HSF health plan

Don't delay Get covered today!
Fast track Application Form inside

The health plan for everyone, from under €11 a month

The Corporate Direct **Family** scheme

Helping generations of families cover the cost of staying healthy

Like most things today, the cost of leading a healthy lifestyle isn't cheap.
If you take a moment to think about how much you have to pay just to visit the dentist or GP, how much your prescription charges are and if you require more major treatment - the bill can run into hundreds of euro.

With HSF health plan, you can have an affordable way to cover the costs of everyday health care. The HSF health plan covers you and your family for the simple day to day health costs like dental and optical bills as well as providing over 35 valuable benefits that help you get cash back for a wide range of treatments and out of pocket expenses. You can see the wide range of cover the HSF health plan provides in the benefit summary opposite.

With schemes starting at just ***€10.27 a month*** for the whole family, you can be sure that there is a level to suit your budget. To join simply complete the ***application form*** on ***page 21***. When you need to make a claim, you can be assured that it will be dealt with promptly, by one of our Ireland based claims assessors. So that you know fully what your HSF health plan includes you will find the terms of the plan in this brochure from page 13.

Who are HSF?
HSF health plan is the trading company of the charity, The Hospital Saturday Fund.
Our heritage means we have no ostentatious head office building and no overloaded administration or sales commission. Instead there is a culture of care for you and your family and a policy of sharing any surplus with medical charities, local hospitals and hospices as well as individuals with a serious illness or a disability.

We look forward to providing you and your family with the benefits of the ***HSF health plan*** for many years to come.

HSF health plan, The Plan of Choice for your health expenses.

To find out more information about HSF health plan, you can contact us on

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LoCall: 1890 473473
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Benefit Summary

All Schemes are per family, one price: spouse/partner and children* covered at no extra cost! You can choose between Primary Schemes which provide 50% benefit or Extra Cover Schemes which provide up to 100% benefit.

	Primary Schemes							Extra Cover Schemes		
	FC1	FC2	FC3	FC4	FC5	FC6	FC7	FCA	FCB	FCC
	€10.27 a Month	€15.51 a Month	€21.93 a Month	€28.60 a Month	€38.13 a Month	€48.88 a Month	€59.58 a Month	€57.20 a Month	€71.50 a Month	€88.18 a Month
 **Dental & Optical**										
	50% €80	€160	€260	€290	€360	€450	€550	100% €500	€650	€800
Dental Trauma	€250	€500	€650	€700	€825	€1000	€1200	€1500	€2000	€2500
 **General Practitioner and Emergency Department**										
	Not Available on Schemes FC1, FC2 or FC3. However our GP Advice line is included on these schemes.			€13	€19	€25	€32	€19	€25	€32
 **Prescription - Amount per script**										
	Not Available on Schemes FC1, FC2 or FC3.			€7	€10	€13	€16	€10	€13	€16
 **Practitioner** - *Physiotherapy, Physical Therapy, Osteopathy, Chiropractic*										
	50% €65	€130	€195	€215	€260	€325	€390	100% €350	€500	€650
 **Wellbeing & Alternative Treatments** - *Acupuncture, Homoeopathy, Chiropody / Podiatry*										
	50% €65	€130	€195	€215	€260	€325	€390	100% €350	€500	€650
 **Consultations**										
	50% €170	€330	€490	€510	€550	€640	€730	100% €680	€860	€1040
 **Medical Tests** - *Including Allergy Testing and Health Screening*										
	50% €100	€200	€300	€340	€360	€420	€480	100% €440	€560	€680
 **Birth & Adoption**										
	Fixed Sum €125	€250	€400	€440	€500	€650	€800	Fixed Sum €700	€850	€1000
 **Hospital (Amounts per night)**										
	Fixed Sum €20	€40	€64	€71	€84	€100	€120	Fixed Sum €80	€100	€120
 **Recuperation - After 7 Nights Stay in Hospital** (*Benefit available for 15 night stays, see benefit section for more details*)										
	Fixed Sum €50	€100	€125	€140	€155	€190	€230	Fixed Sum €155	€190	€230
 **Day Case Surgery & Treatment (Amounts per day)**										
	Fixed Sum €20	€40	€64	€71	€84	€100	€120	Fixed Sum €80	€100	€120
 **Surgical Appliances & Hearing Aids**										
	50% €95	€150	€285	€330	€380	€475	€570	100% €550	€700	€850
 **Personal Accident - See page 8 for full details of benefits**										
	Permanent Disability up to €5,000	€10,000	€13,000	€14,000	€16,500	€20,000	€24,000	up to €30,000	€40,000	€50,000
	Accidental Death Fixed Sum €2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	Fixed Sum €15,000	€20,000	€25,000
 **HSF Assist**										

GP Advice Line, Virtual Doctor, Private Prescription Service, Counselling Service, Medical Information and Legal Advice.

**Dependent Children, Living at the same address, up to age 21.*

Our Schemes

Our Primary Schemes FC1 to FC7 cover a wide range of health categories at an affordable price. With Primary Schemes we reimburse you 50% of your professional treatment costs up to the maximum amounts shown below.

Our Extra Cover Schemes FCA to FCC are for those who want to pay a little more in order to get higher benefits in return. With Extra Cover Schemes, we reimburse you 100% of your professional treatment costs up to the higher maximum amounts shown below.

All of our schemes include HSF Assist: GP Advice Line, Virtual Dr, Private Prescription Service, Medical Information Helpline, Stress Counselling Helpline and Legal Helpline.

Pre-existing conditions and health problems

If anyone has a pre-existing health condition, there will be a waiting time before cover for certain claims will start. The waiting time will be 5 years, from when you are first registered for cover (waiting periods will apply seperately to spouse/adult dependant and any children). In addition, for later increases in cover the waiting time before the increased cover takes effect will be 2 years from the time of the increase (see "Waiting periods" and "Restrictions" on page 17 for full details and concessions for previous cover).

You may start making claims three months after your registration date, unless otherwise stated. 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. See page 18 for full details.

Monthly costs *(net of partial Standard Rate Tax Relief)*

Primary

Monthly Cost	FC1	FC2	FC3	FC4	FC5	FC6	FC7
	€10.27	€15.51	€21.93	€28.60	€38.13	€48.44	€59.58

Extra Cover

Monthly Cost	FCA	FCB	FCC
	€57.20	€71.50	€88.18

Dental and Optical

Help towards the cost of all dental treatment including check-ups, and the cost of a sight test and optical appliances, up to the maximum shown. This benefit may be used flexibly according to requirements for both categories. It is payable between all eligible registered persons in any 12 consecutive calendar months. The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments are included in Scheme FC3 onwards and the Extra Cover Schemes, but claims for this particular treatment can only be accepted at least 6 months after the policy start date.

