HSF Health Plan®

OptiLife Health Plan

Your Health. Your Plan. Your Way.

OptiLife Health Plans are designed to protect your health and well-being, while giving you peace of mind. From everyday care to specialist support, our plans ensure you and your family have the flexibility and cover you need, whenever you need it.

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Welcome to OptiLife

A health plan that grows with you, bringing optimism, support, and benefits you'll love every step of the way.

At HSF Health Plan, we're delighted to introduce **OptiLife**, our health plan designed to empower your well-being and provide peace of mind for you and your family at every stage of life.

Why OptiLife?

Health Cover

OptiLife provides a broad range of benefits, including dental, optical, and specialist consultations, ensuring you have a health plan that enables you to claim back on essential healthcare services.

HSF Assist

HSF Assist supports your well-being with 24/7 GP advice and a counselling service, guiding your mental health journey. It helps you feel supported, find balance, and live a happier, more fulfilling life.

Exclusive Perks

As an OptiLife policyholder, you gain access to HSF Perkbox, offering discounts on gyms, entertainment, retail, and travel, enhancing your lifestyle and overall well-being.

Your Health on Your Terms

Health needs can change over time, and at HSF Health Plan, we're committed to being there for you.

That's why we designed **OptiLife** with thoughtful flexibility, ensuring your plan consistently meets your health priorities.

Our focus is on your well-being by providing reliable support and care that you and your family can trust.

Statement of Demands and Needs

This product meets the demands and needs of individuals and families seeking support for expenses such as dental and optical, consultations, and other healthcare-related costs.

The product is not available from HSF Health Plan on an advised basis. HSF Health Plan is not in a position to determine whether the product is appropriate for you.

Applicants should choose the scheme to suit their personal circumstances and review in the future whether this remains suitable.

Key Benefits Explained

Your Health, Covered

Cover You Can Count On

We're here to make healthcare easy and stress-free for you and your family. Our plans help you save on everyday health costs while giving you the support you need, whenever you need it. You can go privately to get the treatment your body deserves from a professional!

Key Features:

Dental Care:
Be reimbursed for routine check-ups, treatments, cosmetic dentistry, and emergency dental care.

Specialist Investigations: Includes consultations, health screenings, vaccinations, scans, and diagnostic tests.

Optical & Hearing Tests:
Cover your costs for sight tests, prescription glasses, contact lenses, laser eye surgery, and hearing tests.

Birth & Adoption Grant:
Expanding your family? Whether through birth or adoption, our grant provides financial support to help with the costs.

Mental Health Support:
Access consultations and treatment with a Counsellor, Psychiatrist, or Psychologist to support your emotional well-being.

Family Cover:
Our Core plan covers dependent children under 21 at no extra cost, while our Enhance plan and above include your spouse or partner (if living at the same address as you).

Practitioners:
Claim back expenses for physiotherapy, sports massage therapy, osteopathy, chiropractic care, chiropody, and speech therapy.

Pre-Existing Conditions Covered:
Pre-existing conditions are covered from day one. The qualifying periods are 10 months for the Birth and Adoption Grant and 12 months for laser eye surgery.

Monthly Premium	Core	Enhance	Empower	Optimum	Optimum+
	Employer Funded	£10.00	£20.00	£31.00	£45.00
	Children under 21	Partner and Children under 21		Partner and Children under 21	
Dental	£70	£125	£175	£400	£600
Optical/Hearing Tests	£70	£125	£175		
Hearing Aid		not applicable			
Mental Health	£100	£150	£200	£250	£300
Practitioner	£75	£100	£150	£400	£600
Alternative Treatments Acupuncture, Homeopathy, & Reflexology	£75	£100	£150		
Specialist Investigations	£200	£300	£400	£550	£700
Birth & Adoption Grant	£100	£200	£300	£400	£500
Hospital Amount per night up to a maximum of 30 nights	£20	£35	£50	£75	£100
Post Admission Support A lump sum payment will be made after the 7th paid night of the hospital stay	£60	£80	£100	£120	£160
Day Case Surgery Amounts per day up to a maximum of 5 occasions	£30	£45	£60	£85	£125
Home Help	£100	£250	£350	£500	£750
Prescriptions	£20	£30	£40	£50	£60
Accident Cover					
Permanent Disability	£3,000	£4,000	£5,000	£6,250	£7,500
Accidental Death	£1,500	£2,000	£2,500	£3,200	£3,800
Dental Trauma	£300	£400	£500	£625	£750
Temporary Disability				£60	£90
Fracture (Leg)				£375	£575
Fracture (Arm)		not applicable		£200	£300
Fracture Total				£950	£1,450
Facial Disfigurement				£1,500	£2,300
HSF Assist Available on all plans	24/7 GP Advice Line, Virtual Doctor, Prescription Service, Counselling Service and Legal Advice.				
Perkbox Available on all plans	Your Go-To Online Platform for Discounted Gym Memberships, Retail Discounts, Entertainment Deals, Travel Savings and more to enhance your well-being.				

***HSF Assist:** The 24/7 GP Advice Line is for all adults covered, while the Counselling Support service is for policyholders aged 16 and over.

Live Your Best Life

For a Healthier, Happier You

HSF Assist

Say goodbye to long waits and hello to convenience! Enjoy round-the-clock access to a 24/7 GP advice line, virtual doctor consultations (8am – 10pm), prompt prescription delivery to your local pharmacy, and counselling support for those aged 16 and over.

Perkbox

Ready to save big and treat yourself? Perkbox is your one-stop shop for discounted gym memberships, retail deals, entertainment perks, and travel savings.

It's packed with ways to help you crush your goals while keeping some extra cash in your pocket.

Plus, their Wellness Hub is full of resources to help you feel your best - mind, body, and soul.

Worldwide Cover

Accident Cover

Life is unpredictable, but OptiLife's Personal Accident Cover helps you stay prepared. It provides lump sum payments for bodily injury, permanent disability, or accidental death, offering financial support for you and your loved ones.

You're covered, whether at home, work, or during leisure activities. If an accident leads to disability or disfigurement, you'll receive a one-time payout. For temporary disability, you'll get ongoing financial support to help manage expenses.

In the event of accidental death, a lump sum will be provided to your beneficiaries. Wherever life takes you, Optilife ensures you're protected.

For full details and the personal accident benefits table, refer to **page 17** in the terms and conditions.

Set Up Your Plan

Discover MyPolicy

Everything You Need, All in One Place.

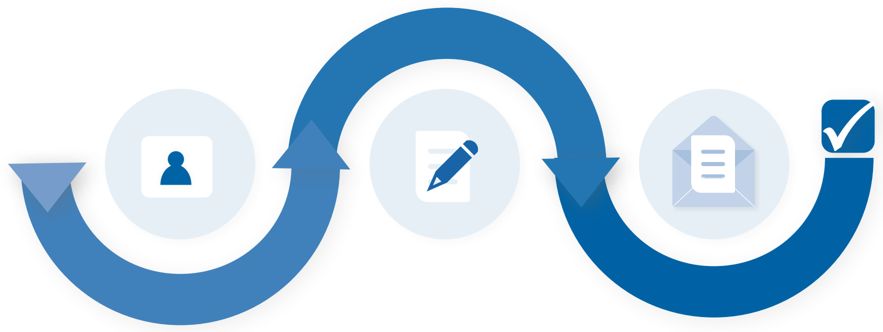
With MyPolicy, managing your HSF Health Plan is effortless.

