

# POLICY DOCUMENT & APPLICATION FORM

CHAMBER PRIMARY  
HEALTH CASH PLAN  
DIRECT DEBIT

making a healthy difference



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## INTRODUCTION

This **Policy Document** sets out everything you need to know about how your plan works. Please read this booklet carefully and keep it in a safe place for future reference. If you have any questions about the **Policy Document** please contact our Customer Service Department on **0114 250 2000** and we'll be happy to help.

## POLICY SUMMARY

The Chamber Primary Health Cash Plan provides cover towards the costs associated with routine healthcare such as new prescription glasses, dental treatment, physiotherapy and consultations. You also have quick and unlimited access to MRI and CT Scanning Facilities as well as a range of health services designed to help support your overall wellbeing.

This Health Cash Plan is underwritten by Westfield Contributory Health Scheme Limited.

The Personal Accident cover provided by the plan is underwritten by ACE European Group Limited (ACE).

### Key features of your Health Cash Plan

- Four levels of cover available
- A total of 12 healthcare benefits and services
- Employees can opt to pay for For Kids cover too, if not already provided by your employer
- For Kids covers dependent children for 5 healthcare benefits
- 100% reimbursement for a range of routine healthcare expenses, up to set limits
- MRI, CT and PET Scans for the policyholder, when a scan is arranged by you telephoning our Scanning Facilities service
- Access for the policyholder to have up to 6 face to face counselling sessions including Cognitive Behavioural Therapy
- DoctorLine™ available 24hrs a day, every day, for you and your resident family
- Concessionary deals for you on health and fitness club annual membership
- Personal Accident cover for you, the policyholder
- Additional value added benefits can also be provided to eligible employees, at the discretion of your employer
- Employees who are eligible for corporate paid cover do not have to wait for a qualifying period before making a claim, except when choosing an upgrade option
- For eligible employees, pre-existing medical conditions are covered, except for Personal Accident cover

### Key limitations and exclusions

- To be eligible to apply to upgrade your policy, or apply for partner cover, you must be under 66 years of age (see section 1, General Terms and Conditions)
- Professional and semi-professional sports people are not eligible for cover (see section 1, General Terms and Conditions)
- To be eligible for cover you must live in the UK, Channel Islands or Isle of Man for a minimum of six months each year (see section 1, General Terms and Conditions)
- Employee upgrades and partner policies are not available to residents of Guernsey, Alderney or Sark (see section 1, General Terms and Conditions)
- Westfield Health must receive claims within 13 weeks of the date of each payment made for treatment, goods or services (see section 7, General Terms and Conditions)
- For partners of eligible employees who take out cover your policy is intended to cover new medical conditions only. Pre-existing medical conditions are not covered for any benefit other than for Optical and Dental (see section 1, General Terms and Conditions)
- For Kids cover is not available for employees' partners to purchase (see section 1, General Terms and Conditions)
- Qualifying periods apply to most benefits (see section 4, General Terms and Conditions)
- There is a 3 month qualifying period for partner cover applications (see section 4, General Terms and Conditions)
- All policyholders choosing to upgrade their cover will have to wait a qualifying period of 3 months in order to claim at the higher level (see section 4, General Terms and Conditions)
- MRI, CT and PET Scanning Facilities is not a cash benefit, your scan must be arranged through our Scanning Service (see Benefit Rules MRI, CT and PET Scanning Facilities)
- Policyholders are not covered for pre-existing medical conditions for Personal Accident cover (see section 1, General Terms and Conditions; Benefit Rules – Personal Accident)

### Duration of cover and cancellation rights

For eligible employees, cover will only continue to be provided at the corporate paid level provided your employer continues to pay the premiums for your cover to Westfield Health. If you upgrade your cover from the company provision; or are purchasing partner cover, the cover that you are paying for yourself will be renewed automatically on a monthly basis, unless your cover is cancelled or lapses. Employees have the right to cancel an upgrade option and partners with cover have the right to cancel their policy. For any cover that you are paying for yourself you have a 14 day cooling off period from the date we accept your application. If you decide to change your mind during this cooling off period you should contact us. Providing that you have not made, or intend to make a claim, we will refund any premiums paid by you. After the expiry of the cooling off period you can still cancel the premiums that you pay at any time. However, you will not be entitled to a refund, except for any premiums paid beyond the date your cover ceased. Please refer to sections 1 and 2, General Terms and Conditions.

### Making a claim

Detailed information on how to claim is found in sections 4 and 7, General Terms and Conditions.

Westfield Health will provide you with a claim form when we welcome you as a new policyholder. Further claim forms can be ordered online at [www.westfieldhealth.com](http://www.westfieldhealth.com) or by calling our Customer Service Department on **0114 250 2000**.

Once completed, please send your claim form with the required supporting information to Westfield Health, Westfield House, 87 Division Street, Sheffield S1 1HT. We will pay your claims directly into your bank or building society account.

Westfield Health will arrange for a Personal Accident claim form to be sent to you if required. After completion, this should be sent to Westfield Health at the above address.

### If you wish to complain

We are committed to providing the highest possible level of service to our customers. However, if the services provided do not meet your expectations please contact us at: Customer Service Department, Westfield Health, Westfield House, 87 Division Street, Sheffield S1 1HT.

In the event that you are not satisfied with our response, please ask for your complaint to be reviewed by an Executive Director. If you remain dissatisfied with our final response you can write to the Financial Ombudsman Service. The Ombudsman will only consider your complaint after you have written confirmation from us that our internal complaints procedure has been applied in full.

### Compensation

Westfield Health is covered by the Financial Services Compensation Scheme. In the unlikely event that we are unable to meet our obligations you may be able to claim compensation. Further information is available from the Financial Services Compensation Scheme, 7th Floor, Lloyds Chambers, Portoken Street, London E1 8BN.

**This Policy Summary provides only an outline of the main features of the plan and should be read in conjunction with the full Terms and Conditions and Benefit Rules featured within this booklet.**

## BENEFIT RULES

Full details of each benefit are listed on the following pages. Cover is subject to the General Terms and Conditions specified on pages 12 to 20.

Where words or phrases appear in **bold type**, they have the special meaning for the purposes of the **plan** as detailed in the Definitions section. Information on how to claim benefits is given in section 7 and **benefit periods** in section 6 of the General Terms and Conditions.

At the discretion of **your** employer For Kids, cover for **your dependent children**, may also be provided to eligible employees as part of **your** corporate paid cover. **Your** welcome letter will detail whether **your** employer has provided **you** with For Kids cover. Employees who are not eligible for corporate paid For Kids can choose to include cover for **your dependent children**, for an additional premium.

For Kids can only be provided/selected at the same **plan** level as the **policyholder's** cover.

If there is anything about these benefit rules that you don't understand please contact **our** Customer Helpline on **0114 250 2000** and **we** will be happy to help.

### DENTAL

**Policyholder:** **Your** maximum benefit is available over a one year **benefit period**.

**For Kids:** **You** have a separate allowance for **dependent children** – the maximum benefit is available over a one year **benefit period** and is shared between all **your dependent children**.

#### When...

- **you** pay a **Dentist** and
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

#### We will cover...

- 100% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet

#### For...

- dental treatment, full or partial dentures and dental check-ups

#### We will not cover...

- insurance or dental care scheme premiums/payments, registration or administration fees
- dental treatment as a result of an accident (see Dental Trauma benefit)
- teeth whitening
- prescription charges
- sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

### DENTAL TRAUMA

**Policyholder:** **Your** maximum benefit is available over a one year **benefit period**.

**For Kids:** **You** have a separate allowance for **dependent children** – the maximum benefit is available over a one year **benefit period** and is shared between all **your dependent children**.

#### When...

- **you** pay a **Dentist** for treatment carried out as a result of accidental injury to teeth, caused by direct external impact to the head e.g. sports injuries, falls, or other accidents that cause injury by external force **and**
- the **Dentist's** receipt specifically confirms treatment is a consequence of an accidental injury **and**
- **you** give **us** details of the accident (for **partner** cover policies the accident must have occurred after **you** applied for the **plan**) **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

#### We will cover...

- 100% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet

#### For...

- dental treatment directly related to the accidental injury

#### We will not cover...

- any payment made more than 24 months after the date of the accident
- any insurance or dental care scheme premiums/payments
- prescription charges
- sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

### OPTICAL

**Policyholder:** **Your** maximum benefit is available over a one year **benefit period**.

**For Kids:** **You** have a separate allowance for **dependent children** – the maximum benefit is available over a one year **benefit period** and is shared between all **your dependent children**.

#### When...

- **you** pay an **Optician** and
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

#### We will cover...

- 100% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet

#### For...

- eyesight tests
- prescription spectacles, sunglasses and/or contact lenses
- prescription lenses to an existing frame
- payments that **you** make for prescription contact lenses supplied under a monthly scheme, when **you** obtain an itemised receipt

#### We will not cover...

- repairs to frames
- frames purchased without prescription lenses
- non-prescription spectacles or sunglasses or contact lenses
- solutions for contact lenses
- any insurance or peace of mind guarantee
- sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

## THERAPY TREATMENTS

### Physiotherapy, Acupuncture, Chiropractic, Homeopathy and Osteopathy

The maximum benefit allowance represents the total for any one or combination of treatment types.

