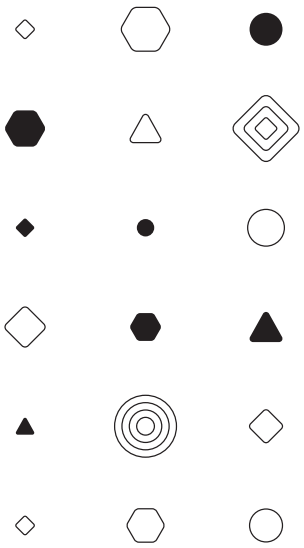
Simplyhealth

Your Simply Cash Plan

Policy document
Part 1

Inside you'll find all you need to know about what is and isn't covered
Effective from 1st September 2018



Part 2 will tell you about adding your family, changing cover and claiming - as well as some other important information.

Your table of cover

	Level 1	Level 2	Level 3	Level 4	Level 5
Monthly premium for you	£13.43	£17.51	£21.65	£27.38	£43.91
Monthly premium for you and your partner	£24.80	£29.39	£38.18	£51.66	£73.36
Cover for up to four of your children under the age of 18	FREE				

Premiums include Insurance Premium Tax where applicable

myWellbeing	Available to all levels of cover
Speak to a GP Speak to a GP over the phone 24 hours a day, 7 days a week. If the GP feels it's clinically appropriate, they may privately prescribe you some medication. They can arrange for this to be delivered to you at home or at work. You'll be charged for the cost of the medication and the cost of the delivery.	
Telephone counselling Speak to a qualified counsellor over the phone 24 hours a day, 7 days a week	
Wellbeing and lifestyle guidance Speak to someone over the phone about your wellbeing, legal and financial challenges or relationship issues 24 hours a day, 7 days a week	

We also have a range of health-related information and services which can be accessed through your online account

To help keep your eyes and teeth healthy	We pay	Annual limit for each person				
Dental Includes check-ups and treatment, for example fillings, crowns and bridges, hygienist's fees, dentures	100% of your receipt up to your annual limit	£100	£120	£160	£190	£280
Dental accident (3 month qualifying period) Treatment to help return your oral heath to its pre-accident state		£100	£250	£500	£750	£1000
Optical Includes sight tests, prescription glasses and contact lenses		£100	£120	£160	£190	£280
To help you feel your best	**We pay**	**Annual limit for each person**				
Physiotherapy, osteopathy, chiropractic, acupuncture You can use your annual limit for one or all of these treatments	50% of your receipt up to your annual limit	£295	£345	£420	£520	£770
Chiropody / podiatry, homeopathy and reflexology Includes treatment and assessments, for example gait analysis, by a chiropodist or podiatrist as well as homeopathy and reflexology		£100	£125	£150	£200	£300
To help you find out what's wrong	**We pay**	**Annual limit for each person**				

Diagnostic consultation Consultant's fees for a diagnostic consultation that is to find or help to find the cause of your symptoms. Includes allergy testing	**50%** of your receipt up to your annual limit	**£175**	**£200**	**£260**	**£320**	**£525**
X-rays and scans Consultant referred X-rays and scans (this does not include CT, MRI or PET scans)		**£75**	**£90**	**£110**	**£250**	**£370**
To help you find out more about your health	**We pay**	**Annual limit for each person**				
Health assessment Helps towards the costs of a detailed assessment of your health with a nurse, doctor or pharmacist. The benefit is not available to children	**50%** of your receipt up to your annual limit	**£100**	**£125**	**£150**	**£200**	**£300**
To help you when you need it most	**We pay**	**Annual limit for each person**				
Hospital Cash amount when you are admitted to hospital, or staying overnight with your child. Pre-existing conditions are excluded for the first 12 months	For each day / night (max 20 each year)	**Adult £28** **Child £14**	**Adult £35** **Child £18**	**Adult £40** **Child £20**	**Adult £60** **Child £30**	**Adult £90** **Child £45**
Medical apparel (maximum two items each policy year) Helps towards the costs of items that you need to wear for medical reasons	**50%** of your receipt up to your annual limit	**£250**	**£300**	**£400**	**£500**	**£750**
Prescriptions charges Prescriptions issued by a GP or Dentist	**100%** of your receipt up to your annual limit	**£8.60**	**£17.20**	**£25.80**	**£34.40**	**£43.00**
Redundancy premium protection (12 month qualifying period) We will cover the premiums for a maximum of six months in the event the policyholder is made redundant and subsequently unemployed		✓	✓	✓	✓	✓
To help you when your family grows						
New child payment (12 month qualifying period) One payment for each child if you or your partner have a baby or adopt		**£175**	**£200**	**£250**	**£325**	**£450**

