

POLICY DOCUMENT & APPLICATION FORM

GOOD4YOU HEALTH
CASH PLAN

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 before applying for cover 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 Good4you Health Cash Plan provides cover towards the costs associated with routine healthcare such as new prescription glasses, dental treatment, physiotherapy, in-patient stays and consultations for quick access to diagnosis. This plan also includes a range of health and wellbeing 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

- Five levels of cover to choose from
- Up to 20 healthcare benefits and services
- Cover for your dependent children for some benefits at no extra cost
- 100% and 75% payback for a wide range of routine healthcare expenses, up to set limits
- Fixed cash payouts following an in-patient stay, day surgery or the arrival of a new baby
- GP Telephone Consultation Helpline available 24hrs a day, every day for you and your resident family
- Concessionary deals for you on health and fitness club annual membership
- Freephone 24hr Counselling and Advice Line for you and your resident family
- Personal Accident cover on selected levels
- Access for you and your resident family to our comprehensive online A-Z Health Website

Key limitations and exclusions

- To be eligible to apply for cover or to upgrade your policy you must be aged 16-65 (see section 1, General Terms and Conditions)
- To be eligible for cover you must live in the UK, Jersey or Isle of Man for a minimum of six months each year (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)
- Qualifying periods apply to most benefits (see section 4, General Terms and Conditions)
- Pre-existing medical conditions are not covered for any benefit other than for Optical and Dental (see section 1, General Terms and Conditions; Benefit Rules – Personal Accident)
- 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)
- Claims for In-patient, Recuperation and Day Surgery must reach Westfield within 13 weeks of the date that the patient is discharged as an in-patient or attends for day surgery. Maternity/Paternity benefit must be claimed within 13 weeks of the child's birth or adoption (see section 7, General Terms and Conditions)

Duration of cover and cancellation rights

Your policy will be renewed automatically on a monthly basis unless your cover is cancelled or you allow it to lapse. 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 you should contact us. Providing that you have not made, or intend to make a claim, we will refund your full premium. After the expiry of the cooling off period you can still cancel the cover you have chosen 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 qualifying periods and 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 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 and ACE are members of the Financial Services Compensation Scheme. In the unlikely event that we are unable to meet our obligations you may be able to claim compensation. Most insurance contracts are covered for 100% of the first £2,000 and 90% of the remainder of any claim. Further information is available from the Financial Services Compensation Scheme, 7th Floor, Lloyd's 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 in the back of 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 13 to 18.

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.

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.

ESSENTIAL COVER

OPTICAL

Your maximum benefit is available over a two year **benefit period**. **You** have a separate allowance for **dependent children** – the maximum benefit is available over a two 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
- 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)

DENTAL

Your maximum benefit is available over a one year **benefit period**. **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
- 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)

*Full Dentures

If you need full dentures (either a full upper set, full lower set or both) you can claim up to double the maximum Dental Benefit, but this allowance will be available over a two year **benefit period**. **Your** receipt must confirm that full dentures have been supplied. Once you have made a claim for full dentures, all subsequent dental or denture claims will then also be assessed over a two year **benefit period**. If you do not claim the maximum benefit on the first claim you submit for dentures, any remaining balance may be used, within the two year **benefit period**, for claims for either dental treatment or dentures.

DENTAL TRAUMA

Your maximum benefit is available over a one year **benefit period**. **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, which 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
- 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
- prescription charges
- sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

CHIROPODY

Your 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...

- 75% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- 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)

CONSULTATION

Your maximum benefit allowance is available over a one year **benefit period**. You can use **your** benefit allowance for yourself, **your partner** and/or **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...

- 75% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- diagnostic consultations on all levels of the **plan**
- payments **you** make to a **Consultant Physician** or **Consultant Surgeon** for treatment on levels 3, 4 or 5 of the **plan**

We will not cover...

- treatment on levels 1 or 2 of the **plan**
- 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)

THERAPIES PHYSIOTHERAPY, ACUPUNCTURE, OSTEOPATHY AND CHIROPRACTIC

Your maximum benefit allowance is available over a one year **benefit period** and represents the total for any one or combination of treatment types.

