WILTSHIRE

FRIENDLY

SOCIETY LIMITED

GROUP PERSONAL INCOME REPLACEMENT PLANS FOR EMPLOYEE GROUPS AND MEMBERS OF SPORTS AND LEISURE CLUBS

POLICY SUMMARY

V1.1 January 2020

IMPORTANT NOTES

This document summarises important information about our Group Personal Income Replacement Plans For Employee Groups And Members Of Sports And Leisure Clubs. ("the Plan" / "your Plan" / "my Plan").

It is designed to help you decide if the Plan is right for you and that it meets your own particular needs.

For clarity, some of the text in this document assumes you are already a policyholder.

You should read this document in conjunction with your Personal Quotation which sets out the cost of the Plan you select. You should read these documents carefully so that you understand what you are buying, and then keep them safe for future reference.

This document does not contain the full terms and conditions of your Plan. These can be found in the Policy which is set out in the separate Policy Document ("Policy") and our formal offer of cover ("Offer"), copies of which will be sent to you when you have applied for and been accepted for your Plan. A copy of the Policy Document can also be found on our website: www.wiltshirefriendly.com.

It is your responsibility to make sure that your Plan is in all respects suitable for your circumstances, including those relating to your Income. The Society is not able to advise you about this and if you are in any way unsure you are strongly recommended to seek advice from an Independent Financial Adviser.

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1 INTRODUCTION

1.1 Who Is Wiltshire Friendly Society?

Wiltshire Friendly Society Limited ("the Society") is an insurance firm and a mutual society. Being mutual means that the Society is owned by its members and therefore has no shareholders to consider. It exists only for the benefit of current and future generations of Society Members ("Member(s)" / "Membership").

We were founded in 1887 and specialise only in providing Income Replacement Insurance; as a Member you will have the right to attend and vote at our Annual General Meeting.

1.2 What Should I Consider?

Circumstances are personal and will vary from person to person, however there are a few considerations that will apply to all.

- Will I receive sick pay from my employer and will this be sufficient and will it last for long enough?
- I am self-employed - who will pay me if I lose income because of incapacity?
- Are my savings sufficient to support me if I lose income because of incapacity, will they last long enough and do I want to use them for this purpose?
- Am I eligible for State Benefits and will they be sufficient to support my lifestyle?

1.3 What Are The Objectives Of My Plan?

Our Income Replacement Plans are policies of insurance which are designed to replace a proportion of the income that you lose, when you are unable to work as the direct consequence of illness or of injury sustained in an accident. Cover is arranged on "Permanent Health" terms which mean we, the insurer, cannot cancel them other than in accordance with the terms of the policy. Such policies may also be known as income protection insurance.

The objectives are:

- To pay regular benefit ("Benefit") to replace a pre-agreed part of any (pre-tax) income you lose if you suffer incapacity and, as a consequence of which, you are unable to work.
- To provide a plan specifically designed to meet the needs of Members who are:
  - grouped together by virtue of being employees of a particular employer; or are
  - members of a particular club or organisation established for leisure purposes; and, as the case may be
  - under arrangements made with an employer or the governing body of the club or organisation.

Although your Plan is set up under facilitating arrangements made with your employer or the management of the club or organisation of which you are a member; you will be the owner and the beneficiary of the Plan. It must be paid for from your income after deduction of income tax or, if you are self-employed, it can be paid for by way of drawings from your business.

1.4 Under The Policy Terms - What Does The Society Have To Do?

- To provide cover in accordance with the Policy and the Rules of the Society (the "Rules").
- To continue to provide cover until your Plan ceases in accordance with the terms of the Policy and the Rules, irrespective of the number of times you claim.
- Treat you and your fellow members, fairly, equally and objectively.

1.5 Under The Policy Terms - What Do I Have To Do?

- To take reasonable care to answer truthfully, without mis-representation and to the best of your knowledge, accurately and fully all of the questions we ask when you first apply for your Plan and later if you apply to amend it.
- To provide true, accurate and full information about your incapacity, income and relevant circumstances we ask for when you submit a claim.
- To abide by the Rules, the Policy and any personal terms set out in the Offer.
- To tell us about any claim you may need to make within the time limits specified in the Policy and to participate fully in our claims admission and management processes when you claim.
- To let us know, as soon as they occur, about any changes in your personal, income and work circumstances that might affect your Plan and the cover it provides.
- To review your Plan regularly to ensure that it continues to meet your needs and remains appropriate for your circumstances.

