

■ At Ease

Now that you have seen for yourself the benefits we offer and the subscription costs, we feel confident that you will agree with us that the Medicinal Cash Plan offers a truly value for money service.



■ How to Join

You can join the scheme by completing the attached form and returning it to our office (personal callers welcome).

Payments may be paid direct to the Fund Office by cash, cheque or direct debit. If you are employed, we will check to see if your employer will make payroll deductions for you.

■ Who is Eligible to Join

All UK residents aged up to 60 years may join the Medicinal Cash Plan (existing contributors may continue their Plan after their 60th birthday).

■ No Medical Requirement

A medical examination is not required as a condition of joining the Medicinal Cash Plan. You only need to complete and sign a declaration form. There is, however, a qualifying period of three months before claims can be made against a new plan.

■ Transfer of Employment

If you pay through an 'employer scheme' and you leave your present employer, just notify us of your new circumstances and we will ensure that your Plan continues unaffected. Please include your original membership number in all communications.

■ Transfer between Plans

You may upgrade your Plan at any time by completing a new application form obtainable from the Fund's office which takes effect when authorised by the Fund's office. Please include your original membership number in all communications. There is a qualifying period of three months before claims can be made against a new plan. For known medical conditions benefits will be paid on the original plan chosen, or if a new joiner, benefits will not be paid for known medical conditions in the first 12 months of joining and/or upgrade.

NB. Downgrading is not permitted.

■ Dependants

Dependent children under 16 years and partners are covered for Hospital In-patient benefit at no extra cost.

■ How to Claim

To claim your benefits, send an **original** receipt to the Fund's Office e.g. a prescribed Optical or Dental Receipt, or Hospital Note – Hospital appointment cards are acceptable if each date of attendance is authorised and stamped. **All claims must be made within three months** of discharge from hospital or date of treatment received. All receipts must be signed, original, identifiable, dated and stamped.

Altered receipts/hospital notes or copies of receipts/hospital notes are **NOT** accepted.

If treatment has been obtained by both contributor and partner, the amounts for each must be clearly stated.

Claim forms can be obtained from the Fund's Office. If enrolment/payment is through an employer's scheme, your payroll and/or works number must be quoted.

■ Our Commitment to You

We know that the speed, the quality of response and the simplicity of the application process are important factors in the consideration of medical cash-back plans.

The objective of the Gwent Contributory Fund team is to make everything as easy as possible. We are not only committed to providing value for money Plans, we are dedicated to giving you excellent service – from the initial application to simple and quick turnaround of qualifying cash benefit payments and long term management of your Plan, all at no charge to you.

Whatever Plan you choose, you can be assured that we deliver.

■ Immediate Action for New Contributors

Don't wait until you are ill before thinking about joining Medicinal Cash. Just fill in the application form at the back of this brochure and return it to us

Gwent Hospitals Contributory Fund,
Medicinal Cash Plan, FREEPOST, SWC0614,
Newport, South Wales NP20 1YY.

Freephone on 0800 479 8003

General Conditions

- Responsibility cannot be accepted for any known condition from which contributors or their dependants suffered prior to joining the Fund (dental & optical excepted).
- Persons wishing to rejoin the Fund will be subject to a review of past claims prior to re-admittance.
- All claimants will need to satisfy the Fund's Office of validity of membership and claims. Personal and/or employment details may be requested.
- Physiotherapy, Osteopathy, Chiropractic & Acupuncture treatment must be provided by a qualified and registered person. Claims supported by a doctor's note will also be considered.
- BENEFITS**
 - will only be paid whilst contributions are being made.
 - will only be paid to UK residents.
 - are reviewed periodically by the Executive Committee.
- Failure to cash cheques within six months will jeopardise payment of benefit. The Fund's liability in respect of benefit cheques paid will cease after SIX MONTHS from the date of issue.
- Maximum Rule:** For in-patient and out-patient, day surgery and medical professional fees, the maximum is the equivalent of a ten weeks in-patient benefit in any 5-year treatment period.
- Maternity Benefit is not payable within 12 months of joining the Fund, nor upgrading from an existing scheme. In the case of upgrading, the benefit will be paid at the previous scheme benefit level.
- In the event of a joint claim, only those contributors residing at the same address are eligible to claim.
- Complaints about any aspect of our service should be reported to the Chief Executive on 01633 266152 or write to us at 13 Cardiff Road, Newport NP20 2EH. Complaints we cannot settle may be referred to the Financial Ombudsman Service..

Please contact the Fund's Office if you require further details regarding the Rules and Conditions. These rules supersede all previously published rules.

Helpline Service

This added helpline service is available to contributors only. The telephone number is available from the Fund's Office. **USE IT – OR LOSE IT!**

For first class assistance in an emergency, simply telephone the special HELPLINE number which is provided when you become a contributor. Helpline services include:

- **Homecall**
- **Legalcall**
- **Medical Information**
- **Travel Information**
- **Stress Counselling**
- **Redundancy Counselling**
- **Bereavement Counselling**
- **Debt Counselling**

Medicinal Cash - working to help you when it becomes difficult to help yourself.



