My PMI

Policy Conditions

Private medical insurance
that's just right for you

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My Private Medical Insurance (My PMI) offers a range of private medical insurance policies that cover the cost of eligible medical treatment in the UK by recognised consultants, therapists and practitioners where we have pre-authorised treatment.

Each policy level in the range is designed to cover acute medical conditions likely to be curable with treatment but not chronic conditions which are long term conditions without cure or likely to come back. These will be handled by the NHS.

If you decide to take out the policy, we will offer you terms for 5 years at a time. Your premiums will be reviewed each year but will not be affected by your own claims history during the 5 year term.

These Policy Conditions give further details about how we administer each policy, how you can make a claim and how to apply to make changes to your cover.

Your Policy Summary provides the key information you need to know before deciding whether to apply for one of these policies.

Should your application for a policy be accepted you will be provided with a Policy Schedule which shows the personalised details of the cover provided by the policy you choose.

Your contract with National Friendly consists of these documents, the information contained in your application and any additional information you provide us with after you take out the policy. Reading these documents should help you identify whether the policy meets your needs, which you should continue to assess throughout your policy term. When we refer to 'we', 'our', or 'us', we mean the National Deposit Friendly Society Limited, trading as National Friendly.

Each policy is generally suitable for someone who is looking to cover the cost of a range of health expenses, but Levels 1 and 2 are tailored to specific out-patient and in-patient needs respectively. We have not provided you with any advice regarding this policy but if you bought it through a financial adviser they should have discussed your demands and needs with you.

You must always take reasonable care to give full and correct information to the questions we ask. You should keep all of these documents together in a safe place in case you need to refer to them in future.

Definitions

We will use the following words in defining your policy so you may need to refer to this list just to check your understanding.
All other words and phrases in this Policy Conditions document are left to their natural (dictionary) meaning.

Acupuncturist: A practitioner who is a member of one or more of the following:

- British Acupuncture Council (BAC);
- Acupuncture Association of Chartered Physiotherapists (AACP);
- The British Medical Acupuncture Society (BMAS);
- British Academy of Western Medical Acupuncture;
- The Association of Traditional Chinese Medicine and Acupuncture (ATCM).

Acute condition: Any medical condition that is likely to respond quickly to treatment that aims to return you to the state of health you were in before or which leads to your full recovery.

Annual allowance: The maximum amount that we will pay towards the cost of eligible claims for treatment in a policy year. The amount of your annual allowance is shown on the Policy Schedule.

Chiropodist: A practitioner registered under the Health Professions Council (HPC) and a member of the Society of Chiropodists and Podiatrists.

Chiropractor: A practitioner on the Register of Chiropractors kept by the General Chiropractic Council as required as part of the Chiropractors Act 1994.

Chronic condition: A medical condition that has one or more of the following characteristics:

- it continues indefinitely and has no known cure;
- it comes back or is likely to come back;
- it needs ongoing or long-term control or relief of symptoms;
- you need to be rehabilitated or specially trained to cope with it;
- it needs long-term monitoring through consultations, check-ups, examinations or tests.

Counsellor: A practitioner accredited with the British Association for Counselling and Psychotherapy or a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapists.

Day-patient treatment: Treatment for which you have to go into a hospital or day-patient clinic/ unit because you need time to recover under medical supervision, but for which you do not need to stay overnight.

Eligible (claims or treatment): Services, products and practice allowable under the policy terms and which are consistent with generally accepted standards of good medical practice in the medical profession in the UK.

Exclusion: An illness, injury or other medical condition not covered by your policy.

Extended hospitals: We will pay for treatment at a hospital on our extended list if you select this option during the application process. Selecting this option will increase your premium. The up-to-date list is published on our website or it can be provided on request.

GP: A general practitioner (doctor) with a licence to practise and who is registered with the General Medical Council in the UK.

Guided treatment: our claims process under which the claims team will source and arrange treatment for you with appropriate consultants and at an appropriate medical facility.

Hospital: A private hospital in the UK which is registered in accordance with UK law and which has specialist facilities for major surgical operations.

Incidentals: gratuities and other minor fees or costs incurred in addition to the main service, such as transportation and meals.

In-patient treatment: Treatment which, for medical reasons, means you have to stay in hospital overnight or longer.

Medical condition: Any disease, illness or injury, including psychiatric illness.

Medically necessary: Any medical treatment or service necessary to diagnose or improve medical outcome which is deemed appropriate by a qualified medical practitioner or specialist and where, if not carried out, this would have an impact negative to the patient's health.

Moratorium: The period during which we will not pay for medical conditions for which you had signs or symptoms in the five years before the start of your policy.

Musculoskeletal: Treatment for pain in the back, neck, muscles or joints.

Nurse: A nurse with a 'Registered' status on the register of the Nursing and Midwifery Council (NMC) identifiable by an NMC personal identification number.

Nursing: Treatment administered by a qualified nurse.

Occupational therapist: a therapist registered with the British Association of Occupational Therapists.

Osteopath: A practitioner on the Register of Osteopaths kept by the General Osteopathic Council.

Out-patient treatment: Treatment given at a hospital, consulting room or out-patient clinic where you are not admitted for day-patient treatment or in-patient treatment.

Physiotherapist: A practitioner registered with and regulated by the Health Professions Council.

Policy year: A period of 12 months from the policy commencement date or subsequent anniversaries.

Practitioner: A practising acupuncturist, chiropractor, counsellor, physiotherapist, psychiatrist, psychotherapist or osteopath.

Pre-existing condition: Any disease or injury for which you have had medication, advice or treatment, or that has produced signs or symptoms, whether or not a medical condition was diagnosed, in the five years before the start of your policy.

Psychiatrist: A clinician who is a current member or fellow of the Royal College of Psychiatrists (RCPsych). A clinician registered with the General Medical Council and a current licence to practise.

Psychotherapist: A psychotherapist accredited by the UK Council for Psychotherapy, the British Association of Counselling and Psychotherapy or the British Psychoanalytic Council.

Sign: Any objective evidence of disease which can reasonably be recognised by a patient, healthcare professional or other person.

Speech therapist: A member of the Royal College of Speech and Language Therapists

Specialist: A medical specialist registered on the General Medical Council's Specialist Register www.gmc-uk.org, who is a specialist in the treatment you are referred for. The specialist must hold a current licence to practise and must also hold a certificate of Higher Specialist Training in their speciality that is issued by the Higher Specialist Training Committee of the appropriate Royal College or Faculty.

Standard hospitals: We will pay for treatment at all hospitals in the UK other than those on our extended hospitals list if you select the standard hospitals option during the application process. You will pay more for this than if you select our guided treatment option.

Symptom: A sensation (such as pain) felt by the patient and caused by a disease or illness.

Treatment: Surgical or medical services (including diagnostic tests) to diagnose, relieve, treat or cure a disease or injury.