When ...

- your **GP** or **Consultant Physician/Consultant Surgeon** recommends that **you** receive treatment. If requested at any time, **you** must provide **us** with written evidence of this recommendation at **your** own expense **and**
- you receive and pay for treatment from a registered **Physiotherapist, Chiropractor** or **Osteopath**, or an **Acupuncturist** 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...

- 75% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- physiotherapy, acupuncture, chiropractic, osteopathy treatment

We will not cover...

- any treatment that is not physiotherapy, acupuncture, chiropractic or osteopathy
- scans e.g. MRI (see 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** or **Osteopath**
- exclusions (see section 5, General Terms and Conditions)

ADDITIONAL BENEFITS

IN-PATIENT

Your benefit is payable for a maximum of 20 nights in a one year **benefit period**. Each of **your dependent children** has a maximum allowance of 20 nights in a one year **benefit period**.

Benefit per night	Level 1	Level 2	Level 3	Level 4	Level 5
Policyholder	£11.50	£22	£38	£55	£77
Each Dependent Child	£5.50	£9	£16.50	£21	£33

When ...

- you are admitted as an **in-patient** to an **NHS** or private **hospital**, **registered treatment centre** or **hospice** **and**
- you submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- you at the nightly rate for **your plan** level, detailed in the table above
- overnight **in-patient** admissions for treatment, tests or investigations
- maternity related **in-patient** admissions, from the 11th night that **you** have been an **in-patient**. You must give **us** evidence of the first 10 nights that **you** have spent in **hospital** (these nights do not have to be consecutive)
- a **dependent child** required to remain in **hospital** following its birth, from the date that the mother is discharged
- claims submitted when the patient is discharged as an **in-patient**

We will not cover...

- maternity related admissions for the first 10 nights
- any type of **in-patient** admission where the **hospital** could be regarded as your permanent residence
- admissions for rehabilitation, domestic reasons or respite care
- exclusions (see section 5, General Terms and Conditions)

DAY SURGERY

Your benefit is payable for a maximum of 10 days in a one year **benefit period**.

Each of **your dependent children** has a maximum allowance of 10 days in a one year **benefit period**.

Benefit per day	Level 1	Level 2	Level 3	Level 4	Level 5
Policyholder	£13	£24	£42	£61	£85
Each Dependent Child	£6	£10	£18	£23	£36

When...

- you are admitted to an **NHS** or private **hospital**, or **registered treatment centre** as a day case patient **and**
- you are required to sign a consent form and are allocated a **bed** – the use of which is normally for a period of supervised recovery **and**
- you undergo a **surgical procedure** involving the use of theatre facilities **and**
- you submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- you at the daily rate for **your plan** level, detailed in the table above

We will not cover...

- **out-patient** attendances, including procedures carried out in an **out-patient** setting
- tests or investigations e.g. biopsies and endoscopies carried out for investigative purposes only

- treatment and/or pain relief administered by injection
- cardioversion
- attendances at a GP or Dental surgery
- attendances immediately prior to or following an overnight stay for which a claim is payable under In-patient benefit
- exclusions (see section 5, General Terms and Conditions)

RECUPERATION

Your benefit is payable once in a two year **benefit period**. Benefit is payable once per **dependent child** in a two year **benefit period**.

When...

- you are discharged following an **in-patient** stay of 14 or more consecutive nights **and**
- you are entitled to claim In-patient benefit for those nights **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- you at the rate for **your plan** level, see table of benefits in the accompanying leaflet
- you for Recuperation benefit in addition to In-patient benefit

We will not cover...

- you if you are not discharged
- exclusions (see section 5, General Terms and Conditions)

MATERNITY/PATERNITY/ADOPTION

Benefit(s) are payable once in a one year **benefit period**.

When...

- **you** are named as mother or father on the child's full birth certificate, or **you** are named as the child's adopter **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- **you** at the rate for **your plan** level, see table of benefits in the accompanying leaflet
- single or multiple births, benefit is payable per child
- adoptions when the child is **placed** with **you** before their 16th birthday
- stillbirths when **you** send **us** the stillbirth certificate

We will not cover...

