



Global Health Elite Plan Agreement

For all Global Health Elite customers
whose period of cover starts on or after
1st January 2017

Welcome

Thank you for choosing a William Russell Global Health **plan**. This document explains what is and what is not covered by **your plan** and how **your claims** will be administered.

Please take time to read this document along with **your certificate of insurance** and **application form** as together they form the contract between **you** and **us**.

Certain words used within this document have a special meaning that **we** would like to draw to **your** attention:

We/us/our – means William Russell Limited on behalf of the **insurer**.

The **Assistance Service** – means the company whom **we** have appointed to provide **you** with 24-hour medical assistance at the time of **your claim**.

You/your – means **you** and all **insured persons** on this **plan**, as shown on **your certificate of insurance**.

Throughout this document certain words and phrases are in bold type. The meanings of these are provided in the 'Definitions' section at the back of this document.

Cooling off period – your right to cancel within 30 days

If **you** decide **your plan** does not meet **your** needs, simply contact **us** and advise **us** that **you** wish to cancel. Provided **we** receive **your** written instruction within 30 days of **your date of entry**, and provided no **claims** have been made, **we** will refund **your premium** in full.

If **we** receive **your** instruction to cancel **your plan** more than 30 days after **your date of entry**, the terms of **our** cancellation policy will apply.

William Russell Limited

William Russell Limited is the administrator of **your** Global Health **plan**. William Russell Limited is authorised and regulated by the UK Financial Conduct Authority under reference number 309314.

Allianz Benelux N.V.

Allianz Benelux N.V. Coolsingel 139, Postbus 64, NL-3000 AB Rotterdam, Netherlands, is the **insurer** of **your** Global Health **plan**. Allianz Benelux N.V is an EEA **insurer** situated in the Netherlands.

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Contents

The Global Health Elite plan agreement	3	General information about your plan	22
Your area of cover	4	Premiums	22
The benefits provided by each Global Health plan	5	Making changes	22
Costs not covered by your plan	17	At renewal	24
Making a claim	20	Discounts	24
		Cancellation	25
		Other information	25
		Definitions	27

The Global Health Elite plan agreement

This **agreement** together with **your application form**, and **your certificate of insurance** make up the contract between **you** and **us**. The terms of this **agreement** apply to **you** and to all of **your eligible dependants** as stated in the schedule of **insured persons** on **your** (the **plan holder's**) **certificate of insurance**.

The purpose of your plan

Your plan provides **you** with benefit for the cost of treating eligible medical conditions which arise after **your date of entry**.

We will pay for the **reasonable and customary** costs of **medically necessary**, recognised **treatment** of medical conditions covered by **your plan**. **We** will only pay for such **treatment** if it is received during **your period of cover**, and provided **your premium** payments have been kept up to date.

Any reimbursement **we** make may be subject to an **excess** and/or **co-insurance**, and certain benefits are subject to a benefit limit. **Your excess** amount will be stated on **your certificate of insurance**. Any **co-insurance** and benefit limits will be as stated in the **table of benefits** for **your plan type**.

Your obligation to provide information relating to your own, and to your eligible dependants' medical

We rely on the information **you** supply to **us** in **your application form** when **we** decide whether or not to accept **your application**, and whether or not **we** need to apply **special terms**.

If **your application form** omits facts or contains materially incorrect or incomplete facts, **we** have the right to declare **your Global Health plan** void. Alternatively **we** may impose **special terms** on **your particular plan** which will apply from **your date of entry**.

If **your** state of health, or the state of health of any of **your eligible dependants** changes between the time **you** complete **your application form** and **your date of entry**, **you** must tell **us** in writing about the change, and **we** may only be able to accept **your application** with **special terms**.

Pre-existing medical conditions and related conditions

Unless **we** have agreed otherwise, **your plan** will not cover any **pre-existing medical conditions** or **related conditions**.

Age limits

You must be under 70 years of age at the commencement date of **your Global Health plan**.

You may apply for cover on behalf of **your** spouse or partner (provided they are under 70 years of age) and/or on behalf of **your** unmarried children, provided they are aged less than 18 years old, or less than 25 years old if in continuous full-time education.

Commencement of your cover

Your cover will commence from the **date of entry** stated on **your certificate of insurance**. **We** will not commence **your** cover until **we** have accepted **your application** and **we** have received payment of **your** full annual, half-yearly, quarterly or monthly **premium**.

If the USA is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the USA is or becomes **your country of residence**, irrespective of **your** nationality. If the USA becomes **your country of residence** **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the USA.

Your area of cover

Your cover is restricted to the **area of cover** stated on your **certificate of insurance**. The available areas of cover and their corresponding territorial limits are:

Area One

Worldwide cover excluding the USA.

Area Two

Worldwide cover excluding the USA. However, **we** will cover **you** in the USA for temporary trips of up to 45 days duration from the date on which **you** enter the USA. Any trip of longer than 45 days will not be covered. There is no limit to the number of temporary trips **you** can make to the USA during any **period of cover**. The maximum amount **we** will pay in respect of **treatment you** receive in the USA is US\$100,000 per **period of cover**, unless the payment is in respect of **emergency treatment** for a condition covered by **your plan** following an **accident** or a sudden and unforeseen illness **you** have never suffered from before, in which case the maximum **we** will pay is US\$250,000 per **period of cover**.

An emergency evacuation is not classed as a temporary trip. In the event that **you** suffer a **life-threatening condition** that cannot adequately be treated locally **you** will be evacuated to the nearest **hospital**, in a country other than the USA, capable of treating **your** condition.

Area Three

Worldwide cover excluding the USA. However, **we** will cover **you** in the USA for temporary trips of up to 90 days duration from the date on which **you** enter the USA. Any trip of longer than 90 days will not be covered. There is no limit to the number of temporary trips **you** can make to the USA during any **period of cover**. The maximum amount **we** will pay in respect of **treatment you** receive in the USA is US\$250,000 per **period of cover**.

An emergency evacuation is not classed as a temporary trip. In the event that **you** suffer a **life-threatening condition** that cannot adequately be treated locally **you** will be evacuated to the nearest **hospital**, in a country other than the USA, capable of treating **your** condition.

Area Four

This **area of cover** is only available to residents of **Africa and the Indian subcontinent**. If **you** have Area Four cover **you** will be eligible for cover in all countries within **Africa and the Indian subcontinent**.

No cover at all is provided in the USA, Canada, any **Caribbean country or island**, and anywhere within the **London area**.

If **you** travel to a country which is not the USA, Canada, any **Caribbean country or island**, and is not anywhere within the **London area**, **your plan** will provide **you** with cover for **emergency treatment** only for a period of up to 90 days from the date on which **you** departed from **Africa and the Indian subcontinent**. **We** will not pay for cover if **you** have travelled knowing that **you** may require medical **treatment**. The maximum benefit **we** will pay in respect of all **emergency treatment you** receive outside **Africa and the Indian subcontinent** is £62,500 or US\$100,000 or €120,000 per **period of cover**.

An emergency evacuation is not classed as a temporary trip. In the event that **you** suffer a **life-threatening condition** that cannot adequately be treated locally **you** will be evacuated to the nearest **hospital**, in a country other than the USA, Canada, any **Caribbean country or island**, or within the **London area**, capable of treating **your** condition.

The benefits provided by each Global Health plan

The following **table of benefits** sets out the cover provided by each **plan type**. The **plan type** you have is as shown on your **certificate of insurance**. We will pay only for the **treatment** or services stated in the **table of benefits** relating to the **plan type** you have.

Where there is a lifetime benefit limit, this is the maximum amount we will pay in respect of that particular benefit during your lifetime.

Certain benefits in the **table of benefits** specify a **waiting period**. You must be covered by the same **plan** for the full duration of the specified **waiting period** before you can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

The limits shown in the **table of benefits** are the maximum amounts we will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limit.

Each benefit limit in the **table of benefits** is expressed in Sterling, US Dollars and Euros. The currency of the benefit limits that we will apply to your **plan** is shown on your **certificate of insurance**.

IMPORTANT: The **table of benefits** should be read in conjunction with the 'Costs not covered by your plan' section.

Where the term 'Full cover' appears, this means full refund of **reasonable and customary** charges, less any **excess** applicable to your **plan**, and subject to any **co-insurance**, any annual benefit limits, any **session** limits shown in the **table of benefits**, any exclusions in your **certificate of insurance**, or any limits in other benefits elsewhere in the **table of benefits** applying to your **claim**. This includes any restrictions or exclusions under the 'Terminal illnesses' and '**Chronic conditions**' benefits.

Key ○ Full cover within annual plan benefit limit ○ Partial or limited cover ○ No cover

Cover	Bronze	Silver	Gold
Annual benefit limit			
The overall maximum limit that each insured person can claim during any one period of cover .	US\$1,500,000 or £950,000 or €1,100,000	US\$2,500,000 or £1,500,000 or €1,800,000	US\$5,000,000 or £3,000,000 or €3,600,000
Hospital costs Important note: You must obtain pre-authorisation for all benefits included in this section.			
Hospital accommodation The cost of a standard single room with an en-suite bath or shower room, when you are an in-patient or day-patient .	○ Full cover	○ Full cover	○ Full cover
Hospital treatment Treatment you receive while you are an in-patient or day-patient , including surgeons' and anaesthetists' and doctors' fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, diagnostic tests and physiotherapy. We will also pay for pre-admission tests that you undergo on an out-patient basis for hospital treatment you are scheduled to receive that is covered by your plan . We will also pay for in-patient surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month waiting period and covered only when the surgery is performed by a medical doctor (not a dentist) in a hospital (not a dental surgery) and under general anaesthetic.	○ Full cover	○ Full cover	○ Full cover
Parent accommodation The cost of one parent staying in hospital with a child under 18 years of age while the child is receiving eligible treatment covered by their plan .	○ Full cover	○ Full cover	○ Full cover

Individual Global Health Elite Plan Agreement 2017

Key ○ Full cover within annual plan benefit limit ○ Partial or limited cover ○ No cover

Cover	Bronze	Silver	Gold
Hospital costs (continued)			
Road ambulance The cost of a private road ambulance if you need hospital treatment covered by your plan and if it is medically necessary for you to travel to hospital by ambulance.	○ Full cover	○ Full cover	○ Full cover
Hospital cash benefit Payable for each night spent in a hospital when you receive treatment eligible for cover by your plan for which no charge is made by the hospital . Benefit is paid for up to a maximum of 60 nights per period of cover .	US\$40 or £25 or €30 per night	US\$80 or £50 or €60 per night	US\$250 or £156 or €187 per night
Cancer treatment			
Important note: You must obtain pre-authorization for all benefits included in this section.			
Cancer treatment Cancer treatment , including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. We will also pay for restorative dental treatment following chemotherapy or radiotherapy.	○ Full cover	○ Full cover	○ Full cover
Cancer genome tests The cost of tests to sequence the genes of cancer cells.	○ Cover up to US\$2,000 or £1,250 or €1,500 per period of cover	○ Cover up to US\$2,000 or £1,250 or €1,500 per period of cover	○ Cover up to US\$2,000 or £1,250 or €1,500 per period of cover
Cash benefit upon diagnosis of cancer (6-month waiting period) Payable if you are diagnosed with cancer. By ‘cancer’ we mean the presence of tumours that consist of cells that are malignant, due to characteristics which can be shown microscopically. These cells can multiply and spread to other parts of the body uncontrollably – cancers such as breast cancer, lung cancer, bowel cancer and cancers of the blood (also known as leukaemia). The following are not covered: <ul style="list-style-type: none"> • non-melanoma skin cancer unless it has spread to lymph nodes or organs • prostate cancer unless it has spread to other glands or organs 	○ No cover	○ No cover	US\$5,000 or £3,125 or €3,750 with a lifetime limit of one claim per insured person
Wigs Help towards the cost of a wig following chemotherapy, covered by your plan .	○ Lifetime limit of US\$150 or £94 or €113	○ Lifetime limit of US\$150 or £94 or €113	○ Lifetime limit of US\$150 or £94 or €113
Counselling Consultations with a registered psychologist/counsellor when you have received cancer treatment covered by your plan , up to a lifetime limit of 10 consultations. We do not cover any drugs prescribed under this benefit.	○ Lifetime limit of US\$500 or £313 or €376	○ Lifetime limit of US\$500 or £313 or €376	○ Lifetime limit of US\$500 or £313 or €376
Dietician Consultation with a registered dietician when you have received cancer treatment covered by your plan , up to a lifetime limit of 2 consultations.	○ Lifetime limit of US\$100 or £63 or €76	○ Lifetime limit of US\$100 or £63 or €76	○ Lifetime limit of US\$100 or £63 or €76

Individual Global Health Elite Plan Agreement 2017

Key  Full cover within annual plan benefit limit  Partial or limited cover  No cover

Cover	Bronze	Silver	Gold
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Organ, bone marrow or tissue transplants

Important notes: **You** must obtain pre-authorization for all benefits included in this section.

