

Policy Disclosure Statement

The details of **your policy** are in this **Policy**. In the first section **you** will find explanations of how **your benefits** will be paid, along with information on how **your policy** works, how to make changes as well as how **your policy** continues and how to cancel **your policy**.

Always, if there's anything that **you** don't understand or **we** can help **you** with, please don't hesitate to get in touch.

As **your policy** is placed with **us** by an intermediary (insurance agent or insurance broker), please consult with **your** intermediary whenever **you** wish to inquire or be assisted concerning **your policy**.

This **Policy** wording version is: **KIL2015CBP01**.

Policy Wording

1.1 The Insurance Agreement and your insurance documents

The following documents together make up the **Insurance Agreement**. These documents must be read together as a whole, they should not be read as separate documents.

1. **This policy's wording:** this sets out the general terms and conditions of the insurance (and any exclusions) and all the elements of cover that can be provided under **your policy**
2. **Your table of cover:** this shows the **benefits** on each **level**, including the limits that apply or any variations to the **benefits**
3. **Your policy Schedule:** this shows **your** personal details and the **benefit** level chosen and the **inception date** of **your policy** and when **your policy** expires.
 - a. **You** can only become insured under this **policy** if **you** are aged between 18 and 69, and are resident of the country specified in the **Schedule**.
 - b. **We** do not have to accept **you** as an insured. If **we** do accept **you** as an insured, **we** will provide written **Schedule** in confirmation of this.
 - c. Should **your policy** allow, **you** can apply to add **your** partner to be covered under **your** policy, as long as they are aged between 18 and 69. Please note, **we** may agree to insure **you** or **your** partner if **you** are over 69 years old, if **we** allow that, **we** will provide you with a written confirmation of this. **You** can also apply to include **your** children or **your partner's** children as **insured under this policy** if they are under 24, unmarried and not in a civil partnership. Any children and **partner** covered must live permanently with **you** at **your** address. **We** refer to **your partner** and any children who become **insured** under **your policy** as **dependants**. **We** will cover a maximum of four dependent children on **your policy**. Please refer to **your** table of cover for the subscription rates applicable to these varying levels of cover.
 - d. **We** do not have to accept any of **dependants** as an insured. If **we** do accept any of **them** as an insured, **we** will provide written confirmation of this. **You** will need to contact **us** to ask **us** to add or remove any of **your dependants** from **your policy**.
 - e. This insurance **plan** is governed by an **Insurance Agreement** between **you** and **us**. **You** need to read this policy's wording along with the **benefit** section and the **Schedule** **we** issued for **you** for details of **your** cover. Defined terms are set out in bold and have the meanings set out in the glossary. **You** should read the glossary for the meanings of these terms.

Policy Cover

- f. This policy is for **you** and for the persons listed in **your** policy's **Schedule**.
- g. **We** will reimburse **you** for payments **you** made for the benefits listed in **your schedule** subject to the terms and conditions of this policy and also in cases where **you** become eligible under the personal accident cover as stated in this policy.

- h. The amount **we** will pay **you** will be up to the percentage stated in the **schedule** and no more than the amount stated in the **schedule** for each Benefit and per each listed insured.
- i. The payments **we** will make will be for those benefits taken and paid during the period of insurance.

Premiums

- j. All **premiums** are payable annually in advance starting on **your** policy inception date unless **we** agree otherwise. **We** must receive **your premium payment** in full on or before the date they are due to ensure the continuation of **your policy**. The **premiums you** pay are determined by the level chosen.
- k. If **you** are paying **your** premiums through another person, they are to be treated as paying the premiums to **us** on **your** behalf. The premiums are not considered paid until **we** actually receive them.
- l. **Your** premiums do not include Insurance Tax (where applicable). If the government changes this demand **we** reserve the right to amend **your** premiums from the date that the premium tax applies. **We** will notify **you** of this change in line with section 1.5 – making changes.

1.2 Payment of benefits

- a. **You** can only claim **benefits** for treatment and services **you** or **your listed dependants** receive while **you** or they (as the case may be) are insured under this **policy**.

We will pay **benefits** according to the terms and conditions of **your** policy that were in effect at the time the treatment or services were provided. All **benefits** will be paid to **you** and not to **dependants**, unless authorised by **you**. Where **we** refer to payment of **benefits**, **we** mean payment to **you**.

- b. **You** can only claim for treatments that are carried out in the country listed in the **Schedule**.
- c. Any payment of benefits will be made against **your** benefit entitlement on the date that treatments, goods or services have been received.
- d. **Benefits** are subject to **benefit limits** which are set out in your **table of cover**.
- e. **Your benefit** entitlement and that of **your dependants** will be determined by the **level you** have chosen and specified in the **Schedule**.