Dental Trauma

For details on Dental Trauma, please refer to the Personal Accident Section on pages 8, 9, 15 and 16.

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€80	€160	€260	€290	€360	€450	€550

Half the cost up to the maximum

Extra Cover

FCA	FCB	FCC
€500	€650	€800

Whole cost up to the maximum

General Practitioner and Emergency Department

An amount payable towards the cost of a visit to a General Practitioner (Family Doctor) or an attendance at an Accident and Emergency Department in a public or private hospital. Limited to 10 visits in any 12 consecutive calendar months, regardless of which eligible insured person is the patient.

The maximum repaid per visit is as shown or actual charges if less.

		FC4	FC5	FC6	FC7
Primary	***Not Available on Schemes FC1, FC2 or FC3. However our GP Advice line is included on these schemes.***	€13	€19	€25	€32
Extra Cover		FCA €19	FCB €25	FCC €32	

Prescription

An amount payable towards prescription charges. Limited to 4 prescriptions in any 12 consecutive calendar months, regardless of which eligible insured person is the patient.

The maximum repaid per prescription is as shown or actual charges if less.

		FC4	FC5	FC6	FC7
Primary	***Not Available on Schemes FC1, FC2 or FC3.***	€7	€10	€13	€16
Extra Cover		FCA €10	FCB €13	FCC €16	

Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic

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

		FC1	FC2	FC3	FC4	FC5	FC6	FC7
Primary	*Half the cost up to the maximum*	€65	€130	€195	€215	€260	€325	€390
Extra Cover	*Whole cost up to the maximum*				FCA €350	FCB €500	FCC €650	

Wellbeing & Alternative Treatments: Acupuncture, Homoeopathy, Chiropody / Podiatry

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

		FC1	FC2	FC3	FC4	FC5	FC6	FC7
Primary	*Half the cost up to the maximum*	€65	€130	€195	€215	€260	€325	€390
Extra Cover	*Whole cost up to the maximum*				FCA €350	FCB €500	FCC €650	

Consultations

Help towards the cost of specialists' consultation fees listed in the rules, **all undertaken on an outpatient basis**, up to the maximum shown. Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€170	€330	€490	€510	€550	€640	€730

Half the cost up to the maximum

Extra Cover

FCA	FCB	FCC
€680	€860	€1,040

Whole cost up to the maximum

Medical Tests

Help towards the cost of medical tests including, initial allergy testing, vaccination, health screening, pathology tests, x-rays, scans, electrocardiograms and other investigations listed in the rules, **all undertaken on an outpatient basis**, up to the maximum shown. Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€100	€200	€300	€340	€360	€420	€480

Half the cost up to the maximum

Extra Cover

FCA	FCB	FCC
€440	€560	€680

Whole cost up to the maximum

Birth and Adoption Grant

Payable to the policyholder, whether the mother or father of the baby, for each registered birth in hospital or at home. 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.

Claims for this benefit can only be accepted at least 10 months after policy start date.

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€125	€250	€400	€440	€500	€650	€800

Extra Cover

FCA	FCB	FCC
€700	€850	€1,000

Hospital

General and Hospice: For an inpatient admission to a hospital or hospice to receive medical treatment. Payable to each eligible insured person for up to 40 nights in any 12 consecutive calendar months. (See page 15 for full details).

Accident: For an inpatient admission to a hospital immediately following an accident. Payable to each eligible registered person for up to 40 nights in any 12 consecutive calendar months. (See page 15 for full details). No waiting period, if an Accident admission.

Elderly and Mental Illness: For an inpatient admission to a hospital for elderly medical care / long stay / rehabilitation / respite or for a mental illness. Payable to each eligible registered person for up to 50 nights elderly and 50 nights mental illness from first registration, but not for more than 40 nights in a 12 month period. (See page 15 for full details). **All amounts shown are per night.**

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€20	€40	€64	€71	€84	€100	€120

Extra Cover

FCA	FCB	FCC
€80	€100	€120

Recuperation

Following each stay in a hospital or hospice for which benefit has been paid for a minimum of 7 nights, a recuperation grant is payable for each eligible insured person.

Primary

Recuperation Grant after 7 nights

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€50	€100	€125	€140	€155	€190	€230

or

Recuperation Grant after 15 nights

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€75	€150	€185	€210	€230	€280	€340

Extra Cover

Recuperation Grant after 7 nights

FCA	FCB	FCC
€155	€190	€230

or

Recuperation Grant after 15 nights

FCA	FCB	FCC
€230	€280	€340

Day Case Surgery and Treatment

For a planned admission to occupy a bed for a day in a public or private hospital to undergo surgery, treatment or a procedure. Limited to 8 occasions within any 12 consecutive calendar months for each eligible insured person.

All amounts shown are per day.

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€20	€40	€64	€71	€84	€100	€120

Extra Cover

FCA	FCB	FCC
€80	€100	€120

Surgical Appliances and Hearing Aids

An amount payable towards the cost of purchasing a surgical appliance or hearing aid, prescribed or recommended by a doctor (or a practitioner, eg. a physiotherapist, who has treated the policyholder or dependant, and the appliance forms part of that treatment), up to the maximum shown. Payable between all eligible insured persons in any 12 consecutive calendar months.

Primary

FC1	FC2	FC3	FC4	FC5	FC6	FC7
€95	€150	€285	€330	€380	€475	€570

Half the cost up to the maximum

Extra Cover

FCA	FCB	FCC
€550	€700	€850

Whole cost up to the maximum

Personal Accident Benefit

All claims must be submitted within 6 months of the accident occuring.

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 (shown opposite) when they are needed most could ease the financial burden. Policyholders and their partner 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 lump sum payment for dental treatment required as a direct result of a blow to the head.

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 1/7 th of the weekly rate.

Although there is no waiting 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.

