Paycare Gold

Policy Documents

Paycare Rules and Regulations Explained

Paycare

Everyday Health Cover since 1874

About our services

Please find below information that we are required to provide to you in order that you may decide if our services are right for you.

Who are we and who regulates us?

Paycare is an insurance provider and our office is situated at Paycare House, George Street, Wolverhampton. WV2 4DX.

Paycare is a not for profit company limited by guarantee and is authorised by the Prudential Regulation Authority (PRA) and regulated by the Financial Conduct Authority (FCA) and Prudential Regulation Authority.

The FCA's address is 25 North Colonnade, Canary Wharf, London E14 5HS.

You can check the Financial Services Register on the FCA website www.FCA.gov.uk.

Paycare's FCA reference is 202292.

Your client classification

- Policyholder/Consumer

Fees and Commission

If this policy was initially arranged through a Broker, Paycare may pay a fee or commission to the Broker.

Limitation of our services

You will not receive advice or a recommendation from us. We may ask some questions to enable us to discuss the services we can offer you, but we will not give you any advice as to the suitability of the Paycare plans. You will then need to make your own choice about how to proceed.

Please refer to our Privacy Notice for full details of how we handle and manage your personal data.

Paycare Customer Service

Telephone: 01902 371000
(8.30 a.m. to 4.30 p.m. Monday to Friday)
Email: enquiries@paycare.org

Policy Rules

Definitions

Whenever the following words and phrases appear in this Policy, they will always have these meanings.

Benefit(s)

The categories under which you can make a claim as detailed in the Benefit Table.

Benefit Table

A table (current at the date that you were admitted to hospital or incurred costs) issued by us giving the Benefit amounts applicable to each of the Premium levels.

Benefit Year

The calendar year from 1 January to 31 December.

Claim Date

According to the Benefit that you are claiming, the date when:

(a) you or your Partner were admitted as a hospital in-patient (Hospital); or

(b) you paid the cost of treatment (Optical Charges,Dental Charges, Specialist Consultation and Tests,Professional Therapy,Hearing Aids).

Claims will be allocated to a Benefit Year by Claim Date.

Group

A collection of Paycare policyholders set up by us with a specific employer or other organisation. The sponsoring employer or organisation may:

(a) pay the full cost of the Premium payments on behalf of policyholders within that Group;

(b) collect Premium payments from policyholders within that Group; or

(c) a combination of (a) and (b) above.

In-patient

A person who is admitted to spend a night or nights in a hospital for treatment.

Partner

A person who lives with you on a permanent basis as if they were your legal spouse, regardless of gender.

Policy

Our contract of insurance with you providing the cover as detailed in this document and the Benefit Table. The Application Form also forms part of the contract and must be read together with this document and the Benefit Table (each as amended from time to time).

Pre-existing Condition

Any illness, injury or medical condition of which you(and your Partner,if covered by your Policy) had symptoms and/or for which you (and your Partner, if covered by your Policy) were receiving treatment prior to the date that you first applied for cover under the Policy or applied to increase the Premium level.

Premium

The level of payment that you have selected to pay,as shown in the Benefit Table, which determines the level of Benefits available to you.

Registration Date

The date that we create your Policy on our system, as notified to you in writing.

Specialist

A medically qualified person who specialises in a specific field of medicine and is registered as a Specialist with the General Medical Council.

United Kingdom

England, Scotland, Wales and Northern Ireland.

Waiting Period

A period of time (see 3.11) during which Premium payments must be made continuously by you but you cannot claim Benefit(s).

We/Us

Paycare

You

The policyholder

1. Eligibility/Application/Commencement of Cover

1.1 If you are applying for a Paycare Gold Policy for the first time, you must be 64 years of age or over on the date that we receive your completed Application Form. You must also reside permanently in the United Kingdom.

1.2 We do not have to accept your application.

1.3 All the information that you provide to us in relation to your application must be accurate, true and complete to the best of your knowledge and belief.