We only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines.

We do not cover any costs associated with the acquisition of the organ.

<p>Transplant and related treatment Costs incurred while hospitalised, including anti-rejection drugs, and all related out-patient treatment required prior to and after the transplant.</p>	 Full cover	 Full cover	 Full cover
<p>Donor costs Medical costs associated with the donor as an in-patient or day-patient.</p>	 Cover up to US\$25,000 or £15,625 or €18,750 per transplant	 Cover up to US\$25,000 or £15,625 or €18,750 per transplant	 Cover up to US\$25,000 or £15,625 or €18,750 per transplant

Kidney dialysis

Important note: **You** must obtain pre-authorization for this benefit.

<p>Short-term kidney dialysis of up to 4 weeks, if you need this immediately before or after a kidney transplant operation covered by your plan. We will also pay for dialysis for up to 4 weeks if this is needed temporarily for sudden kidney failure resulting from a disease or injury, covered by your plan, which affects another part of your body. We do not cover regular or long-term kidney dialysis.</p>	 Full cover	 Full cover	 Full cover
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Reconstructive surgery

Important note: **You** must obtain pre-authorization for this benefit.

<p>Surgery to restore your appearance after an accident or after surgery for cancer, provided the original treatment for the accident or cancer was paid for by us, and provided the reconstructive surgery takes place within two years of the accident or the original cancer surgery.</p>	 Cover for in-patient, day-patient and post-hospital treatment received within the 90 day period following the date you are discharged from hospital .	 Full cover	 Full cover
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Individual Global Health Elite Plan Agreement 2017

Key ● Full cover within annual plan benefit limit ● Partial or limited cover ● No cover

Cover	Bronze	Silver	Gold
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Congenital abnormalities or hereditary conditions

Important note: **You** must obtain pre-authorization for this benefit.

<p>Treatment for a congenital abnormality or hereditary condition (whether diagnosed as a chronic condition or not), and treatment for any related condition.</p> <p>This benefit does not extend to psychiatric treatment or psychotherapy, complimentary medicine, traditional Chinese medicine, acupuncture or homeopathic treatment.</p> <p>There is no cover for congenital abnormalities or hereditary conditions if they are a pre-existing condition, or related conditions. However, they may be covered for newborn babies under the 'Cover for newborn babies' benefit.</p> <p>The lifetime limit shown includes any benefits already paid from the 'Cover for newborn babies' benefit in relation to any birth defects, congenital abnormalities or hereditary conditions.</p> <p>The lifetime limit shown is irrespective of the number of congenital abnormalities, hereditary conditions and related conditions involved.</p>	<p>● Cover for in-patient, day-patient and post-hospital treatment received within the 90 day period following the date you are discharged from hospital only, up to a lifetime limit of US\$20,000 or £12,500 or €15,000</p>	<p>● Lifetime limit of US\$40,000 or £25,000 or €30,000</p>	<p>● Lifetime limit of US\$80,000 or £50,000 or €60,000</p>
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Psychiatric and psychotherapy treatment

Important notes: **You** must obtain pre-authorization for all benefits included in this section.

All **treatment** must be administered under the direct control of a registered psychiatrist or psychologist.

We do not cover investigations or **treatment** related to psycho-geriatric conditions including Alzheimer's disease or dementia, phobias, hypnotherapy, postnatal depression or marriage counselling.

<p>Lifetime psychiatric and psychotherapy treatment limit</p> <p>The overall lifetime maximum limit that each insured person can claim for all psychiatric and psychotherapy treatment.</p>	<p>Lifetime limit of US\$50,000 or £31,250 or €37,500</p>	<p>Lifetime limit of US\$75,000 or £46,875 or €56,250</p>	<p>Lifetime limit of US\$100,000 or £62,500 or €75,000</p>
<p>In-patient and day-patient psychiatric and psychotherapy treatment (24-month waiting period)</p> <p>In-patient and day-patient treatment received in a recognised psychiatric or psychotherapy unit of a hospital.</p>	<p>● Cover for up to 30 days per period of cover</p>	<p>● Cover for up to 30 days per period of cover</p>	<p>● Cover for up to 30 days per period of cover</p>
<p>Out-patient psychiatric and psychotherapy treatment (24-month waiting period)</p> <p>Specialist psychiatric consultations with a registered psychiatrist or psychologist when you have been referred by a medical doctor.</p> <p>We do not pay for drugs prescribed for out-patient psychiatric and psychotherapy treatment.</p>	<p>● Cover for up to 10 consultations for post-hospital treatment received within the 90 day period following the date you are discharged from hospital per period of cover</p>	<p>● Cover for up to 10 consultations per period of cover</p>	<p>● Cover for up to 10 consultations per period of cover</p>

HIV/AIDS treatment

Important note: **You** must obtain pre-authorization for this benefit.

<p>(24-month waiting period)</p> <p>Treatment arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years.</p> <p>We do not provide cover if the virus was contracted before your date of entry.</p>	<p>● Cover for in-patient and day-patient treatment only, up to US\$5,000 or £3,125 or €3,750 per period of cover</p>	<p>● Cover up to US\$75,000 or £46,875 or €56,250 per period of cover</p>	<p>● Cover up to US\$100,000 or £62,500 or €75,000 per period of cover</p>
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Individual Global Health Elite Plan Agreement 2017

Key  Full cover within annual plan benefit limit  Partial or limited cover  No cover

Cover	Bronze	Silver	Gold
Medical appliances			
<p>Medical aids Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to you (for example crutches, wheelchairs, orthopaedic supports/braces, orthotics, stoma supplies, compression stockings) when it immediately follows in-patient, day-patient or emergency ward treatment covered by your plan. We do not cover medical aids that form part of the care of a chronic condition. We do not cover unprescribed medical aids such as gym equipment, even if you have been advised to use such an aid.</p>	 Cover up to US\$250 or £156 or €187 per medical condition per period of cover	 Cover up to US\$500 or £313 or €376 per medical condition per period of cover	 Cover up to US\$1,000 or £625 or €750 per medical condition per period of cover
<p>Prosthetic implants Surgically-implanted, artificial body parts necessary to replace a joint or ligament, a heart valve, the aorta or an arterial blood vessel, a sphincter muscle, the lens or cornea of the eye, or to control urinary incontinence, or to act as a heart pacemaker, or to remove excess fluid from the brain. As part of this benefit, we will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.</p>	 Full cover	 Full cover	 Full cover
<p>Prosthetic devices External prosthetic body parts, such as prosthetic limbs, fitted at the time of a surgical operation covered by your plan.</p>	 Cover up to US\$500 or £313 or €376 per device	 Cover up to US\$1,000 or £625 or €750 per device	 Cover up to US\$1,500 or £938 or €1,126 per device
Everyday medical costs			
<p>Primary medical care Visits to a GP or doctor, specialist consultations, prescribed drugs and dressings, pathology, scans, radiology and diagnostic tests received as an out-patient.</p>	 Cover for post-hospital treatment received within the 90 day period following the date you are discharged from hospital	 Full cover	 Full cover
<p>Emergency ward treatment Emergency treatment that you have received at a hospital.</p>	 Cover for essential and immediate treatment necessary as the result of an accident , plus one follow-up appointment with a medical doctor	 Full cover	 Full cover
<p>Out-patient surgical procedures Surgical procedures that do not require in-patient or day-patient treatment.</p>	 Full cover	 Full cover	 Full cover

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Cover	Bronze	Silver	Gold
Everyday medical costs (continued)			
<p>Advanced diagnostic tests MRI and CAT (CT) scans performed on the advice of a medical doctor and PET scans performed on the advice of a specialist. Your medical referral letter will be required. We will pay for one consultation only to obtain the results of the diagnostic test.</p>	 Full cover	 Full cover	 Full cover
<p>Complimentary treatments Treatment by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a medical doctor. Your medical referral letter will be required. If your condition becomes a chronic condition and ongoing treatment is aimed at maintaining it rather than curing it, no further payments will be made. Cover is limited to the maximum number of sessions shown per period of cover in respect of all treatment types.</p>	 Cover for up to 10 sessions for post-hospital treatment received within the 90 day period following the date you are discharged from hospital per period of cover	 Cover for up to 10 sessions per period of cover	 Cover for up to 15 sessions per period of cover
<p>Hormone replacement therapy When prescribed by a medical doctor following your diagnosis with premature ovarian failure (i.e. loss of ovarian function before the age of 40).</p>	 No cover	 Cover for a maximum period of 12 months from the date of diagnosis	 Cover for a maximum period of 18 months from the date of diagnosis
<p>Traditional Chinese medicine Cover is limited to the maximum number of sessions shown per period of cover.</p>	 No cover	 Cover up to US\$50 or £32 or €38 per session , up to a maximum of 15 sessions	 Cover up to US\$50 or £32 or €38 per session , up to a maximum of 20 sessions
<p>Physiotherapy Physiotherapy performed on the advice of a medical doctor. Your medical referral letter will be required. After the 10th session, if you need more sessions, you must contact us for pre-authorisation and we will require a further medical referral letter. If your condition becomes a chronic condition and ongoing treatment is aimed at maintaining it rather than curing it, no further payments will be made.</p>	 Cover for post-hospital treatment received within the 90 day period following the date you are discharged from hospital only, up to US\$1,000 or £625 or €750 per period of cover	 Full cover	 Full cover