1.6 Disclosure Of Facts And Circumstances

Under the Consumer Insurance (Disclosure and Representations) Act 2012, when providing information to an insurer you have a duty to take reasonable care not to make a mis-representation.

Therefore, when applying for your plan and later if you apply to amend your cover, you will be required to take good care and make all reasonable efforts to answer all of the questions we ask – in whatever format - truthfully, without mis-representation and to the best of your knowledge, accurately and fully.

We refer to your disclosures as Material Facts which, for example, will include those given when: completing your application form, responding to any follow-up queries we may raise and when participating in a telephone interview during the **Stage 2 Underwriting** process, if that is required. The **Stage 2 Underwriting** process is explained more fully in fully in Section 2.5.

If you are unsure of how to answer a question or its meaning or scope, you must contact us to discuss this and resolve it.

You must take all reasonable care to answer all questions we ask honestly and to the best of your knowledge, if you do not your Plan may be cancelled or amended and, any future claim rejected or not fully paid.

2 THE KEY FEATURES

2.1 Who Can Be Covered And Am I Eligible?

Anyone who is employed with minimum contracted work of 16 hours per week or who is self-employed and who also meets all of the following criteria:

- You must be gainfully employed on a full-time or part-time contract or; if a member of a club or organisation be gainfully employed on a full-time or part-time contract or be self-employed.
- You must be employed by an employer or be a member of a club or organisation with whom we have established formal arrangements to provide the Plan to their employees or members; and in any case you must be:
  - aged 18 or above and not above the age of 59; and
  - not due to retire within the next 5 years; and
  - resident in the United Kingdom ("UK") and, except at our discretion, have been so for at least the last 3 years; and
  - registered with a UK doctor who has access to your medical records from at least the last 3 years; and
  - a UK taxpayer or liable to UK tax on income above the relevant thresholds; and be
  - the holder of a UK bank account.
- Once your Plan has commenced, it will continue whether or not you remain employed by the employer, or you remain a member of the club or organisation, with whom we have established arrangements and if those arrangements cease in the future.

2.2 What Am I Covered For?

When you submit a valid claim because you cannot work as the consequence of an incapacity, your Plan will pay you Benefit for up to two years.

Claims will cease either at the end of two years or, if earlier, when you recover or when you return to work whether you have recovered or not. There are other reasons for a claim to cease before the expiry of two years including, for example, if you die.

Benefit will be payable from the end of the Deferred Period you selected when you took out your Plan or amended it later. (The "Deferred Period" is the optional period at the beginning of your incapacity for which no Benefit is due or payable).

If you do not fully recover but nevertheless you are sufficiently fit to return to your own or other work, you may qualify for Proportionate Benefit if you continue to lose income because of your incapacity.

2.3 How Much Cover Can I Have?

For levels of cover of £1,000 per month or below, you may select monthly amounts of cover that match your Total Insurable Income, within the ranges set out in the following table.

For levels of cover above £1,000 per month the amount of cover you request cannot exceed our limit of cover which is the lower of 65% of your Total Insurable Income or £3,250 per month – equivalent to £39,000 per annum ("Maximum Cover Limit").

If you select and/or maintain a higher level of cover than your income entitles you; at the time of any claim we may not pay all of the Benefit you are expecting and, if so, we will not refund any excess contributions you may have paid.

Total Insurable Income (In the ranges)	**Maximum Monthly Cover**	**Minimum Monthly Cover**
£4,500 to £6,000	**£325**	Minimum cover for any Plan and subject to a minimum of 16 hours paid work per week
£6,001 to £9,230	**£500**	-
£9,231 to £13,846	**£750**	-
£13,847 to £18,462	**£1,000**	-
Above £18,462	Additional cover may be purchased in multiples of £100 per month subject to your income	
Your Total Insurable Income is your annual income from all sources, on which the amount of cover you are eligible to hold will be based		

2.4 What Is Not Covered?

- Your Plan will only cover you for the amount of Benefit you have chosen to insure, subject to the Maximum Cover Limit. There are reasons for us not accepting a claim and the principal ones are as follows:
  - your incapacity:
    - first arose before the commencement date of your Plan;
    - does not last for longer than your deferred period; and it
    - relates to a medical condition that we tell you we will not insure in our letter offering you cover ("Offer");
  - you suffer from an historic medical condition or a medical condition that also existed at the time you applied for cover; either of which, when asked, you did not tell us about when you applied for your Plan or applied to amend it later, and which, if you had done so, would have resulted in us excluding it from your Plan, declining to offer you cover or applying other special personal terms;
  - except at our sole discretion, any incapacity that does not fully prevent you from working, although you may be eligible for Proportionate Benefit which pays Benefit reduced to reflect any continuing income you may earn whilst claiming;
  - attempted suicide, intentional self-injury or exposure to unnecessary danger (except in an attempt to save human life);
  - being under the influence of, or addiction to, alcohol, narcotics, solvents or drugs - other than drugs normally available over the counter of a retail pharmacy or other properly authorised retailer;
  - any medical or surgical treatment not certified by a registered medical practitioner as necessary for your health;
  - sterilisation other than when medically necessary; and
  - any incapacity that arises while your cover is suspended.

