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IMPORTANT DOCUMENT
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WESLEYAN PRACTICE PROTECTOR PLUS

WESLEYAN

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KEY FEATURES OF PRACTICE PROTECTOR PLUS

The Financial Conduct Authority is a financial services regulator. It requires us, Wesleyan Assurance Society, to give you this important information to help you to decide whether our Practice Protector Plus Plan is right for you. You should read this document carefully so that you understand what you are buying, and then keep it safe for future reference.

HELPING YOU DECIDE

This document gives the main points about our Practice Protector Plus Plan. It doesn't explain all the definitions and exclusions or include all the Terms and Conditions. That information is in the Plan Document which we send you when we accept your application. If you'd like a copy, please contact our Head Office using the contact details on page 10.

In this document, when we use 'you' and 'your' we mean the practice who is taking out this Plan. 'We' or 'us' means Wesleyan Assurance Society. A 'member' is a partner or employee of the practice who is insured on this Plan.

The payments you make for the Plan are called premiums.

When we use 'incapacity' or 'incapacitated' in this document we mean that the member is not able to carry out the essential duties of their occupation because they are ill or have suffered an injury. (Essential duties are those which cannot be left out without affecting a member's ability to carry out their normal occupation).

ITS AIMS

To make regular benefit payments to you if a member of the Plan is unable to work because they are incapacitated and you have to cover the cost of:

- employing a locum or role replacement
- partners or practice employees working extra hours, or
- contractual sick pay benefits you have to pay to the member who is unable to work.

YOUR COMMITMENT

We ask you to do the following:

- To pay all premiums when they are due for the term of the Plan.
- Regularly review the type and level of cover you need for each member. Your Specialist Financial Adviser from Wesleyan Financial Services will be able to help you with this.
- Give us all the information we ask for when we ask for it.
- Tell us about any changes to a member's circumstances, such as:
  - their occupation or duties
  - their UK residency status (for example, if they stop living in the UK)
  - if they retire
  - if they leave the practice, or
  - if they take maternity leave or a sabbatical career break. (A sabbatical career break is when a member takes a temporary break from their normal occupation with permission from their employer).
- Tell us if a member returns or plans to return to work after they have recovered from an illness or injury.
- Tell us if a member is unable to work because they become ill or have suffered an injury, within the time limits we set.
- Have three or more members in the Plan at all times.
- Tell us if the legal status of the practice changes. For example, if it changes from a partnership to a limited company.

RISKS

- We may not pay benefit if you or any of the Plan members:
  - gave us misleading information or information which you or the member knew was not correct when you applied for the Plan or added a member, or
  - if you give us false or misleading information if you claim.
- You may have less cover than you need if you don't regularly review each member's cover.
- If you pay for more cover than you need for a member you will not receive the full benefit you have paid for if you make a claim. If this happens, we won't give you back any money which you have paid.
- You won't be covered if you stop paying premiums.
- A benefit you receive from this Plan might affect any claims you make under other locum cover, role replacement expense cover or sick pay cover Plans.
- We will recalculate your premiums each year. We will let you know if we are going to make any changes to your premiums.
- The underlying premium rates that we use to calculate your premiums might increase at the end of a premium rate guarantee period.
- We don't cover certain claims. (See 'Are there any circumstances when benefit won't be paid?' on page 7.)

QUESTIONS AND ANSWERS

How do I know if Practice Protector Plus is right for my practice?

Practice Protector Plus may be right for your practice if you are looking for protection against the cost of:

- employing a locum, or
- employing a partner or other practice employee for extra hours worked, or
- paying contractual sick pay benefits to the member who is unable to work, or
- if a member of the Plan were to suffer an illness or injury and become unable to work as a result.

The Plan is designed to pay out a regular monthly income if this should happen.

The Plan enables you to choose from a number of options including the period of time you want each member to be covered, the amount of benefit you could receive, how long after the start of the member's incapacity you want the benefit payments to start, and for how long you would like the benefits to be payable.

It may not be right for your practice if:

- you want a cash lump sum (rather than a regular monthly benefit)
- the range of available options does not adequately meet your needs, or
- your costs would be adequately covered by support payments provided by the NHS.

Who can be covered by the Plan?

