IMPORTANT DOCUMENT – PLEASE READ

keyfacts®

KEY FEATURES OF THE PROFESSIONAL EXPENSES PLAN

HELPING YOU COVER YOUR PERSONAL LIABILITY FOR ONGOING EXPENSES

WESLEYAN

we are all about you

KEY FEATURES OF THE PROFESSIONAL EXPENSES PLAN

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 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. It doesn't explain all the definitions and exclusions or include all the terms and conditions – that information is in the Plan Document, which we send you when we accept your application. If you 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 Professional Expenses Plan. For details of all definitions and exclusions, please read the Plan Document.

Aims of the plan

The Professional Expenses Plan aims to help you pay certain costs if you're not able to work because you suffer an illness or injury. The plan can help you pay:

- the ongoing practice expenses for which you are personally responsible, or
- the cost of employing someone else to carry out your insured occupation (that is the occupation or occupations 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 you change your occupation or your duties or if you retire.
- 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 give us misleading information or information which you 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 you have to claim and have paid for more cover than you need. If this happens, we won't give you back any money which you have paid. (There is 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. (There is more information about this in condition C4 of the Plan Document.)

Questions and answers

What is the Professional Expenses Plan?

This plan is designed to pay you a regular income to cover either:

- the ongoing fixed costs of your practice, or
- the costs of paying someone to carry out your normal duties,

if you are not able to work because you suffer an illness or injury.

You decide:

- the amount of cover you need
- how soon you want the benefit to start after you are not able to work because of an illness or injury
- how long you want the benefit to be paid for, and
- how long you want the cover to last.

Who can take out the Professional Expenses Plan?

- You can take out the Professional Expenses Plan if you are a doctor, dentist or lawyer, 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 you reach the age at which you want the plan to end (the plan end age).
- The plan must end no later than your 70th birthday.

When will the plan pay out?

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

To be eligible for benefit under the plan, you must also be personally responsible for the costs of temporarily employing someone to replace you or to pay your share of the continuing fixed expenses of your practice.

How much benefit can I get?

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

Depending on the amount of cover you've chosen, we will pay your ongoing practice expenses or the costs of temporarily employing someone to replace you.

Ongoing practice expenses

These are the fixed costs you are committed to pay to run your practice and which must still be paid while you are not able to work. These could include rent, rates, staff salaries and interest on loans.

We will pay out the full amount of benefit you've chosen under your plan or the maximum benefit outlined below, whichever is lower.

The maximum benefit is 100% of your average weekly fixed expenses less:

- the amount of any benefit you are receiving from other professional expenses or staff-replacement insurance, and
- other allowances or insurance payments which you receive because you are not able to carry out your normal occupation because of illness or injury. We will only take these into account if:
  - the benefits are being used to meet your fixed expenses, and
  - it means that you don't suffer any reduction in the income you receive from your practice.

If you share the fixed expenses costs with other people, we will only pay your share of those expenses.

Temporarily employing someone to replace you

We will pay out the full amount of cover you've chosen or the maximum benefit, whichever is lower. The maximum benefit to cover the cost of temporarily employing someone to replace you (because your illness or injury means you are totally unable to carry out the essential duties of one or more of your insured occupations) is:

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

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

- Other professional expenses or staff-replacement insurance.
- Other insurances against illness or injury (which may not have been taken out for a similar purpose). But we'll only deduct these if:
  - the benefits are being used to meet your locum expenses, and
  - you don't suffer any reduction in the income you receive from your practice.
- Your primary care organisation (if you're a medical or dental practitioner) to help with locum fees.

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

We'll ask for evidence of your expenses.

There is more information about this in condition A7 of the Plan Document.

When will benefit payments start?

There will be a period when you are 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, you will need to be incapacitated for at least seven days before you can make a claim.

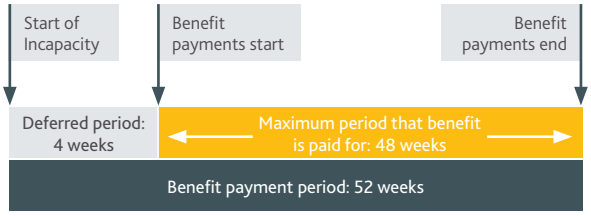
How long will you pay benefits for?

You can choose to have the benefit paid for up to 26 or 52 weeks from when you are 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 A2 of the Plan Document for more information.

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

- You are no longer incapacitated.
- You're 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 detailed under 'How much benefit can I get?', 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 stop being responsible for expenses (for example if you sell the practice).
- The plan ends.
- You die.

How long will the cover last?