- There are also reasons that may result in us not paying all or any of the Benefit you are expecting to be paid and the principal reasons are as follows:
  - you make a fraudulent claim;
  - you deliberately or recklessly mislead us in any way;
  - you have not truthfully, without mis-representation and, to the best of your knowledge, accurately and fully given the Society all the information requested when you first applied for your Plan, later applied to amended it and during the progress of a claim;
  - your contributions are not up to date;
  - you fail to notify us of your incapacity within our time limits for notification;
  - you continue working or you do not suffer any loss of income during your incapacity;
  - you only suffer partial loss of income during your incapacity, in which case we may only pay Proportionate Benefit;
  - your actual income from all sources immediately before you claim is lower than the income you have insured;
  - you receive benefit from other similar policies (Income Protection Policies) when you are incapacitated and this causes you to be over-insured; and
  - your incapacity arises when you are working or living in any country outside the EU. In such cases payment of Benefit will only be made when you have been repatriated to the UK. This does not normally refer to travel undertake solely for leisure purposes lasting less than 3 months, unless we are unable to obtain medical information in English from your treating medical attendants.

- Pregnancy is not an illness and is outside the scope of your cover. However, your Plan does insure complications of either pregnancy or childbirth, provided your cover is not suspended during any part of your pregnancy.

2.5 How Much Will My Plan Cost?

- Standard rates of contribution, which can also be known as premiums ("standard rates") are set out in tables that are published by the Society from time to time ("standard table(s)"). You will be provided with a copy of the current relevant standard table when we send you our Offer. The current standard tables are also available on our website. (Please see the "Useful Information" section on page 13 for our contact details).

The cost of your Plan will depend on a number of personal and more general factors.

- The contributions you pay will depend partly on:
  - your age at the commencement of your Plan and in each subsequent year. Our standard tables are set out in age bands and your contributions will increase as you move from one age band to the next. This will take place at the beginning of the month following that in which you attain the lower age of the next age band;
  - the cover you select;
  - the Deferred Period you choose - and available deferments are 1 week, 2 weeks and 4 weeks;
  - the Plan Retirement Age (which is fixed at the earlier of your State Pension Age or your 68th birthday);
  - whether or not you are a smoker; and
  - any additional contributions we may need to charge as a consequence of the underwriting processes.

- There are also more general factors that can influence the cost of plans provided by the Society and these include:
  - the Society's claims and general expenses;
  - inflation;
  - legislative and regulatory changes – for example changes in the levels of capital and reserves we are required to hold;
  - changes in taxation; and
  - other economic and environmental factors, outside of our control, that may influence our costs but which we could not reasonably have foreseen when originally pricing our plans.

- The cost of providing our plans is reviewable in the light of the factors set out above. This means that we can review our standard tables each year and either increase or decrease contributions by any amount, although we are not obliged to make any such amendments.

  However, if we do make any such changes they will be fair and reasonable and we will provide you with at least 1 clear month's notice before they take effect.

2.6 How Do I Apply And What Is The Assessment Process?

Application

- You must have applied for your Plan or any subsequent increase in cover using our prescribed application form, which must be completed truthfully, without mis-representation and, to the best of your knowledge, accurately and fully.

- We are not obliged to provide any insurance or, if you already have a Plan, to agree to any increase in your cover.

Assessment

- When you apply for your Plan (and later if you apply to increase or otherwise amend your cover) your application will be subject to underwriting – which is the name for the processes we use to assess applications and decide whether we can offer standard cover, if we need to apply special personal terms that reflect your circumstances or if we can offer cover at all.

- Our processes are designed to minimise delay in getting your Plan up and running. To do this we underwrite in two clear stages which are designed to ensure we are treating you fairly in our assessment of your circumstances.

  - **Stage 1 Underwriting** - is designed so that we can make an initial assessment of your application form and personal circumstances to see if we can issue our Offer and your Plan can commence immediately.

