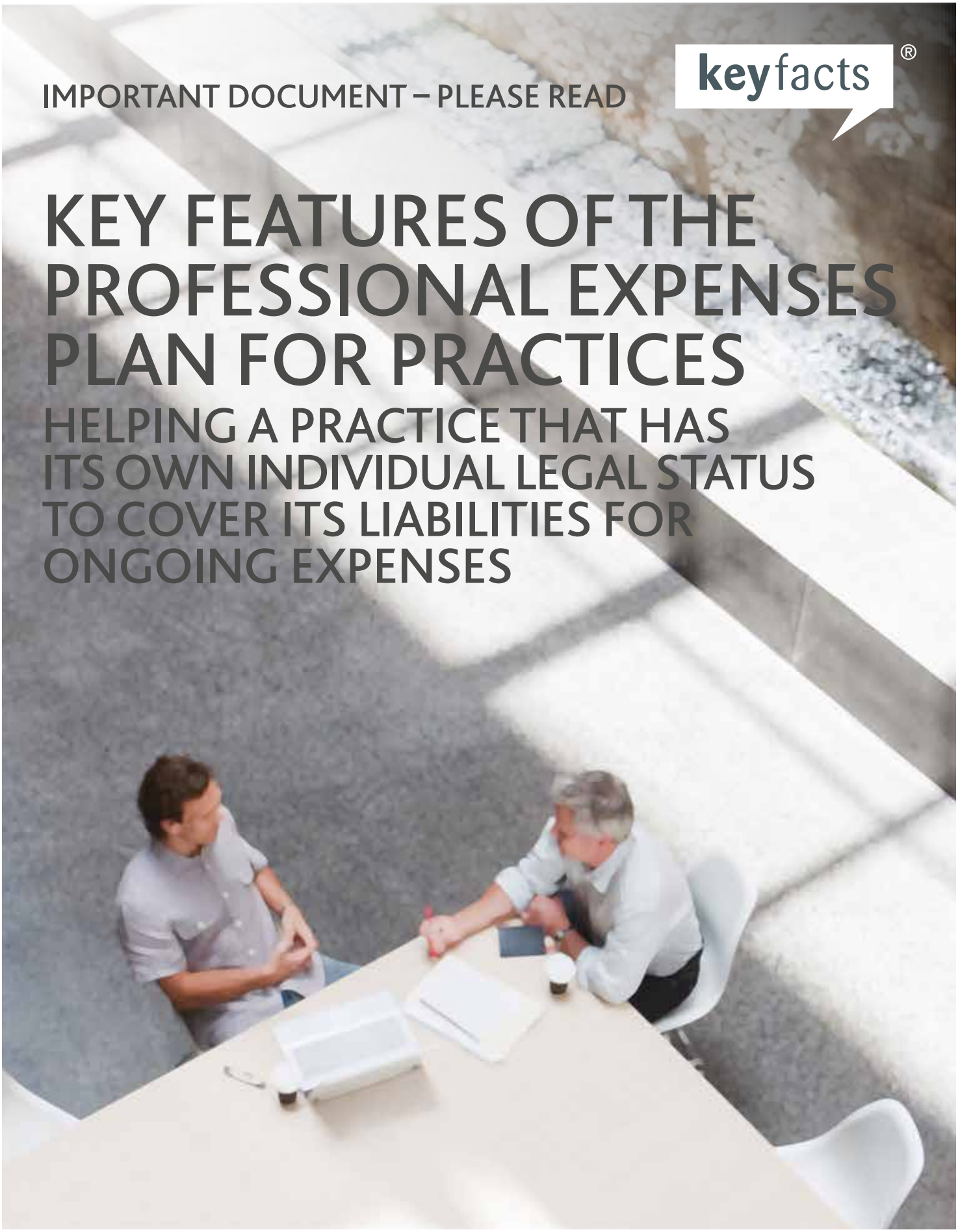
IMPORTANT DOCUMENT – PLEASE READ

keyfacts®

KEY FEATURES OF THE PROFESSIONAL EXPENSES PLAN FOR PRACTICES

HELPING A PRACTICE THAT HAS ITS OWN INDIVIDUAL LEGAL STATUS TO COVER ITS LIABILITIES FOR ONGOING EXPENSES



WESLEYAN

we are all about you

KEY FEATURES OF THE PROFESSIONAL EXPENSES PLAN FOR PRACTICES

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

This document gives the main points about our Professional Expenses Plan for Practices. It doesn't explain all the definitions and exclusions or include all the terms and conditions – that information is in the Plan Document, which we send to you when we accept your application. If you would like a copy, please contact our Head Office.

