

~ Saint John's Hospital Cash Plan ~

Cash Plan Medical Cover

Information Pack

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# Saint John's Insurance Private Medical Cover

This membership guide applies to anyone joining the scheme on or after 1st February 2008.

Please contact us via [info@stjohnsinsurance.com.mt](mailto:info@stjohnsinsurance.com.mt) for all enquiries.

General rules and benefits are with effect from the date *you* join. All terms and conditions apply until further notice.

*You* might need to refer to the Benefits section of this pack and *your membership letter* when reading the following section.

## I. General rules

Please refer to the **glossary** section for the meaning of the terms in *bold and italic* as they have a specific meaning in this information pack.

### 1. Introduction

This Cash Plan Scheme is a group cover scheme, which is regulated by an *agreement* between the *sponsor* and *us*. *We* have appointed **Saint John's Insurance** to be responsible for the administration of the scheme. **John's Hospital Cash Plan** will vet and pay claims, according to the terms and conditions of *your membership*, on *our* behalf.

### 2. Memberships

To be eligible as a member of this scheme, *you* have to be

- *UK* resident
- aged between 16 and 65
- a current employee of the *sponsor*.

*You* can only become a member of this scheme with the *sponsor's* agreement. However, *we* do not have to accept *you* as a member. *We* will provide written confirmation if *you* are rejected.

Under no circumstances should any member be registered with more than one Saint John's Hospital Cash type products.

### 3. Starting and continuing your memberships

*Your membership* and *your benefit year* start from the date of *your registration*.

*Your membership* would be renewed automatically on a weekly basis, provided that *your sponsor* continues to pay for *your* subscription promptly.

#### 4. Ending membership

*You* may end *your membership* at any time by providing *your sponsor* with written notice.

If *your membership* ends and restarts either within the *benefit year* or within 3 weeks of the end of that *benefit year*, the date of *your registration* will remain unchanged and no cover, other than in the circumstances set out in *benefit* 3-7, will be provided for the period during which *you* were not a *member*. The date *your membership* restarts under these circumstances will NOT become *your* new date of *registration*.

*Your membership* will end immediately if

- *we* notify *your sponsor our* intention to do so
- *our agreement* with the *sponsor* ends for any reasons
- *you* stop living in the *UK*
- *you* die

*We* can also end *your membership* if *we* have good reason to believe that *we* have been given misleading and/or false information (including information being carelessly or intentionally kept from *us*), which may have influenced the decision to accept *you* onto the scheme, on the amount *you* have to pay for subscriptions and/or on the amount which *you* are entitled to claim.

*We* will not refuse to renew *your* membership for reasons relating to any changes in *your* health state that occurs after *you* have become a member of *our* Cash Plan Scheme, or the number of claims that *you* have made since the inception of *membership*.

#### 5. Subscriptions

Subscriptions are not paid until *we* receive the full payment. Payment should reach *us* on or before the due date.

#### 6. Paying benefits

Claims for treatment and services can only be made while *you* are on the scheme, except in the case of *Benefits* 3-7, 14 and 15. Please see the relevant notes in the **Benefits** section for details.

*Benefits* are paid with reference to *your membership's* terms and conditions that were in effect at the time *you* received the treatment/services.

All *benefits* are subject to **General rule** 7 and 8 and the maximum payment amounts defined in this pack (See **Benefits** section). These amounts are the maximum amount *we* would pay in any given *benefit year*.

If any part of the first *benefit year* for *your membership* falls within 12 months of *you* ceasing to be a member of any other Saint John's Hospital Cash Plan type products,

*we* will treat any *benefits you* received under the scheme as falling within the first *benefit year* of *your* current *membership* (unless otherwise agreed).

*We* are responsible for payment of all *benefits* except *benefit 20*. Although *benefit 20* is payable by the *personal accident insurer*, *we* will deal with all initial enquiries on this *benefit* and arrange payment on behalf of the *personal accident insurer*. This arrangement with the *personal accident insurer* is made under a Master Policy in Insurance for the benefit of *our* Insurance Cash Plan *members*.

If *you* have submitted a claim relating to a week *we* have not yet received payment for, *we* will hold payment of the claim for a maximum of two weeks. *We* will reject the claim after two missed subscription payments.

## **7. Benefit limits**

The *Benefit* limits shown in the **Benefits** section are the maximum amount *you* can claim for any treatment or service as specified in the **Benefits** section.

*You* may claim up to 80 nights in hospital in relation to *benefit 3* to *6* in any *benefit year*. This is the overall total number of nights that *you* may claim collectively and not for individual *benefit*. There are also individual limits and other restrictions to these *benefits*. Please refer to the **Benefits** section for further information.

## **8. General exclusions**

Please be aware that there are certain conditions that are not covered by this Cash Plan Scheme.

Please read the following section carefully.

Pre-existing conditions

*We* will not pay *benefits 3* to *8* for a *pre-existing condition* or a condition which results from or is related to a *pre-existing condition*.

Chronic conditions

*We* will not pay *benefits 4-8* for *chronic conditions*.

*We* will only pay *benefit 3* for a single period of treatment, up to a maximum of 21 consecutive nights once, during any *member's* lifetime and *membership* of this, or any other **Saint John's Hospital** Cash type products, even if there is a break in their cover or they rejoin the scheme, when the treatment or services they receive is for a *chronic condition*, or which result from or relate to a *chronic condition*.

