Dental

Overheads Platinum Plus

Your Policy Document

Important information

Dental Insurance Services

tel: 01245 265 541

email: info@dentist-overheads-insurance.co.uk

Customer Service

tel: 01245 265 541

email: info@dentist-overheads-insurance.co.uk

website: www.dentist-overheads-insurance.co.uk

Claims

tel: 01245 265 541

email: info@dentist-overheads-insurance.co.uk

website: www.dentist-overheads-insurance.co.uk

Financial Ombudsman Service

tel: 08000 234 567

fax: 020 7964 1001

website: www.financial-ombudsman.org.uk

Contents

Welcome

Thank you for choosing this Policy which is provided and underwritten by ACE European Group Limited

The Policy, consisting of this booklet, a Policy Schedule and the information provided by **You**, is a contract between **You** and **Us**. **We** agree to insure **You**. The information **You** gave **us** either over the telephone and/or on **Your** Application Form is part of **Your** contract with **Us**. The Policy Schedule shows the cover **You** have chosen and the maximum **We** will pay for each benefit. Dates refer to Local Standard Time at **Your** address shown in the Policy Schedule. This booklet and the Policy Schedule must be read together. Please check these carefully to be sure the cover meets **Your** needs. If **You** have any questions please contact Dental Insurance Services on **01245 265 541**.

If **Your** needs change, or if any information **You** gave **Us** changes, please tell **Us** because **We** may need to change the Policy. **We** will update the Policy and send **You** a new Policy Schedule each time **We** agree a change with **You**.

This Policy shall be governed and construed in accordance with the Law of England and Wales and the English Courts alone shall have jurisdiction in any dispute. All communication of and in connection with this Policy shall be in the English language.

We are required to notify **You** that other taxes or costs may exist which are not imposed by **Us**.

You and **We** have agreed that it is not intended for any third party to have the right to enforce the terms of this contract. **You** and **We** can cancel or vary the terms of this contract without the consent of any third party to this contract, who might seek to assert that they have rights under the Contracts (Rights of Third Parties) Act 1999.

You must ensure that all of the information which **You** have provided to **Us** in the Application Form, on the Declaration, by correspondence, over the telephone, on claim forms and in other documents is true, complete and accurate. Please note that providing incomplete, false or misleading information could affect the validity of this Policy and may mean that all or part of a claim may not be paid. **You** acknowledge that **We** have offered the Policy and calculated the premium using the information, which **You** have provided and that any change to the responses above may result in a change in the terms and conditions of the Policy and/or a change in the premium.

One of **Our** authorised representatives must sign the Policy Schedule for **Your** cover to be valid.

Andrew Kendrick
President
ACE European Group Limited

Definitions

Throughout the Policy, there are words and phrases, which have special meaning. These are listed here.

'**£**'
United Kingdom pounds sterling.

'**Absent/Absence**'
Unable/being unable to attend to, or excused from, **Your Usual Occupation** because of an **Insured Event**.

'**Accident**' and '**Accidental**'
A sudden identifiable violent external event which happens by chance and which could not be expected; or unavoidable exposure to severe weather.

'**Adoption Leave**'
The statutory leave granted to **You** as a result of **You** caring for a child that has been placed for adoption with **You** or **Your Partner** whilst this Policy is in force.

'**Benefit Amount**'
The maximum monthly amount of **Practice Overheads We** can pay based on:

- the level of cover **You** have at the time of the **Temporary Total Disablement** or **Absence** as shown in the Policy Schedule; or
- 80% of **Your** average monthly **Practice Overheads** during the 12 months immediately preceding the period of **Temporary Total Disablement** or **Absence** as verified by **Us** in the event of a claim;

whichever is the lower. If **You** are entitled to receive benefit under any other insurances for the reimbursement of **Practice Overheads**, the amount payable under this Policy will be limited to its rateable proportion of such costs.

'**Benefit Period**'
The maximum, but not necessarily consecutive, period for which benefit is payable as shown in the Policy Schedule.

'**Bodily Injury**'
Injury to **You** which happens while the Policy is in force and which:

- is caused only by an **Accident**; and
- on its own, leads to **Temporary Total Disablement** within 24 months of the **Accident**.