- exclusions (see section 5, General Terms and Conditions)

HOMEOPATHY

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

When...

- **your GP** or **Consultant Physician/Consultant Surgeon** recommends that **you** receive treatment **and**
- **you** receive and pay for treatment from a **Homeopath** who is a member of an approved professional organisation, 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...

- 75% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- homeopathic consultations and treatment
- homeopathic prescriptions supplied by a **Homeopath** as part of a consultation

We will not cover...

- any treatment that is not homeopathy
- herbs, herbal remedies, supplements or vitamins even if these have been recommended or supplied by **your Homeopath**
- sundry items
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

HOME CARE

Your maximum benefit allowance is available over a one year **benefit period**. You can use **your** benefit allowance for yourself **and/or your partner**.

When...

- your local authority has carried out a full needs assessment **and**
- you are required to pay a contribution to your local authority towards the package of care that they have commissioned* **and**
- you provide **us** with evidence of this by sending **us** a copy of your current Care Plan **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- 75% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- payments that you have made towards the Home Care detailed on your Care Plan

We will not cover...

- services or additional hours not detailed on your Care Plan
- exclusions (see section 5, General Terms and Conditions)

*If you have opted for Local Authority Direct Payment **we** will only pay **you** towards the contribution you are required to pay for the Home Care as detailed on your current Care Plan. **You** must provide **us** with a copy of your current Care Plan, proof of your assessed contribution, details of local authority payments to you and a fully itemised receipt from the service provider with each claim.

SURGICAL APPLIANCE

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

When...

- **you** pay for an appliance prescribed by **your GP, Consultant Physician/Consultant Surgeon, Chiropodist/Podiatrist, Physiotherapist, Acupuncturist, Chiropractor or Osteopath** **and**
- **you** provide **us** with evidence that the appliance was prescribed for **your use** **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- 75% of the cost, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- hearing aids (including repairs); surgical supports worn by **you** (including hosiery); surgical shoes (custom-made for **your** specific medical needs); orthotics; wigs; mastectomy bras/prosthesis/swimwear

We will not cover...

- any item not specifically listed above
- hearing aid batteries
- exclusions (see section 5, General Terms and Conditions)

HEALTH SCREENING

Your maximum benefit allowance is available over a two year **benefit period**.

When ...

- **you** pay for and receive a health screening check **and**
- the screening check is carried out by medically qualified staff **and**
- **you** submit **your** claim in accordance with section 7, General Terms and Conditions

We will cover...

- 75% of the cost if **you** have cover on level 4 or 5, up to the maximum for **your plan** level, see table of benefits in the accompanying leaflet
- full health screening; well-woman screening; well-man screening; breast screening; heart disease screening; bone density screening*

We will not cover...

- any other screening check or test not carried out as part of one of those listed above
- any health screening check, medical examination, consultation or report for the purpose of **your** employment, legal or insurance reasons
- missed appointment fees
- exclusions (see section 5, General Terms and Conditions)

*For a bone density screening check, **you** must supply evidence that it has been specifically recommended by **your GP**.

YOUR HEALTH AND WELLBEING SERVICES

GP TELEPHONE CONSULTATION

Available on all levels of the **plan**.

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

The GP Telephone Consultation 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 two 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 GP Telephone Consultation 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 GP Telephone Consultation 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**.

A-Z HEALTH WEBSITE

You and **your** family normally resident with **you**, can access a wide range of health information at our A-Z Health Website by logging onto **www.westfieldhealth.com**. First go to the My Westfield section and simply click on A-Z Health Website, **you** will be asked to enter **your** name and Westfield Health account number. You can then browse through our essential guide to everything you need to know about your health; topics include an A-Z of medical conditions, first aid, diet and nutrition, health while travelling abroad and much more. We even publish the latest health news to keep you up to date on any health warnings and developments.

HEALTH CLUB CONCESSION

For the **policyholder** on all levels of the **plan**.

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–5.00pm (except public holidays).