1.4 We will only consider applications that are submitted on the correct Application Form that has been produced or approved by us.

1.5 If you are a member of a Group, cover under your Policy will commence on the first day of the period covered by the wage/salary/pension payment from which your employer makes the first deduction. If the employer/organisation that sponsors your particular Group makes a contribution to the cost of the Premium, cover will commence on the first day of the first pay period for which they make a contribution.

1.6 If you pay your Premium direct to us, cover under your Policy will commence on your Registration Date.

1.7 We will confirm the date of commencement of cover to you in writing.

1.8 You must declare with your application any Pre-Existing Condition(s) for which you (and your Partner,if you are applying for Hospital cover) are currently receiving treatment (including being on a waiting list for consultation or treatment), or any symptoms or ailments that may need medical consultation or treatment in the future.

2. Premium Payments

2.1 The level of Premium that you pay determines the Benefits available to you. The Benefits applicable to each Premium level are shown in the Benefit Table,which is a separate document that you should read in conjunction with this document.

2.2 If you are a member of a Group, your Premium payments are paid to us by the employer/organisation that sponsors your particular Group. Either the entire Premium or part of the Premium may be deducted from your wage/salary/pension and then paid over to us.

2.3 If you are a member of a Group, each Premium payment relates to cover for the relevant pay period, which is normally either one week or one month. If we have not received payment of the Premium by the due date that has been agreed with the sponsoring employer/organisation, we reserve the right to delay payment of any claims that we receive from you until the Premium has been paid to us.

2.4 If you pay your Premium direct to us, each Premium payment relates to cover for the relevant period, which is normally one month. You must continue to pay your Premium in order to be entitled to claim Benefits. If we have not received payment of the Premium by the due date, we reserve the right to delay payment of any claims that we receive from you until the Premium has been paid to us.

2.5 Any change to the rate of Premium applicable to your Policy will take effect from the first payment date following the end of the notice period (see 7.1).

2.6 If you pay all or part of your Premium by deduction from your wage/salary/pension, and you have a period of unpaid absence from work, you may preserve continuity of cover for a period of up to 6 months by paying your Premium direct to us. If your unpaid absence lasts for a period of more than 6 months, your membership of the Group will lapse, but you can continue to pay your premium direct to us as a direct policy holder.

2.7 If your Premium payments are more than three months in arrears, we will automatically cancel your Policy and you will not be entitled to claim any Benefits.

2.8 If you increase or decrease your Premium level,any claims paid in the Benefit Year under your previous Premium level or any previous Paycare policy will count towards the maximum entitlement available under the new Premium level/policy.

2.9 You can increase your Premium level once in a calendar year, but you must stay on that Premium level for a minimum of twelve months before you can increase your Premium level again.

2.10 You may decrease your Premium level at anytime, providing that you have been on your current Premium level for a minimum of twelve months.

2.11 You will be allowed only one Premium level increase after your 65th birthday.

2.12 Other than in exceptional circumstances, we will not make any refund of Premium payments.

3. Claims

3.1 You (or your Partner, if you have cover for Hospital Benefit) must have received treatment and paid any amounts due to the provider before you can make a claim.

3.2 You must use the Claim Form that we provide for making claims for Benefit. If you do not have a Claim Form, please telephone our Customer Service Department. You may also be able to download a Claim Form from our web site.

3.3 If your claim is for reimbursement of costs paid by you, you must send the original receipt and/or bill. This must identify you as the patient and show: the name, address and qualifications of the person providing the treatment/service; the date and description of the treatment/service provided; the amount and date paid.

3.4 If your claim is for Hospital Benefit, the appropriate section of the Claim Form must be completed, stamped and signed by the relevant hospital. Alternatively, you can send the original hospital discharge note with your Claim Form, provided it gives all the information that is required by the Claim Form.