Other general exclusions

*We* will not pay *benefits 3-8* for treatment or services *you* receive if they are for, or relate to, or arise out of any of the following:

- Geriatric care
- **Convalescence care** or **rehabilitation**
- The first 10 nights of a **member's** maternity in-patient hospital stay
- Hospital admissions arranged for social or domestic reasons
- A hospital attendance for casualty or emergency treatment which does not require a formal admission to a hospital bed
- **In-patient treatment** which is not provided by and where the overall responsibility does not rest with a **consultant**
- 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 a **member's** appearance after an accident or surgery for cancer)

## 9. Making a claim

In order to make a claim, **you** must complete the claim form **we** provide. Claim forms can be found in the Appendices of this pack or are available upon request.

In order to make a successful claim, **you** should send **us your** fully completed claim form and all relevant receipts within 90 days, i.e. from the date **you** received the treatments/services **you** intend to claim. Exception is rare unless written evidence is provided.

**We** may ask **you** to provide proof to support **your** claim. For example, medical reports and other information about the treatment for which a **member** is claiming; or the results of any independent medical examination **we** may ask a **member** to undergo at **our** expense.

**We** cannot accept copied receipts or original receipts which have been altered.

**We** would not pay any amount **you** are charged by a hospital or doctor or other person for filling in **your** claim form.

**We** do not have to pay any claim if **you** have violated any of the terms and conditions of **your membership**.

## 10. Making changes

**We** may make changes of the terms and conditions of **your membership** including **your** cover upon 60 days' notice.

**We** may, with the agreement of **your sponsor**, vary any of the terms of **our agreement** with **your sponsor** at any time.

**We** may, with the agreement of **your sponsor**, cancel **our agreement** with **your sponsor** at any time.

**We** will write to **your sponsor** at least 60 days before **we** change terms of **our agreement**.

## 11. General information

*Your membership* is regulated by English law. Any dispute that cannot be resolved otherwise will be dealt with by the courts of the *U.K.*

Please inform *us* the change of address as soon as possible as all correspondence to do with *you* will be sent to the address *your sponsor* last gave *us*.

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

*We* do not normally return the claimed receipts. However, we will return *your* receipts to *you* if *you* request at the time when *you* are making the claim and enclose a stamped and addressed envelop.

Only *you* can make or confirm any changes to *your membership*.

Only the *sponsor* and *us* have legal rights under this *agreement*. This means that only the *sponsor* or *us* may endorse the agreement. Nonetheless, *we* will allow anyone covered to have complete access to *our* complaint process.

*We* reserve *our* right to take legal action in the future if necessary.

## 12. Data protection

Confidentiality: *We* value the confidentiality of patient and member information. *We*, therefore, strongly adhere to the Data Protection Legislation and Medical Confidentiality Guidelines.

*We* may use third parties to process data on its behalf. Such processing, although may be carried out outside the EEA, is subject to contracted restrictions with regard to confidentiality and security. In addition, *we* are aware of *our* obligations imposed by the Data Protection Act.

Member details: All *membership* documents and confirmation of how *we* have dealt with *your* requests/claims will be sent to *you* and *you* only.

Telephone calls: For quality control and training purposes, calls may be recorded and monitored.

Personal information: Aggregated data may be used by *us*, or disclosed to others, for research purposes. *We* will ensure *your* names remain anonymous under all circumstances.

Fraud information may be disclosed to others with a view to prevent fraudulent or improper claims.

Names and addresses: *We* do not make names and addresses of members available to other organisations outside the **John's Insurance Limited**.

Keeping you informed: **Saint John's Insurance Limited** would contact *you* to promote *our* projects and services which *we* believe is of interest to *you*.

Contact address: Please write to **Saint John's Insurance Limited** if *you* do not wish to receive information about *our* products and services.

### **13. Complaints procedure**

*We* are always pleased to hear from *you*. *We* have a simple procedure to ensure *your* opinion are responded to in a timely and effective manner.

#### Getting in touch

**Saint John's Insurance Limited** should always be your first point of contact. Please email us via [info@stjohnsinsurance.com.mt](mailto:info@stjohnsinsurance.com.mt) for help and support.

#### Making a complaint

If *we* have not be able to meet *your* requirement and *you* wish to take the issue further, *you* can contact *us* and request for a full copy of *our* complaints procedure.

It is very rare that *we* cannot settle a complaint, however, if it does happen, you may contact the **Financial Ombudsman Service** by writing to them at South Quay Plaza, 183 Marsh Wall, London E14 9SH or calling them on 0845 020 1800.

Please note none of these procedures will affect *your* legal rights.

## **II. Benefits**

### **Notes on benefits**

The following section explains fully the *benefits you* are entitled under *your membership*.

*We* only pay for treatments and services received in the **UK** except to the extent that these are covered under *benefit 6* (Worldwide Emergency Cover).

For all claims, *you* will need to send *us your* fully completed claim form and original receipts, where applicable.

#### Benefit 1 - Dental

Dental *benefit*: *We* pay 50%, up to a maximum of £52, of the amount *you* pay for the dental services set out below, which *you* receive during *your benefit year*.

#### Dental note

The dental *benefit* sets out the total amount *we* pay for all dental services during *your benefit year* NOT for each type of service or item charged individually.

## Dental services

Dental treatment or dental check-ups provided by a dentist in the *UK*.