UK: This means England, Scotland, Wales and Northern Ireland, but not the Channel Islands or the Isle of Man.

1.0 What's covered

Throughout this document we will refer to treatment and this will mean treatment that is established as best medical practice and is practised widely within the UK. Such treatment should be clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the treatment is provided.

It should either been shown to be safe and effective for the treatment of your medical condition through substantive peer reviewed clinical evidence in published authoritative medical journals, or been approved by NICE (The National Institute of Health and Care Excellence) as a treatment which may be used in routine practice.

If the treatment is a drug, we will cover drugs licensed for use by the Medicines and Healthcare products Regulatory Agency (MHRA) and used according to that licence.

We have divided cover into out-patient and in-/day-patient benefits so we can explain each benefit in general and detail any variations by policy level. For a breakdown of cover by policy level, please see the My PMI Policy Summary.

Depending which level you choose, different elements of cover will apply
to you, and some might not apply to
you at all.

1.1 Our out-patient cover

Out-patient treatments are covered on Levels 1, 3 and 4. They do not apply to Level 2, though this Level does have limited cover for scans and tests as described on page 7.

In the following section we have set out treatments and diagnostic procedures which we will cover and have detailed any limitations of cover. As well as the general policy exclusions we list, some medical conditions may be excluded from your cover because you suffered from them before you joined.

Details of how we treat pre-existing conditions are listed in the Policy Summary.

We have started by listing out-patient cover. This is usually appointment-based treatments which at an early stage may not need hospital treatment. On Levels 1 and 3, out-patient treatments have a choice of two monetary cover levels. You will choose whether you want to cover each person on the policy for £2,000 or each person for £5,000 in each policy year and will responsible for any expenses which exceed these limits.

In section 4 – Making a claim we set out how we will work with you to manage your treatment. Eligible claims for treatment are covered as long as they are carried out by a relevant and qualified GP, specialist or practitioner.

This policy is designed to get you access to a specialist consultant as early as possible to assist your recovery.

Benefit and limitations – out-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Private GP consultations	We will pay for face to face visits to a Private GP where these lead to a referral to a specialist for diagnosis of a medical condition. Your policy also has the built-in advantage of access to our virtual GP service. It's called Friendly GP and is provided by our partners at HealthHero. It can be accessed over the phone or online 24 hours a day, 7 days a week, without restriction. The service includes GP telephone consultations, video consultations, private prescriptions and open referrals. For more information please see the Existing Members page on our website, or use the telephone details on the final page of this document.	We do not pay for medication, reports or administration fees even if these are to support your treatment. We will pay for one face to face private GP consultation up to £100 per policy year which does not require further medical tests or lead on to a referral to a specialist; that's to say your condition was managed by advice and perhaps medication.
Diagnostic consultations with a specialist	Out-patient consultations carried out by a specialist to diagnose a medical condition. If you choose our guided option this will be a consultant we choose and book for you.	

Diagnostic tests to find or help find the cause of your symptoms	Diagnostic scans and tests recommended by your GP or specialist after referral from your GP. These include:
	• pathology (tests such as blood and urine tests);
	• removal of tissue for diagnostic purposes (biopsies) and subsequent histology (tests using a microscope);
	• radiology such as, but not limited to:
	• angiogram;
	  • computerised tomography (CT) scans;
	  • magnetic resonance imaging (MRI) scans;
	  • positron emission tomography (PET) scans;
	  • x-rays.
	The tests listed above may be undertaken as part of diagnosis of heart and cancer issues as well as for other illnesses and conditions.
	• scans and tests for gait assessment (podiatry);
	• electrocardiogram (ECG);
	• colonoscopy and endoscopy;
	• arthroscopy and keyhole surgery;
	• treadmill tests;
	• hospital costs as a result of the scans and tests above.
		Level 1
		Arthroscopies are not covered.
		We do not pay for angioplasty as this is a day-patient or in-patient treatment.
		Level 2
		The only out-patient benefits available are diagnostic scans and tests.
		The annual limits of cover are £1,500 for diagnostic scans and £1,000 for diagnostic tests for each person covered.
		We do not pay for any private out-patient consultations, including those for such scans and tests.
		All levels
		We do not at any level of cover pay for genetic testing, screening, or for preventive treatments prior to diagnosis.

Benefit and limitations – out-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Physiotherapy, osteopathy, chiropractic or acupuncture therapies	Where carried out by a relevant practitioner before in-patient treatment or day-patient treatment is performed. This includes costs for being treated at home, residential home and nursing home where appropriate, where your practitioner deems this medically necessary.	We do not pay for acupuncture for non-medical reasons, such as but not limited to help stop smoking or cure phobias.
Podiatry/ Chiropody	Where carried out by a relevant practitioner. We will pay for: 1. gait assessment to diagnose a medical condition. 2. medically necessary podiatry and chiropody treatment, including for bunions, hammer toes and heel spurs.	We don't pay for routine foot care which is not medically necessary such as, but not limited to: • fungal disorders; • cutting or removal of blisters, corns and calluses; • cosmetic foot care and pedicures, such as the trimming, cutting, and clipping of nails, hygienic or other preventive maintenance (for example cleaning and soaking the feet). We don't pay for insoles, hosiery or footwear of any type.
Psychiatric assessment/ counselling/ psychotherapy	We will pay for one initial psychiatric assessment per policy year, carried out on an out-patient basis where carried out by a psychiatrist. We will pay for up to 10 face-to-face sessions per policy year with a counsellor or psychotherapist. Cover includes the cost of being treated in your own home, a care home or nursing home, where your practitioner deems this to be appropriate.	We do not pay for any subsequent psychiatric treatment. We do not pay for group or couples therapy.

Benefit and limitations – out-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Minor Surgery	Following referral from your GP, we will pay for the following three minor surgery treatments where carried out by a private GP or specialist. They should be performed on an out-patient basis at your private GP or specialist's normal clinic or surgery. 1. carpal tunnel decompression. 2. joint injections. We will pay for the injection into, or removal of fluid from, a damaged joint as treatment for tendonitis and bursitis, respectively. 3. excision and cauterisation. We will pay for the treatment by excision and cauterisation of medical conditions such as skin cancer, lipoma, sebaceous cysts and moles, which appear to be cancerous.	We do not pay for any other joint injections. We do not pay for excision and cauterisation procedures for cosmetic purposes such as but not limited to the removal of tags or cysts.

1.2 Our in-and day-patient cover – Levels 2, 3 and 4.

The next section looks at in- and day-patient cover during which you are likely to need hospital treatment. Levels 2 and 3 have a total annual claims limit of £1 million per person on the policy. There are no restrictions on total claims on Level 4 unless specified in the table below.

Claims for treatment will be managed as set out in section 4 – Making a claim. Eligible claims for treatment are covered as long as they are carried out by a relevant and qualified GP, specialist or practitioner.