1.3 When your policy starts, continues and ends

- a. **Your policy** and **your benefit year** will start from **your inception date** stated in the **Schedule**.
- b. **Your policy** will be in effect until expires on the date specified as Expiration Date stated in the **Schedule**.
- c. Subject to section 1.3g, **your policy** will continue provided **we** receive **your** premiums on or before they are due.

- d. If **you** wish to upgrade/increase **your** level of cover, you need to do that via your intermediary and in writing. Such upgrade/increase will become effective when we confirmed this in writing.
- e. **You** may cancel **your** policy or the cover of any of **your dependants** within 21 days from the date **you** receive **your Schedule** confirming **you** are insured. If **you** cancel **your policy** during this period, **we** will allow **you** to cancel the policy from inception and refund all premiums paid by **you**. If **you** placed a **claim** on your policy, no premium refund applies.
- f. **You** may end **your** policy at any time by providing **us** with a written notice of **your** intention to do so. **We** will refund to **you** the premium for the period left and unused. If **you** placed a **claim** on your policy, no premium refund applies.
- g. **Your** policy will end if:
- o **You** do not continue to pay **your** premiums on or before the date they are due
 - o **you** stop living in the country stated in the **Schedule**. **You** must inform **us** if **you** stop living in the country stated in the **Schedule**
 - o **you** die.
- h. **Your dependants'** policy will end:
- o if **your** policy ends
 - o if they stop living with **you** at **your** address in the country stated in the **Schedule**
 - o in the case of child **dependants**, immediately following their 24th birthday or
 - o in the case of child **dependants**, if they marry or enter into a civil partnership
 - o if they die.
- i. **You** must inform **us** of any changes to marital status.
- j. If **we** decide to end **your** cover, or **we** do not agree to **your** insurance or the insurance of any of **your dependants** continuing, **we** will write to let **you** know with at least 30 days' notice.
- k. **We** can end someone's policy if **we** have good reason to believe that they have misled **us**, or have attempted to mislead **us**. By this **we** mean giving false information or keeping information from **us** (intentionally or carelessly) which may influence **us** when deciding:
- o whether they or anyone else can take the **policy**
 - o what premiums they have to pay
 - o whether **we** have to pay any claim (see 'Claiming section').

Should **we** end **your** policy due to these reasons **you** will be refunded the proportional premium **you** paid for the remaining period left till expiry.

1.4 Qualifying periods

- a. If **your** cover includes the Maternity and Adoption benefit then please note that a 52-week qualifying period applies before benefits will be payable. A birth or adoption certificate should be provided as supporting evidence for these claims.
- b. No other **qualifying periods** apply to **your** cover.
- c. If **we** agree to increase **your membership level**, for **you** and/or **dependants** there is no qualifying period on this **policy**, other than for the Maternity and Adoption benefit detailed in 1.4 sub-section a.

1.5 Making changes

Changes we can make

- a. **We** may change the terms and conditions of **your** policy upon 30 days' notice.

These changes could affect for example:

- o how much the premiums will be
 - o how often **you** have to pay premiums
 - o the **benefits we** will pay
 - o the terms and conditions governing **your** policy.
- b. **Your** premiums may increase when **we** change the terms and conditions of **your** policy. If you choose to increase your **policy level** then you will need to pay any increase in premiums in order to continue your policy.
- c. **You** may end **your** policy if **you** do not accept the changes and tell **us** this before the end of the 30-day notification period. If **you** do end **your** policy within the 30 days because **you** do not accept the changes, **we** will treat the changes as not having been made and will terminate **your** policy at the end of the 30-day period and, if applicable, will provide a pro-rata refund of premiums from the termination date.

Changes you can make

- d. **You** should call, email or write to tell **us** if **you** change **your** address. If **you** do not contact **us** to tell **us** **you** have changed **your** address **we** will not be able to notify **you** of changes to **your** **policy** and any written communication will be issued to the address **you** last gave **us**.
- e. **You** can change **your policy level** should **your** **policy** allow and **you** meet the criteria set out in section 1.1a. Any increases to your **policy level** will take effect for the remaining period of the policy. Should you wish to cancel your policy during this time you can do so by following the actions outlined in sections 1.3e and 1.3f. Should **you** wish to decrease your **policy level**, **you** can do so by emailing or writing us.
- f. **You** can add or remove partners and/or **dependants** children should **your** **policy** allow and **you** meet the criteria set out in section 1.1.

