

ADVANTAGE HEALTH DENTAL CARE PLAN

**For Employees of Prada Denmark,
Ireland and Sweden**

**Period of Cover 1st February 2024
to 31st January 2025**

Please read this policy document together with the IPID and retain it along with a copy of your welcome email for future reference in the event of making a claim.

Contents

Introduction	2
Definitions	2
Benefit Table	4
Benefit Rules	6
General Exclusions	9
General Conditions	10
Claims Procedure	11
Complaints Procedure	12
Financial Services Compensation Scheme	13
Statement of Demands & Needs	13
Applicable Law	13
Sanctions	13
Data Protection	14
Your Right to Change Your Mind	15
How to Contact Us	15

Introduction

There are different parties involved in providing the insurance services and benefits under this **Policy**:

Iceni International Ltd

Your Policy is arranged by Iceni International Limited, registered in England and Wales under No.04893269 at Zeppelin House, 3rd Floor, 59-61 Farringdon Road, London, EC1M 3JB. Financial Services Register No. 418441. Iceni International Limited is an appointed representative of Bespoke International Limited. Bespoke International Limited, registered in England and Wales, No. 04520834, is authorised and regulated by the Financial Conduct Authority. Financial Services Register No. 314872.

Denis UK

Your Policy is administered by Denis UK Limited registered in England and Wales under No. 06399615 at Grove House, Lutyens Close, Basingstoke Hants RG24 8AG, Financial Services Register No. 600303. Denis UK Limited is an appointed representative of Healix Insurance Services Limited.

Healix Insurance Services Limited

Your Policy is underwritten by Healix Insurance Services Limited on behalf of the insurer, Hamilton Insurance DAC. Healix Insurance Services is registered in England and Wales under No.5484190 and authorised and regulated by the Financial Conduct Authority. Financial Services Register No. 437248.

Hamilton Insurance DAC

Your **policy** is insured by Hamilton Insurance DAC, a designated activity company registered in Ireland, number 484148, at 2 Shelbourne Buildings, Crampton Avenue, Ballsbridge, Dublin 4, D04W3V6, Ireland. Hamilton Insurance Dac is authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Conduct Authority and Prudential Regulation Authority in connection with its UK branch.

All of these details can be checked on the Financial Services Register by visiting www.fca.org.uk.

Definitions

We have defined below words or phrases used throughout this **Policy** document. To avoid repeating these definitions please note that where these words or phrases appear in bold they have the precise meaning described below unless otherwise stated. Where words or phrases are not listed within this section, they will take on their usual meaning within the English language.

Accident

Injury caused by direct impact outside of oral cavity to an **Insured Person's** teeth and gums (this includes damage to dentures whilst being worn).

Child/Children

Persons under 26 years of age at the **Commencement Date/Review Date** who are permanently resident with **You** or are in full time education and live with parents/guardians outside term time.

Claims Administrator

Denis UK Limited, P.O. Box 6833, Basingstoke, Hampshire, RG24 4PR, United Kingdom.

Commencement Date

The date on which this **Policy** commences. This **Policy** runs for one calendar year. If **You** join part way through the year, **Your Commencement Date** will be **Your Date of Entry** and **Your Policy** will run from **Your Date of Entry** until the **Review Date** and thereafter in periods of one calendar year.

Cosmetic Treatment/Cosmetic

Treatment not necessary to maintain dental health and which is solely for the purpose of improving the **Insured Person's** appearance.

Cover

The provision of the benefits detailed in the Benefits Table for **Treatment** and/or **Emergency Treatment** subject to the terms and conditions of the **Policy**.

Date of Entry

The date on which an **Insured Person** was included under this **Policy**.

Dental Services

The **Dental Services** described in this **Policy**.

Dentist

A dental practitioner appropriately registered, qualified and practicing in the country in which the **Treatment** is administered.

Emergency Treatment

Dental Services or supplies provided to an **Insured Person** for the immediate relief of severe pain, trauma, swelling or bleeding by their Dentist outside normal surgery hours or by any other Dentist whilst the **Insured Person** is away from home.

Insured Person/You/Your

A person resident in the **Insured Territory** who is an employee of the **Policyholder** (or the **Partner** or dependent **Child** of an employee) for whom **We** receive and accept a completed application form and a premium is paid and who is entitled to **Cover** in accordance with the terms of this **Policy**.

