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 an Introduction section and any other required recommendation sections in the usual way. Once you have downloaded the report created via PPOL to Word, simply insert (copy & paste) the relevant section(s) below into the report as appropriate and then edit the text to reflect your individual requirements. It is also recommend 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.

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

You confirmed that you had an existing PMI scheme with <INSERT INSURER> which you required reviewing. You asked me to investigate whether there was a scheme available, which was cheaper than your existing one and / or better suited to your needs.

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 scheme and effect 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 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 down grade 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.

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

You have concerns over the levels of care and waiting times experienced through your local NHS care for routine and non-serious conditions. You requested therefore that we put forward a recommendation for private medical insurance for you / you and your spouse/ you and your immediate family in line with your affordability.

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

* You have no such benefit available through your work
* You require speedy treatment in comfortable and private surroundings
* You require peace of mind knowing you will not have to wait on the NHS for eligible treatment
* You want to be able to choose where and when you are treated to ensure the treatment fits in with your home and business schedules.
* Patient postcodes will have a lower impact on the quality of care that you might otherwise receive in the NHS
* You wish for cover to be extended to your immediate family

***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.

I am recommending the level of excess on this policy be set at <£0> £<100> <£250> <£500> <£1,000> for <INSERT NAME> and a different level of excess set at £0> £<100> <£250> <£500> <£1,000> for <INSERT NAME>

In line with your affordability, you have selected the 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.

*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 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 are able to 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 family members
* 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 whilst you are overseas
* <INSERT ADDITIONAL REASONS HERE>

The extent of cover on the recommended plan 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>**

* 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**

Your renewal premium will primarily be determined by the claims experience of all of schemes often referred to as “community rating”. Although the recommended plan will be predominately community rated, a number of other factors may affect the actual premium you are charged at renewal. For instance, your own claims experience. While some plans with a high claims experience may see a larger premium increase at renewal, equally, it also means the recommended provider can reward you where the plan’s claim experience has been good.

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.

Individual PMI 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 – 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.

**Private Medical Insurance**

* 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 for full disclosure of any pre-existing medical conditions, treatment and consultations. Failure to do so may lead to claims being refused in the future.
* A new plan will start only when the application has been accepted by the insurer and any existing plan should not be cancelled until acceptable terms have been provided.
* 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.
* Where other individual health insurance benefits exist there may be restrictions on the amount of benefit that would be paid out on any claim through an additional PMI plan.
* Premiums will normally increase annually due to medical inflation and or age increases.

**Notes on Financial Products**

**Private 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. PMI policies can cover individual members or family groups, as well as groups of employees under company arrangements. In a similar way to car insurance, premiums are paid to an insurer who then covers some or all of the cost of treatments as and when required, subject to policy restrictions. Policy holders must understand that there may be restrictions on the amount of benefit that would be paid out on any individual claim. PMI benefit will be lost if premiums cease (i.e. the plan lapses) or when the maximum age covered under the plan is reached. There may also be restrictions on the insurer covering pre-existing conditions. Additionally, although there may be a choice of medical establishment where treatments may be carried out, the level of cover chosen and paid for may well be a limiting factor on this availability. Most schemes do not cover minor ailments in order to keep premium costs to a realistic level.

In the event of a claim, you will be referred to your doctor or to a private consultant, who will then 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.

**Types of Treatment**

You can select the type of cover and benefit level to suit your budget. 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 still 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 PMI 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)

You are asked to give details of your medical history. The insurer may write to your doctor for more information. If you have had 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 of time dependent on the terms granted.

*Moratorium underwriting*

You are not asked to give details of your medical history. Instead, the insurer does not cover treatment for any medical or related condition that you have received treatment for, taken medication for, asked advice on or had symptoms of. In other words, you will not be covered for any condition that existed in the past few years. Five years is the usual time period. These conditions may automatically become eligible for cover, but this will only happen when you 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 your policy has started.

**Policy pricing**

It is likely that whatever policy you choose your premiums will rise above the rate of general inflation. The cost of healthcare will increase for a number of reasons:

* As methods used to diagnose conditions become more advanced and are used more, doctors are able to identify some conditions earlier and patients can be treated more quickly
* As new drugs such as those for the treatment of cancer, become available and as the technology used in surgery becomes more advanced, PMI usually extends to cover new medical developments, as they become established medical practice
* As you get older you are more likely to need treatment. Premiums usually increase with your age to reflect this
* Premiums can also vary greatly for PMI policies, but it is possible to reduce costs by agreeing to a policy excess of, for example, the first £100 or £200 of any claim.

**Taxation**

Premiums include Insurance Premium Tax, however, there is no tax relief on plan contributions for the policy holder but benefits are payable tax free.