It's your all-in-one platform to track benefits, claims, and extras anytime:

- Check claims and payments instantly
- Track your benefits and what's left to use
- Download digital claim forms
- Access extras like **HSF Assist®** and **Perkbox**
- View policy details whenever you need them

How to Set-Up Perkbox

Don't let your exclusive benefits slip away! Register now to unlock a world of rewards designed to elevate your everyday. With a quick sign-up, you'll tap into perks that are tailor-made for you. Start enjoying the advantages you deserve!



Unlock Your Benefits

Head over to mypolicy.hsf.eu.com to register or sign in.

Unleash your perks by clicking **Benefits** and **HSF Perkbox website.**

Submit Your Form

Fill out the form with your awesome details.

Find your **policy number** in your welcome pack.

Start Saving

Receive a friendly welcome email within a few working days.

Kickstart your savings journey by downloading the Perkbox app (Domain name: **HSF**).

How to Claim

It's as Simple as 1-2-3

We've streamlined the claims process, so you can focus on what truly matters, your well-being. Follow these three easy steps:

Step 1: See a Practitioner

Visit a registered practitioner of your choice.

Our health plans help cover consultation and treatment fees, saving you money.

Ensure the practitioner is registered and qualified.

Not sure if your practitioner is eligible?

Check the "make a claim" tab on our website or call us on **020 7202 1381,** and we'll assist you.

Step 2: Visit MyPolicy and submit your claim

Once you've received your treatment, it's time to submit your claim.

Attach your receipt(s): Make sure your receipt includes;

- **Your name**
- **Practitioner details**
- **Treatment provided**
- **Date of the treatment**
- **Total cost**

For personal accident claims, special claim forms are required. Contact us at **claims@hsf.eu.com** to request one.

Step 3: Get Your Cashback

Once your claim is approved, you'll get an email notification to check your MyPolicy account.

Head to your MyPolicy Mailbox to find your payment confirmation letter.

That's it, your cashback will be processed quickly and conveniently!

Terms and Conditions

Becoming a Policyholder

Cover is provided continuously from month to month until it is cancelled or otherwise comes to an end. Your policy will automatically renew every time your premium is paid, so unless we change the terms and conditions of your policy you will not receive renewal documentation.

The named policyholder must be a parent of the stated children under 21 or be the legal guardian of them. Children in a fostering arrangement are not eligible for inclusion, and neither are children who are on weekend/school holiday stays. Any dependent children must all reside at the same address. Young people aged 16 and 17 may join an HSF Health Plan policy in their own right but if either parent is a policyholder as well, the young person will cease to be a dependent for cover on the parent's scheme.

Completing the Application Form

You must complete the application form on **pages 25 and 26,** reading the declaration carefully before signing. Add any dependent child(ren) (must be under the age of 21, living at the same address as the applicant) on **page 25,** if you would also like them to be covered on your policy.

Restrictions

Claims cannot be accepted for: anything related to plastic surgery and consultations / treatment for cosmetic reasons; misuse of alcohol or drugs; self-harm; or self-inflicted injuries.

Benefits Overview

There is a total limit on benefits calculated on a rolling balance over a 12 month basis with a further limit from the start of your policy on some hospital benefits.

Switching between schemes is allowed. See 'Increasing scheme cover' and 'Decreasing or ceasing scheme cover' on **pages 13** for the terms.

Paying Premiums and Changing Your Mind

Credit and Debit card payments will only be accepted for ad-hoc payments. It is the Policyholders responsibility to check that payments have commenced and maintained, either by checking their payslip, with their payroll, or by checking their bank statement, in order that they are received regularly by HSF Health Plan.

When your application is accepted you will receive a welcome letter or email from HSF Health Plan with instructions explaining how to register for MyPolicy. MyPolicy enables Policyholders to access all their policy details in one place. On receiving your welcome letter of cover, you have 14 days in which to change your mind and withdraw your application or via email to customer@hsf.eu.com. If any premiums have been paid in that time, you will receive a full refund providing no claims have been settled. See 'Decreasing or ceasing scheme cover' on **pages 13** for cancelling after this period.

If premiums fall into arrears for more than three months, a qualifying period of one month will be imposed from the date of payment before entitlement to claim is resumed. Policyholders who fall into arrears for more than six months will normally be required to re-join under the usual conditions of enrolment.

If you leave employment, it is your responsibility to inform HSF Health Plan of this. If your premiums cease, your cover will cease from the end of the month your last premium was paid. If you wish to continue your policy after you leave employment, please contact HSF Health Plan to discuss the options available to you.

If any premiums are missed during this process, then payment of these will be required to maintain your policy.

Making a Claim

Qualifying Periods

There is a qualifying period of 10 months for the Birth and Adoption Grants and this time also applies to other benefit categories if the claim is related to pregnancy or infertility. A qualifying period of 12 months applies to Eye Laser Treatment and Implantable Contact Lenses.

There is no qualifying period for the majority of claims. Submitted claims must relate to fees incurred, treatment received, or hospital stays occurring after your joining date or, if applicable, after the end of the qualifying period.

Claim forms are available to download from this brochure (see page 10), through our website www.hsf.co.uk, or upon request. Please quote your policy number, which can be found on your welcome letter. An original, or good copy of the receipt must be submitted with the claim form. Claims will only be accepted where accumulated receipts total £5 or more. Your payment will be made direct to your bank account (a current account in your name or joint names).

Claims will not be paid unless the appropriate premiums are up-to-date. Claims must be made within six months from the date of the treatment/purchase or discharge from hospital or the accident taking place. All claims are subject to premium checks and it may be necessary to ask you for supporting information in connection with any claim. 'Please see Paying premiums and changing your mind' on this page.

Claims will not be accepted for any consultation, treatment, or medical service that has been arranged, funded, or provided by the employer, including those received through employer-run health schemes, occupational health programmes, or on employer premises. All eligible claims must be independently arranged and paid for by the policyholder in accordance with the policy terms.

Reimbursement of most claims is made on a rolling balance principle over any 12 consecutive months. This period starts from the date we pay your claim (not from your joining or scheme increase date or from a calendar year).

For example: a Empower Plan policyholder, who has up to £175.00 to claim for dental expenses in any 12 consecutive months; could have the following claim record:

Date Claim Paid	Claim Paid Amount	Remaining Balance in the Empower Plan Dental Category
17 June 2024	£50.00	A balance of £125.00 remains.
5 October 2024	£125.00	Now a nil balance is left. The next available amount will be £50.00 on 17 June 2024.
11 August 2025	£25.00	A balance of £25.00 remains.

Within any consecutive 12-month period, the claim paid amount has not exceeded £175.00. After each claim is paid the amount becomes available again 12 months later.

Balances available in each category can be checked by checking MyPolicy or telephoning the claims department who will give guidance on when to submit a claim.

Benefit payments which relate to amounts paid for a service provided will be up to 100% of the cost, depending on the maximum shown in the brochure.

If there are any issues with your claim or premiums paid on your account, this can cause a delay in processing your claim.

The receipts (which will not be returned must:

a. be originals, or good copies;

b. include the practitioner's stamp / name, qualifications and date of issue;

c. include the patient's full name and address;

d. state the type of service and items provided;

e. be for a service for which payment has been met directly by a person registered as a policyholder or dependent;

f. be for a service covered by the HSF Health Plan categories only and not for any insurance premiums paid to cover that service.

In circumstances where part or all of the amount stated on the receipt has been met by another organisation or insurance company, HSF Health Plan will limit or decline benefit payment to ensure that overall a policyholder does not receive more than the amount paid as to do so would be an illegal act.

Claims cannot be accepted for purchases or treatment or services provided outside the United Kingdom and Ireland. Claims cannot be accepted for treatment or purchases from service providers who are related to the insured person(s) or for treatment or consultation carried out in the workplace. There are no location restrictions under the Personal Accident categories.

