

Group Critical Illness for Voluntary and Flexible Benefits Policies

Policy wording (GR03003 - 01/2017)

Welcome to Group Protection from Aviva

What the policy wording explains

This policy wording tells you:

- what to do if you need to claim.
- what is covered.
- explanations of some of the terms used in this document.

We've tried to make this document as easy to understand as possible, but if you have any questions or queries about the policy please contact us and we will be pleased to help you.

How the policy works.

If you provide us with the information we ask for, when we ask for it and pay the premiums when they are due, we will cover members and children for their insured benefits, and pay these benefits should a member or child be diagnosed with a critical illness or undergo an operation covered by the policy.

Outline of the Policy

This policy wording, along with the policy schedule and any endorsements sets out details of the cover we have agreed to provide to you. It is evidence of a legal contract between you and us. We recommend you keep this document somewhere safe.

Some terms of the policy depend upon the information provided by you. Failing to disclose information, giving false information or failing to tell us where any facts have changed since they were provided where done deliberately or recklessly gives us the right to cancel the policy. If the information was given carelessly or the failure to disclose the information was careless then we will have the right to amend the policy to be consistent with what the terms should have been based on the correct information (or cancel the policy if we would not have offered any terms for the policy applied for).

If you fail to comply with all of the policy terms and conditions, we may not pay claims. We may also cease to accept further premiums, meaning cover under the policy will cease.

The policy will not have or accrue any surrender value.

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Please note

Throughout this document certain words are shown in **bold** type. These are defined terms and have specific meanings when used in this policy wording. The meanings are set out in the definitions section at the back of this document.

Critical illnesses, operations, and their associated conditions

There are two levels of cover – Standard and Extended. The level of cover **you** have chosen is shown on the **policy schedule**. If **you** have chosen Extended cover, this includes the **critical illnesses** and **operations** shown in Standard cover. No other conditions or operations are covered.

We use the Association of British Insurers (ABI) definitions for all **critical illnesses** that have been defined by them. These definitions are marked with an asterisk.

The right hand column shows the **associated conditions** for each **critical illness** or **operation** - these **associated conditions** are used in a **policy** exclusion - see the **pre-existing conditions** exclusions and other exclusions section for full details.

Critical illness/ operation	Definition	Associated conditions
Standard		
*Alzheimer’s disease – <i>resulting in permanent symptoms</i>	A definite diagnosis of Alzheimer’s disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following: <ul style="list-style-type: none"> remember; reason; and perceive, understand, express and give effect to ideas. For the above definition, the following are not covered: <ul style="list-style-type: none"> other types of dementia. 	Head injury, pure amnesia, depression, psychosis, dementia
*Cancer – <i>excluding less advanced cases</i>	Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes: <ul style="list-style-type: none"> leukaemia sarcoma lymphoma (except cutaneous lymphoma - lymphoma confined to the skin). The following are not covered: <ul style="list-style-type: none"> All cancers which are histologically classified as any of the following: <ul style="list-style-type: none"> pre-malignant; non-invasive; cancer in situ; having either borderline malignancy; or having low malignant potential. Malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin). Any non-melanoma skin cancer (including cutaneous lymphoma) that has not spread to lymph nodes or metastasised to distant organs. All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above, or having progressed to at least TNM classification T2bN0M0. 	Polyposis Coli, papilloma of the bladder or any cancer in situ.

Critical illness/operation	Definition	Associated conditions
Cancer – <i>Second and subsequent</i>	<p>This provides some cover for members who have been previously diagnosed with cancer. A benefit would be payable for a diagnosis of a new, unrelated cancer as defined by the policy terms.</p> <p>If cover is selected, the pre-existing condition exclusion applies in the normal manner to subsequent cancer claims unless:</p> <ul style="list-style-type: none"> the member has been treatment free for a period of 5 years from the date of the most recent previous diagnosis of cancer, and there is no evidence, confirmed by appropriate up-to date investigations and tests, of any continuing presence, recurrence or spread of the previous cancer, and the new cancer: <ul style="list-style-type: none"> affects an organ that is physically and anatomically separate to any previous cancer, and is not a secondary cancer or histologically related to any previous cancer; or for haematological cancers, the new cancer is categorised or divided according to defined cell characteristics in a distinctly different manner to any previous cancer. <p>Treatment includes chemotherapy, radiotherapy, monoclonal antibody therapy, and invasive or non-invasive surgery, but does not include long term maintenance hormone treatment.</p> <p>In addition to the above, in no circumstances will a claim for subsequent cancer be payable if the employee has:</p> <ul style="list-style-type: none"> any signs, symptoms or investigations, that lead to a subsequent diagnosis of cancer regardless of when the diagnosis is made, or a subsequent diagnosis of cancer, <p>which gives rise to a claim during the 120 days following:</p> <ul style="list-style-type: none"> commencement of the policy, or the member joining the scheme, or an increase in benefit (claims will still be considered for the pre-increase amount). 	None
Cardiac Arrest	<p>Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:</p> <ul style="list-style-type: none"> Implantable Cardioverter-Defibrillator (ICD); or Cardiac Resynchronization Therapy with Defibrillator (CRT-D) 	Coronary artery disease, heart failure and cardiomyopathy, left ventricular hypertrophy, myocarditis, hypertrophic cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy, brugada syndrome, idiopathic VF (also called primary electrical disease), congenital or acquired long QT syndrome, familial SCD of uncertain cause, Wolff-Parkinson-White syndrome.
*Coronary artery by-pass grafts – <i>with surgery to divide the breastbone</i>	The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.	Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease

Critical illness/operation	Definition	Associated conditions
Creutzfeldt-Jakob disease (CJD) – <i>resulting in permanent symptoms</i>	A definite diagnosis of CJD by a Consultant Neurologist. There must be permanent clinical impairment of motor function and loss of the ability to: <ul style="list-style-type: none"> ● remember ● reason, and ● perceive, understand, express and give effect to ideas. For the CJD definition, we do not cover other types of dementia.	Organic brain disease, disease of the central nervous system, Parkinson’s disease, depression, epilepsy, dementia, amnesic memory disorder, aphasia, psychosis.
Dementia – <i>resulting in permanent symptoms</i>	A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to: <ul style="list-style-type: none"> ● remember ● reason and ● perceive, understand, express and give effect to ideas We do not cover dementia secondary to alcohol or drug abuse.	Stroke, cerebrovascular disease, organic brain disease, brain tumours, disease of the central nervous system, hydrocephalus, Alzheimer’s disease, Creutzfeldt-Jakob disease, Parkinson’s disease, depression, epilepsy, pure amnesia, aphasia, psychosis.
*Heart attack – <i>of specified severity</i>	Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction: <ul style="list-style-type: none"> ● the characteristic rise of cardiac enzymes or Troponins ● new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests. The evidence must show a definite acute myocardial infarction. The following are not covered: <ul style="list-style-type: none"> ● other acute coronary syndromes ● angina without myocardial infarction. 	Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease
*Kidney failure – <i>requiring dialysis</i>	Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.	Familial polycystic kidney disease, diabetes mellitus or any chronic renal disease or disorder
*Major organ transplant	The undergoing as a recipient from another donor of a: <ul style="list-style-type: none"> ● transplant of a bone marrow, or ● transplant of a complete heart, kidney, liver, lung or pancreas, or ● transplant of a lobe of liver, or ● transplant of a lobe of lung, or ● inclusion on an official UK waiting list for such a procedure. Transplantation of any other organ is not covered.	Cardiomyopathy, coronary artery disease, cardiac failure, chronic liver disease, chronic pancreatitis, pulmonary hypertension, cystic fibrosis, chronic lung disease or chronic kidney disease
*Motor neurone disease – <i>resulting in permanent symptoms</i>	A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist: <ul style="list-style-type: none"> ● Amyotrophic lateral sclerosis (ALS) ● Primary lateral sclerosis (PLS) ● Progressive bulbar palsy (PBP) ● Progressive muscular atrophy (PMA). There must also be permanent clinical impairment of motor function.	Progressive muscular atrophy, primary lateral sclerosis, progressive bulbar palsy