3.5 You should send us the Claim Form and any appropriate paperwork (including receipts) as soon as possible. We will not accept any claim that is received by us more than thirteen weeks after the Claim Date. Claims will be allocated to a Benefit Year by Claim Date

3.6 You must provide us with any information or evidence to support your claim if we make a reasonable request for you to do so. This may include a request for your authorisation to obtain a medical report or other information from your doctor or the practitioner who is treating you (or your Partner,if you have cover for Hospital Benefit). If you do not agree to this, we may not be able to pay your claim.

3.7 We do not accept photocopies of invoices or receipts, credit card slips or non-itemised till roll receipts.

3.8 We do not return any original invoices or receipts.

3.9 We do not accept receipts or invoices that have been defaced or altered in any way. Any alteration will be investigated and may be treated as a fraudulent claim.

3.10 We will not reimburse any amounts that you may be charged by a hospital, doctor or other person for completing your Claim Form and/or for medical information requested by you in support of your claim. Any such charges will be your responsibility.

3.11 There is a Waiting Period of thirteen weeks from the date of commencement of cover, during which time you will not be eligible to claim any Benefits. The only exceptions to this are:

(a) if you took out your Policy in response to a special promotional offer of a reduced Waiting Period; or

(b) if you are claiming Hospital Benefit for a hospital stay that commenced during the Waiting Period, and the admission to hospital was the result of an accident.

The thirteen-week Waiting Period applies if you increase your Premium level. During this Waiting Period, you will be eligible for the Benefits applicable to your previous Premium level.

3.12 If you decrease your Premium level, there is no Waiting Period, and the Benefits applicable to the lower level will apply from the date of transfer. Any claims paid in the Benefit Year under your previous Premium level or any previous Paycare policy will count towards the maximum entitlement available under the new Premium level/policy.

3.13 We will not pay claims for Hospital, Specialist or Professional Therapy Benefits that relate to any Pre-existing Condition that existed on the date that you applied for cover under the Policy. If you increase your Premium level, claims for Hospital, Specialist or Professional Therapy Benefits that relate to Pre-existing Conditions that have arisen between the date of your original application for cover and the date that you applied to increase your Premium level will be eligible for Benefits applicable to your previous Premium level.

3.14 We will not pay claims resulting from war,terrorism, flying (other than as a passenger), attempted suicide, self-inflicted injuries, drug or alcohol abuse, cosmetic surgery and fertility problems.

3.15 Your Policy covers you for the Benefits detailed in the Benefit Table for treatment/service within the United Kingdom only.

3.16 We will reduce the amount of any claim that you make for costs that you have recovered or can recover from another insurer or a third party.

3.17 We reserve the right to recover any overpayments of Benefit from the Benefit payable to you and/or directly from you. This includes the right to recover any payment of Benefit that we subsequently find that you were not eligible to claim.

3.18 We will pay claims only to you and will notify the amount of the payment to your home address.

4.Benefits

4.1 Optical Charges

We will pay you 100% of the total cost that you have paid to an optician for goods or services provided to you by that optician up to the appropriate maximum entitlement available in the Benefit Year for your chosen Premium level.

WHAT IS COVERED

- Sight Test Fees
- Prescribed spectacles
- Fitting Fees
- Prescribed lenses fitted to existing frames
- Spectacle frames
- Contact lenses
- Repairs to spectacles
- Cleaning materials or solutions supplied as part of a prescription
- Sunglasses, safety spectacles and swimming goggles with prescription lenses
- Contact lenses paid by installment
- Corrective laser eye surgery, including consultation for the same

WHAT IS NOT COVERED

- Goods or services provided to anyone other than you (including, but not limited to, your Partner or dependent child)
- Optical consumables (including, but not limited to,cases, spectacle chains or cords)
- Cleaning materials or solutions purchased in isolation
- Non prescription spectacles
- Items supplied under optical insurance/optical plans
- Payments for optical insurance/optical plans

4.2 Dental Charges

We will pay you 100% of the total cost that you have paid to a registered dental practitioner for dental treatment that you have received up to the appropriate maximum entitlement available in the Benefit Year for your chosen Premium level.