Should any overpayment be made in respect of any of the benefits, the amount in question will be set against any future claims, or a repayment may be requested. Any fee paid by a policyholder to a practitioner for any type of medical statement or to a hospital for a statement concerning admission / attendance cannot be reimbursed by HSF Health Plan.

Payment for Personal Accident Claims

Any money due will be paid to the policyholder, if living, otherwise to his/her personal representative/s within 21 days of the claim being submitted to the satisfaction of HSF Health Plan.

Any receipt which the policyholder or anyone acting on the policyholder's behalf, or his/her representative(s) may give to HSF Health Plan for benefits payable, shall be deemed final and complete discharge of all liability of HSF Health Plan in respect of such benefits.

Change of Circumstances

A policyholder may add their partner or spouse to their cover from the Enhance level onwards, sharing benefit balances under a single policy. The partner's details must be provided to HSF Health Plan via the application form included in this brochure **(pages 25 and 26).** Terms and conditions will align with those of the primary policyholder.

Dependent children under 21 residing at the same address may also be included for cover. Children born in the first 10 months of cover (when it has not been possible to pay a Birth Grant) may be added as dependents. To add children to the policy, a change of circumstances form must be completed. This form is available upon request. The named policyholder must be a parent of the stated child(ren) under 21 or be their legal guardian. Children in a fostering arrangement, and/or children who are on weekend/school holiday stays, are not eligible for inclusion.

An application form is also required for children for whom an Adoption Grant has been paid. The policyholder will be able to make a claim relating to a child, when acceptance has been confirmed, and the terms and conditions will be the same as a new policyholder.

Any change of address must be notified in writing to HSF Health Plan, so that records remain up-to-date.

Increasing Scheme Cover

Any existing policyholder is able to apply to increase to a higher scheme by completing an application form.

The qualifying periods apply at the time of joining and when transferring to any scheme. For more details on qualifying periods, please refer to **page 12.**

If a policyholder increases their level of cover, the 12-month rolling balance principle will continue to apply. Any amounts already claimed under the previous scheme will be deducted from the available balance on the new scheme. The benefit balance will refresh in accordance with the rolling balance cycle.

Any claim for treatment incurred prior to the upgrade will not be settled. Once a policy is increased, entitlement at the prior scheme ceases.

Decreasing or Ceasing Scheme Cover

While it is possible to reduce payments by transferring to a lower scheme, cover at the higher scheme should have been of at least six months' duration before such an application is made. Entitlement at the higher rate then ceases immediately upon transferring. Claims made upon the higher scheme will carry forward and be accounted for in the limits available within the lower scheme. Cover at the new lower rate scheme must be of at least 12 months duration before increasing or decreasing again. Policyholders who wish to cease payments should provide written notification to HSF Health Plan. Past payments will not be refunded. Premiums would be due to HSF Health Plan for the pay period of the cancellation. Entitlement to claim will continue throughout any period of time covered by premiums and subject to any qualifying periods or terms and conditions. Any errors in premium payments must be notified to HSF Health Plan within two years of the occurrence for refunding to be possible.

Any changes to the premium you pay for your policy can take up to 4 to 6 weeks to process and whilst HSF Health Plan will communicate with your payroll team, the policyholder should check with their Payslip or Bank Statement that the increase/decrease has been applied. If for any reason the increase/decrease has not been applied any claim will be paid at rate applicable to the scheme current at the time of claim unless a payment is made to bring payments up to date.

Death of a Policyholder

When a policyholder dies, any outstanding claims at the time of death will be settled as appropriate, payments being made on production of the required proof of entitlement.

Terms and Conditions

Dental

Help towards the cost of routine and cosmetic treatment, including check-ups, up to the maximum shown. It is payable between all eligible named persons on the policy in any 12 consecutive calendar months.

The dentist must be suitably qualified and registered with the General Dental Council. Sundry items purchased at Dental Surgeries premises, eg. cleaners, floss, are not covered and prescription charges for any kind of medication are not covered under this category. Any dental treatment (including teeth whitening) not carried out at a dental surgeon's practice (eg. if undertaken or purchased at a cosmetic/retail outlet) is not covered.

Not Covered
Consultations with Consultant Oral Surgeons, Consultant Facio-Maxillary Surgeons, and Consultant Orthodontic Surgeons are not covered under this category. These should be claimed under the Specialist and Investigations category. The cost of treatment or operative procedures undertaken by these Consultants is not included in any category.

Optical/Hearing tests

Help towards the cost of a sight test and optical appliances, up to the maximum shown. It is payable between all eligible named persons on the policy in any 12 consecutive calendar months.

Claims cannot be accepted for the purchase of spectacles or contact lenses supplied without prescription.

The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments is included.
Qualifying Period – 12 months.

Not Covered
Consultations with Consultant Ophthalmic Surgeons is not covered under this category. These should be claimed under the Specialist and Investigations category. The cost of treatment or operative procedures undertaken by these Consultants is not included in any category. If eye laser treatment or a permanent contact lens implant (to correct long or short sightedness) is carried out by a Consultant Ophthalmic Surgeon or undertaken in hospital as a day case patient or an inpatient, claims cannot be accepted for Specialist and Investigations or for Hospital or Day Case in addition to the Optical category.

Hearing Aid

Help towards the cost you have paid a recognised hearing aid supplier for the cost of a new hearing aid, up to the benefit limit for this category, up to the maximum shown. Payable between all eligible named persons on the policy in any 12 consecutive calendar months.

Mental Health

Help towards the cost of consultations and treatments with qualified mental health professionals, including registered counsellors, consultant psychiatrists, and psychologists. This benefit supports policyholders in accessing professional guidance and therapeutic interventions to manage their mental wellbeing. Claims can be made for consultations and treatment sessions up to the benefit limit stated in the scheme brochure, provided that the practitioner is appropriately registered with a recognised professional body. Reimbursement is based on the cost of the service received, up to 100% of the eligible amount. Claims cannot be accepted for therapy received as part of workplace occupational health services. Additionally, costs associated with self-guided mental health resources, such as digital therapy programmes, meditation or mindfulness apps, and other subscription-based wellbeing services, are not covered under this benefit.

Practitioners

Including Physiotherapy, Sports Massage Therapy. Osteopathy, Chiropractic, Chiropody, and Speech Therapy.

Help towards the cost of consultation and treatment (not including medication or appliances) by a qualified and registered practitioner, up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible named persons on the policy in any 12 consecutive calendar months. The maximum payable between all eligible named persons on the policy is also between each of the above practitioner types.

Policyholders and dependants, in their own interests, should only consult properly qualified practitioners who are registered with that profession's governing body/council e.g. The Health and Care Professions Council - HCPC.

Not Covered
Consultations with Consultant Podiatric Surgeons (of hospital consultant status) are not covered under these benefits. These should be claimed under the Specialist and Investigations category. The cost of treatment or operative procedures undertaken by these consultants is not included in any category.

Alternative Treatments

Including Acupuncture, Homeopathy, and Reflexology

Help towards the cost of consultation and treatment (not including medication or appliances) by a qualified and registered practitioner up to the maximum shown. This benefit may be used flexibly according to requirements for all categories. Payable between all eligible named persons on the policy in any 12 consecutive calendar months. The maximum payable between all eligible named persons on the policy is also between each of the above practitioner types.

Claims will only be accepted with receipted invoices from qualified practitioners of the professions above. Policyholders and dependants, in their own interests, should only consult properly qualified practitioners who are registered with that profession's governing body/council e.g. The Health and Care Professions Council - HCPC or The Association of Reflexologists - AoR. The cost of any appliances or medication supplied or prescribed by the practitioners is not included.