Dental services do not include any service where the fees that *you* have to pay relate to a dental treatment plan whether or not *you* receive any treatment.

## Benefit 2 – Optical

Optical *benefit*: *We* pay 50%, up to a maximum of £47, of the amount *you* pay for the optical services set out below, which *you* receive during *your benefit year*.

### Optical note

The optical *benefit* sets out the total amount *we* pay for all optical services received by *you* during *your benefit year* and NOT for each type of service or item charged individually.

### Optical services

- Prescribed glasses, contact lenses and routine sight tests when provided by a qualified ophthalmic practitioner.
- Corrective laser eye treatment carried out by an ophthalmic surgeon who is a *consultant*. Please contact *us* if *you* want to know if *your* consultant is recognised by *us*.

### Optical services do not include

- Industrial spectacles if they have not been prescribed
- Sunglasses without prescribed lenses
- Lens solution, cleaning materials, and other optical accessories

## Benefit 3 – Hospital in-patient

Hospital in-patient *benefit*: *We* pay £17.50 for each night *you* receive *in-patient treatment* during *your benefit year*.

If *your membership* ends in the circumstances stated in **General Rule 4**, *we* will pay this *benefit* during the period *you* are not a *member* if the treatment or services for which *you* are claiming have been received within 3 weeks of the end of *your* last period of *membership*.

### In-patient note

*In-patient treatment* must be provided by and the overall responsibility must rest with a *consultant*. *We* will not pay this *benefit* if the *in-patient treatment* is for, or relates to or results from, a psychiatric or addictive condition. Please see *benefit 5*.

Please refer to section 7 for *benefit* limits.

## Benefit 4 - Hospital parental stay

Hospital parental stay **benefit**: *We* pay £10.00 for each night **you** stay overnight in hospital with a child (under the age of 12, who lives with **you** at **your** address) whilst the child receives **in-patient treatment** up to the maximum set out during **your benefit year**.

If **your membership** ends in the circumstances stated in **General Rule 4**, *we* will pay this **benefit** during the period **you** are not a **member** if the treatment or services for which **you** are claiming have been received within 3 weeks of the end of **your** last period of **membership**.

#### Benefit 5 - Hospital mental health

Hospital mental health **benefit**: *We* pay £17.50 for each night **you** spend in a hospital for **in-patient treatment** due to psychiatric or addictive conditions, including alcoholism, drug addiction and eating disorders which **you** receive during **your benefit year**.

If **your membership** ends in the circumstances stated in **General Rule 4**, *we* will pay this **benefit** during the period **you** are not a **member** if the treatment or services for which **you** are claiming have been received within 3 weeks of the end of **your** last period of **membership**.

Hospital mental health note

Only one claim for this **benefit** may be made for any **member** during their lifetime and **membership** of this, or any other **Saint John's Hospital Cash Plan** type product, even if there is a break in their cover and they rejoin the scheme.

**In-patient treatment** must be provided by and the overall responsibility must rest with a **consultant**.

*We* will pay this **benefit** for up to a maximum of 21 nights only and only if **you** are in a psychiatric hospital or a psychiatric unit of a hospital.

If **your membership** ends in the circumstances stated in **General Rule 4**, *we* will pay this **benefit** during the period **you** are not a **member** if the treatment or services for which **you** are claiming have been received within 3 weeks of the end of **your** last period of **membership**.

*We* will pay this **benefit** instead of and not in addition to **benefit 3**.

Please refer to **General Rule 7** for **benefit** limits.

#### Benefit 6 – Worldwide emergency cover

Worldwide emergency cover **benefit**: *We* will pay **benefit 3** to **5** in accordance with the amount shown (up to the maximum set out) if **you** receive **in-patient treatment** overseas resulting from an emergency whilst on a holiday, the intended duration of which did not exceed 28 days **during your benefit year**.

If ***your membership*** ends in the circumstances stated in **General Rule 4**, ***we*** will pay this ***benefit*** during the period ***you*** are not a ***member*** if the treatment or services for which ***you*** are claiming have been received within 3 weeks of the end of ***your*** last period of ***membership***.

Worldwide emergency cover note

Please refer to the ***Benefit Notes*** for ***benefit*** 3 to 5 to confirm what ***we*** will pay for hospital stays whilst ***you*** are abroad.

Any ***benefits*** paid under ***benefits*** 6 will count towards the total number of nights of ***in-patient treatment*** for which ***we*** will pay ***benefit*** 3 to 5.

Please refer to **General Rule 7** for ***benefit*** limits.

#### Benefit 7 – Hospital day patient surgery

Hospital day-patient surgery ***benefit***: ***We*** will pay £17.50 to ***you*** for each day-patient admission for surgery that requires the use of an operating theatre during ***your benefit year***.

If ***your membership*** ends in the circumstances stated in **General Rule 4**, ***we*** will pay this ***benefit*** during the period ***you*** are not a ***member*** if the treatment or services for which ***you*** are claiming have been received within 3 weeks of the end of ***your*** last period of ***membership***.

Hospital day-patient surgery note

- ***We*** will pay for up to a maximum of 10 day-patient surgery admissions during ***your benefit year***.

#### Benefit 8 - Recuperation grant

Recuperation grant ***benefit***: ***We*** pay a £60 grant if ***you*** have to stay in hospital to receive ***in-patient treatment*** for 14 or more consecutive nights during ***your benefit year***.

Recuperation grant note

This ***benefit*** is payable to ***you*** only once during ***your benefit year***.