**Policyholder:** **You** maximum benefit is available over a one year **benefit period**.

**For Kids:** **You** have a separate allowance for **dependent children** – the maximum benefit is available over a one year **benefit period** and is shared between all **your dependent children**.

#### When...

- you receive and pay for treatment\* from a registered **Physiotherapist, Chiropractor or Osteopath**, or an **Acupuncturist or Homeopath** who is a member of an approved professional organisation. Registration/membership must be relevant to the treatment that they are providing (see Definitions section) **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

#### We will cover...

- 100% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet

#### For...

- physiotherapy, acupuncture, chiropractic, homeopathy, osteopathy treatment
- homeopathic prescriptions supplied by a **Homeopath** as part of a consultation

#### We will not cover...

- any treatment that is not physiotherapy, acupuncture, chiropractic, homeopathy or osteopathy
- scans e.g. MRI, ultrasound (see Scanning Facilities and/or Consultation benefit)
- sundry items
- missed appointment fees
- herbs, herbal remedies, supplements or vitamins even if these have been recommended or supplied by your **Physiotherapist, Acupuncturist, Chiropractor, Homeopath or Osteopath**
- exclusions (see section 5, General Terms and Conditions)

\*To ensure that you choose the most appropriate treatment **we** strongly recommend that you take advice from your **GP or Consultant Physician/Consultant Surgeon**. For any ongoing treatment **we** may ask **you** to provide **us** with written confirmation from your **GP or Consultant Physician/Consultant Surgeon** that they recommend a continued course of treatment for your medical condition.

## CONSULTATION

**Policyholder:** **You** maximum benefit is available over a one year **benefit period**.

**For Kids:** **You** have a separate allowance for **dependent children** – the maximum benefit is available over a one year **benefit period** and is shared between all **your dependent children**.

#### When...

- your **GP** recommends referral to a **Consultant Physician or Consultant Surgeon** **and**
- **you** pay a registered **Consultant Physician or Consultant Surgeon**, who holds an appropriate qualification (see Definitions section) **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

#### We will cover...

- 100% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet

#### For...

- diagnostic consultations
- **you** for treatment from a **Consultant Physician or Consultant Surgeon**, but only towards payment that **you** have made for a private medical insurance policy excess

#### We will not cover...

- treatment (except for any treatment charges that **you** pay as part of a private medical insurance policy excess)
- the **policyholder** for MRI, CT or PET scans or the associated Radiologist's/Nuclear Medicine Consultant's report†, please refer to Scanning Facilities (if **you** have For Kids cover this exclusion does not apply to **your dependent children**)
- consultations or treatment relating to vasectomy or sterilisation (including reversal)
- consultation or treatment relating to cosmetic surgery
- medical examinations, consultations or reports for the purpose of your employment, legal, or insurance reasons
- room fees, nursing charges, prescription items/charges or sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

†Except see section 8 – Worldwide cover, General Terms and Conditions.

## CHIROPODY

**Policyholder:** **You** maximum benefit allowance is available over a one year **benefit period**.

#### When...

- **you** receive and pay for treatment from a registered **Chiroprapist/Podiatrist** (see Definitions section) **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

#### We will cover...

- 100% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet

#### For...

- chiropody and podiatry consultations, assessments and treatment

#### We will not cover...

- any treatment that is not chiropody or podiatry
- sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

## MRI, CT AND PET SCANNING FACILITIES

For the **policyholder** only.

Scanning Facilities are provided on behalf of Westfield Health by Alliance Medical Limited, Icen Centre, Warwick Technology Park, Warwick CV34 6DA a **UK** based provider of managed imaging services for MRI, CT and PET scans.

In order to access this facility **you** will first need to see **your** consultant in order to gain a referral for a scan. Once **you** have this referral please contact the Scanning Helpline on **0845 345 4556**, available Monday to Friday 8.00am to 8.00pm. For the scan to be covered by **your plan you**, the **policyholder**, must contact the Scanning Helpline and allow them to arrange the scan on **your** behalf. Costs towards scans arranged in any other way cannot be claimed (except see Worldwide cover, General Terms and Conditions).

Helpline staff will explain the process for booking **your** scan and will require written confirmation from **your** consultant confirming **your** validity in order that all necessary arrangements can be made. Under the **plan** appointments can be quickly arranged and often take place within 2 weeks of initial contact. **You** will be required to complete a full safety questionnaire prior to scanning. Following **your** scan a report will be sent to **your** consultant, usually within 10 days.

Patients will need to travel, at their own expense, to access the nearest available Alliance Medical Scanning Facility. CT and PET scans are available at selected locations only.

**MRI and CT Scanning** If an eligible **policyholder\*** is referred by a registered **Consultant Physician/Consultant Surgeon** for an MRI or CT scan this, and the associated Radiologist's report, will be provided under the **plan** at no charge to the **policyholder**.

For all MRI scans a consultant radiologist will check the appropriateness of **your** scan before it is arranged. For MRI scans, **policyholders** who have certain conditions will not be able to be scanned e.g. cardiac pacemaker; heart valves; metallic objects in eyes and metallic implants. **Policyholders** who are pregnant or who are over 21 stone in weight will not be able to be scanned.

Certain types of complex MRI scans or scans which involve contrast or specific x-rays are excluded e.g. those requiring general anaesthetic; for an in-patient; cardiac scans interventional MRI; including MRI arthrography; contrast enhanced angiography; Oncology patients; Liver imaging with ferrous contrast agents (e.g. Endorem).

For all CT scans, the regulations relating to x-rays means that a Consultant Radiologist will have to authorise the scan for additional patient safety. For CT scans, **policyholders** who have certain conditions will not be able to be scanned e.g. diabetics taking metformin. Certain types of complex CT scans are excluded e.g. those requiring general anaesthetic; for an in-patient; virtual colonoscopy or angiography which requires the on site assistance of a Radiologist. **Policyholders** who are pregnant or who are over 21 stone in weight will not be able to be scanned.

**PET Scanning** If an MRI or CT scan indicates that a PET scan is necessary then a maximum of one PET scan and report, during a 12 months period, will be provided under the **plan** at no charge to the eligible **policyholder\***. For all PET scans a referral will be required from a Consultant Oncologist or Surgeon. All PET Scans will also require authorisation from a Consultant Nuclear Medicine Consultant to comply with ARSAC and IRMER medical regulations, since the scan involves radiation. For PET scans, **policyholders** who have certain conditions e.g. diabetics taking metformin will not be able to be scanned. **Policyholders** who are pregnant or who are over 21 stone in weight will not be able to be scanned.

If **you** need a scan when **you** are temporarily travelling outside the **UK**, Channel Islands or Isle of Man please refer to section 8 – Worldwide cover, General Terms and Conditions and Consultation benefit in the Benefit Rules section.

Scanning Facilities are not available for **your dependent children**: however, if **your** cover includes For Kids, **you** may claim Consultation benefit towards the cost of a MRI, CT or PET scan for **your dependent child**, subject to the terms and conditions of the **plan**.

\*Please refer to section 5. Exclusions, in the General Terms and Conditions.

## PERSONAL HEALTH RISK ASSESSMENT

For the **policyholder** and **your** resident family.

This service is provided on behalf of Westfield Health by roadtohealth Ltd.

This confidential† online personal health risk assessment gives you an easy to understand, visual representation of your current health status.

Completing the thorough 15 minutes online questionnaire allows you to easily see any major risks to your health, understand the impact your lifestyle may be having and identify the steps you can take to make improvements. Your results will include a **Q-Score™** telling you where you would appear in a queue of 100 people of the same age, gender and race. The better your overall health and lower your health risk, the further down the queue you will be.

You can use the online personal health risk assessment as often as you like to help you to track your progress. Simply log on to [www.westfieldhealth.com](http://www.westfieldhealth.com) and go to the My Westfield area. You will need to enter the service access code supplied in the **policyholder's** Welcome Pack (or that can also be obtained from Westfield Health).

There is also a range of optional extras that may be provided by **your** employer as part of **your** corporate paid cover, part funded by **your** employer, or alternatively available for you to purchase.

†This is a confidential service: no information identifying you, as an individual, will be shared with Westfield Health or your employer. Some employers may receive a statistical report relating to their workforce: this will not in any way identify individuals who have completed the assessment.

## 24 HOUR COUNSELLING AND ADVICE LINE Counselling, legal, health and wellbeing advice

For the **policyholder** and **your** resident family.

The 24 Hour Counselling and Advice Line is provided on behalf of Westfield Health by FirstAssist Services Ltd., Wheatfield Way, Hinckley, Leicestershire LE10 1YG.

This easy to use confidential\* telephone counselling and advice service gives **you**, and family members who are usually resident with **you**, unlimited access to a team of qualified professionals 24 hours a day – 365 days a year. Even if you are temporarily away from home, simply Freephone **0800 092 0987\*\*** if you are calling from the **UK**, Channel Islands or Isle of Man or call **44 (0) 1455 255 123\*\*\*** from anywhere else in the World.

To confirm your eligibility to use this service, callers will be asked to quote the special Scheme number supplied in the **policyholder's** Welcome Pack (or that can also be obtained from the Westfield Customer Helpline). This Scheme number does not identify you as an individual and if you prefer you don't have to give your name.

\*This is a confidential service and the content of your call will not be divulged unless there is a serious risk to you or someone else. Some employers may request usage statistics, however these will not include any individual's personal information.

\*\*Call charges may apply from some networks.

\*\*\*Call charges will apply.