If you or any other eligible person (Insured Person) suffer Bodily Injury as a direct result of an Accident which within 24 months of the Accident results in Permanent Disability, Facial Disfigurement or Death the following will be paid:

	Primary							Extra Cover		
	FC1	FC2	FC3	FC4	FC5	FC6	FC7	FCA	FCB	FCC
Permanent Disability	up to	up to	up to	up to	up to	up to	up to	up to	up to	up to
A proportion of this sum will be paid depending upon the degree of permanent disability in accordance with the following scale:	€5,000	€10,000	€13,000	€14,000	€16,500	€20,000	€24,000	€30,000	€40,000	€50,000
Permanent Total Disablement	€5,000	€10,000	€13,000	€14,000	€16,500	€20,000	€24,000	€30,000	€40,000	€50,000
Loss of Sight in one or both eyes	€5,000	€10,000	€13,000	€14,000	€16,500	€20,000	€24,000	€30,000	€40,000	€50,000
Loss of hearing in both ears	€3,750	€7,500	€9,750	€10,500	€12,375	€15,000	€18,000	€22,500	€30,000	€37,500
Loss of hearing in one ear	€750	€1,500	€1,950	€2,100	€2,475	€3,000	€3,600	€4,500	€6,000	€7,500
Loss of the use of:										
a) an arm, hand or leg above the knee	€5,000	€10,000	€13,000	€14,000	€16,500	€20,000	€24,000	€30,000	€40,000	€50,000
b) a leg below the knee or a foot	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	€15,000	€20,000	€25,000
c) a shoulder or elbow	€1,250	€2,500	€3,250	€3,500	€4,125	€5,000	€6,000	€7,500	€10,000	€12,500
d) a hip, knee, ankle or wrist	€1,000	€2,000	€2,600	€2,800	€3,300	€4,000	€4,800	€6,000	€8,000	€10,000
e) a thumb	€1,000	€2,000	€2,600	€2,800	€3,300	€4,000	€4,800	€6,000	€8,000	€10,000
f) any finger or big toe	€500	€1,000	€1,300	€1,400	€1,650	€2,000	€2,400	€3,000	€4,000	€5,000
g) any other toe	€250	€500	€650	€700	€825	€1,000	€1,200	€1,500	€2,000	€2,500
Facial Disfigurement	N/A	N/A	€500	€560	€800	€1,000	€1,200	€1,400	€1,600	€1,800
Accidental Death	€2,500	€5,000	€6,500	€7,000	€8,250	€10,000	€12,000	€15,000	€20,000	€25,000
Dental Trauma	€250	€500	€650	€700	€825	€1,000	€1,200	€1,500	€2,000	€2,500

In addition there are the following payments for Temporary Disability and a Fracture of the specified bone or bones listed below:

Temporary Disability	N/A	N/A	€25 per week	€30 per week	€40 per week	€50 per week	€60 per week	€70 per week	€80 per week	€90 per week
Fracture Grant - Only payable for these specified bones:										
Leg – ankle, tibia and fibula, kneecap, femur and hip	N/A	N/A	€125	€140	€200	€250	€300	€350	€400	€450
Arm – wrist, radius and ulna, humerus and shoulder.	N/A	N/A	€60	€70	€100	€130	€160	€190	€220	€250
*Fractured fingers/thumbs/toes or hand/foot bones **NOT** covered*										
Overall limit per Accident	N/A	N/A	€320	€380	€500	€630	€760	€890	€1,020	€1,150

All claims must be submitted within 6 months of the accident occurring.

See pages 15 and 16 for Definitions and Exclusions.

HSF Assist

HSF Assist provides unlimited access to a variety of assistance helplines and services which are available to all policyholders and their families. The services available are:

***GP Telephone Advice** - 24 hour access to a Doctor*

***Virtual Doctor** - a webcam based "face to face" consultation service with a Doctor*

***Health Information Website** - a medically validated and regularly updated website*

***Counselling Service** - a telephone and, if needs be, a face to face counselling service*

***Legal helpline** - telephone access to Solicitors and Barristers*

***Prescription Service** - if appropriate the GP can offer a Private Prescription for medication*

You can use any part of the HSF Assist service as many times as you need.

HSF Assist is currently provided for HSF health plan by Medical Solutions UK Limited.

HSF Assist calls are made to LoCall 1890 numbers.
Please check with your service provider for the costs on using these numbers.
HSF health plan cannot be responsible or liable for any call charges.

GP Advice Line

This service is available 24 hours a day, 7 days a week and the telephone number will be given to you in your welcome pack. The service allows you to speak with a qualified practising GP free of charge and at a convenient time. After making the initial call the doctor will telephone you. Every call is confidential and your details will not be passed on to anyone without your prior consent.

You can ask about all sorts of things including:

- an ache or pain that won't go away
- sensitive or confidential concerns
- explanations of diagnosis or treatment you may have been prescribed
- possible after-effects of surgery
- side-effects of any medication you are taking
- vaccinations you may need when you are travelling abroad and other health precautions relevant to your own personal medical history

IMPORTANT NOTE

This is not an emergency service, in an emergency you should always contact your own GP or the emergency services so as not to delay any necessary treatment. Nor can it be used if you are, or might be, pregnant for any health related condition whether or not it is related to pregnancy.

In such cases you should always consult your own doctor.

The GP Telephone Consultation service is not intended to replace the personal care offered by your own doctor and cannot be used to obtain referral for treatment.

The GP Telephone Consultation Service is provided via a LoCall number to UK based qualified, experienced, practising General Practitioners under the jurisdiction of the Irish Medical Council, General Medical Council and the English courts.

Virtual Doctor.

HSF Assist provides you with the next generation in GP services: Virtual Doctor - an online doctor to see you at a time to suit you.

Now you don't need to leave home or work to see a qualified GP. With HSF Virtual Doctor, the Ireland's first online webcam GP consultation service, you can arrange an online face to face consultation at a time that fits with your busy life between Monday to Friday 8.30am to 6.30pm (telephone consultations are available 24/7).

- At home – you don't need to wait days for an appointment and travel to a busy surgery and wait for your appointment.
- At work – imagine your own company doctor service without having to leave the office.

The Virtual Doctor Service is further enhanced by using state of the art explanatory 3D medical images and health information enabling you, the patient, to have a more complete understanding of your condition.

Health Information Website

These days we are all lucky to have a wealth of general information available to us about looking after our health. But it can get a bit confusing knowing which sources you can completely rely on.

The HSF health plan Health Information Service offers medically validated and regularly updated information on health and medical matters, including new treatments, drugs or surgical procedures. If you're trying to overhaul your lifestyle you can also get guidance on areas such as nutrition, exercise or avoiding sports injuries.