Benefit and limitations – in- and day-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Private hospital in-patient and day-patient costs	We will pay for in-patient and day-patient costs for the treatment of acute conditions. We also pay for acute flare-ups of chronic conditions, to bring your medical condition back to a controlled state. Treatment includes: • pre-operative tests; • specialists' fees for surgery, anaesthesia and physicians' fees; • operating theatre costs; • hospital accommodation costs; • investigative procedures such as keyhole surgery and arthroscopy; • any medication and dressings necessary to aid your recovery while a day-patient or in-patient; • associated nursing care.	We do not pay for non-medical or personal items such as but not limited to: newspapers, telephone calls, additional food items, flowers etc. We do not pay for accident and emergency treatment or accident and emergency admission. We will pay for eligible private treatment which results from accident and emergency admission only after you have first been medically discharged from an NHS hospital and have the choice to switch to private care. We do not pay for the treatment of chronic conditions. We do not pay for out-patient medication and dressings for use at home.
Medical appliances or prostheses	Any appliance or prosthesis fitted, inserted or attached as part of a treatment we have authorised.	
Concierge service – transport to/ from treatment.	Where a treatment requires sedation and you are advised not to drive yourself, we will pay towards your taxi fare.	Maximum allowance £50 per taxi journey, payable upon proof of sedation requirements from your consultant and upon proof of your travel payment (a receipt).

Benefit and limitations – in- and day-patient cover		
Benefit	Extent of cover	Limitations of cover
Follow-ups and monitoring	Following treatment which we have authorised we will pay for further authorised treatment which will complete the recovery process until your medical condition is stabilised. This includes: • follow-up consultations; • removal of stitches and casts; • out-patient drugs and dressings administered or applied immediately after surgery; • out-patient treatment essential to your recovery from a covered in-patient treatment or day-patient treatment, such as physiotherapy or occupational therapy following an operation on a limb joint or speech therapy following an eligible operation or a stroke.	We do not pay for out-patient drugs and dressings for use at home. We do not pay for routine monitoring after stabilisation. Level 2 policies have a limit of £500 for follow-up consultations and these must take place within 6 months of the covered treatment. Level 2 policies have a limit of £500 for follow-up therapies and these must take place within 6 months of the covered treatment.
Dental procedures	We will pay for the following dental treatments: 1. surgical removal in hospital of any impacted teeth or buried teeth or roots (including apicectomy); and 2. the enucleation of cysts of the jaw. Treatment must be carried out by an oral or maxillofacial specialist in a dental or other hospital which has facilities for general anaesthesia.	We do not pay for any other dental procedures, such as but not limited to: • hygienist procedures • orthodontics. We do not pay for any dental procedures in a dental surgery.
Optical procedures	We will pay for eye treatment for acute conditions where treatment leads to lasting recovery, such as cataract surgery. We pay for surgery for ptosis (drooping eyelids) if you are referred by your optometrist to a consultant ophthalmologist and where your field defects are determined to breach DVLA requirements for safe driving.	We do not cover refractive surgery (a corrective procedure) for short sight or long sight, such as but not limited to laser eyesight correction surgery. We do not pay for treatment for permanent eyesight damage or deficiency (such as but not limited to short sight, long sight, astigmatism) by way of glasses, or contact lenses etc.
Aural procedures	We will pay for treatment in a hospital for the repair of a perforated eardrum.	We do not pay for: • transplants (such as but not limited to cochlea transplants); • hearing aids or devices; • any other aural procedures.

Benefit and limitations – in- and day-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Accompanying a child in a private hospital	We will pay reasonable private hospital accommodation costs incurred by the parent or guardian named as proposer on the policy when staying with a child policyholder under the age of 18 who is receiving eligible treatment under this policy.	We do not pay for: • any expenses incurred as a result of NHS hospital stays; or • for incidental costs not linked to the child's treatment, such as but not limited to newspapers and television rental.
NHS overnight stay benefit	Levels 2 and 3 Benefit payable at £100 per night to a maximum of 10 nights (£1,000) Level 4 Benefit payable at £100 per night to a maximum of 20 nights (£2,000)	We pay this when: You are admitted for in-patient treatment and stay overnight and your treatment is one we would have covered privately. You can also receive this cash payment if you have treatment in an NHS Intensive Therapy or Intensive Care unit, whether it follows private treatment or not. Payment of this benefit will not affect your excess. This benefit is not payable if you have accepted an offer under the fixed cash allowance benefit (see below).
Use of NHS facilities/fixed cash allowance	On some eligible in-patient operations and day-patient operations we may offer a cash alternative to private treatment, known as a fixed cash allowance, where: You elect to have your treatment performed on the NHS and our medical claims team has authorised the treatment in advance. We will pay the fixed cash allowance where the treatment meets certain criteria. Contact our claims team for details.	If this benefit is claimed, you cannot claim the NHS overnight stay benefit for the same treatment.
Private land ambulance	Where your consultant advises this is medically necessary.	We do not pay for air ambulance transportation or for elective use of any private land ambulance under this benefit.

Benefit and limitations – in- and day-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Tonsillectomy/ adenoidectomy	We will pay for tonsillectomies and adenoidectomies where deemed medically necessary to resolve a medical condition.	We do not pay for tonsillectomies or adenoidectomies as a preventive measure.
Varicose vein treatment	We will pay where the medical condition has caused a venous ulcer or is about to cause a venous ulcer if not treated immediately.	We will cover one procedure per leg over the lifetime of the policy. We will cover foam injection (sclerotherapy), ablation or other conventional surgery. We do not cover any other varicose vein procedures.
Complications of pregnancy and childbirth	Where you are a mother who has chosen to have your baby delivered in a private hospital facility we will pay for an emergency caesarean section where, for medical reasons presenting risk to the life of the baby or you, the baby needs to be delivered early. We will also pay for private treatment of the following: • retained placental membrane • ectopic pregnancy; • stillbirth; • hydatidiform mole; • post-partum haemorrhage (heavy bleeding following and as a result of the birth).	We do not pay for treatment of covered pregnancy/childbirth complications which occur within the first 12 months of your policy. We do not pay for any other treatment of medical conditions relating to pregnancy, such as, but not limited to: • nausea; • backache; • high blood pressure. We will not pay for any termination of a pregnancy. We don't pay for treatment of the baby after birth.
Heart treatment	We will pay for the following surgical procedures for heart-related medical conditions: • coronary angioplasty; • coronary artery bypass; • the implantation of devices such as a pacemaker or defibrillator; • cardiac valve surgery. We pay for scans and tests requested by your specialist after diagnosis of a medical condition has been established. We pay for monitoring until your medical condition has been stabilised.	We do not pay for: • routine heart and circulatory checks such as but not limited to monitoring blood pressure; • the maintenance or replacement of pacemakers, defibrillators and other heart-related devices once inserted.

