**Group** **Private Medical Insurance Recommendation [Existing Contract]**

**INSTRUCTION TO USER** – The following section has been designed for inclusion within a report generated by the PPOL suitability report writing solution. You will need to use the PPOL software to create a report containing a ‘Corporate Introduction’ section and any other required recommendation sections in the usual way. Once you have downloaded the report created via PPOL to Word, simply copy and paste the relevant section(s) below into the report as appropriate and then edit the text to reflect your individual requirements. It is also recommended that you include the accompanying Notes on Financial Products and Risk Warnings within the Appendix of the resultant report.

The text has been colour coded to aid with your understanding. Where the text is highlighted in blue this tends to suggest that the text may not be appropriate in all instances, and you may need to delete some or all of it. Where the text is highlighted in red, this will require your input.

You currently run a small / medium sized business, and you have a contractual responsibility to provide private medical insurance to your employees. This is presently offered to the following personnel:

<DELETE OR ADD OPTIONS IF NOT APPROPRIATE>

* All your employees
* The Equity Partners
* The Directors
* The members of <INSERT> pension scheme
* <ADD ADDITIONAL OPTION>

You are unsure if you wish to maintain cover through your existing arrangement and have asked that this can be reviewed to ensure it remains appropriate to your current financial situation and business circumstances. I understand you have the following existing cover in place.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Scheme Reference** | **Company** | **Renewal Date** | **Underwriting Basis** | **Annual Premium** | **Policy Excess** |
| Insert | Insert | Insert | Insert | Insert | Insert |

Your existing contract is a Comprehensive / Mid-Range / Budget plan and offers the following additional features:

|  |  |
| --- | --- |
| **Feature** | **Included** |
| NHS Cash Benefit | Yes / No / N/A |
| Cancer Cover | Yes / No / N/A |
| Psychiatric Cover | Yes / No / N/A |
| Choice of Hospital | Yes / No / N/A |
| Diagnostic Tests | Yes / No / N/A |
| Overseas Cover | Yes / No / N/A |
| Private Ambulance | Yes / No / N/A |
| Dental Cover | Yes / No / N/A |
| Other <INSERT> | Yes / No / N/A |

I have recommended that you **discontinue** the above and affect new cover for the following reasons:

* The overall cost of my new recommendation is lower than your existing arrangement
* Your existing cover does not reflect your current circumstances and requirements
* Your cover is inferior compared to others within the marketplace
* You wish to add additional benefits, and this is not possible under your current arrangement
* You wish to cover different groups of employees which is not possible under the current scheme
* You wish to increase the maximum levels of cover and this is not possible under your current arrangement
* You wish to upgrade to a **Mid-Range / Comprehensive** plan
* You wish to downgrade to a **Budget / Mid-Range** plan
* You are unhappy with the current providers claims history and process
* You are unhappy with the service received from the present provider
* <INSERT ADDITIONAL REASONS HERE>

**Material Differences** - If the recommended alternative plan is established on any basis different to that of your existing cover the illustrated premiums will not act as a wholly fair comparison. You should also satisfy yourself that any existing additional benefits within the policy are no longer required before proceeding with my new recommendation. I do stress that you should not cancel your existing protection until we have received underwriting terms on the proposed new plan, and it has been placed on risk.

**Group Private Medical Insurance Recommendation [NEW - If None in Place]**

You currently run a small / medium sized business and you have a contractual responsibility to provide private medical insurance to your employees. You wish to ensure this is offered to the following personnel:

**<DELETE OPTIONS IF NOT APPROPRIATE>**

* All your employees
* The Equity Partners
* The Directors
* The members of <INSERT> pension scheme
* <ADD ADDITIONAL OPTION>

I have recommended therefore, that you take out a **Group Private Medical Insurance (GPMI)** policy for the following reasons:

*For the employer*

* It can help manage the cost of short-term sickness absence and other impacts on the business and provides treatment to employees so they can return to work as quickly as possible
* It can serve as an excellent recruitment, motivation and retention tool for your employees
* You will be perceived as a caring employer and will promote good employer-employee relations
* It helps towards satisfying your overall responsibilities as an employer
* Employees are probably the most important asset a company has, so looking after their health is crucial to your business
* Staff with PMI cover are seen quickly, are generally treated faster and, as a result can get back to work much sooner than someone with a similar condition going via the NHS thus reducing ‘down time’ and cost to the company.
* GPMI provides a high-value benefit and peace-of-mind to attract and retain experienced employees
* GPMI is normally an allowable business expense for corporation tax purposes under current tax rules.
* Your company has no such cover in place at the current time
* <INSERT ADDITIONAL REASONING HERE>