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

Available on all levels of the **plan**.

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 **01455 255123***** 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.

**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.

Legal Advice

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.

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.

PERSONAL ACCIDENT COVER

For the **policyholder** on levels 3, 4 and 5 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 <http://www.fsa.gov.uk/register> or by contacting the FSA on 0845 606 1234.

If **you** suffer **Bodily Injury** as a direct result of an **Accident** which within 24 months of the **Accident** results in death or disablement, benefit will be paid in accordance with the scale outlined below.

	LEVEL 3	LEVEL 4	LEVEL 5
1 Death as a result of an Accident	£15,000	£25,000	£50,000
2 Permanent Total Disablement	£15,000	£25,000	£50,000
3 Loss of Sight – both eyes	£15,000	£25,000	£50,000
4 Loss of Speech	£15,000	£25,000	£50,000
5 Loss of Limb – one or more limbs	£15,000	£25,000	£50,000
6 Loss of Sight – one eye	£7,500	£12,500	£25,000
7 Loss of Hearing – both ears	£7,500	£12,500	£25,000
8 Loss of Hearing – one ear	£2,250	£3,750	£7,500
9 Loss of:			
a foot below the level of the ankle (talo-tibial joint)	£7,500	£12,500	£25,000
a hip, knee, ankle or thumb	£3,000	£5,000	£10,000
a forefinger or big toe	£2,250	£3,750	£7,500
any other finger	£1,500	£2,500	£5,000
any other toe	£750	£1,250	£2,500
10 Permanent and total loss of use of:			
the back or spine below the neck, with no damage to the spinal cord	£6,000	£10,000	£20,000
the neck or cervical spine, with no damage to the spinal cord	£4,500	£7,500	£15,000
a shoulder, elbow or wrist	£3,750	£6,250	£12,500

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.

Note

- 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**.
- 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.
- ACE will not pay the **Permanent Total Disablement** benefit if **you** are 75 or over.
- 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**.
- ACE will only pay the Personal Accident Benefit if at the time of the **Accident you** were registered as a current **policyholder** on levels 3, 4 or 5.
- 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:

- 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.
- Intentional self-injury, suicide or any attempt thereat.
- Your** engaging in any form of aerial flight other than as a passenger.
- 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:

- 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 on page 12.
- the date **you** cease to be a current **policyholder** on Good4you Plan level 3, 4 or 5.

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 join the Good4you Health Cash Plan

You must reside in the **United Kingdom**, Jersey or Isle of Man for a minimum of six months each year to be a Good4you **policyholder**.

You must be at least 16 years old and younger than 66 years of age to apply for the **plan**. Existing **policyholders** applying to transfer to a higher level of cover 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.

Professional and semi-professional sports people are not eligible for the **plan**.

You must satisfy yourself that this **plan** and the level of cover **you** decide to apply for are right for **you**. Neither Westfield Health nor ACE will provide any advice in this regard but **you** are of course free to seek information or advice from a professional advisor.

You do not need a medical before **you** apply for cover. **You, your partner or dependent child(ren)** will not be entitled to benefits for any illness, injury or condition, which existed before **you** applied for the **plan** or **you** applied to transfer to a higher level of the **plan**. This exclusion does not apply to Optical or Dental benefit.

The application form includes a declaration that must be signed by **you** or on **your** behalf before **we** will accept **your** application. If anyone who will be covered under **your** policy is unable to satisfy the health requirements **you** must send **us** written details with **your** application form. This application form, together with any information that **you** give, forms part of the contract of insurance. Applications can be accepted subject to a proviso that these **pre-existing medical condition(s)** will not be covered on **your** policy or if **you** are increasing **your** level of cover, from the date **you** qualify for benefit at the higher level of the **plan**.

Like any responsible insurer **we** reserve the right to decline an application, for cover or to upgrade **your** policy, when **we** believe that this would be detrimental to the Scheme and/or a significant number of **our** policyholders.

You can only hold one Good4you Health Cash Plan policy at any one time.

