

# Health Cash Plan

Policy wording and information pack



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## SECTION 1 – INTRODUCTION

### About Your Insurance

Welcome to **your** Health Cash Plan insurance **policy** wording. **Your** tables of benefits are shown on page 6 - 8.

Please take time to read the “Important Information” section on pages 4 - 6 of this **policy** wording. It tells **you** about things **you** need to check and the actions **you** need to take. It also contains details of the initial **qualifying period** when **you** cannot claim and the amount **you** must contribute when **you** make a claim. Information about the insurer’s right to change **your** cover or **premium** are also shown here.

- The insurance is administered by Union Income Benefit Holdings Limited (“Union Income Benefit”) who are referred to as the “**administrator**” in this **policy** wording.
- The contact details for the **administrator’s** Customer Service Team are:  
email: customercare@uibuk.com  
phone: 0343 178 1255  
post: Customer Services Team, Union Income Benefit, 39/51 Highgate Road, London NW5 1RT;
- The insurance is underwritten by Stonebridge International Insurance Ltd. who are referred to as the “**insurer**”, “**we**”, “**us**” and “**our**” in this **policy** wording.
- Claims are handled by the **administrator** Union Income Benefit, on behalf of the **insurer** Stonebridge International Insurance Ltd.

**Your** insurance is a monthly renewable **policy**. **You** will be covered for one month from the **policy start date** and then the **policy** will automatically renew for each further consecutive monthly period for which **we** accept a **premium** from **you**.

Some words and phrases in this **policy** wording and in **your policy schedule** will always have the same meaning wherever they appear. To make them easier to recognise when they are being used, they will be shown in **bold**. They are all listed and explained in the “Definitions” section which can be found on page 10 of this **policy** wording.

All insurance documents and all communications with **you** about this **policy** will be in English.

Please contact the **administrator** if **you** need any documents to be made available in braille and/or large print and/or in audio format. Their contact details are shown above.

### How to Make a Claim

To make a claim under the **policy** please contact the **administrator** for a claim form. The contact details for the **administrator’s** Claims Team are:

email: claims@uibuk.com

phone: 0800 014 7024

post: Claims Team, Union Income Benefit, 39/51 Highgate Road, London NW5 1RT

### The Insurance Contract

This **policy** wording and **your policy schedule** are **your** insurance documents and together they make up the contract between **you** and **us**. It is important that **you** read this **policy** wording carefully along with **your policy schedule** so **you** can be sure of the cover provided and to check that it meets **your** needs.

This **policy** wording and **your policy schedule** are issued to **you** by the **administrator**. In exchange for **your** payment of the **premium** shown on **your policy schedule**, **you** are insured in accordance with the terms & conditions contained in the **policy** wording and on **your policy schedule** (and any amendments made to them) for the duration of **your policy**.

### Demands and Needs

This Health Cash Plan would meet the demands and needs of those who would benefit from help towards covering the costs of everyday healthcare such as dental treatment, optical care, therapy treatments, consultations with specialists and more. Neither **we** nor the **administrator** are offering advice or personal recommendation on the suitability of this product, **you** need to decide based on the information provided whether this cover is right for **you** and meets **your** needs.

## SECTION 2 - IMPORTANT INFORMATION

It is important that:

- **You** check **your policy schedule** to ensure the details are correct;
- **You** check that **you** are eligible for this insurance (see “Eligibility” below);
- **You** check the information **you** have given **us** is accurate (see “Disclosure of Important Information” below);
- **You** notify the **administrator** as soon as possible of any inaccuracies on **your policy schedule**, or if **you**

- are not eligible for the insurance; and
- **You** comply with any duties detailed under each section of the **policy** wording and under the insurance as a whole.

### **Making a claim**

There are conditions which relate specifically to making a claim, and these can be found in the “Making a Claim” section on page 10. If **you** do not meet these conditions, **we** may reject a claim payment or a claim payment could be reduced. In some circumstances, **your policy** may be cancelled.

### **Qualifying period**

**Benefits** have a **qualifying period** which is the period before **you** are entitled to any **benefit**. **You** become eligible for **benefits** 90 days from the **start date** of the **policy**.

The exceptions to this are the following **benefits**:

**Dental Accident** – no **qualification period**

**Hospital inpatient and Day-Case treatment** resulting from an **accident** – no **qualification period**

**New Child Expenses** – 300 days **qualification period**

### **Information You Give Us**

Eligibility

When **you** applied for this insurance **we** asked **you** to confirm that **you** were eligible for cover. **We** will cover **you** under this **policy** if **you**:

- permanently reside in the United Kingdom; and
- **you** are aged between 18 and 60 years inclusive at the **start date**.

Please contact the **administrator** as soon as possible if **you** are not eligible for this insurance or if **you** have any queries. Their contact details are shown on page 13 of this **policy** wording.

### **Disclosure of Important Information**

In deciding to accept this insurance and in setting the terms and **premium**, **we** have relied on the information **you** have provided. **You** must take reasonable care to provide complete and accurate answers to the questions **you** are asked when **you** take out or make changes to **your policy**. If the information provided by **you** is not complete and accurate:

- **we** may cancel **your policy** and refuse to pay any claim, or
- **we** may not pay any claim in full, or
- **we** may revise the **premium**, or
- the extent of the cover may be affected.

If **you** become aware that any information **you** have given is incomplete or inaccurate, please contact the **administrator** as soon as possible. Their contact details are shown on the back page of this **policy** wording booklet.

### **Our Right to Change the Cover or Price**

**You** will receive at least 30 days written notice if **we** decide or need to change **your policy** cover or the price of **your** insurance. **We** may do this for any of the following reasons:

- to make minor changes to the **policy** wording that do not affect the nature of the cover or the **benefits** provided, such as changes to make the **policy** easier to understand;
- to reflect changes in law, regulation (including any decision of a regulatory body), or any code of practice or industry guidance that affects **us**, the **administrator** or **your policy**;
- to reflect changes to any taxation applicable to **your policy** (such as a change to the rate of insurance premium tax);
- to reflect any increases or reductions in the cost (or projected cost) of providing **your** cover, such as a change to the number, cost or timing of claims which **we**, as part of **our** pricing **policy**, have assumed or projected will be made under this insurance product;
- to meet the cost of any changes to the cover or **benefits** provided under this **policy**, such as the removal of one or more **policy** exclusion(s);
- to meet the cost of changes to the systems, services or technology used in support of this **policy**.

**We** may make changes immediately and advise **you** within 30 days of the change having been made if the change is favourable to **you**. A favourable change could include, but is not restricted to, a reduction in the rate of Insurance Premium Tax, a general reduction in the price of **your policy** or an improvement to the cover and benefits (such as an increased limit of cover).

Upon receiving notice of any changes or proposed changes, **you** may cancel cover in accordance with the “Cancellation of the **policy**” section on pages 11 of this **policy** wording.

### Paying premiums

- **You** pay for **your** cover by monthly Direct Debit through the **administrator**.
- **You** must provide **your** bank details to the **administrator** who will collect **your** Direct Debit each month. **Your policy** will end automatically if **you** do not pay any **premium** when it becomes due. If this happens, **you** will be contacted requesting payment within 30 days. If **we** do not receive payment within this period, **we** will contact **you** again to notify **you** that **your policy** will be cancelled.
- If **you** are receiving **benefit** under this **policy**, **you** must continue to pay the **premium** when it is due. If **you** do not pay the **premium** **you** will be contacted requesting payment within 30 days. If **we** do not receive payment within this period, **you** will be written to again notifying **you** that **your policy** will be cancelled, **we** will cancel **your policy** and **you** will not be entitled to any further **benefits**.
- If there are any changes to the current level of Insurance Premium Tax (IPT) or any new charges are placed on **us**, **we** will change **your premium** from the date any changes are put in place and will write to inform **you** of the change.

### How long your cover lasts

**Your** insurance is a monthly renewable **policy**. **You** will be covered from the **policy start date** and the **policy** will automatically renew for each consecutive monthly period for which **we** accept a **premium** from **you**.

### When cover ends

All cover under this **policy** will end when:

- **you** die; or
- the first monthly renewal after **you** reach the age of 62; or
- **you** cease to be a **UK resident**; or
- **you** or **we** cancel this **policy** as shown in Section 7; or
- **you** do not pay the premium when due

whichever is earlier.

## SECTION 3 – WHAT IS COVERED

These are the rules that apply in each **benefit year** before **we** will pay **you** the **benefit** shown below. Please read the claims procedure before making a claim. **We** will not pay more than the amounts shown in the table of **benefits**.

### Qualified Practitioner Qualified Practitioner or Specialist

Claims will only be paid if the person providing **your treatment** is a **qualified practitioner** or **specialist** who meets the following criteria and has the relevant qualification for the **benefit** being claimed. A **Qualified Practitioner** cannot be **you**, or anyone related to **you** or anyone living with **you**. They must be:

- A dentist or dental hygienist who is registered with the General Dental Council (GDC);
- An optician who is registered with the General Optical Council (GOC);
- A physiotherapist who is registered with the Health and Care Professions Council (HCPC);
- An osteopath who is registered with the General Osteopathic Council (GOC);
- A chiropractor who is registered with the General Chiropractic Council (GCC);
- An acupuncturist who is a member of the British Acupuncture Council (BAC);
- A homeopath who holds full membership of the Faculty of Homeopathy or Society of Homeopaths;
- A specialist who is registered with the General Medical Council (GMC);

## TYPE 1 BENEFITS

### A. Dental treatment

**We** will pay **benefit** for **treatment** (including a check-up or new dentures) as set out in the table below:

Contribution	Maximum Benefit
100% of what <b>you</b> have paid directly to a <b>qualified practitioner</b>	Up to £130 per <b>benefit year</b> .

- **We** will not pay **benefit** for any **premiums** **you** paid under a dental-care contract scheme.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**.

### B. Optical expenses

**We** will pay **benefit** for eyesight tests or prescribed spectacles, lenses or contact lenses as set out in the table below:

Contribution	Maximum Benefit
100% of what <b>you</b> have paid directly to a <b>qualified practitioner</b>	Up to £130 per <b>benefit year</b> .

- **We** will not pay **benefit** for contact lens check-ups or solutions, non-prescribed spectacles, spectacle repairs, new frames, replacements needed after accidental damage, or where costs have been paid for by using an employer funded voucher,
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**.

#### C. Therapies

**We** will pay **benefit** for physiotherapy, osteopathy, chiropractic, acupuncture and homeopathy **treatment** provided by a **qualified practitioner** as per the scale set out below:

Contribution	Maximum Benefit
75% of what <b>you</b> have paid directly to the <b>qualified practitioner</b>	Up to £150 per <b>benefit year</b> .

- **We** will not pay more than the maximum **benefit** in any one **benefit year** for all **treatments** received from a **qualified practitioner**.
- **We** will only pay the **benefit** for **treatment** of a **medical condition**. **We** will not pay **benefit** for **diagnostic tests** or consultations.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**.

#### D. Chiropody and podiatry

**We** will pay **benefit** for chiropody or podiatry **treatment** with a **qualified practitioner** as per the scale set out below.

Contribution	Maximum Benefit
75% of what <b>you</b> have paid directly to the <b>qualified practitioner</b>	Up to £100 per <b>benefit year</b> .

- **We** will not pay more than the maximum **benefit** in any one **benefit year** for all **treatments** received from a **qualified practitioner**.
- **We** will only pay the **benefit** for **treatment** of a **medical condition**. **We** will not pay **benefit** for **diagnostic tests** or consultations.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**.

#### E. Specialist diagnostic consultation fees

**We** will pay a **benefit payment** for a consultation with a **specialist** as per the scale set out below.

Contribution	Maximum Benefit
75% of what <b>you</b> have paid directly to the <b>specialist</b>	Up to £300 per <b>benefit year</b> .

- This **benefit** is only available if **your** general practitioner refers **you** for the consultation.
- **We** will pay **benefit** for all **diagnostic tests** except for examinations carried out for legal reports, or for insurance, employment and emigration reasons.
- **We** will pay **benefit** for pathological examinations, PET/MRI scans, ultrasounds and blood tests in relation to the diagnostic consultation.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**.

#### F. Health Screening

**We** will pay **benefit** for the following list of health screening assessments performed in a **hospital** or health screening centre by medically qualified staff : Well woman, Well man, mammography, osteoporosis and screening that prevents an illness.

Contribution	Maximum Benefit
75% of what <b>you</b> have paid directly to the <b>hospital</b> or health screening centre.	Up to £150 per <b>benefit year</b> .

- **We** require a certificate from the **hospital doctor** or health screening centre confirming that the check has been completed and the **receipt** for the amount paid.
- **We** will not pay **benefit** for any screening other than as stated above (and specifically not for tests carried out at home, via internet or post, a retail outlet, health club, fitness centre or the like)

- **We** will not pay **benefit** for screening or examinations in respect of pension, insurance, emigration, or employment matters or for legal or industrial actions.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**

## TYPE 2 BENEFITS

### G. Hospital Inpatient treatment

**We** will pay **benefit** at the nightly rate as shown in the table below for the period that **you** are in **hospital** for **inpatient treatment** when the **hospital** stay has exceeded four consecutive nights.

Contribution	Maximum Benefit
£30 per night for up to a maximum of 20 nights per <b>benefit year</b> .	Up to £600 per <b>benefit year</b> .

- If **you** are in **hospital** for less than four consecutive nights, then no **benefit payment** will be payable.
- In any event **we** will not pay **benefit payment** for more than 20 nights of **inpatient treatment** in any one **benefit year**.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**, unless **treatment** is required as the result of an **accident** in which case no **qualification period** applies.
- **We** will not pay **benefit** if **your treatment** relates to a **pre-existing condition**.

### H. Day-Case treatment

**We** will pay for **day-case treatment** in a **day-case unit**, at the daily rate as shown in the table below for the period **you** receive **day-case treatment**.

Contribution	Maximum Benefit
£20 per day for up to a maximum of 10 days per <b>benefit year</b>	Up to £200 per <b>benefit year</b> .

- In any event **we** will not pay **benefit payment** for more than 10 days of **day-case treatment** in any one **benefit year**.
- **You must** have been on cover for longer than the 90 days **qualification period** at the **treatment date**, unless **treatment** is required as the result of an **accident** in which case no **qualification period** applies.
- **We** will not pay **benefit** if **your treatment** relates to a **pre-existing condition**.

### I. New Child Expenses

- **We** will pay **benefit** of £200 for the birth of each child where **you** are named on the birth certificate. **You** must send an original or certified true copy of the full (not short) birth certificate for each child to support **your** claim. **We** will not pay **benefit** until **we** receive this.
- **We** will pay **benefit** of £200 for each child under the age of one that **you** legally adopt. **You** must send **us** the legal adoption papers to support **your** claim. **We** will not pay **benefit** until **we** receive these.
- **You must** have been on cover for longer than the 300 days **qualification period** at the date of birth or legal adoption of the child.

### J. Dental Accident

**We** will pay **benefit** for the following costs of dental **treatment** up to £500 per **dental accident** that arises after **your policy start date**.

Contribution	Maximum Benefit
100% of what <b>you</b> have paid directly to a <b>qualified practitioner</b> for <b>treatment</b> following <b>dental injury</b>	Up to £500 per <b>accident</b> and £1,000 per <b>benefit year</b> .

- There is no **qualifying period** for this section.

### Annual Maximum Benefit Limits

Type 1 Total Maximum Benefit	Maximum Benefit
Total <b>benefit</b> payable across all Type 1 <b>benefits</b> listed above.	£500 per <b>benefit year</b> .

Type 2 Total Maximum Benefit	Maximum Benefit
Total <b>benefit</b> payable across all Type 2 <b>benefits</b>	£ 2,500 per <b>benefit year</b> .



Total Maximum Plan Benefit	Maximum Benefit
Total <b>benefit</b> payable across all <b>benefits</b> payable by the <b>plan</b>	£3,000 per <b>benefit year</b> .

## SECTION 4 – WHAT IS NOT COVERED

We will not pay **benefit**:

1. Until after the relevant **qualifying period** has passed.
2. If the **maximum benefit** for the claimed **benefit** has been paid in that **benefit year**.
3. If the claim relates to a **type 1 benefit** and the **type 1 total maximum benefit** has been paid in the **benefit year**.
4. If the claim relates to a **type 2 benefit** and the **type 2 total maximum benefit** has been paid in the **benefit year**.
5. If the **total maximum plan benefit** has been paid in that **benefit year**.
6. We will not pay **benefit** if **treatment** is needed as a direct or indirect result or consequence of:
  - a) engaging in any sport as a professional or semi-professional.
  - b) boxing, base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang gliding, paragliding or microlighting, parachuting, potholing, skiing off-piste or any other winter sports activity carried out off-piste, hunting on horseback, powerboat racing or any race, trial or timed motor sport event.
  - c) suicide or attempted suicide or **you** deliberately injure **yourself** or put **yourself** in danger (unless **you** are trying to save someone's life).
  - d) taking part in a criminal act.
  - e) taking alcohol or drugs, unless the drugs are taken under the qualified medical advice or supervision of a **doctor** (and provided **you** have not exceeded the prescribed dose or failed to comply with any advice given in connection with taking such drugs).
  - f) **war** or **terrorist acts**.
  - g) **you** engaging in active war.
  - h) **CBRN terrorism**.
  - i) medical operations or treatments which are not medically necessary to **your** quality of life, including cosmetic or beauty treatments.
7. **You** may not claim for more than one **benefit** in respect of the same **treatment** or **hospital** stay.
8. In respect of **Type 1 A. Dental treatment** and **Type 2 J. Dental accident: we** will not pay **benefit** for:
  - a) fees that are recoverable or otherwise covered by other insurance policies.
  - b) injury caused by foodstuffs (including foreign bodies therein) in the course of consumption.
  - c) injury caused other than by **extra oral** impact.
  - d) **treatment** that relates to damage or injury caused whilst participating in any contact sport when the appropriate mouth protection was not being worn.
  - e) any prescription charges or associated costs.
  - f) mouthguards, gum shields or any dental appliances.
  - g) costs which **we** consider are not necessarily incurred or which are charged in excess of any published amounts for that **treatment**.
  - h) implants, cosmetic and orthodontic **treatment**.
  - i) damage to dentures, other than whilst being worn.
  - j) reimbursement for travelling expenses or telephone calls in connection with any **treatment**.
  - k) extraction of wisdom teeth, other than those extracted in an emergency at the **dentist's** surgery.
  - l) damage caused by tooth brushing or other oral hygiene procedures.
  - m) any **treatment**, care or repair to, or in connection with tooth jewellery.
  - n) **treatments** for normal wear and tear.
9. In respect of **Type 1 E. Specialist diagnostic consultation** :

We will not pay **benefit** for:

  - a) cost of a referral
  - b) dietician services
  - c) surgery or anaesthetic fees
  - d) biopsy
  - e) counselling services
  - f) assisted conception, fertility treatment or pregnancy care
  - g) check-ups
  - h) treatment charges

- i) ambulance charges
10. In respect of **Type 2 G. Hospital inpatient and Type 2 H. Day-case treatment:**  
**We will not pay benefit for:**
- a) **treatment** that relates to a **pre-existing condition**
  - b) outpatient appointments including injections, x-rays or scans
  - c) kidney dialysis
  - d) day care, for example psychiatric, respite care, care for the elderly and maternity
  - e) cancelled operations before admission
  - f) **treatment** not in a **hospital**, for example operations carried out in a GP's surgery or clinic or attendance at an **accident** and emergency department.
  - g) pre-admission appointments
  - h) pregnancy termination or sterilization, vasectomy
  - i) laser eye surgery or cosmetic surgery

## SECTION 5 - GENERAL CONDITIONS

### Qualification Periods

The **qualification periods** apply from the **start date** on the **policy**.

**You** cannot keep in force or claim **benefit** under more than one Health Cash Plan administered by Union Income Benefit Holdings Ltd and underwritten by Stonebridge International Insurance Ltd.

If a **policy** is cancelled for any of the reasons set out in **Section 7. Cancellation of the Policy**, the **insurer** will not accept an application for a new Health Cash **policy** underwritten by Stonebridge International Insurance Ltd. within 24 months of the cancellation date of the previous **policy** held by the same **policyholder**.

### Territorial Coverage

**We** will only pay **benefits** for **treatments that** take place in the UK and where the cost is incurred in the UK.

## SECTION 6 – MAKING A CLAIM

### Who to Contact

If **you** need to make a claim please contact the **administrator** Union Income Benefit who handle claims on behalf of the **insurer** Stonebridge International Insurance Ltd:

- email [claims@uibuk.com](mailto:claims@uibuk.com)
- phone: 0800 014 7024 (please note all calls are recorded)
- post: Claims Department, Union Income Benefit, 39/51 Highgate Road, London NW5 1RT

A claim form will be sent to **you**. **You** will need to fill this in and send it back to the **administrator** within 60 days of the Treatment or Expense that **you** are claiming **benefit** for, or as soon as **you** can, giving all the information requested so **your** claim can be processed.

### Supporting evidence

This must be provided to the **insurer** along with **your** completed claim form.

### For Type 1 Benefits (A to D)

1. A valid receipt for the **treatment** or expense. This must be in the name of the **policyholder**. **We** cannot accept **receipts** made out in joint names.
2. The **receipts** should also fully describe:
  - a. the **benefit/treatment** received, or the items paid for
  - b. the date of the **benefit/treatment**
  - c. the full cost
  - d. the date the cost was paid.

**We** cannot accept till slips, credit card sales vouchers, photocopied or altered **receipts**.

### For Type 1 Benefits (E to F)

A valid receipt as set out above.

A copy of :

1. For (E) a GPs letter referring **you** to the **specialist**
2. For (F) a Certificate from the **hospital doctor** confirming the health screen checks have been completed

### For Type 2 Benefits (G,H & J)

1. A valid receipt as set out above.
2. An admission / discharge confirmation from the **hospital doctor**

We will not return **your receipts** or supporting documents unless **you** ask **us** to and send **us** a stamped-addressed envelope. **We** always recommend that **you** send **us** original **receipts** by recorded mail.

**You** must pay for **benefit/treatment** before **you** make a claim.

**You** must give the **administrator** permission to see **your** medical records &/or reports as set out in the Data Protection Act 2018 &/or the Access to Medical Reports Act 1988. If the **administrator** wants **you** to have a medical examination, **you** must do so or **your** claim may not be paid. **We** will pay any costs involved for the medical examination (such as **your** travel costs).

**You** must meet any appointed representative, **specialist** or loss adjuster if the **administrator** thinks **you** need to.

### How we pay claims

**We** treat claims as arising in a **benefit year** according to:

- the dates **you** are in **hospital** – for **hospital inpatient treatment**;
- the date **you** receive **treatment**, or purchased the **benefit** as shown on the **receipt**, for other claims;
- **We** will pay **benefits payments** by electronic transfer direct to the bank account from which the **premiums** for the **policy** are paid.
- **We** will not refund any charges **you** have to pay for filling in a claim form, providing a medical certificate or report, or for appointments for **treatment** that **you** miss.

### Other Insurance

If, at the time of a valid claim under this **policy**, there is another insurance **policy** in force which covers **you** for the same loss or expense, **we** may at **our** discretion seek a recovery of some or all of **our** costs from the other insurer or reduce the benefits payable on this **policy** by the amounts received from the other insurer. **You** must give **us** any help or information **we** may need to assist **us** with **our** loss recoveries.

### Fraudulent Claims or Misleading Information

**We** take a robust approach to fraud prevention in order to keep **premium** rates down so that **you** do not have to pay for other people's dishonesty. If any claim under this **policy** is fraudulent, deliberately exaggerated, or is intended to mislead, or if any deliberately misleading or fraudulent means are used by **you** or anyone acting on **your** behalf to obtain **benefit payments** under this **policy**, **your** right to any **benefit payments** under this **policy** will end, **your policy** will be cancelled without any **premium** refund and **we** will be entitled to recover any **payments** paid as a result of any such fraudulent or deliberately misleading claim. **We** may also inform the police.

To prevent fraud, insurers sometimes share information. Details about **your** insurance application and any claim **you** make may be exchanged between insurers.

## SECTION 7 – CANCELLATION OF THE POLICY

### Your Cancellation Rights

**You** can cancel **your policy** within 14 days of the **policy start date** or, if later, 14 days of the date **you** receive this **policy** wording. **We** will refund any **premiums you** have paid as long as **you** have not made a claim and do not intend to make a claim. **You** can also cancel **your policy** at any other time. **You** will not be entitled to a refund as **you** will only have paid for the cover **you** have already received.

Please contact **your administrator** if **you** wish to cancel **your policy**.

- email [customercare@uibuk.com](mailto:customercare@uibuk.com)
- phone: 0343 178 1255 (please note all calls are recorded)
- write to: Customer Services Team, Union Income Benefit, 39/51 Highgate Road, London NW5 1RT

### The Insurers' Cancellation Rights

**We** or the **administrator** reserve the right to cancel **your policy** when there is a valid reason to do so. Valid reasons include, but are not limited to:

- **You** fail to pay the premium when due
- **You** act in a fraudulent manner
- **You** fail to supply requested validation documents
- **You** fail to take reasonable care to ensure that information provided by **you** is accurate and not misleading

**We** will not cancel **your policy** alone solely because of:

- any change in **your** health or physical condition;
- the number of claims presented or the amount of **benefit** paid under this **policy**.

**We** may cancel **your policy**, but **we** will do this only when:

- **we** cancel all **policies** which **we** have issued under this **plan**; or
- **you** have taken out another **policy** within 24 months of the cancellation of an earlier **policy** and **we** are exercising our right not to accept this application as set out in Section 5. General Conditions.

If **we** cancel **your policy** **we** shall provide **you** with 14 days prior notice to the contact details that **we** hold

for **you**. Within this notice **we** will advise **you** of **our** reasons for cancelling **your policy**. If **we** are unable to collect a payment **we** will use reasonable endeavours to collect the outstanding payment(s) before exercising **our** right to cancel the **policy**.

## SECTION 8 – HOW TO MAKE A COMPLAINT

**We** and the **administrator** always try to provide a first-class standard of service. However, sometimes things can go wrong. If **you** have a complaint **you** should contact the **administrator** who arranged this insurance for **you**:

- email [customerrelations@uibuk.com](mailto:customerrelations@uibuk.com)
- phone: 0343 178 1255 (please note all calls are recorded)
- post: Customer Relations Team, Union Income Benefit, 39/51 Highgate Road, London NW5 1RT

If the **administrator** cannot resolve the complaint to **your** satisfaction, **you** can contact the Financial Ombudsman Service:

- email: [complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)
- phone: 0800 023 4567
- post: Financial Ombudsman Service, Insurance Division, Exchange Tower, Harbour Exchange, London E14 9SR

FOS is an independent organisation that arbitrates on complaints about general insurance products. It will consider complaints after the firm has given **you** written confirmation that they have been through their full complaints procedure. **You** have six months from the date of the firm's final response in which to refer **your** complaint to the FOS.

Making a complaint to FOS does not affect **your** right to take legal proceedings. **We** and the **administrator** are bound by a FOS or decision but **you** are not.

## SECTION 9 – LEGAL, REGULATORY & OTHER INFORMATION

### Financial Services Compensation Scheme (FSCS)

In the unlikely event **we** are unable to meet **our** liabilities, **you** may be entitled to compensation under the Financial Services Compensation Scheme. Further information can be obtained from the Financial Services Compensation Scheme by visiting their website at [www.fscs.org.uk](http://www.fscs.org.uk), by contacting them via email on [enquiries@fscs.org.uk](mailto:enquiries@fscs.org.uk) in writing to Financial Services Compensation Scheme, PO Box 300, Mitcheldean, GL17 1DY; or by telephone 0800 678 1100 or 020 7741 4100.

### Data Protection Notice

The Personal Information **you** provide.

Stonebridge International Insurance Ltd, the **insurer (we/us)** and Union Income Benefit Holdings Ltd, the **administrator**, are the joint data controllers (as defined in the Data Protection Act 2018 and any successor regulation (DPA)) and fully accept the responsibility of protecting the privacy of customers and the confidentiality and security of personal information provided to either party.

In this notice, Personal Information is personal data (as defined in the DPA) and means any information that identifies an individual and includes any special category personal information (as defined in the DPA e.g. information about health or medical condition(s)).

Where this notice refers to **you** or **your** Personal Information, this will include any information that identifies another person whose information **you** have provided to **us** or the **administrator**. **We** and the **administrator** will assume that they have appointed **you** to act for them. **You** agree to receive on their behalf any data protection notices from **us** or the **administrator**.

**Your** Personal Information will be used for the purpose of providing insurance services: to decide if **we** can offer insurance to **you**; to administer **your policy** and to handle claims. The Personal Information **we** collect will include name, address, date of birth and financial information. If a claim is made, **we** will collect additional information about the claim. Where this includes special category data e.g. information relating to health, where appropriate **we** will ask **you** for consent to collect this information.

**Your** Personal Information will be used by **us** and the **administrator** for legitimate interests **we** or the **administrator** have as a business including customer profiling to better understand customers, **improve products and to suggest other products that may be relevant to customers including marketing** and for management and audit of business operations. **We** or the **administrator** will only communicate with **you** in line with any marketing preferences that **you** have given **us** or the **administrator** and this may continue after **your policy** has ended. **Your** marketing preferences can be updated at any time by contacting the **administrator**:

By email: [customercare@uibuk.com](mailto:customercare@uibuk.com)

By phone: 0343 178 1255

By post: Customer Services, Union Income Benefit, 39/51 Highgate Road, London NW5 1RT.

**We** or the **administrator** may share **your** Personal Information with the Embignell group, reinsurers, business partners and agents to help administer the products and services and to keep regulatory obligations.

**We** or the **administrator** may also pass **your** Personal Information to other insurers and regulatory and law enforcement bodies for the prevention of fraud, financial crime or where the law requires **us** or the **administrator** to do so.

**We** or the **administrator** may transfer **your** Personal Information to countries outside the EEA which may not have the same level of data protection as in the United Kingdom, but if this is necessary it will be ensured that appropriate safeguards are in place to protect **your** Personal Information.

**We** may carry out automated decision making based on **your** Personal Information. This will include **your** age and the level of cover and is used to calculate the price of cover that **we** provide.

**We** and the **administrator** may monitor and/or record **your** communication with **us** or the **administrator**, either ourselves or using reputable organisations selected by **us**, to ensure consistent servicing levels and operations.

**We** or the **administrator** will keep information about **you** only for so long as it is appropriate. **We** and the **administrator** need **your** personal information to administer **your policy** or handle any claims whilst **your policy** is in force. **We** may need to keep information after **your policy** has ended to ensure **we** and the **administrator** have an accurate record of our relationship to **you** and communications that **we** or the **administrator** had or where we are required to keep the information for legal, regulatory or tax purposes.

**You** have the right to ask **us** to delete **your** data or cease processing it at any time, however **we** may not be able to do this if **we** require **your** data in respect of our contract with **you**. The **administrator** has a dedicated Data Protection Officer who **you** can contact for any queries or to exercise any of **your** rights under data protection regulations including: data subject access requests, correcting **your** information, making a complaint. If **you** believe **we** or the **administrator** are holding inaccurate information about **you** or wish to request a copy of **your** information, **you** should contact the **administrator**.

Contact Details:

Data Protection Officer

By email: [dataprotection@embignell.com](mailto:dataprotection@embignell.com)

By post: Data Protection Team, Union Income Benefit 39/51 Highgate Road, London NW5 1RT.

The information that **you** have requested will be provided in a suitable format to meet **your** requirements.

If the complaint cannot be resolved to **your** satisfaction, **you** can contact the Information Commissioner's Office who are the Supervisory Authority in the UK protecting the rights of individuals under current Data Protection regulations.

Website: [www.ico.org.uk](http://www.ico.org.uk)

By post: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF

By telephone: 0303 123 1113

More detail is also available in the **administrator's** Privacy Policy which can be viewed online at [www.embignell.com/privacy-policy](http://www.embignell.com/privacy-policy)

### **Rights of Third Parties**

A person who is not a party to this **policy** has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this **policy** but this does not affect any right or remedy of a third party which exists or is available apart from that Act. For **your** information, the Contracts (Rights of Third Parties) Act 1999 allows a person who is not a party to a contract to be able to enforce that contract if the contract expressly allows for that or if the contract confers a benefit upon them. However, the Act will not be applied if the parties make it clear in the contract that the third party does not have the right to enforce it. For further guidance please see [www.legislation.gov.uk](http://www.legislation.gov.uk) or contact the Citizens Advice Bureau.

### **Law and Jurisdiction**

Unless specifically agreed to the contrary, this **policy** shall be governed by the laws of England and Wales and subject to the exclusive jurisdiction of the courts of England.

### **Sanctions**

**We** will not be liable to provide cover (including payment of a claim or provision of any other benefit) under this **policy** if **we** are prevented from doing so by any sanction which prohibits **us** from providing cover under this **policy**. Sanctions change from time to time and can include prohibiting the transfer of funds to a

sanctioned country, freeze the assets of a government, the corporate entities and residents of a sanctioned country, or freeze the assets of specific individuals or corporate entities. This means that if **you** or any **insured person**, suffers a loss which would otherwise be covered under the **policy**, are the subject of a sanction, **we** may not be able to provide cover under the **policy**.

### Other important information

Health Cash Plan is underwritten by Stonebridge International Insurance Ltd, authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority, register number 203188.

Union Income Benefit Holdings Ltd and Stonebridge International Insurance Ltd are both members of the same group of Companies and are ultimately owned and controlled by the Parent Company Embignell Ltd, registered in England no 05871053. Union Income Benefit Holdings Ltd acts as the **administrator** for the **insurer** for sales, administration, claims management and complaints.

## SECTION 10 – DEFINITIONS

Where **we** explain what a word means, that word will have the same meaning wherever **we** use it in **your policy**. These words are highlighted in **bold**.

### Accident

A physical injury that is caused directly and only by a sudden, unexpected external and visible event, anywhere in the world during the **period of cover**.

### Benefit(s)

The amounts shown in the **policy schedule** that are payable in the event of a claim.

### Benefit year

The 12-month period starting on the **start date** and every 12-month period after that for which **you** pay and **we** accept **your premiums**.

