GROUP CRITICAL ILLNESS

Policy Conditions

These Policy Conditions are introduced from 1 March 2019

Canada Life
Group Insurance

Your Policy

The contractual terms of the **Policy** are set out in:

- these **Policy Conditions** and any subsequent updates and/or replacements,
- the information provided in the Proposal Form,
- your **Policy Particulars** and any subsequent updates and/or replacements,
- the information provided prior to the **commencement date**, or in relation to any alteration to the cover provided under the **Policy**,
- any questionnaire or written statement relating to an **insured person**, including, but not limited to, a Health Declaration Form,
- any **decision letter** issued in writing by us in respect of any **insured person**, and
- any special terms, exclusions or limitations issued by us in writing.

The **Policy** provides evidence of a legal contract between you and us and takes effect from the **commencement date** for insurance to cover benefits in the event that an **insured person** or **child** suffers from an **insured illness**.

The terms of the **Policy** are dependent upon the information we are provided with. If this is mis-stated, or has changed since the information was provided, or is proved to have not been a **fair presentation of the risk** we may amend, discontinue or void the **Policy**.

If you do not comply with the **Policy** terms and conditions, we may not pay claims. We may not be bound to accept any further premiums and we may cease cover under the **Policy**.

You must advise us if you change or dismiss your intermediary.

You may not assign, sell, transfer or otherwise dispose of the benefits payable under the **Policy**.

This **Policy** will not have or accrue any surrender value.

This **Policy** is subject only to English law. If there is any dispute between the parties about anything to do with the **Policy**, the English Courts are the only courts which may make a judgment about the dispute.

Any person or company who is not a party to this **Policy** does not and shall not have or acquire any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this **Policy**. But after a claim has been made by the **policyholder**, the **member** to which the claim relates can pursue that claim as if they were the **policyholder**.

The **member** can also, for any complaint or dispute in connection with that claim, pursue their complaint or grievance through our normal complaints procedures. If they remain dissatisfied, they can then refer the matter to the Financial Ombudsman Service before seeking a remedy at law.

This **Policy** can be amended, varied or cancelled without the consent of any third party who might benefit from its terms or have enforceable rights hereunder.

Signed for and on behalf of Canada Life Limited:

Tim Stoves
Managing Director, Group Insurance

Doug Brown
UK Division Chief Executive Officer

Please read this Policy carefully, and then keep it in a place of safety for future reference.

Contents

Your Policy 3

Terms and Expressions we use 8

Section 1 Who is covered 15

1.1 Normal entrants 15

1.2 When any benefits need to be underwritten 15

1.3 Provision of cover for discretionary and late entrants 15

1.4 Provision of cover before an underwriting decision has been made 15

1.5 Underwriting decisions which can be made 16

1.6 Provision of cover during a period of temporary absence from work 16

1.7 Cover that is provided while a member is outside the UK 17

1.8 Cover for children 18

Section 2 What is covered 19

2.1 Discretionary benefits 19

2.2 Insured Illnesses 19

2.3 Core Insured Illnesses 19

2.4 Second Claims 19

2.5 Core Illness Definitions 20

Section 3 Optional additional cover 31

3.1 Additional insured illnesses 31

3.2 Additional Illness Definitions 31

3.3 Total permanent disability 49

3.3.1 Exclusions for total permanent disability, on an own occupation or suited occupation basis 52

3.4 Cover for spouse or civil partner 53

3.4.1 Terms of Cover 53

Section 4 What is not covered 54

4.1 Exclusions 54

4.1.1 Pre-existing conditions 54

4.1.2 Related conditions 54

4.1.2.1 Insured Illnesses where a related conditions exclusion applies indefinitely 54

4.1.2.2 Insured Illnesses where a related conditions exclusion is applied for a period of 2 years. 55

4.1.2.3 Application of the related conditions exclusion to increases in benefit. 55

4.2 Other exclusions 55

4.2.1 Exclusions as a result of underwriting 55

4.3 Circumstances where a second claim will not be allowed 55

4.4 Other illnesses where we will not pay a second claim 55

Section 5 When cover ceases 56

5.1 When cover ceases for a member 56

5.2 When we can cease cover under a Policy 56

Section 6 Policy limitations 57

Section 7 Premiums 57

7.1 How we calculate your premiums 57

7.1.1 Single premium basis 57

7.1.2 Unit rate basis 58

7.2 Revision of premium rates and basis 58

7.3 The information we need to calculate your premiums 59

7.4 When premiums are payable 60

7.4.1 What we will do 60

7.4.2 How you can pay your premiums 60

7.4.3 What will happen if you do not pay your premiums 60

Section 8 Alterations to the Policy cover 61
8.1 Keeping the Policy up to date 61
8.2 Alterations which may affect your premiums and/or terms and conditions 61
8.3 Changes to the nature of your business or the locations where members work 62
8.4 When we can make alterations 62
8.5 How you can cancel the Policy 62