You choose how long you want cover to last by specifying the age when you want your plan to end. We call this the 'plan end age'. This is usually the age when you think you would no longer need the benefits. The date you choose should be no later than your planned retirement age, because you cannot receive any benefit from the plan if you have retired.

There must be at least five years between the date your plan starts and the age you choose it to end. The plan must end no later than your 70th birthday.

We may limit the plan end age 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 your 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.

Will my premiums change in the future?

This plan offers a choice between 'guaranteed' and 'reviewable' premium rates.

If you choose guaranteed premium rates, your premiums will stay the same throughout the length of your plan. However, the actual premium you pay could change if your cover changes.

If you choose reviewable premium rates, your premiums may change when we carry out a premium review and this review shows we expect the costs of providing cover will change. We will review your premium on the fifth anniversary of the plan 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 will review premiums in a fair and reasonable way, and consider:

- our experience on all our similar protection products
- information reasonably 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.

The reviews will compare the costs allowed for in your premiums with what we think future costs will be. We will not look to recover past losses or redistribute past profits as part of a review and your premiums will not be directly affected by whether you have claimed or not.

We will give you at least 14 days' notice of any changes that result from a review of your premiums. If we tell you that we plan to increase the cost of providing your cover, we will increase your premiums so that the level of cover is continued. However, you will also have the option to leave your premiums 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 premiums and the level of cover will stay the same.

Please see conditions C3 and C4 of the Plan Document for more details.

How will you assess my claim?

- We'll look at the nature of your illness or injury, the duties of your occupation and your ability to do them.
- We'll ask for evidence of the expenses you have to pay and evidence of your age.

We will also ask for a medical report from the medical practitioner in charge of your case and we may also need further medical information as well as that provided by your GP.

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. If your illness or injury means you can't tell us yourself, certain close family members or people who are legally authorised to act for you can tell us.

The shortest deferred period under the plan	When you should tell us about your incapacity
Immediate, four weeks	Within **two weeks** of being unable to work
Eight weeks	Within **three weeks** of being unable to work
13 weeks, 26 weeks	Within **four weeks** of being unable to work

If you do not tell us about your incapacity within these periods, payment of your claim is likely to be delayed.

Please see condition A4 of the Plan Document for more details on notification periods that apply.

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. Please see condition A8 of the Plan Document.

What happens if I return to work part-time?

You may be able to claim some benefit if you return to work part-time while we're paying benefit under the plan. Please see condition A9 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 continue to pay premiums if we are paying a claim to ensure your cover continues.

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 your state of health. Please see condition B2 of the Plan Document for more details.

If you want to take out more cover than this, you may need to provide us with new evidence of your state of health, occupation and other personal information.

Whenever your cover is increased, your premiums will also increase. See 'How much will I pay?' on page 6 for more information.

You can't increase the cover to more than £3,500 per week.

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 your 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 I take a break from my career?

You can choose to suspend your professional expenses cover and premiums for up to 12 months if you take one of the following breaks.

	Eligibility	For how long?
Maternity or Paternity Break	If you take a recognised period of maternity or paternity leave.	Up to 12 months
Sabbatical Break	If you are temporarily excused (with written agreement beforehand from your employer), from carrying out your normal occupation with a guaranteed position to return to.	Up to 24 months
Carer's Break	If you stop all paid work to provide unpaid help to a person, and they could not manage without this support. As a carer, you may be supporting a relative, partner or friend, who is ill, frail, disabled, or who has mental-health or substance-misuse problems.	Up to 12 months

If you reinstate cover within 12 months of the start of the break, you will not need to provide further evidence of the state of your health. We will reinstate the cover to the level that applied before your break and we'll confirm your premiums at that time.

You cannot reinstate cover if you are incapacitated.

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

For more details, please see condition D2 of the Plan Document.

Will you still pay benefit if I am outside the United Kingdom?

We will cover you if you 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 you are in the United Kingdom, any country or territory which is a member 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 you are not in one of the countries or territories 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 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 A10 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 you become unemployed.

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

Are there any other significant or unusual exclusions or limitations?

We may add exclusions, conditions or limitations in some cases, depending on your medical, lifestyle or family medical history. 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?

Your monthly premiums are normally allowed as a business expense, which means you should be able to deduct them from your profits before calculating tax.

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

What charges apply to my plan?

The premiums you pay include all the costs of administration, underwriting, claims and selling expenses. There is a plan fee of £3 per month, 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 completed 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 any time after the three months has ended, but we won't refund any premiums.

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 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 notify us of a claim, please:

- call us on 0345 351 2352.
- write to the Health Claims Department at the address above
- email: 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 Service 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.

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

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

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Head Office
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