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Cover	Bronze	Silver	Gold
Well-being benefits			
<p>Preventive health and well-being (6-month waiting period) Insured persons who are adults may use this benefit to pay for preventive health checks and tests, including:</p> <ul style="list-style-type: none"> • health screens (e.g. tests for cholesterol, high blood pressure, diabetes, anaemia, lung/kidney/liver function, cardiac risk) • Papanicolaou (PAP) test • mammogram, prostate cancer, and colon cancer screens • flu jabs • hearing test • eye examination 	 No cover	 Cover up to US\$300 or £188 or €226 per period of cover	 Cover up to US\$750 or £465 or €563 per period of cover
<p>Vaccinations Insured persons who are adults may use this benefit to pay for the cost of drugs and consultations to administer all basic immunisations and booster injections required under regulation of the country in which treatment is being given, and any medically necessary travel vaccinations and malaria prophylaxis.</p>	 No cover	 Cover up to US\$150 or £94 or €113 per period of cover	 Cover up to US\$250 or £156 or €187 per period of cover
<p>Well-child benefit (12-month waiting period) Insured persons who are children may use this benefit to pay towards routine vaccinations and developmental check-ups. There is no waiting period for children added to the Silver or Gold plan within their first 30 days of life, provided one parent has been insured with us for at least 12 months on the same, or an enhanced, plan type.</p>	 No cover	 Cover up to US\$200 or £125 or €150 per period of cover	 Cover up to US\$400 or £250 or €300 per period of cover
Chronic conditions Important note: Terminal medical conditions and chronic conditions that then develop into terminal medical conditions (both to include persistent vegetative state), are not covered under these benefits, but may be covered under the 'Terminal illnesses' benefit.			
<p>Acute flare-ups Short-term treatment to treat acute flare-ups of a chronic condition – that is, unexpected complications or worsening of a chronic condition. Cover is provided in conjunction with the benefits listed elsewhere in the table of benefits for your plan type, and is subject to the limits for those benefits. For example, if you needed physiotherapy to treat an acute flare-up of an eligible chronic condition, this would be covered under the 'Physiotherapy' benefit.</p>	 Cover for in-patient, day-patient and post-hospital treatment received within the 90 day period following the date you are discharged from hospital .	 Full cover	 Full cover
<p>Monitoring and maintenance Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a chronic condition. This benefit is limited to these treatments and does not include other medical treatments (e.g. physiotherapy aimed at maintaining stability). We do not provide cover if the chronic condition is a pre-existing condition, or related condition. Any claims relating to congenital abnormalities or hereditary conditions that are chronic will not be eligible to be paid from this benefit, but may be covered under the 'Congenital abnormalities or hereditary conditions' benefit.</p>	 No cover	 Full cover	 Full cover

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Key  Full cover within annual plan benefit limit  Partial or limited cover  No cover

Cover	Bronze	Silver	Gold
<p>Rehabilitation treatment Important note: You must obtain pre-authorization for this benefit.</p>			
<p>Rehabilitation treatment you receive as an in-patient, carried out under the control and supervision of a specialist in a recognised rehabilitation hospital or unit, and only when it immediately follows in-patient treatment for illness or injury covered by your plan.</p> <p>This benefit is payable only when the admission takes place on the written recommendation of your treating specialist and the admission must take place immediately following your discharge from hospital.</p>	<p> Cover for up to 7 days per medical condition</p>	<p> Cover for up to 15 days per medical condition</p>	<p> Cover for up to 30 days per medical condition</p>
<p>Home nursing costs Important note: You must obtain pre-authorization for this benefit.</p>			
<p>The medical services of a qualified nurse to treat you in your own home when it is medically necessary and relates directly to an illness or injury covered by your plan.</p>	<p> Cover for up to 12 weeks per medical condition</p>	<p> Cover for up to 12 weeks per medical condition</p>	<p> Cover for up to 12 weeks per medical condition</p>
<p>Terminal illnesses Important note: You must obtain pre-authorization for this benefit.</p>			
<p>Palliative and/or Hospice care, and care for persistent vegetative state</p> <p>On diagnosis of a terminal medical condition covered by your plan, all costs for treatment received on the advice of a medical practitioner or specialist for the purpose of offering relief of symptoms. This includes all hospital or hospice accommodation, and nursing care by a qualified nurse.</p> <p>All treatment and care received after you have been in a persistent vegetative state for a period of eight consecutive weeks due to an injury or illness covered by your plan.</p>	<p> Lifetime limit of US\$25,000 or £15,625 or €18,750</p>	<p> Lifetime limit of US\$50,000 or £31,250 or €37,500</p>	<p> Lifetime limit of US\$100,000 or £62,500 or €75,000</p>
<p>Dental costs Important notes: All dental treatment must be carried out by a dentist in a hospital emergency room or dental surgery. Treatment for damaged crowns, dentures, bridge work or false teeth is only covered under the 'Dental plus' benefit. We do not cover orthodontic consultations or treatment of any kind. Surgical procedures to remove wisdom teeth are covered elsewhere within the 'Hospital costs' benefits.</p>			
<p>Emergency restorative treatment you receive as an in-patient</p> <p>In-patient treatment required to restore sound and natural teeth following an accident covered by your plan, provided that treatment is received within 15 days of the accident.</p>	<p> Full cover</p>	<p> Full cover</p>	<p> Full cover</p>
<p>Emergency restorative treatment you receive as an out-patient</p> <p>Out-patient treatment required to treat or replace sound and natural teeth which are lost or damaged following an accident, provided that treatment is received within 72 hours of the accident.</p>	<p> No cover</p>	<p> Cover up to US\$500 or £313 or €376 per period of cover</p>	<p> Cover up to US\$1,000 or £625 or €750 per period of cover</p>

Individual Global Health Elite Plan Agreement 2017

Key  Full cover within annual plan benefit limit  Partial or limited cover  No cover

Cover	Bronze	Silver	Gold
Dental costs (continued)			
<p>Dental basic (6-month waiting period) We will pay for the following basic dental costs:</p> <ul style="list-style-type: none"> • screening (e.g. checks, X-rays, assessments) • scaling and polishing • sealing • fillings (both composite and amalgam) • simple extractions • root canal treatment <p>The 'Dental basic' benefit is optional on the Silver plan, and covered as standard on the Gold plan.</p>	 No cover	 Cover up to US\$1,000 or £625 or €750 per period of cover , subject to a 20% co-insurance (only if 'Dental basic' option is selected)	 Cover up to US\$1,500 or £938 or €1,125 per period of cover
<p>Dental plus (12-month waiting period) We will pay for the following advanced dental costs:</p> <ul style="list-style-type: none"> • denture repair • full/partial dentures • dental bridges • crowns, inlays, and onlays • dental implants <p>The 'Dental plus' benefit is optional on the Silver and Gold plans.</p>	 No cover	 Cover up to US\$1,500 or £938 or €1,125 per period of cover , subject to a 20% co-insurance (only if 'Dental plus' option is selected)	 Cover up to US\$1,500 or £938 or €1,125 per period of cover , subject to a 20% co-insurance (only if 'Dental plus' option is selected)
<p>Maternity costs Important notes: Dependant children included in your plan are not eligible for these benefits. We do not cover the treatment of any newborn child born following assisted reproduction (e.g. IVF) in the event of the birth occurring within 36 weeks of conception. Any charges that would have been incurred as the result of normal childbirth (including planned caesarean section if this was scheduled) will be paid from the 'Routine maternity care and childbirth' benefit and cannot be claimed under any other benefit. Any subsequent additional surgeons', anaesthetists' and theatre fees that occur as a result of a complication which necessitates an emergency surgical procedure will be covered under the 'Childbirth necessitating an emergency surgical procedure' benefit. We do not cover pregnancy testing. We do not cover pre-natal classes or doulas. We do not cover termination of pregnancy or any treatment or investigations that arise as a result of complications relating to termination of pregnancy.</p>			
<p>Routine maternity care and childbirth (10-month waiting period) We will pay for the following routine maternity costs:</p> <ul style="list-style-type: none"> • pre-natal tests and examinations • post-natal treatments and examinations • natural childbirth • childbirth by planned caesarean section • home birth • supplements and vitamins as recommended by a medical doctor <p>The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any hospital accommodation costs will be limited to the cost of a standard room.</p>	 No cover	 No cover	 Cover up to US\$15,000 or £9,375 or €11,250 per pregnancy

Individual Global Health Elite Plan Agreement 2017

Key  Full cover within annual plan benefit limit  Partial or limited cover  No cover

Cover	Bronze	Silver	Gold
Maternity costs (continued)			
<p>Complications of pregnancy (10-month waiting period) In-patient or day-patient treatment necessary as a direct result of a complication of pregnancy. We do not provide cover under this benefit for childbirth. Childbirth is however covered elsewhere within this section. We do not provide cover under this benefit arising from a pregnancy established through assisted reproduction (e.g. IVF) until after the standard 12-week scan, irrespective of how long you have been covered by the plan.</p>	<p> Cover up to US\$4,800 or £3,000 or €3,600 per period of cover</p>	<p> Cover up to US\$15,000 or £9,375 or €11,250 per period of cover</p>	<p> Full cover</p>
<p>Childbirth necessitating an emergency surgical procedure (10-month waiting period) Surgeons', anaesthetists' and theatre fees for childbirth which necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure. This includes childbirth by emergency caesarean section.</p>	<p> No cover</p>	<p> No cover</p>	<p> Full cover</p>
<p>Cover for newborn babies (10-month waiting period) We will pay the following costs during your baby's first 90 days of life provided you have been insured by the Silver or Gold plan for a period of 10 continuous months at the baby's date of birth:</p> <ul style="list-style-type: none"> • treatment your newborn baby receives as an in-patient or day-patient (including treatment of birth defects and congenital or hereditary conditions) • accommodation costs for one parent to stay with the newborn baby if the baby is hospitalised • any hospital accommodation costs for the newborn baby • basic newborn healthcare (physical examination, Vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, and blood tests for PKU, congenital hypothyroidism and G6PD) <p>The limits shown apply to each pregnancy, regardless of the number of children born.</p>	<p> No cover</p>	<p> Cover up to US\$10,000 or £6,250 or €7,500 per pregnancy</p>	<p> Cover up to US\$100,000 or £62,500 or €75,000 per pregnancy</p>
Expat benefits			
<p>Medevac basic If you, (or any child covered by the newborn benefit within its first 90 days of life) have a life-threatening or limb-threatening condition covered by your plan which requires immediate treatment that cannot be adequately provided locally the Assistance Service will arrange for you to be moved by air and/or by surface transportation, to the nearest hospital within your area of cover where appropriate medical treatment is available. We do not cover any other costs under this benefit such as hotel accommodation charges. We do not cover emergency evacuation or repatriation to the USA. The Assistance Service retains the absolute right to decide whether your medical condition is eligible for evacuation, where you are evacuated to and the means and method of the evacuation.</p>	<p> Full cover</p>	<p> Full cover</p>	<p> Full cover</p>

Individual Global Health Elite Plan Agreement 2017

Key  Full cover within annual plan benefit limit  Partial or limited cover  No cover

Cover	Bronze	Silver	Gold
Expat benefits (continued)			
<p>Medevac plus</p> <p>The following benefits apply in addition to those under the 'Medevac basic' benefit:</p> <p>Evacuation if you, (or any child covered by the newborn benefit within its first 90 days of life) need advanced imaging or cancer treatment such as radiotherapy or chemotherapy that cannot be adequately provided locally.</p> <p>All eligible evacuations will include transportation to your home country if it is within your area of cover, or to your country of residence.</p> <p>If you request repatriation to your home country or to your country of residence, it may, in some cases, not be appropriate immediately due to your medical condition. In these cases we will first evacuate you to the nearest place where appropriate treatment is available within your area of cover. Once you have been stabilised, we will then repatriate you to your home country if it is within your area of cover, or your country of residence.</p> <p>If you do not have anyone to accompany you on an evacuation, we will pay the economy class round-trip airfare to have one relative or friend flown from anywhere in the world to be with you while you receive your treatment. We will also pay up to US\$150 per day (for up to 30 days), towards their hotel accommodation costs until you are fit to travel and treatment can be administered in your country of residence.</p>	<p>Covered only if you have selected the optional 'Medevac plus' benefit</p>	<p>Covered only if you have selected the optional 'Medevac plus' benefit</p>	<p>Covered only if you have selected the optional 'Medevac plus' benefit</p>
<p>24 medical assistance helpline</p> <p>If you have a medical emergency which requires immediate medical assistance, you can contact our 24-hour helpline (provided by CEGA) at +44 (0) 1243 621155 or william.russell@cegagroup.com.</p>	 Full cover	 Full cover	 Full cover
<p>Return airfare</p> <p>Following an emergency evacuation covered by your plan, we will pay for your economy return airfare to your country of residence.</p>	 Full cover	 Full cover	 Full cover
<p>Expenses of a companion</p> <p>The transportation costs of another person to accompany you on your emergency evacuation, and their economy class ticket back. If it is not possible for them to accompany you on your medical evacuation because of the method of evacuation, we will pay either for their economy class round-trip airfare on a scheduled flight, or their suitable round-trip surface transportation, whichever is the most appropriate.</p> <p>If your companion is then staying with you while you are hospitalised following your evacuation, we will pay towards the costs of their hotel accommodation up to US\$72 per night on the Bronze plan, US\$96 per night on the Silver plan, and US\$250 per night on the Gold plan (limited to a maximum of 15 nights per period of cover).</p>	 Full cover	 Full cover	 Full cover

Individual Global Health Elite Plan Agreement 2017

Key ○ Full cover within annual plan benefit limit ○ Partial or limited cover ○ No cover

Cover	Bronze	Silver	Gold
Expat benefits (continued)			
<p>Compassionate home visit (12-month waiting period) If a close family member dies during your period of cover we will pay for your round-trip economy airfare to attend the funeral. Your travel must take place within 28 days of the date of death.</p>	<p>○ Lifetime limit of one claim per insured person</p>	<p>○ Lifetime limit of one claim per insured person</p>	<p>○ Lifetime limit of one claim per insured person</p>
<p>Repatriation of mortal remains If you die as the result of a condition that is covered by your plan while you are outside your home country, we will pay for your body or ashes to be transported to your home country or country of residence. This benefit is not available if a claim is made for 'Burial or cremation' at the place where you died. We do not provide cover under this benefit if the cause of death is suicide.</p>	<p>○ Full cover</p>	<p>○ Full cover</p>	<p>○ Full cover</p>
<p>Burial or cremation If you die as the result of a condition that is covered by your plan while you are outside your home country, we will pay for you to be buried or cremated at the place where you died. This benefit is not available if a claim is made under the 'Repatriation of mortal remains' benefit. We do not provide cover under this benefit if the cause of death is suicide. We do not provide cover under this benefit if you die in your home country. We do not provide cover under this benefit for the costs of a religious practitioner.</p>	<p>○ Cover up to US\$1,600 or £1,000 or €1,200</p>	<p>○ Cover up to US\$1,600 or £1,000 or €1,200</p>	<p>○ Cover up to US\$1,600 or £1,000 or €1,200</p>

Costs not covered by your plan

The following are not covered by **your plan**, as well as any specific exclusions on **your certificate of insurance**, and other exclusions given within the **table of benefits**. Other benefits, as given within the **table of benefits**, may also be restricted or excluded depending on **your plan type**.

All conditions, tests, **treatments** or increased **treatment** costs **you** incur because of complications that occur directly or indirectly as a consequence of **treatment** of any excluded condition will also not be covered.

As well as the exclusions stated below, **we** also do not cover the following fees:

- fees for the completion, or providing of, claim forms or medical reports
- bank charges incurred as a result of **us** transferring money
- losses **you** may incur due to fluctuations in exchange rates
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information
- administration, registration, or cancellation fees charged by **hospitals, doctors**, or other providers of medical services
- any charges made by **your** bank or credit card company

Addictive conditions/disorders and alcohol, drug and solvent abuse

Treatment related to:

- addictions (such as alcohol or drug addiction) or substance abuse (such as alcohol, drug or solvent abuse)
- any illness or injury needed directly or indirectly as a result of any such abuse or addiction
- any illness or injury needed directly or indirectly as a result of being under the influence of any substance (such as alcohol, drugs or solvents)

Allergy testing and/or desensitisation

Treatment related to:

- allergy testing by hair analysis
- allergy desensitisation or food neutralising injections

We will only pay for patch testing if **you** have been referred by a **medical doctor** and this is limited to one patch testing investigation over the lifetime of **your plan**. **Your medical referral letter** will be required.

Alternative treatment and therapies

Alternative **treatments** and therapies, including, but not limited to, aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Ayurveda and massage therapy.

Birth control, sexual problems and gender reassignment

Treatment directly or indirectly arising from or connected with:

- contraception or sterilisation
- sexual problems (including impotence and decreased libido)
- gender reassignment

Chemical exposure and contamination

Treatment costs directly or indirectly related to **treatment** for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

Circumcision

Unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

Convalescence, rehabilitation, nursing homes and health spas/hydros

- **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence, **rehabilitation** or supervision
- relaxation or rest **treatments**, or **treatments** in nature cure clinics, health spas and health hydros
- private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode

Please note however that some/all of the above may be covered under the '**Rehabilitation treatment**' benefit.

Cosmetic surgery and treatment

Investigations or **treatment** related to:

- cosmetic or aesthetic **treatment** to enhance **your** appearance, even when medically prescribed
- the removal of fat or surplus tissue
- breast enlargement or reduction
- sclerotherapy for spider veins, **treatment** of superficial varicose veins
- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation disorder

Criminal activity

Treatment arising from or related to injuries sustained while **you** are engaged in a criminal, illegal or unlawful act.

Development, learning difficulties, speech disorders and behavioural problems

Consultations, tests required to diagnose, or **treatment** of or related to:

Individual Global Health Elite Plan Agreement 2017

- developmental delays
- learning and education difficulties, including, but not limited to, dyslexia and speech disorders
- behavioural problems, including, but not limited to, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and Tourette's syndrome
- physical development of any kind
- teething

Please note however that tests for some of the above may be covered under the 'Well-being benefits' section.

Dietician

Treatment or advice by a dietician or nutritionist. Please note however this may be covered following a diagnosis of cancer – please see the 'Dietician' benefit within the 'Cancer **treatment**' section.

Experimental drugs and treatments

Treatment which is experimental, or has not been proven to be effective. This includes, but is not limited to:

- **treatment** that is provided as part of a clinical trial
- **treatment** that has not been approved by the National Institute for Clinical Excellence (NICE)
- any drug or medicine that is prescribed for a purpose for which it has not been licensed for or approved by NICE
- any combination of drugs or medicines prescribed for the purpose for which they have not been licensed for, or approved by NICE

Eyesight

- **treatment** to correct **your** eyesight, such as laser **treatment**, refractive keratotomy and photorefractive keratotomy
- spectacles, and other visual aids, **treatment** of strabismus (squint) or amblyopia (lazy eye)
- sight tests - please note however these may be covered under the 'Well-being benefits' section

Failure to follow medical advice

- **treatment** arising from or related to **your** unreasonable failure to seek or follow medical advice and/or prescribed **treatment**, or **your** unreasonable delay in seeking or following such medical advice and/or prescribed **treatment**
- complications arising from ignoring such advice

Foetal surgery

Surgery undertaken on a child while it is in its mother's womb.

Genetic testing and/or genetic engineering

Please note however that genetic testing may be covered under the 'Well-being benefits' section, and genome testing may be covered under the 'Cancer genome tests' benefit within the 'Cancer **treatment**' section.

Hearing

- **treatment** for or arising from deafness caused by maturing or ageing
- **treatment** for or arising from deafness caused by a congenital abnormality if either the abnormality was diagnosed, or **you** were showing signs or symptoms of the abnormality, before **your date of entry** - please note however that this may be covered for newborn children during their first 90 days of life under the 'Cover for newborn babies' benefit
- hearing aids
- hearing tests - please note however these may be covered under the 'Well-being benefits' section

Infertility, ivf and assisted reproduction

- testing or diagnosis related to infertility
- infertility **treatment**, **assisted reproduction** (e.g. IVF **treatment**), including establishing pregnancy

Menopause and puberty

- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty
- bone densitometry
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (HRT) - please note however this may be covered under the 'Hormone replacement therapy' benefit within the 'Everyday medical costs' section if **you** suffer loss of ovarian function before the age of 40

Nasal septum deviation

Treatment related to nasal septum deviation and nasal concha resection.

Persistent vegetative state and neurological damage

We will not pay for **treatment** while staying in **hospital** for more than eight continuous weeks for permanent neurological damage, or if **you** are in a persistent **vegetative state**, apart from eligible cover under the 'Terminal illnesses' benefit.

Pre-existing medical conditions or related conditions

Treatment related to:

- any **pre-existing** and **related conditions** which **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise
- any **pre-existing medical conditions** of the following types and any **related conditions**, if **you** have ever had them at any time before **your date of entry**, unless **we** have agreed otherwise:
 - brain or nervous system conditions
 - cancer, tumours or growths
 - heart or circulatory conditions
 - psychiatric or psychological conditions, drug and alcohol issues or sleep disorders

Individual Global Health Elite Plan Agreement 2017

Preventive surgery

Surgery when no physical signs or symptoms are shown, or diagnosis has been made.

Professional sports and motorised racing as an amateur or a professional

Treatment for an illness or injury related to:

- participation, to include training for or practising for, in any kind of professional sport or professional racing (by professional we mean sport where **you** are being paid to participate)
- participation, to include training for or practising for, in any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle

Scalp conditions

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia
- wigs – please note however this may be covered following chemotherapy – please see the ‘Wigs’ benefit

Search and/or rescue

- search and/or rescue operations, including, but not limited to, mountain rescue or rescue from ski slopes or pistes
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht

Second opinions or duplicate tests

Second or subsequent opinions from a **medical doctor**, **medical practitioner** or **specialist** or for duplicate tests for the same condition.

Self-inflicted injuries

Treatment of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

Sexually transmitted diseases

Treatment related to sexually transmitted diseases including genital/anal warts.

Sleep disorders

Diagnostic tests for or **treatment** of any sleep related disorder, including, but not limited to, insomnia, snoring and sleep apnoea.

Stem cell harvesting

Stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

Sundry medical supplies

Non-prescribed items such as hot and cold packs and support bandages.

Travel costs

Travel costs including airfares and hotel accommodation, unless specifically covered under the ‘Expat benefits’ section.

Treatment by a related party

Treatment provided by and/or under the control of and/or on referral from:

- any family member, including, but not limited to, a spouse, partner, parent, brother, sister, child, grand-parent, grand-child, uncle or aunt
- any **medical services provider**, **medical practitioner** or **specialist** where the **insured person** has a financial interest and/or a professional interest, including, but not limited to, employees, employers, consultants and owners

Vitamins, dietary supplements and natural substances

Naturally available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals and organic substances.

Please note however these may be covered under the ‘Routine maternity care and childbirth’ benefit.

War and terrorism

Treatment arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of siege, or attempted overthrow of government unless **you** are an **innocent bystander** who is not in a country or region within a country that the British Foreign and Commonwealth Office has advised its citizens to leave.

Weight-related conditions and eating disorders

Investigations or **treatment** related to:

- obesity, or which is necessary because of obesity
- weight monitoring or control, such as slimming classes, aids and drugs
- bariatric surgery, or complications resulting from bariatric surgery
- eating disorders of any kind, such as anorexia nervosa or bulimia

Wilful exposure to needless danger

Treatment of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.

Making a claim

As stated in the **table of benefits**, there are certain benefits and **treatments** for which **you** must obtain pre-authorisation.

If **you** need to **claim** for a benefit or **treatment** for which **you** must obtain pre-authorisation, **you** must contact **us** in advance of starting **your treatment** and give **us** all the information **we** require to assess if **your** proposed **treatment** will be eligible for cover under **your plan**. If **your** proposed **treatment** is eligible for cover, **we** will pre-authorise all eligible expenses. **We** will not pay for any **treatment** costs or expenses that have not been pre-authorised by **us** in advance.

Eligible medical services providers

You have the freedom to choose when and where **you** receive **your medical treatment** within **your area of cover**. **We** do not have **hospital** lists which restrict where **you** can have **your treatment**.

If you have Area Two or Area Three cover and you seek treatment in the USA

All **treatment** **you** receive in the USA must be pre-authorised in advance by **us** or by the **Assistance Service**. **We** will not pay for any **treatment** in the USA that has not been pre-authorised, other than the first consultation.

If **we** instruct a local agent to arrange the billing and/or cost adjustment of **your medical treatment** expenses in the USA, any fees charged by the local agent will be deducted from the USA benefit limit available under **your plan**, as stated in the '**Your area of cover**' section.

If you are admitted to hospital

All **in-patient** and **day-patient hospital treatment** must be pre-authorised by **us** or by the **Assistance Service**.

Please contact **us** as soon as **you** know **you** need to have **in-patient** or **day-patient treatment** so **we** can contact the **hospital** to obtain the necessary medical information.

We will ask **you** to complete a pre-authorisation form and a consent form for the **hospital** to release details to **us**. Once **we** have received all information required from the **hospital** and **yourself** (to include any additional information **we** may request) **we** will advise **you** if the proposed **treatment** will be covered by **your plan**.

Please note, if **you** contact **us** less than 48 hours in advance of **your** admission **we** may be unable to authorise **your treatment** in time and **you** may be required to pay for the **treatment yourself** and submit a **claim** for reimbursement.

If **you** are admitted to **hospital** in an emergency and it is not reasonably possible for **you** to contact **us** in advance of **your** admission, **we** will consider **your claim**, provided **you** contact **us** within 72 hours of **your** admission. If **you** do not contact **us** within 72 hours, **we** may decline **your claim**, or subject **your claim** to 20% **co-insurance**.

If you have out-patient treatment

Although most **out-patient treatment** does not need to be pre-authorised in advance by **us**, **we** recommend that **you** do contact

us or the **Assistance Service**, even in the event of an emergency, before undergoing any **treatment** to ensure that the **treatment** is covered by **your plan**.

How to claim back your eligible treatment costs

If **you** are claiming for a medical condition, **you** will need to download a claim form from **our** website.

Please complete section A of the claim form. If the total amount of **your claim** is likely to exceed US\$500 (or the foreign currency equivalent), please take the claim form with **you** when **you** visit **your doctor** and ask him or her to complete and sign section B of the claim form.

Scan the completed claim form and the fully itemised invoices and receipts for the **treatment** **you** have received, and send to claims@william-russell.com.

Even if **your claim** is less than US\$500 **we** may in some cases require **your doctor** to complete and sign section B of **your** claim form before **we** can settle **your claim**.

We can only reimburse **your claim** when **we** have fully itemised invoices and receipts which give a breakdown of the **treatment** and medical services **you** have received, and any drugs **you** have been prescribed.

Please retain **your** original invoices, receipts and claim forms for up to 12 months. **We** may require these for auditing purposes.

Claim forms are not required however when **you** are claiming for the following benefits:

Well-being and dental claims: If **you** are claiming for the well-being benefit, or dental benefit please send **us** the fully itemised invoices and receipts for which **you** are claiming reimbursement, together with **your** bank account details.

Compassionate home visit claims: If **you** are claiming for the compassionate home visit benefit please send **us** a copy of the death certificate of **your close family member**, together with a copy of the invoice for **your** round-trip airfare, stating the class of travel, and **your** bank account details.

Claims for which a medical referral letter is required

If **you** are claiming for **out-patient** physiotherapy, any **treatment** under the 'Complimentary benefits' benefit, **out-patient** psychiatric or psychotherapy **treatment**, a dietician consultation or an MRI or CAT (CT) scan **you** must also send **us your medical referral letter**. If **you** are claiming for a PET scan, **you** must also send **us your specialist's medical referral letter**.

Supplying the information required to process your claim

We can accept the information required to process **your claim** via email. Simply, scan in PDF format **your** itemised invoices, receipts, **medical referral letter** (when required) and **your** fully completed claim form and email them all to claims@william-russell.com. Please always retain the original copies of everything for a period of 12 months as **we** reserve the right to receive these documents before **we** assess **your claim**. **We** may also require them at any time for auditing purposes. Or, **you** can send the information

Individual Global Health Elite Plan Agreement 2017

required to process **your claim** by post.

You must submit **your claim** within 6 months of **your treatment** date, unless it was not reasonably possible for **you** to submit the **claim** within this time.

We will not pay fees charged by a **medical practitioner**, or anyone else, for completing a claim form.

Paying your claim

Where possible **we** will settle invoices for **in-patient** or **day-patient treatment** direct with the **hospital** or **medical services provider**. **We** will deduct any **excess** or **co-insurance** amount, as well as any other ineligible items, and **you** will be responsible for paying the shortfall direct to the **hospital** or **medical services provider**.

If **we** are paying **you** direct, **our** preferred method of payment is bank transfer.

We will only make payment to **you** or to the **medical services provider** that provided **your treatment**. Payment will not be made for **treatment** that has not been received yet.

If **we** or the **Assistance Service** pre-authorise costs which subsequently turn out to have been related to a condition which is not covered by **your plan**, **you** will be responsible for all the costs incurred, and if **we** have made any settlement on **your** behalf, **you** will be responsible for repaying to **us** the amount **we** have paid.

Exchange rates

We will settle **your claim** in the currency in which **you** pay **your premium** unless **you** instruct **us** otherwise. If **we** have to make a currency conversion, **we** will use the historic exchange rate (provided by oanda.com) applicable on the date of each separate invoice **you** submit.

Exchange rates are imported into **our** computer system overnight, each night, using the live exchange rate at the time of the import. This may vary slightly from the historic exchange rates shown on oanda.com for the relevant day, which are based on the average exchange rate for the day.

If **we** have placed a Guarantee of Payment **we** will use the exchange rate applicable on the date **we** placed the guarantee.

Excesses, co-insurance and benefit limits

The **excess** shown on **your certificate of insurance** is the amount **you** will have to pay towards the cost of **your treatment**.

If **your plan** has an **excess** and the benefit **you** are claiming for has **co-insurance** and/or limits, **we** will apply the **co-insurance** first, then the **excess**, then the limit.

If **you** have chosen a **plan** which has an **excess** per **claim**, this is the amount **you** will have to pay each time **you** make a new **claim** for **treatment** covered by **your plan**. New **claims** are those that are for a condition which is not related to an existing **claim**.

If **your claim** is for the **treatment** of a **chronic condition**, AIDS/HIV, or for **out-patient** follow-up consultations and/or tests for cancer and the **treatment** continues into a new **period of cover**, **we** will treat it as a new **claim**. In these circumstances **we** will re-apply the **excess** at **your plan renewal date** and each subsequent **plan** renewal until the **claim** is finished.

If **your claim** is in respect of the well-being benefits, **your excess** will be applied once per **period of cover**.

If **your excess** is per annum it will be applied once per **period of cover**. For example, if **your excess** is US\$250 per annum, **we** will not pay for the first US\$250 of eligible expenses **you** incur during **your period of cover**. **We** will apply one **excess** per **period of cover** irrespective of the number of **claims you** make. **You** must submit all eligible **claims** to **us** - even **claims** within **your** annual **excess**, as **we** will only be able to reimburse **you** when the value of the eligible expenses **you** incur exceeds the amount of **your** annual **excess**. When **you** renew the **plan**, the annual **excess** will apply again in respect of **your new period of cover**.

Our right to request additional information

We may need to ask for additional information to enable **us** to assess **your claim**, such as further medical reports or tests, or an independent medical examination. If **you** do not agree to supply **us** with any reasonable additional medical information **we** ask for, **we** will not be able to assess **your claim**.

If **you** require ongoing **treatment** **we** may ask for further medical information and if **we** do, the cost of providing this information must be borne by **you**. **We** are unable to return original documents such as invoices or medical letters, but **we** will send **you** copies upon request.

Our right to request a treatment review

We will not pay for **treatment** which in **our** opinion is inappropriate based on established medical and clinical practice and **we** are entitled to conduct a review of **your treatment** when it is reasonable for **us** to do so.

Illness or injury caused by a third party

If **you** are claiming for an illness or injury that was caused by some other person or organisation (a third party) **you** must let **us** know in writing straight away, or tell **us** on **your** claim form. **We** will then pay benefit in accordance with the terms of this **agreement** provided that **you** take all necessary steps **we** ask **you** to take to assist **us** in recovering **our** costs from the person or organisation at fault (such as through their insurance company) the cost of the **treatment** paid for by **us**, plus interest, at **your** own expense.

If **you** pursue a personal **claim** for damages against the third party, **you** must provide **us** with the full name and address of the solicitor handling the action. **We** will then contact the solicitor to register **our** interest and seek to recover **our** own costs, plus interest, in addition to any damages that **you** may recover or be awarded. **We** reserve the right to appoint **our** own solicitor to act on **your** behalf in this matter and to take over the conduct of the action.

If **you**, or any **insured person**, are able to recover from the third party (whether or not through legal action) compensation that includes any **treatment** costs **we** have paid, **you** must repay that amount to **us**. Any interest that **you** or any **insured person** may also have been awarded that relates to the recovered **treatment** costs **we** have paid for must also be repaid to **us**. If **you** only receive a proportion of **your claim** for damages then **you** must repay to **us** the same proportion of **our** costs.

If you are covered by another insurance plan

If **you** have any other insurance that covers the same costs as **we** do, **we** will only pay **our** proportionate share of the **claim**. In this event, **you** must provide **us** with full details of the other insurance, including the name and address of the other insurer, their policy and **claim** number and any other relevant information, when **you** first submit **your claim**. **We** will then contact the other insurance company to ensure that **we** only pay **our** proportion of the **claim**. This may involve **us** sending **your** personal information regarding **your claim** to the other insurer.

General information about your plan

Premiums

Plan premiums

The **plan premiums** are age-related and will increase as **you** get older. The **plan premiums** are not guaranteed for the duration of **your plan** and are subject to annual review.

All **premiums** are payable in advance of the **premium due date** as shown on **your** invoice. **Premiums** must be paid in the **plan** currency.

You may pay **your premiums** by the following method:

- annually by cheque or direct debit from a UK bank account, bank transfer, or an acceptable credit or debit card
- half-yearly, quarterly, or monthly by an acceptable credit or debit card, or by direct debit from a UK bank account

We can only accept credit or debit card payments if **you** have a sterling, euro or dollar **plan**.

We can only accept direct debit payments if **you** have a sterling **plan**.

If **you** pay **your premiums** by direct debit, **we** will require **your** original, signed direct debit mandate before **we** can commence **your plan**.

If **you** live in Bali, China, Hong Kong, Japan, Macau, Singapore or Taiwan **you** must tell **us** and **you** must pay the applicable Orchid rate.

If insurance **premium** tax or any similar charge is levied by the government in **your country of residence**, **you** must also pay to **us** the amount of such tax.

Premiums must be paid directly to **us**. If **you** pay **your premiums** to anyone else such as an intermediary or insurance broker, then that person is acting on **your** behalf as **your** agent. **We** are not responsible for any **premiums** paid to any third party.

When **you** provide **us** with **your** debit/credit card details or direct debit mandate **you** are authorising **us** to debit **your** account with the appropriate **premiums** due for the current **plan** year and for all subsequent renewal **premiums** due as invoiced by **us**, until such time as **you** advise **us** in writing that **you** wish to alter **your** payment method or cancel **your plan**. It is **your** responsibility to keep **us** informed about **your** current credit/debit card details. Provided the details **we** hold for **you** are still valid, **we** will automatically debit **your** account with **your** renewal **premium** on or before **your** renewal date.