### Telephone Counselling

Counsellors are available to help day or night, for example you may be concerned with such issues as:

- Stress
- Family difficulties
- Money management
- Relationships
- Substance misuse
- Anxiety
- Bereavement
- Depression
- Problems at work

All counsellors are fully qualified and trained. Each telephone session can last up to an hour and, if you wish, you can continue to work with the same counsellor by arranging convenient appointments for future sessions.

### Face to face counselling sessions, including Cognitive Behavioural Therapy (CBT): up to 6 sessions for the policyholder only

If **your** telephone counsellor considers that **you**, the **policyholder**, would benefit from face to face counselling/CBT FirstAssist will arrange the sessions, with a fully qualified counsellor or therapist, at a location† close to **your** home or work.

The cost of up to 6 face to face counselling sessions or 6 CBT sessions, in any 12 consecutive month period starting from the first session, will automatically be paid for by **your plan**. Cognitive Behavioural Therapy will be offered, entirely at the discretion of **your** FirstAssist telephone counsellor, if they recommend that it would be the most appropriate treatment for **you**.

Counselling is confidential and **your** counsellor will only divulge the content of **your** session if there is a serious risk to **you** or someone else.

**You** will only be covered for the counselling sessions/CBT arranged by FirstAssist and cannot purchase additional sessions with the same counsellor.

†**Policyholders** will need to travel at their own expense to the nearest available FirstAssist associate counsellor/therapist: **you** may be required to travel further to access CBT or counselling to meet any special requirement.

### Legal Advice and Information

You can get free telephone legal advice and information, from an experienced legal professional, on a wide range†† of issues, for example:

- Consumer disputes
- Motoring
- Debt
- Matrimonial
- Wills and probate
- Property
- Landlord/Tenancy
- Welfare benefits
- Family

The Legal Consultants will explain your legal position so that you can decide on your best course of action. For complicated ongoing issues you may find it helpful to speak at intervals to the same consultant.

††This service cannot give advice on employment disputes.

## Health and Wellbeing Advice

A sympathetic professional is always at the end of the phone to devote time for you to discuss your health and wellbeing. The team of nurses and doctors will provide you with easy to understand expert advice and information on a wide range of health and lifestyle issues including:

- Medical symptoms and conditions
- Hospital tests and procedures
- Childhood illnesses
- Disability aids
- Reducing alcohol consumption
- Diet and exercise
- Pre-travel advice
- Medical and surgical treatments
- Patient rights
- Baby and child development
- Caring for the elderly
- Sexual health
- Stopping smoking
- Details of a range of local and national support groups

Please note, this service provides general guidance only and is not intended to replace your normal personal medical care. This is not an emergency service and will not provide diagnosis or prescribe treatments.

## DOCTORLINE™

For the **policyholder** and **your** resident family.

The DoctorLine™ service is provided on behalf of Westfield Health by Medical Solutions UK Ltd., 44 Finchampstead Road, Wokingham, Berkshire RG40 2NN.

The DoctorLine™ service provides **you** and family members normally resident with **you**, with access to telephone consultations with a **GP**, 24 Hours a day – every day. By arrangement you will be telephoned by a qualified practising **GP**, at a time convenient to you. There is no limit to the duration of the telephone consultation or number of times that you can use the service\*.

The service gives you the reassurance of speedy access to completely confidential telephone advice from a **GP** whenever you need it. Because the consultation is carried out by a fully qualified **GP**, who will take into account your personal medical history, the Doctor will in many cases be able to provide a diagnosis of your symptoms and recommend an appropriate course of action. With your consent a report of the telephone consultation can be forwarded to your **GP** within 2 working days, if required. If you wish to seek further information about a medical condition or proposed course of treatment the **GP** can discuss all areas relating to health from surgical procedures, diseases, injuries and prescription medicines to new treatments, foreign travel, exercise and nutrition.

If you would like to arrange a telephone consultation, simply call the DoctorLine™ service on **08456 123 861\*\*** from the **UK**, Channel Islands or Isle of Man, or if calling from overseas on **44 (0) 118 936 5633\*\***. To confirm your eligibility to use the service you will be asked for the **policyholder's** Westfield account number. An experienced healthcare operator will request some preliminary information regarding the nature of your enquiry before booking an appointment for a **GP** to call you back, even if you are temporarily outside the **UK**, Channel Islands or Isle of Man. You will only pay the cost of the initial telephone call to book the consultation\*\*\*.

This is not an emergency service. The DoctorLine™ service is not intended to replace the personal care offered by your own Doctor and cannot be used to obtain a referral for treatment that can be claimed under the **plan**.

\*In exceptional cases where Medical Solutions consider that there has been excessive or inappropriate use by a caller the service may be limited or withdrawn from that individual.

\*\*For your protection calls will be recorded. Please be assured that all consultations remain confidential.

\*\*\*Your network provider may charge for a call received to your mobile telephone while you are outside the **UK**.

## HEALTH CLUB CONCESSION

For the **policyholder** only.

This service is provided on behalf of Westfield Health by roadtohealth Ltd., PO Box 2877, Eastbourne, East Sussex BN22 0WD.

**We** believe in the importance of promoting good health and wellbeing. This service provides access to a national network of health clubs who will offer **you** membership at a concessionary rate†. By constantly updating the offers available the service

aims to find **you** the very best health club membership deal in **your** area. Even if there are presently no health clubs within 15 miles of **your** home or workplace able to offer **you** a concession, the service will endeavour to locate a club, that meets the standards required by roadtohealth, willing to participate in the scheme.

For information on the range of health club deals currently available to **you** log on to **www.westfieldhealth.com** and go to the My Westfield section then simply follow the instructions on the screen. Alternatively **you** can telephone **0845 123 5327††**.

Once **you** have selected **your** preferred deal a voucher, that contains all the necessary information for **you** to present to the health club of **your** choice, will be available to download from the website or emailed to **you** immediately. If **you** choose to register by telephone the voucher will be posted to **you**.

†A health club may decline to offer a concession to their existing club members.

††Available Monday to Friday 9.00am to 5.00pm (except public holidays).

## PERSONAL ACCIDENT COVER

For the **policyholder** only.

For the Personal Accident cover, Westfield Contributory Health Scheme Ltd., Westfield House, 87 Division Street, Sheffield, S1 1HT is an agent acting on behalf of ACE European Group Limited (ACE) – a provider of Accident and Health insurance, whose registered office is at ACE Building, 100 Leadenhall Street, London EC3A 3BP. Authorised and regulated by the Financial Services Authority (FSA). Registration number FRN202803. Full details can be found on the FSA's Register by visiting [www.fsa.gov.uk/pages/register](http://www.fsa.gov.uk/pages/register) by contacting the FSA on 0300 500 5000.

If **you** suffer **Bodily Injury** as a direct result of an **Accident** which within twenty four months of the **Accident** results in death or disablement, benefit will be paid in accordance with the scale outlined on page 12.

### Note

1. The maximum ACE will pay **you** for any one **Accident** is the amount shown in Item 2 of the scale – **Permanent Total Disablement**. If **you** are paid the benefit for **Permanent Total Disablement** **you** will not be paid a benefit for any other **Permanent Disability** arising from the same **Accident**.
2. If ACE pays **you** a benefit for permanent total **Loss** of use of a whole limb, then **you** cannot claim for parts of that limb.
3. ACE will not pay the **Permanent Total Disablement** benefit if **you** are 75 or over.
4. ACE will take account of any disability or condition **you** already had when they assess the amount of disablement benefit they will pay as a result of a subsequent **Accident**.
5. ACE will only pay the Personal Accident Benefit if at the **Time** of the **Accident** **you** were registered as a current **policyholder** with Personal Accident cover on the Chamber Primary Health Cash Plan.
6. This benefit does not apply to **dependent children**.

### Exclusions

ACE shall not be liable in respect of **Bodily Injury** resulting directly or indirectly from or contributed to by:

1. War, whether declared or not, between any of the following countries – France, **United Kingdom**, Peoples Republic of China, Former Constituents of the Union of Soviet Socialist Republics, and the United States of America, or war in Europe, whether declared or not (other than civil war, but including any enforcement action by or on behalf of the United Nations), in which any of those countries or armed forces thereof are engaged. This exclusion shall be inoperative in the event of war being declared whilst **you** are actually engaged on a journey outside **your** country of residence. ACE may cancel insurance hereunder in respect of war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, insurrection, military or usurped power by sending 48 hours' notice to Westfield at their last known address. Insurance in respect of a journey involving travel outside **your** country of residence which had been commenced before the expiry of such notice shall not be affected thereby.
2. Intentional self-injury, suicide or any attempt thereof.
3. **Your** engaging in any form of aerial flight other than as a passenger.
4. **Your** suffering from sickness or disease not resulting from **Bodily Injury**.

## Termination of Cover

The Personal Accident Cover shall terminate immediately on the earliest of the following dates:

- a) the date payment of benefit is made to **you** or **your** personal representative under any one of injuries 1 to 5 of the scale of benefits outlined below.
- b) the date **you** cease to be a current **policyholder** on the Chamber Primary Health Cash Plan.