Insured Territory

Denmark, Ireland and Sweden

Insurer

Hamilton Insurance DAC

Oral Cancer

Cancer of the following areas only: the lips, tongue, major salivary glands, gums, mouth, or pharynx or the oral cavity from lip to pharynx.

Orthodontic Treatment

Treatment undertaken by a **Dentist** for the prevention and correction of irregularities of the teeth.

Partner

An **Insured Person's** spouse or **Partner** who permanently resides with an **Insured Person** in a domestic relationship.

Period of Cover

For each **Insured Person** accepted for **Cover** on or after the **Commencement Date**, the period commencing on the **Commencement Date** or on the **Date of Entry** and ending on the date **You** notify **Us** of the termination of their **Cover**, or the **Review Date**, whichever occurs first.

Physical Contact Sports

Rugby, hockey, boxing, wrestling, lacrosse, ice hockey, Gaelic Football or any other sport where it is common practice to wear mouth, gum or head protection.

Policy

This contract being **Our** contract with the **Policyholder** providing the **Cover** as detailed in this document.

Policyholder

The company or corporate entity from whom premium is received. In the event of a claim, it is understood that settlement will be made to the principal **Insured Person**. Claims payments are not made to **Partners** or dependent **Children**.

Review Date

1st February 2025

Treatment

Dental Services or supplies described in this document which are clinically necessary for the maintenance and/or restoration of the oral health of an **Insured Person** provided that such services are:

- provided by a Dentist;
- provided in accordance with accepted standards of dental practice;
- received by an **Insured Person** during a **Period of Cover**.

We/Our/Us/Insurer

Hamilton Insurance DAC.

Benefit Table

Cover

The purpose of this **Policy** is to provide an **Insured Person** with **Dental Services** as described in the Benefits Table below during the **Period of Cover** for **Treatment** by a **Dentist** at a dental surgery. **We** will pay benefits up to the maximum value shown according to the plan selected in **Your** application process provided that such **Treatment** is clinically necessary and received by the **Insured Person** during the **Period of Cover**.

Treatment description	€ Benefit (Republic of Ireland)	SEK Benefit (Sweden)	DKK Benefit (Denmark)
Private Treatments			
Preventative Treatments			
Examination	€79.00	SEK700.00	DKK560.00
X-rays (annual allowance)	€68.00	SEK600.00	DKK480.00
Scale & polish	€102.00	SEK900.00	DKK720.00
Fissure sealant	€33.00	SEK250.00	DKK200.00
Topical fluoride application	€52.00	SEK400.00	DKK320.00
Restorative Treatments			
One surface amalgam	€78.00	SEK600.00	DKK480.00
Two surface amalgam	€99.00	SEK760.00	DKK608.00
Three plus surface amalgam	€143.00	SEK1,100.00	DKK880.00
Composite filling anterior small	€98.00	SEK750.00	DKK600.00
Composite filling anterior large	€137.00	SEK1,050.00	DKK840.00
Composite filling posterior small	€111.00	SEK850.00	DKK680.00
Composite filling posterior medium	€124.00	SEK950.00	DKK760.00
Composite filling posterior large	€137.00	SEK1,050.00	DKK840.00
R.C.T. Incisor/Canine	€358.00	SEK2,750.00	DKK2,200.00
R.C.T. Premolar	€468.00	SEK3,600.00	DKK2,880.00
R.C.T. Molar	€520.00	SEK4,000.00	DKK3,200.00
Open root canal for drainage	€111.00	SEK850.00	DKK680.00
Extractions (annual allowance)	€227.00	SEK2,000.00	DKK1,600.00
Dressings	€52.00	SEK400.00	DKK320.00