Other parties

g. No other person is allowed to make or confirm any changes to **your** policy on **our** behalf, or decide not to enforce any of **our** rights.

h. No change to **your** policy will be valid unless it is confirmed in writing by **us**.

1.6 General information

Correspondence and documents

a. Letters between **us** must be sent with the postage costs paid before posting.

We can each assume that the letter will be received seven days after posting, however **we** will still require the physical delivery of postal claim forms in order to process these.

b. All correspondence with **you** and other insured covered under **your** policy, will be sent to **you**.

c. If **you** wish to contact **us**, **we** suggest **you** do that via **your** intermediary.

Applicable law

d. **Your** policy will be governed by English law. Any dispute that cannot otherwise be resolved will be dealt with by the courts of the **United Kingdom**.

1.7 Making a complaint

We are committed to providing **you** with an excellent service at all times and will make every effort to meet the high standards **we** have set. If **you** feel that **you** are dissatisfied in any way, then this is the procedure that **you** should follow.

If **we**, or any of **our** representatives, did not sell **you** this policy and this complaint is about the sale of the policy, please contact the party who sold the policy. If **you** need help or support or if **you** have any comments or complaints, **you** can contact **us** in several ways:

By email: info@klapton.com

Via our website: www.klapton.com.

Please be aware information submitted to **us** via email is normally unsecure and may be copied, read or altered by others before it reaches **us**.

How will we deal with your complaint and how long is this likely to take?

If **we** cannot resolve **your** complaint immediately **we** will write to **you**, within five working days, to acknowledge receipt of **your** complaint.

We will then continue to investigate **your** complaint and aim to send **you our** full written final decision within 15 working days. If **we** are unable to resolve **your** complaint within 15 working days **we** will write to **you** to confirm that **we** are still investigating **your** complaint.

Within eight weeks of receiving **your** complaint **we** will either send **you** a full written final decision detailing the results of **our** investigation or send **you** a letter advising that **we** have been unable to complete the review of **your** complaint.

Your complaint will be dealt with confidentially and will not affect how **we** treat **you** in the future.

Claiming

2.1 Making a claim

a. **You** may claim cash back for treatment which has been paid for and received.

We do not pay any amounts for treatments, goods or services which have not yet been incurred and paid for by the insured. **We** only pay for treatment, goods and services received in the country stated in the **Schedule**. Goods (eg spectacles or contact lenses, including those purchased over the internet) must be provided by a company based and registered in the country stated in the **Schedule**, and you must be invoiced in that country's local currency.

b. In order to make a claim **you** should use **our** Cash Back Plan Claim Form. If you do not have a claim form please contact **your** intermediary to request one in the post.

c. When making claims **you** will need to provide **your** fully completed claim form and a copy of your original itemised receipted account where applicable.

d. All copies of receipts must include the name and contact details of the practitioner, date of the treatment and the name of the person receiving the treatment.

e. **You** must provide any additional information or proof to support **your** claim if **we** make a reasonable request for **you** to do so. For example, **we** may need to ask you for one of the following:

- o medical reports and other information about the treatment for which **you** are claiming
- o the results of any independent medical examination **we** may ask **you** to undergo at **our** expense
- o evidence and details of previous cash back plan cover held if **you** have switched provider to **us**
- o till receipts
- o birth or adoption certificates
- o proof of prescription.

f. Please keep **your** original receipt(s) safe until **your** claim has been paid, in case there is a query.

g. **We** do not pay any amounts **you** may be charged by a **hospital** or doctor or other person for completing **your** claim form. These charges will be **your** responsibility.

h. **We** do not have to pay any claim if **you**, or **your dependants** break any of the terms and conditions of **your** membership guide.

i. If **your** cover includes a 'Consultation' benefit and **you** wish to claim against the cost of a consultation booked with **our** team, then **you** should send **us** the receipt for this as **you** would with any other cash back benefit.

j. **We** will reimburse health insurance excess claims that relate only to eligible health benefits covered by **your** cash back plan. Claims paid for excesses will be deducted from the respective benefit limit to which the claim relates on **your** table of cover.

k. When **you** claim for costs **you** have paid out for treatment **you** need because of an injury or medical condition that was caused by or was the fault of someone else (a 'third party'), for example, an injury suffered in a road accident in which **you** are a victim, all of the following conditions apply when **you** make such a claim:

- o **you** agree **you** are responsible for the payment of any costs (e.g legal costs) which you may ultimately recover from the third party.
- o **you** must notify **us** as soon as possible that **your** treatment was needed as a result of a third party. **You** must provide **us** with any further details that **we** reasonably ask **you** for
- o **you** must take any reasonable steps **we** ask of **you** to recover from the third party the cost of the treatment paid by **us** and claim interest if you are entitled to do so
- o **you** (or your solicitor) must keep **us** fully informed in writing of the progress and outcome of your claim
- o if **you** recover the cost of any treatment paid for by **us**, **you** must repay the amount and any interest to **us**.