Cooling Off Period – If you change your mind

Your policy contains a 14 day cooling off period from the date **we** accept **your** application. If **you** 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 **your** full premium.

2. The contract between Westfield Health and you

This 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. **Your** policy 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

You have the right to cancel **your** 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 **your** premium 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 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 the **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.

Terminating your cover

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 or applied to increase **your** plan level
- **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.

The above does not affect **your** statutory rights.

3. Premiums

Your policy will lapse if **you** do not keep **your** premiums up to date. If **you** owe more than one month's premium on levels 3, 4 or 5 or three months' premiums on levels 1 or 2 **you** will not be entitled to remain in the **plan**.

If when **we** receive your claim **your** premiums 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 **you** have made a payment that covers the date(s) for which you are claiming. If **you** do not continue to pay **your** premiums all benefit under the **plan** will cease on the date that **you** have paid up to.

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.

4. Qualifying Period

New **policyholders** or those who transfer to a higher level of cover will have to wait the relevant **qualifying period** before they are eligible for most benefits. The **qualifying period** starts from **your** date of **registration**, at that **plan** level. Following **your** date of **registration** **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**: -

GP Telephone Consultation; Health Club Concession; 24 Hour Counselling and Advice Line; A-Z Health Website; In-patient – but only as a consequence of an accident; Personal Accident cover (where applicable to the **plan** level)

10 months **qualifying period** – all **plan** levels: -

Maternity/Paternity/Adoption benefit

3 months **qualifying period** – levels 1 and 2: -

All other benefits (where applicable to the **plan** level)

6 months **qualifying period** – levels 3, 4 and 5: -

All other benefits (where applicable to the **plan** level)

If **you** transfer to a higher **plan** level **qualifying periods** for benefit at the higher level are as shown above. During the **qualifying period** **we** will pay benefit at the lower **plan** level, if **you** have benefit available.

If **you** transfer to a lower level of cover **we** will pay benefits at the lower **plan** level from the **registration** date of the transfer, providing **you** had already completed the required **qualifying period** during the time **you** were at the higher **plan** level. **Benefit periods** and benefits paid at the higher **plan** level will be taken into account when assessing entitlement to benefit at the lower level.

Former Policyholders

In addition to the above, if **you** have been a former **policyholder** with Westfield and **your** policy has lapsed, **we** will take into account claims paid under **your** previous cover when assessing entitlement to benefit on **your** new policy. The date that each benefit will be available to claim will depend upon: -

- a) the Good4you Plan level that **you** are applying for
- b) the plan and plan level that **you** were previously covered on
- c) claims previously paid and the **benefit periods** relating to those claims

Transferring Plans

For **policyholders** who transfer to the Good4you Plan from another Westfield Health plan previous claims that **you** have made may be taken into account when assessing your entitlement to benefit.

Our Helpline staff can explain the **qualifying periods** and benefit entitlement that will apply to **you**, following a lapse in **your** cover or transfer from another Westfield Health plan.

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** (with the exception of Optical and Dental benefit);
- any charges that a **hospital**, practitioner or any other organisation makes for filling in a claim form or providing any information **we** ask for relating to a claim;
- 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 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

A separate **benefit period** applies to each benefit and these are detailed in the Benefit Rules section.

You must have benefit available for the date(s) on which you paid for treatment, goods or services. For In-patient, Day Surgery, Recuperation and Maternity/Paternity/Adoption benefits you must have benefit available, for the date(s) that **you** are claiming.

When you have FULL BENEFIT available the **benefit period** will start on the following dates: -

- For In-patient, Day Surgery and Recuperation benefits the **benefit period** begins on the first day or night that **we** pay benefit for
- The Maternity/Paternity/Adoption **benefit period** begins on the date of birth or the date a child is **placed** with **you** for adoption
- For all other benefits the **benefit period** begins on the date that **you** paid for the treatment, goods or service

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.

The **benefit period** that each claim falls into is determined by:

the date of birth/adoption **placement** for Maternity/Paternity/Adoption benefit;
the date that you are an **in-patient**;
the date that you attend for day surgery;
the date of your payment for treatment goods or services.