In this document, 'we', 'us' and 'our' refer to Wesleyan Assurance Society, who provides the cover for the plan. For details of all definitions and exclusions, please read the Plan Document.

Aims of the plan

The Professional Expenses Plan for Practices is designed to help dental and legal practices cover certain costs within their organisation if a person who works within their business becomes unable to work due to illness or injury.

For simplicity, throughout this document we refer to this person as the 'insured employee', although, in some circumstances, the working relationship might not actually be employer/employee (such as a partner or member of an LLP, for example). Please see 'Who can take out the plan?' on page 3, for more information.

The plan can help your business cover:

- the ongoing fixed expenses involved in running the practice, or
- the cost of employing someone else to carry out the insured employee's work (that is, the occupation that we have agreed to insure under the plan).

Your commitment

We ask you to do the following.

- Give us all the information we ask for when you apply for the plan and if you need to make a claim.
- Make all the regular premium payments for the length of the plan.
- Tell us if the insured employee's occupation or their work duties change, or if they leave your business.
- Tell us if the insured employee's employment status changes (for example, if they become a partner or self-employed after being an employee or a company director). We may not be able to pay a claim if this happens.
- Tell us about a claim within the time limits we set (where reasonably possible).
- Review your level of cover regularly to make sure you don't have more cover than you can claim for.

Risk factors

- You won't be covered if you don't pay your premiums when they are due.
- We may not pay benefit if you or the insured employee gives us misleading information or information which you or they knew was not correct at the time you applied for the plan.
- You may have less cover than you need if you don't review your plan regularly to keep it in line with your expenses.
- You will not receive the full benefit if, when you have to claim, you have paid for more benefit than the plan allows. If this happens, we won't give you back any money which you have already paid. (There's more information about this in condition A6 of the Plan Document.)
- Claims you make under this plan may affect benefits paid under other professional expenses or staff-replacement insurance you have.
- The tax rules that apply to this plan could change.
- Your premium may increase if you have chosen reviewable premium rates. In this case, we may, in the future, change how much you pay because of factors such as our claims experience and interest rates. The first review won't happen for five years and we'll tell you before we make any changes to your premium. (Please see 'Will my premiums change in the future' on page 5, and condition C4 of the Plan Document.)

Questions and answers

What is the Professional Expenses Plan for Practices?

This plan is designed to pay your practice a regular monthly benefit to cover either:

- a proportion of the ongoing fixed costs of your practice, or
- the costs of paying someone to carry out the insured employee's normal duties,

if the insured employee is not able to work because they are ill or have suffered an injury. You cannot claim because the insured employee becomes unemployed.

You decide:

- the amount of cover you need
- how soon you want the benefit to start after the insured employee becomes unable to work
- how long you want the benefit to be paid for, and
- how long you want the cover to last.

Who can take out the plan?

- The plan is available to dental and legal practices with one or more people working within the business whose absence from work would affect whether the business was able to cover its ongoing costs. This person will normally be employed by or be an office holder of the practice (for example, as a director of the company or company secretary). However, if the business is a limited liability partnership, partners as well as employees can be covered.
- In England, Wales and Northern Ireland, as well as limited companies and limited liability partnerships, the plan may also be used for sole traders and ordinary partnerships as long as the insured employee is not also the sole trader or a partner in the business.
- In Scotland, the plan can also be taken out by a Scottish partnership or Scottish limited partnership, in which case the insured employee may be an employee or a partner in the partnership.
- The insured employee must be aged between 20 and 65 when the plan starts.
- There must be at least five years between the date you take out the plan and the date the insured employee reaches the age at which you want your plan to end (the 'plan end age').
- The plan must end no later than the insured employee's 70th birthday.