#### Benefit 9 – Physiotherapy, osteopathy, chiropractic & acupuncture

***Therapy benefit***: ***We*** pay 50%, up to a maximum of £150, of the amount ***you*** pay for the ***therapy*** services set out below which ***you*** receive during ***your benefit year***.

Physiotherapy, osteopathy, chiropractic & acupuncture services

Services provided by a ***physiotherapist, osteopath, chiropractor, or acupuncturist***.

Physiotherapy, osteopathy, chiropractic & acupuncture note

The **benefit** above sets out the total amount **we** pay **you** for all physiotherapy, osteopathy, chiropractic, and acupuncture **benefits** received by **you** during each **benefit year** and **NOT** for each type of service or item charged individually.

Treatment must be provided by a **physiotherapist, osteopath, chiropractor, or acupuncturist**, recognised by **us**. Please contact us if **you** want to know if a practitioner is recognised by **us**.

#### Benefit 10 - Chiropody

Chiropody **benefit: We** pay 50%, up to a maximum of £48, of the amount **you** pay for the chiropody services set out below which **you** receive during **your benefit year**.

Chiropody services

Chiropody treatment provided by a **chiropodist**.

Chiropody note

The chiropody **benefit** above sets out the total amount **we** pay for all chiropody **benefits** received by **you** during **your benefit year** and **NOT** for each type of service or item charged individually.

#### Benefit 11 - Homoeopathy

Homoeopathy **benefit: We** pay 50%, up to a maximum of £48, of the amount **you** pay for the homoeopathy services set out below which **you** receive during **your benefit year**.

Homoeopathy services

Homoeopathy treatment provided by a **homoeopath**.

Homoeopathy note

The homoeopathy **benefit** above sets out the total amount **we** pay for all homoeopathy **benefits** received by **you** during **your benefit year** and **NOT** for each type of service or item charged individually.

#### Benefit 12 - Occupational therapy and dietician

Occupational therapy and dietician **benefit: We** pay 50%, up to a maximum of £48, of the amount **you** pay for the occupational therapy and dietician services set out below which **you** receive during **your benefit year**.

Occupational therapy and dietician note

The occupational therapy and dietician **benefit** above sets out the total amount **we** pay for all occupational therapy and dietician **benefits** received by **you** during **your benefit year** and **NOT** for each type of service or item charged individually.

Treatment must be provided by an occupational therapist or dietician recognised by **us**. Please contact us if **you** want to know if a practitioner is recognised by **us**.

### Benefit 13 - Consultation

Consultation **benefit**: **We** pay 50%, up to a maximum of £105, of the amount **you** pay for the consultation services set out below which **you** receive during **your benefit year**.

Consultation note

The consultation **benefit** above sets out the total amount **we** pay for all consultation **benefits** received by **you** during each **benefit year** and **NOT** for each type of service or item charged individually.

Consultation services

**We** will pay **benefit** for:

- consultations **you** have with a **consultant** (by a consultation **we** mean a meeting with a **consultant** to assess **your** condition).
- hospital charges for X-rays, but excluding other radiological investigation such as MRI scans;
- a consultant radiologist's fees for reporting on X-rays for **you** but excluding reports on other radiological investigations such as MRI scans.

### Benefit 14 - Maternity

Maternity **benefit** : **We** pay £100 to **you**, for each child born to **you** during **your benefit year** and subject to the following qualifying period. To be eligible for this **benefit you** must have been a **member** for at least 6 months during the 12 months immediately preceding the birth of **your** child.

Maternity note

Please enclose a full birth certificate (as issued by the registry office) with **your** claim form.

### Benefit 15 - Adoption

Adoption **benefit** : **We** pay £100 to **you**, for each child under the age of 16 adopted by **you** during **your benefit year** and subject to the following qualifying period. To be eligible for this **benefit you** must have been a **member** for at least 6 months during the 12 months immediately preceding the adoption of **your** child.

Adoption note

- **We** will only pay if **you** are not the natural parent of the child. **You** should enclose an adoption certificate with **your** claims form. For **you** to claim **your** name must be on the certificate.

#### Benefit 16 - Infertility (diagnostics)

Infertility (diagnostics) **benefit**: **We** pay 50%, up to a maximum of £50, of the amount **you** pay for private diagnostic tests directly related to treatment for infertility that **you** receive during **your benefit year**.

#### Infertility note

The infertility **benefit** above sets out the total amount **we** pay for all infertility **benefits** received by **you** during **your benefit year** and not for each type of service or item charged individually.

#### Benefit 17 - Audiology

Audiology **benefit**: **We** pay 50%, up to a maximum of £45, of the amount **you** pay for hearing appliances prescribed for **you** by a qualified **audiologist** to correct **your** hearing during **your benefit year**.

#### Audiology services

Hearing appliances prescribed by a qualified **audiologist** to correct hearing.

#### Audiology note

The audiology **benefit** sets out the total amount **we** pay for all audiology **benefits** received by **you** during **your benefit year** and NOT for each type of service or item charged individually.

**We** will not pay for the repair of hearing aids or for the purchase of batteries for hearing aids.

#### Benefit 18 - Surgical appliances

Surgical appliance **benefit**: **We** will pay 50%, up to a maximum of £45, of the amount **you** pay for a wearable surgical appliance, such as a wig or a truss, when it is prescribed for **you** by a **GP** or hospital during **your benefit year**.