  - **Stage 2 Underwriting** - if we are unable to offer you cover immediately, our Stage 2 Underwriting process is designed to help us find out more about your health and lifestyle so that we can accurately assess your application before we issue our Offer.

    We will ask you to complete a more detailed questionnaire than the initial one on your application form. Normally this will be completed in a telephone interview conducted by a qualified nurse. Our leaflet "Your Guide to Telephone Interviews" will tell you everything you will want to know about the interview.

    Additionally and with your consent, we may also ask your doctor for more information and, exceptionally we may request you to undergo tests, however this is not required in the majority of cases.

Offer

- When we have completed our assessment of your application we will send you our Offer. This will confirm: the type of cover we are offering, the proposed start date, any special personal terms we may need to apply as a consequence of our underwriting process and the contributions you will pay.

- If you are happy with the terms offered, you may accept them by paying your first monthly contribution and your cover will then commence.

- For a limited time afterwards you will have the right to cancel your Plan.

2.7 Can I Change My Mind And Cancel My Plan?

When your Plan commences we will send you a cancellation notice, setting out your right to cancel.

If you change your mind and do not wish to continue with your Plan, you may cancel it, provided you do so within 30 days of the later of its commencement date or the date on which you receive the cancellation notice. If you cancel within this period, you will receive a full refund of any contributions you have paid.

You may cancel by returning the form attached to the cancellation notice or by contacting the Society by any of the methods set out in the "Useful Information" section, which can be found on page 13.

If you do not cancel your Plan as set out above and wish to cancel it later, you will be bound by the Policy and therefore you will need to give notice to terminate your Plan. Please see Section 2.9 for further information about this.

No refund of contributions will be made other than during the 30 day cancellation period referred to above.

2.8 Can I Vary My Cover Or Take A Break?

- You may apply to the Society at any time to vary the cover you have under your Plan, provided you are aged 59 or below and your circumstances support such variation.

  For any application to increase your cover or to decrease the Deferred Period, the process will be the same as for new applications as set out in Section 2.6.

  If you apply to increase your cover it may be necessary to offer the increase with special personal terms applied which may be different to your existing cover. For example, this may arise because your health has deteriorated since your Plan commenced.

  If we have already applied special personal terms to your existing cover, these will be applied to the increased or amended cover too. However, if we did not originally apply such terms to your existing cover any new special personal terms would only apply to the increase and normally will not be applied retrospectively to your existing cover.

- You may apply to suspend the cover provided by your Plan if you experience a temporary change to your circumstances and as a consequence, either you do not need your cover temporarily or you cannot afford it for the time being.

  For example you may have become unemployed, you wish to take unpaid study leave or a career break or you have financial difficulties.

  You may also suspend cover during maternity leave, although if you do so you will be unable to claim for any complications arising from the pregnancy or childbirth and you will need to have returned to work before your cover can be reinstated.

  Provided your contributions are up to date, you have received our written agreement and your Plan has been running for at least 12 months you will be eligible to apply to suspend your Plan:
  - if we agree you may suspend for;
    - up to 1 year (or for a number of shorter periods totalling 1 year) within any 2 year period;
    - a minimum period of 3 months on any one occasion; and
    - a maximum of 3 aggregate periods totalling 1 year during the life of your Plan;

- You will be unable to submit a claim for any incapacity that arises while your cover is suspended.

- When you are ready to reinstate cover you must have returned to work, be in good health and you will need to provide us with a statement of good health and of your income. If your income does not justify the amount of cover you have, we will only reinstate the amount of cover that is supported by your income at the time and the balance of your cover will be cancelled.

2.9 When Will My Plan Terminate?

- Your Plan, the cover it provides and your Membership will cease altogether at the end of the month in which you reach the Plan Retirement Age. Normally this will occur in the month that you attain your State Pension Age or the age of 68, whichever occurs first.

  Within the time limits set out in Section 2.7 and immediately following the date on which your Plan is first set up, you may cancel it by giving notice to the Society. You will receive a full refund of any contributions you have paid.

  After your Membership has been in force for 30 days you may give notice to the Society that you wish to cancel your Plan at the end of the month in which you give that notice.

- Your Plan will cease immediately if you die.

- Under normal circumstances we are obliged to continue to provide your Plan and Membership until any of the above applies on the terms set out in our Offer of initial cover or, of any subsequent cover amendment.