When will the plan pay out?

You can make a claim under the plan if the insured employee is incapacitated. By this we mean that, because of their illness or injury, the insured employee is totally unable to carry out the essential duties of their insured occupation (and is not doing any other paid or unpaid work). By 'essential duties' we mean those duties which cannot be left out without affecting the insured employee's ability to carry out their insured occupation.

How much cover can I get?

The maximum amount of cover you can apply for is £3,500 per week, even if your expenses or costs are higher than this.

Depending on the amount of cover you've chosen, if you make a valid claim under the plan, we will provide a regular payment which your business can use to cover some or all of the ongoing expenses of your practice or the costs of temporarily employing someone else to replace the insured employee.

Fixed expenses

Fixed expenses are the costs that the business is committed to pay to run your practice and which must still be paid while the insured employee is not able to work. These are all the ongoing practice expenses which stay the same regardless of the amount of revenue made. They could include rent, rates, insurance, heating, lighting, staff salaries and interest on loans. Fixed expenses don't include a fall in the value of the fixed assets of the business over time (depreciation).

If you make a valid claim for fixed expenses, we will pay out the lower of:

- the amount of cover you've chosen under your plan, and
- the maximum benefit calculated as shown by the formula below. The aim of the formula is to work out a share of these costs based on the income earned by the insured employee compared with the total amount of money earned by everyone else working at the practice.

$$\frac{\text{The insured employee's income (from this employment) before a claim}}{\text{The total income before a claim in relation to everyone working within your practice (including partners and employees)}} \times \text{Total fixed expenses of your practice}$$

less:

The amount of any benefit you are receiving, or are entitled to receive from other professional expenses or staff-replacement insurance for the insured employee.

Temporarily employing someone to replace the insured employee

If you make a valid claim for locum costs, we will pay out the amount of cover you've chosen or the maximum benefit, whichever is lower. The maximum benefit we will pay you to cover the cost of temporarily employing someone to replace the insured employee is:

- the actual amount you must pay each week to employ a locum, or
- the amount you must pay to other partners or practice staff for extra hours they work.

We will deduct from this the weekly equivalent of any amount you receive from:

- other professional expenses or staff-replacement insurance, and
- your Primary Care Organisation to help with locum fees (if the insured employee is a dental practitioner).

If you pay for a locum or for other staff in the practice to do the insured employee's work, they must be able to carry out the essential duties of the insured employee's normal occupation and they must be suitably qualified.

We'll ask for evidence of your expenses.

For more information, please see 'How will you assess my claim?' on page 6 and condition A5 of the Plan Document.

When will benefit payments start?

There will be a period when the insured employee is first unable to work because of illness or injury for which we do not pay benefit. This is called the 'deferred period'. Once we accept a claim, your benefit payments will start after the deferred period has finished.

You choose the deferred period (or periods) to meet your needs. You can choose a deferred period of 0, 4, 8, 13 or 26 weeks.

You can have up to two deferred periods on the plan.

If you have chosen two deferred periods and your claim is successful, your benefit payments will start as each deferred period ends and according to the amount of cover you have for each.

If you have chosen a zero-week deferred period for any part of the benefit under your plan, the insured employee will need to be incapacitated for at least seven days before you can make a claim.

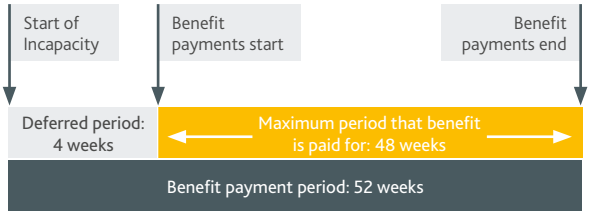
How long will you pay benefits for?

You can choose to have the benefit paid for up to 26 or 52 weeks from when the insured employee is first incapacitated. This is called the 'benefit payment period'.