Weekly premium for you	**£3.10**	**£4.05**	**£5.00**	**£6.32**	**£10.14**
Weekly premium for you and your partner	**£5.72**	**£6.80**	**£8.82**	**£11.92**	**£16.94**

The joining age for this policy is from 18 years old up to 79. If anyone on the policy is aged 80 or over, you will not be able to increase the level of cover.

You can find full policy details in the policy documents.

Introduction

Thank you for buying a Simplyhealth cash plan. This document explains the policy rules, and how the policy works. These rules apply to all members of the policy.

Please take the time to read them and keep them safe in case you need them again. If you have any questions, then please contact us.

We aim to make information about us and this policy accessible to you, whatever your needs, and information is available in large print or audio.

We want you to have a policy that meets your needs, and this product you have chosen meets the needs of someone who would benefit from support with the costs of their healthcare appointments. Please remember to review your cover on a regular basis to make sure that it continues to meet your needs.

How does my cash plan work?

It's simple: we'll pay your eligible claims up to the amounts shown for your level of cover for each benefit, every **policy year**. Your summary of cover will show which level applies to you.

For some of your benefits, we'll pay you a percentage of the costs you've paid for your treatment or service. For example, if your payback level is 75% and you've paid £100, we'll give you £75 back. Your **table of cover** shows the percentage of your costs that we'll pay back.

Section 1: How to make a claim

How do I make a claim?
The first thing you need to do is pay for the costs of the treatment or service to the person providing them (for example, your optician). You then claim those costs back from us.

It's really easy to claim online. Please visit simplyhealth.co.uk/register and follow the simple registration process.

If you're unsure about how to claim online then please contact us.

What do I need to provide so my claim can be paid?
Before we're able to pay your claim, we need to be sure that the policy covers it. For example, we need to be sure that the person who receives the treatment or service is a **member**, and that there is not an exclusion that applies.

You'll need to send us evidence (for example your receipts) that shows:

- who the patient is
- who gave the treatment or service and how much they've charged
- the details and date of the treatment or service and
- the amount that you've paid.

We won't be able to pay a claim if you don't send us everything that we need to assess it.

We don't accept receipts that have been altered, bank statements, invoices or credit or debit card receipts without supporting evidence. We are unable to return receipts.

What happens if more information is needed to assess my claim?
We may need to ask the person who provided the service or treatment for more details. We won't pay if there's a charge for this.

We may ask for a second opinion but we'll pay the cost for this.

Section 2: Your cover

This section explains what is and isn't covered for each of the benefits on this **policy**. You decide the treatments and services that you need, and the people who provide them. We aren't responsible for the treatment or services you receive or for any consequences that may result from them.

myWellbeing

We have a range of services and health-related information available to you. You can access these services through your online account. If you haven't already registered please visit simplyhealth.co.uk/register and follow our simple registration process. The information and services available on the myWellbeing website can change without notice from time to time.

Some of the myWellbeing services are only available in the UK. The website will tell you which of the services this applies to.

Speak to a GP
The service is available 24 hours a day, 365 days a year by calling 0330 102 5443. eConsultations are also available from 8am to 10pm, Monday to Friday, 8am to 8pm on Saturday and 10am to 6pm on Sunday.

If the GP feels it's clinically appropriate, they may privately prescribe you some medication and they can arrange for it to be delivered to you at home or at work. Next day delivery is available where the

request is received by the pharmacy before 3pm, Monday to Friday and the items are available. You will be charged for the cost of the medication and the cost of the delivery.