  However, there are some circumstances in which we can terminate your Plan in full or cancel part of the Cover provided by it. We may do so if you:
  - are unable to resume suspended cover within our set time-limits, your Plan will cease automatically or, if your income does not justify resumption of full cover, the balance will be cancelled;
  - fail to disclose truthfully, without mis-representation and, to the best of your knowledge, accurately and fully all Material Facts we ask for when we first set up your Plan or later. when you apply to amend your cover;
  - deliberately or recklessly make an untrue and/or misleading statement in connection with any aspect of your Plan or Membership of the Society;
  - make a fraudulent claim. For example this would occur if you submit a claim when you are not totally incapacitated for work, if you are actually working during that claim or you do not fully lose income and you do not tell us about these facts;
  - are the subject of a custodial sentence; or if
  - you or someone acting for you, subjects any officer of the Society or other member of the Society's staff to physical violence or extreme abuse in any format.

- We also reserve the right to consider terminating your Plan or amending the terms if you take up a more hazardous occupation or pastime than that applicable when we carried out our underwriting processes. We will only do this if we would have declined in the first place to offer you cover or would have applied special personal terms on this basis. You are strongly recommended to inform us immediately you contemplate any such change and when such a change occurs.

3 ADDITIONAL INFORMATION

3.1 Claims And Claiming

- All claims are subject to the Society's acceptance and validation processes, the purpose of which is to ensure that claims comply with the terms of the Policy and any special personal terms that we may have applied.

- All information given by you in connection with claims, must also be given truthfully, without mis-representation and, to the best of your knowledge, accurately and fully.

- When you are totally unable to work because of incapacity you can submit a claim (provided the claim lasts for more than 3 days). We will first assess your claim and provided it is in order, payment of Benefit will begin from the end of the agreed Deferred Period.

- Whether or not you submit a claim for it, you must notify us of any incapacity requiring hospitalisation for any length of time, or if you receive medical supervision, care and/or treatment lasting for greater than 6 weeks.

- Payment of Benefit will be made at four weekly intervals whilst your claim is in progress and will be made by direct transfer into the bank account you nominate on your claim form (we may have to carry out further checks if this is not the account from which your contributions are paid by Direct Debit). If you are paid weekly we may agree to pay Benefit weekly in arrears - but that will be at our sole discretion.

- Once you have been eligible to receive Benefit for greater than 28 days, we will refund any contributions paid after the date on which this occurs, until the claim ceases.

- During the progress of a claim there may be circumstances that mean you can work, but because of your incapacity this can only be at a reduced level. Under these or similar circumstances, payment of Benefit will not cease immediately you return to work and the Society will consider payment of Proportionate Benefit.

  Examples of such circumstances might be as follows:
  - you are not fully fit to return to work, but nevertheless you are working reduced hours at reduced income during your recovery;
  - you have been medically certified as unfit to return to your original occupation but you are fit to return to an alternative and you do so, albeit at reduced income; or
  - your incapacity does not fully prevent you from working but, because it has an impact on your availability to work it also causes you to lose income - for example you might need to take regular time off to attend long-term specialised treatment.

- If you meet the criteria for payment of Proportionate Benefit the amount of Benefit payable will be reduced Proportionately, to reflect the actual reduction in your income when compared to that at the beginning of your claim. The following is a summary of the terms that will apply:
  - Proportionate Benefit will decrease on every subsequent increase in your income and unless, in our sole opinion, your medical circumstances warrant it, will not increase if your income later falls again;
  - if we agree to this, we will also agree terms with you that are appropriate to your circumstances. This will include an appropriate duration and applicable criteria for the remainder of the claim;
  - if they occur sooner, all of the normal criteria for the cessation of a claim will also apply;
  - in any event Proportionate Benefit will cease altogether and your claim will terminate when your income from all sources equals or exceeds that immediately prior to your incapacity;
  - if your medical circumstances warrant it, the Society will also consider payment of Proportionate Benefit from the outset of a claim; and
  - for the avoidance of doubt, eligibility for payment of Proportionate Benefit cannot be based on the success or otherwise of a commercial venture or of a particular work activity.

3.2 Taxation

- Benefit is paid free of income tax and capital gains tax under current legislation and the rules of H.M. Revenue & Customs ("HMRC").

- For the tax exempt status to apply, your contributions must be made by you from your income after deduction of tax. If your contributions are deducted from your pay and remitted to us by your employer, you must ensure that such deductions are made from your net pay. If you fail to do this any Benefit you receive would be treated as income and taxed accordingly.