Not Covered
Claims will not be accepted for reiki healing or hypnotherapy nor for prophylactic/maintenance treatments.

Specialist and Investigations

Help towards the cost of specialists' consultation fees, allergy testing, vaccination, health screening, pathology tests, x-rays, scans, electrocardiograms and other investigations listed below, all undertaken on an outpatient basis, up to the maximum shown. Payable between all eligible named persons on the policy in any 12 consecutive calendar months.

Claims must be for consultations in a hospital or clinic on an outpatient basis only and carried out by a doctor of consultant status. Treatment (including radiotherapy) and operative procedures (including delivery of a baby) are not covered, neither is any radiography during such treatment/procedures.

Claims cannot be accepted for examinations / investigations carried out while an inpatient or as a day case or for medico-legal reports, possible legal evidence (including paternity testing), or for insurance, employment fitness /occupational assessments or immigration/emigration purposes.

The Following are Covered Under Investigations:

Any investigations undertaken, on an outpatient basis only, in a hospital x-ray, scanner, pathology or nuclear medicine / medical physics department (or its equivalent elsewhere); electrocardiogram, electroencephalogram; electromyogram, audiogram and orthoptic investigations. Minor invasive investigations carried out at the same time as an out patient consultation, and not requiring the use of a separate treatment room, are also covered.

For Health Screening; Claims are accepted for visits to health screening clinics.

For Vaccinations: The cost of a vaccination administered at a GP surgery or clinic, or the issue of a prescription for a vaccination (which may be in the form of vaccine or medication).

For Allergy Testing: the initial consultation and diagnosis of problems by a qualified practitioner, with a personal consultation in a clinical environment **(not a retail outlet)** is covered, for the lifetime of the policy, but not for any subsequent consultation or treatment.

The Following are Not Covered Under Investigations Nor Health Screening

Consultations with a Consultant Psychiatrist are not covered under this category, this should be claimed under Mental Health. Invasive investigations, such as endoscopies, carried out with some form of anaesthetic, and requiring the use of an out-patient treatment room (for which the hospital or clinic charges an additional fee) or occupancy of a bed on a day stay basis. The Hospital and Day Case benefit may be claimed in these circumstances if applicable.

We do not cover any form of postal testing.
We do not cover Autism, Dyslexia, ADHD, Dyspraxia assessments or similar.

Birth & Adoption Grant

A Birth or Adoption grant is payable to the policyholder, whether they are the mother or father of the baby, for each registered birth in hospital or at home that occurs after the 10 month qualifying period. Hospital benefit is payable for the mother in addition to the grant from the sixth night onwards. The grant is also payable for a registered adoption up to the age of 10.

Hospital benefit relating to the mother or baby is not payable to male policyholders who do not reside at the same address as their partner. The Birth Grant is also paid for a still birth if an official certificate is submitted. Adoption is included in this category, however, a claim under this category may not be submitted until HSF Health Plan cover has been of at least 10 months' duration. The adoption certificate should be dated after the end of this qualifying period and before the child's 10th birthday. Children already named on the policy may not subsequently be the subject of an Adoption Grant by either parent. Claims for overseas births and adoptions are not covered, but may be considered at our discretion.

Any inpatient treatment and all other categories for consultation, investigation and treatment associated with or arising as a consequence of pregnancy is also subject to the enhanced qualifying period.
Qualifying Period – 10 months.

Hospital

General and Hospice: For an inpatient admission to a hospital or hospice to receive medical treatment. Payable to each eligible named person on the policy for up to 30 nights in any 12 consecutive calendar months. The hospital or hospice must be in the United Kingdom or Ireland and its name and admission and discharge dates should be clearly stated on the claim form. The amount payable is the stated grant and no direct costs are covered (e.g. Consultants fees, room charges, medication/dressings involved with the hospital admission, including consultants' fees) are covered.

Accident: For an inpatient admission to a hospital immediately following an accident. Payable to each eligible named person on the policy for up to 30 nights in any 12 consecutive calendar months.

Elderly and Mental Illness: For an inpatient admission to a hospital for elderly medical care / long stay / rehabilitation / respite / GP care or for a mental illness. Payable to each eligible named person on the policy for up to 40 nights elderly and 40 nights mental illness from the start of your policy, but not for more than 30 nights in a 12 month period. The hospital or hospice must be in the United Kingdom or Ireland and its name and admission and discharge dates should be clearly stated on the claim form. Benefit is payable to each eligible named person on the policy for up to 30 nights or days in any consecutive 12 calendar months. The amount payable is the stated grant and no direct costs are covered (e.g. Consultants fees, room charges, medication/dressings involved with the hospital admission, including consultants' fees).

Benefit is restricted to 40 nights in total in a period of continuous cover, regardless of scheme, for each named person on the policy to whom it applies for admissions: for congenital and prematurity disorders in babies and children for whom a Birth Grant has been paid to a parent; to mental illness and geriatric (elderly medical / long stay / rehabilitation / respite care/ General Practitioner care) wards. These 40 nights are counted as part of and not in addition to the ruling in the sentence above eg. within a 12 month period the number of nights for which benefit is payable will not exceed 30 regardless of the reason for admission.

In accordance with the usual practice, the date of admission is counted as the first night but the date of discharge is not counted. Time spent within an Accident and Emergency Department (A&E) is not considered as part of an admission unless the hospital declares it to be so in accordance with their records. Claims must be submitted after each discharge from hospital. Weekend leave or longer periods of home leave do not count as a discharge, although no amounts will be paid for nights spent at home. Transfers from one hospital to another without a period at home in between are counted as a continuous period in hospital.

In cases of long stay admissions a claim may be submitted after 30 nights and an amount will be paid up to the number of nights due within the rules. Post admission support, as appropriate, will be payable upon discharge. However, if an admission extends beyond 12 months a further claim may be submitted. There are special rules for these unusual circumstances. If, on the date of admission to hospital, the benefit limit is shown to have been reached in the preceding 12 months then no payment is made for that admission at all unless the current admission is of a duration which takes it past the anniversary of the discharge date 12 months earlier. In these cases the balance of nights due will be paid.

Not Covered
Adults staying with their children at the hospital/hospice are not entitled to Hospital or Day Case benefit; nor are children who are staying with their parents.

Post Admission Support

Following each stay in a hospital or hospice for which benefit has been paid for a minimum of 7 nights, a post admission support grant is payable for each eligible named person on the policy. This grant is paid automatically, subject to qualifying for the appropriate number of nights in the hospital categories and the patient being discharged. There is no requirement to make an additional claim. If readmissions occur after less than 10 nights following discharge, and the second or subsequent admissions by virtue of their length would also qualify for a grant, only one such grant will be paid.

Not Covered
The grant is not payable when the patient dies in hospital or an admission includes a confinement and qualifies for the Birth Grant.

Day Case Surgery and Treatment

For a planned admission to occupy a bed for a day in a hospital or clinic to undergo surgery, treatment or a procedure. Limited to 5 occasions within any 12 consecutive calendar months for each eligible named person on the policy.

The claim form must be signed by an official at the hospital and bear the official stamp to verify the information given by the policyholder. Anyone admitted overnight following a Day Case attendance will be entitled to the Hospital and not the Day Case benefit. The following are not included: Geriatric, psychiatric or rehabilitation day hospitals or units; an unplanned day or period spent in an Accident and Emergency or Casualty Department; minor surgery, treatment or procedures undertaken in outpatient or similar departments. The amount payable is the stated grant and no direct costs, e.g. Consultants fees, room charges, medication/dressings involved with the hospital admission including consultants' fees are covered.