PERSONAL ACCIDENT	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
1 Death as a result of an <b>Accident</b>	£5,000	£10,000	£15,000	£20,000
2 <b>Permanent Total Disablement</b>	£5,000	£10,000	£15,000	£20,000
3 <b>Loss of Sight</b> – both eyes	£5,000	£10,000	£15,000	£20,000
4 <b>Loss of Speech</b>	£5,000	£10,000	£15,000	£20,000
5 <b>Loss of Limb</b> – one or more limbs	£5,000	£10,000	£15,000	£20,000
6 <b>Loss of Sight</b> – one eye	£2,500	£5,000	£7,500	£10,000
7 <b>Loss of Hearing</b> – both ears	£2,500	£5,000	£7,500	£10,000
8 <b>Loss of Hearing</b> – one ear	£750	£1,500	£2,250	£3,000
9 <b>Loss of:</b> a foot below the level of the ankle (talo-tibial joint) a hip, knee, ankle or thumb a forefinger or big toe any other finger any other toe	£2,500 £1,000 £750 £500 £250	£5,000 £2,000 £1,500 £1,000 £500	£7,500 £3,000 £2,250 £1,500 £750	£10,000 £4,000 £3,000 £2,000 £1,000
10 Permanent and total loss of use of: the back or spine below the neck, with no damage to the spinal cord the neck or cervical spine, with no damage to the spinal cord a shoulder, elbow or wrist	£2,000 £1,500 £1,250	£4,000 £3,000 £2,500	£6,000 £4,500 £3,750	£8,000 £6,000 £5,000

Payment for any **Permanent Disability** not listed above will be based on a medical assessment of **your** disability in relation to this table and not in relation to **your** ability to work.

# GENERAL TERMS AND CONDITIONS

Where words or phrases appear in **bold type**, they have the special meaning for the purposes of the **plan** as detailed in the Definitions section.

If there is anything about these general terms and conditions that you don't understand please contact **our** Customer Helpline on **0114 250 2000** and **we** will be happy to help.

## 1. Who can have cover

This **plan** is not available to purchase directly from Westfield Health. It is primarily available on a corporate paid basis; therefore an employer must pay premiums for an eligible employee – for one level of the **plan**.

**Your** cover will cease if the agreement between the employer and Westfield Health comes to an end.

**You** must reside in the **United Kingdom**, Channel Islands or Isle of Man for a minimum of six months each year to be a Chamber Primary Health Cash Plan **policyholder**.

**We** do not accept professional and semi-professional sports people for cover on the **plan**.

**We** like any responsible insurer, and to the extent permitted by all applicable laws, reserve the right to decline an application for a policy or a request to upgrade **your** cover. If **your** application is not accepted **we** will refund any premium that **you** have paid for the cover that **we** have declined to offer (providing that **we** have not paid a claim under that cover).

**You** can only hold one Chamber Primary Health Cash Plan policy at one time.

## Corporate Paid Cover

If **you** are eligible, **your** employer will pay premiums for **you** on one level of the **plan**. If **you** have previously declined to accept the cover offered by **your** employer, and subsequently change **your** mind, **we** will only allow **your** cover to start on the first day of a new **benefit period**.

There is no restriction regarding the age of an eligible employee taking out cover on the **plan** at the level provided by **your** employer.

**You** do not need a medical before **you** are accepted for cover. **Pre-existing medical conditions** are covered for **you** and, when **your** employer is also providing For Kids cover, **your dependent children**: subject to the terms and conditions and benefit rules of the Chamber Primary Health Cash Plan. However, if **your** employer is also providing **you** with Surgery Choices value added benefit please refer to **your** Schedule of Cover and Surgery Choices leaflet for full details of the terms and conditions, including any exclusions relating to **pre-existing medical conditions**, that apply to **your** Surgery Choices cover.

For Personal Accident cover ACE will take into account any disability or condition that **you** already had when they assess the amount of disablement benefit they will pay as a result of a subsequent **Accident**.

## Value added benefits

In addition to the Chamber Primary Health Cash Plan an employer can, at their discretion, provide their employees with a range of value added benefits. Details of any value added benefits provided as part of **your** corporate paid cover are included in **your** Welcome Pack. Some value added benefits are only available to employees when **your** employer decides to provide them as part of **your** corporate paid cover; they are not available for **you** or **your partner** to purchase.

## Employee Upgrade Options and Partner Cover

Employees who are eligible for corporate paid can:

- Pay an additional premium\* to upgrade (where applicable) **your** corporate paid **plan** level. If **your** corporate paid cover already includes cover for **your dependent children**, For Kids will be upgraded to the level **you** select for no extra charge
- Pay an additional premium\* to cover **your dependent children**, if **your** employer has not provided **you** with For Kids. For Kids cover must be at the same **plan** level as **your** cover: if **you** have chosen an upgrade option, For Kids will be at **your** upgrade level
- Pay an additional premium\* to purchase Surgery Choices, if **your** employer is providing cover for employees but **you** are not eligible for corporate paid Surgery Choices cover. However, please note that the Surgery Choices purchased by an employee will not have exactly the same terms and conditions as the Surgery Choices cover provided as part of an employee's corporate paid cover. **Your** Surgery Choices leaflet explains the terms of **your** cover; including the exclusions relating to **pre-existing medical conditions**

**Partners** can:

- Apply for cover\* on any level of the **plan**
- Pay an additional premium\* to purchase Surgery Choices cover, if the employer is providing Surgery Choices for employees. However, please note that the Surgery Choices purchased by an employee's **partner** will not have exactly the same terms and conditions as the Surgery Choices cover provided as part of an employee's corporate paid cover. **Your** Surgery Choices leaflet explains the terms of **your** cover; including the exclusions relating to **pre-existing medical conditions**

The opportunity for employees and their **partners** to purchase Surgery Choices is made entirely at the discretion of Westfield Health.

**Partners** choosing to have cover on the **plan** will hold a separate policy. An employee's **partner** cannot hold a policy on this **plan** if the employee is not currently in receipt of corporate paid cover: it is a condition of **your partner** cover that **you** notify **us** immediately if for any reason **you** no longer meet this criteria. Please also refer to section 3, Premiums – Change of employer or retirement.

**We** will accept applications for employee upgrades and **partner** cover within one month of the employee's date of **registration** for corporate paid cover on this **plan**. Further opportunities to apply for an employee upgrade or **partner** cover will be offered at **our** discretion, usually on or near the start of a new **benefit period**.

Employees applying for an upgrade option, **partners** applying for cover and all existing **policyholders** applying to transfer to a higher level of the **plan**, must be under 66 years of age. However, **policyholders** are not required to leave the **plan** once they become 66 and can transfer to a lower **plan** level at any age.

**You** must satisfy yourself that this **plan** and the level of cover **you** decide to apply for are right for **you**. Westfield Health, ACE European Group Limited (ACE) or Great Lakes Reinsurance (UK) PLC will not provide any advice in this regard but **you** are of course free to seek information or advice from a professional advisor.

\*Employee upgrade options and **partner** cover are not available for residents of Guernsey, Alderney or Sark.

### Pre-existing medical conditions – Employee Upgrades

**Pre-existing medical conditions** will be covered if **you** are receiving corporate paid cover, (including for any **dependent children** covered on **your** policy), even if **you** upgrade **your plan** level and/or purchase For Kids cover. The exception to this is Surgery Choices cover, if **you** decide to purchase it **your** Surgery Choices leaflet explains the exclusions relating to **pre-existing medical conditions**.

For Personal Accident please refer to Corporate Paid Cover and the Personal Accident benefit rule.

### Pre-existing medical conditions – Partner Cover

**Partner** cover policies are only intended to cover **new** medical conditions and **you** will not be entitled to claim for any **pre-existing medical conditions**. Please read the definition of a **pre-existing medical condition** on page 23 carefully, if **you** are not sure whether a fact needs to be declared **you** should tell **us** so that **we** can decide whether it is relevant or not. Failure to tell **us** about a **pre-existing medical condition** may invalidate **your** policy. The application form, together with any information that **you** give, forms part of the contract of insurance.

If **we** discover that **we** have paid any claims relating to a **pre-existing medical condition**, **we** will seek to recover any monies from **you** that have been paid to **you** that **you** were not due to under the terms and conditions of the **plan**. **We** may terminate **your** policy and **we** may seek to recover from **you** any costs that **we** have incurred.

It may be necessary for **us** to request a medical report from **your GP, Consultant Physician or Consultant Surgeon**. **We** will only request a report when it is reasonably necessary and, under the Access to Medical Reports Act 1988, if a medical report is required **we** will write to **you** first to tell **you** why. If **you** do not give **us** your consent **we** may decline **your** application for cover, or terminate **your** policy.

**We** will usually agree to accept **your** application on condition that any **pre-existing medical conditions** are not covered on **your** policy; if **you** are applying to increase **your** level of cover **you** will not be entitled to claim for **pre-existing medical conditions** from the date that **you** qualify for benefit at the higher level of the **plan**.

When **you** apply for a new policy, or ask **us** to increase **your** level of cover, it is **your** responsibility as the **policyholder** to send **us** written details of any **pre-existing medical conditions**. If **you** are providing information about another person **you** should ensure that **you** have their consent to do so.

If **your** application form was completed and signed by someone else on **your** behalf **you** must provide this information to Westfield within 7 days of **us** welcoming **you** as a **policyholder**, or 7 days of **us** acknowledging **your** request to move to a higher **plan** level.

This exclusion does not apply to claims for Optical benefit and Dental benefit. For Personal Accident please refer to the Personal Accident benefit rule.