Section 9 Making a claim 63
9.1 When you should tell us about a claim 63
9.2 What we need to assess a claim 63
9.3 Claim assessment outcomes 63
9.4 What we need if a member suffers an insured illness outside the UK 64
9.5 How your claim benefits will be paid 64

Section 10 Further information 65
10.1 The Company 65
10.2 Queries and complaints 65
10.3 Compensation 65

Section 11 General Information 66
11.1 Confidentiality 66
11.2 Intellectual Property 66
11.3 Bribery and Slavery 66
11.4 Money Laundering 66
11.5 Data Protection 66

Terms and Expressions we use

In this **Policy** the words 'we', 'us' or 'our' mean Canada Life Limited. When we refer to 'you' or 'your', we mean the **policyholder** named in the **Policy Particulars** that attach to this document.

Some terms have specific meanings. These are listed below in alphabetical order, together with their meanings and are highlighted in bold text where they appear in these **Policy Conditions.**

If a particular term cannot be identified you may need to combine more than one of the definitions listed below.

Actively at work:
means that a person:

- is present at their place of work, and
- has not received medical advice to refrain from work, and
- is mentally and physically capable of performing fully the normal regular duties associated with the job they are engaged to do, and
- is working their normal contracted number of hours, either at their normal place of work or at a place that the business requires.

Alcohol abuse
Where an **insured illness** arises from inappropriate use of alcohol including but not limited to consuming too much alcohol.

Annual revision date:
the date in each calendar year when the premiums are calculated. The date is shown in your **Policy Particulars**.

Associated policy:
the policy or policies which have been taken out with us in association with this **Policy** as detailed in your **Policy Particulars**.

Cease age:
the age agreed between us as being the age at which cover for an **insured person** ceases, as set out in your **Policy Particulars**. The maximum age must not exceed any **insured person's** 70th birthday.

Child:
any natural or legally adopted child or step child (by marriage or registered civil partnership) of the **member** who is

- under 18 years old, or
- under 22 years old, if they are in full time education

at the time they suffer an **insured illness**.

Full time education means' attending school, college or university full time and includes work placements that are part of the course. Any break from education such as a gap year is excluded.

Circulatory system illnesses:
for the purposes of assessment of a claim the following are all considered to be **circulatory system illnesses**:

- aorta graft surgery,
- balloon valvuloplasty,
- cardiac arrest,
- cardiomyopathy,
- coronary artery bypass grafts,
- heart attack,
- heart transplant,
- heart valve replacement or repair,
- open heart surgery,
- primary pulmonary hypertension,
- pulmonary artery surgery, and
- stroke.

Civil partner:
a person who is the **member's civil partner**, for the purposes of Section 1 of the Civil Partnership Act 2004, at the time they suffer an **insured illness**.

Claim benefit:
the amount of **insured benefit** or **child's** benefit that we have agreed to pay following:

- the diagnosis of an **insured illness**, or
- the date of surgery for specified **insured illnesses**, or
- the date of inclusion on an official UK transplant waiting list, or the date of surgery, for the **insured illness** major organ transplant.

Commencement date:
the date that the **Policy** starts, as set out in your **Policy Particulars**.

Decision letter:
written confirmation issued by us following our assessment of medical and other evidence obtained for an **insured person**.

For the purpose of this definition this will include:

- acceptance of benefits,
- declinature of benefits,
- postponement of a decision,
- restriction of benefits.

Discretionary benefit:
a benefit you want us to provide

- for a **member**, that is larger or smaller than the **scheme benefit** for which the **member** would be eligible, or
- for the **spouse** or **civil partner** of a **member**, that is larger or smaller than the amount of cover for a **spouse** or **civil partner** (if insured) which is shown in your **Policy Particulars**.