The benefit payment period runs from when we first accept your claim. However, you won't actually start to receive benefit until the deferred period ends. This means the maximum period of time during which you'll actually receive benefit is the length of your chosen benefit payment period less the length of the deferred period you have chosen.

If you have two deferred periods on the plan, this will apply to each deferred period you have chosen.

The illustration below shows how we would pay benefits for a plan with a 52-week payment period and four-week deferred period.



Please see condition A1 of the Plan Document for more information.

We will pay the benefit until the first of the following happens.

- The insured employee is no longer incapacitated.
- You are no longer entitled to benefits under the plan because you're receiving payments from other sources (such as other insurances or from a Primary Care Organisation) as set out under 'How much cover can I get?' on page 4, or because there are no locum costs to cover.
- We have paid benefit for the maximum benefit payment period that applies to your plan.
- You no longer employ the insured employee (or, if they are not an employee, they no longer work within the practice).
- The insured employee dies.
- You stop trading.
- The plan ends.

How long will the cover last?

You choose how long you want the cover to last. The cover usually ends when the insured employee reaches an age at which you would no longer need to cover them under the plan, known as the 'plan end age'.

The plan end age you choose should be no later than the insured employee's planned retirement age because you cannot receive any benefit from the plan if they have retired.

The plan must end no later than the insured employee's 70th birthday.

We may limit the plan end date to an earlier age for some occupations. We will tell you before your plan starts if this applies to you.

How much will I pay?

Your premium payments depend on the insured employee's age, occupation, smoking habits, medical history, other personal circumstances and the level and features of the cover you choose.

You will receive a personalised illustration which will show the typical cost of the cover you have chosen.

We will tell you the actual cost you will pay once we have assessed your application.

When you are claiming benefits, you will not have to pay your premium payments. These will restart when your claim ends so that you still have cover.

Will my premiums change in the future?

This plan offers a choice of either 'guaranteed' or 'reviewable' premium rates.

- If you choose guaranteed premium rates, your premiums will stay the same throughout the length of your plan. However, the premium you pay could change if your cover changes.
- If you choose reviewable premium rates, your premiums may change if we carry out a premium review and it shows that we expect the costs of providing your cover to change. We will review your premium on the fifth anniversary of the date the plan started and every year after that. The premium may go up or down, or it may stay the same as a result of the review. We can increase or reduce your premiums by any amount and there is no limit to the size of any change.

We review premiums in a fair and reasonable way, and consider:

- our experience on all our similar protection products
- information available to us on the actual and expected experience of insurers of similar income protection plans, and
- economic information such as interest rates and tax rates.

We will not look to recover past losses or redistribute past profits as part of a review and your premium will not be affected by whether you have claimed or not.

We'll give you at least 14 days' notice if we change your premium following a review.

- If we tell you that we plan to increase the cost of providing your cover, we will increase your premium so that the level of cover is continued.
- You could leave your premium unchanged for a reduced level of benefit, which will be based on the revised cost of providing cover.
- If the cost of providing cover reduces, we will reduce your premium and your level of cover will remain unchanged.

Please see condition C4 of the Plan Document for more details.

How will you assess my claim?

- We'll look at the nature of the insured employee's illness or injury, the duties of their occupation and their ability to do them.
- We'll ask for evidence of the expenses you have to pay and evidence of the insured employee's age.
- We will also ask for a medical report from the medical practitioner in charge of the insured employee's case and we may also need further medical information as well as that provided by their GP.
- If you are claiming for fixed expenses, we will also need evidence of the insured employee's income and the total amount of money earned by everyone else working at the practice.
- If you are claiming for locum expenses, we will need to see invoices.

Please see condition A5 of the Plan Document for more information.

Is there a deadline for claiming?

You should tell us as soon as possible that you want to make a claim. The notice periods are set out in the table below.