l. If **you** hold other insurance cover with **us** or another insurer, including health insurance, which covers the costs of goods, treatments or services that **you** are claiming for under **your** cash back plan, then **you** must provide **us** with full details of this policy or policies as soon as possible.

m. Where the same costs are covered by more than one insurance policy each insurer is only liable to pay its proportionate share of the costs of the overall claim. They will decide this between them.

n. **We** will only pay cash benefits up to the amounts for eligible goods, treatments or services that have been received and paid for by **you**. If part of the costs that **you** have paid are reimbursed by one insurance policy then, in relation to the same costs, **you** will only be entitled to claim from any other insurer for the remaining outstanding amounts **you** have paid (if any). This shall apply to all benefits covered by **your** policy except for the following, where **we** will pay cash benefits in full up to **your** annual policy limits for eligible claims which may have been covered in part or in full by another insurance policy:

- o Hospital in-patient stays
- o Hospital day-case stays
- o Maternity and Adoption benefit claims
- o Funeral benefit claims
- o. If **we** reasonably suspect that **you** have misled **us** or attempted to do so, **we** will not be obliged to pay any claim that the matter relates to and may end **your** membership (and any other insurance policies with **us**). The following list contains examples of practices **we** would class as attempts to mislead **us**, although the list is not exhaustive:

- deliberately giving **us** false information about **you**, a person on **your** policy or a claim on **your** policy
- making any claim under **your** policy where **you** know the claim is false, or is exaggerated in any respect
- making a statement in support of a claim where **you** know the statement is false in any respect
- sending **us** a document in support of a claim where **you** know the document is forged, false or otherwise misleading in any respect
- making claims under more than one insurance policy in order to receive a sum greater than the cost (to **you**) of treatment.

2.2 How we will deal with your claim

- a. Once **we** receive the claim form, if **we** have all the correct information, **we** will aim to pay **your** claim as soon as possible.
- b. **We** will pay the money into **your** nominated bank account.
- c. **We** will also send **you** confirmation that the claim has been paid.
- d. If **we** reject the claim **we** will send **you** notification with an explanation as to why **we** have rejected the claim.
- e. If **we** do not receive the correct or complete information to process **your** claim **we** will contact **you** and request further or correct details. **We** will not be able to pay **your** claim until **we** receive these details and claims will remain open for a maximum of 21 days.

Benefits

Please take a look at **your table of cover** for a list of the specific **benefits** of **your** chosen **policy** and what the **payback criteria** are applied to that **benefit**. Any **benefits** that **you** see described in this policy that are not listed on or are shown as 'not covered' on **your table of cover** are not included in **your policy**. The amount shown on **your table of cover** is the total amount **we** pay for goods/treatments/services received and paid for by **you** or by each **insured** covered under **your** policy during **your benefit year** and not for each type of treatment or service or item charged individually.

We will pay eligible claims in line with **your** terms and conditions when receiving goods/treatments/services, alongside the criteria detailed on **your table of cover** and in this policy up to **your level**, during **your benefit year**.

Dental

We will cover the cost towards:

- o dental services provided by a **dental professional**

We will not cover:

- o any service where the fees that **you** have to pay relate to a dental insurance or treatment plan, whether or not **you** receive any treatment
- o tooth cleaning and tooth whitening materials and kits purchased for home use
- o any medications prescribed or non-prescribed
- o missed appointment or registration fees.
- o administration fees or charges for completing the claims form.

Dental injury

We will cover the cost towards:

- o treatment for a **dental injury** arising as a direct or indirect result of an external impact, which is provided by a **dental professional** except as specified below.

We will not cover:

- o any dental treatment resulting from or related to any injury sustained whilst participating in a physical contact sport including, but not limited to, sports such as rugby or boxing
- o any dental treatment resulting from or related to a deliberate self-inflicted injury
- o any **dental injury** treatment arising as a direct or indirect result of an external impact which occurred before the **inception date**

- o any **dental injury** treatment arising as a direct or indirect result of an external impact which occurred outside the country stated in the **Schedule**
- o administration fees or charges for completing claim forms.

The claim form must be submitted with the details of the accident and the treatment received from the **dental professional**, alongside a fully paid receipt to confirm the treatment has been carried out and paid for.