Discretionary entrant:
someone:

- who is not an **eligible employee** but who you wish to include in the **Policy**, or
- who is an **eligible employee** but who you want covered from a different date to their **normal inclusion date**, or
- who is a **late entrant**.

Drug abuse
Where an **insured illness** arises from inappropriate use of drugs including but not limited to the following:

- taking an overdose of drugs, whether lawfully prescribed or otherwise.
- taking Controlled Drugs (as defined by the Misuse of Drugs Act 1971) unless in accordance with a lawful prescription.

Earlier claim:
any claim paid for an **insured illness** in respect of the **insured person** either:

- under this **Policy**, or
- under any group critical illness policy arranged by you in connection with the **member's** employment.

Eligible employee:
as shown in your **Policy Particulars**.

Employer:
any company, partnership or organisation that we have agreed to include in the **Policy**.

Evidence of insurability:
any documentary or medical evidence that we may reasonably require to include someone for benefits in the **Policy**.

Existed:
an **insured illness** or **related condition** is said to have existed if it was:

- first diagnosed, or
- treated, or
- known to the **insured person** or **child**

prior to the date of inclusion (as detailed in **Section 4 – What is not covered**) or the date of any increase in benefit.

As long as a later diagnosis confirms this, we will consider an **insured illness** or **related condition** to have existed if the **insured person** or **child**:

- has had symptoms of, or
- has sought or been given advice or counselling on, or received treatment for, or
- has undergone or is awaiting diagnostic tests for

the **insured illness** or **related condition** even if the condition has not been formally diagnosed.

In addition, in respect of a claim for a **child**, we will consider an **insured illness** or **related condition** to have existed where

- the **insured person** or either parent knew or had received medical advice or counselling in respect of that **insured illness** or **related condition** in relation to the **child**.
- the **insured person** or either parent, prior to the birth of the **child**, had received medical advice or counselling in respect of that **insured illness** or **related condition** before the **insured person's** inclusion in the **policy** or on the date of any increase in benefit.

Fair presentation of the risk:
Under the terms of the Insurance Act 2015, you have a duty to provide us with all information you know, or ought to know, about the cover required, so that we can determine whether we need to make any further enquiries in order to allow us to correctly assess the risk for which the cover is required.

Any individuals who have key or senior roles within any of the **employers** covered under the **Policy** must be aware of, and accountable for, all information and knowledge relating to the **employer's** insurance cover.

Disclosure of information to us must be made in a clear and accessible manner and must be factually correct. This duty is also placed on any intermediary acting on your behalf in connection with this **Policy**.

Free cover limit:
the amount of a **normal entrant's scheme benefit** that we will cover on standard terms without the need for **evidence of insurability**.

This will be shown in your statement of account. The free cover limit is calculated at the **commencement date** and at each subsequent **annual revision date**, based on the number of lives and the benefit basis. Should either of these change, the free cover limit may also change.

HMRC:
HM Revenue & Customs.

Insured benefit
The total amount of benefit for which an **insured person** has been accepted under the **Policy**.

Insured illness:
one of the medical conditions or events described in **Section 2 – What is covered** and **Section 3 – Optional additional cover** of this **Policy**. Your **Policy Particulars** will state which apply to your **Policy**.

Insured person:
someone who is a **member**, a **member's spouse** or **civil partner** who is covered by the **Policy**.

Your **Policy Particulars** will state whether cover for **spouses** or **civil partners** is provided by your **Policy**.

Irreversible:
an **insured illness** that cannot be cured by medical treatment and/or surgical procedures used by the National Health Service in the UK at the time of the claim.

This definition is associated with the following **insured illnesses**:

Blindness, Deafness, Liver failure, Loss of independent existence, Loss of speech and Paralysis of a limb.

Late entrant:
a person who joins an **employer's** pension arrangement after the date on which they first became eligible to join that arrangement where entry and/or the benefit entitlement under this **Policy** is dependent on membership of that arrangement.

Member:
an **eligible employee** included in the **Policy**.

Neurological illnesses:
for the purposes of assessment of a second claim the following are all considered to be **neurological illnesses**:

- Alzheimer's disease
- Creutzfeldt-Jakob disease
- Dementia/Pre-senile dementia
- Parkinson's disease.