We will also allow sums paid by another insurer to be offset against the **excess** payable under **your plan** with **us**, subject to receiving confirmation from the other insurer of any amounts already paid by them, and subject to the **treatment** costs being eligible for cover under **your plan** with **us**.

Unpaid or late premiums

We will automatically cancel **your** cover if **you** fail to pay **your premium** on or before the **premium due date**, or if **we** are unable to collect **your premium** from **your** credit/debit card, or by direct debit for any reason.

We may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **you** pay the outstanding **premium** within 30 days of the **premium due date**. During this 30 day period **we** will not accept any **claims** for **treatment** incurred on or after the **premium due date** until **you** have paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **you** do not pay **your premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**. Once **we** have cancelled **your plan**, **you** will have to complete a new **application form** which will be subject to **medical underwriting**.

Making changes

Enhancing your cover

You may apply to enhance **your** cover at any time by completing a new **application form**, and the enhanced cover will be subject to **medical underwriting**.

If **we** accept **your application** for enhanced cover, **we** will issue an invoice for the increased **premium**. **Your** enhanced cover will commence from the date **we** receive **your premium**, provided it is received within 30 days of the date of **your application**.

If **you** enhance **your plan type**, **claims** in respect of benefits that are subject to a **waiting period** will be assessed in accordance with **your** former **plan type** until the expiry of **your** new **plan's** **waiting period** for that benefit. For example, if **you** are covered by the Silver **plan**, and **you** enhance **your plan** to the Gold **plan**, any benefit payable in respect of the 'Well-being benefits' section will be restricted to the Silver **plan** benefit limit for the first 6 months of **your** Gold **plan**.

If **you** apply to reduce **your excess**, **we** will continue to apply **your** previous **excess** to any **claim** for any condition that first manifests itself after **your** original **date of entry** to **your** previous **plan**, but before the date **your excess** is reduced.

Reducing your cover

If **you** wish to reduce the cover under **your plan** in any way, **you** must tell **us** in writing and **we** will make the change from **your** next **renewal date** only.

We may refuse any request to change **your excess** to a per annum basis.

If **you** wish to cancel the optional 'Dental basic', 'Dental plus' or 'Medevac plus' benefits, they will be cancelled for all **insured persons** on **your plan**.

Changing your plan currency

Once cover under **your plan** has commenced, **you** cannot change **your plan** currency.

However **you** can cancel **your plan** and apply for a new **plan**. **You** will have to complete a new **application form** which will be subject to **medical underwriting**.

Adding dependants to your plan

You may apply for cover on behalf of **your** spouse or partner, provided they are under 70 years of age on their **date of entry**.

You may also apply for cover for **your eligible dependant** children, provided they are under 18 years old, or under 25 years old if they are in continuous full-time education. **We** reserve the right to request proof of a child being in full-time education.

We will not commence cover for a new **eligible dependant** until **we** have accepted their **application** and **we** have received payment of their **premium**.

Adding newborn babies to your plan

You may add **your** newborn child to **your plan**, without any **medical underwriting**, provided **you** notify **us** of their full name and date of birth, and make payment of their **premium**, within 30 days of their date of birth. If **you** have been insured with **us** for a continuous period of ten months or more at the date of birth, the **date of entry** can be backdated to their date of birth. The child's cover will be restricted to the cover provided by **your** (the **plan holder's**) **plan type**.

If **you** wish **your** child to have cover that is enhanced in any way in comparison to **your** (the **plan holder's**) cover, **we** will require an **application form**, and **your** child's **application** will be subject to **medical underwriting**.

If **you** do not inform **us** about the birth of **your** child within 30 days of their birth, and/or **you** do not pay the additional **premium** within 30 days of their date of birth, **you** will have to make a new **application** for **your** child to be added to **your plan**, and this **application** will be subject to **medical underwriting**.

Newborn children who have been born as a result of **assisted reproduction treatment** and born within 36 weeks of conception are always subject to **medical underwriting**.

If **your** newborn child is not added to **your plan** they may still have some cover under **your plan** for their first 90 days of life. Please see the 'Cover for newborn babies' benefit for full details.

In the event of the death of an insured person

If **you** (the **plan holder**) die, provided no **claim** has been made on **your plan**, **we** will refund any **unused premium** from **your** date of death.

If **you** (the **plan holder**) have **eligible dependants** insured under **your plan**, as the contract is between **us** and **you** as the **plan holder**, **we** will have to transfer **your eligible dependants** on to their own **plan**.

To enable **us** to do this **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your** date of death. Provided **we** receive the new **application form**, and provided **premiums** continue to be paid up to date, **we** will continue their cover as before.

If **your eligible dependants** want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **your eligible dependants** are under the age of 18, their legal guardian will have to sign the **application form** as the **plan holder** on their behalf.

If an insured **eligible dependant** dies, please inform **us** as soon as possible. If they have made no **claim** on their **plan**, any **unused premium** from their date of death will be refunded. However if the deceased **insured person** had made a **claim**, no **premium** refund will be made.

Divorce and separation

If **you** (the **plan holder**) have **your** spouse or partner included under **your plan** and **you** become separated or divorced, **we** will have to transfer **your** insured spouse or partner on to their own **plan**. To enable **us** to do this **we** will require **your** spouse or partner to complete a new **application form** which must be completed and returned to **us** within 30 days of **your** date of divorce or separation.

Provided **we** receive the new **application form**, and provided **premiums** continue to be paid up to date, **we** will continue to cover **your** insured ex-spouse or partner as before. If **your** ex-spouse or partner wants to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

When a child dependant is no longer eligible to be covered under your plan

If one of **your** children has married, or has reached the age of 18 (or the age of 25 if they are in full time education) they will no longer be eligible to be included in **your plan** from the **renewal date** following their marriage/birthday.

However, **your** child may apply to continue their cover on their own **plan**, at the applicable adult **premium** rate, provided they send **us** their completed **application form** and **we** receive the appropriate **premium** within 30 days of **your renewal date**.

If they want to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and any enhancement in their cover will be subject to **medical underwriting**.

Individual Global Health Elite Plan Agreement 2017

If **we** do not receive **your** child's **application form** and **premium** within 30 days of **your renewal date**, their cover will automatically cease from midnight on the day before **your renewal date**. If they subsequently wish to apply for cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

Changing your address, country of residence or nationality

You must inform **us** if **you** change **your** address and provide **us** with the new details.

If **you** change **your country of residence** or **you** change **your home country**, **you** must tell **us** straight away.

If **you** live in Bali, China, Hong Kong, Japan, Macau, Singapore or Taiwan **you** must tell **us** and **you** must pay the applicable Orchid rate.

If **you** have Area Four cover and **you** move to a country outside **Africa and the Indian subcontinent** **you** will no longer be eligible for Area Four cover and **you** will have to apply to change **your area of cover**, and **your application** will be subject to **medical underwriting**.

If **you** have Area One, Area Two or Area Three cover and **you** return to **your home country** **you** may continue to renew **your plan** provided that the local laws in **your home country** permit **us** to continue to offer cover to **you**, and provided that **we** agree to offer cover in that country. **We** reserve the right to refuse to offer cover in certain countries.

If the USA is or becomes your country of residence

Under the terms of this **agreement** cover is not available to **you** if the USA is or becomes **your country of residence**, irrespective of **your** nationality. If the USA becomes **your country of residence** **you** must tell **us**. **Your** cover will automatically terminate from the date on which **you** take up residence in the USA.

At renewal

Renewing your plan

You may continue to renew **your plan**, each year, regardless of **your** age or state of health, or the number or value of **claims** **you** have made. **We** will not cancel **your plan** unless **we** are entitled to do so under **our** cancellation policy.

Prior to **your plan renewal date** **we** will send **you** an invoice by email stating **your premiums** for **your new period of cover**.

Your premium for each new **period of cover** will be determined by the following:

- **your** age at the start of **your new period of cover**
- the ages of **your eligible dependants** at the start of their new **period of cover**
- the number of eligible children **you** insure
- **your plan type**
- **your area of cover**
- **your excess** amount

If **you** live in Bali, China, Hong Kong, Japan, Macau, Singapore or

Taiwan **you** must tell **us** and **you** must pay the applicable Orchid rate.

Other factors may affect **your renewal premiums**, such as general changes **we** make to **our Global Health plan premiums** annually, and changes to the discounts **we** apply to increase the standard **excess**, to the loadings **we** make to decrease the standard **excess**, to the child **premium** discounts, and to the surcharge for instalment **premiums**.

We may also change the methods of payment **we** offer.

Your premiums may also be affected by the introduction of, or increase to insurance **premium** tax or other tax, levy or charge applicable in **your** county of residence.

We may also change the benefits offered by **your plan type** and if **we** do, **we** will write to **you** before **your renewal date** to confirm these benefit changes. Any changes **we** make to **your** benefits will come into effect from the **renewal date** of **your plan**.

From time to time **we** may decide to discontinue the **plan** **you** are a member of. If this happens **we** will transfer **your** membership to another similar **plan**.

Paying your renewal premium

You must pay **your** renewal **premium** on or before the due date.

If **you** pay **your premium** by credit or debit card or by direct debit, unless **you** tell **us** not to, and provided **your** credit and debit card details are current, **we** will withdraw **your** renewal **premium** on or around its due date.

If **you** do not pay **your** renewal **premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**.

We may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **you** pay the outstanding **premium** within 30 days of the **premium due date**. During this 30 day period **we** will not accept any **claims** for **treatment** incurred on or after the **premium due date** until **you** have paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorized.

If **you** do not wish to renew **your plan** **you** must inform **us** in writing as soon as **you** receive **your** renewal **premium** invoice and prior to **your renewal date**.

Discounts

Child premium discounts

When **you** have **eligible dependant** children included in **your** (the **plan holder's**) **plan**, the child **premium** discounts will be applied as follows:

- the first child will be charged 100% of the child **premium** rate
- the second child will be charged 80% of the child **premium** rate
- the third child and all subsequent children will be charged 60% of the child **premium** rate

If a child leaves **your** (the **plan holder's**) **plan**, **we** will re-calculate the **premiums** for the remaining children with effect from the date on which the child leaves. This means that the child **premiums** **you** pay will always be based on the actual number of children **you** insure.

No claim incentive (applicable only to persons whose date of entry is prior to 1st January 2007)

For as long as **you** make no **claim** on **your plan**, **we** will use **your** age at **your date of entry** (or if **your date of entry** is before 1st January 1999 **your** age at **your renewal date** in 1999), when **we** calculate **your** renewal **premium**. This does not mean that **your premium** will remain the same each year. There are other factors that may affect **your** renewal **premiums**, such as the general rate of medical inflation that **we** apply to all of **our** **premiums** each year, insurance **premium** tax or other tax, levy or charge applicable in **your** county of residence.

If **you** make a **claim** (other than a well-being **claim**), **your** entitlement to this no **claim** incentive will cease from the date on which **you** first suffered the symptoms which gave rise to **your claim**, or from the date on which **you** first received **treatment**, whichever date is the earlier. Then, with effect from **your** next **renewal date**, **you** will be required to pay the **premium** applicable to **your** actual age at **your renewal date**.

If **we** are not notified of **your claim** until after **we** have issued **your** renewal **premium** invoice, or until after **you** have paid **your** renewal **premium**, **you** must pay to **us** the difference between the **premium** **we** invoiced before **we** knew about **your claim**, and the **premium** based on **your** actual age at **your renewal date**. If **you** pay **your** **premiums** annually, **we** will issue an invoice for the difference in **premium**. If **you** pay **your** **premiums** in instalments, **we** will debit **your** card for the difference in **premium** and adjust **your** future **premium** instalment payments. If **you** do not pay **us** the difference in **premium** **we** reserve the right to deduct the amount owing to **us** from **your claim** settlement.