When a **benefit period** ends full benefit will again become available to claim. Any unused benefit will not be carried forward from one **benefit period** to the next. The new period for that benefit will not begin until **you** submit the next claim and will start according to the criteria set out above.

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**.

For all benefits where **you** (or a person eligible to claim on **your** policy) have paid for treatment, goods or services **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, when you are claiming for treatment, 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 also confirms that prior to claiming you have received the treatment, goods or service. The receipt must detail the date(s) you received the treatment, goods or service and **we** must receive your claim within 13 weeks of the **payment** date – see below

*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**.

For Maternity/Paternity benefit **we** need **your** baby's full birth certificate with **your** claim. To claim for Adoption **you** must send **us** proof of the child's name and age, together with confirmation from an adoption agency of the date that the child was **placed** with **you** for adoption.

To claim In-patient, Day Surgery and Recuperation benefits **your** Westfield claim form must be completed, signed and stamped by the **hospital, registered treatment centre or hospice**. **We** do not accept photocopies of completed claim forms.

We will not pay your claim unless it is received within 13 weeks of the following: -

- the date that you tender **each** payment (i.e. cash; credit/debit card; cheque) to the practitioner/supplier for treatment, goods or services
- the date on which you were discharged as an **in-patient**
- the date of each attendance for Day Surgery
- the child's date of birth; the date a child is **placed** with **you** for adoption

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.

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 partner** or **dependent child** **we** may require proof of **your** relationship with them. It is **your** responsibility to provide complete and accurate information with the claim.

For audit purposes **we** will carry out checks on the information **you** and practitioners provide to **us**. 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.

GP Telephone Consultation, Health Club Concession, 24 Hour Counselling and Advice Line and A-Z Health Website

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.

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 partner** or **dependent child**) must be resident in the **UK**, Jersey or Isle of Man for a minimum of six 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.

The GP Telephone Consultation 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**, the contract between **us** will be governed by the General Terms and Conditions and Benefit Rules of the **plan**. That contract will also be subject to the powers of the English Courts and those of no other jurisdiction.

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.

The Maternity/Paternity/Adoption benefit will remain in place if **you** continue to be a Good4you Plan **policyholder** unless **we** give **you** 12 months' notice that it is to be withdrawn.

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 plan.

Data Protection Act

The information **you** provide together with any further information concerning **your plan** will be used by Westfield Health or ACE to provide **you** with the benefits for which **you** apply and for maintaining your records. This information may be passed to selected third parties for underwriting; claims handling procedures; to provide you with the services included in the **plan**; to prevent and detect fraud. For a small fee **you** are entitled to a copy of the details and information which **we** hold about **you** if **you** apply, in writing, to the Data Subject Rights Officer, Westfield Contributory Health Scheme Ltd., 87 Division Street, Sheffield S1 1HT. **We** may share **your** contact details with other selected organisations to send **you** information about other products and services. If **you** do not wish **us** to do so, please tick the box on the application form or advise **us** in writing to the Data Subject Rights Officer at the above address.

In the interests of continuously improving our service to customers and for training purposes telephone calls to Westfield Health will be recorded and monitored. This will include the recording and monitoring of Sensitive Personal Data such as data relating to health and medical conditions.

Language

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

The information contained within this booklet is effective from 1st April 2009 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.

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.

Bed

A **bed**, or similar facility e.g. a reclining chair that the treatment provider classes as a **bed**.

Benefit Period

The period of time over which 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**

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.

Hospice

An institution that provides palliative care for the terminally ill.

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 residential care home.

In-patient

Admission to a **hospital**, **hospice** or **registered treatment centre** for a full night stay, or longer. An **in-patient** stay will only be classed as a full night stay if the patient is admitted before 12, midnight.

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.

NHS

National Health Service

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.

Out-patient

A person attending a **hospital** or **registered treatment centre** for advice, consultation and/or treatment, but who does not receive admitted patient care.

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.

Placed/Placement

When a child comes to live with **you** permanently with a view to being formally adopted by **you** in the future.

Plan

The Good4you Health Cash Plan.