WHAT IS COVERED

- Dental inspections
- Treatment by a dental surgeon, periodontist or orthodontist
- Hygienist's fees
- Dental brace or gum shield provided by a dental surgeon or orthodontist
- Dental crowns, bridges, fillings
- Dentures
- Repairs to dentures
- Laboratory fees and dental technician's fees if referred by a dental surgeon or orthodontist
- Dental X-rays

WHAT IS NOT COVERED

- Treatment provided to anyone other than you (including,but not limited to, your Partner or dependent child)
- Dental prescription charges
- Dental consumables (including, but not limited to,toothbrushes, mouthwash, dental floss)
- Missed/cancelled appointment fees or administration fees
- Cosmetic procedures (including, but not limited to,tooth whitening)
- Payments for dental insurance
- Dental practice plan payments
- Joining fees

4.3 Hospital

We will pay you at the appropriate nightly rate for your chosen Premium level for the period that you or your Partner are admitted for in-patient treatment at a recognised hospital up to a maximum of 30 nights in a Benefit Year and a maximum of 60 nights in any three consecutive Benefit Years (the current year plus the 2 preceding years). The maximum Benefit applies to you and your Partner jointly, and may not be claimed by both of you.

For example:

1. If you are in hospital for 20 nights and your Partner is in hospital for 10 nights in the same Benefit Year, all 30 nights will be covered.

2. If you are in hospital for 25 nights and your Partner is in hospital for 10 nights in the same Benefit Year,only the first 30 nights will be covered.

WHAT IS COVERED

• Any overnight stay in a recognised hospital or hospice (NHS or private) for treatment or investigation of a medical condition that developed after the date of commencement of cover under your Policy.

WHAT IS NOT COVERED

• Any overnight stay in an NHS or private hospital for treatment or investigation of a Pre-existing Condition

• In-patient stays by anyone other than you or your Partner

• Outpatient treatment

• Hospital Day Case admissions

• Hotel ward admissions

• Attendance at an Accident and Emergency Department

• Admission resulting from attempted suicide,self-inflicted injuries, drug or alcohol abuse

• Admission for cosmetic surgery (unless medically advised by your GP or Specialist)

• Assisted conception or fertility treatment

• Pregnancy termination (unless medically advised by your GP)

4.4 Specialist Consultation and Tests

We will pay you 100% of the total cost that you have paid to a Specialist for a diagnostic consultation for yourself up to the appropriate maximum entitlement available in the Benefit Year for your chosen Premium level.

WHAT IS COVERED

• Initial and follow-up appointments, where the initial consultation was recommended by your GP

• Tests and other procedures carried out by/ at the request of the Specialist in order to assist diagnosis(including, but not limited to, X-rays, blood tests, or colonoscopy)

• Room and equipment hire charges in relation to private consultations.

WHAT IS NOT COVERED

• Consultations and tests in relation to a Pre-existing Condition

• Consultations and tests for anyone other than you (including, but not limited to, your Partner or dependent child)

• Charges for treatment

• Operation fees (including private hospital fixed price surgery packages)

• Consultations that have not been recommended by your GP

• Medical examinations and reports for insurance,legal or employment purposes

• Health screening services

• Visits to clinics and GP's

• Consultation resulting from attempted suicide,self-inflicted injuries, drug or alcohol abuse

• Consultation in relation to cosmetic surgery (unless medically advised by your GP or Specialist)

• Assisted conception, fertility treatment and pregnancy care

• Pregnancy termination (unless medically advised by your GP)

4.5 Professional Therapy

We will pay you 100% of the total cost that you have paid to a physiotherapist, osteopath, chiropractor,acupuncturist, chiropodist, homeopath, hypnotherapist or reflexologist for treatment that you have received(including initial assessment) up to the appropriate maximum entitlement available in the Benefit Year for your chosen Premium level. The practitioner must be qualified and registered with an appropriate, approved professional organisation that is recognised by us. A list of appropriate,approved organisations recognised by us (as amended from time to time) is available upon request.