#### Surgical appliances note

The surgical appliance **benefit** above sets out the total amount **we** pay for all surgical appliances **benefits** received by **you** during **your benefit year** and NOT the total that you can claim up to for each surgical appliance.

**We** do not pay for appliances implanted into **your** body.

#### Benefit 19 - Home help

Home help **benefit**: **We** pay 50%, up to a maximum of £163, of the amount **you** pay for home help services provided by local authority services, social services or an authorised agent of these bodies during **your benefit year**.

Home help services note

The Home Help **benefit** above sets out the total amount **we** pay for all Home Help **benefits** received by **you** during each **benefit year** and NOT for each type of service or item charged individually.

**We** will only pay **benefits** if the home help services are provided by the local authority services, social services or authorised agents of these bodies.

### Benefit 20 - Personal accident

Personal accident **benefit** : If **you** suffer any of the following while covered under the Saint John's Hospital Cash Plan, the **personal accident insurer** will pay the amount shown up to an overall maximum of £12,000 in respect of accidental bodily injury resulting in:

1. Death as a result of an accident.....	£10,000
2. Permanent total disablement.....	£10,000
3. Permanent and incurable paralysis of all limbs.....	£10,000
4. Permanent and incurable insanity.....	£10,000
5. Loss of entire sight of both eyes.....	£10,000
6. The permanent total loss of use of both hands or both feet.....	£10,000
7. Loss of entire sight of one eye.....	£5,000
8. The permanent total loss of use of one hand or one foot.....	£5,000
9. Permanent loss of hearing in:	
a Both ears.....	£5,000
b One ear.....	£1,500
10. Permanent total loss of the lens of one eye.....	£2,500
11. The permanent total loss of use of four fingers and thumb of either hand....	£4,000
12. The permanent total loss of use of four fingers of either hand.....	£2,000
13. The permanent total loss of use of one thumb of either hand:	
a Both joints.....	£2,000
b One joint.....	£1,000
14. The permanent total loss of use of fingers on either hand:	
a Three joints.....	£500
b Two joints.....	£350
c One joint.....	£200
15. The permanent total loss of use of toes:	
a All-One foot.....	£1,500
b Big-Both joints.....	£500
c Big-One joint.....	£200
d Other than big, each toe.....	£200
16. Established non-union of fractured leg or knee cap.....	£1,000
17. Shortening of leg by at least 5cm.....	£750
18. Funeral expenses following death as a result of an accident.....	£2,000

## Personal accident note

This *benefit* is payable to *you* only. The overall maximum that the *personal accident insurer* will pay for all claims during a *member's* lifetime, even if there is a break in their cover and they rejoin the scheme is £12,000.

## Exclusions

The *personal accident insurer* will not pay for any of the above injuries suffered while, or in connection with:

- flying as a member of the crew of an aircraft
- piloting an aircraft
- war whether declared or not
- intentional self inflicted injury, suicide or any attempted threat
- from sickness or disease not resulting from bodily injury

A copy of the master policy is available on request.

Cover provided by:  
the *personal accident insurer*

## Benefit 21 - Helpline

The following telephone advice helpline are available to Saint John's Insurance Cash Plan members.

Legal	Provides advice on personal matters (please note business-legal advice is excluded)
Domestic	Provides members with practical advice and assistance for a wide range of domestic situations and emergencies including access to plumbers, builders, roofers, etc.
Medical	Confidential advice on health related matters provided by a team of fully qualified staff
Debt counselling	Practical help and solutions to personal financial problems
Redundancy counselling	Help and advice for people who have been made redundant
Stress counselling	Advice and support offered by registered nurses to those who need to combat stress
Welfare	Advice is available in all areas of welfare including Social security benefit entitlement, travel advice and education etc.
Tax	Expert help to those who require advice on PAYE tax affairs (this does not extend to actual completion of forms)

The helpline number to access each of the above helpline is (0800 085 1376)

The helpline is open 24 hours a day, 365 days a year. All calls are charged at national rates in the UK.

### III. Glossary

*We* explain, in this section, what *we* mean by various words (written in bold and italic) in this information pack. These words are particularly important as they have a specific meaning to *your membership*.

Please contact *us* before starting treatment to clarify if *you* are unsure.

Word/phrases	Meaning
<b><i>acupuncturist</i></b>	means an acupuncturist, under age 70, registered as a Member or fellow of the British Acupuncture Council (MBAcC of FBAcC). British Medical Acupuncture Society (BMAS), or Acupuncture Association of Chartered Physiotherapists (AACP), at the time you receive your treatment.
<b><i>agreement</i></b>	means the agreement between us and your sponsor under which we have accepted you into membership of the scheme.
<b><i>audiologist</i></b>	means a practitioner, under age 70, qualified as an audiologist, at the time you receive you treatment.
<b><i>benefit</i></b>	means the individual benefit set out in the Benefits Notes 1 to 21.
<b><i>benefit year</i></b>	means a twelve month period commencing on your registration date or an anniversary of your registration date.
<b><i>chiropodist</i></b>	means a person, under age 70, registered as a chiropodist with the Health Professions Council (HPC), at the time you receive your treatment.
<b><i>chiropractor</i></b>	means a chiropractor, under age 70, registered as a member of the General Chiropractic Council (GCC), at the time you receive your treatment.
<b><i>chronic condition</i></b>	means a disease, illness or injury which has at least one of the following characteristics <ul style="list-style-type: none"><li>• it continues indefinitely and has no known cure</li><li>• it comes back or is likely to come back</li><li>• it is permanent</li><li>• you need to be rehabilitated or specially trained to cope with it</li><li>• it needs long-term monitoring, consultations, check-ups, examinations or tests</li></ul>