If the **table of cover** shows cover for **children**, the **child's** parent or legal guardian will need to call the service on their behalf.

Telephone counselling
The service is available 24 hours a day, 7 days a week by calling 0330 102 5445.

This service is not available to anyone aged 16 or under. Please see the myWellbeing website for more information.

Wellbeing and lifestyle guidance
This service is available 24 hours a day, 7 days a week by calling 0330 102 5445.

This service is not available to anyone aged 16 or under. Please see the myWellbeing website for more information.

Dental

This benefit is to help towards the costs when you see a qualified dental professional (for example a dentist or hygienist) in a dental surgery.

What the dental benefit covers
- ✓ dental check-ups
- ✓ treatment provided by a dentist, periodontist or orthodontist
- ✓ endodontic (root canal) treatment
- ✓ hygienists' fees
- ✓ local anaesthetic fees and intravenous sedation
- ✓ dental brace or gum-shield provided by a dentist or orthodontist
- ✓ dental crowns, bridges and fillings
- ✓ dentures
- ✓ laboratory fees and dental technician fees referred by a dentist or orthodontist
- ✓ dental X-rays
- ✓ denture repairs or replacements by a dental technician.

What the dental benefit does not cover
- × dental prescription charges
- × dental consumables, for example toothbrushes, mouthwash and dental floss
- × dental implants and bone augmentation procedures, for example sinus lift, bone graft
- × cosmetic procedures, for example dental veneers, tooth whitening, the replacement of silver coloured fillings with white fillings
- × laboratory fees not connected to dental treatment or performed by a dentist
- × dental treatment provided at a hospital as a day-patient or in-patient
- × **general exclusions**.

Dental accident

This benefit is to help towards the costs of returning your oral heath to its pre-accident state following an accident. An accident is an incident that happens by chance, which could not have been expected, causes a significant dental injury and requires medical or dental attention.

This benefit has a **qualifying period** of three months.

In order for us to assess your claim, we'll need evidence that an accident has taken place and that the treatment you've received is clinically necessary and as a direct result of the accident. You must send us a copy of your dental or medical records (which should include any relevant X-rays) confirming this.

We will ask for additional evidence, such as witness statements, photographs and police incident numbers if your records do not provide the information we need to assess your claim.

What the dental accident benefit covers
- ✓ restorative treatment to return your oral health to its pre-accident state if you receive medical or dental attention within 30 days of the accident
- ✓ the standard NHS rate for one prescription (whether the prescription is an NHS or private prescription). The prescription must be written by a dentist or doctor**.** This does not cover Prescription Prepayment Certificates (PPC) or any medicine obtained using one.

What the dental accident benefit does not cover
- × dental treatment that you need as a direct result of an accident that occurred before you joined the **policy** or within the **qualifying period**
- × further dental treatment that you need after the immediate restoration of the accident damaged area, for example remedial improvements to, or the modification of, work carried out as a result of the accident
- × dental treatment that you need as a result of participating in a sport that has a higher than average likelihood of dental injury and where it is reasonable to expect you to wear face or mouth protection, for example hockey or rugby, and where you were not wearing the appropriate face or mouth protection
- × dental treatment that you need as a result of injury caused by foreign bodies or foodstuffs while eating, chewing or drinking

- × any dental treatment undertaken in a hospital following a referral from a dentist
- × dental treatment that you cannot provide evidence of being clinically necessary, for example cosmetic procedures
- × any preparation for and treatment connected with having implants or veneers fitted. This exclusion does not apply to an existing veneer which is damaged in an accident covered by the **policy**, or for an existing implant abutment, crown or bridge which is damaged in an accident covered by the **policy**
- × claims relating to treatment arising directly or indirectly from:
  - you participating in a criminal act
  - an accident while you were under the influence of alcohol or drugs
  - deliberate self-inflicted injury
- × dental treatment that you need as a result of war or terrorist activity
- × **general exclusions**.