WHAT IS COVERED

• Physiotherapy treatment provided by a professional who is registered with a physiotherapy organisation recognised by us

• Osteopathy treatment provided by a professional who is registered with an osteopathy organisation recognised by us

• Chiropractic treatment provided by a professional who is registered with a chiropractic organisation recognised by us

• Acupuncture treatment provided by a professional who is registered with an acupuncture organisation recognised by us

• Chiropody treatment provided by a professional who is registered with a chiropody organisation recognised by us

• Homeopathy treatment provided by a professional who is registered with a homeopathy organisation recognised by us

• Hypnotherapy treatment provided by a professional who is registered with a hypnotherapy organisation recognised by us

• Reflexology treatment provided by a professional who is registered with a reflexology organisation recognised by us

• Consumables supplied by the professional as part of the treatment, including, but not limited to dressings,acupuncture needles or homeopathic medicines

WHAT IS NOT COVERED

• Treatment of a Pre-existing Condition

• Treatment provided to anyone other than you(including, but not limited to, your Partner or dependent child)

• Treatment provided by a professional who is not registered with a organisation recognised by us

• All other treatments, including, but not limited to,aromatherapy, herbalism, massage, psychotherapy or counselling

• X-rays, MRI scans, CT scans or other investigative procedures

• Appliances of any kind, including, but not limited to,orthotics, back supports, lumbar rolls or TENS machines

• Cosmetic treatment

• Homeopathic or other alternative medicines purchased from any source other than the professional providing the treatment

• Consumables, including, but not limited to, dressings,acupuncture needles or homeopathic medicines purchased in isolation

4.6 Hearing Aid

We will pay you 100% of the total cost that you have paid for a hearing aid for yourself up to the appropriate maximum entitlement available in the Benefit Year for your chosen Premium level.

The hearing aid must have been supplied by a recognised hearing aid audiologist.

WHAT IS COVERED

• The supply of a new prescribed hearing aid

• Fitting fees

• Installment payments for a new hearing aid

• Repairs to a hearing aid

WHAT IS NOT COVERED

• Hearing aids supplied for anyone other than you(including, but not limited to, your Partner or dependent child)

• Non-prescribed or disposable hearing aids

•Payments for hearing aid insurance

• Consumables, including, but not limited to, batteries

• Voice loops

4.7 Paycare Gold Care Advisory Service and Help Line

All Paycare Gold policyholders have access to these services, which are provided by third parties under contract to us. We reserve the right to change providers for these services without notifying you, but we will advise you of any changes in the type of service or the telephone numbers in accordance with the notice periods in section 7.

The advisory service and help line can give you advice and help if you are ill and need assistance with daily living, in a domestic emergency, or if you are in need or upset. You must pay the cost of the call and any costs arising from the advice that you receive.

You will find full details of these services, together with the telephone numbers, on the information sheet that accompanies this document.

4.8 24 Hour GP Telephone Consultation Service

As a policyholder you have access to this GP service, which is provided by a third party under contract to us. We reserve the right to change providers for this service without notifying you, but we will advise you of any changes in the type of service or the telephone number in accordance with the notice periods in section 7.

The 24 hour GP service is an appointment based service so you can specify a convenient 15 minute time slot and a GP will call you back. You must pay the cost of the call to the help line and any costs arising from the advice that you receive.

In an emergency situation, you should contact your own NHS GP or the emergency services directly so and

not delay appropriate treatment.

Please contact our customer services team for full details of this service on 01902 371000.

5. Termination and Cancellation

5.1 All cover under your Policy will end and all Benefits will cease automatically when:

(a) you decide to cancel your Policy,in which case we will not refund any Premium (if you are a member of a Group, it is your responsibility to ensure that your employer ceases making any deduction from your wage/salary/pension, if applicable);

(b) you stop paying your Premium or miss paying the Premium for a continuous period of thirteen weeks;

(c) you die (although your family may be able to claim any Benefits that were due to you or a refund of any Premium paid more than one full month in advance – they should contact our Customer Service department);

(d) we cancel the Policy at any time by giving not less than one month's written notice; or

(e) we cancel the Policy with immediate effect and without notice because we believe that you have attempted to make a fraudulent claim.