### CBRN Terrorism

An unlawful act committed for political, religious or ideological purposes with the aim of influencing a government and/or causing fear among the public that results directly or indirectly in the release of chemical, radiological, biological or nuclear agents.

### Day-case treatment

A **treatment** which, for medical reasons, means **you** have to go into a **hospital** or **day-case unit** because a period of clinically supervised recovery is needed but they do not have to stay overnight.

### Day-case unit

A centre in which **day-case treatment** (including **hospitals**) is carried out but excluding GP's surgery or clinic or attendance at an **accident** or emergency department.

### Dental accident

A sudden and unexpected injury to the mouth, which causes damage to the teeth and/or gums, and results from a direct **extra oral** impact.

### Diagnostic tests

Investigations, such as x-rays or blood tests, to find or to help to find the cause of **your** symptoms.

### Doctor

A qualified medical practitioner registered in the **UK** with the General Medical Council. A **doctor** cannot be **you**, or anyone related to **you** or anyone living with **you**.

### Extra Oral

Outside or external to the oral cavity including anything external to the lips and cheeks.

### Hospital

An institution, which has accommodation for residential patients and facilities for diagnosis, surgery and **treatment**. It does not include a long-term nursing home, a rehabilitation centre, a geriatric or a convalescence home or an extended-care facility.

### Illness

A sickness or disease which first occurs during the period of cover and results in a claim covered by this insurance within the **benefit year**.

### Inpatient treatment

Any **treatment** which, for medical reasons, means **you** have to stay in **hospital** overnight or for longer.

**Maximum benefit**

The **maximum benefit** payable for any **benefit** listed on **your policy schedule** in any one **benefit year**.

**Medical condition**

Any disease, **illness** or injury, including psychiatric **illness**.

**Period of cover**

The period between the **start date** and the date up to which **you** have paid the correct **premium**.

**Plan**

This Health Cash Plan.

**Policy**

The full terms of the insurance contract between **you** and **us** are set out in a number of documents including the **policy schedule** and this **policy** wording.

**Pre-existing condition**

Any sickness, injury or condition that **you** knew about, or in **our** reasonable opinion should have known about, at the **start date** of **your policy**, for which **you** have received treatment, medical advice or taken medication for in the 24 months prior to the **start date** of **your policy**.

**Premium(s)**

The amount **you** pay in return for the cover **you** have chosen as set out on **your policy schedule**.

**Qualification period**

The period before **you** are entitled to most **benefits**. The **qualification period** that applies to each **benefit** is shown on the table of **benefits**. **We** will not pay **benefit** if **you** receive any **treatment** during these **qualification periods**.

After an **accident** the **qualification period** does not apply to the 'hospital inpatient treatment and day-case treatment' or 'dental accident and emergency' **benefits**, as long as **we** have received **your first premium** or have issued **your policy** wording and **policy schedule**.

**Receipt**

The original **receipt** provided by the **qualified practitioner**. All **receipts** for **treatments** must show the full name of the person who received the **treatment**. **We** will not accept **receipts** made out in joint names. The **receipts** should also fully describe the **treatment** received or the items paid for; the date of the **treatment**, the full cost and the date the account was paid. **We** will not accept till slips, credit card sales vouchers, photocopied or altered **receipts**.

**Start date**

The date **your policy** begins as shown on **your policy schedule**.

**Terrorist act**

Any clandestine use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal.

**Treatment(s)**

Surgical or medical services (including **diagnostic tests** and **day-patient treatment**) that are needed to diagnose, relieve or cure a disease, **illness** or injury as set out on the **policy schedule**.

**Type 1 Total Maximum Benefit**

The amount shown on the **policy schedule** as the total **benefit** payable across all Type 1 **treatments** provided to **you** in any **benefit year**.

**Type 2 Total Maximum Benefit**

The amount shown on the **policy schedule** as the total **benefit** payable across all Type 2 **treatments** provided to **you** in any **benefit year**.

**UK Resident**

Resident in England, Scotland, Wales, Northern Ireland for 7 months out of each year. This includes those currently employed as an offshore worker, seafarer or mariner, whose permanent residence remains in the UK.

**War**

A contest carried on by force of arms between the armed forces of separate nations and which is usually characterised by the pursuit of territorial gain.

**We, our, us**

Stonebridge International Insurance Ltd.

**You, your**

The person who purchased this **policy** and who is named on the **policy schedule** as the **policyholder**.

# Contact Us

Telephone calls may be recorded for monitoring and quality purposes.

Lines open: Mon to Fri 9am to 6pm

## Customer Services

Telephone: 0343 178 1255

Email: [customercare@uibuk.com](mailto:customercare@uibuk.com)

Address:

Union Income Benefit  
39-51 Highgate Road  
London  
NW5 1RT

## Claims

Telephone: 0800 014 7024

Email: [claims@uibuk.com](mailto:claims@uibuk.com)

Address:

Claims Department  
Union Income Benefit  
39-51 Highgate Road  
London  
NW5 1RT