Extractions – post-operative care	€42.00	SEK320.00	DKK256.00
Gingivectomy	€59.00	SEK450.00	DKK360.00
Mucoperio, Flap bone surgery	€163.00	SEK1,250.00	DKK1,000.00
Abnormal haemorrhaging	€91.00	SEK700.00	DKK560.00
Veneer	€481.00	SEK3,700.00	DKK2,960.00
Inlay	€533.00	SEK4,100.00	DKK3,280.00
Crown	€572.00	SEK4,400.00	DKK3,520.00
Implant	€1,730.00	SEK13,000.00	DKK10,400.00
Post & core	€117.00	SEK900.00	DKK720.00
Gold post & core	€176.00	SEK1,350.00	DKK1,080.00
Conventional bridge	€780.00	SEK6,000.00	DKK4,800.00
Adhesive bridge	€260.00	SEK2,000.00	DKK1,600.00
Re-fix crown	€65.00	SEK500.00	DKK400.00
Re-cement crown	€65.00	SEK500.00	DKK400.00
Re-cement bridge (any)	€65.00	SEK500.00	DKK400.00
Acrylic Full Denture U or L	€390.00	SEK3,000.00	DKK2,400.00
Acrylic Full Denture U and L	€845.00	SEK6,500.00	DKK5,200.00
Chrome Denture upper	€806.00	SEK6,200.00	DKK4,960.00
Chrome Denture lower	€806.00	SEK6,200.00	DKK4,960.00
Reline dentures	€59.00	SEK450.00	DKK360.00
Repair dentures	€59.00	SEK450.00	DKK360.00
Mouthguard	€98.00	SEK750.00	DKK600.00
Anaesthetic fee	€130.00	SEK1,000.00	DKK800.00
Emergency treatment	€78.00	SEK600.00	DKK480.00
Apisectomy	€260.00	SEK2,000.00	DKK1,600.00
Overnight hospital stay	€85.00	SEK650.00	DKK520.00
Call-out fee	€130.00	SEK1,000.00	DKK800.00
Incising an abscess	€52.00	SEK400.00	DKK320.00
Occlusal splint	€130.00	SEK1,000.00	DKK800.00
Child Orthodontics	€680.00	SEK6,000.00	DKK4,800.00
Personal Protective Equipment (annual limit)	€39.00	SEK300.00	DKK240.00
Annual Aggregate Maximums			
Routine Treatment	€6,800	SEK60,000	DKK48,000
Accident Treatment	€6,800	SEK60,000	DKK48,000
Oral Cancer	€26,000	SEK200,000	DKK160,000

Benefit Rules

The following benefit rules apply to all Advantage Health Dental Care Plan levels of cover.

1. Children and Partners

Where **Children** or **Partners** are insured under the **Policy**:

- i. The level of **Cover** must be the same as that selected by **You**;
- ii. The maximum reimbursement, annual maximums and limits during the **Period of Cover**, shall be shared amongst all of **Your Children** up to a maximum of three **Children**;

2. Durability of Treatments

Fillings: **Cover** is available once per tooth in a 2 year period.

Root Canal Treatment: **Cover** is available once per tooth in a 2 year period.

Crown, inlay, denture: **Cover** is available once per tooth in a 3 year period for the placement of a crown, inlay or denture.

3. Frequency limits

Insured persons are limited to the number of **Treatments** as detailed below during any one **Period of Cover**.

Treatment Type	Limit per year
Examination	2
Small xray	4
Medium xray	4
Panoral xray	1
Scale and polish	4
Implants	1
Call out fee	1
Child orthodontics	1

*With a full case assessment, the **Dentist** will provide **You** with a written **Treatment** plan. A copy of this plan must be submitted in the event of a claim for this **Treatment**.

4. Orthodontic Treatment

- a. **Child Orthodontic Treatment** benefit is payable for **Treatment** received following the **Child's** eighth birthday up to the **Child's** seventeenth birthday.
- b. **We** will assess an **Insured Persons Orthodontic Treatment** in line with the Dental Health component of the Index of Orthodontic Treatment Need (IOTN). Only grade 3 and higher where there is a definite health need will be considered for **Cover**.
- c. **Orthodontic Treatment** for aesthetic or **Cosmetic** reasons is not included under this **Policy**.
- d. **Child Orthodontic Treatment** in progress (appliances placed prior to eligibility under this **Policy**) is covered but only for costs associated with **Treatment** occurring after the **Date of Entry** and not for any costs relating to **Treatment** incurred prior to this.
- e. Benefit is valid once the appliance has been fitted (benefit will not be valid prior to final placement of the brace).

5. Dentist Identification

For **Your** protection and to comply with regulations regarding professional registration and conduct, all claims must positively identify the **Dentist** who rendered the **Treatment**. Within the **Insured Territory** the **Dentist's** registration body number provides this identification and must be entered on the claim form. Where **Treatment** is undertaken outside of the **Insured Territory**, the reference number allocated to the **Dentist** by the governing body of that country should be stated.

6. Pre-existing Conditions

This **Policy** does provide **Cover** for pre-existing conditions, that being a condition diagnosed or for which the clinical signs were exhibited prior to the **Insured Persons Date of Entry**. However, pre-existing **Oral Cancer** is not covered under this **Policy** and, even if **You** have had the option to purchase any additional implant cover, any pre-existing requirement for dental implants are not covered under this **Policy**.

7. Tooth Numbering

In order to provide effective management of dental health claims, it is important that **We** know which tooth has received **Treatment**. **Dentists** will be conversant with tooth numbering and will be able to enter the relevant tooth number on the **Insured Person's** claim form. The tooth number must be in FDI format.

8. Annual Maximums

The maximum amount payable in any one **Period of Cover** shall not exceed the amounts stated for the applicable plan as detailed in the Benefit Table.

9. Dental Implants and Fixtures

- a) The insured benefit is paid on receipt of a valid claim where the dental surgeon is positively identified by his or her dental registration body license number.
- b) The Dental Implant site must be identified by the FDI tooth number of the tooth position it fills.
- c) Dental Implants placed in the site of 2nd or 3rd molars are excluded from benefit.
- d) The insured benefit is only paid once per beneficiary per tooth site and the **Insurer** is not liable for any future costs incurred by Dental Implant complications such as rejection, fracture or infection.
- e) Teeth lost prior to the purchase of the Advantage Health Dental Care Plan are not included under the benefit.
- f) Dental Implant **Cover** does not extend to the replacement of existing crowns or fixtures.
- g) No benefit shall be payable in respect of any Dental Implant **Treatment** undertaken within 90 calendar days of the **Insured Persons Date of Entry**.
- h) No benefit shall be payable in respect of the placement of a Dental Implant into a pre-existing edentulous space or where a **Dentist/specialist Dentist** deems it not clinically appropriate, or replacement following the failure of a Dental Implant to integrate or due to a subsequent breakdown of integration.
- i) No benefit shall be payable in respect of any Dental Implant **Treatment** which was necessary, prescribed, planned or is taking place at the **Insured Persons Date of Entry**.

10. Oral Cancer

Benefits are available upon diagnosis of **Oral Cancer** subject to the following conditions:

- The benefit covers the **Insured Person** for **Treatment of Oral Cancer**.
- The **Oral Cancer** must be diagnosed during the **Period of Cover** by a qualified doctor or **Dentist** (including a specialist) who is licensed to practice in the **Insured Territory**;
- The benefits will be paid only for **Treatment** received within 18 calendar months of the date of diagnosis;
- Benefits will be paid for one course of **Treatment**. Once **You** have claimed for a course of **Treatment** for **Oral Cancer** this cover ends;
- Benefit will be paid only for **Treatment** given by a consultant who is recognised as a specialist in **Oral Cancer Treatment**;
- Benefit will not be payable for **Oral Cancer** resulting from smoking or chewing tobacco products (including betel nut juice).

Hospital charges for in-patient or day-patient Treatment: We will pay in full subject to **Your** lifetime limit for **Oral Cancer Treatment**.

Surgeons and anaesthetists fees for in-patient or day-patient Treatment: We will pay in full subject to the lifetime limit for **Oral Cancer Treatment**.

Specialist consultations and services, pathology, and x-rays received as an out-patient:

We pay up to a total amount of €650(ROI), SEK5,000(Sweden) or DKK4,000(Denmark) each **Period of Cover** for all such services collectively and not for each type of service or charge individually, subject to the lifetime benefit limit for **Oral Cancer Treatment**. **Specialists' fees for radiotherapy and chemotherapy treatment:**

We pay up to the limits stated below subject to the lifetime benefit limit for **Oral Cancer Treatment**.

Radiotherapy treatment:

Up to €520(ROI), SEK4,000(Sweden) or DKK3,200(Denmark) for each course of radiotherapy **Treatment**. 1 course is 15 attendances for radiotherapy.

Chemotherapy treatment:

We will pay up to the following amounts from the date the chemotherapy begins or **We** consider it begins, which **We** shall regard as the start date, until the date the **Treatment** ends:

1 week – up to €182(ROI), SEK1,400(Sweden) or DKK1,120(Denmark) 1 week is start date to 7th day of **Treatment**

2 weeks – up to €351(ROI), SEK2,700(Sweden) or DKK2,160(Denmark) 2 weeks is start date to 14th day of **Treatment**

3 weeks – up to €520(ROI), SEK4,000(Sweden) or DKK3,200(Denmark) 3 weeks is start date to 21st day of **Treatment**

4 weeks – up to €676(ROI), SEK5,200(Sweden) or DKK4,160(Denmark) 4 weeks is start date to 28th day of **Treatment**

We do not pay each week of a course of **Oral Cancer Treatment** separately when such **Oral Cancer Treatment** begins on the start date and lasts more than one week. Twenty-eight days after the start date, **We** shall consider any further costs **You** incur for **Oral Cancer Treatment** to be new **Oral Cancer Treatment** for the purposes of the scheme and a new start date shall apply.