There's a travel section too, so you can check on vaccinations needed for your destination and other useful advice on: protection from sun, food hygiene and insect bites etc.

If you're not online, don't worry, just call and we will print off the information and post it to you.

Counselling Service

Our team of experienced, professionally trained counsellors are available to assist you explore and resolve your issues 24 hours a day, 7 days a week. You can discuss any aspects that are worrying you including; Home, Family, Relationships, Work, Bereavement, Trauma, Substance abuse or any stress related issue.

You can call the service as often as you need. If you arrange a series of regular telephone counselling sessions with the same counsellor; this service is week day only.
Should you need face to face sessions, then the telephone counselling service will identify local counsellors in your area for you to meet with.

With HSF Assist you can receive, from first registration, up to 6 face to face counselling sessions **after** your telephone counselling. If you use the face to face counselling, you will pay the counsellor direct and then submit the receipted invoices to HSF health plan for reimbursement under the Practitioners category. We cannot consider any face to face counselling claims that have been organised independently by you. All face to face counselling must follow helpline counselling sessions undertaken via HSF Assist and be on their recommendation. *(Please note that up to a maximum of 6 sessions for each person named on your policy, for the lifetime of your policy may be claimed. There is no pre-existing condition rule applicable to HSF Assist including the face to face counselling).*

Legal Helpline

Our lawyers can advise on any matter relating to European law.
Staffed by solicitors and barristers specially selected for their skill in explaining complex legal matters in everyday language, the advice line has helped many thousands of policyholders through a multitude of legal problems.

Together they are able to provide specialist knowledge in the areas of personal injury, negligence, property, contract disputes and consumer law to name but a few.
Where we do not have the specialised skills in-house, we can call on our panel of lawyers and, for European legal advice, lawyers in our sister offices across Europe.

Legal advice is available 9am - 5pm, Monday to Friday, excluding public and bank holidays. If you call outside these times, we will arrange to call you back.

Prescription Service

When you consult with one of our GPs either on the telephone or by using Virtual Doctor, if the GP feels it is appropriate, they can offer you a private prescription for medication. This prescription will be faxed to a pharmacy you nominate so you can obtain your medication. This service is available Monday to Friday between 8am and 5pm and Saturday from 9am to 4pm (excluding Bank Holidays). You will need to allow up to 4 hours for the prescription to be received at the pharmacy.
If a prescription is offered after these times, it will be available the next working day.

Policy summary

keyfacts®

HSF health plan Limited is the provider of this health plan.
The Personal Accident cover outlined is underwritten for HSF health plan by Chubb Insurance Company of Europe SE. The underwriter of the Personal Accident cover may be changed occasionally.

About the HSF health schemes in this brochure

They provide cover for you and your family (a spouse / adult dependant and all children up to the age of 21 who live permanently at the same address) against the everyday costs of such things as a visit to the dentist, optician and various practitioners, and make grants for hospital admission and the birth of a baby.

Some amounts relate to the cost of the services you have received which are payable when you send in your paid receipts. Other amounts are a fixed rate, for example a fixed amount for each night spent in hospital or for the birth of a baby, or bodily injury from an accident. The amounts provided by the various schemes are explained in this brochure. A number of conditions apply with the main ones being (and explained fully in the relevant section of the 'Rules and further explanations of categories' or 'General terms and conditions'):

- There is a total limit on payments calculated on a rolling balance over a 12 month period basis with a further limit from registration on some hospital benefits. See 'Claims' on page 18 and 'Hospital' on page 15.
- Claims cannot be accepted until at least three months after your policy start date, unless otherwise stated.
- Pre-existing health conditions and health problems present when you join or increase premiums, are not covered for an initial period under many scheme categories. See 'Waiting periods', 'Restrictions' and 'Increasing premiums' on pages 17 and 18.
- Switching between schemes is allowed. See 'Increasing premiums' and 'Decreasing or ceasing premiums' on page 18 for the terms.

Full policy terms and conditions, and the cover provided, are shown in this brochure.

Paying premiums and changing your mind

Details of the prices of each scheme are shown in this brochure. Payment can be made by direct debit or credit/debit card. When your application is processed you will receive a welcome pack. This will include details of any restrictions which will need to be placed if you or a member of your family has any existing medical conditions. On receiving confirmation of your policy, you have 14 days in which to change your mind and withdraw your application (telephone or write to the HSF office in Ennis – details on page 20). If any premiums have been paid you will receive a full refund providing no claims have been settled. See 'Decreasing or ceasing premiums' on page 18 for cancelling after this period.

Duration of cover in the plan

Cover is provided continuously from month to month, beginning with your policy date, until it is cancelled or otherwise comes to an end.
It is automatically renewed.

Making a claim

At the conclusion of three months after the start date of the policy or another stated period you may start claiming. Claim forms are provided on request by telephoning 1890 473473, or writing to HSF health plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare, or by downloading from our website www.hsf.ie. If you telephone or write you may enquire about how much you may receive. Please quote your policy number. Original receipts must be sent with the claim form. Your payment will be made direct into your bank account (a current account in your name or joint names).

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 Ennis address. If your complaint is not resolved to your satisfaction, you may write to HSF's Managing Director. There are appeal options available and any complaint which cannot be settled may ultimately be referred to the Financial Services Ombudsman 3rd Floor Lincoln House, Lincoln Place, Dublin 2, or call them on 1890 882 090. 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 times. These procedures do not prevent you from taking legal action.

Regulation and Compensation

HSF health plan Limited is approved in Ireland by the Department of Health and Children and registered with the Health Insurance Authority. It is registered as a Branch, No. 904935, by the Companies Registration Office in Ireland and authorised by the Prudential Regulation Authority in the United Kingdom, No. 202182. Chubb Insurance Company of Europe SE is regulated by the Irish Financial Services Regulatory Authority and authorised by the Prudential Regulation Authority in the UK, No. 481725 (the UK details of HSF health plan and Chubb may be checked on the Financial Services Register on The FCA website). HSF health plan Limited is covered by the Financial Services Compensation Scheme (FSCS). In the unlikely event that we are unable to meet our obligations you may be able to claim compensation. Further information is available from the Financial Services Compensation Scheme, 10th Floor, Beaufort House, 15 St Botolph Street, London EC3A 7QU. The Head Office of HSF health plan is 24 Upper Ground, London SE1 9PD, England.

Statement of demands and needs

This product meets the demands and needs of individuals and families who wish to manage their healthcare expenses such as dental and optical, hospital admissions, consultations, medical tests and personal accident. Advice is not available from HSF, and applicants should choose the scheme to suit their personal circumstances and review in future whether this remains suitable.

Annual Premium Calculator

Here are the annual premiums for the HSF health plan schemes.

Primary Schemes	Extra Cover Schemes
FC1 €135.36	FCA €745.80
FC2 €204.60	FCB €950.40
FC3 €290.40	FCC €1,161.60
FC4 €369.60	
FC5 €508.20	
FC6 €646.80	
FC7 €785.40	

Rules and further explanations of benefit categories

Dental and Optical

The dentist or optician must be suitably qualified and registered with the Comhairle Fiaclóireachta, The Dental Council or The Health & Social Care Professionals Council (H&SCPC). Sundry items purchased at Dental Surgeries and Opticians premises, eg. solutions, cleaners, contact lens removers, floss, are not covered and prescription charges for any kind of medication are not covered under this category. Claims cannot be accepted for the purchase of spectacles or contact lenses or contact lenses supplied without prescription or for any dental treatment (including teeth whitening) not carried out at a dental surgeon's practice (eg. if undertaken at a cosmetic/retail outlet).

Consultations with Consultant Oral Surgeons, Consultant Facio-Maxillary Surgeons, Consultant Orthodontic Surgeons and Consultant Ophthalmic Surgeons are not covered under this category. These should be claimed under the Consultations 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 Consultations, Medical Tests or for Hospital or Day Case, in addition to the Optical category.

The cost of Eye Laser Treatment, Implantable Contact Lenses (to correct long or short sightedness) and assessments is included in Scheme FC3 onwards and the Extra Cover Schemes, but claims for this particular treatment can only be accepted at **least 6 months** after registration.

Rules concerning pre-existing conditions do not apply to this particular category.

General Practitioner and Emergency Department

The amount is repaid up to the maximum (but if the actual charge is less, only this amount will be refunded) on the production of a paid receipt invoice supplied by a General Practitioner, clinic or a hospital indicating attendance at an Accident and Emergency Department. The stated amount is paid for attendances by any eligible registered person up to an overall limit of 10 visits (regardless of which eligible registered person is the patient) within a 12 month period. Any procedures carried out during the visit are covered by this benefit and may not be claimed for separately under this or any other category.

Rules concerning pre-existing conditions do not apply to this particular category.

Prescription

The amount is repaid up to the maximum (but if the actual charge is less, only this amount will be refunded) on the production of a paid receipt invoice supplied by a Pharmacy (Dispensing Chemist), indicating that a prescription supplied by a General Practitioner has been dispensed. Only one amount is payable on each receipt regardless of the number of items. The stated amount is paid up to an overall limit of 4 prescriptions within a 12 month consecutive period regardless of which eligible registered person is the patient.

Rules concerning pre-existing conditions do not apply to this particular category.

Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic

The maximum payable between all eligible registered persons is also between the above four headings. It is not, for example, on Scheme FCC €650 for each of the four. Claims will only be accepted with paid receipts from qualified practitioners. Policyholders and dependants, in their own interests, should only consult properly qualified practitioners who are registered with professional organisations which maintain high standards. Benefit does not include the cost of any medication or any surgical appliances supplied or prescribed by the practitioners. Claims cannot be accepted for prophylactic treatments or sports massage/therapy.

Wellbeing & Alternative Treatments: Acupuncture, Homoeopathy, Chiropody / Podiatry

The maximum payable between all eligible registered persons is also between the above four headings. It is not, for example, on Scheme FCC €650 for each of the four. Claims will only be accepted with paid receipts from qualified practitioners. Policyholders and dependants, in their own interests, should only consult properly qualified practitioners who are registered with professional organisations which maintain high standards. Benefit does not include the cost of any medication or any surgical appliances supplied or prescribed by the practitioners. Consultations with Consultant Podiatric Surgeons (of hospital consultant status) are not covered in this category. These should be claimed under the Consultations category.

The cost of treatment or operative procedures undertaken by these consultants is not included in any category. Rules concerning pre-existing conditions do not apply to Chiropody/Podiatry.

Consultations & Medical Tests

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. Reimbursement is only on the initial consultation with a Consultant Psychiatrist, subsequent visits are classified as treatment. 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 Medical Tests:

Any investigations undertaken, on an outpatient basis only, in a hospital x-ray, MRI/CT scanning, pathology or nuclear medicine / medical physics department (or its equivalent elsewhere); electrocardiogram (ECG), electroencephalogram (EEG); electromyogram (EMG), 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. Claims are accepted for visits to health screening clinic and for; 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 but not any subsequent consultation, therapy or treatment.

The following are NOT covered:

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 Day Case benefit may be claimed in these circumstances if applicable.

Birth Grant and Adoption Grant

The period of at least 10 months before claims can be accepted in this category also relates to inpatient treatment and all other categories for consultation, investigation and treatment associated with the pregnancy. Hospital benefit relating to the mother or baby is not payable to male policyholders who do not reside at the same address as their spouse /adult dependant. 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 cover has been of at least 10 months' duration. The adoption certificate should be dated after the end of this 10 months' period and before the child's 10th birthday. Children already registered 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.

Hospital

The hospital or hospice must be in Ireland or the United Kingdom and its name and admission and discharge dates should be clearly stated on the claim form. Benefit is payable to each eligible registered person for up to 40 nights in any consecutive 12 calendar months. The amount payable is the stated grant and no direct costs (e.g. Consultants' fees, room charges, medication/dressings involved with the hospital admission) are covered. Stays in nursing or convalescent homes are not covered.

Benefit is restricted to 50 nights in total in a period of continuous cover, regardless of scheme, for each eligible registered person 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) wards. These 50 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 40 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 40 nights and an amount will be paid up to the number of nights due within the rules. Recuperation only, 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. 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.

Recuperation

This grant is paid automatically, subject to qualifying for the appropriate number of nights in the hospital categories and actually having been discharged. There is no requirement to make an additional claim. If re-admissions occur after less than seven 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 at the rate set for the longest of the admissions. The grant is not payable when the patient dies in hospital or if an admission includes a confinement and qualifies for the Birth Grant.

Day Case Surgery and Treatment

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 are covered.

Surgical Appliances and Hearing Aids

The types of appliances will be restricted to those that are worn eg. blood pressure monitors, corsets/belts, stockings, trusses, insoles and wigs, and do not include anything disposable or hired.

Personal Accident

1. Payment for any Permanent Disability not shown in the table on page 9 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:
   a) the Permanent Disability after the Accident; and
   b) 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

1. **Accident** means a sudden unforeseen and fortuitous identifiable event and the word accidental shall be construed accordingly.
2. **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.
3. **Permanent Disability** means disablement which has lasted for at least 12 months and from which it is believed the Insured Person will never recover.
4. **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.
5. **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.
6. **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 5% of the Permanent Disability Benefit of the cover selected. The Maximum for this on Scheme FCC is €2,500. 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.
7. **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.
8. **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.
9. **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/ 7 th of the specified weekly rate.
10. **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.

The Personal Accident categories are underwritten on behalf of HSF health plan by Chubb Insurance Company of Europe SE whose registered office is at One America Square, 17 Crosswall, London, EC3N 2AD and is a European Company incorporated in England & Wales under Company number SE13 which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority for the conduct of business in the UK. HSF health plan is an intermediary acting on behalf of the policyholder dealing exclusively with Chubb Insurance Company of Europe SE. The entire administration of the Personal Accident benefits, which may include medical and other enquiries, is carried out by Chubb as soon as receipt of your claim has been acknowledged. The address and contact telephone number will be indicated in the acknowledgement letter.

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). There is no limit on how many times you use the services except for face to face counselling. If you are advised by the telephone counselling service that you would benefit from face to face counselling, they can arrange for you to have a session or sessions with a local counsellor. HSF Assist will cover up to 6 sessions with a face to face counsellor which you will pay for and then claim back under the Practitioner category by submitting the receipts for the session(s) you have (up to a maximum of 6 per named person on the policy, for the lifetime of your policy). There is no limit on how many times you use the telephone counselling service.

General terms and conditions

Registration

Anyone aged 18 or over may join and cover will continue for life, if the policyholder so wishes, and if your premium payments are kept up to date and the rules and conditions are adhered to.

Cover is provided continuously from month to month until it is cancelled or otherwise comes to an end. You will not receive renewal documentation unless we change the terms and conditions of your policy. When your application is processed you will receive a welcome pack. Upon its receipt you have 14 days in which to change your mind (telephone 1890 473473 or write to HSF health plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare). If any premiums have been paid you will receive a full refund providing that no claims have been settled during this period.

One policy also covers a spouse / adult dependant and children under 21, permanently residing at the same address. The named policyholder or spouse / adult dependant 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.

An "adult dependant" is an adult living at the same address as the policyholder whose relationship with the policyholder is similar to that of a spouse. The term does not refer to any other adult who may be dependent on the policyholder for any care or financial support.

Couples in a relationship may each have a separate policy under a Primary Scheme only.

Waiting periods

Claims may be submitted as soon as three months has elapsed from your policy start date, unless stated otherwise. There is a longer period of 10 months for the Birth and Adoption Grants and this time also applies to other categories if the claim is related to pregnancy. Any restrictions, which are temporary (see paragraph below), include any conditions which existed or for which symptoms were present before your cover began; any development of existing conditions; any recurrence of conditions which have existed in the past; any hereditary, congenital or perinatal conditions which may already exist but which manifest symptoms only after cover commences and any which previously existed but were not disclosed. Until waiting periods have been served, it may also be necessary to refuse claims relating to a particular area or structure of the body where there has been a problem in the past unless medical advice indicates that there is no connection.

The above restrictions for pre-existing conditions are removed after set waiting periods from first registration or from the date of any increase in cover. The set waiting periods will apply separately to the policyholder, a spouse / adult dependant, and any children.

The set waiting periods are:

a) On first registration; **5 years.**

and

b) For increases; **2 years.**

The set waiting period may be reduced for cover from registration (but not increases) where;

i) Immediately prior to cover on this policy starting you were covered for the pre-existing condition under an HSF health plan policy in which case the previous level of cover will be maintained or

ii) Within 3 months prior to this policy starting you were covered by a policy from an insurer authorised by the Health Insurance Authority or HSF health plan in which case the set waiting period will be reduced by the premium paying period with that insurer before cover for the pre-existing condition will be provided at the previous level of cover.

iii) At the time of making a claim using above you should request a reduction in the set waiting period. You will need to supply original written evidence regarding the nature, level and residual waiting period from your previous insurer.

Any claim for any benefit that relates to an accident can be made immediately once your policy has been issued. Should you need to claim during the Waiting Period as a result of an accident, you will need to include with your claim submission, details of the accident and any substantiating evidence that the treatment you received; for which you are claiming for, was a result of that accident.

Any Pre-existing health conditions will be taken into account as to the injuries sustained.

An accident is defined in our Personal Accident benefit.

Restrictions

Claims cannot be accepted for anything related to plastic surgery and consultations / treatment for cosmetic reasons; addictions (eg misuse of alcohol or drugs); self harm or self inflicted injuries or HIV / AIDS. Conditions which begin during the three month period after cover commences should be notified in writing and you will then be advised if any restrictions apply. Optical, Dental, Chiropody/Podiatry, General Practitioner/Emergency Department, Prescription, Personal Accident and HSF Assist are the only categories not subject to the pre-existing condition rules, although some Personal Accident benefits may be limited if a disability or medical condition existed before the Accident.

No policyholder or dependant may be registered in both an Extra Cover and a Primary Scheme. It is, however, permissible to be a policyholder in one Primary Scheme and a dependant in another Primary Scheme. These rules are based on the insurance principle of not being able to make a profit from the reimbursement of any expenditure.

Change of circumstances

When a policyholder marries or re-marries, and wishes to include his or her spouse (and any children under 21 permanently residing at the same address), a further application form must be completed and submitted to HSF for approval and registration. The policy number should be shown and the form marked 'Change of Circumstances'.

An adult dependant residing at the same address is accepted by HSF providing that an application form, which also shows the full name of that person, is completed and submitted for approval and registration.

Children born in the first 10 months of cover (when it has not been possible to pay a Birth Grant) may be added as dependants on completion of an application form with medical information. An application form is also required for children for whom an Adoption Grant has been paid.

A policyholder will be able to make a claim relating to a spouse /adult dependant or child when acceptance has been confirmed and the terms and conditions will be as for a new policyholder.

When a child under the age of 21 reaches that age they must sign a completed application form to agree to the terms and conditions of their new HSF policy and authorise payment of premiums.

