The Police Mutual Healthcare Scheme

Rules

Police Mutual
ALL PART OF THE SERVICE

Contents

1. Introduction

1.1 These are the rules of the Healthcare Scheme for members joining the Healthcare Scheme from 1 May 2013 and shall take effect from 1 February 2014.

1.2 The Healthcare Scheme is a discretionary healthcare scheme which is owned and operated by the Company and none of the Members have any ownership or rights to any of the assets of the Healthcare Scheme.

1.3 All benefits provided under the Healthcare Scheme are granted at the absolute discretion of the Board.

1.4 All defined terms in these rules are set out in Appendix 1

2. Membership of the Healthcare Scheme

2.1 Any person shall be entitled to apply to become a Member of the Healthcare Scheme provided that such person:

2.1.1 is a serving or retired police officer or police staff; or

2.1.2 is an employee of the Police Mutual Group; or

2.1.3 the immediate family (including parents, brothers and sisters, children and grandchildren) of a serving or retired Police Officer or Police Staff; and

2.1.3 has completed an application in a form and manner approved by the Board from time to time; and

2.1.5 is aged between 18 years and 65 years old.

2.2 The Board shall have an absolute discretion to determine the eligibility of and whether or not to admit, any person to membership of the Healthcare Scheme and the Board's decision shall be final and binding. The Board reserves the right to refuse admission notwithstanding that an individual would normally be eligible.

2.3 A register of Members of the Healthcare Scheme shall be maintained by the Company but it is not open to inspection by the Members or to the public or any other party except to the extent (if any) required by law.

2.4 Any member may resign as a Member by giving the Company notice in writing. The resignation shall take effect after 30 days' notice has been given from the date which the Company receives the notice but the Member shall not be entitled to any refund of subscriptions or other sums which have been paid in advance.

2.5 The Board may terminate the membership of a Member by giving the Member not less than 30 days' notice in writing and the Member and his Family Members shall not be entitled at the expiry of such 30 day period to any further benefit or payment from the Healthcare Scheme save (other than in the case of dishonest or fraudulent conduct) for any sums due to the Member at the date of cessation of the membership.

2.6 If a Member shall:

2.6.1 fail to pay any sum due to the Company from time to time within 30 days of the due date; or

2.6.2 obtain any benefit or payment in circumstances where such benefit or payment has been obtained as a result of the Member knowingly or recklessly furnishing or omitting to furnish the Company with all material facts or otherwise dishonestly securing such benefit or payment; or

2.6.3 complete a Medical Claim Form in a manner in which the Member knowingly or recklessly omits a material fact or knowingly or recklessly includes an incorrect fact or fails to supply such other documents as may be requested by the Company; or

2.6.4 make a dishonest or fraudulent claim of whatever kind; or

2.6.5 commit any material breach of these rules; or

2.6.6 prejudice or because of his behaviour is likely in the reasonable opinion of the Board to prejudice the interests or reputation of the Company;

then the Board may, in its absolute discretion, resolve to expel the Member forthwith from the Healthcare Scheme. The Member shall be entitled to appeal this decision to the Board. The decision of the Board shall be final.

2.7 Membership of the Healthcare Scheme is not transferable and shall cease on the death of a Member in respect of himself and his Family Members but without prejudice to a Family Member's entitlement to apply for membership in their own right under rule 2.

2.8 Once a Member has ceased to be a Member, his name shall be removed from the register of Members and neither he nor any of his Family Members shall be entitled to any further benefit or payment from the Healthcare Scheme save (other than in the case of an Expelled Member or in the case of dishonest or fraudulent conduct) for any sums due to the Member at the date of cessation of the membership.

3. Subscriptions

3.1 Each Member shall pay a monthly subscription in order to remain a Member. The subscription rates shall be such sums as the Board shall from time to time determine.

3.2 The subscription shall be paid by deduction from the Member's salary or wages by direct debit or in such other manner as the Board may agree from time to time.

3.3 If the Member's cover is provided as a benefit of employment, the subscription can be paid by the Member's employer and the Member and/or the Member's employer will be responsible for the appropriate tax.