11. General

For all claims, the relevant date for determining the benefits available for **Treatment** shall be the actual date of the **Treatment**.

All expenditure for which benefit is claimed must be clinically necessary and incurred wholly and exclusively for the purpose of **Treatment**.

General Exclusions

Benefits will not be available for:

1. Services or supplies for **Treatment** which a **Dentist** is unable to provide due to circumstances beyond the control of such **Dentist**;
2. Services or supplies which are not described in the Benefit Table or which are specifically excluded under these General Exclusions;
3. **Cosmetic Treatments** and **Treatments** not clinically necessary;
4. **Treatment** involving the necessity of hospital in-patient, day-patient or out-patient care, except in the case of **Oral Cancer**;
5. Services or supplies which are experimental in nature, or not normally supplied by a dental practice;

6. Any **Treatment** resulting from self-inflicted injury;
7. **Treatment** received prior to the commencement of the **Period of Cover**, and **Treatment** received after the **Period of Cover** ceases;
8. Any **Treatment** once the annual maximum number of **Treatments** or maximum annual benefit limit has been reached for that **Treatment**;
9. Reimbursement for travelling expenses or telephone calls in connection with any **Treatments**; or charges for completing the claim form;
10. Charges resulting from missed appointments;
11. Any Claims for the replacement of dentures damaged whilst not being worn;
12. For costs which **We** consider are not necessarily incurred. All benefits will be paid in accordance with customary and accepted levels of charges for the **Treatment** received. The charges must be necessary, incurred wholly and exclusively for the purposes of **Treatment** and in line with **Our** dental advisors opinion;
13. Any **Treatment** relating to damage or injury caused whilst participating in any **Physical Contact Sports** when the appropriate tooth, mouth or head protection was not being worn;
14. Injuries sustained while engaged in illegal, unlawful or anti-social activities;
15. **Oral Cancer** diagnosed, suspected, or for which tests were conducted or planned or for which a referral to a specialist had been made prior to the **Commencement Date** or the **Insured Person's Date of Entry**;
16. **Oral Cancer** resulting from smoking or chewing tobacco products (including betel nut juice);
17. Any **Treatment** charges which qualify for reimbursement under State dental provision or any other form of insurance, regardless of whether or not the **Insured Person** claims these benefits from the State or other insurance provider.
18. Any claims arising from unauthorised, malicious or criminal acts involving access to, processing of, use of or operation of any computer or computerised systems.

General Conditions

The following conditions apply:

Compliance with Policy Terms

Our liability under this **Policy** will be conditional upon each **Insured Person** complying with the terms and conditions of this **Policy**.

1. Selection of Plan Benefits

The plan benefits selected by **Your Partner** or **Children** must be the same as that selected by **You**.

2. Policy Duration and Payment

- a. This insurance **Policy** is an annual **Policy** running from the **Commencement Date** until the subsequent **Review Date** and for annual periods thereafter.
- b. If **You** join the plan after the **Commencement / Review Date**, **Your Period of Cover** shall be from **Your Date of Entry** until the following **Review Date** and annually thereafter.

- c. The premium payable shall be that prevailing generally at the **Commencement Date** or if later, the appropriate **Review Date**.
- d. Premiums shall be collected by **Your** employer by deduction from **Your** monthly salary. The premium payable may be changed by **Us** from time to time. However, this **Policy** will not be subject to any alteration in payment rates generally introduced until the next **Review Date**. **You** will be notified at least 30 days prior to the **Review Date** of any change in premium. Premiums may however be subject to changes mid-term in response to changes in the prevailing rate of Insurance Premium Tax or any other applicable state or regional taxes.