If you are starting a new Plan or applying to add a member to your existing Plan, it's important that you check that each person is eligible to be covered. The type and amount of cover depends on a member's occupation. For locum and role replacement cover, members must be partners in the practice or employees of the practice, and must be a recognised health professional such as:

- doctor
- healthcare assistant
- practice manager
- pharmacist
- nurse practitioner
- nurse clinician
- physician's assistant
- physiotherapist, or
- practice nurse.

For sick pay cover, members must be employed by the practice in any of the roles listed above or as:

- a practice receptionist
- a member of the practice administrative or management staff, or
- a health professional

A member can only be covered for locum and role replacement cover, or sick pay, but not for both.

Please ask your Specialist Financial Adviser from Wesleyan Financial Services if you are unsure whether an occupation within the practice can be covered under this Plan.

The requirements listed below must be met.

- Each member must be a UK resident (for tax purposes).
- Each member must be aged between 18 and 69 to join the Plan.
- To add a member to the Plan or to increase or enhance the current level of cover (for example, to shorten a member's deferred period), you must confirm that the member or proposed member:
  - is working at your practice
  - has not been off work due to illness or injury for more than 10 working days in the past two months, and
  - does not have any expectations of incapacity of five or more working days in the next three months (for example, they are not scheduled to have an operation which will mean they need time off work).

We may also ask for more information about a member's medical history. This might be when you start the Plan, when you add a new member, when you enhance your current level of cover or when we are assessing a claim.

How many members must be covered?

- At least three members must be covered by the Plan at all times.
- Each year, we will review the number of members covered by the Plan, including any members who are on maternity leave or a sabbatical career break.
- If, when we carry out this review, there are fewer than three members, we will cancel the Plan immediately.
- You can restart the Plan within three months if you apply to add members which would take the total number to three or more.

When can I add a new member to the Plan?

You can apply to add a member to the Plan at any time. We might ask for medical information to help us process the application.

How can I make sure the Plan meets my needs?

You should review the Plan regularly and seek advice from your Specialist Financial Adviser from Wesleyan Financial Services if needed.

The amount of benefit

You choose the amount of benefit you'll need for each member. The levels of benefit you can choose are different for locum or role replacement cover and sick pay cover.

It is important that you review your Plan regularly to make sure you continue to have the right level of cover. If you make a claim and the amount we pay is less than the amount of benefit you selected, we will not refund any premiums.

Locum or role replacement cover

You can choose a benefit between £200 and £4,000 each week for each member.

The most we will pay is the cost of employing a locum or role replacement, or the cost of extra clinical hours worked by doctors, or non-clinical overtime worked by employees or partners in the practice, less the following.

- Any payments that you receive or are entitled to receive from NHS England or an equivalent body in Scotland, Wales or Northern Ireland (or other organisation) towards these costs.
- The value of benefits from any other relevant locum or role replacement, or accident or sickness insurance policies which you or a partner in the practice holds. (For further details see condition A5 of the Plan Document.)

For example, if a member's benefit is £3,000 and it costs you £3,000 to employ a locum, assuming you get £867 from the NHS body and £500 from another insurance Plan, the most we would pay out is £1,633.

Please note, the maximum we will pay out is the amount of benefit you have chosen for a member, even if the cost of hiring a locum or role replacement is higher than this.

For example, if a member's benefit is £3,000 and it costs you £6,000 to employ a locum, assuming you get £867 from the NHS body and £500 from another insurance Plan, we would still only pay out £3,000.

We will not pay the cost of any ongoing or fixed subscriptions that the practice makes to a deputising service. (A deputising service is where a doctor stands in for a regular doctor if they are unable to work).

Sick pay cover

You can choose a benefit between £50 and £2,000 each week for each member.

The maximum weekly benefit we will pay is the lower of:

- the amount of sick pay the practice is contractually liable for each week, or
- the member's annual income in the previous 12 months, divided by 52.

We will deduct any benefit you receive or are entitled to receive from:

- any other illness or injury insurance you hold for that member, or
- sickness or accident insurance you hold on the member's life.

The maximum amount we will pay out for a member's cover is £2,000, even if your costs for sick pay cover are higher than this.

We won't reduce the amount we pay if the member receives or is entitled to receive:

- a continuing salary
- payments from other insurance Plans which you or a partner in the practice holds (including those providing income protection benefits), or
- state benefits.