Optical

We will cover the cost towards:

- o glasses with prescribed lenses, prescribed contact lenses and routine sight tests when provided by a qualified ophthalmic practitioner
- o corrective laser eye treatment carried out by an ophthalmic surgeon who is a **consultant**.

We will not cover:

- o eyewear if they have not been prescribed
- o eyewear without prescribed lenses
- o missed appointment fees
- o optical insurance or plan fees
- o items that are not prescribed or part of a regular prescription such as (but not limited to) solutions, chains, cases
- o administration fees or charges for completing claim forms.

Hospital in-patient

We pay cash benefits for:

- o up to the number of nights per **benefit year** as specified on **your table of cover** for an overnight stay in a **hospital**. **You, your partner or your dependants** must be admitted to a **hospital ward** before midnight on the previous day to qualify as receiving **in-patient treatment**
- o parental stay is payable if **you or your partner** stays overnight in **hospital** with your (or their) child **dependant**, under age 16, whilst the child receives **in-patient treatment**.

We will not pay cash benefits for:

- o geriatric care
- o **in-patient treatment** which is not provided by and where the overall responsibility does not rest with a **consultant**
- o **hospital** admissions arranged for social or domestic reasons
- o convalescence care or **rehabilitation**

- o cosmetic or reconstructive surgery undergone for cosmetic or psychological reasons (however, **we** will pay **benefits** if the treatment is for a surgical operation to restore **insured's** appearance after an accident or surgery for cancer)
- o the first 10 nights of **the insured's** maternity in-patient **hospital** stay
- o a **hospital** attendance for casualty or emergency treatment which does not require a formal admission to a **hospital** bed
- o mental health or addictive conditions.
- o administration fees or charges for completing the claims form.

Hospital day care

We will pay cash benefits for:

- o up to the number of days per **benefit year** as specified on **your table of cover** for day-patient admissions for treatment or investigation.

We will not pay cash benefits for:

- o cosmetic or reconstructive surgery undergone for cosmetic or psychological reasons (however, **we** will pay **benefits** if the treatment is for a surgical operation to restore the insured's appearance after an accident or surgery for cancer)
- o a **hospital** attendance for casualty or emergency treatment, which does not require a formal admission to a **hospital** bed
- o any admissions that are not classed as day-case eg treatment not in a **hospital**, respite care, out-patient check-ups, out-patient scans
- o administration fees or charges for completing the claims form
- o claims made for laser eye surgery. This can be claimed under the Optical benefit only.

Physiotherapy

We will cover the cost towards:

- o physiotherapy treatment services provided by an **physiotherapist**.

We will not cover:

- o associated prescription fees or medication
- o administration fees or charges for completing the claims form.

Osteopathy

We will cover the cost towards:

- o osteopathy treatment services provided by an **osteopath**

We will not cover:

- o associated prescription fees or medication
- o administration fees or charges for completing claim forms.

Chiropractic

We will cover the cost towards:

- o chiropractic treatment services provided by a **chiropractor**

We will not cover:

- o associated prescription fees or medication
- o administration fees or charges for completing claim forms.

Reflexology

We will cover the cost towards:

- o reflexology treatment services provided by a **reflexologist**.

We will not cover:

- o associated prescription fees or medication
- o administration fees or charges for completing claim forms.

Acupuncture

We will cover the cost towards:

- o acupuncture treatment services provided by an **acupuncturist**.

We will not cover:

- o associated prescription fees or medication
- o administration fees or charges for completing claim forms.

Chiropody/Podiatry

We will cover the cost towards:

- o chiropody/podiatry treatment provided by a **chiropodist/podiatrist**

- o any items recommended or prescribed by a **chiropodist/podiatrist**
- o administration fees or charges for completing claim forms.

We will not cover:

- o associated prescription fees or medication
- o sundry items such as insoles that are not recommended or prescribed by a **chiropodist/podiatrist**

Note: items that have been prescribed or recommended **we** require written confirmation from the **chiropodist/podiatrist** to be able to pay your claim

Homeopathy

We will cover the cost towards:

- o homeopathy treatment services provided by a **homeopath practitioner**

We will not cover:

- o associated prescription fees or medication
- o administration fees or charges for completing claim forms.

Prescriptions

We will cover the cost towards:

- o prescription charges paid for a prescription provided by a **General Practitioner**,

Dental Professional or Consultant

We will cover the cost towards:

- o prescription prepayment certificates.

We will not cover:

- o administration fees in relation to a prescription
- o administration fees or charges for completing claim forms.