'**Commencement Date**'
The day, month and year shown in the Policy Schedule for the cover to start.

'**Compassionate Leave**'
Discretionary leave granted to **You** in the event of the Death, serious injury or serious sickness of an immediate family member, whether directly related or not, as allowed for in the Employments Rights Act 1996.

'**Death**'
Death caused by **Bodily Injury**.

'**Deferment Period**'
The first 30 days of any period of **Absence** or **Temporary Total Disablement** during which no benefit is payable.

'**Effective Date**'
The day, month and year shown in the Policy Schedule for any change in cover to start.

'**Illness**'
Sickness or disease contracted by **You** which:

- commences while the Policy is in force; and
- on its own, leads to **Temporary Total Disablement**.

'**Insured Event**':

1. **Compassionate Leave**; or
2. **Maternity/Adoption Leave**; or
3. **Paternity/Adoption Leave**; or
4. **Jury Service**; or
5. **Suspension From Duty**.

'**Jury Service**'
You having received a jury summons to serve as a juror in the **UK** Courts.

'**Loss of Hearing**'
Total and permanent loss of hearing in both ears that in the opinion of an independent qualified medical referee acceptable to **Us** is never going to improve.

'**Loss of Limb**'
Total and permanent loss:
1) by physical separation, or
2) of use
of a hand at or above the wrist or a foot at or above the ankle.

'**Loss of Sight**'
Total and permanent loss of sight which will be considered as having occurred if **Your** name has been added to the register of Blind Persons maintained by the government on the authority of a fully qualified ophthalmic specialist.

'**Maternity Leave**'
The statutory leave granted to **You** as a result of **You** being due to give birth to a child anytime from 11 weeks before the due birth date.

'**On Duty**'
When carrying out **Your** normal occupation, in **Your** Dental Practice, including travelling to and from **Your** normal place of work.

'**Partner**'
1. **Your** spouse; or
2. **Your** civil partner, registered pursuant to the Civil Partnership Act; or
3. someone of either sex with whom **You** have been living for at least three months as though they were **Your** spouse or civil partner.

'**Paternity Leave**'
The statutory leave granted to **You** as a result of the birth of a child and who is either the biological father of a child, the mother's husband or **Partner**, or the child's adopter or the **Partner** of the adopter.

'**Permanent Partial Disablement**'
Loss of Hearing, **Loss of Limb**, **Loss of Sight**.

'**Permanently Resident**'
Resident in the first instance for at least 3 months and thereafter for 40 weeks on average each year.

'**Permanent Total Disablement**'
Any permanent disablement other than **Permanent Partial Disablement** which having lasted without interruption for at least 12 months, has no reasonable prospect of improving, and in the opinion of an independently qualified medical referee acceptable to **Us**, will in all probability permanently, completely and continuously prevents **You** from engaging in **Your Usual Occupation**.

'**Policyholder**'
You.

'**Practice Overheads**'
Regular overheads including, but not limited to, employee salaries and wages; rent or mortgage payments for practice; rates; equipment rental or loan repayments; utility costs, accountancy fees and insurance; depreciation; all for which **You** are contractually responsible. Excluded are **Your** drawings and any costs which are only incurred whilst **You** are working – eg dental materials and lab costs.

'**Pre-existing Medical Condition**'
Illness or injury for which **You** have, or should reasonably have, received relevant medical treatment or advice by a **Qualified Medical Practitioner** during the 12 months immediately before **Your** initial **Commencement Date** or **Effective Date** if later.

'**Qualified Medical Practitioner**'
A doctor or specialist, registered or licensed to practise medicine under the laws of the country in which they practise who is neither:
- **You**, or
- a relative of **Yours**

unless approved by **Us**.

'**Scheme**'
The Dentist Overheads Expense Insurance Scheme.

'**Suspension From Duty**'
Any period when **You** are unable to carry out all aspects of **Your** duties that form **Your Usual Occupation** whilst under investigation, by any regulatory body or health care organisation to which they are contracted, for reasons relating to discipline, health or performance or due to criminal investigations or proceedings.

'**Temporary Total Disablement**'
Temporarily being unable to perform all the duties of a dentist and being under the regular care and attendance of a **Qualified Medical Practitioner**.