When we review a claim, we will ask for evidence of sick pay costs you have paid, and evidence of the member's income (before tax and other deductions).

If the cost of paying sick pay to a member is higher than the amount you've insured a member for, we will only pay out up to the amount they are insured for.

The maximum benefit payment period

- You can choose for us to pay the benefit for a maximum period from when the member is first not able to work because of illness or injury.
  - For locum or role replacement cover you can choose 26 or 52 weeks.
  - For employee sick pay you can choose 13, 26 or 52 weeks.
- The shorter the payment period, the cheaper your Plan will be.

How long cover will last

The terminating age for the Plan is 70 for all members.

When benefit payments start

- When you add members to the Plan, you choose how long you want to wait before you start receiving benefit payments. This is called the deferred period.
- You can normally choose a deferred period of 0, 2, 4, 6, 8, 13 or 26 weeks. Not all deferred periods are available to certain occupations. If this applies to any of your members your Specialist Financial Adviser will let you know.
- If we accept your claim and you have chosen a deferred period of '0' weeks, we will pay the benefit from the first day the member was not able to work, but only after they have been unable to work for at least seven days.
- You can also split the cover over two deferred periods, which you can use in the following ways.
  - For locum or role replacement cover, this enables you to choose an appropriate amount of benefit allowing for any support payments you would get from the NHS body (or other organisation).
  - For sick pay cover, you can fit the cover you need around the contractual sick pay arrangements already in place for practice employees.

How do I make a claim?

Telling us about a claim

We will need to gather certain information before we can pay your claim so you should tell us as soon as possible if you think it is likely you will be making a claim. This will help us to ensure benefit payments can start as soon as the deferred period ends.

- If the member's deferred period is eight weeks or less, you need to tell us no later than two weeks from when the member was first incapacitated. If you leave it longer than two weeks, we will assume the date the member was first not able to work was two weeks before the date you told us.
- If the member's deferred period is 13 weeks or more, you need to tell us no later than eight weeks from when the member was first incapacitated. If you leave it longer than eight weeks, we will assume the date the member was first incapacitated was eight weeks before the date you told us.

You can find the contact details for making a claim on page 11 under 'Making a claim'.

How do you assess my claim?

- We'll look at the duties of the member's occupation and their ability to do them.
- For locum or role replacement cover, we'll ask for evidence of the expenses you have to pay and evidence of the member's age.
- For sick pay cover, we'll ask for evidence of a member's health, age and their earnings (before tax) before they were incapacitated.
- You'll qualify for the benefit if a member is totally unable to carry out the essential duties of their normal occupation (and is not doing any other work) and if you are responsible for the costs of employing a locum or replacement, extra hours worked or employee sick pay. (For further details see 'Are there any circumstances when benefit won't be paid?' on page 7.)

How long the claim is paid for

If you make a claim and it's successful, we will pay the benefit until the first of the following happens:

- The member recovers.
- We have paid benefit out for the maximum payment period you chose for that member.
- The member leaves the Plan.
- The Plan ends.
- The member dies.

Claiming again after a member has returned to work

There is no limit to the number of claims you can make. If you need to claim again within 13 weeks of a member returning to work following a period of absence which we've paid benefit for, the deferred period won't apply. In the period that the member returned to work they must have worked at least 30 hours a week (or, if they worked less than 30 hours a week, they must have worked at least the number of hours they were working before they were first unable to work). This will count as one continuous claim so we will only pay out for the rest of the maximum payment period.

Going back to work part-time

If a member is covered for locum or role replacement cover, we will pay you rehabilitation benefit if they go back to work part-time after a period where we have paid benefit if:

- before they returned to work the member had not been able to work for at least 13 consecutive weeks, and
- the member has returned to work for less than 30 hours each week.

When the benefit would be paid

If we accept a claim, we will pay benefit at the end of each month from the end of the deferred period.

Premiums when claiming

You will have to carry on paying your premiums while you are receiving benefits under the Plan.

Can I increase the cover?

Yearly increase

The amount of benefit for each member who is actively at work will automatically increase every year on the Plan anniversary shown in the schedule. Before each Plan anniversary, we will let you know what the benefits and premiums will be for the following year. The increase will be in line with the change in the Retail Prices Index (RPI) over the 12-month period, which ends five months before the increase takes effect. (The RPI calculates the change in the cost of goods and services over the year.). We will use a similar replacement index if the RPI is not available.