- The following will apply if you are self-employed or a director of a limited company ("director(s)"):
  - if you are self-employed and choose to pay your contributions through your business they should be treated as drawings and not a tax deductible business expense. Any Benefit claimed is paid to you personally and is not taxable;
  - if you are a director and choose to pay your contributions from company funds, any such payment must be treated as a benefit in kind and taxed accordingly or be deducted from your net salary. If you fail to ensure this is the case any Benefit you receive would be treated as income and taxed accordingly. Any Benefit claimed is paid to you personally and is not treated as income of your company. However, as directors may be treated differently to other employees under HMRC rules, you should seek the advice of your tax adviser or HMRC about your specific circumstances.

Important Note:-
Legislation and/or the rules of HMRC could change in the future and affect the information set out above. That information does not constitute advice. If you are in any doubt you are strongly recommended to seek advice from your own tax advisers.

3.3 General Matters

Law

The Plan and associated arrangements between the policyholder and the Society shall be governed by and construed in accordance with the Laws of England, and any dispute shall be subject to the exclusive jurisdiction of the English Courts.

Third Party Rights

The Contracts (Rights of Third Parties) Act 1999 is excluded under the terms of your Plan.

Assignment

You may not assign your Plan without our consent.

Surrender Or Maturity Value

Your Plan will not acquire a surrender or maturity value at any time.

Terms And Conditions

The full terms and conditions comprise of this Policy, our Offer and the Rules. In the event the Offer differs from the Policy, the Offer will take precedence.

3.4 Privacy Policy

The Society wants to give you the best standard of service it can and the Society is serious about protecting your personal information. It is especially important that you trust the Society to look after sensitive information, including your medical history. The way the Society collects and shares your information is equally important and you expect the Society to manage your information privately and securely.

Our Privacy Policy will tell you how the Society collects and processes your personal information. Please take a few minutes to read it and show it to anyone else who may be connected to the information you provide to the Society.

This Privacy Policy may be subject to change – you can find the most recent version of this policy at wiltshirefriendly.com/privacy.

The Society never discloses personal data to any third parties for direct marketing or other similar purposes.

4 USEFUL INFORMATION

If you would like information about an application or you need to complain about the advice you received when you set up or amended your Plan, you should contact the adviser who arranged it for you. His or her contact details and information about how to complain will be found on the Client Agreement given to you when your Plan was arranged.

If your application was submitted directly or through a Society adviser, you should contact us directly. Please see below for our contact details and complaints procedure.

4.1 Society Contact Details

- By telephone:

General enquiries	01225 752120
Application queries	01225 756783
Claims	01225 756793

- By email: group@wiltshirefriendly.com

- Or you can write to us at:

Wiltshire Friendly Society Limited
Holloway House
Epsom Square
White Horse Business Park
Trowbridge
Wiltshire
BA14 0XG

- Our website: www.wiltshirefriendly.com

4.2 How To Complain About The Service Provided By The Society

We aim to provide you with the very best service possible. However, if we have fallen short, please do let us know.

If you wish to complain about any aspect of your membership or the service you have received from us, please let us know by any of the means shown above. If you choose to do so by letter please address it to the Governance & Compliance Manager. When we receive your complaint we will acknowledge its receipt and provide you with a copy of our complaints procedure. We will then investigate your complaint and try to resolve it with you. If, when we have completed our procedures and issued you with our final response, you are not satisfied with the outcome, or if after 8 weeks we have failed to issue you with a final response, you may be able to refer your complaint to the Financial Ombudsman Service (FOS) at:

Address:	Exchange Tower, London, E14 9SR
Telephone No:	0800 0 234 567
Website:	www.financial-ombudsman.org.uk
By email:	complaint.info@financialombudsman.org.uk

For commercial clients who are not eligible to refer complaints to FOS; the Society maintains a panel of arbitrators, appointed in accordance with the Friendly Societies Act 1992, to consider disputes. Such appointments are renewed each year at the Society's Annual General Meeting.

4.3 Financial Services Compensation Scheme

In the unlikely event that the Society cannot meet its financial obligations you may be entitled to compensation from the Financial Services Compensation Scheme (FSCS). More information is available from the FSCS at:

Address:	PO Box 300, Mitcheldean, GL17 1DY
Telephone No:	0800 678 1100
Website:	www.fscs.org.uk

WILTSHIRE

FRIENDLY

SOCIETY LIMITED

INCOME REPLACEMENT INSURANCE SINCE 1887

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Incorporated under the Friendly Societies Act 1992 Register No. 746F
Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority