irreversible deterioration in, or loss of, mental capacity which results in a need for continual daily care or supervision. In addition it results from an identifiable physical or organic defect of the brain or nervous system and is evidenced by a deterioration in your:

- short- and long-term memory;
- ability to know who and where you are;
- ability to identify others;
- awareness of time;
- ability to solve simple problems;
- ability to make rational decisions.

What options can I choose?

When you apply for your Assisted Living Insurance policy you have two choices to make which will affect how much you pay in premiums and the levels of cover available:

1. Choice of cover level

You can choose how much cover you want at the outset. You can choose either £20,000 or £30,000 cover at the outset.

Things to bear in mind:

- The premium for a policy with £30,000 cover will be higher than for a policy with £20,000 cover.
- A policy with £30,000 cover will be able to pay claims for longer than a policy with £20,000 cover.

You should consider how much you can afford to pay in premiums and for how long you want claims to be paid, before making your choice of cover level.

2. Choice of deferred period

You can choose at the outset when you want your claim to start to be paid (the deferred period) following your assessment confirming you meet the claim criteria. You can choose a deferred period of either 6 weeks or 13 weeks.

Things to bear in mind:

- The premium for a policy with a 6-week deferred period will be higher than for a policy with a 13-week deferred period.
- A policy with a 6-week deferred period can pay claims sooner than a policy with a 13-week deferred period.

You should consider how much you can afford to pay in premiums and how soon you want claims to be paid, before making your choice of deferred period.

What are the cover levels?

£20,000
or
£30,000
of cover to help with the costs of living independently in old age

Respite Care Allowance

Up to £2,000

for occasional short term respite care, should you have an unpaid carer who needs to take a short break.

Assisted Living Allowance

Up to £1,000 per month

for care services delivered by a registered care provider in your home.

Assistive Devices Allowance

Up to £10,000

towards assistive devices and minor home modifications to help you carry out activities of daily living.

Care Advice Benefit

Access to expert care advice when you need it. Our care advice team will help you navigate the support available should you become less able to live independently.

The overall maximum you can claim is the cover level you choose at outset. This means that claims for any allowance could affect how much cover remains for the other allowances.

In order to help offset the effect of inflation, the total cover level and each allowance, less any claims made, will automatically increase by 2% on each policy anniversary.

The table below shows an example of cover increasing by 2% each year. In it we have assumed a total initial cover level of £20,000 and that no claims are made in the first ten years of the policy. Figures in this table have been rounded to the nearest whole £1.

Beginning of year	Total cover level	Maximum Assisted Living Allowance per month	Maximum Assistive Devices Allowance	Maximum Respite Care Allowance
1	£20,000	£1,000	£10,000	£2,000
5	£21,649	£1,082	£10,824	£2,165
10	£23,902	£1,195	£11,951	£2,390

Each time a claim is made:

- the total cover level will be reduced by the amount of the claim; and
- the relevant allowance will be reduced by the amount of the claim.

How long is the policy term?

This policy can be held for your lifetime and it will end upon the first of these events:

- the full value of the total amount of cover under the policy has been paid out;
- your premiums are three months in arrears and remain so at the end of the third month;
- you cancel your policy;
- you die.

When your policy ends there is no cash value.

How much will my premiums be?

The monthly premiums due in the first year of your policy will depend on your age, the total amount of cover you have selected and the deferred period you have selected.

We, or your broker, will be able to provide you with a personalised quotation.

We will confirm the monthly premiums payable in the Policy Schedule which we send to you after we have accepted your application.

After the first year an increase of 2% will be applied each year to your premium in line with the annual increase to your cover level.

Your premium will also be reviewed each year until the end of the policy and will take into account:

- the expected future frequency and value of all claims paid on all our Assisted Living Insurance policies;
- changes in other factors such as taxation, regulation, National Friendly's costs or any other factor that we have reasonable grounds to believe will change the expected future profitability of Assisted Living Insurance policies from the level anticipated when the premium rates were originally set.

The combined effect of the 2% annual increase and the annual premium review could result in your premium rising, falling, or staying the same, and this will take effect from the next policy anniversary.

We will notify you of your new premium in good time before your policy anniversary.

When are premiums due?

Premiums are payable each month by direct debit throughout the lifetime of the policy, except when you are receiving, or qualify to receive, the Assisted Living Allowance. We will let you know the due date for your premiums when you take out a policy.

Tax and means-tested benefits

This policy should not affect your personal liability to income and capital gains tax.

This information is our current understanding of tax law and practice however this information should not be relied upon as advice in respect of your personal tax situation. Tax law and practice can change in future.

You should seek specialist advice on your personal tax situation where needed.

Our care advice team will provide guidance on whether payments made from this policy may affect your entitlement to means-tested benefits to which you might be entitled however you are encouraged to check this yourself with your local benefits agency.

Who can apply for a policy?

You can apply for a policy if you are:

- A permanent UK resident;
- Aged 50 or over but below 76.

Each policy will only cover one person.

Anyone can pay the premiums on behalf of a policyholder.

How can I apply?

There are a number of ways you can apply:

- via your broker;
- online on our website;
- by calling us to complete an application over the phone;
- using the paper application form supplied.

Our contact details can be found on the back page.

What is your approach to claims?

Our aim is to make the claims process easy and straightforward. When you want to make a claim simply call us for authorisation using the details on the back page of this booklet. We'll explain what you can claim for and be on hand to answer any questions you have. Through the Care Advice Benefit we can also guide you on your care options throughout your claim if you need it. Full details on how to claim will be included in your policy Terms and Conditions document.

You are able to name a person to act as second contact, such as a family member or friend, should you ever need to claim. The second contact can start a claim on your behalf and help to provide us with the information we need to assess and authorise a claim.

Where we need confirmation or evidence to support your claim we will ask you to provide this, or ask for your permission to obtain this from your GP or occupational therapist.

Once we have authorised your claim and your deferred period has elapsed we will pay your claim.

Can I change my mind?

You can cancel your policy within 30 days of receiving your policy documents. A cancellation notice will be included with your policy documents, to use if you wish to change your mind and cancel your policy. Alternatively you can write to us at the address given on the back page. You will receive a full refund of any premium paid, provided you have not made a claim in that time.

You can cancel the policy after 30 days, although you will not receive a refund on premiums paid. More information on this is given in our Terms and Conditions document.

How do I make a complaint?

We always do our best to provide a high standard of customer care, but if something goes wrong, please tell us so we can put it right. You can contact us using the details listed on the back page of this document. We will give you a complaints leaflet explaining how we deal with complaints. This leaflet is also available at any time to view or download from our website.

We will investigate your complaint and try to resolve it promptly to your satisfaction. We aim to resolve complaints and send you our final response in writing as quickly as possible, or within eight weeks.

If you are not satisfied with our final response you may have the right to take your complaint to the Financial Ombudsman Service. This service is free and using it in no way affects your legal rights.

Further information about their service can be found on their website www.financial-ombudsman.org.uk

Am I covered by the Financial Services Compensation Scheme (FSCS)?

You are covered by the FSCS and may be entitled to claim compensation from them if we cannot meet our liabilities. Details can be found on their website www.fscs.org.uk.

Can I get this in alternative formats?

All literature can be made available in Braille, large print or audio. To request a copy, please email us or call us between 8am and 6pm Monday to Friday (excluding bank holidays).

Who regulates you?

National Friendly is the trading name of National Deposit Friendly Society Ltd which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our financial services register number is 110008.

You can check this at: https://register.fca.org.uk

Contact us

For information on setting up this policy please call your broker. Alternatively you can call us on:

0333 014 6244 Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes.
Lines are open 8am-6pm, Monday to Friday excluding bank holidays.
Calls are recorded for training and quality purposes.

Or email us on:
info@nationalfriendly.co.uk

Or visit us at:
www.nationalfriendly.co.uk

Or write to us at:
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National friendly

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Financial Ombudsman Service

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