Note: one of the following needs to be sent to **us** accompanying the claim form

- o counterfoil from prescription
- o All till receipts including those with labels from medication to accompany all claims

Consultations

We will cover the cost towards:

- o consultations with a **consultant** (by a consultation **we** mean a meeting with a **consultant** to assess **your** condition)
- o consultations **you, your partner** or **your dependants** have with a **dietician, therapist** or **occupational therapist** recognised by **us**

We will not cover:

- o the costs of any diagnostic tests under this benefit (except for those for conditions linked to or related to fertility treatment)
- o any radiologist's fees
- o a general GP appointment
- o non-health related consultations
- o administration fees or charges for completing the claims form.

Diagnostic tests or scans

We will cover the cost towards:

- o diagnostic tests and scans requested by **your consultant** to help determine or assess **your** condition as part of an out-patient investigation. **We** will require a letter from **your consultant**, along with **your** claim form stating that the test is to determine or assess **your** condition as part of an out-patient investigation

We will not cover:

- o the cost of diagnostic tests or scans for conditions linked or related to fertility treatment – which are covered under the Consultation benefit
- o any test performed as part of health screens, routine tests, health tests or wellness reviews
- o any tests done as part of an in-patient or day-case procedure
- o any services provided by an orthodontist
- o administration fees or charges for completing claim forms

Maternity and adoption

We pay the amount to **you** (up to the maximum set out for **your level**) for each new child born or adopted by **you** during **your benefit year** and subject to the 52 week **qualifying period**.

Maternity note:

- o enclose a full copy of the birth certificate (as issued by the registry office) with **your** claim form. For **you** to claim **your** name must be on the birth certificate.

Adoption note:

- o enclose an adoption certificate with **your** claim form. For **you** to claim **your** name must be on the adoption certificate
- o adoption **benefit** may not be claimed in respect of children aged 16 years or over.

Allergy testing

We will cover the cost towards:

- o private diagnostic tests performed by a **consultant**, directly related to the investigation of allergies,

We will not cover:

- o treatment or medication charges
- o home testing kits
- o administration fees or charges for completing claim forms

Medical Devices

We will cover the cost towards:

- o **Medical Devices** that are recommended for **you, your partner** or **your dependants** by a **GP, consultant, physiotherapist, osteopath, chiropractor, acupuncturist** or **chiroprapist/podiatrist** or **hospital** mastectomy wear and wigs as a result of treatment for cancer

Note – Any claim for this **benefit** (excluding mastectomy wear and wigs as a result of treatment for cancer) must be accompanied by a note from **your GP, a hospital** or an accredited medical professional confirming that the device is a medical necessity.

We will not cover:

- o devices that are not deemed a medical necessity by a GP, hospital or accredited medical professional
- o administration fees in relation to the issuing of the device
- o administration fees or charges for completing claim forms

Flu jabs

We will cover the cost towards:

- o Flu vaccination charges

We will not cover:

- o administration fees in relation to vaccine
- o administration fees or charges for completing claim forms

Note: one of the following needs to be sent to us accompanying the claim form

- o counterfoil from prescription
- o all till receipts including those with labels from medication

Health assessment

We will cover the cost towards

- o the following health assessments carried out:
 - Health Core
 - Health Focus
 - Health Enhanced

We will not cover:

- o health assessments where **you** do not incur a receipted charge for the service.

Health screening

We will cover the costs towards

- o health assessments carried out in a hospital or health screening centre

We will not cover

- o online health assessments
- o health assessments not carried out in a hospital or health screening centre

Home help

We will cover, for main insured only, the costs towards:

- o home help services required by you and provided by local authority services, social services or an authorised agent of these bodies at **your** home address.

Recuperation at home

We will cover, for main insured only, the costs towards:

- o home recuperation expenses that are recognised as a medical necessity by a local authority service, social service, hospital, GP or an authorised agent of these bodies at **your** home address.

Funeral grants

Upon the death of a policy's main insured, **we** will pay funeral grants where:

- o proof of death has been provided and attested by a coroner, a mortician, a GP, a hospital or an otherwise recognised medical professional.

We will not pay funeral grants where:

- o proof of death cannot be established by a coroner, a mortician, a GP, a hospital or an otherwise recognised medical professional.
- o death has been self-inflicted
- o death has been caused by a result of gross negligence on the part of the deceased party.