If **you** decide to purchase Surgery Choices cover, **your** Surgery Choices leaflet explains the exclusions relating to **pre-existing medical conditions**.

### Cooling Off Period – If you change your mind

If **you** apply for an upgrade option or **partner** cover **your** policy contains a 14 day cooling off period from the date **we** accept **your** application. If **you** decide to change **your** mind during this cooling off period the **policyholder** should contact **us**.

Providing that **you** have not made, or intend to make a claim, **we** will refund the full premium paid by **you**.

## 2. The contract between Westfield Health and you

### Corporate Paid Cover

For eligible employees, cover will only continue to be provided, at the corporate paid level, on condition that **your** employer continues to pay the premiums for **your** cover to Westfield Health.

### Employee Upgrade Options and Partner Cover

For **employees** who have chosen an upgrade option and **partners** who take out cover on the **plan**, **your** health cash **plan** policy operates on the basis that each calendar month a new contract is formed between Westfield Health and **you**. **We** do not issue monthly reminder notices. The cover that **you** are paying for yourself will be automatically renewed each month providing **you** pay **your** premium and abide by the terms and conditions of the **plan**, unless **we** receive notice from **you** that **you** do not wish to continue **your** cover, or **we** give **you** notice that **we** are not willing to accept **your** monthly renewal.

### Your Cancellation Rights – Employee Upgrade Options and Partner Cover

**Employees** have the right to cancel an upgrade option and **partners** with cover have the right to cancel their policy.

If **we** receive notice that **you** wish to cancel before the 15th day in any month **we** will cancel **your** monthly contract for that month and refund the premium paid by **you** for that month. If **we** receive notice of cancellation on or after the 15th day of the month, then **we** will not refund **your** premium for that month but any further premiums will not be payable. Any premium that **you** have paid, in advance or that is not due following cancellation, will be refunded to **you**. **We** will not pay a claim for any benefit beyond the date that **you** have paid up to.

To cancel **your** policy please contact **our** Customer Helpline, email **us** or write to **our** Membership Team at **our** address, detailed on the back cover.

### Re-applying for cover after you have cancelled

If **you** cancel **your** policy and then decide to re-apply for cover with **us** **you** will be subject to any **qualifying periods** for a new applicant to the plan **you** apply for. **You** will also need to sign a new declaration on the application form. Previous claims may be taken into account when **we** assess **your** entitlement to benefit on **your** new policy.

### Terminating your cover – All Policyholders

**We** reserve the right to cancel **your** cover at any time, (with retrospective effect where appropriate), if: -

- Under the terms and conditions of the **plan** **you** are not eligible for cover
- **You** provided false information and/or failed to disclose all the relevant required information when **you** applied for cover, applied to increase **your plan** level, or submitted a claim
- **You**, or anyone covered on **your** policy, fails to comply with **our** request for information relating to a claim or an application for cover
- **You** submit a claim that is fraudulent or that **we** reasonably believe to be intentionally false, and/or misleading, and/or exaggerated
- **You** (or anyone covered on **your** policy) act in a threatening or abusive manner, e.g. violent behaviour; verbal abuse; sexual or racial harassment, towards a member of **our** organisation, or one of **our** suppliers
- **You** fail to abide by any of the terms and conditions of this **plan**

Should **we** cancel **your** cover **you** will not have any right to make any further claim on the **plan**. In addition, **we** may also seek to recover any monies from **you** that have been paid to **you** that **you** were not due to under the Terms and Conditions of this **plan**.

If premiums for **your** cover have been paid in advance **we** may refund premiums paid beyond the date for which **you** have had the benefit of cover. However, **we** retain the right to withhold such premiums if **you** owe **us** money.

**We** will notify **you** in writing **our** reason for cancelling **your** cover and **you** have the right to appeal to **us** through **our** published Complaints Procedure, which is available on request.

If **your** policy is terminated **we** will not accept **you** for cover with **us** again on any plan.

### 3. Premiums

#### Corporate Paid Cover

**You** cover will continue on condition that the premium due each month is paid and **you** abide by the terms and conditions of the **plan**.

You will not be entitled to use any of the services included in the **plan** and **we** will not pay **your** claim if premiums have not been paid to cover the date(s) for which **you** are claiming. If when **we** receive **your** claim **your** employer has not paid the premiums for **your** cover for any reason, **we** will not process **your** claim at that time. If **you** remain in the **plan**, claims will be held until a payment is made to cover the date(s) for which **you** are claiming. If **you** leave **your** employment, or lose entitlement to corporate paid cover, **we** will not pay **you** any benefit, and you will not be entitled to use any of the services included in the **plan**, beyond the date that **your** premiums are paid up to.

If **you** have chosen an employee upgrade option please see below.

#### Employee Upgrade Options and Partner Cover

Premiums are payable by monthly Direct Debit to Westfield Health.

**Your** employee upgrade option or **partner** cover policy will lapse if **you** do not keep **your** premiums up to date. Employees' upgraded level of cover will cease and **your** cover will revert to the corporate paid level when **your** upgrade premiums are more than three months in arrears. **Partners** with a policy will cease to be **policyholders** when their premiums are more than three months in arrears.

If when **we** receive **your** claim the premiums that **you** pay yourself are not paid up to date for any reason, **we** will not process **your** claim at that time. If **you** remain in the **plan**, claims will be held until a payment is made to cover the date(s) for which **you** are claiming.

If **you** do not continue to pay **your** premiums for an upgrade option benefits will cease at the higher **plan** level, on the date that **you** have paid up to. All benefit will cease on the date **you** are paid up to, if **your** premiums for cover as a **partner** of an eligible employee are not paid.

If the employer's payment is in arrears and they fail to bring their corporate paid premiums up to date, **your** employee upgrade option or **partner** cover policy will cease: **we** will notify **you** of the date that **your** policy ends.

**We** will not accept payment for more than 13 months' cover in advance.

Premiums include Insurance Premium Tax at the current rate and are subject to review in respect of any changes in taxation.

Where a benefit included in the **plan** is underwritten by another insurer, **our** agency agreements with insurers allow **us** to hold the premiums **you** pay in respect of these elements of the product as agent of the insurer and therefore payment to **us** means the same as if you have paid that insurer direct. This does not affect elements that **we** underwrite.

#### Change of employer or retirement

An employee's **partner** cannot hold a policy on this **plan** if the employee is not currently in receipt of corporate paid cover: it is a condition of **your partner** cover that **you** notify **us** immediately if for any reason **you** no longer meet this criteria.

When an employee retires or leaves their employment they should ask their employer to notify Westfield Health and each **policyholder** should contact **us** immediately.

**Policyholders**, who wish to continue to have cover with **us**, must transfer to an alternative plan and **our** Customer Helpline will be happy to arrange this for **you**.

**Policyholders** who have already provided their bank/building society details to **us** to pay premiums for their employee upgrade option or **partner** cover policy will be automatically transferred onto an alternative plan. **We** will send **you** advance notice of **your** new premium rate and details of the plan to enable **you** to notify **us** if **you** do not wish to continue **your** cover with Westfield Health.

### 4. Qualifying Period and Benefit Availability

#### Corporate Paid Cover

Eligible employees qualify for all benefits at the corporate paid level, from **your** date of **registration**, at that **plan** level. This includes For Kids when **your** employer is providing **you** with this cover.

However, if **you** have been provided with Surgery Choices please refer to **your** leaflet for the full terms of **your** cover.

#### Employee Upgrade Options and Partner Cover

**You** will have to wait a **qualifying period** before **you** are eligible for most benefits if **you** are:

- Applying for an employee upgrade option and/or adding For Kids cover
- Applying for **partner** cover, or applying to upgrade **your partner** cover policy

Following **your** date of **registration**, at that **plan** level, **you** must renew **your** monthly contract with **us** for the required minimum number of consecutive months, detailed below, to qualify for each benefit.

Available from the date of **registration**:-

MRI, CT and PET Scanning Facilities; Personal Health Risk Assessment; 24 Hour Counselling and Advice Line including face to face counselling/CBT sessions; DoctorLine™; Health Club Concession; Personal Accident

3 months **qualifying period**:-

Dental; Dental Trauma; Optical; Therapy Treatments; Consultation; Chiropody

If **you** have purchased Surgery Choices please refer to **your** leaflet for the full terms of **your** cover.

#### Changes to your level of cover

**We** will usually only accept applications to increase **your** level of cover at the start of a **benefit period**.

If **you** transfer to a higher level of the **plan** until **you** have completed the **qualifying period** **we** will pay benefit at the lower **plan** level, if **you** have benefit available.

If **your** level of cover is reduced during a **benefit period**, **we** will pay benefits at the lower **plan** level from the **registration** date of the transfer, if **you** have benefit available. Benefits paid at the higher **plan** level will be taken into account when assessing **your** entitlement to benefit at the lower level.

#### Former Policyholders

In addition to the above, if **you** were previously covered on the **plan** and **your** policy lapsed or was cancelled, **we** may take into account claims paid under **your** previous cover when assessing entitlement to benefit on **your** new policy. This will depend upon:-

- a) the **plan** level for **your** new policy
- b) the level of the **plan** **you** were previously covered on
- c) the date **your** new policy commences
- d) the start date of the **benefit period**

**Our** Helpline staff can explain the benefit entitlement that will apply to **you**, following a lapse in **your** cover.

### 5. Exclusions

The list of exclusions, below, should be read in conjunction with the Benefit Rules section before receiving treatment or paying for goods and services for which **you** intend to claim.