Critical illness/operation	Definition	Associated conditions
*Multiple sclerosis – <i>with persisting symptoms</i>	A definite diagnosis of multiple sclerosis by a consultant neurologist, that has resulted in either of the following: <ul style="list-style-type: none"> clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least three months; or two or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on Magnetic Resonance Imaging (MRI). All of the evidence must be consistent with multiple sclerosis.	Any form of neuropathy, encephalopathy or myelopathy (disorders or functions of the nerves) including but not restricted to the following: abnormal sensation (numbness) of the extremities, trunk or face/ weakness or clumsiness of a limb/ double vision/partial blindness/ocular palsy/vertigo (dizziness)/difficulty of bladder control/optic neuritis/spinal cord lesion/abnormal MRI scan
*Parkinson's disease – <i>resulting in permanent symptoms</i>	A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor and muscle rigidity. The following are not covered: <ul style="list-style-type: none"> Parkinsonian syndromes/Parkinsonian. 	Treatment with dopamine antagonist, tremor, extra pyramidal disease
Progressive supranuclear palsy – <i>resulting in permanent symptoms</i>	A definite diagnosis of progressive supranuclear palsy by a Consultant Neurologist. There must be permanent clinical impairment of eye movements and motor function.	Organic brain disease, disease of the central nervous system, Parkinson's disease, treatment with dopamine antagonist, tremor, extra pyramidal disease, depression, epilepsy, dementia, amnesic memory disorder, aphasia, psychosis.
*Stroke – <i>resulting in permanent symptoms</i>	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either: <ul style="list-style-type: none"> permanent neurological deficit with persisting clinical symptoms; or definite evidence of death of tissue or haemorrhage on a brain scan; and neurological deficit with persistent clinical symptoms lasting at least 24 hours. The following are not covered: <ul style="list-style-type: none"> transient ischaemic attack death of tissue of the optic nerve or retina/eye stroke. 	Atrial fibrillation, transient ischaemic attack, diabetes mellitus, hypertension, intracranial aneurysm or occlusive arterial disease
Childcover benefit (Included within standard cover)		
Cerebral palsy	We will pay childcover benefit if the child receives a definite diagnosis of cerebral palsy made by an attending consultant.	None
Children's intensive care benefit – <i>requiring mechanical ventilation for 7 days</i>	We will pay childcover benefit , if during the period of cover, a child due to sickness or injury is requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) unless it is as a result of the child being born prematurely (before 37 weeks).	None
Cystic fibrosis	We will pay childcover benefit if the child receives a definite diagnosis of cystic fibrosis made by an attending consultant.	None
Hydrocephalus – <i>Treated with the insertion of a shunt</i>	We will pay childcover benefit if the child suffers hydrocephalus if the hydrocephalus is treated with an insertion of a shunt.	None

Critical illness/operation	Definition	Associated conditions
Loss of independent existence	<p>We will pay childcover benefit if in the opinion of a specialist the child will not at 18 years old be able to perform routinely at least three of the following six tasks without the assistance of another person, even with the use of special devices or equipment.</p> <p>The tasks are:</p> <ol style="list-style-type: none"> 1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. 2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances. 3. Feeding yourself – the ability to feed yourself when food has been prepared and made available. 4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function. 5. Getting between rooms – the ability to get from room to room on a level floor. 6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again. 	None
Muscular dystrophy	We will pay childcover benefit if the child receives a definite diagnosis of muscular dystrophy made by a consultant neurologist	None
Spina bifida	<p>We will pay childcover benefit if the child receives a definite diagnosis of spina bifida myelomeningocele or rachischisis by a paediatrician.</p> <p>The following are not covered:</p> <ul style="list-style-type: none"> ● spina bifida occulta, and ● spina bifida with meningocele. 	None
Extended		
*Aorta graft surgery – <i>for disease</i>	<p>The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the affected aorta with a graft.</p> <p>The term aorta includes the thoracic and abdominal aorta but not its branches.</p> <p>For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> ● any other surgical procedure, for example the insertion of stents or endovascular repair. 	Any disease or disorder of the heart or any obstructive/occlusive arterial disease.
Aplastic anaemia – <i>with permanent bone marrow failure</i>	A definite diagnosis of aplastic anaemia by a Consultant Haematologist. There must be permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.	Polyposis Coli, papilloma of the bladder or any cancer in situ.
Bacterial meningitis – <i>resulting in permanent symptoms</i>	<p>A definite diagnosis of bacterial meningitis resulting in permanent neurological deficit with persisting clinical symptoms.</p> <p>We do not cover any other form of meningitis, only meningitis caused by bacterial infection.</p>	Chronic ear disease or hydrocephalus

Critical illness/ operation	Definition	Associated conditions
*Benign brain tumour – resulting in permanent symptoms or removed via craniotomy	<p>A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in either of the following:</p> <ul style="list-style-type: none"> ● permanent neurological deficit with persisting clinical symptoms ● removal of the tumour by craniotomy (surgical opening of the skull). <p>For the above definition the following are not covered:</p> <ul style="list-style-type: none"> ● Tumours in the pituitary gland. ● Tumours originating from bone tissue. ● Angioma and cholesteatoma. 	Neurofibromatosis (von Recklinghausen’s disease), haemangioma (von Hippel- Lindau disease)
Benign spinal cord tumour	<p>A non-malignant tumour in the spinal canal or spinal cord, resulting in either of the following:</p> <ul style="list-style-type: none"> ● permanent neurological deficit with persisting clinical symptoms or ● invasive surgery to remove the tumour. <p>For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> ● Radiotherapy for any tumour. 	Neurofibromatosis, meningomyelocele, and syringomyelia.
*Blindness – permanent and irreversible	<p>Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 20 degrees or less of an arc, as certified by an ophthalmologist.</p>	Stroke or transient ischaemic attack. No benefit will be payable under the blindness critical illness in respect of an insured member or child who at any time prior to the date of entry into the policy has been registered blind
Cardiomyopathy – of specified severity	<p>A definite diagnosis of cardiomyopathy by a Consultant Cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classification’s of functional capacity[^].</p> <p>For the cardiomyopathy definition, we do not cover:</p> <ul style="list-style-type: none"> ● cardiomyopathy secondary to alcohol or drug abuse. ● any other form of heart disease, heart enlargement and myocarditis. <p>[^] NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.</p>	Any disease or disorder of the heart, diabetes mellitus or any obstructive/ occlusive arterial disease
*Coma – resulting in permanent symptoms	<p>A state of unconsciousness with no reaction to external stimuli or internal needs which:</p> <ul style="list-style-type: none"> ● requires the use of life support systems; and ● results in permanent neurological deficit with persisting clinical symptoms. <p>For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> ● coma secondary to alcohol or drug abuse. 	Self inflicted injury or misuse of drugs or alcohol
Coronary angioplasty – to 2 or more coronary arteries	<p>The undergoing of balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of two or more coronary arteries as a single procedure.</p>	Any disease or disorder of the heart, diabetes mellitus or any obstructive/ occlusive arterial disease
*Deafness – permanent and irreversible	<p>Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.</p>	Acoustic nerve tumour, neurofibromatosis (von Recklinghausen’s disease)