*For the Employee*

* Peace of mind as members will not have to wait on the NHS for eligible treatment
* Employees can choose where and when they are treated to ensure their treatment fits in with home and business schedules.
* Patient postcodes have a lower impact on the quality of care that members might otherwise receive in the NHS
* Cover can often be extended to the members family as well (either company paid or on a voluntary basis).
* <INSERT ADDITIONAL REASONING HERE>

***Options Available***

**Hospital cover –** I am recommending the following hospital cover which contains hospitals suited to your location:

**<DELETE OPTIONS THAT ARE NOT APPLICABLE TO YOUR RECOMMENDATION>**

* Local hospital list
* Countrywide hospital list
* London hospital list
* Premier hospital list

**Excess options**

An excess is a fixed amount of money that is paid towards the cost of treatment. It’s a great way to reduce premiums without compromising cover. A decision needs to be made regarding how much you’re comfortable to pay if a claim is made. There are typically five levels of excess which are £0, £100, £250, £500 and £1,000. An excess is paid on a claim-by-claim basis, which means that every time a new claim is made the excess amount is payable. It is possible to pay on a yearly basis, which means the excess is only payable once in a plan year even if more than one claim is made. Discounts are higher however if the excess is paid on a per claim basis.

**<REPEAT THE FOLLOWING IF THE BASIS IS DIFFERENT FOR MANAGEMENT>**

I am recommending the level of excess on this policy be set at <£0> £<100> <£250> <£500> <£1,000> for <INSERT CLASS OF EMPLOYEE>. To lower premiums / meet your budget, you have selected the following excess option payable on a <per claim> <per plan year> basis.

**Underwriting options**

As discussed, the underwriting option that is chosen is important as it could affect the level of cover received from the recommended provider. You have selected the following option as it best suits your current circumstances:

**<DELETE OPTIONS THAT ARE NOT APPLICABLE TO YOUR RECOMMENDATION>**

*Moratorium underwriting -* This will exclude any member conditions which existed or which they were aware of in the five years before the cover start date.

*CPME underwriting* – This is called Continued Personal Medical Exclusions and allows members moving from one provider to another to do so on ‘no worse’ terms.

*Full medical underwriting* – This will require members full medical history disclosure which dependent on the answers given could result in certain exclusions.

For further details on underwriting, please refer to the Notes on Financial Products section within the Appendix of this report.

**Summary of Recommendations**

Having researched the marketplace, I have recommended the following Group Private Medical Insurance plan for the reasons highlighted below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Scheme Reference** | **Company** | **Renewal Date** | **Underwriting Basis** | **Annual Premium** | **Policy Excess** |
| Insert | Insert | Insert | Insert | Insert | Insert |

* They offer a competitive premium for the policy required
* The research tool I have used to review the marketplace showed them to be offering the most suitable and competitive product to meet your needs and objectives
* They are well established and financially strong
* They will accommodate a switch from the current provider on a ‘no worse terms basis’
* They have provided us and our clients with an excellent service in the past
* They are known for having a good claims history and paying claims quickly
* They can insure on the requested underwriting basis
* They offer temporary cover during the underwriting process
* Their annual policy limits are industry leading
* They offer annual policy limits in excess of your present provider
* They offer a high no claims discount structure.
* They offer a comprehensive suite of enhancements
* They offer a Dental and Optical benefits within the main arrangement
* They offer an inclusive Hospital Cash Plan scheme
* They offer a mix and match approach with different tiers of cover available for different groups of employees.
* They can offer the flexibility of different excess levels within the same arrangement
* They have a large and widespread network of specialist treatment centres
* I have calculated the level of benefits and cover you required based on your financial circumstances and we agreed the premium is affordable for the foreseeable future.
* They offer cover for overseas employees
* <INSERT ADDITIONAL REASONS HERE>

<INSERT PLAN NAME> extent of cover is set out below:

**<DELETE OR AMEND TABLE CONTENTS TO SUIT YOUR RECOMMENDATION>**

|  |
| --- |
|  **In-patient & Day-patient Cover** |
| Hospital Fees | Included / Excluded | Full / Limited Cover |
| Specialists’ Fees | Included / Excluded | Full / Limited Cover |
| Diagnostic Tests | Included / Excluded | Full / Limited Cover |
| Cancer treatment  | Excluded / See table below |
|  **Out-patient** |
| Diagnostic Tests: MRI, CT, PET scans | Included / Excluded | Full / Limited Cover |
| Cancer treatment  | Excluded / See table below |
|  **Additional Benefits** |
| NHS Hospital Cash Benefit | Included / Excluded | Full / Limited Cover |
| Childbirth Cash Benefit | Included / Excluded | Full / Limited Cover |
| Oral Surgery | Included / Excluded | Full / Limited Cover |
| Home Nursing | Included / Excluded | Full / Limited Cover |
| Private Ambulance | Included / Excluded | Full / Limited Cover |
| Parent Accommodation | Included / Excluded | Full / Limited Cover |

|  |
| --- |
|  **Cancer Cover** |
| Investigations and consultations | Full Cover / Limited Cover / No Cover |
| Out-patient costs | Full Cover / Limited Cover / No Cover |
| Radiotherapy /chemotherapy | Full Cover / Limited Cover / No Cover |
| Biological therapies | Full Cover / Limited Cover / No Cover |
| Hormone / bisphosphonate therapy | Full Cover / Limited Cover / No Cover |
| Surgical treatment | Full Cover / Limited Cover / No Cover |
| Subsequent reconstructive surgery | Full Cover / Limited Cover / No Cover |
| Palliative care costs | Full Cover / Limited Cover / No Cover |

The following cover enhancements are available within the recommended arrangement to offer members the additional peace of mind:

**<DELETE THOSE WHICH ARE NOT APPLICABLE TO YOUR RECOMMENDATION>**

* Employee Assistance Programme
* Psychiatric Cover
* Therapies Cover
* Out-patient Cover
* Out-patient Diagnostics
* Full Cancer Cover
* Private GP Helpline
* Dental Cover
* Worldwide Travel Cover

**INSTRUCTION TO USER** – The following section concerning charges of the recommended plan or provider will need to be merged with the Important Information (Cost of Services) section produced by the PPOL Suitability Report Builder. Where the text is highlighted in blue this tends to suggest that the text may not be appropriate in all instances. Please delete the charges which are not applicable to the recommended plan or provider. Where the text is highlighted in red, this will require your input.

**Important Information**

 **Further Information and Risk Warnings**

A summary of the risk warnings associated with my advice can be found in the Appendix of this report and should be read with particular care. Additional information regarding the recommendations can be found in the Key Features Document(s) provided.

**Cost of Services**

A summary of how my company can be remunerated for the advice received and the provision of my services is detailed in the disclosure documentation provided.

Group PMI Plan Charges <INSERT PROVIDER>

|  |  |  |  |
| --- | --- | --- | --- |
| **Entry** | **Ongoing** | **Event** | **Exit** |
|  |  |  |  |  |  |  |  |

**Entry Charges**: One off charges taken before or on investment.

• Advisor Charge: A fee paid to the advisor for advice and services received.

• AC Paid By Provider: The Advisor Charge will be paid by the product provider.

* AC Paid By Client: The Advisor Charge will be paid by directly by you.
* AC Paid By Fund: The Advisor Charge will be paid from the fund.
* Consultancy Charge: Charge agreed with employer for advice or services provided on a group pension scheme

* AC Paid By Cash Account: The Advisor Charge will be paid from the cash account within your investment.

• Commission: A payment made to the advisor directly by the recommended product provider.

• Provider Charge: A charge taken from the premium prior to investment.

• Fund Charge: The difference between the buying and selling prices of units or shares in a dual priced fund - often termed a Bid/Offer spread.

• Regular Premium Charge: A charge taken from each new premium for the term.

• Wrap Fee: Charge taken by the Wrap service provider for administering a specific tax wrapper

• Platform Fee: Charge taken by the Platform service provider for administering a specific tax wrapper.

**Ongoing Charges**: Regular charges, typically taken over a year.

• Advisor Charge: A fee paid to the advisor for ongoing advice and services received.

• AC Paid By Provider: The Advisor Charge will be paid by the product provider.

• AC Paid By Client: The Advisor Charge will be paid by directly by you.

* AC Paid By Fund: The Advisor Charge will be paid from the fund.
* AC Paid By Cash Account: The Advisor Charge will be paid from the cash account within your investment.

• Discretionary Fund Management Charge: An additional charge for day-to-day investment management decisions of client assets held in a nominee name by a professional investment firm.

• Investment Management Fee: Or Annual Management Charge (AMC). A fee levied by the investment firm paid out of the fund for the costs of investment management and fund administration.

• Total Expense Ratio (TER): Annual cost of a fund which includes the AMC and other services paid for by the fund i.e. trustee, depositary and custodian fees.

• Trading / Broker Fee: Necessary costs when investing in shares or active funds if the manager or broker buys and sells.

• Plan Fee: A set charge typically applied on the plan anniversary to cover provider administration.

• Wrap Fee: Charge taken by the Wrap service provider for administering a specific tax wrapper

• Platform Fee: Charge taken by the Platform service provider for administering a specific tax wrapper.

• Trust Fee: Charges taken from the trust property for on-going trustee duties and expenditure

* Other Fees: Attributable on-going charges to the plan or investment strategy not already mentioned.

**Event Based Charges**: Ad hoc charges related to specific events.

• Advisor Charge: A fee paid to the advisor for specific advice or services.

• AC Paid By Provider: The Advisor Charge will be paid by the product provider.

* AC Paid By Client: The Advisor Charge will be paid by directly by you
* AC Paid By Cash Account: The Advisor Charge will be paid from the cash account within your investment.
* AC Paid By Fund: The Advisor Charge will be paid from the fund.
* Income Review Fee: A charge levied by the plan provider to review the maximum GAD income drawdown level ahead of the statutory triennial review or transfer in.

• Fund Switch Fee: A charge to sell one fund to buy another.

• Income Withdrawal Charge: A charge levied by the plan provider to commence or maintain income payments from capital.

* Other Fees: Attributable specific charges to the plan or investment strategy not already mentioned.

**Exit Charges**: One off fees taken on termination.

• Exit Charge: Applicable under the plan or investment rules following early sale, surrender, encashment, or transfer.

• Market Value Adjustment (MVA) Charge: A penalty which may be applied to a with-profit fund on early surrender.

**Risk Warnings – Group Private Medical Insurance**

**General**

* For a full explanation of the features of this plan, please refer to the personalised illustration and Key Features and or Policy Brochure documentation supplied by the product provider.
* The figures on any quotations provided are for illustration purposes only and are not guaranteed.
* The recommendations are based on current taxation, law and practice and the current legal and administrational framework and are based on my current interpretation and understanding of those, all of which may be subject to change

**Protection**

* If policy premiums are stopped the cover will cease.
* If the policy pays out a death benefit, cover will cease.
* The actual premium payable may vary after assessment by the provider.
* Please be aware certain causes of claim are excluded.
* The provider may not pay out if any information is withheld, or if the information provided is incorrect.
* Where premium protection has not been included and an illness prevents the policy holder from working and premiums cannot be maintained the protection will cease.
* If indexation is not included, then the real value of the sum assured / policy benefits will be eroded by inflation over time.
* The protection levels should be periodically reviewed to ensure they continue to meet objectives.
* During any point through life, events (illness) may mean an individual becomes uninsurable. This would prevent a policy from possibly being altered or changed or preventing new policies being set up.

**Group Private Medical Insurance**

* Employers should take legal advice on the need to outline the benefits provided by the policy in employees’ contracts of employment and that the benefits promised are not discriminatory.
* The policy is an insurance plan and contains no investment element and therefore will not acquire a surrender or maturity value at any time
* It is vitally important that members of a scheme fully disclose any pre-existing medical conditions that they may have along with any current treatment or consultations that they are having. Failure to do so may lead to claims being refused in the future.
* A new plan will start only when your application has been accepted by the insurer and any existing plan should not be cancelled until you have been provided acceptable terms.
* Reinstatement of the scheme after a lapse in premiums will require new medical underwriting with associated risk of premium increases due to changed medical risk
* GPMI benefit will be lost for any employee on leaving service of the employer
* Where employees have individual PMI benefits there may be restrictions on the amount of benefit that would be paid out on any claim through a Group Policy
* Premiums will normally increase annually due to medical inflation and or average age increases within the membership

**Notes on Financial Products**

**Group Permanent Medical Insurance**

As National Health waiting lists grow longer and the quality of its service is brought ever more into public debate, Private Health Care is becoming increasingly viewed as a necessity rather than a luxury. Furthermore, speedy treatment in comfortable and private surroundings is something most people can’t afford to insure for. Nowadays, it can be part of a standard benefits package that larger employers provide for their staff. A Group Private Medical Insurance (GPMI) scheme can help you minimise the costs of sickness absence. It also helps your managers, particularly when it comes to handling employee sickness issues, they might not be comfortable or even qualified to deal with. Just as importantly, it can also help you comply with health and safety legislation and the Disability Discrimination Act.

GPMI is established on the lives of employees by their employer. GPMI policies not surprisingly cover multiple people and are usually purchased by companies for their staff to help manage sickness absence and to ensure staff make a speedy return to work after illness or an operation. They can be cheaper to the company, because a large group of people is more likely to conform to averages of life, death and morbidity. GPMI is offered as part of a benefits package which may also include life assurance, critical illness and income protection. A good employee benefits package will act as a perk to recruit and retain staff, especially those that are key to the business.

In the event of a claim, the member patient will be referred by their doctor to a private consultant, who will arrange treatment or surgery. Whilst the National Health Service provides well for acute and life threatening conditions, there can often be a long delay waiting for treatment for non-life threatening conditions.

Premiums can also vary greatly for GPMI, but it is possible to reduce costs by agreeing to a policy excess of, for example, the first £100 or £200 of any claim.

**Types of Treatment**

Employers can select the type of cover and benefit level to suit their budget as they will meet the whole cost of the cover. Policy benefits can vary greatly however there are effectively three bases of Private Medical Insurance schemes. These are comprehensive, mid-range and budget plans. All will usually cover consultations, diagnostic tests and treatment, whether as an inpatient or an outpatient. Only some will also include psychiatric cover, NHS cash back (where the employee receives a cash payment if they are treated by the NHS) and cover for private ambulances. Other plans may offer additional benefits such as medical and GP helplines, health information and online health risk assessments. It is very important therefore to ensure when comparing one scheme with another that the comparison is undertaken on a like for like basis.

The type of treatments covered by a GPMI plan will be consistent with the eligibility criterion which usually means the treatment of an ‘acute condition’ described below, following an initial referral from a GP.

*Acute Condition* - A disease, illness or injury 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.

**Underwriting**

There are two main methods that PMI companies use to deal with the application process for new plans. These are ‘*full medical’* underwriting and ‘*moratorium*’ underwriting. All PMI companies will offer the full medical underwriting option. Only some companies offer the moratorium option.

*Full medical underwriting* (medical history declaration)

Members are asked to give details of their medical history. The insurer may write to their doctor for more information. If a member has a medical condition that is likely to come back, the insurer will issue a policy, but that condition (and any related to it) might not be covered. This condition may never be covered or not covered for a set period dependent on the terms granted.

 *Moratorium underwriting*

The member is not asked to give details of their medical history. Instead, the insurer does not cover treatment for any medical or related condition that they have received treatment for, taken medication for, asked advice on, or had symptoms of. In other words, they will not be covered for any condition that existed in the past few years. Five years is the usual period. These conditions may automatically become eligible for cover, but this will only happen when they have no symptoms and receive no treatment, medication, tests and advice (from a GP, healthcare professional or a specialist) for that condition, usually for a continuous period of two years after their policy has started.

A third method of underwriting used only by GMPI providers is Continued Personal Medical Exclusions *(CPME) underwriting*. This term applies to situations when a change of insurer or change in policy is under consideration (also called a 'no worse terms switch facility'). This process allows companies to transfer from one insurer to another on renewal without losing cover for conditions that arose after the start of the original scheme.

**Policy pricing**

GPMI is most often costed by product providers on a community rated health insurance scheme basis. This pricing basis involves four criteria:

* group size
* location
* The number of tiers / benefits chosen
* underwriting status

 Risk pooling is then undertaken which enables the provider of the insurance to offer the most appropriate price for the risk. For example:

* to offer competitive rates to good risk business
* to offer a fair and realistic price for a high-risk business

 Each group member is then priced into one of seven age bands (18-29, 30-39, 40-49, 50-59, 60-64, 65-69, 70+) and four categories of membership: single, couple, family, single parent family.

 Group renewal pricing will factor in a general scheme increase which covers the expected number of people claiming as well as the increasing cost per claim (known as medical inflation). Then any product and membership changes are factored in such as different tiers of cover and optional extras requested. Increases for an ageing membership will also be factored in as an increased risk as it is expected that as the membership gets older the claim rate will increase. To reflect this increased risk subscriptions for each age band become higher and therefore as a member moves into a higher age band, they will incur this price increase. It may be possible to achieve a discount by varying the underwriting on new registrations to a fully underwritten basis or take on a higher level of policy excess.

 **Taxation**

Premiums include Insurance Premium Tax and employer contributions are a deductible expense for corporation tax purposes. However, they are also considered to be a benefit in kind in the hands of the employee or director which means that the contribution is considered to be additional salary and taxed accordingly at the individual’s highest rate of income tax. Any policy claims are paid free of all taxes.