Benefit and limitations – in- and day-patient cover		
Benefit	**Extent of cover**	**Limitations of cover**
Cosmetic and aesthetic treatment	We will cover reconstructive surgery which we have authorised in advance to restore function or appearance following an accident or covered surgery which took place after this policy started.	We do not pay for: • any other procedures to change physical appearance such as but not limited to: facelifts, breast reduction or augmentation or tummy tucks; • removal of tissue which is not diseased, such as but not limited to removal of surplus fat or healthy tissue, for example warts and verrucas; • removal of, or treatment of infections caused by, tattoos.

Benefit and limitations - in- and day-patient (Level 4 only)		
Benefit	**Extent of cover**	**Limitations of cover**
Women's health benefit	We will pay for consultations in respect of the three stages of the menopause and any associated tests which will inform and assist a healthier lifestyle, to strengthen bones and reduce the risk of fractures.	Maximum allowance £300 per consultation. Maximum of 3 consultations permitted every 5 years. No benefit payable in first 3 months of the policy. We won't pay for the cost of drugs.
Men's health benefit	We will pay for consultations in respect of the prostate specific antigen (PSA) test and any associated tests which will inform and assist a healthier lifestyle.	Maximum allowance £300 per consultation. Maximum of 3 consultations permitted whilst every 5 years. No benefit payable in first 3 months of the policy. We won't pay for the cost of drugs.
Concierge service – 2nd medical opinion	Where we are satisfied this is appropriate we will seek a second opinion from a different consultant on your diagnosis.	We won't pay for any second opinion we have not agreed and authorised in advance.

1.3 Our cancer cover

We will support you throughout your cancer treatment using our experienced claims team. We will cover treatment for any new cancer and for any recurrence of a cancer within the policy term. The descriptions below and over the page apply to Levels 2, 3 and 4 **unless otherwise specified by asterisks.** Those with an asterisk apply to Levels 3 and 4 only.

Please be aware that should you require treatments listed as not covered, you will be required to pay costs for these.

Benefit and limitations – cancer cover		
Benefit	Extent of cover	Limitations of cover
Cancer treatment	We will pay for the following treatment intended to affect the growth of the cancer by shrinking the cancer, or stabilising it to slow the spread of the disease: • conventional surgery for the treatment of cancer • chemotherapy, including home treatment where deemed medically necessary by your specialist; • *immunotherapy (monoclonal antibodies); • *hormonal therapy where this is to shrink a tumour before you have surgery or radiotherapy; • *targeted therapy (tyrosine kinase inhibitors); • radiotherapy; • medications prescribed by your specialist to help alleviate cancer-related bone damage and side effects of chemotherapy.	We do not pay for: • preventive treatment; • experimental treatment of any type; • clinical trials other than listed; • biological therapies other than those listed; • hormonal therapies other than listed; • gene therapy; • genetic testing or screening; • administration or transport costs relating to cancer treatment; • out-patient medication (such as but not limited to hormone replacement therapy) prescribed by your GP.

Benefit and limitations – cancer cover		
Benefit	**Extent of cover**	**Limitations of cover**
Cancer treatment	All cancer drugs must be approved and licensed by The Medicines and Healthcare products Regulatory Agency (MHRA) and/or NICE (The National Institute of Health and Care Excellence). All such drugs must be used according to that licence, including those on phase III clinical trials*. • **stem cell and bone marrow treatment; • wigs purchased as a result of hair loss caused by cancer treatment up to a maximum of £400 per policy year; • prostheses which are provided as part of active treatment of your cancer. Treatment can be administered at a private hospital, day-patient unit or scanning centre or in your own home, care home or nursing home where administered by a healthcare professional under guidance from your cancer specialist. An example might be administering intravenous drugs. * Levels 3 and 4 only **Level 4 Only Restrictions as asterisked	Where your treatment is not covered under the policy, our claims team will work with you to explain any shortfall you may have to pay and to point you to alternative sources of treatment where these are viable.
Palliative care **Level 4 Only	We will cover treatment costs in respect of clinically proven palliative drugs and treatment provided at end stage cancer to manage symptoms. We will also pay a sum of £500 to your provider of hospice care should you enter the palliative (end of life) stage of the disease.	One hospice payment of £500 only.

2.0 What's not covered

None of these policies are designed to cover all medical conditions, or all medical services. We will not authorise or pay for treatment carried out by a health care professional who is not recognised by us and qualified to provide your treatment.

In addition to the limitations of cover specified in the previous sections there are a number of significant exclusions from cover which are detailed in this section.

2.1 Accident and emergency: We do not pay for treatment where you are admitted to hospital via an accident and emergency facility.

2.2 Addiction: We do not pay for treatment of any medical conditions caused by your addiction to, or abuse of drugs, substances or alcohol such as, but not limited to:

- cirrhosis;
- mental health problems.

2.3 Age-related medical conditions: We do not pay for treatment for any medical condition solely associated with the ageing process such as, but not limited to:

- puberty (for example acne, growth spurts);
- the menopause (other than as detailed in the Women's health section of what's covered-Level 4).

2.4 Allergies: We do not pay for treatment to desensitise or neutralise your allergic reaction.

2.5 Chronic conditions: We do not pay for treatment of any chronic condition where the treatment is solely provided to relieve your symptoms.

2.6 Complementary medicine: We do not pay for complementary medicine (other than for acupuncture).

2.7 Congenital conditions: We do not pay for treatment of any medical condition you were born with.

2.8 Corrective treatment: We do not pay for treatment to correct any treatment we have not paid for under your policy.

2.9 Criminal activity and public order offences: We do not pay for treatment of any medical condition caused by your involvement in criminal activity or public order offences.

2.10 Cruise ship treatment: We do not pay for diagnosis or treatment administered whilst on a cruise ship even if this occurs in UK waters.

2.11 Developmental/behavioural conditions: We do not pay for treatment or investigations for any medical condition relating to physical or psychological development, or for impaired development of speech or learning, such as, but not limited to:

- dyslexia;
- dyspraxia.

We do not pay for treatment for any behavioural medical condition such as, but not limited to:

- ADHD (attention deficit hyperactivity disorder);
- Asperger syndrome;
- autism.

2.12 Dialysis: We do not pay for regular planned kidney dialysis treatment for a chronic condition.

2.13 Elective treatment: We do not pay for treatment which has not been recommended by your specialist.

2.14 Epidemics/Pandemics: we do not pay for treatment of any medical condition caused as a direct result of an epidemic/pandemic.

2.15 Experimental treatment: We do not pay for treatments or remedies which are:

- experimental or unproven by established medical practice in
  the UK;
- not recognised or regularly carried out by the NHS; or
- not approved or licensed by the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE (The National Institute of Health and Care Excellence) and we won't pay for drugs used outside of the scope of their UK licence.