5.2 If you are a member of a Group, cover under your Policy will end on the last day of the period covered by the wage/salary/pension payment from which your employer makes the last deduction. If the employer/ organisation that sponsors your Group makes a contribution to the cost of the Premium,cover will end on the last day of the last pay period for which they make a contribution, or on the date you leave that employer/organisation, whichever is the earlier. You may be able to maintain cover by transferring to direct payment – contact our Customer Service Department for more information.

5.3 If you pay your Premium direct to us, cover under your Policy will end on the last day of the period covered by the last payment that you make to us.

6.Customer Service

6.1 Cooling Off Period

If you decide that this Policy is not suitable for you or does not meet your needs, please return all the documentation to us within 28 days of receiving this Policy. We will refund any Premium payments that you have made, provided that you have not made a claim.

6.2 Changes of Personal Details

You must inform us as soon as is reasonably possible of any changes to the information that you have given to us, including any change of address, name, marital status, or any other material change. Failure to do so may result in a claim being refused or your Policy being cancelled.

6.3 Complaints

At Paycare we aim to provide the highest possible standard of service to all of our customers. However,there may be occasions when something goes wrong in the delivery of a service. If you are unhappy with any aspect of our service please let us know by contacting our Customer Service Department. This is of vital importance to us in our aim of delivering on-going improvements in our service to you. Whenever possible, we will ensure that the root cause of the complaint is addressed and resolved for the individual customer and for other customers.

We will contact you initially within five business days of receiving your complaint. We will either send a full reply or an acknowledgement letter which will tell you:

- Who will be dealing with your complaint.
- When we will contact you again.

If your complaint is particularly complex, we may need time to investigate it more fully. In these cases, if we've not sent you a full response within four weeks of receiving your complaint, we'll contact you again to let you know how our investigations are on-going.

We resolve all complaints in a fair manner, and our final response will explain our conclusions to you clearly. However, if you're unhappy after receiving our final response, or we haven't resolved your complaint eight weeks after you first told us about it, you may have the right to refer your complaint to the Financial Ombudsman Service.

If you are unhappy with our final response and wish to refer to the Ombudsman, you must do so within six months of the date of our final letter.

You can contact the Financial Ombudsman Service at: Exchange Tower,London, E14 9SR. Telephone: 0300 123 9123

Email: complaint.info@financial-ombudsman.org.uk

www.financial-ombudsman.org.uk

7. Changes to Terms and Conditions

7.1 We have the absolute right to change any of the Terms and Conditions relating to your Policy. We will give the following periods of notice:

(a) in respect of any changes to the Benefits, at least one month's prior notice in writing;

(b) in respect of any changes to the Policy Terms and Conditions, at least one month's prior notice in writing; and

(c) in respect of any changes to the Premium, at the earliest opportunity,but at least one month's prior notice in writing.

7.2 Where we have notified you of changes in Benefits, we will pay claims in accordance with the Terms and Conditions in operation on the Claim Date.

7.3 We will not be responsible if, for any reason, such notification fails to come to your attention (see rule 6.2 in this regard).

8. Legal Information

8.1 Waiver

Waiver by us of any Term or Condition of this Policy will not prevent us from relying on such Term or Condition thereafter.

8.2 Enforcement

Only you or we may enforce this contract or any part of it. No other insured person or third party may do so,and no term of this agreement shall be enforceable pursuant to the Contracts (Rights of Third Parties) Act 1999.

8.3 Disclosure of material points

(a) Choice of law – if you buy insurance in the United Kingdom, you can choose which Law will apply to the Policy

(b) English law will apply to your Policy (unless we make a written agreement saying otherwise before we issue this Policy to you) and all matters to do with these Terms and Conditions will be dealt with by the Courts in England.