Normal entrant:
an **eligible employee** who you include in the **Policy**:

- on the first day that they meet the entry conditions shown in your **Policy Particulars**, and
- for their **scheme benefit**.

Normal inclusion date:
the first day that an **eligible employee** qualifies for inclusion in the **Policy**. The day is explained in your **Policy Particulars**.

Partnership partner:
an equity partner of a partnership or a member listed in the incorporation document of a Limited Liability Partnership.

Periodic review date:
the date when your premium rates, **Policy Conditions** and **policy fee** are reviewed. The date is shown in your **Policy Particulars**.

Permanent:
an **insured illness** that is expected to last throughout life irrespective of when the cover ends or the **insured person** or **child** expects to retire.

This definition is associated with the following **insured illnesses**:

Alzheimer's disease, Aplastic anaemia, Blindness, Cardiomyopathy, Creutzfeldt-Jakob disease, Deafness, Dementia/Pre-senile dementia, Kidney failure, Liver failure, Loss of a hand or foot, Loss of independent existence, Loss of speech, Motor neurone disease, Parkinson's disease, Primary pulmonary hypertension and Progressive supranuclear palsy.

Permanent neurological deficit with persisting clinical symptoms:
dysfunction in the nervous system that is present on clinical examination and expected to last throughout the **insured person's** or **child'** s life.

Dysfunction of the nervous system includes:

- 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,
- 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, e.g. brisk reflexes without other symptoms,
- symptoms of psychological or psychiatric origin.

This definition is associated with the following **insured illnesses**:

Bacterial meningitis, Benign brain tumour, Benign spinal cord tumour, Coma, Encephalitis, Stroke, Systemic lupus erythematosus and Traumatic brain injury.

Policy:
This is comprised of:

- these **Policy Conditions** and any subsequent updates and/or replacements,
- the information provided in the Proposal Form,
- your **Policy Particulars** and any subsequent updates and/or replacements,
- the information provided prior to the **commencement date**, or in relation to any alteration to the cover provided under the **Policy**,
- any questionnaire or written statement relating to an **insured person**, including, but not limited to, a Health Declaration Form,
- any **decision letter** issued in writing by us in respect of any **insured person**, and
- any special terms, exclusions or limitations issued by us in writing.

Policy fee:
an annual charge for each **Policy** towards our costs.

Policy Particulars:
The document issued with these **Policy Conditions** which shows the basis of cover which has been agreed for your **Policy**.

Policy year:
any 12 month period from an **annual revision date** during which the **Policy** is in force.

Policyholder:
As shown in your **Policy Particulars**.

Pre-existing conditions exclusion:
As described in **Section 4 - What is not covered** of your **Policy Conditions**.

Related condition:
a medical condition described in **Section 2 - What is covered** and **Section 3 – Optional additional cover** which is either directly or indirectly associated with, or is likely to have led to the occurrence of an **insured illness**.

Restricted person
means a person or entity subject to any sanctions, prohibitions or restrictions under:

- the United Nations' resolutions, treaties or conventions, or
- trade or economic sanctions, laws or regulations of the European Union, United Kingdom, Canada or United States of America.

The foregoing includes but is not limited to the following and their equivalents in force from time to time:

- United Kingdom HM Treasury's Office of Financial Sanctions Implementation Consolidated List of Financial Sanctions Targets in the UK (designated by the United Nations, the European Union and the United Kingdom relating to current financial sanctions regimes), or
- United Kingdom Home Office's List of Proscribed International Terrorist Groups, or
- United Kingdom Home Office's List of Proscribed Groups Linked to Northern Ireland Related Terrorism.

For the purpose of this **Policy**, an entity would also be deemed a restricted person, should a restricted person control or own a vested interest in 25% or more of its shareholding.

Scheduled territories:
the United Kingdom, all European Union (EU) countries, Andorra, Australia, Canada, the Channel Islands, Gibraltar, Hong Kong, Iceland, the Isle of Man, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA and the Vatican City.

Scheme benefit:
as shown in your **Policy Particulars**.

Scheme salary:
the basis of salary you have agreed with us and shown in your **Policy Particulars**.

Secondment:
A period of time when an employee is sent to work somewhere other than their normal place of work by an **employer** on a temporary basis with an expectation of return to their original job, or to their original **employer** in their original location.

Self-inflicted injury
Where an **insured illness** arises from intentional self-inflicted injury.