#### We will not cover:

- any claim that is not submitted in accordance with section 7, General Terms and Conditions;
- any claim that arises as a result of a **pre-existing medical condition** for eligible employees' **partners** who take out cover (with the exception of Optical and Dental benefit);
- benefit for treatment, goods or services within **your qualifying period**. If **you** transfer to a higher level of the **plan** a new **qualifying period** will apply. Until **you** have completed the new **qualifying period** **we** will pay **you** benefit at **your** previous **plan** level, provided that **you** have entitlement to that benefit;
- any claim that is submitted where **you**, or **your dependent child**, are in breach of the **plan** and/or General Terms and Conditions;
- any charges that a practitioner or any other organisation makes for filling in a claim form or providing any information **we** ask for relating to a claim;
- any claim or expense of any kind arising as a direct consequence of any criminal proceedings brought against you;
- any claim or expense of any kind caused directly or indirectly by ionising radiation or contamination by any nuclear fuel, or the radioactive, toxic explosive or other dangerous properties of any explosive nuclear machinery or part of it;
- any claim or expense of any kind directly or indirectly arising as a result of war, invasion, rebellion or revolution.

## 6. Benefit Period

The maximum allowance for each cash benefit is available over a 12 months' **benefit period**. The **benefit period** will start on the same date each year and applies to all **policyholders** whose premiums are paid by or through each specific employer: for Surgery Choices claims please refer to **your** leaflet.

If **you** become eligible for corporate paid cover during a **benefit period you**, and **your partner** if they choose to have cover, can claim up to the full benefit allowances during the remainder of the **benefit period**.

During each **benefit period you** can submit more than one claim under each benefit, however **we** will not pay more than the maximum allowance for **your plan** level. Any unused benefit will not be carried forward from one **benefit period** to the next.

**You** must have benefit available for the date(s) on which you pay for treatment, goods or services. The date of your payment also determines the **benefit period** that each claim falls into.

## 7. How to claim

Claims can only be submitted on one of **our** claim forms. The claim form must be signed and dated by the **policyholder**.

To be entitled to claim, the premiums for **your cover must be paid up to and including**:

- the date on which you made each payment for treatment, goods or services;
- the date of **your** scan for MRI, CT and PET Scanning Facilities;
- the date of **your** first session, for face to face/CBT counselling;
- the date of **your Accident**, for Personal Accident.

**We will not pay your claim unless it is received within 13 weeks of the date that you tender each payment (i.e. cash; credit/debit card; cheque) to the practitioner/supplier for treatment, goods or services.**

It is **your** responsibility to ensure that **you** allow sufficient time for the claim to reach **us** within the **13 weeks'** deadline. **We** will not accept any responsibility for claims (or supporting evidence) lost, delayed or damaged in the post.

**You** must send **us** a full receipt detailing the payment you have made. This must include the supplier's or practitioner's name and address and for Therapy Treatments, Chiroprody and Consultation benefits your receipt must also specify the practitioner's qualification (see Definitions section). The receipt must also name the person who has received the treatment, goods or service.

**We** do not accept the following: -

- photocopies of receipts, invoices without a supporting receipt or credit/debit card receipts without an accompanying itemised receipt
- receipts where only a part payment or deposit\* has been paid, including receipts showing a balance outstanding for payment
- claims for payment(s) made in advance for a course of treatment, a service or goods: except when the receipt confirms that prior to claiming you have received the treatment, goods or service. The receipt must detail the date(s) that you received the treatment, goods or service and **we** must receive **your** claim within 13 weeks of the **payment** date - see above

\*The only exception to this is when **you** provide **us** with written evidence that you have entered into a payment arrangement/credit agreement for treatment, goods or services that you have received. The date that you pay the first instalment determines the **benefit period** that **your** claim falls into and **we** will pay **you** up to the benefit balance available **on that date ONLY** towards the full cost of the treatment, goods or service purchased by the credit agreement. **We** do not cover administration/interest charges. Dental insurance or care scheme premiums/ payments are not covered on the **plan**.

If **you** can claim part or all of your costs under another Westfield plan, or from any other source, you are not entitled to receive more than the total amount that you have paid. If you are claiming from another insurer **we** will pay **our** proportionate share of the cost, subject to benefit being available and the terms and conditions of **your plan**.

**You** should only submit a claim if the person who has received the treatment, goods or service is eligible to claim under that specific benefit. If the claim is for **your dependent child we** may require proof of **your** relationship with them. It is **your** responsibility to provide complete and accurate information with the claim. When **you** submit a claim, for audit purposes **we** will carry out checks on the information **you** and practitioners provide to **us** and **we** will not process that claim, or **any** further

claims on **your** policy, until **we** have successfully completed **our** internal audit checks. If **we** make a reasonable request for additional information, this must be provided at **your** own expense.

If **you** have a **partner** cover policy **pre-existing medical conditions** are not covered on the **plan** (except for Optical benefit and Dental benefit). In order for **us** to verify a claim it may be necessary for **us** to request a medical report from **your GP, Consultant Physician or Consultant Surgeon** at any time. **We** will only request a report when it is reasonably necessary and, under the Access to Medical Reports Act 1988, if a medical report is required **we** will write to **you** first to tell **you** why. If **you** do not give **us your** consent **we** will withhold payment of **all** claims and may terminate **your** policy.

If **we** discover that **we** have paid any claims relating to a **pre-existing medical condition we** will seek to recover any monies from **you** that have been paid to **you** that **you** were not due to under the terms and conditions of the **plan**. **We** may terminate **your** policy and **we** may seek to recover from **you** any costs **we** have incurred.

If you are providing information about another person you should ensure that you have their consent to do so.

If **you** submit a claim that is false **we** will terminate **your** policy and **your** benefits as a **policyholder** will end immediately. **We** will not refund premiums paid for the **plan** and always take legal action for fraudulent claims.

### How we pay you

**We** will pay **your** claims directly into **your** bank/building society account and send **you** a remittance advice as confirmation. Alternatively **we** can pay **your** claims by cheque.

### Scanning Facilities; Personal Health Risk Assessment; 24 Hour Counselling and Advice Line, including face to face counselling/CBT; DoctorLine™; Health Club Concession

For information on how to access these services please refer to the Benefit Rules section.

### How to claim Personal Accident

Please contact the Westfield Customer Helpline and **we** will arrange for a claim form to be sent to **you** or the person acting on **your** behalf. Once a claim has been submitted you will deal directly with ACE in connection with that claim. Any document or evidence reasonably required by ACE to verify the claim shall be provided by **you** or on **your** behalf at **your** own expense. Any medical examination required by ACE to verify the claim will be at ACE's expense. Any receipt which **you** or anyone acting on **your** behalf may give to ACE for benefits payable shall be deemed a final and complete discharge of all liability of ACE in respect of such benefit.

### Surgery Choices

Please refer to **your** individual Surgery Choices leaflet.

## 8. Worldwide cover

If a claim arises when you are temporarily travelling away from home anywhere in the World, on business or for pleasure, **you** can still make a claim. **You** (and if the claim relates to them **your dependent child**) must be resident in the **UK**, Channel Islands or Isle of Man for a minimum of 6 months each year to be eligible for cover on this **plan**. When **you** submit a receipt for money that **you** have paid, **we** will use the currency exchange sell rate, supplied by **our** bank, on the date **we** process the claim.

If **we** request it **you** must provide **us** with evidence of your travel dates. All documentation supporting your claim should be in English. Entirely at **our** discretion **we** may agree to accept an English translation accompanying the original documents, when **you** have provided this at **your** own expense.

**Policyholders** can use their Consultation benefit towards the cost of MRI, CT or PET Scanning outside the **UK**, Channel Islands or Isle of Man subject to pre-authorisation by Westfield Health.

The DoctorLine™ service is available worldwide. This **plan** is not a travel insurance policy.

## 9. General Conditions

### Governing Law

Once **your** application to register for the **plan** has been accepted by **us**, this **agreement** shall be governed by and construed in accordance with the laws of England and the parties irrevocably and unconditionally submit to the exclusive jurisdiction of the courts of England in respect of any dispute or difference between them arising out of this **agreement**.

### Changes to this Contract

From time to time upon renewal it may be necessary for **us** to increase the amount of the premium for the **plan**, alter the benefits payable under the terms of the **plan** or amend the rules relating to the **plan**. If **we** decide to make any such changes **we** will give **you** reasonable notice to enable **you** to decide if **you** do not wish to continue **your** policy, except when it is not possible for **us** to do this, for example changes required by law. Any revisions will not extend the **benefit period** relating to each separate benefit. A person who is not a party to this **agreement** shall not have any rights under or in connection with it by virtue of the Contracts (Rights of Third Parties) Act 1999 except where such rights are expressly granted in these terms and conditions but this does not affect any right or remedy of a third party which exists, or is available, apart from that Act. The rights of the parties to terminate, rescind or agree any variation, waiver or settlement under this **agreement** is not subject to the consent of any person that is not a party to this **agreement**.

**We** reserve the right to cancel the **plan**. If **we** intend to completely withdraw the **plan** **we** shall provide **you** with reasonable notice. Where possible, **we** will try to offer **you** an alternative Westfield Health plan.