'**United Kingdom**', '**UK**'
England, Scotland, Wales, Northern Ireland, the Channel Islands and the Isle of Man.

'**Usual Occupation**'
The tasks, duties, and other functions, which **You** perform under **Your** contract of employment.

'**We**', '**Our**', '**Us**'
ACE European Group Limited.

'**You**', '**Your**'
The person named in the Policy Schedule who has taken out the Policy and is a registered dentist working in dental practice either individually or in partnership.

The cover we provide

Pre-requirement for cover to apply

You must:

1. be under the age of 70 years.
2. under the age of 65 years at their **Commencement Date**.
3. be **Permanently Resident** in the **UK**.
4. not be serving full-time in the armed forces of any country or international organisation.
5. not be **Absent** or suffering from **Temporary Total Disablement** due to **Bodily Injury** or **Illness** on the **Commencement Date**. Where **You** are **Absent** on the **Commencement Date**:
   a) no cover will apply for the continuance of that specific **Bodily Injury** or **Illness** until **You** have returned to **Your Usual Occupation** for 60 days; or
   b) due to any other **Insured Event**, no cover will apply for continuance of such **Insured Event** until **You** have returned to **Your Usual Occupation**.

When and where cover applies

The cover applies 24 hours a day anywhere in the world.

The cover is provided in sections.

Temporary Total Disablement

The Policy Schedule identifies the specific cover. If, whilst the Policy is in force, **You** are in employment and suffer an **Illness** or have an **Accident** and suffer **Bodily Injury**, which leads to **Temporary Total Disablement** lasting the length of the **Deferment Period**, **We** will pay the monthly **Benefit Amount** for the subsequent period during which **You** continue to suffer **Temporary Total Disablement**.

Conditions of cover

1. to make a claim for **Temporary Total Disablement you** must see a **Qualified Medical Practitioner**. **We** will treat the first day of **Your Temporary Total Disablement** as the day **Your Qualified Medical Practitioner** confirms **You** cannot perform all the duties of **Your** employment.
2. **You** must remain under the care of a **Qualified Medical Practitioner** throughout the **Deferment Period**.
3. at the end of the **Deferment Period**, and after every subsequent 30 day period or whenever **We** request, **You** must provide **Us** with a **Qualified Medical Practitioner's** certificate confirming **Your** continuing **Temporary Total Disablement**.
4. **We** will pay a monthly **Benefit Amount** on or after 30 days beyond the **Deferment Period** and continue to pay similar monthly amounts for each complete 30 day period for the duration of the **Benefit Period** for any one period of **Temporary Total Disablement** or until **You** are no longer suffering **Temporary Total Disablement**.
5. **We** will pay 1/30th of the monthly **Benefit Amount** for each day of any period of **Temporary Total Disablement** after the **Deferment Period** that ends less than a complete month after the previous monthly **Benefit Amount** became due.

Personal Accident

We will pay **You** £100,000 if, whilst this Policy is in force, **You** suffer **Bodily Injury** which within 12 months thereof solely, directly and independently of any other cause results in **Your**:

1) **Death**
2) **Permanent Total Disablement**
3) **Permanent Partial Disablement**.

Absence on Compassionate or Family Emergency Leave

If, whilst this Policy is in force, **You** are **Absent** on **Compassionate Leave We** will reimburse **You** the **Benefit Amount** for up to one **Working Week**, or until **You** are no longer **Absent** whichever the sooner, in any one 12 month period provided that the reason for **Compassionate Leave** could not reasonably have been foreseen by **You** prior to the **Commencement Date** or **Effective Date**.

Conditions applicable to cover for Absence for Compassionate Leave

1. No **Deferment Period** will apply.
2. Where **Your** period of **Absence** is less than a complete **Working Week** the amount payable for each **Working Day** shall be the proportional equivalent of the amount payable for **Your** normal **Working Week**.
3. The maximum **We** will pay in total in respect of all **Absences** for **Compassionate Leave** occurring during any one 12 month period is the **Benefit Amount** for one **Working Week**.