Optical

This benefit is to help towards the costs when you see a qualified optical professional (for example an optometrist or optician).

What the optical benefit covers

- ✓ sight-test fees, scans or photos for an eye test
- ✓ fitting fees
- ✓ prescribed lenses and accompanying frames for:
  - glasses
  - sunglasses
  - safety glasses
  - swimming goggles
- ✓ adding new prescribed lenses to existing frames
- ✓ glasses frames
- ✓ contact lenses (including contact lenses paid for by instalment)
- ✓ consumables supplied as part of an optical prescription, for example solutions and tints
- ✓ repairs to glasses.

What the optical benefit does not cover

- × eye surgery (for example laser eye surgery, lens replacement surgery or cataract surgery)
- × optical consumables, for example contact lens cases, glasses cases and glasses chains/cords, cleaning materials
- × magnifying glasses
- × eyewear that does not have prescription lenses
- × ophthalmic consultant charges or tests related to an ophthalmic consultation
- × **general exclusions**.

Physiotherapy, osteopathy, chiropractic, acupuncture (POCA)

Important: In order to be able to practise in the UK:

- Physiotherapists must be registered with the Health and Care Professions Council (HCPC)
- Osteopaths must be registered with the General Osteopathic Council (GOsC)
- Chiropractors must be registered with the General Chiropractic Council (GCC).

We will not pay for treatment by someone who is not registered with the HCPC, GOsC or GCC (as appropriate).

What the POCA benefit covers

- ✓ physiotherapy
- ✓ osteopathy
- ✓ chiropractic
- ✓ acupuncture.

What the POCA benefit does not cover

- × any other treatments, for example reflexology, aromatherapy, herbalism, sports/remedial massage, Indian head massage, reiki, Alexander technique
- × X-rays and scans
- × appliances, for example lumbar roll, back support, TENS machine
- × **general exclusions**.

Chiropody/podiatry, homeopathy and reflexology

Important: In order to be able to practise in the UK chiropodists / podiatrists must be registered with the Health and Care Professions Council (HCPC).

We will not pay for chiropody / podiatry treatment by someone who is not registered with the HCPC.

What the chiropody/podiatry, homeopathy and reflexology benefit covers

- ✓ treatment supplied by a chiropodist or podiatrist
- ✓ assessments, for example gait analysis, performed by a chiropodist or podiatrist
- ✓ consumables prescribed by and bought from the chiropodist or podiatrist at the time of treatment, for example orthoses, dressings
- ✓ consultations with a podiatric surgeon

- ✓ homeopathy and homeopathic medicines prescribed by and bought directly from a homeopath
- ✓ reflexology.

What the chiropody/podiatry, homeopathy and reflexology benefit does not cover

- × cosmetic pedicures
- × X-rays and scans
- × consumables not bought from the chiropodist or podiatrist at the time of treatment, for example corn plasters bought from a pharmacy
- × surgical footwear, for example corrective footwear
- × homeopathic medicines bought from a professional who is not a homeopath or bought from a chemist, health food shop, by mail order or over the internet
- × **general exclusions**.

Diagnostic consultation

A diagnostic consultation is to find or to help to find the cause of your symptoms.

What the diagnostic consultation benefit covers

- ✓ the fees for a diagnostic consultation that you have as a private patient. The consultation must be with a medical professional who is (or has been) a consultant in an NHS hospital or the Armed Services. The consultant post must be a substantive appointment (that is to say not as a locum).

  In addition, the consultant must hold a current licence to practise and also be included on the:

  - General Medical Council's specialist register (please see www.gmc-uk.org)

  or

  - General Dental Council's dentist's register (please see www.gdc-uk.org).

  If you have any questions as to whether your consultant meets these criteria then please contact us.
- ✓ blood tests or visual field tests directly connected to a diagnostic consultation
- ✓ allergy tests performed by a GP or consultant (not tests or advice about nutrition or food intolerance).