Policyholder

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

Pre-existing Medical Condition

Any medical condition whether fully diagnosed or not that **you** should declare if **you** are unable to satisfy the application form declaration. See section 1, General Terms and Conditions.

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. The **qualifying periods** are detailed in 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

We will take **your** date of registration as: -

The first day of the current month for application forms **we** receive before the 15th of that month.

The first day of the following month for application forms **we** receive on or after the 15th of the month.

Surgical Procedure

A surgical procedure requiring the use of local, regional or general anaesthetic, for the purpose of treating disease, injury or abnormality by operating directly on or removing the affected part, or removing a foreign body.

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. or something belonging to **us**.

You/your

The named Westfield **policyholder** or something belonging to **you**.

APPLY NOW...

To apply for cover, upgrade your existing cover or if your family and friends would like to apply for their own cover, simply follow the steps below:

STEP 1 Choose a level of cover to suit your needs

STEP 2 Apply online at www.westfieldhealth.com or complete the **application form** attached to this leaflet

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

FREEPOST SF30
Westfield Health
87 Division Street
Sheffield
S1 1HT

No stamp required.

We will send you all the information you need to start enjoying your new cover.

IMPORTANT INFORMATION: PLEASE READ BEFORE COMPLETING YOUR APPLICATION FORM

All applicants must be aged 16 to 65 years (i.e. not yet 66). Please complete all relevant sections of the application form using BLOCK CAPITALS.

SECTION A: APPLICANT ONE

To apply for cover for yourself, please complete all information in this section.

SECTION B: APPLICANT TWO

If your family or friends would like to apply for their own cover they can do so by providing their details here.

SECTION C: DETAILS OF YOUR DEPENDENT CHILDREN

If you have any dependent children that are eligible for cover under your policy, please provide their details here.

SECTION D: DECLARATION

(Please read your declaration carefully before signing)

Pre-existing medical conditions

If anyone intended to be covered on this plan has any pre-existing medical conditions to declare, please provide written details of these with your application.

DIRECT DEBIT INSTRUCTION

We need the bank or building society account details for each applicant so that premiums can be paid 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.

WESTFIELD HEALTH

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

ENQUIRIES. 0845 602 1629

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

EMAIL. enquiries@westfieldhealth.com

westfieldhealth.com

Westfield Health is a registered trademark of Westfield Contributory Health Scheme Ltd., which is authorised and regulated by the Financial Services Authority. Details of registration can be found at www.fsa.gov.uk/register or by contacting the Financial Services Authority on 0845 606 1234. Westfield Health is registered and incorporated in England as a company limited by guarantee. Registered no.303523.



GOOD4YOU HEALTH CASH PLAN APPLICATION FORM

SECTION A – APPLICANT 1

Title (Mr/Mrs/Miss/Ms/Other) _____

Surname _____

Forename(s) _____

Date of birth DD/MM/YY _____

Address _____

Postcode _____

Tel work _____

Tel home _____

Email _____

Tel mobile _____

National Insurance number _____

Your current Westfield account number (if applicable) _____

PROMOTION CODE: _____

	Amount per month	I wish to:	PLEASE TICK AS APPLICABLE		
			Join on level	Change level to	Remain on level
LEVEL 1	£5.35		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 2	£11.20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 3	£16.60		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 4	£23.20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 5	£34.00		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B – APPLICANT 2

Title (Mr/Mrs/Miss/Ms/Other) _____

Surname _____

Forename(s) _____

Date of birth DD/MM/YY _____

Address _____

Postcode _____

Tel work _____

Tel home _____

Email _____

Tel mobile _____

National Insurance number _____

Your current Westfield account number (if applicable) _____

PROMOTION CODE: _____

	Amount per month	I wish to:	PLEASE TICK AS APPLICABLE		
			Join on level	Change level to	Remain on level
LEVEL 1	£5.35		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 2	£11.20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 3	£16.60		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 4	£23.20		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEVEL 5	£34.00		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C – DETAILS OF YOUR DEPENDENT CHILDREN

APPLICANT 1

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

APPLICANT 2

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

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.