This incentive does not apply in respect of **eligible dependant** children, or in respect of children insured under **your plan** who leave **your plan** and take up their own **plan**.

Cancellation

Cancelling your plan

If **you** decide **you** wish to cancel **your plan**, **you** must instruct **us** in writing by letter, email or fax. **We** will cancel **your** cover from the date **we** receive **your** written instruction unless **you** have instructed **us** to cancel **your plan** from a date in the future. **We** cannot cancel **your plan** prior to receiving **your** written instruction.

Provided there have been no **claims** made, **we** will refund any **unused premium**. If a **claim** has been made by any **insured person**, no **premium** refund will be paid.

Cancelling cover for a dependant

If cover is no longer to be provided for an **eligible dependant**, **you** must instruct **us** in writing by letter, email or fax. **We** will cancel their cover from the date **we** receive **your** written instruction unless **you** have instructed **us** to cancel their cover from a date in the future. **We** cannot cancel their cover prior to receiving **your** written instruction.

Provided there have been no **claims** made by the **eligible dependant**, **we** will refund any **unused premium**. If a **claim** has been made, no **premium** refund will be paid.

When we can cancel your plan

We have the right to cancel **your plan** immediately if:

- **you** do not pay **your premium** and other charges such as insurance **premium** tax within 30 days of any **premium due date**
- **you** are no longer eligible to be included in the **plan** or **you** move to a country where **we** are unable to offer health cover
- **you** have not provided **us** with medical information **we** have requested to enable **us** to assess a **claim** or any potential **claim** that may arise in the future
- **you** have not repaid to **us** fully any ineligible **claim** payments **we** have invoiced **you** with
- **you**, any **insured person** or any person acting on **your** behalf has made any threatening or abusive comment, or used any unacceptable language towards **us** or any member of **our** staff, or any service provider acting on **our** behalf, whether verbally (including any telephone conversation) or in writing (including any electronic communication)
- **we** reasonably suspect that any **insured person** has misled **us** or attempted to mislead **us**, whether intentionally or carelessly, either at the time of joining or when making a **claim**, by:
 - making a **claim** under this policy knowing it to be dishonest, intentionally exaggerated or fraudulent in any way
 - providing **us** with incomplete or false information
 - working with another party to provide false information to **us**
 - changing original documents

If **we** cancel **your plan** for any of the above reasons **we** will not refund any **premium** **you** have paid to **us**. **We** may also report the matter to the relevant authorities, if appropriate.

Other information

When we may apply special terms to your plan

We have the right to apply **special terms** to **your plan** if **you** give **us** inaccurate or incomplete information. Such **special terms** will be applied from **your date of entry**.

Arbitration/applicable law

All disputes arising out of or in connection with the present contract shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce of Paris by one or more arbitrators appointed in accordance with the said rules, and shall take place in Paris. The arbitration shall be conducted in English and English law shall apply. A sole arbitrator shall be appointed by the International Chamber of Commerce of Paris unless the parties to the dispute agree otherwise.

Our liability under this plan

Our liability under this **plan** is limited to paying for **treatment** or services in respect of eligible **claims** under this **plan**. The choice of provider of the **treatment** or services for which **you** are claiming under this **plan** is **your** responsibility. **We** make no representations or recommendations regarding the availability

Individual Global Health Elite Plan Agreement 2017

and standard of any **treatment** or services offered or provided by any **hospital** or **medical services provider**. We will not be held liable to **you** or any **insured person** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by any **hospital** or **medical services provider**. This **plan** represents the whole and only **agreement** between **you** and the **insurer** relating to the provision of private medical insurance.

Your responsibilities as the plan holder

It is **your** responsibility to:

- ensure that all **premiums** are paid when they are due
- inform **us** if **your** personal details, or the personal details of any **insured person**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, country of residency or **home country**

Complaints procedure

We want to provide **you** with a first class standard of service at all times. If **you** feel that **our** service has been poor or **you** feel that any decision **we** make about a **claim** is unfair and not in accordance with the terms of this **agreement**, please let **us** know. **You** may telephone or write to **us** at:

William Russell Limited
William Russell House,
The Square,
Lightwater,
Surrey, GU18 5SS, UK

T: +44 1276 486455
F: +44 1276 486466
E: enquiries@william-russell.com

The time it takes **us** to resolve **your** complaint will depend on how complex it is and how much investigation **we** have to do. **We** will always try to resolve **your** complaint as quickly as possible, keeping **you** informed of **our** progress. **We** will acknowledge **your** complaint promptly, and tell **you** who is dealing with **your** complaint so contacting **us** is easier.

We will then fully investigate **your** complaint and send **you** a detailed written report about **our** findings. **We** will clearly explain the reasons behind **our** decision and what action **we** will take to put things right, if appropriate.

We want to resolve complaints to **your** satisfaction whenever possible. If **we** cannot reach agreement with **you**, **you** may refer **your** complaint to the **insurer**.

Allianz Benelux N.V.
Coolingel 139, Postbus 64,
NL-3000 AB Rotterdam,
Netherlands

If **you** are dissatisfied with the response **you** receive from the **insurer** **you** may submit a complaint to the Netherlands Financial Services Complaints Institute:

Klachteninstituut Financiële Dienstverlening (Kifid)
Postbus 93257,
2509 AG Den Haag,
Netherlands

E: consumenten@kifid.nl

If **your** complaint relates to a service provided to **you** by William Russell Limited, for example a delay in providing **you** with information or documents, or a complaint about any aspect of **our** sales process, and more than 8 weeks from the date of **your** complaint **you** haven't received **our** final response, or **you** are dissatisfied with **our** final response **you** may write to The Financial Ombudsman Service.

The Financial Ombudsman Service
Exchange Tower,
London, E14 9SR

T (inside the UK): 0800 023 4567
T (outside the UK): +44 207 9640 500
F: 020 7964 1001
W: financial-ombudsman.org.uk
E: complaint.info@financial-ombudsman.org.uk

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms. If **you** are going to ask the Financial Ombudsman to review **your** case, **you** should do so within 6 months of **us** giving **you** **our** final decision on **your** complaint.

If **you** contact the Financial Ombudsman Service, this does not affect **your** right to take legal action if **you** are dissatisfied with, and do not accept the outcome of their review.

Data protection notice

We think it is important for all **our** customers to be made aware of what information **we** hold about them and to have the reassurance of knowing that **we** comply with the Data Protection Act 1988 and the EU Data Protection Directive 95/46/EC.

We will use **your** information (including information provided about **your** eligible dependants) for the purposes of underwriting and administering **your** plan and processing **claims**. By taking out a **plan** with **us**, **you** agree to **us** processing **your** personal information and sensitive personal information (e.g. health information). **We** will also use **your** information for statistical data analysis, management information and fraud prevention purposes.

If **you** wish to make a **claim** on **your** plan, this will invariably mean that **you** will have to provide **us** with information regarding **your** medical condition which **we** will then process in order to administer **your** claim.

Please note calls to William Russell Limited are recorded and may be monitored and used for training purposes.

Who we may give personal information to

We may disclose **your** personal information to **our** business associates, agents and service providers for the purposes above. **Your** information may be processed by service providers in a country outside the European Economic Area, which may not have the same standard of data protection as in the UK.

We will ensure appropriate safeguards are in place to protect **your** information. **We** will pass **your** information to any legal or regulatory body if **we** are required to do so.

We may also use **your** information or give it to others, for research, statistical purposes or to improve **our** services, but **we** will remove **your** name and address from this first.

Individual Global Health Elite Plan Agreement 2017

If **you** have appointed an insurance adviser **we** will send them copies of correspondence relating to **your plan** and any renewal documentation. **We** may disclose information about a **claim** to them, although no medical information will be sent to them without **your** consent.

Your information may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper **claims**.

Processing claims

In the event of a **claim** **we** may have to give some information to those involved in **your treatment** or care, and/or **your** representative (if **you** have chosen one), this will be done confidentially.

An **insured person** aged 16 or over has the right to confidentiality in relation to their **claims** and information. In order for them to exercise this right please contact customer services.

If **you** have another insurance **plan** that covers the same costs that **you** are claiming from **us**, then **we** may also disclose **your** relevant personal information to that other insurer so that **we** can ensure **we** only pay **our** proportion of the **claim**.

Definitions

This section explains what **we** mean by certain words and phrases bolded in this **agreement**.

Accident

A sudden, unexpected, unusual, specific, violent, external event which occurs at a single identifiable time and place independently of all other causes, which results directly, immediately and solely in physical bodily injury which results in a loss. In no event shall the contracting of any disease and/or illness (including, but not limited to, heart attack, stroke or cancer), nor the injection or ingestion of any substance, be considered an **accident**. An event which directly or indirectly exacerbates a previously existing physical bodily injury shall not be considered an **accident**.

Acute medical condition

A disease, injury or illness that is likely to respond quickly to **treatment** which aims to return **you** to the state of health **you** were in immediately before suffering the disease, illness or injury, or which leads to **your** full recovery.

Advanced imaging

Diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging (PET).

Africa and the Indian subcontinent

Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde Islands, Central African Republic, Chad, Congo (Brazzaville), Djibouti, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mayotte, Morocco, Mozambique, Namibia, Niger, Nigeria, Republic of Sudan, Rwanda, Sao Tome & Principe, Senegal,

Obtaining a copy of the information we hold about you

You have the right to request a copy of the information **we** hold about **you** (for which **we** may charge a fee) and to have any inaccurate information corrected by writing to **us** at the below address. Where information has been supplied by a **medical practitioner**, **you** should be aware that **we** need their consent before **we** can supply this to **you**, or alternatively **you** can request such information direct from the practitioner.

Data Protection Officer
William Russell Limited
William Russell House,
The Square,
Lightwater,
Surrey, GU18 5SS, UK

Disposal of information

We will continue to hold information about **your plan** for a reasonable period of time after it has ended. **We** will then dispose of **your** personal information in a responsible way to maintain **your** confidentiality.

Sierra Leone, Somalia, South Africa, South Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, West Sahara, Zaire (Democratic Republic of Congo), Zambia, Zimbabwe, Ascension Island, St Helena, Equatorial Guinea and the Indian subcontinent countries of Afghanistan, Bangladesh, Bhutan, Myanmar, British Indian Ocean, Comoros, Heard Island, India, Maldives, Mauritius, Nepal, Pakistan, Seychelles and Sri Lanka.

Agreement

This booklet. The **agreement** should be read in conjunction with **your** completed and signed **application form** and **your certificate of insurance**. Together these items make up **your** Global Health **plan** contract with **us**.

Application/Application form

The **application form** **you** have completed and signed on behalf of **yourself** and on behalf of any **eligible dependants** for whom cover is requested. Please note that on some occasions an alternative form such as a health declaration or an upgrade form may be required to be completed instead of a full **application form**. **We** will advise **you** when this is the case. The alternative form will then be classed as the **application/application form** for the purpose of this **agreement**. Information on previously completed **application forms**, if applicable, may also be used by **us** for underwriting and **claims** assessment reasons.

Area of cover

The territorial limits of **your plan**.

Assistance Service

The emergency assistance company contracted by **us** to provide assistance services to **plan** members at the time of **your claim**.

Individual Global Health Elite Plan Agreement 2017

The contact details for the **Assistance Service** can be found in the 'Contact details' section at the front of this **agreement**.

Assisted reproduction

The use of medical techniques, including, but not limited to, in-vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), egg donation and intra-uterine insemination (IUI) with ovulation induction, received during the 3-month period prior to conception.