What the diagnostic consultation benefit does not cover

- × follow-up consultations and check-ups after you have been diagnosed, for example cancer remission checks or management of a condition
- × treatment charges, for example private hospital charges, operation fees, anaesthetic fees
- × consultations with a podiatric surgeon
- × diagnostic tests and procedures, for example X-rays and scans, endoscopy, tests on body tissue samples, ECGs, health screening
- × counselling, for example psychological counselling, speech therapy and dyslexia services
- × assisted conception, fertility treatment or termination, pregnancy care
- × **general exclusions**.

X-rays and scans

What the X-rays and scans benefit covers

- ✓ X-rays and scans when you have been referred by a consultant who must be (or have been) a consultant in an NHS hospital or the Armed Services. The consultant post must be a substantive appointment (that is to say not as a locum).

  In addition, the consultant must hold a current licence to practise and also be included on the:

  - General Medical Council's specialist register (please see www.gmc-uk.org)

  or

  - General Dental Council's dentist's register (please see www.gdc-uk.org).

  If you have any questions as to whether your consultant meets these criteria then please contact us.

What the X-rays and scans benefit does not cover

- × dental X-rays
- × any form of imaging using computerised tomography (CT), magnetic resonance (MR) or positron emission tomography (PET)
- × **general exclusions**.

Health assessment

This benefit is to help towards the costs of a detailed assessment of your health.

What the health assessment benefit covers

✓ tests which you have in order to assess your general health. The tests must be carried out within one appointment:

- by a doctor registered with the General Medical Council (GMC) or
- by a nurse registered with the Nursing and Midwifery Council (NMC) or
- by a pharmacist registered with the General Pharmaceutical Council (GPhC)
- at an establishment registered with the General Pharmaceutical Council (GPhC) or Care Quality Commission (CQC). For example, these could include a hospital, GP practice, pharmacy or health screening clinic.

The doctor, nurse or pharmacist must hold a current licence to practise.

The health assessment must include at a minimum (although it can include additional tests):

- body composition measurement including height, weight (BMI) and body fat percentage
- blood pressure measurement
- cholesterol or diabetes check, and
- kidney or liver function test.

When you make a claim, you should give us a list of the tests included in your health assessment, along with your receipt. If you do not give us a list of the tests that you have had, we may not be able to pay your claim.

What the health assessment benefit does not cover

× any test that you have which is:

- not carried out at a CQC or GPhC registered establishment
- not carried out by a registered person
- not part of a health assessment, or
- has been carried out at a separate appointment (for example, having a blood test, or a magnetic resonance, CT or other high-tech scan on its own)

× **general exclusions**.

We have a partnership with Nuffield hospitals which will give you a discount on their health assessments. For details, visit our webpage simplyhealth.co.uk/healthassessment

For help with GMC, NMC, GPhC and CQC registration checks please visit:

www.gmc-uk.org

www.nmc-uk.org

www.pharmacyregulation.org

www.cqc.org.uk

Hospital

This benefit can help towards costs such as meals for visitors, telephone calls, travel costs or even hospital parking fees, if you are admitted to hospital.

You can claim a maximum of 20 days or nights each **policy year**.

To make an online claim for hospital cover you'll need a copy of your discharge letter as evidence of your admission. If you do not have your discharge letter, you'll need to get written confirmation of your hospital stay (for example a letter on headed paper from the hospital).

What the hospital benefit covers:

✓ an admission to hospital as a day-patient for tests or treatment.

A day-patient is a patient who is admitted to a hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight. If you are admitted as a day-patient and then stay overnight, we will pay one night's hospital cover (not one day and one night)

✓ an overnight stay in a hospital as an in-patient for tests or treatment.

An in-patient is a patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons

✓ out-patient cancer treatment, for example chemotherapy or radiotherapy

✓ an overnight stay in a hospital for one parent who has accompanied their **child** where the **child** is an in-patient for tests or treatment. Both the parent and **child** must be covered by the **policy**.

What the hospital benefit doesn't cover:

× pre-existing conditions during the first 12 months that you are covered by the **policy**. We may ask for evidence that your condition is not pre-existing if you claim for this benefit during the first 12 months of cover.