You can turn down the yearly increase for any of the members and you won't lose the right to accept any future increases if you do this.

Unless you turn down the yearly increase, your premiums will increase every year to pay for the cost of the additional cover.

We will not apply yearly increases for a member if:

- the member is not actively at work
- we have applied special conditions that state we will not apply yearly increases, or
- the increase would take the member's total benefit over £8,000 for locum or role replacement cover or £4,000 for sick pay cover.

At each anniversary, it is important that you check that the benefit for each member will not increase to an amount that would exceed the maximum we would pay out. (See 'The amount of benefit' on page 4.)

Three-year increase option

At the third Plan anniversary after the date a member joined the Plan, and every three years after this date, you can apply to increase your locum or role replacement cover for that member by up to 25% without providing medical evidence.

Other conditions that affect the three-year increase option are set out below.

- The maximum increase of 25%, includes any yearly increases that were applied on the current anniversary date and the previous two anniversary dates. For example, if the increases from the previous two anniversaries and the current anniversary total 10%, the three-year increase can only be 15%.
- The total insured benefit after the increase must not be more than £4,000 each week, and must not be more than double the amount of cover you originally had when the member first joined your Plan.

- The current level of the member's benefit must be based on an assessment of medical evidence that we have already been given. It can't be based on cover as detailed in the section 'The Cover Without Medical Evidence (CWME) option' on page 9.
- The member must be aged 60 or under.
- We will send you a Scheme Review Form and you must fill this in no later than 14 days after the Plan anniversary date. Please note, the member must be actively at work when you fill in the form.

Other increases

You can apply to increase cover for a member who is actively at work at any time. The increase must not take the total benefit for a member over:

- £4,000 each week for locum or role replacement cover, or
- £2,000 each week for sick pay cover.

We might need more medical information in order to progress an application for a member. If this happens, you can choose to start the increased cover and premiums straight away (known as interim cover) or delay the start date (see 'What medical and other details will I need to give you?' on page 8 for more information).

Are there any circumstances when benefit won't be paid?

- We sometimes set special conditions that apply to members of the Plan. This means we may not pay the benefit if a member is not able to work because of certain medical conditions. If special conditions apply to a member, we will tell you when their cover starts (or, if the special condition relates to an increase in cover, we will tell you when the increase takes place).
- A member is covered if they fall ill or suffer an injury anywhere in the world, but we will only pay benefits when they are actually in certain countries or territories, including:
  - the UK
  - the United States of America
  - Australia, or
  - a member of the European Union.

The full list of countries and territories can be found in the Plan Document. (Please see condition A8 – Geographical limits.)

- For interim cover, we won't pay out if the member is not able to work because of any pre-existing medical condition. A pre-existing medical condition is a physical or psychological condition that a member has:
  - had in the past five years, and
  - had medical consultations or needed treatment for from a general practitioner (GP), a hospital doctor, a consultant or other relevant health professional. (See 'Interim cover' on page 8 for more information.)
- We will not pay a claim if a member is unable to work because of normal pregnancy, but we will cover complications of pregnancy. (See 'What happens if a member goes on maternity leave?' on page 10 for more information.)

How much will my premiums be?

- We work out the cost for each member's cover and then add these costs together to decide the total that you will pay for the Plan.
- The minimum premium is £15 a month (£180 a year).
- The premiums depend on things like:
  - each member's sex
  - each member's age
  - each member's occupation
  - each member's medical history
  - the deferred periods you have chosen for each member, and
  - the level of cover you choose for each member.
  - We'll tell you the actual cost you'll pay when we have assessed your application.
- You can pay by direct debit each month or each year or by cheque each year. There is a 5% reduction if you pay your premiums yearly.
- The payment will change:
  - if members join or leave the Plan
  - if a member dies
  - when we recalculate the premiums on the Plan's anniversary
  - if a member's benefit is increased each year
  - if you choose an extended premium rate guarantee (see 'Can underlying premium rates be guaranteed?' on page 8.)
  - if you change a deferred period or maximum benefit payment period
  - if a member takes a sabbatical career break or maternity leave
  - if a member changes occupation, or
  - if we reduce the cover for a member after we have reviewed their medical evidence.

Your premium will not change as a direct result of any claims you make.

What are the charges?

The premiums you pay cover all costs and any fees for medical examinations which we need the member to have.

If you make a claim for benefit, you or the member must pay for any medical certificate or medical report that we request from the member's GP that confirms they are unable to work.

What if premiums stop?

If you miss a premium and do not pay it within 30 days of the date it was due, your Plan and cover will end.

You won't get any money back. You can restart your Plan within 12 months of missing the first premium. You will have to pay all premiums you have missed and we may need to review each member's medical history.

Can underlying premium rates be guaranteed?

- The premium rates are guaranteed for at least two years. This means we won't change the underlying premium rates even if we receive more claims than we expected, or if our costs to provide cover increase. Although the underlying premium rates that we base your premiums on will not change in the guarantee period, we will still increase your premiums as a result of the following.
  - Increases in the members' ages (which will be reflected in our yearly recalculation of premiums), and
  - You increase or enhance the current level of cover (for example, to reduce a member's deferred period).
- You can extend the underlying premium rate guarantee period to three or five years. If you do this:
  - your premiums will increase by 3% (if you extend the guarantee period to three years), or
  - 7.5% (if you extend it to five years) each year.

  This is called an extended premium rate guarantee.
- When a guarantee period ends, you can choose a new guarantee period. If you don't, it will automatically be set at two years.
- At the end of each premium rate guarantee period, we will review the underlying premium rates that we use for your Plan. This means that your premiums might go up.
- You can first cancel an extended premium rate guarantee exactly one year after the Plan start date. You can cancel an extended premium rate guarantee on the same date each year after that. If you cancel an extended premium rate guarantee, you can't take out another until the one you cancelled would have ended. You can't cancel the standard two-year guarantee.
- Your premiums will not change as a direct result of any claims you make.
- We might have to make changes to the rates because of a change in the law or regulations that apply to this Plan.

What medical and other details will I need to give you?

Medical evidence

We will always ask for medical evidence about a member when:

- you start the Plan or add members to it (unless you use the 'Cover Without Medical Evidence (CWME) option' as explained opposite).
- you apply to increase the benefit and the three-year increase option is not available – for more information, please see 'Can I increase the cover?' on page 6.
- you make a claim
- you shorten a deferred period or lengthen a payment period, or
- you increase the age when cover will end for a member.

Interim cover

It might take a while to gather and review medical information for a new member (or when you apply to increase or enhance a member's cover). However, we will start cover for a new member (or increase cover for an existing member) immediately. This is called 'interim cover'.

- Interim cover will end when the first of the following happens.
  - We send you a new schedule or an amended Plan schedule to confirm your full cover.
  - We tell you or a member that we have refused or postponed acceptance of the application.
  - We have provided interim cover for a period of three months.
  - You cancel the cover.
- If we accept your application, your premiums will be based on the terms we offer and you accept.
- If we refuse or postpone acceptance of your application, or you don't accept the terms we offer, the premiums you pay for interim cover will stop immediately. We won't refund any premiums you have paid for interim cover if you have held the cover for more than 30 days without cancelling.
- At the end of the interim cover there must be at least three members in the Plan (see 'How many members must be covered?' on page 4).
- We won't pay a claim for interim cover if the member becomes ill or has suffered an injury because of a pre-existing medical condition (see 'Are there any circumstances when benefit won't be paid?' on page 7).

The Cover Without Medical Evidence (CWME) option

The CWME facility is available where there are three or more members on the Plan. It allows an element of cover to be provided for a member without taking their individual state of health into consideration.

The amount of CWME available on the Plan is determined by eligible members who have locum or role replacement cover under it.

A weekly benefit limit, called the 'CWME limit', is calculated at the start date of the Plan and on every subsequent anniversary of that date.

The CWME weekly limit will be the lower of the following.

- £150 multiplied by the number of members who are covered on a locum or role replacement basis.
- £2,400.

If you use the CWME facility in relation to a member, we won't need evidence of that member's health for any part of their cover that falls within the CWME limit, as long as, at the time the facility is first used, they:

- are actively at work
- have not been absent from work because of illness or injury for more than 10 working days in the past two months, and
- do not have any expectations of incapacity of five or more working days in the next three months (for example, they are not scheduled to have an operation which will mean they need time off work).

Can the CWME limit reduce?