### Data Protection Act

The information provided to **us** or collected concerning **your plan** in the future will be used to provide the benefits in **your plan** and for maintaining **your** records. This will include the recording and monitoring of Sensitive Personal Data such as health and medical conditions. This information may be passed to selected third parties for underwriting; claims handling procedures; to provide the services included in the **plan**; and to prevent and detect fraud.

Whenever an employer passes information about you to Westfield Health **we** will process the information in accordance with all applicable data protection and medical information laws and regulations. By collecting such information from the employer Westfield Health relies on the employer's compliance with all data protection legislation. The employer warrants that whenever they transfer personal data (including any medical or other sensitive personal data) to Westfield Health for the purposes set out in this policy they have your full authority to do this, and do so in accordance with applicable laws and regulations.

For a small fee **you** are entitled to a copy of the information which **we** hold about **you**. Please write to the Data Subject Rights Officer, Westfield Contributory Health Scheme Limited, 87 Division Street, Sheffield, S1 1HT, telephone number **0114 250 2000**.

**We** may occasionally use your contact information to contact you by post, email, text or phone with marketing offers and details of **our** other products and services. To opt out please contact **us** at the above address.

**We** may also share all your contact details with other selected organisations who may contact you by post or phone about other products and services. To opt out please contact **us** at the above address. If you are happy to receive emails/texts from these other selected organisations please contact **us** at the above address.

In the interest of continuously improving **our** customer service and for training purposes telephone calls to Westfield Health will be recorded and monitored.

### Language

In accordance with FSA regulatory guidance **we** confirm the language **we** will use for communication purposes. It is: English.

### Additional Information

**We** are required to notify **you** that there may also be other taxes or costs which are not paid through, or imposed by, the insurance underwriter.

The information contained within this leaflet is effective from 1st October 2010 and replaces all previously published information.

## DEFINITIONS

Wherever the following words or phrases appear in this document in **bold type**, they have the special meaning for the purposes of the **plan**, as detailed below.

### £

United Kingdom pounds sterling.

### Accident (Personal Accident cover)

A sudden unforeseen and fortuitous identifiable event and the word **Accidental** shall be construed accordingly.

### Acupuncturist

A fully qualified practitioner who is a Member of the British Acupuncture Council or Fully Accredited Member of the British Medical Acupuncture Society.

The **Acupuncturist** must not be **you**, **your partner** or a member of **your** family.

### Agreement

The contract between Westfield Health and **you** for the provision of the **plan** governed by the terms and conditions set out in this leaflet.

### Benefit Period

The period of time over which the maximum allowance for each separate benefit is available to claim. See section 6, General Terms and Conditions.

### Bodily Injury (Personal Accident cover)

Injury which is caused (solely and independently of any other cause) by **Accidental** means and which, within 24 calendar months from the date of the **Accident**, results in **your** death or disablement. **Bodily Injury** does not include any condition that results due to any gradually operating cause or degenerative process.

### Chiropodist/Podiatrist

A fully qualified practitioner who is registered with the Health Professions Council (HPC).

The **Chiropodist/Podiatrist** must not be **you**, **your partner** or a member of **your** family.

### Chiropractor

A fully qualified practitioner who is registered with the General Chiropractic Council. The **Chiropractor** must not be **you**, **your partner** or a member of **your** family.

### Consultant Physician/Consultant Surgeon

A registered **Consultant Physician** or **Consultant Surgeon**, including any individual holding an appropriate consultant position within a private or registered **hospital**, or **registered treatment centre**.

The **Consultant** must not be **you**, **your partner** or a member of **your** family.

### Dentist

A fully qualified dental practitioner holding current registration with the General Dental Council, who works in a general dental practice.

The **Dentist** must not be **you**, **your partner** or a member of **your** family.

### Dependent Child

A child who is:

- **your** child, **your partner's** child, a child that **you/your partner** have legally adopted or have legal guardianship of **and**
- is under 18 years old and unmarried **and**
- lives with **you** or is financially dependent on **you**

A **dependent child** already included on **your** policy will cease to be eligible for all benefits once they become 18 years old.

### GP

General Practitioner i.e. a physician registered with the General Medical Council, who is currently in general practice.

The **GP** must not be **you**, **your partner** or a member of **your** family.

## Homeopath

A fully qualified **Homeopath** is a member of one of the following professional bodies:

- Member of the Faculty of Homeopathy
- Licensed or Registered Member of the Society of Homeopaths
- Registered Member of the UKHMA
- Member of the Alliance of Registered Homeopaths

The **Homeopath** must not be **you, your partner** or a member of **your** family.

## Hospital

An institute which:

has permanent facilities for caring for patients; and has facilities for medical practitioners to diagnose and treat injured or sick people and provides nursing services supervised by Registered General Nurses or nurses with similar qualifications and is not intended to be a nursing home, **hospice**, convalescent home or a residential care home.

**Loss** used with reference to hand, foot, thumb, finger or toe

(**Personal Accident cover**)

The **loss** by physical severance or the total and permanent **loss** of use of said member.

## Loss of Hearing (**Personal Accident cover**)

Total and irrecoverable deafness confirmed by audiometer and sound threshold tests.

## Loss of Limb (**Personal Accident cover**)

An arm – amputation or complete and permanent loss of use – at or above the wrist;

A leg – amputation or complete and permanent loss of use – at or above the ankle (talo-tibial joint).

## Loss of Sight (**Personal Accident cover**)

Shall be deemed to have occurred:

1. in both eyes when **your** name has been added to the register of Blind Persons on the authority of a qualified ophthalmic specialist;
- or
2. in one eye when the degree of sight remaining after correction is 3/60 or less on the Snellen Scale (which means **you** are only able to see at 3 feet that which **you** should normally be able to see at 60 feet) and ACE is satisfied that the condition is permanent and without expectation of recovery.

## Loss of Speech (**Personal Accident cover**)

Permanent and total loss of speech.

## Optician

A fully qualified **Optician** who is registered with the General Optical Council.

The **Optician** must not be **you, your partner** or a member of **your** family.

## Osteopath

A fully qualified practitioner who is registered with the General Osteopathic Council.

The **Osteopath** must not be **you, your partner** or a member of **your** family.

## Partner

- A person **you** live with that **you** are married to, or a person that **you** permanently live with as if **you** are married to them

or

- A person **you** live with in a civil partnership, or a person that **you** permanently live with as if you are in a civil partnership

## Permanent Disability (**Personal Accident cover**)

Disablement that has lasted for at least 12 months and from which it is believed **you** will never recover.

## Permanent Total Disablement (**Personal Accident cover**)

**Permanent Disability** which will in all probability entirely prevent **you** from engaging in or giving attention to gainful occupation of any and every kind for the remainder of **your** life.

## Physiotherapist

A fully qualified practitioner who is registered with the Health Professions Council (HPC).

The **Physiotherapist** must not be **you, your partner** or a member of **your** family.

## Plan

The Chamber Primary Health Cash Plan.

## Policyholder

The person in whose name the **plan** is held.

## Pre-existing Medical Condition

**Partner cover policies are only intended to cover new medical conditions.**

This exclusion does not apply to claims for Optical benefit and Dental benefit.

**When you apply for a partner cover policy, or apply to increase your level of partner cover, you must tell us in writing about any pre-existing medical conditions.**

Please give details of the condition/symptoms; dates; **GP's** name, address and telephone number if **you**:

- Are currently taking any prescribed medication, or have taken prescribed medication in the last 12 months;
- Have consulted a **GP** or **Consultant Physician/Consultant Surgeon** during the last 12 months;
- Have received advice or treatment from a qualified practitioner or therapist i.e. **Physiotherapist, Acupuncturist, Chiropractor, Homeopath, Osteopath, Chiropodist, Podiatrist** or any other complementary medicine practitioner, during the last 12 months;
- Have attended a **hospital** or **registered treatment centre** during the last 12 months;
- Are awaiting any medical tests, investigations or treatment, or are awaiting the results of any medical tests or investigations, whether or not the condition has been diagnosed;
- Attend **your GP, Consultant Physician/Consultant Surgeon** or **hospital** for monitoring or check-ups;
- Have an illness, injury or condition that is permanent, or has ever previously recurred or that is likely to recur.

If **you** are not sure whether a fact needs to be declared **you** should tell us so that **we** can decide whether it is relevant or not.

## Qualifying period

The period that **you** must wait when **you** register for the **plan**, or **register** for a higher level of cover, before **you** can claim benefits. For further information please refer to section 4, General Terms and Conditions.

## Registered Treatment Centre

A treatment centre that is registered with the Department of Health and appears on the National Administrative Code Service Register.

## Registration

For corporate paid cover – **your** date of **registration** is the date that **your** employer elects to pay premiums from, for **you** as an eligible employee.

For upgrade options/**partner** cover – **your registration** date is the first day of the current month for application forms **we** receive before the 15th of that month. For application forms **we** receive on or after the 15th of the month, it is the first day of the following month.

## Time (**Personal Accident cover**)

Local Standard Time at the address of the **policyholder**.

## UK/United Kingdom

The **United Kingdom** of Great Britain and Northern Ireland i.e. England, Scotland, Wales and Northern Ireland.

## We/us/our

Westfield Contributory Health Scheme Ltd.

## You/your

The named Westfield Health **policyholder**.

## NOTES

# ENHANCING YOUR COVER...

You can now enhance your cover with the following options:

- upgrade your plan level
- add cover for your dependent children (if not already provided by your employer)
- arrange cover for your partner

Simply follow the steps below.