A pre-existing condition is any condition for which you:

- have been referred to a consultant or hospital for either tests or treatment before the date that you joined the **policy** or

- are receiving consultant or hospital tests or treatment before the date that you joined the **policy**

or

- reasonably believe that you would be referred to a consultant or hospital for tests or treatment within 12 months of joining the **policy**.

× the first 14 nights of any stay in hospital during which you give birth

× out-patient visits, for example consultations, tests, scans

× out-patient treatment (although treatment for cancer is covered)

× day care, for example psychiatric, respite care (short term temporary relief for a carer of a family member), maternity care and care for the elderly

× kidney dialysis

× attendance at an accident and emergency department, or treatment not in a hospital, for example operations carried out in a GP's surgery or clinic

× pregnancy termination

× laser eye surgery

× cosmetic surgery

× hotel ward admission

× pregnancy or childbirth related admissions for a **child** covered by this **policy**

× a parent staying with their **child** following the **child's** birth (unless the **child** requires further tests or treatment in a hospital)

× **general exclusions**.

Medical apparel

This benefit is to help towards paying the costs of these items that you need to wear for medical reasons. You can claim a maximum of two items / repairs to items each **policy year**.

What the medical apparel benefit covers

✓ surgical shoes

✓ mastectomy items

✓ prosthetic, back support, truss items

✓ arch supports and orthotic insoles

✓ surgical hosiery, when supplied through a medical prescription

✓ wigs, when supplied through a medical prescription

✓ hearing aids

✓ repairs to medical apparel.

What the medical apparel benefit does not cover

× invalid equipment, medical equipment and batteries

× **general exclusions**.

New child payment

This benefit has a **qualifying period** of 12 months.

If, after the **qualifying period,** you have a baby or adopt a **child** we will pay new child payment for that baby or **child.** We only make one payment for each **child** no matter how many policies you or your **partner** are covered on. If you have more than one policy you will have to choose which one to claim the new child payment under.

We will also make a payment following a stillbirth of your **child** after 24 weeks of pregnancy.

To claim the new child payment we may ask you for supporting documents, for example a birth or stillbirth certificate, or adoption papers.

We will make a new child payment after:

✓ the birth of your **child**

✓ the legal adoption of a child by you or your **partner**. However, we will not pay new child payment if that **child** is already related to either you or your **partner** (for example if you adopt your **partner's child**)

✓ the stillbirth of your **child** after 24 weeks of pregnancy.

We will not make a new child payment for:

× a miscarriage of up to 24 weeks' gestation

× foster children

× a baby born to a **child** who is covered under the **policy**

× pregnancy termination

× a **child** born or adopted before or during the **qualifying period**.

Prescription charges

This benefit is to help towards the costs of your prescription charges.

To make a claim for prescription cover you'll need to send us a copy of your receipt as well as evidence to show that the prescription is for you (for example a copy of the prescription slip or the prescription label). To make a claim for an NHS Prescription Prepayment Certificate (PPC) you'll need to send us evidence of your certificate (for example a photo of your card or a copy of the letter that you receive with it).

What the prescription benefit covers

✓ NHS prescriptions issued by a GP or a dentist

✓ NHS Prescription Prepayment Certificates (PPC)

✓ private prescriptions issued by a GP or dentist (this includes medicines prescribed by the GP service).

What the prescription benefit does not cover

× pharmacy items that you buy without using a prescription, for example medicines (sometimes called 'over the counter' medicines)

× **general exclusions**

Redundancy premium protection

We will waive the **policy** premiums for a maximum of six months if the **policyholder** is unemployed as a result of compulsory redundancy. We may ask for reasonable evidence in order to support your claim including confirmation from your employer.

If the **policyholder** starts work again within six months, they must tell us immediately – we will not waive the premium once they start work again.

We will not waive the premium:

- during the 12 month **qualifying period**
- for redundancy of less than one whole month
- if the **policyholder** takes voluntary redundancy
- if the person who pays the premium is not the **policyholder**.