Absence on Maternity/Adoption Leave

If, whilst this Policy is in force, **You** are **Absent** on **Maternity Leave** or **Adoption Leave**, **We** will pay **You** an amount equivalent to one week's **Benefit Amount** upon **Your** return to **Your Usual Occupation**.

Conditions applicable to cover for Absence on Maternity/Adoption Leave

1. cover begins 45 weeks after **Your Commencement Date**.
2. The **Benefit Amount** will be paid as a lump sum once **You** resume **Your** full time **Usual Occupation** provided that this is within 12 months of the date of confinement, or commencement of adoption, and this Policy remains in force.

Absence on Paternity Leave

If, whilst this Policy is in force, **You** are **Absent** following **Your Partner** giving birth to or adopting a child, **We** will reimburse **You** the **Benefit Amount** up to one **Working Week**, or until **You** are no longer **Absent**, whichever the sooner, in any one 12 month period.

Conditions applicable to cover for Absence on Paternity/Adoption Leave

1. Cover begins 45 weeks after **Your Commencement Date**.
2. Where **Your** period of **Absence** is less than a complete **Working Week** the amount payable for each **Working Day** shall be the proportional equivalent of the amount payable for **Your** normal **Working Week**.
3. The maximum **We** will pay in total in respect of all **Absences** occurring during any one 12 month period following **Your Partner** giving birth to or adopting a child or children is the **Benefit Amount** for one **Working Week**.

Absence due to Jury Service

If, whilst this Policy is in force, **You** are **Absent** as a result of **You** being required to attend **Jury Service**, **We** will reimburse **You** the **Benefit Amount** for up to four **Working Weeks** in any one 12 month period, or until **You** are no longer **Absent** whichever the sooner, up to a maximum total amount payable of £8,000.

Conditions applicable to cover for Absence on Jury Service

1. **You** must have received the summons from the court service after **Your Effective Date**.
2. If not called to serve on **Jury Service** on a particular day(s), no **Benefit Amount** will be payable unless it was reasonably impractical for **You** to return to **Your Usual Occupation**.
3. The **Jury Service** must not be a deferred attendance relating to an original summons pre-dating the **Commencement Date**, or **Effective Date** if later.
4. Where **Your** period of **Absence** is less than a complete **Working Week** the amount payable for each **Working Day** shall be the proportional equivalent of the amount payable for **Your** normal **Working Week**.
5. No **Deferment Period** will apply.

6. **We** will reduce **Your** claim by any amounts or costs or expenses recoverable or claimable by **You** from any other source, including claimable allowances from Her Majesty's Courts Service.

Absence following Suspension From Duty

If, whilst this Policy is in force, **You** are **Absent** for more than the **Deferment Period** as a consequence of **You** being suspended from duty by any party legally authorised to do so, due to, but not limited to investigation of employment disputes, **We** will reimburse **You** the **Benefit Amount** for up to the **Benefit Period**, or until **You** are no longer **Absent**, whichever the sooner.

Conditions applicable to cover for Suspension From Duty

1. **You** must not have been aware at **Your Commencement Date** of any existing or impending investigation that may result in **Your** suspension.
2. Cover will not apply to any incident prior to **Your Commencement Date** which gives rise to **Suspension From Duty** even if the suspension occurs after **Your Commencement Date**.
3. if **You**:
   a) have suffered **Suspension From Duty** before, or
   b) **Your Suspension From Duty** ultimately results in **You** being struck off from the Register of Dentists and Dental Care Professionals by the Primary Care Trust or General Dental Council

   You will not be covered under this Extension of the Policy. If **We** have paid a claim for **Suspension From Duty** which ultimately results in **You** being struck off, **You** will reimburse **Us** such claim amounts which **We** have paid to **You**.
4. There must not have been any **Suspensions from Duty** at **Your** dental practice in the sixty months preceding **Your Suspension From Duty**.
5. Where **Your** period of **Absence** is less than a complete **Working Week** the amount payable for each **Working Day** shall be the proportional equivalent of the amount payable for **Your** normal **Working Week**.
6. Where **You** are reinstated after being suspended from duty and are subsequently suspended again within 52 weeks of return from the first period of suspension as a result of the same event or the same series of events or original cause, **We** will deem this to be a continuation of the original suspension and be subject to the same **Benefit Period** and **Deferment Period**.
7. **We** will reduce **Your** claim by any amounts or costs or expenses recoverable or claimable by **You** from any other source.