**STEP 1** Choose a level of cover to suit your needs

**STEP 2** Complete the **application form** attached to this booklet

**STEP 3** Return your completed **application form** to us at:

FREEPOST  
Westfield Health  
87 Division Street  
Sheffield  
S1 1HT

### IMPORTANT INFORMATION: PLEASE READ BEFORE COMPLETING YOUR APPLICATION FORM

All applicants must be aged 65 years or under (i.e. not yet 66). Please complete all relevant sections of the application form using BLOCK CAPITALS.

### SECTION A: COVER FOR YOU THE EMPLOYEE

This section asks for information about you, the employee. Please complete all information in this section even if you are not making changes to your own cover. Please tick the appropriate box to inform us of the changes you wish to make to your policy i.e. upgrade or remain on your current level of cover.

**All additional premiums will be paid by Direct Debit. You must be a named account holder on the bank account used to pay your premiums.**

The upgrade premium rates are as follows:

Upgrade your cover	per month
Level 1-2	£6.67
Level 1-3	£19.11
Level 1-4	£31.85
Level 2-3	£12.44
Level 2-4	£25.18
Level 3-4	£12.74

## SECTION B: FOR KIDS – COVER FOR YOUR DEPENDENT CHILDREN

This section is to be completed by employees wishing to apply for For Kids cover. The premium rates to upgrade your cover and/or add voluntary For Kids cover are detailed below.

Upgrade your cover and add For Kids	per month
Level 1-2	£7.32
Level 1-3	£19.76
Level 1-4	£32.50
Level 2-3	£13.09
Level 2-4	£25.83
Level 3-4	£13.39

To keep your existing level of cover but add For Kids	per month
All levels	£0.65

## SECTION C: COVER FOR YOUR PARTNER

This section is to be completed by employees wishing to apply for cover for their partner. **Your partner will hold his or her own policy and must be a named account holder on the account used to pay their premiums.**

Voluntary partner premiums	per month
Level 1	£6.67
Level 2	£13.34
Level 3	£25.78
Level 4	£38.52

## SECTION D: DECLARATION

**Please read your declaration carefully before signing.**

### **Pre-existing medical conditions – Partner Cover applications** **Partner cover policies are intended to cover new medical conditions only.**

Please read carefully section 1, General Terms and Conditions together with the definition of a **pre-existing medical condition**, before completing your application form. If you have any pre-existing medical conditions to declare you must include written details with your application and send it direct to Westfield Health.

## DIRECT DEBIT INSTRUCTION

We need your bank or building society account details so that you can pay your premiums by direct debit. Please ensure you complete the direct debit instruction on the application form.

### **Payment of claims**

We will reimburse your claims by crediting your bank or building society account directly. Please note we can only make payments into a bank or building society account of which you are one of the named account holders. Once your claim has been processed a remittance advice will be forwarded to you.

# CHAMBER PRIMARY HEALTH CASH PLAN: DIRECT DEBIT APPLICATION FORM



## SECTION A – COVER FOR YOU

Title (Mr/Mrs/Miss/Ms/Other) \_\_\_\_\_

Surname \_\_\_\_\_

Forename(s) \_\_\_\_\_

Date of birth DD/MM/YY \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

Tel work \_\_\_\_\_

Tel home \_\_\_\_\_

Email \_\_\_\_\_

Tel mobile \_\_\_\_\_

Your current Westfield account number (if applicable) \_\_\_\_\_

## PROMOTION CODE: \_\_\_\_\_

PLEASE TICK AS APPLICABLE

I wish to:	Remain on level	Change level to	Add
LEVEL 1	<input type="checkbox"/>		
LEVEL 2	<input type="checkbox"/>	<input type="checkbox"/>	
LEVEL 3	<input type="checkbox"/>	<input type="checkbox"/>	
LEVEL 4	<input type="checkbox"/>	<input type="checkbox"/>	
FOR KIDS			<input type="checkbox"/>

Please refer to pages 21 and 22 for premium rates.

### EMPLOYMENT DETAILS

Name of employer \_\_\_\_\_

Payroll number \_\_\_\_\_

My Employer provides Level 1/2/3/4\* \_\_\_\_\_

My Employer provides For Kids YES/NO\* \_\_\_\_\_ \*Delete as applicable

## SECTION B – FOR KIDS: COVER FOR YOUR DEPENDENT CHILDREN (To be completed only by employees selecting For Kids)

Surname	Forename(s)	M/F	Date of birth DD/MM/YY

Surname	Forename(s)	M/F	Date of birth DD/MM/YY

## SECTION C – COVER FOR YOUR PARTNER

Title	Surname	Forename(s)	Date of birth DD/MM/YY

PLEASE TICK AS APPLICABLE

House no	Postcode	Join	Remain	Change	Level of cover			
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L1	L2	L3	L4
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please refer to page 22 for premium rates.

## SECTION D – DECLARATION – PLEASE READ CAREFULLY BEFORE SIGNING – THIS PART MUST BE COMPLETED

I declare that the information I have given on this form is true and complete and that I have received full details of the policy, which I have read or have had read to me and agree to be bound by the General Terms and Conditions and Benefit Rules of the plan.

If I am applying for, or to upgrade, a **Partner Cover** policy I have carefully read section 1, General Terms and Conditions and I understand that the **Partner Cover** policy covers new medical conditions only and I must inform Westfield Health of any **pre-existing medical conditions**.

Partner Cover

I confirm that I have enclosed written details of any pre-existing medical conditions   
Or  
I confirm that I do not have any pre-existing medical conditions to declare

I understand that all future benefit claims will be reimbursed to my bank/building society account until Westfield Health are notified to cancel the instruction. See Page 23.

I agree that, if I become ineligible for cover on the Foresight Health Cash Plan, Westfield Health can automatically transfer my cover to an alternative plan (Westfield Health will send me advance notice of my new premium and cover to enable me to decide if I do not wish to proceed).

**Data Protection:** The information you provide on, or with, this form or information collected concerning your plan in the future will be used by Westfield Health or selected third parties to provide the benefits for which you have applied and for maintaining your records. This will include the recording and monitoring of Sensitive Personal Data such as health and medical conditions. This information may be passed to selected third parties for underwriting; claims handling procedures; to provide the services included in the plan; and to prevent and detect fraud.

Where you have provided information about another person you should ensure that you have their consent to do so. For a small fee you are entitled to a copy of the information which we hold about you by writing to the Data Subject Rights Officer, Westfield Contributory Health Scheme Limited, 87 Division Street, Sheffield, S1 1HT, telephone 0114 250 2000.

By signing this form, you are agreeing to us occasionally using the contact information you have provided, whether provided now or in the future, to contact you or other persons named here by post, email, text or phone with marketing offers and details of our other products and services.

To opt out please tick here Employee  Partner  or contact us at the above address.

We may also share all contact details with other selected organisations who may contact you or other persons by post or phone about other products and services.

To opt out please tick here Employee  Partner  or contact us at the above address

Please tick here Employee  Partner  if you are happy to receive emails/texts from these other selected organisations.

### WESTFIELD OFFICE USE ONLY

Account number \_\_\_\_\_

Event ID \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Partner Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMPLOYEE**

**Please fill in the whole form and send it to:**

Westfield Contributory Health Scheme Ltd. Westfield House 87 Division Street Sheffield S1 1HT

**INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY  
TO PAY BY DIRECT DEBIT**

Service User  
Number



9 4 1 1 1 0

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

To the Manager of:  Bank or Building Society

Address:   
 Postcode:

**2. Name(s) of Account Holder(s)**

**3. Branch Sort Code**

**4. Bank/Building Society Account Number**

BANK/BUILDING SOCIETIES MAY NOT ACCEPT DIRECT DEBIT INSTRUCTIONS FOR SOME TYPES OF ACCOUNT

**For (Westfield) Official use only**

This is not part of the instruction to your Bank or Building Society.

Write in the box below the date you wish the Direct Debit to be collected on:

Originator's Reference No:

**Instructions to your Bank/Building Society**

Please pay Westfield Contributory Health Scheme Ltd. Direct Debits from the account detailed on this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Westfield Contributory Health Scheme Ltd. and, if so, details will be passed electronically to my Bank/Building Society.

Signature

Date

**PARTNER**

**Please fill in the whole form and send it to:**

Westfield Contributory Health Scheme Ltd. Westfield House 87 Division Street Sheffield S1 1HT

**INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY  
TO PAY BY DIRECT DEBIT**

Service User  
Number



9 4 1 1 1 0

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

To the Manager of:  Bank or Building Society

Address:   
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Write in the box below the date you wish the Direct Debit to be collected on:

Originator's Reference No:

**Instructions to your Bank/Building Society**

Please pay Westfield Contributory Health Scheme Ltd. Direct Debits from the account detailed on this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Westfield Contributory Health Scheme Ltd. and, if so, details will be passed electronically to my Bank/Building Society.

Signature

Date

## **WESTFIELD HEALTH**

**REGISTERED OFFICE.** Westfield House 87 Division Street Sheffield  
South Yorkshire S1 1HT

**CUSTOMER HELPLINE.** 0114 250 2000

Available 8am–6pm, Mon–Fri (except Christmas Eve and public holidays)

**EMAIL.** [enquiries@westfieldhealth.com](mailto:enquiries@westfieldhealth.com)

**[westfieldhealth.com](http://westfieldhealth.com)**

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