Terms and Conditions

Home Help

Home Help Short term assistance towards the cost of Local Authority services and some privately arranged assistance with organisations, up to the maximum shown. Payable between all eligible named persons on the policy in any 12 consecutive calendar months.

This category does not include home nursing and is designed to give short term assistance only (no longer than a period of 6 months) with the costs of housework (cleaning and cooking) for those incapacitated by an illness, and being unable to work, or recuperating at home following a hospital admission. All claims must be submitted with receipts from the Local Authority providing the service. Claims may also be submitted with receipts for home help from private companies or organisations whose businesses provide such services. Claims for child care, shopping or gardening are not covered. We do not accept claims from individual cleaners/service providers paid or employed by you or any insured person.

Prescriptions

Help towards the cost of standard prescription charges or the equivalent rate for private prescription charges on the production of a receipted invoice supplied by a Pharmacy (Dispensing Chemist), indicating that a prescription supplied by a General Practitioner has been dispensed. Payable between all eligible named persons on the policy in any 12 consecutive calendar months , up to the maximum shown in the plan levels.

The Following are Not Covered:

- Any charges for prescriptions outside the United Kingdom & Northern Ireland.
- Any advance prescription prepayment certificate.

HSF Assist®

There are no additional charges to use the services in HSF Assist (except for the cost of the phone call to the service). If you are advised by the telephone counselling service that you would benefit from structured counselling, they can arrange for you to have a session or sessions with a counsellor. HSF Assist will cover up to 6 sessions with the counsellor within the lifetime of your policy.

HSF Perkbox

The HSF Perkbox is provided and facilitated by Perkbox Limited, at the time this brochure was produced. All offers are subject to availability and the terms and conditions as stated on the HSF Perkbox website. Access to these offers is only via the website and Perkbox Application for Mobile Devices. Use of HSF Perkbox website and application is included in your Policy. Access to the site can be via Wi-Fi, or provided by your mobile network provider, but HSF Health Plan or Perkbox cannot take responsibility for the app not working at full functionality if you do not have access to Wi-Fi, and if you do not have any of your data allowance left.

If you are using the app outside of an area with Wi-Fi, you should remember that your terms of agreement with your mobile network provider will still apply. As a result, you may be charged by your mobile provider for the cost of data for the duration of the connection while accessing the app, or other third party charges. In using the app, you are accepting responsibility for any such charges, including roaming data charges if you use the app outside of your home territory (i.e. region or country) without turning off data roaming. If you are not the bill payer for the device on which you are using the app, please be aware that we assume that you have received permission from the bill payer for using the app.

Personal Accident

If an Accident results in Permanent Disability or death the financial consequences can be enormous. Even less serious injuries can result in a lengthy period off work or confinement to the house. Whilst you may be able to cope in the short term, a longer period of disability can put severe pressure on family finances. Lump sum cash payments when they are needed most could ease the financial burden. Policyholders and dependent children are covered 24 hours a day, every day of the year, whether at work, at home or at play.

Permanent Disability: A lump sum cash benefit depending upon the type and degree of Permanent Disability following an Accident.

Facial Disfigurement: A lump sum payment for Permanent facial disfigurement as a result of an accident.

Accidental Death: A lump sum payment if the Accident is fatal.

Dental Trauma: A payment for dental treatment required as a direct result of a blow to the head. See definitions from this page.

Temporary Disability: Not applicable to children under 16 years of age. A weekly sum payable (normally by direct credit, monthly in arrears) if following an Accident, you are: a) unable to take up your normal paid occupation or any other paid employment; or b) confined to the home (applicable only if you are not in paid employment at the time of the Accident) as certified by a qualified medical practitioner.

Payable from the 31st day of your disability for up to 52 weeks. Odd days will be paid at 1/7th of the weekly rate. **Although there is no qualifying period under this section, the Temporary Disability benefit is not payable for the first 30 days (Deferment Period) of each period of temporary disablement.**

Fracture Benefit: A lump sum payment for a fracture or fractures to one or more bones of the arm or leg following an Accident.

1. Payment for any Permanent Disability not shown in the table on the next page will be based on a medical assessment of the disability in relation to the table and not in relation to the Insured Person's ability to work.
2. If the Insured Person was already disabled before an Accident or already had a condition which is gradually deteriorating, the payment will be reduced. The reduced payment will be based on a medical assessment of the difference between:
   - the Permanent Disability after the Accident; and
   - the extent to which the Permanent Disability is affected by the disability or condition before the Accident.
3. If the Insured Person claims for loss of limb, he / she cannot also claim for parts of that limb.
4. The most an Insured Person can receive for Permanent Disability resulting from any one Accident is the amount specified for Permanent Total Disablement.

Definitions

Accident means a sudden unforeseen and fortuitous identifiable event and the word accidental shall be construed accordingly.

Bodily Injury means injury to an Insured Person which solely and independently of any other cause results in the Insured Person's Death, Permanent Disability, Temporary Disability, fracture of a specified bone or bones, or Dental Trauma. Bodily Injury excludes any condition resulting from any gradually operating cause or degenerative process.

Permanent Disability means disablement which has lasted for at least 12 months and from which it is believed the Insured Person will never recover.

Permanent Total Disablement means disablement caused other than by loss of limb or sight which, having lasted for at least 12 months, will in all probability entirely prevent the Insured Person from engaging in or giving attention to a profession or occupation of any and every kind for the remainder of his / her life.

Loss of Sight means total and irrecoverable loss of sight when an Insured Person's name has been added to the Register of Blind Persons or when the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.

Personal Accident Table

Category	Core	Enhance	Empower	Optimum	Optimum+
Permanent Total Disablement	£3,000.00	£4,000.00	£5,000.00	£6,250.00	£7,500.00
Loss of Sight in one or both eyes	£3,000.00	£4,000.00	£5,000.00	£6,250.00	£7,500.00
Loss of hearing in both ears	£2,250.00	£3,000.00	£3,750.00	£4,687.00	£5,625.00
Loss of hearing in one ear	£450.00	£600.00	£750.00	£937.00	£1,125.00
Loss of the use of an arm, hand or leg above the knee	£3,000.00	£4,000.00	£5,000.00	£6,250.00	£7,500.00
Loss of the use of a leg below the knee or a foot	£1,500.00	£2,000.00	£2,500.00	£3,125.00	£3,750.00
Loss of the use of a shoulder or elbow	£1,290.00	£1,720.00	£2,150.00	£2,687.00	£3,225.00
Loss of the use of a hip, knee, ankle or wrist	£600.00	£800.00	£1,000.00	£1,250.00	£1,500.00
Loss of the use of a thumb	£300.00	£400.00	£500.00	£625.00	£750.00
Loss of the use of any finger or big toe	£300.00	£400.00	£500.00	£625.00	£750.00
Loss of the use of any other toe	£150.00	£200.00	£250.00	£312.00	£375.00

Dental Trauma means Bodily Injury resulting from an Accident which is as a direct result of a blow to the head. Payments will be made only for Dental Treatment required following the Accident. Payment will be up to the amount shown in the Dental Trauma benefit for the scheme chosen. In any case the amount will not exceed the stated maximum of the cover selected. The maximum for this on plan Optimum+ is £750.

The benefit will only be paid in respect of treatment an Insured Person receives within 12 months of the date of the Accident. This benefit covers dental treatment directly relating to an Accident such as a sports injury or a fall and includes anaesthetic fees, Dental crowns, bridges and white fillings, Dental veneers and Replacement dentures or repairs. It is a condition of this policy that the dentist confirms on each receipt that the treatment is only to repair the damage to the Insured Person's teeth as a direct result from a blow to the head.

In addition to the Exclusions stated under Personal Accident the following exclusions also apply to this benefit:

1. Cancellation charges made by the dentist (for example, for missed appointments).
2. Damage to dentures when not being worn.
3. Dental consumables (for example, toothbrushes, mouthwash and dental floss).
4. Dental prescription charges.
5. Dental insurance, premiums and joining fees for a practice's dental plan.
6. Any treatment an Insured Person receives 12 months or more after the date of the accident.
7. Dental treatment an Insured Person receives for an accident which happened before joining the plan.
8. Bodily Injury caused by eating and drinking.

Permanent Facial Disfigurement means to the extent of not less than one square centimetre of scar tissue or a scar of not less than two centimetres in length in each case in the area from the hairline to and including the lower jaw and ears.

Temporary Disability means disablement which prevents the Insured Person from engaging in or giving attention to his / her normal, gainful occupation or which confines the Insured Person to his / her home on medical grounds.

Benefit Period means the total period (but not necessarily consecutive period) for which the Temporary Disability Benefit is payable in respect of any one Accident to any Insured Person. Note: Odd days will be paid at 1/7th of the specified weekly rate.

Deferment Period means a period of temporary disablement during which the Temporary Disability Benefit shall not be payable.

Exclusions

No Benefits Will Be Payable:

1. If the Bodily Injury is caused by: war or any act of war; the Insured Person serving full-time in the armed forces of any country or international organisation; suicide, attempted suicide or deliberate self-inflicted injury by the Insured Person (even if they are insane); the Insured Person taking part in air sport or air travel, unless as a passenger; a sickness or disease; Repetitive Stress (Strain) Injury or Syndrome or any other condition or injury which develops over a period of time.
2. For any disabilities caused by or arising from Post Traumatic Stress Disorder or related syndromes or any psychological or psychiatric condition.

Terms and Conditions

General Conditions

Regardless of any amendments, the Birth and Adoption Grant will remain available to all policyholders in the form outlined in the brochure for a minimum of 13 calendar months from the date of joining or changing schemes. This applies to all existing policyholders.

In the interest of the majority of the policyholders, the Board of Directors of HSF Health Plan reserve the right to:

1. vary the premium rates by giving at least 28 days' notice to the policyholder's last known email or home address;
2. vary the range and rates of benefit and the conditions and terms relating thereto;
3. restrict or decline further payments;
4. refuse a new application or refuse to increase or defer increase to a higher premium without giving reasons for doing so;
5. terminate the cover of any policyholder who is in breach of the rules and conditions, has refused to cooperate in the process of settling a claim or whose conduct has, in the opinion of the Board, been unacceptable;
6. take legal action against anyone who makes a fraudulent claim and terminate cover immediately;
7. use information provided on application and claim forms for the prevention and detection of crime;
8. make amendments to these rules with such changes applying at the time of start of the policy or from any subsequent written notification to the policyholder.

Regulatory Information

Regulation and Compensation

HSF Health Plan Limited (No 202182) is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. (This may be checked on the Financial Services Register by visiting the FCA website).

At the time this brochure was produced, HSF Assist is provided for HSF Health Plan by Health Hero whose doctors are experienced GPs who are GMC registered, licensed, on the NHS Performers list, GP Register and have full Medical Council of Ireland registration, qualifying them as "fit to practise".

In the unlikely event of our going out of business, the Company is covered by the Financial Services Compensation Scheme. The Group Policyholder or Insured Person may be entitled to compensation should the Company be unable to meet its financial obligations. You can obtain further information from the Company at 24 Upper Ground, London, SE1 9PD or from the Financial Services Compensation Scheme at the following address: Financial Services Compensation Scheme, 10th Floor, Beaufort House, 15 St Botolph Street, London EC3A 7QU.

Advice and Reviews

HSF Health Plan is not authorised to provide advice and our Account Executives are only allowed to provide factual information on our products. They are not in a position to determine whether the product is appropriate for you.

Applicants should carefully consider the schemes available to them and choose the scheme to suit their personal circumstances. Policyholders should regularly review their policy documents to ensure the scheme remains suitable for their circumstances.

Remuneration of our Account Executives

Our Account Executives receive a salary and also receive a bonus based on sales and on meeting certain quality thresholds.

Compliments and Complaints

We endeavour to provide a high standard of service to our Policyholders and welcome comments and suggestions. Should you find it necessary to make a complaint, you should in the first instance contact our Customer Services Department at our London address.

While we are investigating your complaint, we will keep you regularly updated. If your complaint has not been resolved within 8 weeks, we will explain why it remains unresolved and inform you of your right to refer the matter to the Financial Ombudsman Service at Exchange Tower, London E14 9SR or telephone them on

0800 023 4567.

Their website address is www.financial-ombudsman.org.uk.

Full details of our complaints procedures are automatically sent on receipt of a complaint and at each stage relevant addresses are provided. Such details are available on request at all time.

Governing Law

Cover in your scheme within this HSF Health Plan will be governed by and interpreted in accordance with English Law.

Privacy Policy

This is the privacy notice of HSF Health Plan Limited. In this document, “we”, “our”, or “us” refers to HSF Health Plan Limited.

We are company number 30869 and our registered offices are at 24 Upper Ground, London, SE1 9PD. In Ireland, our company number is 904935 and the registered office is at 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare Ireland.

We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority in the UK. In Ireland, we are regulated by the Central Bank of Ireland for Code of Conduct business rules, with the Department of Health and Children and The Health Insurance Authority in Ireland. Founded 1873 Incorporated 1890. We are the trading company of The Hospital Saturday Fund, a Registered Charity in the UK No 1123381 and in Ireland Registered Charity No 20104528.

Introduction

At HSF Health Plan, we understand the importance of protecting your privacy. This policy is designed to explain what information we may collect about you, how we may use it, and the steps we take to ensure that it is kept secure. It sets out the conditions under which we may process any information that we collect from you, or that you provide to us. It covers information that could identify you (“personal information”) and information that could not. In the context of the law and this notice, “process” means collect, store, transfer, use or otherwise act on information.

We are committed to transparency and take the protection of your privacy and confidentiality very seriously. You have the right to know how your personal data is used, and we are committed to using it only for the purposes you intended. We will never share your information with unauthorised third parties and will always maintain the confidentiality of the data you entrust to us.

How is Your Personal Data Collected and the Data We Collect?

When you apply for a Health Cash Plan, we collect three types of information: your personal details (including those of your partner and any dependents), your medical details (including those of your partner and any dependents), and your payment details.

Personal Details

The personal details we collect are your personal and contact details including title, name, address, date of birth, email address, telephone numbers, PPS number, employers name and payroll number (if applicable). We also collect the name and date of birth of your partner and any dependents (if applicable).

Medical Details

The medical details we collect are any conditions or illnesses you, your partner and any dependents may have had (or have) and the date any of the symptoms began.

Payment Details

The payment details we collect are Direct Debit or Credit Card information. Direct Debit or Credit Card information will be used for automatic payments to be made from the account you provide.

When you agree to set up a Direct Debit arrangement, the information you give to us is passed to our own bank for processing according to our instructions. We do keep a copy of this instruction.

We May Collect Information From:

- The main policyholder if you are a dependant under a family policy.
- Your employer, if you are covered by a policy your employer is funding.
- Brokers and other agents (this may be your broker if you have one, or your employer’s broker if they have one).

Sending a Message to our Support Team: When you contact us, whether by telephone, through our website or by e-mail, we collect the data you have given to us in order to reply with the information you need. We record your request and our reply in order to increase the efficiency of our business.

How We Use Your Personal Data

We will only use your personal data when the law allows us to. Most commonly, we will use your personal data in the following circumstances:

When you make an application for a Health Cash Plan or otherwise agree to our terms and conditions, a contract is formed between you and us. In order to carry out our obligations under that contract we must process the information you give us. Some of this information may be personal information in order to:

- Verify your identity for security purposes
- Sell products to you
- Provide you with our services
- Provide you with suggestions and advice on products, services and how to obtain the most from using our website

We process this information on the basis there is a contract between us and where we have a legal obligation to do so such as processing medical information to support claim assessments in line with that policy contract, or that you have requested we use the information before we enter a legal contract.

Additionally, we rely on legitimate interest as the lawful basis for which we collect and use your personal data where it is necessary for our and your legitimate interests and fundamental rights do not override those interests. When we process your personal information for our legitimate interests, we will consider and balance any potential impact on you and your rights under data protection and any other relevant law. Our legitimate business interests do not automatically override your interests – we will not use your personal data for activities where our interests are overridden by the impact on you (unless we have your consent or are otherwise required or permitted to by law). Our legitimate interests arise as the processing of your personal data is necessary to enable us to set up and administer our products and services.

Where we have a legal or regulatory obligation to use your personal information, for example, when our regulators, the Prudential Regulatory Authority (PRA), the Financial Conduct Authority (FCA), the Information Commissioner’s Office, Central Bank of Ireland (CBI) or Data Protection Commission (DPC) ask us to maintain certain records of any dealings with you.

Where we need to use your personal information to establish, exercise or defend our legal rights, for example when we are faced with any legal claims, or where we want to make any claims ourselves.

Where we need to use your sensitive personal information such as health data because it is necessary for your vital interests, an example would be a life-or-death matter.

We may also aggregate your personal data in a general way and use it to provide class information, for example to monitor our performance with respect to a particular service we provide. If we use it for this purpose, you as an individual will not be personally identifiable.

The Following are Some Examples of When and Why We Would Use This Approach:

- **To Improve and Enhance our Services:** When we do process your data, we will use it to benefit you and to make your experience better and to improve our products and services.
- **Your Best Interest:** Processing your information to protect you against fraud when transacting on our website, and to ensure our websites and systems are secure.
- **Personalisation:** Where the processing enables us to enhance, modify, personalise or otherwise improve our services/ communications for the benefit of our customers.

- **Research:** To determine the effectiveness of promotional campaigns and advertising and to develop our products, services, systems and relationships with you.
- **Due Diligence:** We may need to conduct investigations on existing customers, potential customers and business partners to determine if those companies and individuals have been involved or convicted of offences such as fraud, bribery and corruption.

We will only use your personal data for the purposes for which we collected it, unless we reasonably consider that we need to use it for another reason and that reason is compatible with the original purpose. If we need to use your personal data for an unrelated purpose, we will notify you and we will explain the legal basis which allows us to do so.

Please note that we may process your personal data without your knowledge or consent, in compliance with the above rules, where this is required or permitted by law.

Information Sharing

In order to provide you with our services, we may share your data with third parties and other organisations within our group or other organisations to enable continuity of service, such as;

- Organisations that pay premiums on your behalf in line with the policy contract
- Service providers and partners who provide IT and system administration services, support services.
- Professional advisers including lawyers, bankers, auditors and insurers who provide consultancy, banking, legal, insurance and accounting services.
- Organisation to provide the benefits and service for which you have applied for and to assist with the continuity and provision of benefits

We may also share your data with regulatory bodies when it is a legal requirement to do so for the purpose of monitoring and enforcing compliances such as;

- HM Revenue & Customs, regulators and other authorities who require reporting of processing activities in certain circumstances.
- Fraud detection agencies and other third parties who operate and maintain fraud detection registers.
- The Financial Ombudsman Service and regulatory authorities such as the Financial Conduct Authority, the Information Commissioner's Office and the Prudential Regulation Authority

We require all third parties to respect the security of your personal data and to treat it in accordance with the law. We do not allow our third-party service providers to use your personal data for their own purposes and only permit them to process your personal data for specified purposes and in accordance with our instructions.

International Transfers

The disclosure of personal information to the affiliates and other third parties set out above may involve the transfer of data outside the EU, EEA or states that are considered 'adequate'. Where we need to engage a third party which operates outside of Europe those considered 'adequate' for the provision of services, then we would ensure that an equivalent degree of protection is provided by implementing appropriate technical measures and legal safeguards and standard contractual clauses as required by the legislation.

Data Security

We have put in place appropriate security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorised way, altered or disclosed. In addition, we limit access to your personal data to those employees, agents, contractors and other third parties who have a business need to know. They will only process your personal data on our instructions, and they are subject to a duty of confidentiality.

We have put in place procedures to deal with any suspected personal data breach and will notify you and any applicable regulator of a breach where we are legally required to do so.

Data Retention

We will only retain your personal data for as long as necessary to fulfil the purposes we collected it for, including for the purposes of satisfying any legal, accounting, or reporting requirements.

To determine the appropriate retention period for personal data, we consider the amount, nature, and sensitivity of the personal data, the potential risk of harm from unauthorised use or disclosure of your personal data, the purposes for which we process your personal data and whether we can achieve those purposes through other means, and the applicable legal requirements.

In line with our current retention policy, we retain policyholders' personal data for at least 6 years but no more than 7 years after the health plan policy has ceased.

If You Fail to Provide Personal Data

If you do not provide information, we may not be able to:

- Provide requested services to you;
- To continue to provide and/or renew existing products or services.

We will tell you when we ask for information which is not a contractual requirement or is not needed to comply with our legal obligations.

Your Legal Rights

Right to be Informed: We will always be transparent in the way we use your personal data. You will be fully informed about the processing through relevant privacy notices.

Right to Access: You have the right to request a copy of all information about you held by us.

Please note that we are not obliged to take proactive steps to discover that a subject access has been made. If we cannot view a subject access request without paying a fee or signing up to a service, we will not respond to the request.

Data Portability: You have the right to exercise your right to data portability in certain circumstances.

Right to Object or to Restrict Processing: You have the right to object to our use of your personal information, or to ask us to delete, remove, or stop using your personal information if there is no need for us to keep it. Please note our policy is to only keep personal information for as long as is reasonably required for the purpose(s) for which it was collected. We are required to keep certain transactional records – which does include personal information – for more extended periods to meet legal, regulatory, tax or accounting needs. We are also required to retain an accurate record of dealings with us for at least six years after your last interaction with us, so we can respond to any complaints or challenges you or others might raise later.

We may sometimes be able to restrict the use of your data. This means that it can only be used for certain things, if this is the case we would not use or share your information in other ways whilst it is restricted.

You can ask us to restrict the use of your personal information if:

- It has been used unlawfully but you don't want us to delete it.
- You have already asked us to stop using your data, but you are waiting for us to tell you if we can keep on using it.

Right to Rectification: We want to make sure that the personal data we hold about you is accurate and up to date. If any of your details are incorrect, please let us know and we will amend them.

When we receive any request to access, edit or delete personal identifiable information we shall first take reasonable steps to verify your identity before granting you access or otherwise taking any action. This is important to safeguard your information.

Privacy Policy

Right to Erasure: You have the right to have your data 'erased' in the following situations:

- Where the personal data is no longer necessary in relation to the purpose for which it was originally collected or processed.
- When you withdraw consent.
- When you object to the processing and there is no overriding legitimate interest for continuing the processing.
- When the personal data was unlawfully processed.

Please note that each request will be reviewed on a case-by-case basis and where we have a lawful reason to retain the data or where exceptions exist within our retention policy, then it may not be erased.

If you wish to exercise any of your above right, you can do so by contacting the Data Protection Officer.

Data Protection Officer Contact Details

HSF Health Plan.
24 Upper Ground, London SE1 9PD.
Email: DPO@hsf.eu.com

What We May Need From You

We may need to request specific information from you to help us confirm your identity and ensure your right to access your personal data (or to exercise any of your other rights). This is a security measure to ensure that personal data is not disclosed to any person who has no right to receive it. We may also contact you to ask you for further information in relation to your request to speed up our response.

Time Limits to Respond

We try to respond to all legitimate requests within one month. Occasionally it may take us longer than a month if your request is particularly complex or you have made a number of requests. In this case, we will notify you and keep you updated.

Right to Complain: Should you not be happy with the way we handle your personal data, you have the right to complain. You can do so by contacting the Data Protection Officer.

If your complaint reasonably requires us to contact a third party, we may decide to give to that third party some of the information contained in your complaint. We do this as infrequently as possible, but it is a matter for our sole discretion as to whether we do give information, and if we do, what that information is.

You also have a right to lodge a complaint with the supervisory: Information Commissioner Office.

Compliance with the Law

Our privacy policy has been compiled so as to comply with the law of every country or legal jurisdiction in which we aim to do business. If you think it fails to satisfy the law of your jurisdiction, we should like to hear from you.

Review of this Privacy Policy

We may update this privacy notice from time to time as necessary. The terms that apply to you are those included in this document on the date of your use. We advise you to print a copy for your records.

If you have any questions regarding our privacy policy, please contact us.

Last updated May 2024.

Your Questions Answered

Q Do I have to have a medical to join?

A No, a medical exam is not required.

Q Are pre-existing medical conditions covered?

A Yes, pre-existing medical conditions are covered, and no medical examination is required to join OptiLife.

Q Is there a waiting period before I can claim?

A Birth & Adoption benefits which has a 10-month waiting period, and Eye Laser Treatment which has a 12-month waiting period. Please refer to our Terms & Conditions on pages 12–17 for full details.

Q When does my cover begin?

A Your cover begins on the date stated in your welcome letter or email, and qualifying periods start from that date as well.

Q Is there a limit to how much I can claim?

A Yes. Each benefit category has a set annual limit, calculated on a rolling 12-month basis. Some hospital benefits also have additional limits that apply from the start of your policy. Please refer to your plan details for specific amounts.

Q How do I pay?

A If your plan is fully funded, your employer covers the cost. If it is part-funded, payments are deducted through payroll.

Q Can my partner be covered under my policy?

A Yes, you can add your partner or spouse to the Enhance Plan or a higher scheme by completing an application form.

Q Can I get cover for my children?

A Yes, your up to 21, can be included on your policy for free. Simply list them as dependents on the application form, found on pages 25 and 26 of this brochure.

Q How do I make a claim?

A For full details on how to claim, including steps and where to download the claim form, please refer to page 10 of this brochure.

Q How will I receive my claim be paid?

A Your reimbursement will be paid directly into your bank account.

Q Can I cancel my policy?

A Yes, you can cancel your cover at any time. If you cancel within 14 days of joining, your premiums will be fully refunded.

Q What happens if I change jobs?

A If you wish to continue a HSF Health Plan policy after you leave employment, you can do this and should contact HSF Health Plan to discuss the options available to you.

Q Are my claims taxable?

A No, you keep all you receive from HSF Health Plan.

Q How do I contact customer support?

A Visit page 27 for all contact information to get in touch with the relevant department.

OptiLife Application Form

Please return this completed application form to **customer@hsf.eu.com**

AE code	AE5

Policy number

1 Personal information

About you

Policyholder details (please use capital letters)

Employer			
Full name			
Title		**Date of birth**	
Address			
Postcode		**Phone**	
Email			

2 Family cover

Dependents for cover (must be under 21)

Please list any additional dependents on a separate sheet of paper and include it with this form.

Dependent 1

Full name		**Date of birth**	

Dependent 2

Full name		**Date of birth**	

Dependent 3

Full name		**Date of birth**	

3 Upgrade your plan

I apply to upgrade my HSF Health Plan at the rate indicated. Tick the required option for your chosen plan. ✓

Plan name	Core	Enhance	Empower	Optimum	Optimum+
Policyholder monthly	£0.00	£10.00	£20.00	£31.00	£45.00

Tear along the perforation

4 Add your spouse/partner

Your spouse/partner **(permanently living with you)**

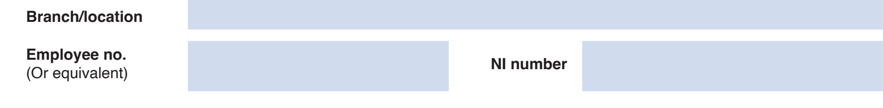
Please complete this section only if you've chosen to increase your cover in section 3.

Spouse/partner full name

Title **Date of birth**

5 Authority for deduction from pay for HSF Health Plan

Please complete the sections below which are applicable to your particular employer



Branch/location

Employee no.
(Or equivalent)

NI number

Please review the **'Upgrade Your Plan'** section in Section 3 to check the cost of your selected plan. Then, enter the amount you want deducted from your pay in the **new deduction box** here.

New deduction

Your pay department will commence deductions as soon as possible after receipt of this mandate form from HSF Health Plan.
Your pay advice should be checked to ensure that this request has been correctly applied.

6 Declaration

I wish to change my policy with HSF Health Plan at the plan indicated. I authorise my employer to deduct from my salary the sum per month shown (or such other amount as may apply after prior written notification), and remit to HSF Health Plan.

I confirm that no advice has been received regarding this application from HSF Health Plan or my employer. I agree to HSF Health Plan holding data relevant to my policy. I agree to abide by HSF Health Plan rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or premiums if deemed necessary.

I declare that all the information I have given on this application form is true and complete to my knowledge and belief and that if found to the contrary HSF Health Plan shall be free to cancel cover at any time.

Signature **Date**

Tear along the perforation

You can return this application form to customer@hsf.eu.com or via post to:
HSF HEALTH PLAN FREE POST RTHJ-GHRG-YKLE LONDON SE1 9PD

HSF Health Plan Ltd is the trading company of The Hospital Saturday Fund, a Registered Charity in the UK No 1123381 and in Ireland Registered Charity No 20104528. In Ireland HSF Health Plan Ltd is authorised and regulated as a Third Country Branch by the Central Bank of Ireland. Registered as Company no 904935, their registered office is at 5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare. In the UK HSF Health Plan Ltd is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Registered as Company in England No 30869, their registered office is at 24 Upper Ground London SE1 9PD.

Get in Touch

Here for You, Every Step of the Way

Got a question? Need to make a change? We've got you. Whether it's making a claim, updating your policy, or getting more information on HSF Health Plan, the right team is ready to help.

Find the right contact details below and reach out, we'll take it from there.

Managing Your Policy

To Make a Claim

Complete our claim form

020 7202 1381

claims@hsf.eu.com

General & Upgrade Enquiries

Andrew Harris

07595 410 825

andrew.harris@hsf.eu.com

Track Your Policy & Claims

Manage claims, balances, and payments via MyPolicy.

Contact Us

We're Here to Help

www.hsf.co.uk

02079286662

HSF Health Plan (UK)

HSF Health Plan

Head Office Address
HSF Health Plan
24 Upper Ground, London, SE1 9PD

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UK0081 March 2025