2.16 Fertility treatment: We do not pay for any consultations or scans and tests to diagnose any medical condition related to fertility or infertility. We do not pay for treatment for infertility or to increase fertility. We do not pay for any egg or sperm donation. We do not pay for any treatment relating to contraception, sterilisation or to reverse sterilisation.

2.17 Gender dysphoria or reassignment/Sex change: We do not pay for treatment for gender dysphoria, re-assignment, sex change or gender confirmation treatment or anything connected with them in any way, such as, but not limited to:

- operations or other surgical treatment;

or

- psychotherapy or similar services.

2.18 Medication and dressings: We do not pay for medication and dressings provided or prescribed for out-patient purchase or for you to take home with you after you have been treated in a hospital or other treatment facility.

2.19 Mental health/ psychiatric treatment: We do not pay for mental health treatment as an in-or day-patient.

2.20 Missed appointments: We do not pay claims for any medical appointments you have missed.

2.21 Natural disasters: We do not pay for treatment of any medical condition caused as a direct result of a natural disaster.

2.22 Overseas treatment: We do not pay for treatment undertaken outside of the UK and we do not pay for repatriation such as but not limited to the costs for bringing you back to the UK for treatment.

2.23 Physical aids and devices: We do not pay for the supply or fitting of physical aids and devices not fitted, inserted or attached as part of a treatment we have authorised, such as but not limited to hearing aids, spectacles or contact lenses, walking sticks, walking frames or crutches.

2.24 Pre-existing conditions: We do not pay for any pre-existing condition that is detailed on your Policy Schedule or which is excluded under any moratorium period applying to your policy.

2.25 Preventive treatment: We will not pay for any vaccinations or treatment to reduce the possibility of contracting a medical condition for which you have no signs or symptoms, such as, but not limited to, treatment to reduce the possibility of developing a medical condition you have inherited.

2.26 Rehabilitation, residence and recovery: We do not pay accommodation costs for residential care, rehabilitation from a medical condition, or for convalescence of any kind which are not eligible treatment.

2.27 Routine monitoring, tests and examinations: We do not pay for monitoring, tests or examinations which are routine in nature and not undertaken on referral from a GP or specialist to diagnose or treat a medical condition.

2.28 Screening: We do not pay for tests, monitoring or examinations of any kind to identify whether you are likely to develop a medical condition that you have, or may have, inherited, and for which you have no signs or symptoms. This exclusion does not apply to the Women's health or Men's health benefits under level 4.

2.29 Second opinion: We do not pay for any second opinion that we have not pre-authorised as part of an eligible claim under Level 4.

2.30 Self-inflicted injury: We do not pay for treatment of intentional self-inflicted injury.

2.31 Sexual health: We do not pay for treatment of:

- sexually-transmitted disease;
- problems relating to sexual dysfunction.

2.32 Sleep disorders: We do not pay for treatment or appliances to help prevent sleep disorders such as, but not limited to:

- narcolepsy;
- insomnia;
- sleep apnoea;
- snoring.

2.33 Spa therapies: We do not pay for therapies such as but not limited to:

- hydrotherapy or detoxification in health clinics
- spas or clinics that promote general health rather than providing treatment for a medical condition.

2.34 Sports and pastimes: We do not pay for treatment for medical conditions sustained:

- as part of a sport for which you receive payment or reward through a wage, sponsorship or grant other than travel cost;
- whilst taking part in one of the following dangerous sports:
- motor racing sports such as, but not limited to cars, motorbikes or quad bikes;
- scuba diving or free diving;
- potholing, mountaineering, rock climbing or abseiling where ropes and guides are required;
- off-piste skiing, whether on skis or a board of any type;
- boxing, wrestling or martial arts;
- aerial activities, other than as a fare paying passenger on an aeroplane or helicopter, such as but not limited to: ballooning, bungee jumping, hang gliding, parachuting, parasailing or paragliding;
- horse racing or equestrianism;
- white-water rafting.

2.35 Transplant operations: We do not pay for transplants of organs or limbs. We do not pay for bone marrow or stem cell transplantation other than for cancer.

2.36 War, terrorist acts and civil commotion: We do not pay for treatment of any medical condition caused as a direct result of:

- act of foreign enemy or invasion;
- war (declared or not), military, paramilitary or terrorist activity (such as the effects of radiological, biological or chemical agents)
- civil war;
- terrorist acts;
- strike action;
- military or paramilitary acts;
- biological contamination or attack.
- use, misuse, escape or the explosion of any gas or hazardous substance (such as explosives, radiological, biological or chemical agents).

2.37 Weight loss treatment and obesity treatment: We do not pay for treatment for obesity, or weight loss treatment of any kind such as, but not limited to:

- gastric bands or sleeves, bypass surgery or other bariatric treatment;
- the removal of fat or surplus tissue which is not diseased;
- the correction of any other weight-loss treatment.

3.0 Making a claim

Your treatment path

Your first contact will normally be with a GP, whether that is your NHS GP, a Private GP or a member of our virtual GP service team.

At that point they will either deal with the problem, perhaps with advice and medication or they will need to take further action.

This will mean recommending tests and/or sending you to a specialist. In either instance, we treat this as what's known as a referral.

3.1 Here's what you should do next, depending on which treatment option you selected when taking out the policy.

Guided treatment – open referral

3.2 Under our guided treatment service, you should ask your GP for an open referral which does not name a particular specialist. An open referral should detail your medical condition/symptoms and the specialism and sub-specialism of the type of consultant that you need to see. We will find a specialist consultant, selected for quality by our claims team and tailored to your particular circumstances. We will then make your appointment for you. That consultant will then oversee your treatment from start to finish, including any required tests, to help you to get the best possible medical outcomes.

3.3 We will not cover treatment or consultations by a specialist we have not pre-authorised and agreed payment terms for.

Where we have recommended a consultant within 30 miles of your home we will cover the cost of the consultation in full to the limits of the cover level you choose. If you choose to see an alternative consultant we will only pay 75% of the consultation cost and you will be responsible for paying the remaining 25%. If the consultant our claims team recommends is more than 30 miles from your home address, and you do not wish to use that consultant, the claims team will source a more local alternative. If you choose a consultant other than the alternative recommended by the claims team, we will pay 75% of the consultation cost and you will be responsible for the remaining 25%. The same applies if your claim goes on to need surgery and/or follow up consultations and you elect to use a treatment source other than that recommended by our claims team.

Level 2 customers selecting guided treatment should still organise all private consultations, diagnosis and treatment through our claims team. If you choose this level you will pay for the consultant our claims team selects and arranges for you, and we will pay for any eligible tests and/or scans to diagnose you, plus any eligible treatment which follows.

3.4 Please note that if you are making a claim for a child under 17, you should ask for a referral to a specific paediatric consultant rather than an open referral.

Choosing your own provider – standard or extended treatment options

3.5 If you chose Standard or Extended treatment when your policy started, and you wish to source treatment with the help of your GP rather than our claims service, you still need to let our claims team know where and when you plan to have your treatment done. This is so that they may check and authorise your claim before treatment is administered. This includes Level 2 customers who will pay for the majority of out-patient treatment, including consultations. The claims team will need to know in case any eligible scans or tests result from your consultation.

3.6 Such checks will be undertaken to ensure your treatment type and cost are within those listed in our Schedule of Fees, a list of codes and prices for medical procedures and published on the Claims page of our website and which can be provided on request. See 3.23 for details of what this could mean for your claim.

Letting us know

3.7 When you have a health concern for which you may wish to make a claim under your policy, you must call us to tell us and check whether your claim is eligible for payment. You should contact us even if the claim value falls entirely within the excess you have chosen so we can keep a record of the amount of excess used.

Please have your membership details to hand when you contact us. You can contact us as follows:

Call us: **0333 014 6244** calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes.Lines are open 8am to 6pm Monday to Friday excluding bank holidays. Calls will be recorded for training and quality purposes.

Email us: **nfclaims@healix.com**

3.8 Our claims team will ask you questions about your health concern and explain the extent of cover available from your policy and any limitations that apply. Where you have a number of options available we will explain these to you.

3.9 We may need a copy of your GP referral or to contact the GP, specialist or practitioner (as relevant) involved in your care to obtain medical evidence for your claim and we may need to obtain your permission to do so.

We will take reasonable steps to obtain relevant medical evidence promptly.

3.10 Where you apply to claim for a musculoskeletal or mental health treatment we will get a specialist in these fields to call you back to ask you some questions about your condition. They will assess whether your claim is eligible and the best course of treatment. You are still free to see a GP but don't have to in order to be referred to a specialist. Where we authorise your claim we will offer to make arrangements for you to receive appropriate treatment.

3.11 This policy is designed to provide private medical cover in the UK only.

3.12 For all eligible claims that we authorise we will give you an authorisation number and, wherever possible, will set up payment arrangements with any GP, specialist, practitioner or hospital involved in your care.

3.13 All claims must be pre-authorised, otherwise you are at risk of us not covering the cost. In exceptional circumstances it may be appropriate for you to pay for something which we then reimburse, but please discuss this with us first.

Where it is not possible to set up such a payment arrangement, for example, for a private GP appointment which is usually payable by the patient, or for valid transport costs (Level 4), we will ask you to pay this yourself and send us your receipt and evidence of payment for reimbursement. We will also need to see proof of your NHS stay where you are claiming the NHS cash benefit. You can send these items to us at:

National Friendly Claims Team, 3 Temple Quay, 5th Floor, Temple Back East, Temple Quay, Bristol, BS1 6DZ

3.14 For authorised musculoskeletal claims we will conduct a review to check that the treatment you are receiving remains appropriate to your recovery.

3.15 For authorised mental health claims: our mental health team will offer to refer you for an initial consultation. Where authorised, we will pay for up to a further 9 sessions of counselling or psychotherapy per policy year, making 10 sessions in total.

We won't pay for psychiatric or in-patient mental health treatment.

3.16 For all claims: We may seek and pay for a second opinion on your treatment where this would be beneficial to the outcome of our assessment of your claim, for example where existing treatment does not appear to be effective. We will not pay for any second opinion that we have not authorised.

3.17 We will pay eligible claims to the following extent:

3.17.1 where the treatment costs are within the range specified in our Schedule of Fees; and

3.17.2 where you have chosen an excess each person on a policy will pay that excess as the first part of their treatment costs in each policy year; and

3.17.3 we will pay for the remaining part of treatment costs for treatment undertaken in each policy year within any benefit allowance which applies.

3.18 An excess is payable in any policy year that you have eligible treatment under your policy. No excess is payable for private GP consultations, NHS overnight stay or Fixed Cash Allowance claims and we won't expect you to pay an excess towards the Women's or Men's health checks under Level 4.

3.19 Where the cost of your claim in a policy year is less than your excess we will deduct the cost of your claim from your available excess and tell how much of your excess remains for that policy year.

3.20 The cost of the treatment will be deducted from any remaining benefit allowance which applies as at the date the treatment takes place, not at the date we receive the invoice.

3.21 Where you have an excess to pay you will be responsible for making arrangements directly with the medical practitioner or facility to pay that amount towards the cost of your claims.

3.22 Any unused cover and/or excess in a policy year cannot be carried forward to use in subsequent policy years nor offset against claims costs falling due in previous policy years.

3.23 Where a claim is not eligible, or when a treatment cost is not covered in full for any reason, including where costs exceed those in our Schedule of Fees, we will discuss alternative courses of action with you. This could include, for example:

a. paying eligible parts of the claim out of your policy and the rest from your own money;
b. using alternative facilities or specialists whose costs would be covered under your policy; or
c. seeking a referral to an NHS specialist.

Claiming from other sources

3.24 Where you make a claim through another insurer or through the courts for a claim that you also make from this policy, you must notify National Friendly and the other insurer. If you are successful in recovering any payments in respect of treatment claims made under the policy, we can pursue claims against any third party for costs.

The importance of providing information

If you do not give us information we ask for, or do not give us the medical consent we need to access your medical records when we ask, we will not be able to assess your claim and so will not be able to pay it.

We may also ask you to pay back money that we have previously paid on the same claim for this medical condition.

4.0 Premiums, reviews and renewals

Your premiums

You can choose to pay your premiums monthly or annually. Premiums are payable in advance of the dates shown on your Direct Debit Confirmation. Annual premiums are due on your policy anniversary.

4.1 If you would like to change the frequency of your premium payments (i.e. monthly to annually or annually to monthly) you can do this at the policy anniversary.

4.2 Premiums include insurance premium tax which is levied by the government and we may change your premium at any time to reflect any changes to the rate of insurance premium tax applicable to the policy. We will let you know in writing of any such change.

4.3 Anyone can pay the premiums on behalf of the policyholder.

4.4 Direct debits are governed by very strict rules summarised in the Direct Debit Guarantee.

This includes a promise that if there are any changes to the amount, date or frequency of your direct debit we will notify you 10 working days in advance of your account being debited or as otherwise agreed. If we make an error you are entitled to a full and immediate refund of the amount paid.

Arrears

4.5 If you do not pay a premium when it is due we will write to you to tell you that you have until the end of the month to pay it. If you do not pay it within this time your premiums will be in arrears, which will mean you will not be entitled to the benefits from the policy in the form of payment of your claims in progress.

We will not authorise any further eligible claims whilst your premium is in arrears.

4.6 You must pay all arrears and all premiums due to restore entitlement to benefits under this policy.

4.7 Should your premiums be three full months in arrears, the policy will lapse which means that it will end and cannot be reinstated.

4.8 Your entitlement to benefits will end with effect from the final day of the period purchased by your last premium.

4.9 Where the policy lapses there is no surrender value payable to the policyholder.

Annual premium reviews

4.10 Each year we will review the premiums payable on all policies like yours to determine the new premium rates for these policies.

4.11 We will write to you in good time before the first, second, third, and fourth anniversaries of your policy to tell you your new premium(s) for the following policy year.

Your premium(s) for each policy year will take into account:

- the standard premium for your age and postcode area at the policy renewal date; and
- any excess you choose; and
- the hospital/provider choice you make; and
- the expected future frequency and value of all claims paid on our similar private medical insurance policies; and
- changes in other factors such as taxation, regulation, National Friendly’s costs or any other factor that we have reasonable grounds to believe will change the expected future profitability of these policies, as relevant to your policy, from the level anticipated when the premium rates were originally set.

4.12 The annual premium review could result in your premium rising, falling or staying the same.

4.13 Before your new premium takes effect on the next policy anniversary, you have the option to choose whether to keep your excess at the same amount or to increase it, in order to help offset any rise in your new premium for the upcoming policy year. You will not be able to decrease your excess to a lower amount. This means if you have already selected the highest excess option (£1,000) you will not be able to increase or decrease the amount of excess you pay towards your treatment costs.

We will remind you of any excess options you have when we write to tell you about your new premium.

Reviewing your treatment provider

You will be given one opportunity in each 5-year term to change your treatment path (guided, standard or extended). You will only be able to do this at an annual premium review and may not use your new choice for any planned medical treatment.

Reviewing who's covered

If you want to add or remove family members to/ from the policy, please contact us and we will let you know what we need from you. All added members must meet the requirements of 'Who can be a policyholder and who can be covered' starting from section 6.13.

Reviewing your cover level

If you want to change your cover level, you can do so at an annual premium review. We will let you know how you can do so, including any medical details we need from you where your claims risk is likely to change.

4.14 The new premium for each policy year will take effect on the next policy anniversary.

You can change your cover level at any policy anniversary. We will let you know if the change you make requires further medical details from you. This will only be where your change adds additional risk of claim under the new choice.

We will let you know the premium and terms for your new cover level once we have assessed your application.

Five-year renewal

4.15 Each policy is a five-year contract that will be renewed every five years.

4.16 We will write to you, in good time before each fifth anniversary, to let you know the proposed terms of your cover for the renewal policy including the premium, which may at that point reflect your claims history.

4.17 Before your new renewal policy takes effect, you have the option to choose whether to:

- keep your excess at the same amount; or
- reduce it, providing you have not already chosen the lowest excess option; or
- increase it, providing you have not already chosen the highest excess option.

Your choice of excess will affect how much you pay in premiums for the renewal policy. We will remind you of any excess options you have when we write to tell you about your renewal options.

You will also be asked which treatment path you wish to choose (guided, standard, extended or any new or revised list which exists at that time).

4.18 We will renew on the same basis as your existing choices unless you tell us otherwise before the renewal takes effect.

4.19 If the policy is no longer available, we will do our best to offer you an alternative.

4.20 You should consider carefully whether the renewal terms are acceptable to you when making your decision whether or not to proceed with the renewal policy.

4.21 You are under no obligation to accept the renewal terms and can choose, if you wish, to end your policy instead.

4.22 If you accept the renewal terms we will send you a new Policy Schedule confirming your policy details, including your new premium and any special terms.

If the policyholder dies

We will not automatically cancel the policy if the policyholder dies. The policy will transfer to the policyholder's spouse or partner or the eldest child over the age of 18, subject to their agreement to continue the policy and accept its terms and conditions, which could be altered to reflect the change.

Circumstances in which your policy cover could end

Your policy and cover under it could end in these circumstances:

- you tell us to cancel the policy;
- you don't pay your premiums for three months and we close your policy;
- you cease to live in the UK and we close your policy;
- we are notified of your death and we close your policy;
- the policy is no longer available for renewal. In this scenario we may invite you to apply for an alternative health insurance policy.

We could also end your policy under the Consumer Insurance (Disclosure and Representations) Act 2012, due to your failure to provide accurate information where it is reasonable to do so when taking out, renewing, claiming on or making changes to, the policy. We will write to the policyholder in advance of doing so and could claim back money claimed fraudulently as set out in 6.20 Fraudulent Claims.

5.0 Cancelling your policy

Cancelling your policy within 30 days

You have the right to cancel your policy within 30 days of receiving your policy documents.

You will receive a full refund of any premiums paid, provided you haven't made a claim in the meantime.

5.1 If you have made a claim in the first 30 days then you will be deemed to have accepted the policy and will not be entitled to a refund of any premiums that relate to the period before the cancellation date. If you have paid annually you will be refunded any premiums you have paid that relate to the period after your cancellation date.

5.2 We will not backdate closures.

5.3 To exercise your right to cancel you should contact us giving instruction to cancel within 30 days of receiving your policy documents.

Cancelling your policy after 30 days

5.4 If you choose to close your policy after 30 days of receiving your policy documents you will not receive a refund of your premiums paid that relate to the period before the cancellation date. If you have paid annually you will be refunded any premiums you have paid that relate to the period after your cancellation date.

5.5 You can close your policy by contacting us and giving us instruction to cancel.

5.6 We will not backdate closures or refund payment of part months.

5.7 When a policy ends, we will pay no further claims and there will be no cash in value.

6.0 Further information

National Friendly is a trading name of National Deposit Friendly Society Limited, which is incorporated in England and Wales no. 369F.

Our registered office is at **11-12 Queen Square, Bristol BS1 4NT**.

6.1 We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our Financial Services Register number is 110008. You can check this at **register.fca.org.uk** or by telephoning **0800 111 6768**.

6.2 Policyholders are automatically members of National Friendly. Policyholders aged 18 or over have voting rights and can attend our Annual General Meeting.

6.3 As a mutual society we're owned by our members and so all of our profits are invested in improving member benefits and our service to our customers, instead of paying dividends to shareholders. The manner in which the Society operates is set out in our Rule Book. This can be found on the About us page of our website. You can also ask us to send you a copy.

6.4 The start date of your contract with National Friendly for your policy is shown on your Policy Schedule(s).

6.5 We will provide you with an annual statement of your benefits in writing.

6.6 It is your responsibility to ensure that the information you provide on your application form is correct. If information becomes known at a later date, such that you would not have been eligible for the policy you hold with us, we may subsequently rescind (which means to undo or unwind) this policy.

6.7 In the event of a dispute this policy will be subject to English law and the jurisdiction of English courts.

6.8 All correspondence will be in English and all currency used will be in GB pound sterling (£).

6.9 We can vary this Policy Conditions document:

- To reflect changes in legislation, regulation or taxation which affect the policy;
- To allow us to administer the policy more efficiently;
- To clarify anything which is unclear;
- To correct any errors.

6.10 We will write to you in good time to give you notice of any change to this Policy Conditions document and explain any options you have at the time.

6.11 Nothing in this Policy Conditions document affects your statutory rights.

Updating your personal information

6.12 Your policy is regionally priced, so if you move to a new address, this may affect your premium on your next policy anniversary. It's also important to keep your details up to date in case we need to contact you. You should let us know as soon as possible if you change your name, address, or contact details, so we can update our records.

Who can be a policyholder and who can be covered

6.13 The policy can be taken out by

- an adult on a single life basis,
- as a couple (two adults)
- as an adult with a child or children
- as a couple with a child or children.

Each policy will have a designated policyholder who must be at least 18 years of age.

The maximum permitted number of children on any policy is ten.

Children must be no older than 22 on joining the policy and must exit the policy no later than their 23rd birthday.

You can add a partner where you are either married to them, in a civil partnership, or living together permanently

You can add any of your children or your partner's children.

We will require medical details for children but babies can be added within 3 months of their birth without medical information though we would point out we do not pay for congenital disorders (issues they were born with).

Please note that few, if any, private hospitals treat children under the age of three.

If you add or remove a person from cover under the policy, we will write to you to confirm the new premium and terms for your cover.

6.14 To apply for a policy for the first time, applicants must be aged 18 years or older and under the age of 86. Where a child cover under the policy is aged under 18 we will correspond with the policyholder until the child has attained age 18.

6.15 We will correspond directly with any adult over age 18 about a claim they are making.

6.16 All other policy administration will require the agreement of the policyholder, including, but not exclusively, changes made to the policy, personal details or cover choices.

6.17 Policyholders and anyone else named on the policy must be permanently UK-resident and registered at all times with a GP in the UK. They must have access to and be able to provide their full medical records in English.

6.18 Policyholders must have a UK bank account throughout membership into which we will pay any money relevant to the policy terms.

6.19 We will verify the identity of the policyholder and, where applicable, the payer, prior to commencement of the policy and at any other time as required by legislation and regulations.

Fraudulent claims

6.20 Throughout your dealings with us we expect you to act honestly. If you or anyone acting for you:

a. knowingly provides information to us as part of your application for your policy that is not true and complete to the best of your knowledge and belief; or

b. knowingly makes a fraudulent or exaggerated claim under your policy; or

c. knowingly makes a false statement in support of a claim; or

d. submits a knowingly false or forged document in support of a claim; or

e. makes a claim for any loss or damage caused by your wilful act or caused with your agreement, knowledge or collusion, then:

i. We may prosecute fraudulent claimants;

ii. We may make the policy void from the date of the fraudulent act;

iii. We will not pay any fraudulent claims;

iv. We will be entitled to recover from you the amount of any fraudulent claim already paid under your policy since the start date;

v. We shall not return any premium paid for your policy;

vi. We may inform the police of the circumstances;

vii. A policyholder may also be expelled from membership of National Friendly in any of the above scenarios, as set out in our Rule Book.

Financial crime

6.21 You agree to comply with all applicable UK legislation relating to the detection and prevention of financial crime (including, without limitation, the Bribery Act 2010 and the Proceeds of Crime Act 2002).

Sanctions

6.22 National Friendly, through your policy, shall not provide cover or be liable to pay any claim where this would expose the Society to any sanction, prohibition or restriction under United Nations resolutions, or trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or United States of America.

Complaint information

6.23 We hope that you never have reason to complain about your policy or the service you receive from us. If you do, you have the right to complain and we would like to put things right.

6.24 You can tell us what's gone wrong by telephone, email, post or any form of communication.

Phone us: **0333 014 6244** 8am-6pm Monday to Friday excluding bank holidays. Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes.

Email us: **complaints@nationalfriendly.co.uk**

Write to us:
Complaints Coordinator
National Friendly, 11-12 Queen Square,
Bristol BS1 4NT

6.25 We will explain our complaints process, investigate your complaint and try to resolve it promptly to your satisfaction.

6.26 We aim to resolve complaints and send you our final response in writing within three business days, or within eight weeks for more complex complaints.

6.27 If we cannot resolve your complaint to your satisfaction, you may be able to refer your complaint to the Financial Ombudsman Service. This service is free and using it in no way affects your legal rights to take civil action.

You can find out more information at www. financial-ombudsman.org.uk.

You can write to the FOS at **Financial Ombudsman Service, Exchange Tower, London E14 9SR**, phone them on: **0800 023 4567**, or email at: **complaint.info@financial-ombudsman.org.uk**

Complaints regarding your medical treatment

Complaints relating to the conduct or competency of your specialist or the facilities at which they practice should be directed to the relevant specialist and hospital or clinic directly.

We will not be involved in this process, but you are welcome to let us know you are proceeding and we will record details of such complaints.

The Financial Services Compensation Scheme (FSCS)

6.28 You are covered by the FSCS and may be entitled to claim compensation from them if we cannot meet our liabilities.

6.29 Full details of what you're protected for can be found at **www.fscs.org.uk** or by telephoning **0800 678 1100** or you can write to them at: **The Financial Services Compensation Scheme, PO Box 200, Mitcheldean GL17 1DY.**

Data protection

6.30 We are committed to protecting your privacy and as such National Friendly will only obtain, hold, and use your personal information where permitted by and in accordance with the Data Protection Act 2018.

For further details on how we obtain, hold, and use your personal data, please see our PMI Privacy Notice at **www.nationalfriendly.co.uk/privacy** which sets out the types of information we collect about you, how we collect and use the information, who we might share the information with and where such information may be transferred, how long we will hold the information for, the steps we will take to make sure it stays private and secure, and your rights in respect of your information.

6.31 You should receive a copy of our PMI Privacy Notice with your policy application form. As well as being available online, you can request a copy of our PMI Privacy Notice by contacting us using the details on the back page of this document.

6.32 You are responsible for making sure you provide us with accurate and up-to-date information. If you provide information for or about another person in the context of your dealing with National Friendly, you will need to tell them how to find the PMI Privacy Notice and make sure they agree to us using their information for the purposes set out in it.

Customer categorisation

6.33 We are required by the Financial Conduct Authority to categorise our customers to determine the level of protection they will receive. If you are a policyholder, proposer, or payer for the policy we will treat you as a retail consumer. This gives you the highest level of protection available under the Financial Conduct Authority rules.

Conflicts of interest

6.34 We will always try to act in your best interest. However, should we identify a conflict with your best interest we will let you know and will take appropriate steps to avoid or remove the conflict.

Here's how you can contact us

We're here to help

You can call us on:

0333 014 6244 8am-6pm Monday to Friday excluding bank holidays.

Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes.

Calls are recorded for training and quality purposes.

Or email us at:

info@nationalfriendly.co.uk

Or visit us at:

www.nationalfriendly.co.uk

Or mail us at:

National Friendly
11-12 Queen Square, Bristol
BS1 4NT

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