8.4 Data Protection

For the purposes of the Data Protection Act (DPA), we are the Data Controller in relation to any personal data that you supply to us. We will store and process your information on our computers and in any other way.

8.5 Information

(a) We will use your information to provide our services,for assessment and analysis (including market and product analysis, research and statistical purposes) for underwriting and claims handling, to develop and improve our services to you and other customers, and to protect our interests. It may also be disclosed to regulatory bodies for the purposes of monitoring and enforcing our compliance with any regulatory codes.

(b) We may use your information to keep you informed by post, telephone, e-mail or other means about other products or services that may be of interest to you. To that end, however,we will not release your information to any third party, other than those who provide services as part of your Policy (including, but not limited to, help line providers or other insurers).This may involve data being transferred outside the EEC.

(c) We may give information about you and how you use our products to:

i) fraud prevention agencies and other organisations who may record, use and give out information to other insurers;

ii) people who provide a service to us or act as our agents, on the understanding that they will keep the information confidential;

iii) anyone to whom we may transfer our rights and duties under this agreement;

iv) We may also give out information about you if we have a duty to do so, or if the law allows us to do so,if the person requesting the information has, in our opinion, a legitimate interest in the disclosure. Otherwise, we will keep information about you confidential.

8.6 Sensitive Data

In order to assess the terms of the insurance contractor administer claims, we may collect data, which the DPA defines as sensitive (such as by agreement to this Policy you will signify your consent to send information being processed by us).

8.7 Personal Details

We follow the rules of the DPA when dealing with your personal information. You have the right to see personal information that we hold. There may be a charge if you want to do this. For more details,contact our Finance Manager.

8.8 Call recording

To ensure that we maintain a high quality service, we may monitor or record telephone calls.

8.9 Subrogation

If you have a claim or right of acting against any third party arising from the circumstances that gave rise to a claim under your Policy, you must notify us of this fact without delay. You must keep us informed in writing of

the basis of the claim or right of action and its progress, and take all steps that we reasonably require in making a claim against the third party.

In addition we shall be entitled if we so wish to pursue a claim for our own benefit in your name against that third party. We will have full discretion in the conduct of any such proceedings and in the settlement of such claim.

8.10 One Policy

(a) You may only hold in your own name or be covered by one Policy with us. We reserve the right to determine which Policy will apply to you if you are registered in our records on more than one Policy and which Policy/ Policies should be removed. If you are registered in our records in relation to more than one Policy, we will only pay Benefit once in respect of a set of facts giving rise to a claim, and only if the Policy that covers you after we have removed the duplicate Policy/Policies provide Benefit in respect of that claim.

(b) If we registered our acceptance of your application in our records prior to 1 January 2005, you may hold or be covered by more than one Policy. This will apply,however, only to any Policies in operation prior to 1 January 2005. Should you decide to transfer to another Policy after that date, then condition 8.10 (a)will apply.

8.11 Compensation

You are protected by the Financial Services Compensation Scheme (FSCS). In the unlikely event that we go out of business or go into liquidation, FSCS protects you by providing cover for any valid claims that are outstanding. Cover is limited to 100% of the first £2,000 and 90% of the remainder of the claim,with no upper limit. You can obtain more details of the scheme by visiting www.fscs.org.uk or by contacting FSCS direct on 020 7892 7300.

Whilst care has been taken in the preparation of this leaflet, errors, omissions and changes to information and rules contained herein may be updated or amended at any time at the discretion of Paycare without prior consultation.

Last amended June 2015
Note: The rules outlined in this booklet are current of the date of issue, and supersede all rules prior to that date.

Paycare

Everyday Health Cover since 1874

Paycare is a not for profit company limited by guarantee.

Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority.

Company Registration Number 820791.

Paycare House, George Street, Wolverhampton WV2 4DX Tel: 01902 371000.
Email: enquiries@paycare.org

www.paycare.org

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