General exclusions

× This **policy** will not pay for:

- any benefit if your **treatment date** is before the date that your cover under the **policy** started
- any treatment or service that you receive from a:
  - member of your immediate family – a parent, child, brother or sister, or your **partner**
  - business that you own
- any consultation with, or treatment by, a trainee (even if they are supervised by a qualified professional)
- any consultation which is not face to face, for example telephone, video or internet consultations (this exclusion does not apply to the services available through myWellbeing)
- insurance premiums for any goods or services, or payment for any type of extended warranty or guarantee for goods or services
- regular payment plans for treatment, for example dental practice plan payments
- postage and packing costs
- administration or referral costs, joining fees or registration fees
- claims where you have paid costs with:
  - discount vouchers or coupons
  - any type of retail points scheme or loyalty scheme
- fees or charges for:
  - missing an appointment
  - completing a claim form or providing a medical report
  - providing further information in support of a claim.

Section 3: Definitions

We give certain words and phrases specific meanings in the policy rules. We use **bold type** to show you which these are and so we don't have to keep explaining what they mean.

When we refer to 'you' or 'your' in this document, we mean anyone who is a **member** under this **policy**. When you see 'we', 'us' or 'our' we mean Simplyhealth Access trading as Simplyhealth, a company incorporated in England and Wales.

Child/children
Natural or legally adopted dependent children of the **policyholder** or their **partner**. Children must be under the age of 18.

General exclusions
Anything excluded under this **policy** as set out in the 'Your cover' section.

Member
Anyone who we have accepted for cover under this **policy**.

Partner
Anyone in a relationship with, and who lives with, the **policyholder**. This could be their husband, wife, civil partner or unmarried partner.

Policy
The insurance contract between Simplyhealth and the **policyholder**.

Policyholder
The first person named on the summary of cover.

Policy year
The 12 calendar months from the **start date** or the last **renewal date**. Your summary of cover shows the dates for your policy year.

Qualifying period
A set period of time in which we will not pay claims:

- for any treatment or service that you receive
- if you have a baby or adopt a **child**

during that time. We will not waive premiums if the **policyholder** is made redundant during this time. The qualifying period starts from the date that you join this **policy** or the date of any increase in cover. The **table of cover** shows any qualifying periods that apply to this **policy**.

Renewal date
The date on which this **policy** will renew. You'll find this on your summary of cover.

Start date
The date on which this **policy** starts. You'll find this on your summary of cover.

Table of cover
The table applicable at the **treatment date**. This will show:

- the levels of cover available
- the benefit entitlements available under each level of cover
- any age rules for joining and changing your level of cover
- whether or not **partners** or **children** can be covered by the **policy**.

Treatment date
The date that the treatment or service was supplied. For new child payment this will be the date of adoption or birth of the child.

Important contact information

If you have any questions about your policy and how it works, here's how you can get in contact with us:

You can call us on:
0370 908 3481

You can write to us at:
Simplyhealth
Hambleden House
Waterloo Court
Andover
Hampshire
SP10 1LQ

You can also email us:
customerservices@simplyhealth.co.uk

If you're unhappy with the service you've received, then please let us know

You can call us on:
0370 908 3310

Or email us: customerrelations@simplyhealth.co.uk

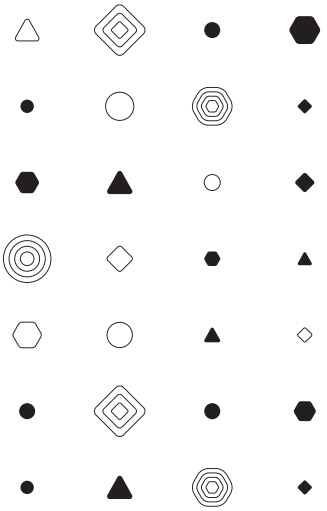
You can also contact us using Facebook or Twitter:
Facebook - @SimplyhealthUk or facebook.com/simplyhealthuk
Twitter - @AskSimplyhealth

Telephone numbers for the myWellbeing services

Speak to a GP:
0330 102 5443

Health and lifestyle guidance:
0330 102 5445

Telephone counselling:
0330 102 5445



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