3.4 From time to time, the Board may increase the subscription rates for the Healthcare Scheme. When such rates are increased, the Board shall take reasonable steps to notify Members of the increase in accordance with rule 5.5, whether by newsletter, mail shot, by posting on the internet site used by the Company or otherwise. When the rates are increased the onus shall be on the Members to increase their payments whether such payments are made by cash, cheque, direct debit, standing order or otherwise. If a Member fails to increase their payment then the Member may not receive the full extent of the Benefits they would otherwise be entitled to be considered for.

3.5 If a change of circumstances occurs which would entitle a Member to a reduced subscription rate, the onus is on the Member to inform the Company in writing. If no notification is made and an overpayment is made, then the Board may in its absolute discretion agree to refund all or part of any such overpayment but in any event, refunds will be limited as follows:

3.5.1 up to a maximum of 12 months of subscriptions where payment continues after the death of a Member; and

3.5.2 up to a maximum of three months of subscriptions in all other cases.

4. Benefits

4.1 Any Member who has paid their subscription up to and including the Medical Relevant Date, may or their Family Members may, at the absolute discretion of the Board, be entitled to benefit from the following:

4.1.1 **Consultations**

Subject to the Financial Limits, the Company may at the absolute discretion of the Board, pay the fee for a Consultation necessarily incurred by a Beneficiary provided that the procedures in rule 4.2 are followed.

4.1.2 **Treatment Covered by the Healthcare Scheme**

4.1.2.1 Subject to the Financial Limits, the Company may at the absolute discretion of the Board, pay the whole or part of the cost of any Treatment for a Beneficiary who has been referred to a Specialist by their GP, provided the procedures in rule 4.2 are followed; or

4.1.2.2 Where a Beneficiary is entitled to be considered for the cost of Treatment in accordance with rule 4.1.2.1, but chooses to have Treatment under the NHS he may, at the absolute discretion of the Board, be entitled to the whole or part of a cash alternative, subject to the Financial Limits.

4.1.3 **Home Nursing and Hospital Accommodation**

Subject to the Financial Limits, the Company may at the absolute discretion of the Board, pay in respect of any Beneficiary and subject to the procedures in rule 4.2 having been followed the whole or part of:

4.1.3.1 the costs of home nursing by a registered nurse following Treatment either as an in-patient or as an out-patient where such care is directed by a Specialist as necessary; and

4.1.3.2 the hospital accommodation expenses for a parent or guardian accompanying a Beneficiary, who is a child under the age of 10 years, whilst receiving Treatment on an in-patient basis.

4.2 **Rules for Claims Procedure**

4.2.1 Any Beneficiary who may be eligible for a Consultation under the Healthcare Scheme shall make an appointment with their GP as soon as possible.

4.2.2 If at that appointment, the GP makes a diagnosis and no referral to a Specialist is recommended then no further action is necessary.

4.2.3 If the GP recommends a referral to a Specialist, then the Beneficiary shall request that an open referral is made to a Designated Hospital. The Beneficiary shall contact the Designated Hospital to provisionally arrange for a Consultation to take place with a named Specialist at the Designated Hospital, subject to the Member first obtaining authorisation for the Consultation under rule 4.2.4.

4.2.4 The Member shall then request authorisation from the Company for the proposed Consultation. The Member must obtain

written authorisation from the Company for the Beneficiary to proceed with the Consultation before undertaking any financial commitment. Once authorisation for the Consultation has been given a Medical Claim Form will be provided to the Member. If the Beneficiary undergoes a Consultation without first receiving the written authorisation of the Company, the Company shall be under no obligation to pay any Benefits.

4.2.5 The Beneficiary must then take the Medical Claim Form to the Consultation and ask the Specialist to complete and sign it, stating what further procedures or operation (if any) is required. Should the Specialist require any tests, these must take place at a Designated Hospital. In the case of MRI or CT scans, written permission must be obtained from the Company prior to an appointment being made.

4.2.6 Where Treatment is required following the appointment with the Specialist, the Medical Claim Form should be forwarded to the Company, for approval before Treatment is commenced.

4.2.7 If no Treatment is required at or following the appointment with the Specialist or the procedure or operation suggested is not within the definition of Treatment then no further action is necessary and no further Benefits will be payable.

4.2.8 The Healthcare Scheme uses BUPA codes for Treatments as guidance in considering whether to approve Treatments, but should other procedures be required not within the codes the application may be considered further by the Board.