Accidental HIV infection

If, whilst the Policy is in force, **You** are diagnosed with Human Immunodeficiency Virus (HIV) which leads to **Temporary Total Disablement** lasting the length of the **Deferment Period We** will pay the monthly **Benefit Amount** for the subsequent period during which **You** continue to suffer **Temporary Total Disablement** provided the condition was caused by:

- a blood transfusion which was given by a **Qualified Medical Practitioner** as part of a medical treatment regime after the **Commencement Date** or **Effective Date** if later; or
- an **Accident** while **On Duty** leading to infection by a needlestick/sharp injury or by exposure to mucus, blood or blood stained fluid occurring after the **Commencement Date**, or **Effective Date** if later, provided that:
  a) within 5 days of the **Accident You** underwent a blood test which indicated the absence of HIV or antibodies to such a virus; and
  b) the **Accident** follow-up included a further blood test within 12 months of the **Accident** which indicated the presence of HIV or antibodies to such a virus.

There must not have been the presence of HIV or antibodies to such a virus prior to the **Commencement Date** or **Effective Date** if later.

Recurring disability

In respect of both **Accident** or **Illness**, if two periods of **Temporary Total Disablement** resulting from the same condition or cause are

separated by less than 90 days **We** will treat this as one claim and the **Deferment Period** will not apply to the second period of **Temporary Total Disablement**. However:

- **We** will not pay for any days when **You** do not suffer **Temporary Total Disablement**; and
- **We** will pay a maximum **Benefit Amount** calculated by multiplying the **Benefit Amount** by the **Benefit Period**.

Exhaustion of benefits and reinstatement of cover

Should **You** be absent from work for the maximum **Benefit Period** as the result of one occurrence of **Temporary Total Disablement** resulting from **Bodily Injury**, **Illness**, or **Suspension From Duty**, cover shall automatically terminate at the end of the **Benefit Period**.

If **You** subsequently return to **Your** regular employment for a period of not less than 30 consecutive days **You** may re-apply for cover, providing:

- **You** meet the then current eligibility and underwriting requirements; and
- **You** pay the required premium payment appropriate to **Your** age and **Scheme** at the time of re-application.

What we do not cover

We will not pay any claim which is caused by or results from:

- war or any act of war;
- serving more than 30 days in any one year on active duty in the armed forces;
- suicide, attempted suicide or deliberate self-inflicted injury regardless of the state of **Your** mental health;
- taking part in air travel, unless travelling as a fare-paying passenger in an aircraft which is provided and operated by an airline or air charter company which must be licensed for this (this exclusion will not apply when **You** are travelling as a passenger in any aircraft while engaged on professional duties);
- participating in or training for professional sport;
- **Your** illegal acts;
- **You** driving any kind of vehicle while the alcohol level in **Your** blood is higher than the legal limit of the country where the **Accident** occurs;
- **You** taking a drug unless it is properly prescribed and was not taken for the treatment of drug addiction;
- Human Immunodeficiency Virus (HIV) or other forms of the virus, Acquired Immune Deficiency Syndrome (AIDS) and AIDS-Related Complex (ARC)*;
- any **Pre-existing Medical Condition** during the first 24 months after the **Commencement Date** or **Effective Date** if later. In the event of a recurrence, **We** shall not pay any **Benefit Amount** for **Temporary Total Disablement** until **You** have been insured for a minimum of 24 months during which **You** have not suffered a further recurrence. If this Policy replaces a previous Policy under this **Scheme**, and provided the cover is continuous, the **Commencement Date** shall be considered as that of the earlier Policy, for the purpose of establishing the period between the **Commencement Date** and the date of any **Pre-existing Medical Condition**. If the **Pre-existing Medical Condition** is controlled during the first 24 months, from the **Commencement Date**, by drugs or regular treatment and there was no actual recurrence or manifestation of the condition then this would be regarded as having served the 24 month probationary period.

*Except as provided in the '**Accidental** HIV infection' section of 'The cover we provide'.

Dual Insurance

You should not be covered under more than one Policy issued under this **Scheme** or elsewhere. If **You** are entitled to receive benefit under any other insurances for the reimbursement of **Practice Overheads**, the **Benefit Amount** payable under this Policy will be limited to its rateable proportion of such costs.

Paying your premiums

When you must pay

The amounts **You** must pay, and when, are shown in the Policy Schedule. Once any applicable free period has ended, if **You** do not start paying the premiums, this Policy will not provide any cover.

Premiums are payable by direct debit through a bank or building society when due.

As there is a period of free cover attaching to this **Scheme**, all premiums will be billed in advance, meaning any payment **You** make will relate to the subsequent month's cover. **Your** first premium will be collected up to 30 days in advance of **Your** first chargeable month, however **You** will still enjoy the full extent of the free period.

If **You** are paying premiums monthly via direct debit, **Your** first billing may include two payments. One payment will relate to the first month of chargeable cover, the second payment will relate to the forthcoming second chargeable month of cover.

For each premium **You** pay, **We** will provide cover until the next premium is due.

Stepped premiums (applies only to the Temporary Total Disablement section)

The premiums payable are based on **Your** age at the **Commencement Date** and each subsequent anniversary thereof. The premium will increase as **Your** age at an anniversary falls into the next higher age band.

Smokers' premium increase (applies only to the Temporary Total Disablement section)

If **You** have not smoked in the 12 months period prior to the **Commencement Date**, or do not intend to smoke in the future, a discount of 10% will apply to the monthly premiums that would have been due had **You** been a smoker.

If the non-smokers discounted premium applies, and **You** start or re-start to smoke **You** may either:

- agree from then on to pay the increase required to bring the monthly premium up to the pre-discounted rate; or
- continue to pay the same premium in which case in the event of a claim the payment due will be reduced by 10%.

Indexation provision

Please refer to **Your** Policy Schedule to see if Indexation applies to the **Temporary Total Disablement** section of **Your** Policy.

At each anniversary date of the **Commencement Date** the **Benefit Amount** and premium will be increased by 5%.

These Indexation provisions are compound and shall continue from the **Effective Date** as shown in the Policy Schedule until **You** write to **Us** asking **Us** to cancel this option.

You can activate or reinstate this provision at any time subject to **Our** approval and any terms and conditions that **We** require to do this.

Ending or changing your cover

Your right to cancel this Policy in the first 14 days

If, for any reason, **You** are not satisfied with this Policy **You** may, within 14 days of receipt, email **Us** at info@dentist-overheads-insurance.co.uk and tell **Us** to cancel the Policy or write to **Us** at:
Dental Insurance Services
131-133 New London Road
Chelmsford
Essex
CM2 0QZ
Tel : 01245 265 541

and **We** will cancel it. If this happens **We** will refund any premiums **You** have paid, however **We** reserve the right to charge **You** a premium commensurate with the cover that has been in force up to the date of **Your** cancellation.

If you want to cancel after 14 days

You can cancel this Policy at any time by emailing **Us** at info@dentist-overheads-insurance.co.uk or write to **Us** at the above address.

We will cancel it from the date **You** email or post **Your** cancellation instruction or any later date **You** give **Us**. There is no minimum duration on **Your** Policy. **Your** premium refund will be calculated on a pro-rata basis.

If we want to cancel

If **We** no longer wish to offer this **Scheme** and need to cancel **Your** Policy **We** will write to **You** at the latest address **We** have for **You**. **We** will then cancel the Policy 30 days after the date of **Our** letter. **Your** premium refund will be calculated on a pro-rata basis.

We may cancel **Your** Policy or revise the covers and benefits for like categories of **Policyholder**'s, but **We** will do this only when **We** cancel or revise all Policies which **We** have issued under this **Scheme**.

We will not cancel **Your** Policy alone because of any change in **Your** health or physical condition, or the number of claims presented or the amount of benefit paid under this Policy.

When cover automatically ends

All cover under **Your** Policy will end:

- if **You** stop paying premiums - from the date **You** owe **Us** a premium; or
- on the first policy anniversary date following attainment of **Your** 70th birthday; or
- on the date **You** cease employment as a registered dentist; or
- at the end of the **Benefit Period** should **You** be absent from work for the maximum **Benefit Period** as the result of one occurrence of **Temporary Total Disablement** resulting from **Bodily Injury** or **Illness** or **Suspension From Duty**; or
- when **You** die;

whichever happens first.

The time cover will end

Cover will stop at midnight on the day this cover ends.

What happens to the premiums when cover ends?

If **You** have paid a premium for any period after cover ends, **We** will refund it. If **You** owe any premiums up to the date cover ends, **We** will ask **You** to pay them.

If we want to make changes to the Policy or premium

We reserve the right to make changes or add to these Policy terms and to change the premiums applicable:

- for legal, regulatory or taxation reasons; and/or
- to reflect new industry guidance and codes of practice; and/or
- to reflect legitimate costs increases or reductions associated with providing this **Scheme**.

If changes become necessary, they will be applied to all Policies issued under this **Scheme**. **We** will not make changes which apply only to **Your** Policy.

We will write to **You** with details at least 30 days before **We** make any changes. **You** will then have the option to continue with, or to cancel, the Policy. Should **You** request **us** to cancel the Policy **We** will comply with **Your** request either from the date **We** receive **Your** letter or from any later date **You** give **Us**.

What happens if you use your Policy for other purposes?

If **You** sell or transfer **Your** Policy, or use it as security for a loan or for any kind of business, **We** will not recognise this. At all times, **Our** contract will be with **You** and **We** will only deal with **You** and/or **Your** legal representatives.

Making a claim

How to claim

If a claim needs to be made, **We** must be notified within 30 days of commencement of **Your Absence**, **Accident** or **Illness**.

Written notice must be sent to:
Dental Insurance Services
131-133 New London Road
Chelmsford
Essex
CM2 0QZ
Tel : 01245 265541
email: info@dentist-overheads-insurance.co.uk

We will then ask for a claim form to be completed to register **Your** claim. If **You** cannot do this yourself, a Personal Representative can do this for **You**.

Our contact details are:
ACE European Group Limited
Claims Department
PO Box 4511
Dunstable
LU6 9QA
Tel : 0845 841 0059
Fax : 01293 597 323
e-mail: claims@acegroup.com

You will need to send any medical certificates or other documents, which **We** ask for. **We** will not pay for these. **You** must agree to a medical examination if **We** ask for it. **We** will pay for this. **You** will need to submit accounts to support **Your** claim for **Practice Overheads**. **Your** claim payment cannot exceed 80% of the overheads figures as evidenced in the accounts. The claim payment may also be limited by the level of cover **You** have as shown in the last Policy Schedule **We** sent **You** before the **Accident**, **Illness** or **Absence**.

You may be required to meet with external agents, approved by **Us**, to substantiate **Your** claim.

Paying claims

If **You** have a claim, **We** will deal with it based on the cover details shown in the last Policy Schedule **We** sent **You** before the **Accident**, **Illness** or **Absence**.

If **You** are entitled to receive benefit under any other insurances for the reimbursement of **Practice Overheads**, the **Benefit Amount** payable under this Policy will be limited to its rateable proportion of such costs.

Interest

No sum payable under this Policy shall carry interest unless payment has been unreasonably delayed following **Our** receipt of all the required information, documents or other evidence necessary to support the claim.

Temporary Total Disablement, Absence & Accidental HIV infection

We will pay the **Benefit Amount** or the assessed percentage to **You** and **Your** receipt shall be a full discharge of all liability by **Us** in respect of the claim for such **Benefit Amount** or the assessed percentage.

Jury Service

You will need to submit the following to support **Your Jury Service** claim:

- a copy of **Your** original summons letter; and
- a copy of **Your** subsequent confirmation letter indicating the dates **You** were expecting to serve and confirming whether **Your** attendance was deferred; and
- **Your** Certificate of Attendance from the Jury Officer at the Court.

Your commitment to your Policy

You must keep to the terms of **Your** Policy. If they do not, **We** may not accept a claim.

Dishonest claims

We will not pay for dishonest claims. If **You** makes a dishonest claim, **We** may cancel the Policy immediately.