Critical illness/operation	Definition	Associated conditions
Encephalitis – <i>resulting in permanent symptoms</i>	A definite diagnosis of encephalitis by a Consultant Neurologist. There must be permanent neurological deficit with persisting clinical symptoms.	There are no associated conditions for encephalitis
*Heart valve replacement or repair	The undergoing of surgery including balloon valvuloplasty on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.	Any disease or disorder of the heart, or any obstructive/occlusive arterial disease.
*HIV infection – <i>caught from a blood transfusion, a physical assault or at work in an eligible occupation</i>	<p>Infection by Human Immunodeficiency Virus resulting from:</p> <ul style="list-style-type: none"> ● a blood transfusion given as part of medical treatment; ● a physical assault; or ● an incident occurring during the course of performing normal duties of employment from the eligible occupations listed below; <ul style="list-style-type: none"> – ambulance workers – chiropodists – dental nurses – dental surgeons – district nurses – fire brigade firefighters – general practitioners – hospital caterers – hospital cleaners – hospital doctors, surgeons and consultants – hospital laboratory technicians – hospital laundry workers – hospital nurses – hospital porters – midwives – nurses employed by general practitioners – occupational therapists – paramedics – physiotherapists – podiatrists – policemen and policewomen – prison officers – radiologists – refuse collectors – social workers <p>after the start of the policy and satisfying all of the following:</p> <ul style="list-style-type: none"> ● the incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures 	We will not pay a lump sum benefit for HIV infection to a member who, at any time before joining the policy , has been infected with any Human Immunodeficiency Virus (HIV) or has demonstrated any antibodies to such virus.

Critical illness/operation	Definition	Associated conditions
	<ul style="list-style-type: none"> where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident there must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus <p>For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> HIV infection resulting from any other means, including sexual activity or drug abuse. 	
Liver failure – of advanced stage	<p>Liver failure due to cirrhosis and resulting in:</p> <ul style="list-style-type: none"> permanent jaundice ascites, and encephalopathy <p>We do not cover liver disease secondary to alcohol or drug abuse.</p>	Chronic liver disease, including but not limited to hepatitis B & C, primary sclerosing cholangitis, and portal hypertension
*Loss of hand or foot – permanent physical severance	Permanent physical severance of any combination of one or more hand or foot at or above the wrist or ankle joints.	Diabetes mellitus, peripheral vascular disease, bone and soft tissue cancer.
Loss of independent existence – permanent and irreversible	<p>The permanent loss of the ability to perform routinely at least three of the following six tasks without the assistance of another person, even with the use of special devices or equipment.</p> <p>The tasks are:</p> <ol style="list-style-type: none"> Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances. Feeding yourself – the ability to feed yourself when food has been prepared and made available. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function. Getting between rooms – the ability to get from room to room on a level floor. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again. 	Multiple sclerosis, muscular dystrophy, motor neurone disease, or any disease or disorder of the brain, spinal cord or column
*Loss of speech – permanent and irreversible	Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.	Stroke, transient ischaemic attack, motor neurone disease, brain or throat tumour, laryngeal polyps.
Open Heart Surgery – with surgery to divide the breastbone	The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist, to correct any structural abnormality of the heart.	Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease.

Critical illness/operation	Definition	Associated conditions
*Paralysis of limbs – <i>total and irreversible</i>	Total and irreversible loss of muscle function to the whole of any limb.	Multiple sclerosis, muscular dystrophy, motor neurone disease or any disease or disorder of the brain, spinal cord or column
Primary pulmonary arterial hypertension	A definite diagnosis of pulmonary arterial hypertension of unknown cause. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity (marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain). The following is not covered: <ul style="list-style-type: none"> ● Pulmonary hypertension secondary to any other known cause i.e. not primary 	Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease.
Pulmonary artery graft surgery	The undergoing of surgery on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft. For the pulmonary artery graft surgery definition, we do not cover any other surgical procedure, for example endovascular repairs or the insertion of stents.	Pulmonary valve stenosis, pulmonary atresia, truncus arteriosus, Fallot's tetralogy, patent ductus arteriosus
Respiratory failure – <i>of advanced stage</i>	Advanced stage emphysema or other chronic lung disease, resulting in: <ul style="list-style-type: none"> ● the need for regular oxygen treatment on a permanent basis; and ● the permanent impairment of lung function tests where Forced Vital Capacity (FVC) and Forced Expiratory Volume at 1 second (FEV1) are less than 50% of normal. 	Any disease or disorder of the respiratory system including the lungs, bronchi and trachea
Rheumatoid arthritis – <i>chronic and severe</i>	A definite diagnosis of rheumatoid arthritis by a Consultant Rheumatologist: <ul style="list-style-type: none"> ● there must be morning stiffness in the affected joints lasting for at least one hour ● there must be arthritis of at least three joint groups, with soft tissue swelling or fluid observed by a physician ● the arthritis must involve at least the: <ul style="list-style-type: none"> – wrists or ankles – hands and fingers, or – feet and toes ● there must be symmetrical arthritis ● there must be radiographic changes typical of rheumatoid arthritis. 	Inflammatory polyarthropathy
Systemic lupus erythematosus – <i>with severe complications</i>	A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following: <ul style="list-style-type: none"> ● permanent neurological deficit with persisting clinical symptoms; or ● the permanent impairment of kidney function tests as follows: <ul style="list-style-type: none"> – Glomerular Filtration Rate (GFR) below 30 ml/min. 	Hughes syndrome, rheumatoid arthritis, and Sjogren's syndrome