4.2.9 If during a period of Treatment a Member ceases to be a Member, the Company shall not be responsible for the cost of the Beneficiary's Treatment forthwith from the date the Member ceases to be a Member.

4.2.10 The Member must return the Medical Claim Form correctly completed and signed to the Company and obtain written authorisation from the Company to proceed with Treatment before undertaking any financial commitment. For the authorisation of Treatment requiring an overnight stay, there is a two day wait for the decision from the date the Medical Claim Form is returned to the Company, unless the circumstances are exceptional.

4.2.11 The written authorisation to proceed with the Treatment must be produced at the time of admission to the Designated Hospital. If the Beneficiary undergoes any Treatment without first receiving the written authorisation of the Company, the Company shall be under no obligation to pay any Benefits.

4.2.12 In order to process the Medical Claim Form fairly and quickly it may be necessary for the Company to obtain a medical report from a Beneficiary's GP or Specialist. The obtaining of the medical report in this manner is governed by the Medical Reports Act 1988. If the Beneficiary refuses to give consent on the Medical Claim Form for the Company to obtain the medical report, then the Company may not be able to process the Medical Claim Form or give consideration to the application and therefore no Benefits may be payable.

4.2.13 The Company does not pay for Treatment or costs relating to admissions to NHS hospitals or Treatment or costs in respect of transfers to Designated Hospitals or other hospitals from NHS Hospitals or Treatment thereafter. For further items not covered by the Company see Appendix 2.

4.2.14 Where the Company determines to pay for part only of the fees or costs of the Treatment, home nursing, hospital accommodation or any other Benefits referred to in rule 4.1, the Company shall be entitled to require from the Member or any Family Member of his, prior to any authorisation being given, payment of such sum as the Beneficiary is to contribute towards the Treatment, home nursing, hospital accommodation or other Benefit The receipt of such contribution by the Company does not amount to an acknowledgment that the Benefit will necessarily be paid but if the decision is made not to pay the Benefit then the contribution will be returned. The fact that the Company may have authorised or paid out a Benefit in respect of a Beneficiary before receiving the contribution shall not preclude the Company from subsequently recovering any such contribution from a Member in respect of himself and any Family Member.

4.2.15 Once a period of six months has elapsed since the Beneficiary last received any Treatment or if the Member does not return the Medical Claim Form to the Company within the period of six months from the date it was originally sent to the Member, the claim shall be closed at the expiry of such period and any Treatment requested or provided after this date shall be treated as a new claim and a new Medical Claim Form will be required to be submitted.

4.3 **Rights of Recovery by the Company against Third Parties**

4.3.1 If the medical consultation or treatment required by a Beneficiary is for an injury, condition or illness which was caused by a Third Party or the Beneficiary is able to claim for the costs of medical consultation or treatment through an insurer or scheme other than the Healthcare Scheme (an Other Scheme) (for example travel insurance) the Beneficiary must notify the Company of this fact on the Medical Claim Form and the following provisions of this rule 4.3 shall apply.

4.3.2 Where a Beneficiary has an Other Scheme he shall take all reasonable steps as are required by the Other Scheme to claim for his medical consultation and treatment costs before requesting the Healthcare Scheme to consider paying any Benefits. The Company may request documentation regarding the Beneficiary's reasonable steps in obtaining medical consultation and treatment under the Other Scheme before making any decision as to whether or not to provide Benefits under the Healthcare Scheme.

4.3.3 If the Company nevertheless pays any Benefits in circumstances where the Beneficiary has a right to recover such sums from his insurers, a Third Party or the Third Party's insurers (the Claim):

4.3.3.1 the Member shall procure that he and his Family Members take such lawful action as the Company may reasonably request (including instructing professional advisers as approved by the Company and taking all necessary legal action) to pursue the Claim to recover the Benefits paid by the Company;

4.3.3.2 to the extent permitted by law, the Member shall procure that he and his Family Members at the request of the Company allow the Company to have absolute control of the conduct of the Claim or proceedings using, where necessary, the name of the Beneficiary, in so far as the conduct of the Claim is or the proceedings are capable of being dealt with separately from any other claim.

4.3.4 Where a Beneficiary makes a Claim, the Member concerned shall immediately notify the Company of this fact and give the Company full details of the Claim.

4.3.5 The Member shall procure that he and his Family Members shall amend any Claim against their insurers, the Third Party or the Third Party's insurers as reasonably required by the Company to ensure that as far as possible all Benefits paid by the Healthcare Scheme are recovered.

4.3.6 The Member shall procure that he and his Family Members shall at all times provide the Company with such information, documents and/or correspondence relating to the Claim as the Company may reasonably require.

4.3.7 The Member shall procure that neither he, his Family Members nor his professional advisers shall agree to settle a Claim without the written consent of the Company, such consent not to be unreasonably withheld or delayed.

4.3.8 Where a Beneficiary receives or recovers from his insurers, the Third Party or the Third Party's insurers any sums relating to the Benefits and/or the Claim, the Member concerned shall procure that he and his Family Member shall repay to the Company such sums (without any deduction) as represent the Benefits paid by the Company in respect of the condition, illness or accident forming the subject of the Claim.

4.3.9 A Beneficiary is obliged to bring a Claim where he is entitled to do so and the Member concerned shall procure that he or his Family Member include in his Claim any Benefits.

4.3.10 If a Beneficiary is unable to bring a Claim due to death or bankruptcy then, to the extent permitted by law, the Member concerned shall use his best endeavours to procure that he or his Family Member concerned's executors, personal representatives or trustee in bankruptcy (as the case may be) allow the Company to have absolute control and conduct of any Claim or proceedings relating to the recovery of any sums paid to or on behalf of the Beneficiary against the Beneficiary's insurers, the Third Party or the Third Party's insurers.

4.3.11 If a Member or any Family Member of his fails to comply with the provisions of this rule, then the Company reserves the right to reclaim all Benefits from the Member personally.

5. General

5.1 To ensure that the information which the Company maintains about the Healthcare Scheme Members is accurate, Members shall immediately notify the Company of any change of particulars such as for example, a change of name or address.

5.2 Subject always to the provisions of rule 5.3, no provision of these rules is enforceable by any person other than the Company or a Member and no third party shall be entitled to enforce any of these rules whether under the Contracts (Rights of Third Parties) Act 1999 or otherwise.

5.3 All Benefits provided under these rules are granted at the absolute discretion of the Board, whose decision shall be final and binding.

5.4 If there is any dispute as to the interpretation of any of these rules, the decision of the Board shall be final and binding.

5.5 These rules may be revoked, supplemented or varied, from time to time or new rules introduced in their place by a resolution of the Board. Save in the case of minor alterations or alterations which the Board consider in their absolute discretion to be necessary or desirable so as to comply with law, the effect of which shall take place immediately, any change to the rules shall take effect from the date specified by the Board being no earlier than the date which falls 30 days from the date of the resolution of the Board or if the Board failed to specify a date, the date which falls 30 days from the date of the resolution of the Board. A copy of the current rules shall be provided to a Member from time to time upon request and also posted on the Company's website.

5.6 The Company will hold and use information which any Beneficiary provides to the Company for the administration of the Healthcare Scheme and for any other purpose associated with the Healthcare Scheme. The Company may disclose such information to those involved in the provision of any benefits under the Healthcare Scheme (including those involved with any treatment or care). Medical information will be kept confidential and will be disclosed only to those involved with the treatment or care of a Beneficiary, including GP's and their agents. The Company may on occasions wish to inform a Beneficiary of products and services which it considers may be of interest to him. A Beneficiary can ask not to receive such materials by writing to the Company.

5.7 The Board may at any time delegate any of their duties or powers to one or more members of the Board or to any person they deem appropriate on such terms as they may decide.

5.8 The Healthcare Scheme and these rules shall be governed by and construed in accordance with English Law.

6. Notices

6.1 Any notice or other communication to be given by a Member to the Company, or the Board shall be in writing and shall be served by addressing it to the Company marked for the attention of the Board and delivering it personally (which includes delivery by courier) or sending it by pre-paid first class post to the registered office of the Company from time to time. Any such notice shall be deemed to have been received:

6.1.1 if delivered personally, at the time of delivery;

6.1.2 in the case of pre-paid first class post 48 hours from the date of posting.

6.2 Any notice or other communication to be given by the Company or the Board to a Member may be served by delivering it personally (which includes delivery by courier) or sending it by pre-paid first class post to the address of the Member in the register of Members of the Healthcare Scheme or last known residential address or by electronic communications to the email address which has been given by the Member to the Company for communications or (in the case of Members who are serving police officers) to the Member either using the internal intranet of the police force of whom the Member serves or the global email system of such police force. Any such notice shall be deemed to have been received:

6.2.1 if delivered personally, at the time of delivery;

6.2.2 in the case of pre-paid first class post 48 hours from the date of posting;

6.2.3 in the case of electronic communications 48 hours from the time of transmission.

6.3 In proving such service, it shall be sufficient to prove that the envelope containing such notice or communication was addressed to the address of the relevant person set out in rule 6.1 or 6.2 and delivered either to that address or into the custody of the postal authorities as a pre-paid 1st class letter, or that the notice or communication was transmitted to the electronic address of the relevant person referred to in rule 6.2 or posted on the relevant intranet site.

6.4 Any notice shall be deemed to have been given to the personal representatives of a deceased person, notwithstanding that no grant of representation has been made in respect of his estate in England, if the notice is addressed to the deceased person by name or to his personal representatives by title and is otherwise sent or transmitted in accordance with rule 6.2 or posted on the relevant intranet site.

Appendix 1 – Definitions

Some words or phrases used in these rules have special meanings and these meanings are (unless the context otherwise requires) given below:

Any reference to a Member shall include Family Member where appropriate.

Beneficiary means a Member and any Family Member of a Member;

Benefits means any sums paid to or on behalf of a Beneficiary under the Healthcare Scheme in accordance with these rules.

Board means the board of directors of the Company from time to time or the directors of the Company present at a duly convened meeting of the directors of the Company at which a quorum is present.

Chronic Condition means a disease, illness or condition of long duration, often involving very slow changes and often of gradual onset, that requires continuous or on-going treatment and does not imply anything about the severity of the disease, illness or condition and includes (without limitation) conditions such as asthma, diabetes and arthritis.

Consultant means a Fellow of the Royal College of Surgeons or a Fellow of the Royal College of Physicians.

Consultation means attendance with a Consultant or Specialist to receive an opinion on the state of the Beneficiary's health in respect of any matter falling within the scope of Treatment or proposed Treatment but does not include Treatment required prior to, during or pursuant to such attendance.

the Company means the Police Mutual Healthcare Scheme Limited (a private company limited by shares and registered in England and Wales under number 3018474) whose registered office is Alexandra House, Queen Street, Lichfield, Staffordshire WS13 6QS.

Designated Hospital means such private hospital as the Healthcare Scheme has a contract with for the provision of medical services from time to time.

Expelled Member means a Member who has been expelled by the Board in accordance with the rules contained in Appendix 3.

Family Member means the immediate family specifically named and nominated by the Member and accepted by the Company as a Family Member of that Member.

Financial Limits means without prejudice to the discretionary nature of the provision of the Benefits, the maximum amount payable in respect of Benefits as set by the Board for each financial year.

GP means general medical practitioner.

Healthcare Scheme means the healthcare scheme operated by the Company from time to time, details of which are set out in these rules.

Medical Claim Form means a claim form to be completed by a Member and where necessary the Family Member in respect of Treatment.

Medical Relevant Date means in the case of a Consultation each date up to and including the date the Consultation takes place, in the case of Treatment means each date up to and including the date that Treatment finishes and in the case of home nursing costs and hospital accommodation expenses, means each date up to and including the date that the home nursing or hospitalisation finishes.

Member means any person who has been accepted for membership and continues in membership as a Member of the Healthcare Scheme from time to time as determined by these rules.

NHS means the National Health Service.

Police Mutual Group means Police Mutual Assurance Society Limited and any of its subsidiaries from time to time

Pre-Existing Condition means any injury, illness or condition:

(i) for which medical advice, attention or treatment has been received by the Beneficiary.

(ii) of which the Beneficiary was aware or ought reasonably to have been aware, but for which no medical advice, attention or treatment was sought, in either case at any time prior to the date the Member joined the Healthcare Scheme and any related illness, injury or condition which arises at any time whether prior to or after such date.

Specialist means a specialist doctor or healthcare professional, osteopath, physiotherapist or chiropractor.

Third Party means any person or entity other than the Beneficiary.

Treatment means medical treatment, examinations, tests, procedures, operations, scans, surgery, whether in-patient or out-patient but excluding any medical treatment, examinations, tests, procedures, operations, scans or surgery which comprise of or are connected with any of the exclusions set out in Appendix 2.

Appendix 2 – What we do not pay for

We do **NOT** pay for the following:

1. Any treatment for a Pre-Existing Condition save that such Pre-Existing Condition will not preclude the Beneficiary from being considered for Benefit when the Beneficiary has completed 24 months continuous participation in the Healthcare Scheme and the Beneficiary has, since joining the Healthcare Scheme, gone 24 months without receiving any medical advice, attention or treatment for that Pre-Existing Condition.
2. Treatment will not be covered in excess of £30,000 in any one financial year of the Company per Beneficiary detailed in Appendix 2.
3. Oncology, radiotherapy or chemotherapy.
4. Any treatment or surgery to correct long or short-sightedness relating to eyes including eye tests and spectacle prescriptions.
5. Any dental procedure including orthodontics.
6. Any cosmetic or aesthetic surgery or treatment or any surgery or treatment which relates to or is connected because of previous cosmetic or aesthetic surgery or treatment. However, at the absolute discretion of the Board, the Company will consider paying for initial reconstructive surgery where it is necessary after medical treatment which the Healthcare Scheme has paid for and is agreed to by the Board.
7. Any medical treatment relating to or connected with pregnancy or childbirth including in vitro fertilisation (IVF), assisted conception and artificial insemination.
8. Termination of pregnancy or any consequences of it.
9. Investigations into and treatment of infertility, contraception, assisted reproduction, sterilisation (or its reversal).
10. Investigations into and treatment of impotence or any consequences of it.
11. Any procedure or treatment relating to gender reassignment or reversal.
12. Kidney dialysis for a period exceeding six weeks.
13. Treatment for any injury which is deliberately self-inflicted, a result of attempted suicide or caused by another with the Beneficiary's consent.
14. Any treatment in respect of developmental delay, whether physical, psychological or learning difficulties including dyslexia or dyspraxia.
15. Preventative treatment.
16. Vaccination and immunisations.
17. Routine medical check-ups.
18. The cost of providing or fitting any external prosthesis or appliance.
19. Any treatment received outside of the United Kingdom.
20. Any treatment of injuries or conditions resulting from any dangerous or extreme sport or activity including, but not limited to:

20.1 sky-diving, parachuting, hand-gliding or bungee jumping;

20.2 mountaineering, or rock climbing;

20.3 luging, bobsleigh, ski jumping or heli-skiing.

21. Any complementary or alternate medicine including, but not limited to, aromatherapy, reflexology or acupuncture, except as part of an approved course of physiotherapy treatment.
22. Medical appliances or equipment including, but not limited to, walking aids, dialysis equipment, breathing apparatus, mobility devices or drips.
23. Private prescriptions or outpatient drugs.
24. Any in-patient treatment relating to psychological illness.
25. Any treatment of human immunodeficiency virus (HIV) or Creutzfeldt-Jakob disease (CJD or the human form of mad cow disease).
26. Chiropody.
27. Any treatment received by the Beneficiary at a time when the Member has not paid his subscriptions or is in arrears.
28. Any treatment relating to sexually transmitted diseases.
29. Any condition arising from alcoholism or solvent abuse.
30. Any treatment following an emergency admission or transfer from an NHS hospital.
31. Any treatment for obesity including, but not limited to, weight loss surgery, whether Medically Necessary or not.
32. Any chronic condition.
33. Experimental/Not NICE approved procedures (NICE being National Institute for Health and Care Excellence).
34. Genetic Screening.
35. Inpatient admissions for drugs/monitoring.

Appendix 3 – Expulsion and Removal Procedure and Appeals

1.0 Before any Member is expelled by the Board pursuant to the provisions of this Appendix, or a Family Member is removed from the status of Family Member. (such Member or the Member of the Family Member concerned being referred to in this Appendix as the Applicant) a notice (the Notice) shall be served on the Applicant setting out the grounds for the proposed expulsion or removal and in the case of an expulsion of a member where the proposed expulsion is by reason of a breach of these rules and such breach is capable of remedy, setting a time limit, which shall not in any event exceed seven working days, within which the breach shall be remedied. If the proposed expulsion is for a reason other than a breach of these rules or if the breach is not capable of remedy or is not remedied within the time limit stipulated in the Notice or in the case of the removal of the status of Family Member then as the case may be the Member may then be expelled in accordance with this appendix or the Family Member removed from the status of Family Member under rule 7.

2.0 Any application may appeal to the Board against such expulsion or removal. The appeal process shall be administered as follows:

2.1 The Applicant may set out in writing the grounds for appeal in a written statement of no more than 500 words (the Statement) and deliver the Statement to the Board within 14 days of being notified of their expulsion or removal. No appeal will be heard in respect of Statements delivered after the expiry of this 14 day period without the permission of the Board.

2.2 Upon receipt of the Statement, the Board shall meet within 30 working days of the Statement having been lodged and will promptly notify the Applicant of the hearing date.

2.3 The Applicant (and in the case of the removal of a Family Member, with the consent of the Board, the Family Member concerned) may attend the Board hearing, together with a representative of their selection, and may read out the Statement and/or make reasonable representations as may be relevant to the appeal.

2.4 Once the Board hearing has concluded, the Board will deliver their verdict within five working days and such verdict will be final and binding.

2.5 If the appeal is upheld, as the case may be the Member with be re-admitted to the Healthcare Scheme or Family Member reinstated as a Family Member on the same terms as they previously enjoyed. If the appeal is not upheld as the case may be the Member will remain expelled and no subscription shall be refunded to him and the Family Member's status as a Family Member shall remain withdrawn.

3.0 The Board reserves the right to suspend any Member's membership or Family Member's status as a Family Member whilst it conducts an investigation as to whether or not as the case may be the Member should be expelled or Family Member removed of his status. During the suspension period of a Member, the Member shall not pay any subscriptions nor shall any Benefits or payments be paid to or on behalf of the Beneficiary. During the suspension period of a Family Member the Member shall pay subscriptions calculated as if the Family Member was not a Family Member and no Benefits or payments shall be paid to or on behalf of the Family Member.

4.0 Even if the Healthcare Scheme continues to accept subscriptions from a Member, after the Company becomes aware of facts or circumstances that give rise or may give rise to grounds for expulsion or removal as set out in this Appendix, the rights reserved to the Board this Appendix shall not be prejudiced, notwithstanding that the Healthcare Scheme has received and accepted such further subscriptions and/or continued to pay Benefits to or on behalf of a Beneficiary.

5.0 The Healthcare Scheme expressly reserves the right to recover from an Applicant any amounts outstanding or due to the Healthcare Scheme and any sums paid to or on behalf of such Applicant and/or his Family Members.

6.0 Subject to rule 7, Family Members, aged 18 or over, that were entitled to be a Beneficiary as a result of their relationship with an Expelled Member shall, unless determined otherwise by the Board, be entitled upon the expulsion of the Member to apply to become a Member of the Healthcare Scheme subject to the payment of all subscriptions and other sums payable to the Healthcare Scheme.

7.0 If any Expelled Member ceases to be eligible then any Family Member that became a Member as a result of the provisions of rule 6 shall cease to be entitled to be a Member and such Member shall cease to pay subscriptions and receive any further Benefits with effect from the date that the Expelled Member ceases to be an eligible (the Cessation Date). A Member who is no longer entitled to be a Member under this rule 7 shall as soon as possible notify the Healthcare Scheme of the fact that the Expelled Member is no longer eligible and of the Cessation Date. The Healthcare Scheme expressly reserves the right to recover from any Member that ceases to be entitled to be a Member under this rule 7, any Benefits or payments paid to or on behalf of such Member after the Cessation Date.

We serve only the Police family

Serving or retired Police Officers and Specials

Serving or retired Police Staff

Your partner and your wider family

- ✔ Parents
- ✔ Brothers and sisters
- ✔ Children and grandchildren
- ✔ Parents-in-law
- ✔ Brothers and sisters-in-law
- ✔ Nieces and nephews

For more information:
Visit policemutual.co.uk

Police Mutual
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HEALTHBRO 0915