Medicinal Cash Joining Form

For Payroll Deduction: Please complete in BLOCK CAPITALS and send both halves to your employer
THIS HALF TO BE RETAINED BY THE EMPLOYER

Full name
 Date of birth Telephone number:.....
 Address
 Postcode:.....

I authorise my employer to deduct (please ✓ the plan amount from the table) for credit to my Gwent Hospitals Contributory Fund, **Medicinal Cash Plan** or other such contributions as may later apply (subject to my right to give one week's notice of withdrawal).

Plan name	Per Week Cont.	Ptner	Per Month Cont.	Ptner
Foundation @ £1.90	<input type="checkbox"/>	<input type="checkbox"/>	£ 8.23	<input type="checkbox"/>
Bronze @ £2.90	<input type="checkbox"/>	<input type="checkbox"/>	£12.56	<input type="checkbox"/>
Silver @ £4.90	<input type="checkbox"/>	<input type="checkbox"/>	£21.23	<input type="checkbox"/>
Gold @ £6.90	<input type="checkbox"/>	<input type="checkbox"/>	£29.90	<input type="checkbox"/>
Executive @ £8.90	<input type="checkbox"/>	<input type="checkbox"/>	£38.56	<input type="checkbox"/>

Signed Date
 Place of work Clock Number
 Department

If paying Double (payment for partner)

Name of Partner Date of Birth.....

Gwent Hospitals Contributory Fund, Medicinal Cash Plan, 13 Cardiff Road, Newport, South Wales NP20 2EH.
Tel: 01633-266152 or 250112

For Payroll Deduction: Please complete in BLOCK CAPITALS and send both halves to your employer
THIS HALF TO BE RETURNED BY THE EMPLOYER TO THE FUND'S OFFICE

Full name
 Date of birth Telephone number:.....
 Address
 Postcode:.....

I authorise my employer to deduct (please ✓ the plan amount from the table) for credit to my Gwent Hospitals Contributory Fund, **Medicinal Cash Plan** or other such contributions as may later apply (subject to my right to give one week's notice of withdrawal).

Plan name	Per Week Cont.	Ptner	Per Month Cont.	Ptner
Foundation @ £1.90	<input type="checkbox"/>	<input type="checkbox"/>	£ 8.23	<input type="checkbox"/>
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Silver @ £4.90	<input type="checkbox"/>	<input type="checkbox"/>	£21.23	<input type="checkbox"/>
Gold @ £6.90	<input type="checkbox"/>	<input type="checkbox"/>	£29.90	<input type="checkbox"/>
Executive @ £8.90	<input type="checkbox"/>	<input type="checkbox"/>	£38.56	<input type="checkbox"/>

Signed Date
 Place of work Clock Number
 Department

If paying Double (payment for partner)

Name of Partner Date of Birth.....

Gwent Hospitals Contributory Fund, Medicinal Cash Plan, 13 Cardiff Road, Newport, South Wales NP20 2EH.
Tel: 01633-266152 or 250112



Medicinal Cash Joining Form

For Direct Contributors ONLY: Please complete this side only.

For Payroll Deduction:

Fill in the reverse side ONLY and return both halves to your Wages Department

DIRECT *Please complete in BLOCK CAPITALS*

I apply to join the **Medicinal Cash Plan** and, if accepted, agree to the Rules and Regulations and other such conditions as may apply later (subject to my right to give one week's notice of withdrawal).

Please tick against plan and amount required

Plan name	Per Week Cont.	Ptner	Per Month Cont.	Ptner
Foundation	@ £1.90	<input type="checkbox"/>	£ 8.23	<input type="checkbox"/>
Bronze	@ £2.90	<input type="checkbox"/>	£12.56	<input type="checkbox"/>
Silver	@ £4.90	<input type="checkbox"/>	£21.23	<input type="checkbox"/>
Gold	@ £6.90	<input type="checkbox"/>	£29.90	<input type="checkbox"/>
Executive	@ £8.90	<input type="checkbox"/>	£38.56	<input type="checkbox"/>

Full Name:
 Date of birth: Telephone number:
 Address:
 Postcode:

Employer Name:
 Address:
 Postcode:
 Telephone number:

I have previously paid into the Gwent Hospitals Fund YES / NO if YES through:-

(a) Direct (b) Employer

Details please

Direct Debit facilities are available on request

Does your partner currently contribute to the Fund? YES / NO

Please give details of all dependants who are relatives, resident with you and wholly dependent on you.

Full name(s)	1	2	3
Relationship	1	2	3
Date of birth	1	2	3

Have you or any member of your family had any hospital in-patient or out-patient treatment in the last 5 years YES / NO

If yes, please give details:

Are you or any member of your family suffering from any illness? YES / NO

If yes, please give details:

I certify that my dependants and myself are in good health (apart from anything listed above).

Signature Date.....