Critical illness/ operation	Definition	Associated conditions
*Terminal illness	A definite diagnosis by the attending Consultant of an illness that satisfies both of the following: <ul style="list-style-type: none"> the illness either has no known cure or has progressed to the point where it cannot be cured; and in the opinion of the attending Consultant, the illness is expected to lead to death within the earlier of 12 months and the member's cease age. 	Any medical condition that is listed as a critical illness condition
*Third degree burns – covering 20% of the body's surface area or 30 percent loss of surface area to the face	Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20 percent of the body's surface area or 30 percent loss of surface area of the face which for the purposes of this definition includes the forehead and ears.	There are no associated conditions for third degree burns
*Traumatic head injury – resulting in permanent symptoms	Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms .	There are no associated conditions for traumatic head injury
Optional Cover		
In addition to the conditions or operations covered under the Standard and Extended schemes, subject to agreement by Aviva, you may be able to include cover for the Cancer drugs fund and/or total permanent disability. These options will result in an extra cost under both Standard and Extended schemes.		
Cancer drugs fund	<p>If this option is selected, following the diagnosis of cancer for which we have paid a lump sum benefit, we will pay for the cost of drugs recommended by the member's NHS specialist up to a maximum of £100,000 to treat their cancer if their NHS specialist's submission for the provision of cancer drugs is rejected by their local commissioning body on financial grounds. A treatment plan must also have been agreed by the NHS multi-disciplinary team (MDT).</p> <p>We will only pay for drugs recommended by the NHS specialist for cancer treatment if they are:</p> <ul style="list-style-type: none"> proven or established within common UK practice, such as a drug used within the terms of its licence or approved by NICE for use in the NHS, and supported by published, peer- reviewed clinical evidence that proves the treatment has positive clinical outcomes, and recognised as acceptable clinical practice and practised widely by UK specialists. <p>We will pay the cost of cancer drugs, and the charges for administering those drugs, up to a maximum of £100,000. If the treatment costs exceed this the member will have to pay the extra costs themselves.</p>	None

Critical illness/ operation	Defintion	Associated conditions
<p>*Total permanent disability – <i>unable to do a suited occupation ever again</i></p>	<p>Loss of the physical or mental ability through an illness or injury to the extent that the employee is unable to do the material and substantial duties of a suited occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of a suited occupation that cannot reasonably be omitted or modified.</p> <p>A suited occupation means any work the employee could do for profit or pay taking into account their employment history, knowledge, transferable skills, training, education and experience, and is irrespective of location and availability.</p> <p>The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the employee expects to retire.</p> <p>For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.</p>	<p>Multiple sclerosis, muscular dystrophy, motor neurone disease, or any disease or disorder of the brain, spinal cord or column. Arthritis. Chronic or recurrent mental illness. Chronic or recurrent back, neck, joint or muscle pain. Chronic or recurrent fatigue.</p>
<p>*Total permanent disability – <i>unable to do your own occupation ever again</i></p>	<p>Loss of the physical or mental ability through an illness or injury to the extent that the employee is unable to do the material and substantial duties of their own occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of the employee's own occupation that cannot reasonably be omitted or modified.</p> <p>Own occupation means your trade, profession or type of work you do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability.</p> <p>The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the employee expects to retire.</p> <p>For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.</p>	<p>Multiple sclerosis, muscular dystrophy, motor neurone disease, or any disease or disorder of the brain, spinal cord or column. Arthritis. Chronic or recurrent mental illness. Chronic or recurrent back, neck, joint or muscle pain. Chronic or recurrent fatigue.</p>

1 What benefits are covered

The purpose of this **policy** is to pay a **lump sum benefit** if a **member** or **child** is:

- diagnosed with a **critical illness**; or
- undergoes an **operation**;

and survives for 14 days from the day:

- that the **member** or **child** was diagnosed with the **critical illness**; or
- of the **operation**.

We have two levels of cover – Standard and Extended. No other conditions or operations are covered. **We** use the Association of British Insurers (ABI) definitions for all critical illnesses that have been defined by them. These definitions are marked with an asterisk in the **critical illnesses** and **operations** table above. Within the critical illness definitions there are four words or phrases that have very specific meanings. These are also defined by the ABI and are:

- **occupation**;
- **irreversible**;
- **permanent**; and
- **permanent neurological deficit with persisting clinical symptoms**.

2 Who is covered

The **policy** covers:

- **employees**; and
- their **children**.

The **policy** can also cover **employees'** husbands, wives, **civil partners** or **unmarried partners**.

The policy schedule will tell **you** the categories of **employees** who are eligible, and whether or not their husbands, wives, **civil partners** or **unmarried partners** are covered by the **policy**.

New entrants will be included in the **policy** as a **member**:

- on the **policy start date**, if they joined the **policy** on or before that date; or
- from the date they joined the **policy** if later.

The **policy** begins on the **start date** shown on the **policy schedule**, and cover for each **member** begins on the date that they join the **policy**. The eligibility conditions for joining the **policy** are shown on the **policy schedule**.

2.1 Discretionary entrants

You may add **members** to the **policy** at any time, however cover will not be backdated. Any **discretionary entrants** will be treated as a new joiner and will therefore be subject to a new **pre-existing conditions** exclusion.

2.2 TUPE transfers

You may add **members** to the **policy** at any time however cover will not be backdated. For any **TUPE** or other group employment transfer, **employees** and **employees'** husbands, wives or **civil partners** will be treated as **members** switching cover from another insurer.

2.3 Temporary absence

Where an **employee** is off work due to illness or injury, the cover for the **employee** (and if applicable the **employees'** husband, wife or **civil partner**) can continue up to the **cease age** providing premiums continue and a contract of employment is maintained.

Where absence is due to any other reason, such as statutory absence (for example maternity leave or Armed Forces Reserves call up), then cover may continue to be provided for a maximum of 36 months.

However, cover cannot continue once an **employee** has reached the **cease age**.

2.4 Overseas cover

We will cover **members** who are travelling or working **overseas**, or those seconded to another organisation in a different country as long as:

- they still have a UK registered contract of employment covered under this policy
- the premium to cover those **members** is paid in sterling by **you**, and
- they are still eligible for cover on the **policy**

You must tell **us** about any **members** who are working **overseas** at the **policy start date** or **rate guarantee date**.

You must also tell **us** their nationalities and the countries that they will be working in.

If **you** make a claim for a **member** who is based **overseas**, **we** will pay all **lump sum benefit** in pounds sterling and only into a UK bank account that is registered in the **member's** name.

We will only consider paying **lump sum benefit** for these **members** if **we** can obtain satisfactory medical evidence in English. **We** will not be responsible for any costs incurred in translation.

The tax treatment of any **lump sum benefit** paid out for an **overseas member** will depend on whether or not they have been treated as non-resident for tax purposes at any time when covered under the **policy**.

3 Additional policy cover

3.1 Husband, wife, civil partner and unmarried partner cover

Where cover for **employees'** husbands, wives and **civil partners** have been chosen cover ceases on the earlier of:

- the **employee** reaching the **policy cease age**; or

- the husband, wife or **civil partner** reaching the **policy cease age**.

We will not pay a second claim for husbands, wives, **civil partners** or **unmarried partners** (or an individual **child**) of an **employee**. We will cancel their cover when we pay a claim for them.

4 When cover ceases

This depends on the **policy cease age** you have chosen, which can be **state pension age (SPA)** or any fixed age up to a maximum age of 70. If the **cease age** is linked to **SPA**, the **cease age** will be the later of either 65 or the **employee's SPA**.

If the **cease age** is currently either **SPA** or a fixed age lower than 70, and **you** want to include **members** beyond the current **cease age** up to a maximum age of 70, then the **cease age** has to increase for the whole **policy** or applicable membership category.

Cover will stop when the **policy** is cancelled, premiums are not paid within 30 days of the due date, or when a **employee**;

- is no longer employed by **you**;
- is no longer **eligible** for the **policy**;
- reaches the **cease age**; or
- dies.

We will no longer cover a husband, wife, **civil partner**, **unmarried partner** or **child** of an **employee**;

- if we pay a claim for them (see section 8.5 - second claims regarding claims for cancer drugs fund benefit.);
- when they are no longer **eligible** for the **policy**;
- when they reach the **cease age** (for children, when they reach 18 years old (21 if in full time education));
- when they die; or
- if the **employee** leaves the **policy**, for whatever reason.

5 Policy limitations

5.1 Benefit limits

The **policy schedule** will show details of how we calculate the **lump sum benefit**.

If a claim is for an **employee**, the maximum **lump sum benefit** that we will pay is five times their **benefit**, up to a maximum of £500,000.

If a claim is for an **employee's** husband, wife, **civil partner** or **unmarried partner**, the maximum **lump sum benefit** that we will pay is five times the **employee's salary**, up to a maximum of £250,000.

If a claim is for a **child**, the maximum **lump sum benefit** that we will pay is 25% of the **employees benefit** up to a maximum of £20,000.

6 Calculation of premiums

Core/default benefit (if applicable)

We calculate these premiums by multiplying the total **members' core** or **default benefits** by the unit rate that applies at that date. The unit rates are expressed as a rate per £1,000 of benefit.

Where the core or default premium is not calculated monthly, for **members** who join, leave or have changes in the level of benefit during the **policy year** we will make a premium adjustment at the **anniversary date**. The premium adjustment will be calculated based on the average sum insured of all **members** over the **policy year**. This means that all benefit changes are treated as if they occurred mid-way through the **policy year**.

Where the **core** or **default benefits** and **voluntary/flexible benefits** are both provided on the monthly data, any premium adjustment for **members** who join, leave or have changes in benefit will be captured in the monthly calculations.

Voluntary/flexible benefits

Premiums will be calculated using the applicable flex premium rates. This means premiums are recalculated each month based on the monthly data supplied and are dependent upon the age of the **members** at the beginning of each **policy year** or date of joining if later. Premium rates generally increase with age. We also need to know the amount of benefit needed for each **member** on the monthly data and at the **anniversary date**.

Minimum premium

The minimum premium we will charge is £750. All premium payments are to be made in pounds sterling.

Auto Enrolment

(applicable after the **employer** reaches their **auto-enrolment date** for **policies** where eligibility for membership or benefits is linked to pension scheme membership)

We will calculate a premium to reflect time on risk and this will be based on the average sum insured for all **members** of the **policy** between;

- the **start date**/previous **anniversary date** and the **employers auto-enrolment date**, and
- the employers **auto-enrolment date** and the **stabilisation date**, and
- the **stabilisation date** and **your next anniversary date**.

6.1 What information is needed to calculate your premiums

The premium for the **policy** will be recalculated on the **anniversary date**. Based on the monthly data supplied, we will record the premiums

Before that date, we will tell **you** the information we will need to recalculate the premium payable for that **policy year**.

You do not need to tell **us** about new entrants during the **policy year** who have met the **eligibility** conditions, however they must be declared on the monthly data **we** receive if they have **voluntary/flexible benefits** or if **we** receive **default benefits** and **voluntary/flexible benefits** on the monthly data. **We** also do not need details of **children** covered by the **policy**.

For both single premium and unit rate policies, six weeks prior to the **anniversary date** **we** will request the information needed to recalculate the premium for the **policy**. **We** will regularly remind **you** for this up to 90 days after the **anniversary date**. If the information needed is not received after 90 days **we** will process the recalculation of premium and benefits based on the latest information **we** hold. This could result in an uninsured liability.

6.2 When premium rates are reviewed

The rates used to calculate premiums are guaranteed from the **start date** until the **rate guarantee date** and are then reviewed. The **policy schedule** will show the **rate guarantee date**.

The guarantee may not apply if there is:

- a change of 25% or more in the total core or default sum insured (if applicable);
- any change to the benefit basis;
- a change to the **eligibility** criteria; or
- a change in the nature of business or companies included within the **policy**.
- a change of 25% or more in the total core or default sum insured (if applicable) where **you** become subject to the auto-enrolment duties and **eligibility** for the **policy** is linked to pension scheme membership.

We will;

- review changes in the total sum insured on the **stabilisation date** and any change in rate will be effective from the **stabilisation date** until the end of **your** existing **rate guarantee date**.

You must inform **us** promptly if any of these changes take place.

The guarantee may also not apply where a change is made to reflect, in a proportionate manner, a change to the law or interpretations of the law, decisions or recommendations of a Court, Ombudsman, Regulator or similar body

6.3 Payment of premiums

Premiums are paid to **us** by the **employer** for each **member**. It is the responsibility of the **employer** to collect the premium for any **voluntary/flexible benefits** the **member** selects and pays for, in order to pay to **us**. The premium must be paid in advance monthly, quarterly, half yearly or annually by direct debit, or any other method agreed with **us**.

We will charge a 1% loading each year to cover **our** extra administration costs where the premiums are not paid to **us** on an annual basis.

6.4 Non payment of premiums

We will cancel the **policy** upon non payment of premiums. Payment of premiums is expected within 30 days of the original

request date. This will mean **you** will have no cover in place with **us** for future benefits and may result in an uninsured liability.

Subject to **our** reasonable requirements, **we** may reinstate cover if the premium is subsequently paid within a reasonable period, provided there have been no changes which would have altered **our** decision to provide cover.

7 Policy changes and cancellation

7.1 What we need to know

You need to inform **us** immediately if:

- **you** want to change the cover or **eligibility** criteria for the membership;
- there are any material changes to the **employer**;
- a **TUPE** or group employment transfer takes place (either into or out of the **policy**);
- the business location of an **employer** or group of **employees** changes;
- there is a change in the nature of an **employer's** business;
- **you** want to include any additional cover;
- **you** want to add any other **lifestyle events** to the policy;
- the total core or default sum insured (if applicable) increases/decreases by 25% from the last **rate guarantee date** (or **anniversary date** if earlier);
- **you** want to cancel the **policy**.

7.2 When a change can be made

Requests to change the **policy** can be made at any time. **We** will need to be informed in writing prior to the date **you** wish to alter the **policy**. **We** will then inform **you** of any information **we** need. **We** will write to inform **you** of **our** agreement to the change (or reason for declining) and the date from which it is effective.

7.3 When we can make changes to the policy

We may, at each **rate guarantee date**, or at any time if required, make reasonable changes to the terms and conditions provided for in this **policy** and any linked policy which, are needed to:

- respond in an appropriate manner to changes in the way **we** administer policies of this type;
- respond in an appropriate manner to changes in technology or general practice in the insurance industry;
- respond in an appropriate manner to changes in taxation, the law or interpretation of the law, decisions or recommendations of a Court, Ombudsman, Regulator or similar person, or any code of practice with which **we** intend to comply; or
- correct errors that need correcting and it is reasonable to do so.

If **we** consider any change is to **your** advantage or is needed to meet regulatory or legal requirements, **we** may make the change immediately and tell **you** at a later date.

We will tell **you** in writing of any change **we** consider is to **your** disadvantage (other than any change needed to meet any legal or regulatory requirements) at least 30 days before the change becomes effective, unless it is not possible for **us** to do this, in which case **we** will give **you** as much notice as **we** can.

7.4 How to cancel the policy

There is no cooling off period. **You** may cancel this **policy** at any time.

If the **policy** is cancelled for any reason, a final account will be provided based on the cover that **we** have actually provided. **We** will either pay a refund to **you**, or **you** will need to pay any outstanding premiums to **us**.

All cover under this **policy** will stop on the date agreed with **us**. **We** will continue to assess claims for illnesses that were diagnosed and **operations** that took place whilst the **policy** was in force.

There will be no surrender value under this **policy** if it is cancelled at any time.

We reserve the right to cancel the **policy** if:

- the number of **employees** covered is 49 or less.
- **you** do not pay the premium.
- **you** do not give **us** the information that **we** need to administer the **policy**.
- the business location of an **employer** or group of members changes.
- there is a change in the nature of an **employer's** business.

We will not backdate any cancellation.

Sanction Checking

In order for **us** to help manage **our** exposure to the risk of financial crime, **we** will, from time to time, undertake a sanction check of the company, its directors and its ultimate parent company as well as the country in which the company/ultimate parent company is based. If, as a result of **our** investigations **we** reasonably believe that providing a group protection contract would place Aviva at a high risk to exposure of financial crime, **we** reserve the right to cancel or amend the **policy** as appropriate.

8 Claims

8.1 What information is needed to make a claim

If **you** need to make a claim, **you** must give **us** written notice on behalf of the **member** or **child** within 3 months of the date that the **critical illness** is diagnosed or the **member** or **child** undergoes the **operation** or as soon as reasonably practicable. If written notice is not provided to **us** within three months of first diagnosis we will not pay the **lump sum benefit** where any evidence required is no longer available due to the lapse of time, in particular (but without being limited to) where an independent medical assessment does not provide substantive evidence to support the claim. Where written notice is provided to **us** after three months of first diagnosis the **lump sum benefit** will only be payable at **our** discretion.

We will ask for confirmation from a **specialist**:

- of the diagnosis of a **critical illness**, and the date of that diagnosis; or
- that a **member** or **child** has undergone an **operation**, and the date of that **operation**.

We will pay the **lump sum benefit** if, in reasonable **specialist** medical opinion, the **critical illness** or **operation** that the **member** or **child** is claiming for meets the **policy** definition.

In order to assess a claim **we** will need:

- a completed company claim form.
- a completed member claim form.

Depending on whom the claim is for, and what the claim is for, **we** may need to see birth or adoption certificates, marriage certificates or civil partnership certificates, or see evidence of a **lifestyle event**. If **we** need any more information, **we** will contact the people that **we** need to in order to get it (provided that **we** have the appropriate consent to do this). **We** cannot pay a claim if **we** are not able to get the information that **we** need to assess the claim.

Once **we** have received the completed claim forms:

- **we** will assess the claim to see if the medical evidence confirms that the **member** or **child** has suffered an illness or undergone one of the **operations** that the **policy** covers.
- **we** are not responsible for paying for the evidence that **we** ask for in order to assess a claim, for example:
 - any charges made by a doctor for completing a claim form.
 - the costs of sending information to **us**.
 - the costs of translating information into English.

BUT: if **we** ask for any other medical information that comes from the UK (for example a medical report), **we** will pay for it. In some circumstances **we** may ask for an independent medical examination.

Before **we** pay a claim **we** may ask for documentary evidence of earnings. **We** are likely to need:

- for employees – a copy of the last four payslips and the last P60 certificate. A PAYE Coding Notice (or replacement) in respect of benefits in kind.
- for equity partners – documentary evidence of personal earnings which have been assessed for income tax purposes and declared to and agreed by HM Revenue & Customs, together with the profit and loss accounts which relate to this, during the 36 months before the **operation** or diagnosis of the **critical illness**.

If this doesn't give **us** the information **we** need, **we** may also ask for other evidence if it is reasonable to do so.

For claims in respect of cancer drugs fund benefit **we** require:

- a letter from the **member's specialist** that describes the recommended drug treatment in detail and confirms that it's appropriate;
- a letter from the **member's local commissioning body** that clearly rejects the recommended drug treatment on financial grounds; and
- an estimate from the **member's local NHS trust** for the cost of the recommended drug treatment on a self-pay basis.

We will not pay a claim if **we** are not able to get the information that **we** need to assess the claim.

For total permanent disability claims **we** will need the total permanent disability section of the member claim form completed, and a job description.

If the **policyholder** or **member** gives **us** incorrect information, or doesn't give **us** information that **we** need, **we** will not be liable for any mistakes or omissions caused by this. If **we** pay a claim or pay too much for a claim as a result of the **policyholder** or a **member** giving **us** incorrect information, **we** will take steps to recover that money from the **policyholder**.

8.2 How to submit a claim

You can submit a claim by telephoning **us** on 0800 142 2377 or emailing **us** at groupipclaims@aviva.co.uk. **We** will then send the relevant claim forms.

8.3 How a claim is paid

We will pay all **lump sum payments**, except in respect of cancer drugs fund benefit, directly to the **employee** (even if the claim is for the **employee's** husband, wife, **civil partner**, **unmarried partner** or **child** provided it is to a UK bank account). All payments will be in pounds sterling.

We will pay all **lump sum payments** in respect of claims for cancer drugs fund benefit, direct to the **member's** local NHS trust. All payments will be in pounds sterling.

8.4 When a claim is paid

In order to make a claim and to enable **us** to pay a **lump sum benefit** to an **employee** covered by the **policy**, they (or their husband, wife **civil partner** or **child** covered by the **policy**) must have;

- been diagnosed with one of the illnesses; or
- undergone one of the **operations**;

which the **policy** covers, and have survived for 14 days after the date of the diagnosis or **operation**.

If a **member** or **child** is:

- diagnosed with a **critical illness**; or
- undergoes an **operation**;

and **we** pay a **lump sum benefit** for this, the **member** or **child's** cover will stop. Provided that the **employee** is still **eligible** for cover under the **policy** (for example if the claim was for total permanent disability, the **employee** would no

longer be **eligible** for cover under the **policy**) the cover will immediately start again. However, this means that there is a break in cover and the **employee's** start date will become the day of the diagnosis of the **critical illness** or the **operation** that **we** have paid a **lump sum benefit** for. The **employee** will be subject to a new **pre-existing conditions** exclusion from this new start date, and the **critical illness** or **operation** successfully claimed for, will also therefore become a **pre-existing condition** and be excluded from cover if the **employee** makes a second claim for it.

8.5 Second claims

- **We** will not pay a second claim for an individual child of an **employee**. **We** will cancel their cover when **we** pay a claim for them.
- **We** will not pay a second claim for husbands, wives or **civil partners** of an **employee** except for claims in respect of cancer drugs fund benefit. **We** will cease cover in respect of all other **critical illnesses** when **we** pay a claim for them.
- Subsequent claims for cancer drugs fund benefit in respect of husbands, wives or **civil partners** of an **employee** will only be considered if:
 - the **employee** remains a **member** of the **policy**, and the claim for cancer drugs fund benefit relates to the diagnosis of cancer for which **we** paid a **lump sum benefit**
- If an **employee** has been paid a **lump sum benefit** by **your** policy and then suffers another **critical illness** or undergoes a further **operation** covered by the **policy**, **we** may pay a **lump sum benefit**.

Apart from "Cancer - second and subsequent" **we** will not make a payment if that **employee** has already been paid a **lump sum benefit** for:

- that **critical illness** or **operation**; or
- any **related** illness or **operation**;

even if the first payment was from a different insurer. **We** would treat it as a **pre-existing condition**.

For example, an **employee** suffers an unexpected heart attack, **we** pay the claim. However, if the **employee** suffers a further heart attack six months later, **we** will not pay the second claim as the initial heart attack is now a **pre-existing condition**. If the **employee** then went on to undergo a coronary angioplasty, that would not be covered either as angioplasty is **related** to heart attack.

- **We** will not pay a **lump sum benefit** for any illness or **operation** covered by this **policy** if the **employee** has previously claimed for
 - total permanent disability;
 - paralysis of limbs; or
 - terminal illness;

and that claim was paid even if the first payment was from a previous insurer of **your** policy. **We** would treat it as a **pre-existing condition**.

- **We** will not pay a **lump sum benefit** for
 - total permanent disability; or
 - terminal illness;

if the **employee** has previously claimed for any other illness or undergone an **operation** covered by this **policy**.

If **you** have any questions about making a claim, you can email, telephone or write to **us** at:

Aviva Group Protection
Chilworth House
Hampshire Corporate Park
Templars Way
Eastleigh
Hampshire
SO53 3RY

9 What is not covered?

9.1 Pre-existing conditions exclusion and other exclusions

Pre-existing critical illnesses and operations

The **policy** does not cover **pre-existing conditions**. This means if a **member** or **child**:

- has suffered from any **critical illness**; or
- undergone any **operation**;

covered by the **policy** at any time before they join the **scheme** (whether this was insured with **us** or another insurer), **we** will not pay a **lump sum benefit** if they suffer the same **critical illness** (except Cancer - second and subsequent) or undergo the same **operation** whilst they are covered by the **policy**.

If a **member** or **child**:

- is suffering from a **critical illness**; or
- waiting for an **operation**;

when they join **your policy**, **we** will not pay a **lump sum benefit**:

- for that **critical illness** or **operation**; or
- if they suffer the same **critical illness** or undergo that **operation** again (except Cancer - second and subsequent);

whilst they are covered by the **policy**.

We will not pay a **lump sum benefit** in respect of a **child**:

- if symptoms first arose, the underlying condition was first diagnosed or the **member** received counselling or medical advice in relation to the condition before:
 - the **member** joined the **policy**
 - the **member's** legal adoption or legal guardianship of the **child**

- if the condition is brought about by intentional harm inflicted on the eligible **child** by the **member**.

Related pre-existing critical illnesses and operations

The **policy** does not cover **critical illnesses** or **operations** which are directly or indirectly **related** to **pre-existing conditions**.

For this **policy**:

- aorta graft surgery;
- cardiac arrest;
- cardiomyopathy;
- coronary angioplasty;
- coronary artery;
- by-pass graft;
- heart attack;
- heart transplant;
- heart valve replacement or repair; primary pulmonary arterial hypertension;
- pulmonary artery graft surgery;
- stroke; and
- valvuloplasty;

are **related** and therefore considered to be the same insured illness.

For example, if a **member** or **child** had a heart attack before joining the **policy**, **we** would not pay a **lump sum benefit** if they later needed coronary artery bypass surgery.

The **policy** also does not cover:

- total permanent disability;
- loss of independent existence;
- coma;
- paralysis/paraplegia;
- loss of speech;
- blindness; or
- deafness;

that is directly or indirectly **related** to a **critical illness** or **operation** that a **member** or **child** had before joining the **policy**.

Terminal illness

We will not pay a claim for terminal illness if the **member** or **child** died before **you** notified **us** of a claim.

Exclusions for children

We will not pay claims for:

- total permanent disability; or
- Cancer drug fund benefit;

for a **child**.

Associated critical illnesses and operations

We will not pay claims if the **member** or **child** has had an **associated condition** prior to the date they joined **your policy** (whether this was insured with **us** or another insurer).

In respect of increases in **lump sum benefit** (except any increases which are in-line with standard company pay awards which are limited to a maximum of 7% per **policy year**) **we** will not pay the amount of the increase if the **member** or **child** has had an **associated condition** prior to the date that increase takes effect.

For all **critical illnesses** and **operations**, except for:

- total permanent disability;
- loss of independent existence – permanent and irreversible; and
- paralysis of limbs – total and irreversible;

if a **member** or **child** does not suffer the **critical illness** or undergo an **operation** during the first two years from the date they joined **your policy** (whether this was insured with **us** or another insurer) **we** will not exclude claims due to an **associated condition**.

In respect of increases in **lump sum benefit** **we** will not exclude claims for the increase due to an **associated condition** if the **member** or **child** does not suffer a **critical illness** or undergo an **operation** within two years from the date that increase takes effect.

We will not pay a **critical illness** claim if it is caused directly or indirectly from:

Self-inflicted injury

Intentional self-inflicted injury.

10 Further policy conditions

10.1 Accurate information

We rely on the information given to **us**.

If any of the information **you** give **us** is untrue or incomplete, and this might have reasonably affected **our** decision to provide **you** with this **policy** or the terms **we** offered for the **policy**, then **we** may:

- change the terms of this **policy**; or
- restrict the benefits payable under this **policy**; or
- cancel this **policy**.

Where **we** do any of these, **we** will refund any overpayment of premium less **our** reasonable expenses.

10.2 Currency and jurisdiction

We and **you** have a free choice of law that can apply to a contract. **We** propose to choose the law of England and Wales and by entering in to this contract the **policyholder** agrees that the Law of England and Wales applies.

10.3 Contacting us

If **you** need to contact **us** about this **policy**, please contact **us** at the address shown in the **policy schedule**, quoting **your policy** number. Alternatively call **us** on 0800 0157518.

We may refuse to take action until **you** have met all of **our** reasonable requirements. **We** may ask **you** to send **us** any relevant forms or other documents, completed by the appropriate person(s).

10.4 Third party rights

No person other than Aviva Life & Pensions UK Ltd and **you** will have any rights under this **policy**. Any person who is not a party to this **policy** shall have no rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any terms under this **policy**. Reference to, or the consent of, any person who is not a party to the **policy** is not required for any changes to it or its termination.

11 If you have cause for complaint

Our aim is to provide a first class standard of service to our customers, and to do everything we can to ensure you are satisfied. However, if you ever feel we have fallen short of this standard and you have cause to make a complaint, please let us know. Our contact details are:

Group Protection Complaints
Aviva Life & Pensions UK Ltd
PO Box 540
Eastleigh
SO50 0ET

Telephone: 0800 404 9541
E-mail: grcomp@aviva.co.uk

We have every reason to believe that you will be totally satisfied with your Aviva policy, and with our service. It is very rare that matters cannot be resolved amicably. However, if you are still unhappy with the outcome after we have investigated it for you and you feel that there is additional information that should be considered, you should let us have that information as soon as possible so that we can review it. If you disagree with our response or if we have not replied within eight weeks, you may be able to take your case to the Financial Ombudsman Service to investigate. Their contact details are:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Telephone: 0300 123 9123

Email: complaint.info@financialombudsman.org.uk

Website: www.financial-ombudsman.org.uk

Please note that the Financial Ombudsman Service will only consider your complaint if you have given us the opportunity to resolve the matter first. Making a complaint to the Ombudsman will not affect your legal rights.

Financial services compensation scheme (FSCS)

The Financial Services Compensation Scheme (FSCS) may cover your policy. It'll cover you if Aviva becomes insolvent and we are unable to meet our obligations under the policy. For this type of policy, the FSCS will cover you for 100% of the total amount of an existing claim. The FSCS will also provide a refund of 100% of the premiums that have not been used to pay for cover whether you are making a claim under the policy or not.

For further information, see www.fscs.org.uk or telephone 020 7892 7300.

Some of the terms and expressions that **we** use in this Policy Wording have a specific meaning for this type of **policy**. Here are some of the terms explained:

Anniversary date

An anniversary of the **start date**, unless another date has been agreed with **us**. This date is stated in the **policy schedule**.

Associated conditions

Any symptom, condition, illness, injury, disease or treatment which is either;

- recognised by reasonable **specialist** medical opinion to be related to the occurrence of a **critical illness or operation**, or
- is listed in the "associated conditions" column of the critical illness/operation table which begins on page 4.

Auto enrolment date

Your staging date and, if different, the staging date for **employees** covered under this **policy**, or if **you** have chosen to postpone, the date **you** have chosen as **your** deferral date and, if different, the deferral date for **employees** covered under this **policy**.

Cease age

Midnight on the day before the age at which cover for a **member** ceases, as set out in the relevant **policy schedule** applicable to that **member's** category. The maximum age can't exceed midnight on the day before a **member's** 70th birthday.

Child/Children

Any **employee's** child from date of birth to the age of 18 years (or 21 years if in full time education) (this includes adopted children and step-children).

Childcover benefit

These are additional child specific **critical illness(es)** that are only covered in respect of a **child**.

Civil Partner

A person who is the **employee's** Civil Partner registered under the Civil Partnership Act 2004, at the time they suffered the **critical illness** or **operation**.

Commissioning body

- NHS England Clinical Commissioning Groups
- NHS Scotland Health Boards
- NHS Wales Health Boards
- Northern Irish Health and Social Care Board

Core/minimum benefit

The lowest benefit that **employees** can select.

Critical illness(es)

An illness covered by this policy. The **policy schedule** will show whether the **policyholder** chose Standard or Extended cover.

Default benefit

The benefit that is funded by the **employer**.

Discretionary entrant

An **employee** or an **employees'** husband, wife, **civil partner** or **unmarried partner**:

- who is not an **eligible** member but who **you** wish to include in the policy.
- who is an **eligible** member but who **you** want covered from a different date to their normal inclusion date.

Eligible/Eligibility

The factor(s) **we** consider when assessing whether or not a person can be automatically covered by the **policy**. This will be detailed in the **policy schedule**.

Employee(s)

Employees and equity partners of the **employer**.

An equity partner is a partner in the **policyholder's** partnership business who (as evidenced by a partnership deed or contract)

- is a part owner of the assets of the business
- participates jointly and severally in the risks and rewards of the business, and
- is treated by HM Revenue & Customs as a self employed partner for tax purposes.

Employer/you/your

A company, partnership, limited liability partnership or other organisation that is participating in the **policy**.

Irreversible

Cannot be reasonably improved upon by medical treatment and/or surgical procedures used by the National Health Service in the UK at the time of the claim.

Lifestyle event

A lifestyle event allowing a **member** to increase their benefit level. The lifestyle events are detailed in the **policy schedule**.

Lump sum benefit

The total lump sum benefit that would be paid for a **member** in the event of a claim, as shown in **your policy schedule**.

Member

An **employee** or an **employee's** husband, wife, **civil partner** or **unmarried partner**, who is covered by the **policy**.

Operation(s)

An operation covered by this **policy**. The **policy schedule** will show whether the **policyholder** chose Standard or Extended cover.

Overseas

Any country that is not part of the United Kingdom, Channel Islands or Isle of Man.

Permanent

Expected to last throughout the member's life, irrespective of when the cover ends or the member retires.

Permanent neurological deficit with persisting clinical symptoms

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the member's life. Symptoms that are covered include numbness,

hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma. The following are not covered:

- an abnormality seen on brain or other scans without definite related clinical symptoms
- neurological signs occurring without symptomatic abnormality, eg brisk reflexes without other symptoms
- symptoms of psychological or psychiatric origin.

Policy

The Aviva group critical illness insurance policy (including the **policy schedule** together with any endorsements) which covers the policy benefits and forms the contract between **you** and **us**.

Policyholder

The policyholder as stated in the **policy schedule**.

Policy schedule

The current schedule (as issued from time to time) stating details of the **employer**, cover provided by the **policy** and any special terms (if applicable).

Policy year

The period between:

- the **start date** and the first **anniversary date**;
- the **anniversary date** and **rate guarantee date**; or
- an **anniversary date** and the date of termination of the **policy** (if termination occurs before the next **anniversary date**)

Pre-existing condition

Any **critical illness** or **operation** covered by the **policy** for which:

- a **member** or **child** has received medication, advice, treatment or diagnostic tests; or
- a **member** or **child** has experienced symptoms;

whether the condition has been diagnosed or not before the **member** or **child** joined the **policy**.

Rate guarantee date

The date until which rates and terms and are guaranteed to apply, as shown in the **policy schedule**.

Related

Critical illnesses and **operations** are related if it recognised by reasonable **specialist** medical opinion, that one is a result of the other or if each is a result of the same disease, illness or injury.

Salary

If salary is used as a basis for benefit under this **policy**, the definition is in the **policy schedule**.

Specialist

A registered medical practitioner who:

- has at any time held and is not precluded from holding a substantive consultant appointment in an NHS hospital; or
- holds a Certificate of Higher Specialist Training issued by the Higher Specialist Training Committee of the relevant Royal College or faculty; or
- is included in the Specialist Register kept by the General Medical Council;

and who is recognised by **us** to provide the treatment the **member** or **child** needs for their condition.

Stabilisation date

The date three months after **your auto-enrolment date(s)** (unless **you** notify **us** in writing of a lesser period and this is accepted by **us**). This period allows for **your** auto-enrolment pension scheme membership to stabilise following the auto-enrolment process.

Start date

The date the **policy** starts as stated in the **policy schedule**.

State pensionable age (SPA)

The earliest age at which the **employee** can start to receive the UK basic state pension.

The maximum state pension age we will cover is 68.

TUPE

Transfer of Undertaking (Protection of Employment) Regulations 2006.

Unmarried partner

You can define unmarried partner to suit the make up of **your** workforce. This is the person that the **employee** nominates as their partner, regardless of that person's gender or marital status; whom:

- resides with the **employee** within the UK;
- shares a joint financial commitment with the **employee**; and
- is not a member of the **employee's** immediate family, i.e. parents, grandparents, relation, etc.

Voluntary/flexible benefit(s)

The benefit selected as a result of a **member** increasing or decreasing their **benefit** levels at either the **anniversary date** or at a **lifestyle event**.

We/our/us

Aviva Life & Pensions UK Limited.