Caribbean country or island

All countries in the Caribbean region including the West Indies and all islands surrounded by or bordering the Caribbean Sea.

Certificate of insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan type you** have bought, the currency **you** selected, **your area of cover, period of cover, date of entry, renewal date, excess amount, special terms, your country of residence, your home country**, and the schedule of **insured persons**. The schedule of **insured persons** lists the persons insured by **us** under **your agreement** with **us**. If there are any changes to the details on **your certificate of insurance** we will issue **you** with a new one confirming the changes.

Chronic condition

A disease, illness or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- **you** need to be rehabilitated or specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

Claim

A course of **treatment** for a specific illness, injury, medical condition, dental condition or pregnancy, or the use of an expat benefit.

Close family member

Your spouse, civil partner, a co-habiting partner, parent, brother, sister, child or grand-child.

Co-insurance

A contribution that **you** must make towards the eligible costs of **your claim**.

Complications of pregnancy

Treatment received for a medical condition which arises because of the antenatal or postnatal stages of pregnancy.

Congenital condition

Whether hereditary or not, any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not, or any deformity arising during the antenatal stages of pregnancy, or caused during childbirth.

Country of residence

The country in which **you** are habitually resident as specified on **your application form** or subsequently advised to **us** in writing.

Date of entry

The date on which cover for **you**, and each of **your** dependants, first commenced. **Your date of entry** is as stated on **your certificate of insurance**.

Day-patient

A patient admitted to a **hospital** or **day-patient** unit for a medical procedure which for medical reasons could not have been performed on an **out-patient** basis and which requires them to occupy a **hospital** bed for a period of medically supervised recovery, but it is not **medically necessary** for them to occupy a bed overnight.

Dental treatment

Dental procedures undertaken by **your dental practitioner** which are clinically necessary for the maintenance and/or restoration of oral health, and are provided in accordance with accepted standards of dental practice.

Dentist/Dental practitioner

A qualified person legally carrying out this profession in the country in which he or she is located.

Diagnostic tests

Investigations, such as x-rays or blood tests to diagnose the cause of **your** symptoms.

Doctor

See **Medical Doctor**.

Eligible dependants

Your spouse or partner, provided they are under age 70 at their **date of entry**, and **your** unmarried children (i.e. **your** son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. If a child is adopted or the subject of legal guardianship **we** may require proof. **We** may also require proof of a dependent child being in full time education.

Emergency caesarean section

A caesarean section, which has been scheduled to take place less than 24 hours in advance.

Emergency treatment

Essential **treatment**, covered by **your plan**, that is immediately required if **you** suffer an **accident** or a sudden and unforeseen illness **you** have never suffered from before, which is not a **pre-existing condition**, or a **related condition**, or a condition for which **you** have a **personal medical exclusion**.

Excess

The amount stated as the **excess** in **your certificate of insurance**, being the amount **you** must contribute to each **claim**. If **your excess** is per annum, the **excess** stated on **your certificate of insurance** is the amount **you** must contribute towards the cost of eligible **treatment** covered by **your plan** and received within the same **period of cover**.

Home country

Your country of origin, for which **you** hold a passport. If **you** hold more than one passport **your home country** will be the country **you** have declared on **your application form**.

Hospital

An establishment which is legally licensed as a medical or surgical **hospital** under the laws of the country in which it is situated.

Innocent bystander

Someone who is not involved with, participating in or reporting on war, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, or actively participating in operations countering any such activities.

In-patient

A patient who is admitted to **hospital** and who occupies a bed overnight or longer for medical reasons.

Insured person

You and any **eligible dependants** specified in **your certificate of insurance** as being included in the **plan**.

Insurer

The insurance company that provides the insurance cover for **your plan**. The **Insurer** is Allianz Benelux N.V.

Life-threatening condition

A critical medical condition covered by **your plan**, which in the opinion of the **Assistance Service** constitutes a life-threatening situation which requires immediate **in-patient treatment**.

London area

Any address in the United Kingdom within the E, EC, N, NW, SE, SW, W or WC postcode areas.

Medical doctor

A person who is legally qualified in medical practice following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation) to provide medical **treatment** and who is licensed to practise medicine in the country where the **treatment** is received.

Medically necessary

Treatment that is medically appropriate and necessary to treat a condition, and which is consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used for the purpose will be those published by the National Institute for Health and Clinical Excellence (NICE) in the UK.

Medical practitioner

A person who has full registration under the Medical Acts of the country where they practice and who specialises in nursing, homeopathy, acupuncture, orthopaedic medicine, osteopathy, chiropractic, chiropody, podiatry or physiotherapy **treatment**, and to whom **you** have been referred by a **medical doctor**.

Medical referral letter

A letter from **your medical doctor** or **specialist** which refers **you** to another **medical practitioner** for **treatment** covered by **your plan**. We will only pay for **treatment** when the start date of **your treatment** is within 3 months of the date of **your medical referral letter**.

Medical services provider(s)

A **hospital**, **out-patient clinic**, **medical practitioner**, **dental practitioner**, optician or pharmacy.

Medical underwriting

The process of **you** providing and **us** assessing the health and medical information **we** ask for to decide the terms under which **we** will accept **your application** for cover, or for enhanced cover. Based on the information **you** give **us**, **we** may decide to place **special terms** on **your** cover, such as **personal medical exclusions**, or **we** may decide not to offer **you** cover.

Out-patient

A patient who attends a **hospital** consulting room, emergency room or **out-patient clinic**, when it is not **medically necessary** for them to be admitted as a **day-patient** or an **in-patient**.

Out-patient surgical procedure

An **out-patient** procedure where one or more of the following is **medically necessary**:

- general or local anaesthesia or intravenous sedation
- manipulation or relocation of a fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures

Individual Global Health Elite Plan Agreement 2017

- invasive diagnostic procedures involving intra-arterial cannulation
- the use of endoscopic equipment

Period of cover

A period of 12 months from **your date of entry** or from any subsequent **renewal date**. **Your period of cover** is as shown on **your certificate of insurance**.

Personal medical exclusions

A restriction on **your** cover that is stated on **your certificate of insurance** and specifically excludes **treatment** of a certain medical condition or conditions and any **related conditions**.

Plan/Plan type

The Global Health Elite Bronze **plan**, or Silver **plan**, or Gold **plan** on which **you** and **your eligible dependants** are covered.

Plan holder

The person stated as the **plan holder** on the **certificate of insurance**.

Planned caesarean section

A caesarean section which has been scheduled to take place more than 24 hours in advance, whether this be for medical or elective reasons.

Post-hospital treatment

Medically necessary follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan** and received within the 90 day period following the date **you** are discharged from **hospital**.

Pre-admission tests

An **out-patient** assessment during which **your** health is assessed in order to confirm that **you** are medically fit to undergo the planned **treatment** and that **you** are sufficiently prepared for it. The assessment may include an electrocardiogram, blood and/or urine tests and a chest x-ray.

Pre-existing medical conditions

Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which:

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

Premium

The amount(s) **you** are required to pay to **us** either annually, half-yearly, quarterly or monthly for **your** insurance **plan**.

Premium due date

The date on which **your** **premium** is due to be paid.

Preventive health checks

Health tests, screening and/or clinical procedures specifically designed for disease prevention and early detection.

Qualified nurse

A nurse whose name is currently on any official register of nurses maintained by a statutory nursing registration body within the country where **treatment** is provided.

Reasonable and customary

The charge that would typically be made for **your treatment** by medical service providers in the country where **you** receive **your treatment**, and for the **medically necessary** length of stay required. If the cost of **your treatment** is not **reasonable and customary**, **we** will only pay up to the amount which is typically charged in that country. If the length of stay is not **reasonable and customary**, **we** will only pay for the **medically necessary** length of stay required. In the event of a dispute, **we** will identify the amount typically charged for **your treatment** by medical service providers in the country where **you** receive it, by obtaining three quotations and taking a mean average of these three quotations.

Rehabilitation

Treatment in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an acute event such as a stroke.

Rehabilitation hospital or unit

A medical facility licensed under the regulations of the country in which it operates and designed for patients who no longer need acute **hospital** care but who still require medical or nursing supervision and/or assistance with activities of daily living because of their medical disability.

Related condition

Any disease, illness or injury that is caused by a **pre-existing medical condition** or results from the same underlying cause as a **pre-existing condition**.

Renewal date

The anniversary date of **your plan** as shown on **your certificate of insurance**, normally the anniversary of **your** original **date of entry** to the **plan**.

Session

A single continuous consultation during which time **you** may receive advice, **treatment** and/or prescribed medication.

Specialist

A **medical practitioner** who is fully registered by the regulatory body of the country in which he or she practices following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation). They must be on a **specialist** register appropriate for the condition for which **treatment** is sought. Where regulation demands, the **medical practitioner** must

Individual Global Health Elite Plan Agreement 2017

also have a licence to practice. **We** reserve the right to withhold or remove recognition of any **specialist** for reasons such as suspension of registration, fraud or unreasonable charges.

Special terms

Any **personal medical exclusions**, restrictions or **premium** adjustments **we** may apply to **your plan**. Any **special terms** relating to **your plan** will appear on **your certificate of insurance**.

Table of benefits

The table beginning on page 5 which sets out the benefits covered by each **plan type**.

Terminal medical condition

A condition that has been diagnosed as incurable with death from the condition or complications of the condition possible within 12 months of diagnosis.

Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

Unused premium

The amount of **premium** that is attributable to the period from the date after the date of cancellation, up to the date before the next **premium due date**.

In the event of a refund of **unused premium** being eligible, the **unused premium** amount refunded, (using an annually paid **plan** as an example), will be the annual **premium** paid divided by 12 and multiplied by the number of whole calendar months remaining in the **period of cover**. If the **plan** is cancelled part way through a month, an additional amount, equal to one twelfth of the annual **premium** paid, multiplied by the proportion of days without cover in the calendar month of cancellation will also be paid.

For example, if the annual **premium** for an **insured person** is US\$3,000, the **period of cover** is 1st January to 31st December 2017, and the **insured person** leaves the **plan** on 27th September 2017, the **unused premium** will be US\$775, as:

- $((US\$3,000 / 12) \times 3) = US\750 for the three whole months without cover (October, November and December); added to -
- $((US\$3,000 / 12) \times 0.1) = US\25 for the three days in September without cover (the 0.1 calculated in this example by dividing 3 (the days in September without cover, i.e. the 28th, 29th and 30th) by the total number of days in September (30))

Appropriate calculation methods using the same principle as the above example will be used if the **premium** frequency is not annual.

Us, we, our

William Russell Limited on behalf of the **insurer**.

Vegetative state

A state where there is no sign of awareness or any cognitive function, even if the person can open their eyes and/or breathe unaided. If the person is in a **vegetative state** for a continuous period of eight weeks, they will be considered to be in a persistent **vegetative state**.

Waiting period

When specified, the amount of time **you** must be covered by the same **plan** before **you** can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**. When a **waiting period** is not specified there is no **waiting period** applicable.

You, your, yourself

Any and all persons named in the schedule of **insured persons** on **your certificate of insurance**.

We're here to help

William Russell is the leading independent provider of international health, life and income protection insurance. Since 1992 we have specialised in providing protection for our expatriate and international customers all over the world, and with customers in over 160 countries we really do understand your needs.

To us, you're a customer, not a potential claimant or a policy number. From your first contact with William Russell, you'll deal with a named advisor, each one an expert within a dedicated team.

We appreciate the importance of always being able to contact someone who understands your policy, your needs, and your circumstances.

We truly are here to help.

For more information

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or visit william-russell.com

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