Any change of address or other personal circumstance must be notified in writing to HSF so that our records remain up-to-date.

Death of a policyholder

When a policyholder dies, the spouse / adult dependant may become the named policyholder if already covered and qualify for continuity as a full policyholder. This will mean transferring to their own Direct Scheme. Any outstanding claims at the time of death will be settled as appropriate, payments being made on production of the required proof of entitlement.

Payment of premiums

Policyholders should check that payments have commenced in order that they are received regularly by HSF.
Policyholders who fall into arrears for more than six months will normally be required to rejoin under the usual conditions of enrolment.

Increasing premiums

Any existing policyholder is able to apply to increase to a higher scheme by completing an application form.
Acceptance may be subject to a proviso or restriction and a waiting period for any new health condition which may have arisen. In transfers to any scheme, the periods before claims may be submitted are waived in all categories except the following: Birth and Adoption Grants; all other categories if the claim is associated with pregnancy; Eye Laser Treatment in the Dental and Optical category only when transferring from a Primary Scheme to an Extra Cover Scheme. If it is less than three months since the policy start date at the time of any scheme transfer all such periods will apply.

Extra Cover Schemes are entirely separate from the Primary Schemes and policyholders transferring to an Extra Cover Scheme from a Primary Scheme will be subject to rules for new policyholders, particularly relating to medical conditions existing or likely to recur, at the time of transferring. However in terms of pre-existing conditions credit will be given for the earlier period of premiums as set out in the "Waiting periods" and "Restrictions" sections.

Claims related to medical conditions existing at the time of increasing or linked to previous medical conditions will be paid at the appropriate former scheme rate. There may be circumstances where categories are grouped together for flexibility (eg. Practitioners) when it is necessary to settle claims at a former scheme rate for all categories in that group.

Decreasing or ceasing premiums

While it is possible to reduce premiums 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. If the maximum has been reached in any category in the higher rate scheme, there will be a period of six months before claims may be submitted under the new lower rate 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 premiums should provide written notification to HSF. Past premiums will not be refunded. Entitlement to claim will continue throughout any period of time covered by premiums. Any errors in premium payments must be notified to HSF within two years of the occurrence for refunding to be possible.

Claims

Claims must be made within six months of the date of the receipt, discharge from hospital, or of the accident taking place. It may be necessary to ask you for additional medical information in connection with any claim.

All payments are tax free and easy to claim with forms provided on request by telephoning 1890 473473 or writing to HSF health plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare or by downloading from our website www.hsf.ie

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 Scheme FCA policyholder, after serving the first three months of cover, who has up to €500.00 to claim for dental/optical expenses in any 12 consecutive months; could have the following claim record:

Date Claim Paid	*Claim Paid Amount*	*Remaining Balance in the Scheme FCA Dental/Optical Category*
17 June 2016	€450.00	A balance of €50.00 remains.
5 October 2016	€50.00	Now a nil balance is left. The next available amount will be €450.00 on 17 June 2017.
11 August 2017	€250.00	A balance of €200.00 remains.

Within any consecutive 12 month period, the claim paid amount has not exceeded €500.00. After each claim is paid the amount becomes available again 12 months later. Balances available in each category can be checked by telephoning the claims department who will give guidance on when to submit a claim.

Claims will only be accepted where accumulated receipts total €7 or more. Benefit payments which relate to amounts paid for a service provided will be up to 50% of the cost in the Primary Schemes and up to 100% of the cost in the Extra Cover Schemes, depending on the maximum shown in the brochure. Payment will be by direct credit into your own or joint bank account.

Claims will not be paid unless the appropriate premiums are up-to-date, even if the hospital stay or treatment date was before premiums fell into arrears.

The receipts must:

a) be originals, not photocopies/scanned;
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 dependant;
f) be for a service covered by the HSF categories only and not for any insurance premiums paid to cover that service.

Receipts will be returned and they will be stamped to indicate that a payment has been made to the policyholder.
We cannot accept statements or summaries.
In circumstances where part or all of of the amount stated on the receipt has been met by another organisation or insurance company, HSF 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 treatment or services provided outside Ireland and the United Kingdom. There are no such 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.
Claims cannot be accepted from service providers who are related to the insured person(s).

Payment from Chubb 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 substantiated to the satisfaction of Chubb.

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

General Conditions

Regardless of any amendments, the Birth and Adoption Grants 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 reserves the right at renewal to:

a) vary the premium rates by giving at least 28 days' notice to the policyholder's last known home address;
b) vary the range and rates of benefit and the conditions and terms relating thereto;
c) make amendments to these rules with such changes applying at the next time of renewal.

At other times the Board of Directors reserves the right to:

d) refuse to settle the claim of any policyholder who is in breach of the rules and conditions, or has been unwilling to co-operate in the process of considering a claim;
e) take legal action against anyone who makes a fraudulent claim and terminate cover immediately;
f) take legal action against anyone who makes, or is associated with, a fraudulent claim and terminate cover immediately;
g) use information provided on application and claim forms for the prevention and detection of crime.

Data Protection

Information which you provide to HSF or Chubb at registration and in support of any claim will be used in the processing of claims and maintaining your records. The information may be passed to our service providers to assist in the continuity and provision of benefits and to third parties to prevent and detect fraud. For a small fee you may request a copy of the details and information which we hold about you. You may apply to Data Request, HSF health plan, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare.

Governing Law

Cover in your scheme within this HSF health plan will be governed by and interpreted in accordance with Irish Law. All terms and conditions and communications will be in English.

your Questions Answered

Q Can I join at any age?

A Anyone aged 18 or over may join.

Q Can I get cover for others in my family?

A Yes. Give details of your spouse / adult dependant and children on your application form and they will be included.

Q Can I increase to a higher scheme at any time?

A Yes, subject to terms and conditions.

Q Do I have to have a medical to join?

A No. You need only complete and sign the health declaration on the application form.

Q Why do you need medical information?

A In order to explain the cover you will receive, and any restrictions which may be required.

Q Do older people pay higher premiums?

A No, all ages pay the same rates.

Q How do I pay?

A By Direct Debit, Credit Card or Debit Card.

Q Are benefits taxable?

A No. You keep all you receive from HSF.

Q When can I make a claim?

A For most benefits claims will be accepted after 3 months, any exceptions are clearly indicated in the brochure.

Q How do I make a claim?

A Claim forms are available on request by telephoning the number indicated on the reverse of your certificate of cover or from our website.

Q How do I receive my money?