Personal accident

If **you** suffer any of the following while covered under this Cash Back Plan, **we** will pay up to the share shown below, up to an overall maximum stated in the **Schedule** for each of **you** in respect of accidental bodily injury resulting in:

Type of Injury	Annual Benefit Limit
Accidental death	Up to 80%
Permanent total disablement	Up to 80%
Permanent and incurable paralysis of all limbs	Up to 80%
Permanent and incurable insanity	Up to 80%
Loss of sight in both eyes	Up to 80%
Loss of or loss of use of both hands or feet	Up to 80%
Loss of sight in one eye	Up to 40%
Loss of or loss of use of one hand or foot	Up to 40%
Loss of hearing in	Both ears: up to 40% One ear: up to 11%
Loss of or loss of use of the lens of one eye	Up to 20%
Loss of or loss of use of four fingers & thumb of either hand	Up to 35%
Loss of or loss of use of four fingers on one hand	Up to 15%
Loss of or loss of use of thumb of either hand	Both joints: up to 15% One joint: up to 7%
Loss of or loss of use of fingers on either hand	Three joints: up to 4% Two joints: up to 3% One joint: up to 1%
Loss of or loss of use of toes	All – one foot: up to 11% Big – both joints: up to 4% Big – one joint: up to 2% Other, each complete toe: up to 2%
Established non-union of fractured leg or knee cap	Up to 8%
Shortening of leg by at least Five centimetres	Up to 6%
Funeral expenses following accidental death	Up to 15%
Total and Maximum Overall Limit under this cover	Up to 100%

Personal accident definitions

Accident – a sudden unforeseen and fortuitous identifiable event and the word accidental shall be construed accordingly.

Bodily injury – injury to **you** which solely and independently of any other cause results within 24 months of the date of the Accident in your Death, Permanent Disability, fracture or break of a specified bone or bones. Bodily Injury excludes any condition resulting from any gradually operating cause or degenerative process.

Country of permanent residence – the country where you reside indefinitely or where you have the intent to reside indefinitely.

Disappearance – if you disappear and it is reasonable to believe that you have sustained Bodily Injury resulting in Death during the Operative Time the Accidental Death **benefit** shall become payable. In the event of this belief being incorrect the Accidental Death **benefit** shall be repaid to **us**.

Effective date – the inception date stated in the **Schedule**.

Event – any one occurrence or all occurrences of a series consequent upon or attributable to one source or original cause.

Exposure – death or injury to you as a direct result of unavoidable exposure to the elements shall be deemed to have been caused by Bodily Injury.

You – any person who is insured under this policy which includes **Personal Accident Insurance Benefits**, including your **partner** if a **Partner Scheme** option has been opted for.

Loss of Hearing – total, permanent and irrecoverable loss of hearing.

Loss of Sight – the total and irrecoverable loss of sight when the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.

Operative Time – 24 hours a day.

Personal accident exclusions

We will not pay for:

- o Bodily Injury resulting directly or indirectly from or contributed to by:
 - a. you engaging in active service in the armed forces of any nation;
 - b. you committing or attempting to commit suicide or intentionally inflicting self injury;
 - c. you engaging in flying or other aerial activity other than as a passenger;
 - d. sickness, disease, any naturally occurring condition or any gradually operating cause;
 - e. war within the your Country of Permanent Residence
 - f. you participating in any sport as a professional;
- o Any disabilities caused by or arising from Post Traumatic Stress Disorder, other than as a direct result of Accidental Bodily Injury caused by an Event.

Claims Procedure

Written notice should be submitted by **you** or **your** personal representative to **us** within three months of any **accident**. **You** will fill out a claim form for filing proof of claim.

Any document or evidence reasonably **we** required to verify the claim shall be provided by **you** or **your** personal representative at your personal expense. Any medical examination required by **us** to prove the claim will be at **our** expense.



KLAPTON CASH BACK PLAN POLICY

Payment of benefit

Any payment due under this policy will be paid to **you**, if living, otherwise to **your** personal representative within 21 days of the claim being substantiated to **our** satisfaction. Any receipt which **you**, anyone acting on the **your** behalf or **your** representative may provide to **us** for **benefits** payable under this policy shall be a final and complete discharge of **our** liability in respect of such **benefit**.

Arbitration

If any dispute or difference arises between **us** and **you** concerning any matter arising out of this policy such matter shall be referred to two arbitrators (who shall be disinterested parties) one appointed by **us** and one by **you**. The award of such arbitrators or their umpire shall be binding on all parties.

Glossary

Understanding **your policy and plan** can be complicated, so in this glossary you'll find a clear definition of the terms used in bold throughout the policy. This will help **you** to clearly understand what **we** mean when **we** use these terms.

Acupuncturist acupuncturist means an acupuncturist, **recognised by us** or duly registered as a Member or Fellow of a professional guild or on a national registry, at the time you receive your treatment.

Agreement means the agreement between **us** and **you** under which **we** have accepted **you** as an insured under this policy.

Benefit means the individual benefits set out in section 3 – **Benefits**.