The shortest deferred period that applies to your plan	When you should tell us about the insured employee's incapacity
None (zero weeks), four weeks	Within **two weeks** of the start of incapacity
Eight weeks	Within **three weeks** of the start of incapacity
13 weeks, 26 weeks	Within **four weeks** of the start of incapacity

If you don't tell us about the insured employee's incapacity within these notice periods, payment of your claim is likely to be delayed. See 'When will the plan pay out?' on page 3, for what we mean by incapacity.

For more information on notice periods that apply to this plan, please see condition A3 of the Plan Document.

What if I need to claim again?

If you need to claim again within 13 weeks of a previous claim, you may not have to wait before we pay out again. For more information, please see condition A7 of the Plan Document.

What happens if the insured employee returns to work part-time?

You may be able to claim some benefit if the insured employee returns to work part-time while we're paying benefit under the plan. Please see condition A8 of the Plan Document for more information.

How many claims can I make?

There is no limit to the number of claims you can make. However, you must restart paying premiums when your claim ends so that you still have cover.

Can I increase the cover?

Depending on certain conditions, you can ask us to increase your cover at any time.

You can also increase cover by up to 10% each year without giving us any information about the insured employee's state of health, up to a combined overall increase in benefits of £1,150 per week). Please see condition B1 of the Plan Document for more details.

If you want to take out more cover than this, you can apply to do so but you may need to provide us with new evidence of the insured employee's state of health, occupation and other personal information.

You can't increase the cover under the plan to more than £3,500 per week. For more information, please see 'How much cover can I get?' on page 4.

Whenever your cover is increased, your premiums will also increase. For more information, please see 'How much will I pay?' on page 5.

What if my needs change?

To make sure that you have the right amount of cover, you may want to speak to your Wesleyan Financial Consultant.

As well as increasing the amount of cover you have, you can apply to change the plan end age and deferred periods. We may need further medical evidence if you want to do this.

You can also apply to reduce the cover that you have.

What are my options if the insured employee takes a break from their career?

You can choose to suspend your cover and premiums for up to 12 months if the insured employee takes one of the following breaks.

	Eligibility
Maternity or paternity break	If the insured employee takes a recognised period of maternity or paternity leave.
Sabbatical break	If the insured employee is temporarily excused (with your written agreement beforehand) from carrying out their normal occupation and has a guaranteed position to return to.
Carer's break	If the insured employee stops all paid work to provide unpaid help to a person who could not manage without this support. As a carer, the insured employee may be supporting a relative, partner or friend who is ill, frail, disabled, or who has mental-health or substance-misuse problems.

If you reinstate your cover within 12 months of the start of the break, you won't need to provide further evidence of the insured employee's state of health. We will reinstate the cover to the level that applied before the break and we'll confirm your premium to you in writing at that time.

You cannot reinstate cover if the insured employee is incapacitated.

If you do not reinstate cover and restart paying premiums within 12 months, the plan will come to an end.

For more details on breaks, including eligibility and conditions, please see condition D2 of the Plan Document.

Will you still pay benefit if the insured employee is outside the United Kingdom (UK)?

We will cover the insured employee if they suffer illness or injury anywhere in the world. However, there are restrictions on how long we will pay benefit for.

We will pay benefit while the insured employee is in the UK, any member state of the European Union or one of the following.

- Australia
- Canada
- Channel Islands
- Gibraltar
- Iceland
- Isle of Man
- New Zealand
- Norway
- Switzerland
- United States of America

If the insured employee is not in one of the territories or countries listed above, we will only pay benefit for a maximum of six months (depending on the deferred period (or periods) you have chosen) from the start of their incapacity. This means that you won't receive any benefit under the plan that relates to a deferred period of 26 weeks. Please see condition A9 of the Plan Document for more information.

When will the plan not pay out?

The plan has no standard exclusions.

However, please note that the plan is designed to pay benefits in the event of illness or injury; you cannot claim because the insured employee becomes unemployed.

Pregnancy is not an illness, so you cannot claim if a condition arises from the normal effects of pregnancy, childbirth (or both). However, we will cover complications associated with pregnancy.

We will not pay out if the insured employee is not actively at work, other than as a result of their incapacity, even if they are still employed by you (for example if they are taking a career break as described in 'What are my options if the insured employee takes a break from their career?' on page 7).