Data Protection

The information you provide

- **We** will use the information about **You** for the purpose of providing **You** with insurance services and additional products and services. **We** accept fully **Our** responsibility to protect the privacy of customers and the confidentiality and security of information entrusted to **Us**.
- The information **You** provided when **You** took out **Your** Policy, together with other information, will be used by **Us** and **Our** group companies. It will be used for administration, marketing, customer service and profiling **Your** purchasing preferences. **We** may disclose information to **Our** service providers and agents for these purposes.
- It may also be used for the purpose of fraud prevention including passing details to other insurers and regulatory bodies.
- Where **You** have provided information about another person in connection with the purchase and performance of this insurance Policy **You** confirm that they have appointed **You** to act for them, that they have consented to the processing of their personal data, including sensitive personal data and they have consented to the transfer of their information abroad. **You** also agree to receive on their behalf any data protection notices from **Us**.
- Unless **You** have informed **Us** otherwise, **We** may contact **You** by mail or telephone to let **You** know about any goods services or promotions that may be of interest to **You** and/or share **Your** information with organisations that are **our** business partners.
- **You** have the right to withdraw **Your** consent at any time and have **Your** details removed from future marketing programmes. In addition, if **You** ask **Us**, **We** will tell **You** what information **We** hold about **You** and provide it to **You** in accordance with applicable law. Any information which is found to be incorrect will be corrected promptly.
- **We** may monitor and/or record **Your** communication with **Us** either ourselves or by reputable organisations selected by **Us**, to ensure consistent servicing levels and account operation.
- **We** will keep information about **You** only for so long as it is appropriate.

Please telephone **Us** on 0845 841 0056 or write to:
The A&H Customer Service Manager
ACE European Group Limited
200 Broomielaw
Glasgow G1 4RU
e-mail: cust.servuk@acegroup.com

Mis-statement of age

(applies only to the Temporary Total Disablement section)

In the event of a claim, if **You** have mis-stated **Your** age and in doing so obtained a lower monthly premium, the percentage of underpayment made will be applied to any claim payment **We** may make.

If **We** discover that **You** have mis-stated **Your** age before having made a claim, **We** will ask **You** to pay **Us** any outstanding premiums.

Complaints procedures

We are dedicated to providing a high quality service and want to maintain this at all times. If **You** are not satisfied with **Our** service please contact Dental Insurance Services, quoting **Your** Policy details, so **Your** complaint can be dealt with as soon as possible.

Contact details are:
Dental Insurance Services
131-133 New London Road
Chelmsford
Essex CM2 0QZ
Tel:01245 265541
email: info@dentist-overheads-insurance.co.uk

If **You** are not satisfied with the result please contact:
The Customer Relations Dept,
ACE European Group Limited
PO Box 4510
Dunstable
LU6 9PZ
Telephone: 0845 045 0087 (within UK only)
International: +44 (0) 141 285 2999
Fax: +44 (0) 1293 597 376
Email: customerrelations@acegroup.com

You may approach the Financial Ombudsman Service (FOS) for assistance if **You** are not satisfied with **Our** final response. Contact details are given below. A leaflet explaining its procedure is available on request.

Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR
Tel: +44 (0) 800 023 4567
(free from most landlines, charges may apply from a mobile phone)
+44 (0) 300 123 9 123
(calls charged at the same rate as 01 or 02 numbers on a mobile phone)
Fax: 020 7964 1001
www.financial-ombudsman.org.uk

The existence of these complaints procedures does not reduce **Your** Statutory rights relating to this **Plan**. For further information about **Your** Statutory rights contact the Office of Fair Trading or Citizens Advice Bureau.

Financial Services Compensation Scheme

In the unlikely event that **We** are unable to meet our liabilities, **You** may be entitled to compensation under the Financial Services Compensation Scheme (FSCS).

Their contact details are:
Financial Services Compensation Scheme
10th Floor, Beaufort House
15 St Botolph Street
London EC3A 7QU
Tel: 020 7741 4100
Fax: 020 7741 4101

ACE European Group Limited
200 Broomielaw
Glasgow G1 4RU
tel 0845 841 0056
intl tel +44 (0) 141 285 2999
fax 01293 597 376

Head Office:
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100 Leadenhall Street
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