I declare that I and all other persons covered by this proposal are not receiving or expecting to receive a consultation or treatment and have not attended a hospital or received any medical care from a qualified therapist or practitioner in the last 12 months prior to applying for the plan or a higher level of cover [Section 1, General Terms and Conditions].

I understand that all future benefit claims will be reimbursed to the bank/building society account as detailed in the attached direct debit form, until Westfield Health are notified to cancel the instruction. I confirm that I am one of the named account holders (if you wish us to credit a different account please contact us to request a Direct Credit Instruction Form by emailing enquiries@westfieldhealth.com or by calling 0114 250 2000). Once your claim has been processed a remittance advice will be forwarded to you advising of the amount we will be crediting.

Please tick the box if the health conditions described above cannot be satisfied.

Applicant 1 Applicant 2

Applicant 1 Signature _____

Applicant 2 Signature _____

If anyone intended to be covered on the plan has any pre-existing medical conditions, you should send written details together with this form.

Data Protection: The information you provide on this form together with any further information concerning your plan will be used by Westfield Health or ACE to provide you with 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 data relating to health and medical conditions. This information may be passed to selected third parties for underwriting; claims and handling procedures; to provide you with the services included in the plan; to prevent and detect fraud. For a small fee you are entitled to a copy of the details and information which we hold about you if you apply, in writing, to the Data Subject Rights Officer, Westfield Contributory Health Scheme Limited, 87 Division Street, Sheffield, S1 1HT.

We may share your contact details with other selected organisations to send you information about other products and services. If you do not wish us to do so, please tick the box below, or advise us in writing to the Data Subject Rights Officer at the above address.

Applicant 1 Applicant 2

Date _____

Date _____

SECTION E – WESTFIELD HEALTH OFFICE USE ONLY



Account number _____

Event ID _____



Promotion code _____

Media code _____

APPLICANT 1

	Please return this form to: Westfield Contributory Health Scheme Ltd. REGISTERED OFFICE: Westfield House 87 Division Street Sheffield South Yorkshire S1 1HT																
	INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT																
Name(s) of account holder(s) <input type="text"/>		Service user's number <table border="1"><tr><td>9</td><td>4</td><td>1</td><td>1</td><td>1</td><td>0</td></tr></table>	9	4	1	1	1	0									
9	4	1	1	1	0												
Bank/building society account number <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>									Branch sort code <table border="1"><tr><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td></tr></table>			-			-		
		-			-												
Name and full postal address of your bank or building society																	
To: The Manager		Bank/Building Society															
Address <input type="text"/>																	
Postcode <input type="text"/>																	
Indicate the payment collection date <input type="text"/>	For Westfield office use only: This is not part of the instruction to your bank or building society																
Instruction to your bank or building society Please pay Westfield Contributory Health Scheme Limited direct debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Westfield Contributory Health Scheme Limited and if so, details will be passed electronically to my bank/building society.	Originator's reference (Westfield Health use only) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																
Signature(s):		Date:															
Banks and building societies may not accept direct debit instructions for some types of account.																	

APPLICANT 2

	Please return this form to: Westfield Contributory Health Scheme Ltd. REGISTERED OFFICE: Westfield House 87 Division Street Sheffield South Yorkshire S1 1HT																
	INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT																
Name(s) of account holder(s) <input type="text"/>		Service user's number <table border="1"><tr><td>9</td><td>4</td><td>1</td><td>1</td><td>1</td><td>0</td></tr></table>	9	4	1	1	1	0									
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		-			-												
Name and full postal address of your bank or building society																	
To: The Manager		Bank/Building Society															
Address <input type="text"/>																	
Postcode <input type="text"/>																	
Indicate the payment collection date <input type="text"/>	For Westfield office use only: This is not part of the instruction to your bank or building society																
Instruction to your bank or building society Please pay Westfield Contributory Health Scheme Limited direct debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Westfield Contributory Health Scheme Limited and if so, details will be passed electronically to my bank/building society.	Originator's reference (Westfield Health use only) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																
Signature(s):		Date:															
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