Are there any other significant or unusual exclusions or limits?

We may add exclusions, conditions or limits in some cases, depending on the insured employee's medical or family medical history and on certain aspects of their lifestyle. If so, we'll tell you before you start your plan and show this on your Plan Schedule.

Does the plan have a cash-in value?

No, the plan has no cash-in value.

What about tax?

Premiums would normally be treated as a business expense for most insured employees. However, HM Revenue & Customs (HMRC) may not allow tax relief on premiums if the insured employee owns a significant share in the business. You should check your tax position with your local Inspector of Taxes.

Benefit payments are usually treated and taxed as a trading receipt but you can normally deduct the costs of employing a locum and other expenses you have to pay from these before calculating tax.

This is how we understand the current tax rules. They may change in the future.

What if I stop paying premiums?

If you miss a premium and you do not pay it within 30 days of the date it was due, your plan and cover will end. You won't get any money back.

You can restart your plan within six months of missing the first premium. You will have to pay all the premiums you have missed and give us evidence that the insured employee is in good health.

What charges apply to my plan?

The premiums you pay include all the costs of managing your plan such as underwriting, commission, claims, ongoing administration and selling expenses. There is a plan fee of £3 per month (or £36 per year), which is included in the premiums you pay.

Can I change my mind?

After we accept your application, you have three months to change your mind. To do this, you will need to send us a filled-in Cancellation Notice, which we will give you when you take out your plan.

If you cancel your plan within this three-month period, we will refund any premiums paid after we have deducted any benefits we may have paid you.

You can cancel your plan at any time after the three months has ended, but we won't refund any premiums you have already paid if you do this.

How to contact us

If you have any questions, please call us on 0345 351 2352.

Our phone lines are open from 8.30am to 6.30pm Monday to Friday and from 9am to 2pm Saturdays. We may monitor calls to improve our service.

Fax us on 0121 200 2971.

Write to us at our Head Office:
Wesleyan Assurance Society
Colmore Circus
Birmingham
B4 6AR

If you have any questions about making a claim, we will try to answer them promptly.

Claims

If you want to tell us about a claim, please:

- call us on 0345 351 2352
- write to the Health Claims Department at the address above
- email us at phiclaimsadmin@wesleyan.co.uk, or
- fax us on 0121 200 9718.

You can find more information about our claims process at www.wesleyan.co.uk

How to complain

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

- Speak to our Customer Relationship Centre team on 0800 092 1990. Our lines are open from 8.30am to 6.30pm, Monday to Friday and from 9am to 2pm on Saturdays.
- Fill in the online contact form which you can find on our website at www.wesleyan.co.uk
- Email the Compliance Team at compliance@wesleyan.co.uk
- Write to:
  Complaints Team
  Compliance Department
  Wesleyan Assurance Society
  Colmore Circus
  Birmingham
  B4 6AR
- You can also fax your letter to us on 0121 200 9210.

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

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Phone: 0800 023 4567 or 0300 123 9123

Email: complaint.info@financial-ombudsman.org.uk

Website: www.financial-ombudsman.org.uk

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

Law

The plan is governed by the law of England.

Compensation

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

10th Floor Beaufort House
15 St Botolph Street
London
EC3A 7QU

Phone: 0800 678 1100 or 020 7741 4100

Email: enquiries@fscs.org.uk

Website: www.fscs.org.uk


EXIT

For further information, please call 0345 351 2352.
Or visit: www.wesleyan.co.uk

If you would like this document in Braille, large print or audio format, please contact 0345 351 2352.

For regular news, updates and information find us on social media. Visit:

www.facebook.com/wesleyanAS

www.twitter.com/wesleyan

www.linkedin.com/company/wesleyan

Crystal Mark 21873
Clarity approved by Plain English Campaign

Head Office
Wesleyan
Colmore Circus
Birmingham B4 6AR

WP-KFD-21-09/16

FSC
www.fsc.org
MIX
Paper from responsible sources
FSC® C003270