Benefit limits means the maximum amount that **we** will pay for a benefit under **your** cash back plan cover during a **benefit year**. **Your** benefit limits are outlined on **your table of cover or your schedule**.

Benefit year means a period commencing on **your inception date** and ending not later than your **expiry date**.

Chiropodist/podiatrist means a person, **recognised by us** or registered as a chiropodist/ podiatrist Member or Fellow of a professional guild or on a national registry, at the time **you** receive **your** treatment.

Chiropractor means a chiropractor, **recognised by us** or registered as a Member or Fellow of a professional guild or on a national registry, at the time **you** receive **your** treatment.

Consultant means a consultant licensed and registered Member or Fellow of a professional guild or on a national registry.

Dental injury means dental treatment that is carried out in the country stated in **your schedule** which is required as a direct result of injury caused by an external impact.

Dental professional means anyone that is registered with the proper registry and is licensed and permitted to practice at the country stated in **your schedule**.

Dependants means **your** partner and any child of **yours** or **your** partner's who is insured under this policy and named on **your schedule**.

Dietician means a person recognised by us or registered as a dietician with a professional guild or on a national registry, at the time you receive your treatment.

General Practitioner/GP means a doctor who is on the local registry as a general practitioner, and is duly licensed and permitted to conduct this practice.

Level means the level of cover chosen by you as insured and which determines your benefit entitlement.

Hospital means any hospital or private hospital which has facilities for major surgery or which exists principally for the provision of treatment by **consultants**.

Insured means the person listed in the **Schedule** as **Insured**.

Osteopath means an osteopath, recognised or registered as a member of the guild or association or the required registry in the country listed in the **Schedule** at the time **you** receive **your** treatment.

Our/us/we means Klapton Insurance Company Limited. The insurer of this policy.

Partner means **your** husband, wife or civil partner (or the person **you** live with in a relationship similar to that of a husband or wife whether same sex or not).

Medical device any instrument, apparatus, appliance, material or other article, for the use of:

- o Diagnosis, prevention, monitoring, treatment or alleviation of disease, injury or handicap,
- o Investigation, replacement or modification of the anatomy or of a physiological process.

Payback criteria means the percentage amount of the receipted claim up to the benefit limit.

Physiotherapist means a person, recognised by **us** or registered as a **physiotherapist** with a guild or association or required registry, at the time **you** receive **your** treatment and permitted to practice as Physiotherapist

Plan means any cash back plan type **policy** administered by **us**.

Qualifying period means a period of time that must elapse before **we** will accept claims for particular **benefits**. This applies on an individual basis from the date **you** join the policy or from the date of upgrade with regards to increased **benefit levels**. **Reflexologist** means a person **recognised by us** or registered as a reflexologist with an Association of Reflexologists, or The International Federation of Reflexologists or the British Association of Reflexology

Inception date means the inception date shown in the **Schedule**.

Rehabilitation means treatment and or services aimed at restoring health or mobility, or to allow a person to live an independent life, such as after a stroke.

Schedule means the details document where you are specified and your cover details are listed.

Table of cover the table of cover **we** issue sets out the levels of cover of the **policy** and the maximum **benefits** payable for each level of cover.

Therapist means a person recognised by us or registered as a therapist with the required registry, permitted and licensed to practice, at the time you receive your treatment.

Your when printed in bold type – ie **you/your** this means **you**, the **main insured** only who has taken out the policy, and to whom **we** send the notifications. When printed in plain type ie you/your **we** mean you, the **main insured, your partner** and **your dependants**.

Privacy notice

Confidentiality: The confidentiality of patient and insured information is of paramount concern to us. Sometimes we use third parties to process data on our behalf. Such processing, which may be outside of the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security, in addition to the obligations imposed by data protection legislation.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care.

Audit of medical and billing information: When we process claims or investigate complaints on your behalf, we may request and obtain further details from your treatment provider. The information may be sought either at the time of processing or subsequently, for the purposes of ensuring the accuracy of information and the quality of treatment and care. Please note it is a term and condition of your policy that we may obtain medical and billing information from your treatment provider relating to claims or complaints you may make.

Insured's details: All documents and confirmation of how we have dealt with any claim you may make will be sent to the main insured. Your policy and contact details may be shared by us group to enable us to manage our relationship with you as a customer and update and improve our records. Depending on how your cover or policy has been funded or introduced, we may share information with your employer and or an appointed intermediary, solely for policy administration purposes. We do not make the names, addresses and other contact details of our insured available to any other organisations to use for their own purposes.

Telephone calls: In the interest of continuously improving our services to members, calls may be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by us, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to detecting and/or preventing fraudulent or improper claims.