<b><i>consultant</i></b>	means a registered medical or dental practitioner under age 70. If you receive treatment outside the UK this means a surgeon, physician or anaesthetist who is under age 70 and is legally qualified to provide the treatment in that country.
<b><i>convalescence care</i></b>	means staying in a registered nursing home or a registered convalescence home, whether or not the stay follows private or NHS hospital treatment.
<b><i>day-patient treatment</i></b>	means treatment, which for medical reasons means you have to go into a hospital or day-patient unit because you need a period of clinically supervised recovery but do not have to stay overnight.
<b><i>dietician</i></b>	means a person, under age 70, registered as a dietician with the Health Professions Council (HPC), at the time you receive your treatment.
<b><i>GP</i></b>	means a person who is legally qualified in medical practice following attendance at a recognised medical school and is licensed to practice medicine in the UK.
<b><i>health professions council</i></b>	means Health Profession Council (HPC) the state regulatory body, responsible for regulating the activities of, amongst others, chiropractors, dieticians, occupational therapists and physiotherapists.
<b><i>homoeopath</i></b>	means a homoeopath, under age 70, registered as a member of the Association of Registered Homoeopaths (MARH), a Member or Fellow of the Homoeopathic Medical Association (MHMA or FHMA), a Member or Fellow of the Society of Homoeopaths (RSHOM or FSHOM), a member of the Faculty of Homoeopathy (MFHOM) a member or fellow of the British Institute of Homoeopathy (MBIH or FBIH) at the time you receive you treatment.
<b><i>in-patient treatment</i></b>	means treatment which, for medical reasons, means you have to stay in hospital overnight or for longer.
<b><i>member</i></b>	means you, the member of the scheme.
<b><i>membership letter</i></b>	means the membership letter we send you welcoming you as a member.
<b><i>occupational therapist</i></b>	means a state registered occupational therapist, under age 70, registered as an occupational therapist with the Health Professions Council (HPC), at the time you receive your treatment.

<b><i>osteopath</i></b>	means an osteopath, under age 70, registered as a member of the General Osteopathic Council (GOC) at the time you receive your treatment.
<b><i>our/us/we</i></b>	means Saint John's Insurance Limited.
<b><i>out-patient treatment</i></b>	means treatment given at a hospital, consulting room or out-patient clinic where you do not go in for day-patient treatment or in-patient treatment.
<b><i>personal accident insurer</i></b>	means John's Insurance Limited
<b><i>pre-existing condition</i></b>	means any disease, illness or injury for which: <ul style="list-style-type: none"> <li>• you have received medication, advice or treatment; or</li> <li>• you have experienced symptoms; whether the condition was diagnosed or not before the start of your cover</li> </ul>
<b><i>physiotherapist</i></b>	means a person, under age 70, registered as a physiotherapist with the Health Professions Council (HPC) at the time you receive your treatment.
<b><i>registration date</i></b>	means your registration date will be shown in the membership letter we send you welcoming you as a member.
<b><i>rehabilitation</i></b>	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.
<b><i>sponsor</i></b>	means your employer, Focused Consulting Limited, when you join the scheme with whom we have agreed to provide the benefits.
<b><i>therapy</i></b>	means either physiotherapy, osteopathy, chiropractic, acupuncture, and homoeopathy services provide by a physiotherapist, acupuncturist, osteopath, chiropractor or homoeopath recognised by us for that type of treatment.
<b><i>UK</i></b>	means Great Britain, Northern Ireland, the Channel Islands and the Isle and Man.
<b><i>you/your</i></b>	means you, the member who has taken out the membership, and to whom we sent the membership letter.

## IV. Appendices

# SAINT JOHN'S INSURANCE LIMITED

## CLAIM FORM

### REED

**If your address or personal details are incorrect please amend**

Membership number / Payroll number:

Name and address:  
 -----  
 -----  
 -----  
 -----

Were here to help  
 If you have any queries when filling in this form please call us on 0808 2343349  
 (Calls charges at local rate in UK) Calls may be recorded and monitored.  
 Before you send the form to us please make sure that all relevant sections  
 have been completed-this will help us to deal with your claim as quickly as  
 possible. Please post your completed claim form to us at:  
 Saint Johns Insurance Limited  
 California  
 120 Coombe Lane  
 Raynes Park  
 London SW20 0BA

Please complete claim form in BLOCK CAPITALS in blue or black ink-a separate claim form must be completed for each claim for each benefit

#### Section A: Your personal detail

Person covered  Main member  <input style="width: 100%; height: 20px;" type="text"/>	Date of birth  <input style="width: 100%; height: 20px;" type="text"/>	Scheme name:  Please supply telephone numbers we can use to contact you about this claim (including STD code)  Daytime: <input style="width: 100%; height: 20px;" type="text"/>  Evening: <input style="width: 100%; height: 20px;" type="text"/>
Claimant if different  <input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	

#### Section B: Benefit payment method

The claim will be paid directly into your bank please fill in the details below,

Bank/Building Society name:   
  
 Account Name:   
  
 Account number:  Sort code:

Please note: Not all Banks/Building Societies will accept direct credits, in these cases your payment will be made by cheque

#### Section C: Claim details

Please tick the appropriate box for the benefit that you are claiming for, and fill the appropriate section  
 Only tick one box. You will need to complete a separate claim form for each claim/treatment

Benefit description	Additional instructions
<input type="radio"/> Chiropody	Please fill in sections D and G
<input type="radio"/> Consultation/radiologists fee	Please fill in sections D and G
<input type="radio"/> Dental	Please fill in sections D and G
<input type="radio"/> Hearing care	Please fill in sections D and G
<input type="radio"/> Home help	Please fill in sections D and G
<input type="radio"/> Homeopathy	Please fill in sections D and G
<input type="radio"/> Infertility	Please fill in sections D and G
<input type="radio"/> Occ. therapy & dietician	Please fill in sections D and G
<input type="radio"/> Optical	Please fill in sections D and G
<input type="radio"/> Surgical appliances	Please fill in sections D and G
<input type="radio"/> Maternity & adoption	Please fill in sections E and G
<input type="radio"/> Hospital day-case	Please fill in sections F and G
<input type="radio"/> Hospital in-patient	Please fill in sections F and G
<input type="radio"/> Recuperation	Please fill in sections F and G

For personal accident claims, please call the  
 SAINT JOHN'S Cash Plan helpline

FOR OFFICE USE ONLY

Date received

Claim amount paid

Operator

Claim ID

**Section D: Receipted claim**

Amount paid  Receipt amount in words:  pounds  pence  
Receipt date:  Detailed original receipted accounts bearing the name and address of the practitioner and the name and address of the patient must accompany all claims for benefit

**Section F: Maternity or adoption claim**

Please submit a photocopy of the full birth/adoption certificate(s) in support of your

Childs fore name  Surname  Date of birth  Gender   
Childs forename

**Section F: Hospital Admission ( Note: if credited a separate claim does not have o be made for recuperation)**

I Authorise the hospital to disclose in section F (11) the reason for my admission   
Patients signature for signature of legal guardian if patient is under 16

To be completed by hospital

Full name of claimant:  Hospital number   
Hospital name

I certify that the patient was admitted to this establishment

as an in-patient, admitted on:  /  /  discharged on  /  /

if during the above period the patient was away from hospital for one or more nights please give details

from:  /  /  to:  /  /

from:  /  /  to:  /  /

or

As a day-patient surgery admission on: Date:  /  /

The patient was admitted for the following reason (please X as appropriate).

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> In patient for treatment      | <input type="checkbox"/> Accident casualty admission | <input type="checkbox"/> Mental health/ psychiatric treatment |
| <input type="checkbox"/> Antenatal/postnatal treatment | <input type="checkbox"/> Geriatric care              | <input type="checkbox"/> Convalescence care/rehabilitation    |

Official hospital stamp

Please state the condition for which the patient was admitted

Was this episode linked to a chronic condition (the meaning of which is described in the membership guide). Please delete Yes / No\*

Signature of authorising officer:  Date:  /  /  Position held:

**Section G: Member declaration**

I declare the information on this form to be correct to the best of my knowledge and that I am entitled to the benefits claimed:

Main Member's signature  Date:  /  /

Please send your completed claim form back to :

Claims Administrator,  
Saint Johns Insurance Limited ,  
120 Coombe Lane  
Raynes Park  
London  
SW200BA

## Saint John's Data Protection

**Confidentiality:** The Confidentiality of the patient and member information is of Paramount concern to the companies of SAINT JOHN'S GROUP. To this end SAINT JOHN'S GROUP fully complies with Data Protection Legislation and Medical Confidentiality Guidelines. SAINT JOHN'S GROUP sometime uses third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area, is subject to contractual restrictions with regard to confidentiality xxx security in addition to the obligation imposed by the Data Protection Act.

**Research:** Anonymised or aggregated data may be used by SAINT JOHN'S GROUP or disclosed to others for research or statistical purposes.

**Name and addresses:** SAINT JOHN'S GROUP does not make any names and addresses of members or patients available to other organisations.

**Fraud:** information may be disclosed to others with a view to preventing fraudulent or improper claims.

**Keeping you informed:** The SAINT JOHN'S GROUP would on occasion like to keep you informed of the SAINT JOHN'S GROUP products and services which it considers may be of interest to you. If you do not wish to receive information about SAINT JOHN'S GROUP products and services, or have any other Data Protection queries then please write to the SAINT JOHN'S GROUP Information Protection Manager at SAINT JOHN'S GROUP

**Complaints:** it is SAINT JOHN'S GROUP intention to provide a first class service at all times. If you do have cause for dissatisfaction you may write to the Head of SAINT JOHN'S GROUP ..... They will consider your complaint and can provide you with full details of our internal complaint process. It is very rare that we cannot settle a complaint, but if we tell you we can do no more and we have been unable to resolve your complaint to your satisfaction, you may refer your complaint to the Financial Ombudsman Service at South Quay Plaza, 183 Marsh Wall London E14 9SR or telephone 0845 080 1800.

**PERSONAL ACCIDENT CLAIM FORM – JOHN'S HOSPITAL Cash Plan**

**Please complete and return to : Saint John's Hospital Cash Plan, Dale Buildings, Cook Street, Coventry CV1 1JH**

**PART ONE – to be completed by claimant**

**SCHEME NAME: SAINT JOHN'S**

**For Office Use Only**  
Membership No ..... Policy No. 64783694

CONFIRMATION:

If unable to complete personally, this form may be filled in on behalf of the claimant. Please ensure that ALL questions are answered as fully as possible before submitting the claim form. Dashes or spaces will not suffice and could lead to delays in processing of the claim.

**MEMBERS DETAILS**

Mr .... Mrs .... Ms .....Other  
Surname & Forenames

Address

Date of Birth

Occupation

Is the Member also the claimant ?

If not please explain the relationship

1. Nature of Injury

2. When and where did the accident occur? (Please provide precise date and time

3. How did the Accident occur?

4. When did you return to work or when do you anticipate being able to return to work?

**PART TWO** – to be completed by the claimant. Please indicate what you are claiming for by ringing the relevant benefit number.

BODILY INJURY following an Accident resulting in:-

1.	Accidental Death	£10,000	13.	Permanent Total Loss of use of one thumb on either hand (A) both joints	£2,000
2.	Permanent Total Disablement from any and every occupation	£10,000		(B) one joint	£1,000
3.	Permanent and incurable paralysis of all limbs	£10,000	14.	Permanent Total Loss of use of fingers on either hand (A) three joints	£500
4.	Permanent and incurable insanity	£10,000		(B) two joints	£350
5.	Permanent loss of entire sight of both eyes	£10,000		(C) one joint	£200
6.	Permanent Loss of use of both hands or feet	£10,000	15.	Permanent Total Loss of use of toes	
7.	Permanent Loss of sight in one eye	£5,000		(A) all – one foot	£1,500
8.	Permanent Total Loss of use of one hand or foot	£5,000		(B) big – both joints	£500
9.	Permanent Total Loss of hearing in			(C) big – one joint	£200
	(A) both ears	£5,000		(D) other than big, each complete toe	£200
	(B) one ear	£1,500	16.	Established non union of fractured leg or knee cap	£1,000
10.	Permanent Total Loss of the lens of one eye	£2,500	17.	Shortening of leg by at least 5cm	£750
11.	Permanent Total loss of use of four fingers and thumb on either hand	£4,000	18.	Funeral expenses following accidental death	£2,000
12.	Permanent Total Loss of use of four fingers on one hand	£2,000			

**PART THREE** - to be completed by the claimant

**ACCESS TO MEDICAL REPORTS ACT 1988**

As part of your claim a Medical Report is required from your Doctor. However, before Chubb can apply for a Medical Report your consent is needed. Before signing the consent below you should read the following summary of your rights.

- A. You can withhold your consent but if you do so the Chubb may be unable to process your claim.
- B. If you wish to see the Report, we will advise you of when we write to the Doctor and you will then have 21 days to contact the Doctor to make arrangements for you to see the report. Whether or not you say you wish to see the Report before it is sent to us, the Doctor must retain a copy for up to six months after it is supplied.
- C. You can ask your Doctor if he/she will amend any part of the Report which you consider to be incorrect or misleading. If the Doctor is not in agreement you may append your comments.
- D. Your Doctor can in certain circumstances withhold from you the Report or any part of it.

**CONSENT TO OBTAIN A MEDICAL REPORT**

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 as explained above and in connection with my insurance claim I hereby consent to Chubb seeking medical information from any Doctor who at any time has attended me concerning anything which affects my physical or mental health in connection with this claim and I agree that a copy of this consent shall have the validity of the original. I wish to see the Report before it is sent to Chubb Please tick I do not wish to see the Report before it is sent to Chubb

Signed .....

Name .....(PLEASE PRINT)

Date .....

Name & Address of GP .....  
.....  
.....

**DATA PROTECTION NOTICE**

For policy administration purposes, Chubb will use and store the information you provide in this claim form on an electronic database, which may also be available to selected authorised representatives of member insurers of the Chubb Group of Insurance Companies operating outside Europe. Chubb has taken reasonable measures to protect your information once it is transferred outside Europe in accordance with their normal data security policies. Chubb may also disclose your information to outside parties such reinsurers, outside counsel and claims administrators, to provide the insurance and claims services to you, or as allowed by law. By signing this claim form, you consent to Chubb’s use of this information in the manner and for the purposes described above.

I certify that the statements I have made in this claim form are correct. I consent to the seeking of information from other insurers to check the answers I have provided and I authorise the giving of such information.

Signature .....

Date .....

**PART FOUR** - The claimant must arrange, at his or her own expense, completion of the following certificate by a duly qualified and Registered Medical Practitioner.

**MEDICAL CERTIFICATION**

1. When did you first attend on the claimant in respect of the injuries sustained in this accident?  
.....

2. Are you still in attendance ? YES NO  
3. Are you the usual Medical Attendant of the claimant? YES NO

If so, how long have you known him/her?  
.....

4. Please give full details of the injuries. If there has been traumatic or surgical amputation, please give details of the joints involved.  
.....

5. Is there anything in the claimants medical history which may have contributed directly or indirectly to the current injuries or incapacity?

.....  
.....

6. Please confirm that in your opinion the claimant is suffering from the injuries stated overleaf and that they are beyond hope of improvement.

.....  
.....

7. General Remarks.

.....  
.....

I certify that the foregoing statements are correct to the best of my knowledge and belief.

Signature .....

Address .....

.....

.....

Qualifications ..... Date .....

Official Stamp .....