A By direct credit into your Bank account

Q When would my cover begin?

A Cover begins on the date printed on your certificate of cover.

How to join

1: Select the scheme which best suits your needs.
2: Complete the application form opposite, remembering to include the names and dates of birth of everyone to be included.
3: Write all the medical information requested concerning yourself and everyone else included on page 22. (This will help us to explain the cover you receive, but failure to do so will not affect your registration).
4: Complete the Direct Debit or Credit/Debit Card form on page 24.
5: Send both forms to the Ennis address – we will do the rest.

A welcome pack will be sent to your home address and the date stated on the certificate will denote when your cover began.

Ireland Office
5 Westgate Business Park,
Kilrush Road, Ennis, Co. Clare
Tel: 1890 473 473
Email: enquiries@hsf.ie
www.hsf.ie

Head Office
24 Upper Ground, London SE1 9PD
Tel: 0044 20 7928 6662

Application to join HSF health plan

HSF AR Code **AR41**

Date Received – HSF use	Policy No. – HSF use

THIS PART MUST BE COMPLETED IN ALL CASES

I apply to join HSF health plan at the monthly rate indicated (net of partial Standard Rate Tax Relief at source) (PLEASE TICK)

Scheme FC1	Scheme FC2	Scheme FC3	Scheme FC4	Scheme FC5	Scheme FC6	Scheme FC7	Scheme FCA	Scheme FCB	Scheme FCC
€10.27	€15.51	€21.93	€28.60	€38.13	€48.88	€59.58	€57.20	€71.50	€88.18

Surname

Forename(s) Other Initials Mr/Mrs/Miss Ms/Other

Address

Postcode

Email Tel: Work

Date of birth Policyholder Day Month Year Tel: Home

Date of birth Spouse/Adult Dependant Day Month Year Mobile

PPS Number

Spouse/Adult Dependant's Surname

Spouse/Adult Dependant's Forename(s)

If already covered by HSF please state:

Premium	Policy No. (if known)

Children (children must be under 21 years of age)

Child's Surname	Child's Forename(s)	Sex	Date of Birth

Payments of claims will be made direct to your bank/building society account. Please supply your details:

Your Account Name

Your Account Number (IBAN)

Swift BIC

HSF health plan uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF services and those of the Hospital Saturday Fund.

By completing health information on the reverse of this form you will assist us in the administration of your policy. Failure to do so will not affect the registration.

TEAR ALONG PERFORATION

Declaration

This application is made on behalf of myself (the policyholder) and any adult and child dependants listed above. I confirm that no advice has been received regarding this application from HSF. I agree to HSF and Chubb holding data relevant to my scheme registration. I agree to abide by HSF 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, with notice. 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 I understand that HSF may need to impose some restrictions on my cover.

Signature ✗ Date

How did you hear about HSF health plan?

Medical information

Your cover has to be based on the information you supply on the whole of this application form. You must be satisfied that it is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and / or treatments of all persons to be covered could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. To give false information could be considered to be a fraudulent act and lead to termination of cover.

Please state any long term / chronic / congenital conditions even if at present under control and indicate to whom these apply. PLEASE TICK BOX (if using 'Other' section, please state conditions in full and avoid abbreviations)

☐ Transferring from another insurer? PLEASE SUPPLY DETAILS	

Name	Condition/Illness	Date symptoms began
	☐ Arthritis PLEASE STATE PART(S) OF BODY AFFECTED BELOW ..... ☐ Asthma/Chest problems ☐ Diabetes ☐ Epilepsy ☐ Kidney disease ☐ Liver disease ☐ Raised blood pressure/Angina ☐ Congenital (conditions from birth) PLEASE STATE ..... ☐ Clinical Obesity ☐ Other PLEASE STATE	
Name	☐ Transferring from another insurer? PLEASE SUPPLY DETAILS	Date

Please list other illnesses / operations, either current or in the past (stating conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition / illness requiring the treatment.

Name	Condition/Illness	Date symptoms began
Signature ✗		Date

SEPA Direct Debit Mandate

Unique Mandate Reference Policy Number (HSF USE)

Creditor Identifier: IE71ZZZ302170

Legal Text: By signing this mandate form, you authorise HSF health plan Limited to send instructions to your bank to debit your account and your bank to debit your account in accordance with the instruction from HSF health plan Limited.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.
Your rights are explained in a statement that you can obtain from your bank.
Please complete all the fields below marked *
Return the form to HSF health plan, FREEPOST, 5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare.

*Your Name:

*Your Address:

Address Line 1 _____

Address Line 2 _____

*City/postcode:

*Country:

*Account number (IBAN):

*Swift BIC:

Creditor's Name: **HSF health plan Limited**
Creditor's Address: **5 Westgate Business Park, Kilrush Road, Ennis, Co. Clare.**
Country: **Ireland.**

*Type of payment Recurrent ☐ **or** One-Off Payment ☐ (Please tick ✓)

*Preferred date 5th ☐ **or** 20th ☐ (Please tick ✓)

*Preferred Frequency (Please tick ✓) Monthly ☐ Quarterly ☐ 6 Month ☐ Annually ☐

*Signature(s):

*Date of signing:

Payment by Credit and Debit cards to HSF health plan

VISA MasterCard LASER

- Please enter the card number clearly as incorrect numbers cause delays.
- If you wish to pay by LASER also complete the issue number.
- LASER cards also display your account number which is NOT required.

I authorise you, until further notice in writing, to charge my *VISA/MASTERCARD/LASER account the sum of

€ [ ][ ][ ].[ ][ ] or such other amount, advised to me in advance for *six months'/one year's cover.

Please debit with this amount and the same amount *every six months/annually, (or such future amounts as apply to my cover) until cancelled. *DELETE AS APPROPRIATE

Name

(NAME AS IT APPEARS ON YOUR CREDIT/DEBIT CARD, BLOCK CAPITALS PLEASE)

Address

PLEASE ENTER THE CARD NUMBER CLEARLY AS INCORRECT NUMBERS CAUSE DELAYS

My Credit/Debit card number is

Valid from Date / Expiry Date / Issue Number (if applicable) Security Code (CSV)

Signature ✗	Date

Post Form to: HSF health plan, FREEPOST, 5 Westgate Business Park, Kilrush Road, Ennis, Co Clare

Policy Number (*for HSF use*)

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Kilrush Road, Ennis, Co. Clare
Tel: 1890 473 473
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HSF health plan®

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