The CWME limit will reduce if the number of members is reduced. This means that the cover for a member could be more than the reduced CWME limit. If this happens, we will ask for evidence of a member's health so we can decide if the amount of cover that is above the new limit can continue. We will not ask for this if the member's current cover has been set based on medical evidence we have previously been given.

After we review the medical evidence, we might need to increase your premiums or apply special conditions for any benefit above the reduced CWME limit. We will tell you about any changes to your premiums or exclusions that may apply if this happens.

Example:

A practice has four members each requiring the following role replacement cover:

Member no.1 requires a benefit of £2,000 per week.

Member no.2 requires a benefit of £1,000 per week.

Member no.3 requires a benefit of £1,000 per week.

Member no.4 requires a benefit of £600 per week.

The calculated weekly CWME limit is £600. If the CWME facility is used, member no.4 will not need to provide any evidence of their state of health for the required level of cover. For the other members, their individual state of health will only be taken into account in respect of the amount of cover which exceeds the £600 CWME limit. For example, for member no. 1, the first £600 of benefit would be covered by the CWME limit, with the remaining £1,400 being subject to consideration of the member's state of health.

For further information on eligibility for members for different parts of your Plan and details of who is covered under them, please see 'Who can be covered by the Plan?' on page 3.

Can I reduce the cover?

Yes, you can reduce the current level of benefit for a member at any time, as long as it does not go below the minimum benefit amount. Your premiums will reduce immediately.

Can a member's cover be suspended?

Yes, you can suspend a member's cover for up to two years if they take a sabbatical career break from their normal occupation. New members can't join the Plan if they are on a sabbatical career break when the Plan starts.

You can suspend a member's cover if the member has not had a sabbatical career break that ended less than 52 weeks before the start date of a new career break (whether the member was covered by the Plan or not). You won't need to pay any premiums for the Plan for the member, but you won't receive any benefits for that member either. The member's cover will start again with the same cover they had before they took the sabbatical career break, without having to give us further medical evidence. Cover will start again when the member has:

- been back at work for at least three months, and
- told the NHS (or other official body) that they have returned to work if there is a legal or regulatory requirement to do so.

When the member's cover restarts, you can choose to add the yearly increases that would have been added to the benefit if the member hadn't had a sabbatical career break.

What happens if a member goes on Family Leave?

- A member can remain on the Plan during a period of Family Leave. This includes Maternity Leave, Paternity Leave, Adoption Leave, Parental Leave and Shared Parental Leave. The period of leave can be up to 12 months.
- You will not have to pay premiums for a member on Family Leave but Benefits for the member will not be available either.
- When the member returns to work, their cover will continue on the same basis as was in place immediately before their Family Leave. We won't need further medical evidence.
- Premiums will also re-start at this point. You also have the option to add annual increases that would have been added to the benefit during the period of Family Leave.
- You can make a claim for Benefits if the member is unable to return to work at the end of a period of Family Leave because of incapacity resulting from illness or injury (for Maternity Leave this is illness or injury that does not arise from normal pregnancy). When this happens the start date of the deferred period is the date that the member was due to return to work.

What happens when a member leaves the practice?

You must tell us straight away using the contact details below if a member leaves the practice. Cover and payments for that member will stop immediately. If a member leaves your practice, you might have less than the minimum number of members required for the Plan (see 'How many members must be covered?' on page 4).

If a member leaves the Plan, the CWME limit may reduce if you have selected this facility. (For further information, please see 'The Cover Without Medical Evidence (CWME) option' on page 9.)

A member who is insured for locum or role replacement cover might be able to join an existing Wesleyan Practice Protector Plus Plan if they move to a different practice. They must do this within 30 days of leaving the Plan. A member might be able to continue locum or role replacement cover with an individual Plan from Wesleyan, without needing to provide further medical information. They must do this within 30 days of leaving the Plan.

There is more information about continuing cover in the Plan Document (please see condition B17 – Continuation option).

Does the Plan have a cash-in value?

The Plan does not have a cash-in value at any time.

What about tax?