3. Cancellation

- a. If **You** wish to cancel **Your Policy**, **You** must do so within the first 14 days of receiving **Your Policy** documents.
- b. If **You** do cancel **Your Policy** within 14 days of receiving **Your Policy** documents, **Your Cover** and that of any **Insured Persons** covered under **Your Policy** will cease and **You** will receive a full refund of any premiums that have been paid during the 14 days, provided no claim has been made or is pending. There will be no refund of premiums if **You** choose to cancel **Your Policy** after the first 14 days and your cover will continue until the next **Review Date** at which point you may de-select the benefit on your Employee Benefits platform.
- c. If an **Insured Person** cancels **Cover** the **Insured Person** will not be allowed to obtain **Cover** at a later date during the same **Period of Cover**.
- d. **Your** employer has decided to accept this insurance scheme and **You** have joined the scheme as an employee or **Partner** or **Child** of an employee. In setting the terms and premium, **We** have relied on the information **You** have given **Us** via **Your** employer. **You** must take care when answering any questions **We** ask by ensuring that all information provided is accurate and complete. If **We** establish that **You** deliberately or recklessly provided **Us** with false or misleading information, **We** will treat this **Policy** and/or **Your** insurance cover as if it never existed and decline all claims. If **We** establish that **You** carelessly provided **Us** with false or misleading information it could adversely affect the **Policy** and/or **Your** insurance cover and any claim. For example, **We** may:
 - i. Treat this **Policy** or **Your** insurance cover as if it had never existed and refuse to pay all claims and return the premium paid. **We** will only do this if **We** provided **You** with insurance cover which **We** would not otherwise have offered;
 - ii. Amend the terms of **Your** insurance. **We** may apply these amended terms as if they were already in place if a claim has been adversely impacted by **Your** carelessness;
 - iii. Reduce the amount **We** pay on a claim in the proportion the premium that has been paid bears to the premium **We** would have charged **Your** employer; or
 - iv. Cancel the **Policy** and/or **Your** cover in accordance with **Our** cancellation rights.If **You** become aware that information **You** have given **Us** is inaccurate, **You** must inform **Us** as soon as practicable.
- e. If **We** cancel the **Policy**, **We** shall give **You** 30 days' notice sent by first class post to **Your** last known address and e-mail address.

4. Pregnancy

In the event of pregnancy an **Insured Person** may continue with their **Cover** or cancel their **Cover** with the option of re-joining the Advantage Health Dental Care Plan at a later date.

5. Alteration

We may alter any of the terms of this **Policy** at any **Review Date**. Details of the change will be advised to **You** at such time. **We** may allow **You** to change **Your Cover** level at the **Review Date**. **You** can change **Your** address or contact details at any time by contacting your HR department.

6. Waiver

Waiver by **Us** of any term or condition of this **Policy** will not prevent **Us** from relying on such terms or conditions afterwards.

Claims Procedure

At the Dentist

Once the treatment is complete, the **Insured Person** should pay for the **Treatment** and ask the **Dentist** for a detailed **Treatment** invoice. This invoice should be on the official practice format (electronic or paper) and have the following information. It is **Your** responsibility to ensure that this information is on this invoice, as without it **Your** claim will be invalid.

- Treated Persons name and address;
- Dentist or practice name and address;
- Description and date of each **Treatment** rendered, the specific tooth worked on (if applicable) and the fee charged.

Claims Notification

The invoice described above should be submitted to the **Claims Administrator** in one of 4 ways:

- “Snap and Send” via mobile phone on the administrator portal;
- “E-Claim” via the administrator portal on mobile phone or computer;
- Email: If this method is chosen it is essential to add the following information to the email body:

Policy/Member Number

- Bank details for claim payment
- Post: If this method is chosen it is essential to include the following information with the invoice:

Policy/Member Number

- Bank details for claim payment

Claims for Accidents and Emergencies

The process for these claims is identical except that **You** must inform **Us** that the claim is for an **Accident** or an emergency. The way to do this is:

- For claims via the portal: Open a secure message, use the claim number of **Your** finalised claim and describe what happened that resulted in the accidental damage to **Your** teeth or the nature of the emergency;
- For email or postal claims: Write a description of the **Accident** or emergency in the email body or as a separate sheet in the postal claim.

Failure to describe a situation that is clearly an **Accident** or an emergency will result in **Your** claim being processed against the routine benefits offered in **Your** plan.

Claims for Treatment in Foreign Countries

The process for these claims is identical to those for claims for **Treatment** in the UK except that...

- **You** may not use the E-Claim process for foreign claims;
- **You** must provide a translation of the detailed dental invoice if it is not in English

Notes to Claims

- All claims must be notified to the **Claims Administrator** within 180 days of the date of completion of the item of **Treatment**. **We** will not be liable in respect of any claim notified late, unless there is a justifiable reason for the delay.

Claims missing critical information will be rejected and details of what **You** need to do will be sent to **Your** registered email address. **You** will be able to submit a new claim once **You** have the required information. For example: Illegible invoices will be rejected;

Treatment done on specific teeth will be rejected if the specific tooth is not identified;

A **Treatment** estimate or quote is not a valid invoice. An invoice is only provided once the **Treatment** is complete.