- For practices that are partnerships, the monthly or yearly premiums that the practice pays are normally allowed as a business expense. This means you can deduct them from your profits before calculating the tax.
- For practices that are incorporated bodies, such as limited companies, the monthly or yearly premiums don't normally qualify for tax relief.
- Benefit payments are normally treated and taxed as a trading receipt but you can deduct the costs of employing a locum and other expenses you have to pay from these before calculating the tax.
- Sick pay benefits that are paid by the practice to an employee are normally treated as a benefit-in-kind for tax purposes.
- This is how we understand the current tax rules. They may change in the future and your actual tax treatment depends on your personal circumstances. You should consult your local tax office for more information about tax for your specific situation.

Can I change my mind?

When we accept your application we will send you a Cancellation Notice. If you send the Cancellation Notice back to us within 30 days of starting the Plan, we will refund any money you have paid after we have deducted any benefit we may have paid.

If you cancel the Plan, we will stop cover and premiums for all members, and stop paying benefit for any members who are incapacitated. We will also refund any premiums for cover you have paid for but have not received.

HOW TO CONTACT US

If you have any questions about this Plan, you can contact us in the following ways:

- Call us on 0800 294 4006. Our lines are open from 9am to 5pm, Monday to Friday. Calls may be recorded to help us provide, monitor, and improve our services to you.
- Email us at PracticeProtection@wesleyan.co.uk
  However, please avoid sending personal information by email as it is not a secure method of communication.
- Write to us at:
  Practice Protection Team
  Wesleyan Assurance Society
  Colmore Circus
  Birmingham
  B4 6AR

You should send instructions to us in writing to the address above. However, we may accept instructions other than in writing from time to time. We can only communicate with you in English. We can contact you by phone or in other ways to get instructions about your Plan.

MAKING A CLAIM

If you want to make a claim, you can contact us in the following ways:

- Call us on 0800 975 0131. Our lines are open from 9am to 5pm, Monday to Friday.
  Calls may be recorded to help us provide, monitor, and improve our services to you.
- Email us at ProtectionClaims@wesleyan.co.uk
  However, please avoid sending personal information by email as it is not a secure method of communication.
- Write to us at:
  Protection Claims Team
  Wesleyan Assurance Society
  Colmore Circus
  Birmingham
  B4 6AR

HOW TO COMPLAIN

We do everything we can to make sure we always give you the best possible service. If you are unhappy with any part of the service we have given you, and want to complain, you can contact us in the following ways:

- Call us on 0800 294 4006. Our lines are open from 9am to 5pm, Monday to Friday.
  Calls may be recorded to help us provide, monitor, and improve our services to you.
- Complete the online contact form which can be found by visiting our website at www.wesleyan.co.uk/contact/complaints
- Email us at complaints@wesleyan.co.uk
  However, please avoid sending personal information by email as it is not a secure method of communication.
- Write to us at:
  Complaints Team
  Wesleyan Assurance Society
  Colmore Circus
  Birmingham
  B4 6AR

If, after receiving our response, you're still not happy, you can refer your complaint to the Financial Ombudsman Service:

Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Phone: 0800 023 4567 or 0300 123 9123
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

Complaining to the Ombudsman won't affect your legal rights.

OTHER INFORMATION

Law

The Plan is governed by the law of England.

Compensation

If we cannot meet our financial obligations to you, you may be entitled to compensation from the Financial Services Compensation Scheme (FSCS) under the Financial Services and Markets Act 2000. You can get details of the scheme from the FSCS at:

FSCS
PO Box 300
Mitcheldean
G17 1DY

Phone: 0800 678 1100 or 020 7741 4100
Email: enquiries@fscs.org.uk
Website: www.fscs.org.uk

Conflicts of interest

You can find a copy of our Conflicts of Interest policy on our website at **https://www.wesleyan.co.uk/about/corporate-governance**, or you can ask us for a copy.

We are all about you.

Since we were founded over 180 years ago, we have cherished our mutual status. It's an integral part of who we are and with no shareholders, our focus is on members and customers. We work to benefit those who invest in our business. Not only today, but also in the future.

It's why 'we are all about you'.

A guide to the many ways in which the Wesleyan Group of companies can help you to plan, prioritise and secure your financial future.

For you

- Savings & Investments
- Mortgages
- Retirement Planning
- Insurance
- Life & Income Protection

For your business

- Equipment Insurance
- Personal Protection
- Premises Insurance
- Staff Protection
- Finance & Funding

For more information about the Wesleyan Group of companies, visit **wesleyan.co.uk/ourcompanies**

If you would like this document in Braille, large print or audio format, please contact **0800 975 3710.**

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