Fraudulent or Unfounded Claims

If any claim under this **Policy** is in any respect fraudulent or unfounded, all benefit paid and/or payable in relation to that claim shall be forfeited and, (if appropriate), recoverable.

Other Insurance

Without prejudice to any other right or remedy **We** may have against any third party, if there is any other insurance covering any of the same benefits, **You** must disclose or procure that the relevant **Insured Person** discloses the same to **Us**. **We** shall not be liable to pay or contribute more than **Our** rateable proportion. Any payment or contribution over and above such liability shall be at **Our** absolute discretion and shall be without prejudice to this condition.

Settlement of Claims

All settlements will be made by bank transfer to the nominated bank account of the principal **Insured Person**.

Claims Contact Details

Online Portal: www.denisglobal.com

Email: claims@deniseurope.eu

Post: PO Box 6833, Basingstoke, Hampshire, RG24 4PR

Tel: 08006335037

Complaints Procedure

We aim to provide **You** with the highest levels of customer service and care at all times. However, if something has gone wrong, **We** want to do everything **We** can to put it right as quickly and effectively as possible. This is why **We** have put in place a simple procedure for **You** to raise any concerns or complaint **You** may have.

If **You** have a query or complaint regarding the administration of **Your Policy**, **You** should refer to your HR department.

If **You** wish to make a complaint about anything else, in the first instance please contact:

Complaints Department

Email: complaints@deniseurope.eu

Tel: +44 (0) 203 699 6581

We will contact **You** within three days of receiving **Your** complaint to inform **You** of what action **We** are taking. **We** will try to resolve the problem and give **You** an answer within four weeks. If it will take **Us** longer than four weeks, **We** will tell **You** when **You** can expect an answer.

In the event that **You** are unhappy with **Our** response to **Your** complaint, or **You** have not received **Our** response within 8 weeks of the date **We** received **Your** complaint, **You** may be eligible to refer **Your** case to the Financial Ombudsman Service, who can review complaints from eligible complainants, but **You** must do so within 6 months of receiving **Our** final response. Further information can be found at:

www.financial-ombudsman.org.uk

The Financial Ombudsman Service exists to help resolve complaints when **We** have not been able to resolve matters to **Your** satisfaction and the service they provide is free and impartial. Their contact details are as follows:

Financial Ombudsman Service

Exchange Tower

Harbour Exchange Square

London

E14 9SR

Telephone: 0800 023 4567 (calls to this number are free on mobile phones and landline) or 0300 123 9123 (Calls to this number cost no more than calls to 01 and 02 numbers.)

Email: complaint.info@financial-ombudsman.org.uk

This complaints procedure does not affect **Your** legal rights.

Financial Services Compensation Scheme

Healix Insurance Services Ltd and Hamilton Insurance DAC are both covered by the Financial Services Compensation Scheme (FSCS). This means that **You** may be entitled to compensation from the scheme if either cannot meet their obligations to **You** under this contract. This would provide cover for 90% of the claim without any upper limit. Further information about compensation is available from the FSCS at www.fscs.org.uk or telephone 0207 741 4100.

Statement of Demands & Needs

We have not provided **You** with a personal recommendation or advice as to whether this **Policy** is suitable for **Your** specific needs. This product meets the demands and needs of an individual who seeks protection against the costs of Accident and Emergency **Treatment** and routine dental **Treatment**.

Applicable Law

This contract shall be governed by and construed in accordance with English Law unless:

- i. **You** and the **Insurer** agree otherwise; or
- ii. at the **Date of Entry**, **You** are resident of (or, in the case of a business, the registered office or principal place of business is situated in) Scotland, Northern Ireland, Channel Islands or the Isle of Man, in which case (in the absence of agreement to the contrary) the law of that country will apply.

Sanctions

The **Insurer** shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the **Insurer** to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, **United Kingdom** or United States of America.

Data Protection

Hamilton Insurance DAC, the Data Controller, is committed to protecting and respecting **Your** privacy in accordance with the current Data Protection Legislation (“Legislation”). Below is a summary of the main ways in which they process **Your** personal data, for more information please visit www.hamiltongroup.com.

HOW THE INSURER USES YOUR PERSONAL DATA AND WHO THEY SHARE IT WITH

The **Insurer** may use the personal data they hold about **You** for the purposes of providing insurance, handling claims and any other related purposes (this may include underwriting decisions made via automated means), for offering renewal terms, research or statistical purposes and, if they have consent to do so, to provide **You** with information, products or services that **You** request from them or which they feel may interest **You**. They will also use **Your** data to safeguard against fraud and money laundering and to meet their general legal or regulatory obligations.

SENSITIVE PERSONAL DATA

Some of the personal information, such as information relating to health or criminal convictions, may be required by the **Insurer** for the specific purposes of underwriting or as part of the claims handling process. The provision of

such data is conditional for them to be able to provide insurance or manage a claim. Such data will only be used for the specific purposes set out in their notice.

DISCLOSURE OF YOUR PERSONAL DATA

The **Insurer** may disclose **Your** personal data to third parties involved in providing products or services to them, or to service providers who perform services on their behalf. These include their group companies, affinity partners, brokers, agents, third party administrators, reinsurers, other insurance intermediaries, insurance reference bureaus, credit agencies, medical service providers, fraud detection agencies, loss adjusters, external law firms, external auditors and accountants, regulatory authorities, and as may be required by law.

INTERNATIONAL TRANSFERS OF DATA

The **Insurer** may transfer **Your** personal data to destinations outside the European Economic Area (“EEA”). Where they transfer **Your** personal data outside of the EEA, they will ensure that it is treated securely and in accordance with the Legislation.

YOUR RIGHTS

You have the right to ask the **Insurer** not to process **Your** data for marketing purposes, to see a copy of the personal information they hold about **You**, to have **Your** data deleted (subject to certain exemptions), to have any inaccurate or misleading data corrected or deleted, to ask them to provide a copy of **Your** data to any controller and to lodge a complaint with the local data protection authority.

RETENTION

Your data will not be retained for longer than is necessary, and will be managed in accordance with the **Insurer’s** data retention policy. In most cases the retention period will be for a period of ten (10) years following the expiry of the insurance contract, unless they are required to retain the data for a longer period due to business, legal or regulatory requirements.

If **You** have any questions concerning the **Insurer’s** use of **Your** personal data, please contact The Data Protection Officer, Hamilton Insurance DAC – please visit www.hamiltongroup.com for full address details.

HEALIX INSURANCE SERVICES LIMITED

Healix Insurance Services Ltd are a joint Data Controller and are equally committed to protecting and respecting **Your** privacy in accordance with the current Data Protection Legislation (“Legislation”). For more information please visit www.healix.com/insurance-capacity-management/

If **You** have any concerns, a complaint or any request regarding Healix Insurance Services Ltd use of **Your** personal data, please contact: The Data Protection Officer, Healix Insurance Services Ltd, Healix House, Esher Green, Esher, Surrey, KT10 8AB. Or by email: HISprivacy@healix.com

DENIS UK LIMITED

Denis UK Limited are the Data Processors and are committed to protecting and respecting **Your** privacy in accordance with the current Data Protection Legislation (“Legislation”). For more information please visit: www.denisglobal.com

If **You** have any concerns, a complaint regarding how Denis UK Limited administer **Your** personal data, please contact: Head of Legal, Denis UK Limited, Grove House, Lutyens Close, Chineham Court, Basingstoke, Hants, RG24 8AG. Or by email: legal@denisuk.com

Your Right to Change Your Mind

You have 14 days from receiving **Your Policy** documents in which to change **Your** mind. Here are some questions to help **You** decide.

Do **You** understand what **Your Policy** will do for **You**?

- Before **You** complete the application process, **You** must read the Insurance Product Information Document provided.

If there is anything which is still unclear, please contact the **Claims Administrator** on 0800 633 5037 (+44 (0) 203 6996 581 from outside the **Insured Territory**).

If **You** wish to cancel, what should **You** do?

- If **You** wish to cancel **Your Cover**, please de-select the benefit on **Your** employee benefits portal, or call Denis UK Limited on 0800 633 5037 (+44 (0) 203 6996 581 from outside the **Insured Territory**).
- **You** must cancel **Your Cover** on or before the 14th day following receipt of **Your Policy** documents or at the **Review Date**.

How to Contact Us

General & Claims Enquiries

If **You** have any queries at all, please do not hesitate to contact the **Claims Administrator** as specified in the Claims Procedure section. Please remember to quote **Your** member number in all correspondence. Lines are open 10.00 to 18.00 (CET time) Monday to Friday. Calls may be recorded for training and monitoring purposes.