Spouse:
the person that the **member** is legally married to when they suffer an **insured illness**.

State pension age:
the age at which the **insured person** is first entitled to receive the basic state pension or any benefit that may replace it.

Statutory leave:
any leave taken from employment due to an entitlement to:

- maternity leave,
- paternity leave
- adoption leave,
- shared parental leave, or
- parental bereavement leave.

Survival period:
the period that starts after the following insured events that the **insured person** or **child** has to survive before a claim becomes valid:

The 14 day period starts:

- on the day of surgery for:
  - aorta graft surgery,
  - balloon valvuloplasty;
  - a coronary artery bypass graft;
  - a heart valve replacement or repair;
  - open heart surgery; or
  - pulmonary artery surgery.
- for a major organ transplant, on the earlier of:
  - the date the **insured person** or **child** is included on an official UK transplant waiting list for a heart, liver, lung, kidney, pancreas or bone marrow; or
  - the actual date of surgery.
- for any other **insured illness**, on the date the **insured illness** was diagnosed.

Note: For total permanent disability, as described in **Section 3 – Optional additional cover**, the **insured person** must survive for more than six months from the date of total permanent disability.

Underwriting:
the process whereby **evidence of insurability** is obtained and assessed.

War and civil commotion
Where an **insured illness** arises as a result of war, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.

Section 1
Who is covered

1.1 Normal entrants

We will include a **normal entrant** as a **member**:

- on the **commencement date**, if they were included in your existing group critical illness arrangement on or before that date, or
- from their **normal inclusion date**, on or after the **commencement date**.

Your **Policy Particulars** will show what conditions apply.

1.2 When any benefits need to be underwritten

If a **free cover limit** does not apply, all of a person's benefit will be subject to **evidence of insurability** and acceptance by us.

If a **free cover limit** applies but the amount of **insured person's** benefit exceeds the **free cover limit**, the excess will be subject to **evidence of insurability** and acceptance by us.

If we are able to accept benefit, a **decision letter** will be issued showing when further **evidence of insurability** will be required for any increase.

1.3 Provision of cover for discretionary and late entrants

We may agree, if specifically requested, to include a **discretionary entrant** or **late entrant**.

We will need **evidence of insurability** before we can accept cover for any benefit.

We will tell you what **evidence of insurability** we need and the date that any cover for that **insured person** starts.

1.4 Provision of cover before an underwriting decision has been made

If **evidence of insurability** is needed by us before we can accept a person's benefit, we will provide temporary cover.

This will apply for up to 120 days, from the date:

the **insured person** is first included in the **Policy** or

- when an increase in an **insured person's** benefit, applies, or
- when we are notified of a **discretionary entrant** or **late entrant**, or
- when we are notified of any **discretionary benefits**

and will cease when we tell you what our decision is, if earlier.

However, temporary cover will not apply:

- if the person has previously had some or all of their benefit declined or postponed, or
- if any additional premiums chargeable following the issue of our **decision letter** have not been accepted, or
- if a **decision letter** has not been issued where **evidence of insurability** has previously been requested, or
- to any part of the **member's** benefit that exceeds £250,000, or
- if the **insured person** suffers an **insured illness** and that illness has occurred as a result of a **related condition**.

1.5 Underwriting decisions which can be made

When we have received all the **evidence of insurability** that we need to decide whether we can accept a person's benefit our **decision letter** will be issued showing what cover can be provided and whether any special terms will be applied. We may:

- accept the benefit at standard terms, or
- decline the amount of benefit that was being underwritten, or
- postpone making a decision to a later date, or
- charge an additional premium for the amount of benefit that has been underwritten, or
- exclude certain conditions or activities.

If we have asked for **evidence of insurability** to complete **underwriting** and we do not receive it, we will restrict the person's **insured benefit** to the minimum of the following:

- their previous **insured benefit** if they have been previously underwritten, or
- the **free cover limit**, if one applies, if they have not been previously underwritten and they are being underwritten because their benefit exceeds the **free cover limit**, or
- nil benefit if they are being underwritten as a **discretionary entrant**, or
- that person's previous benefit if they are being underwritten for a **discretionary benefit**.

If we can accept that person's benefit we will tell you when cover for that benefit starts.

1.6 Provision of cover during a period of temporary absence from work

If you continue to pay premiums, we will continue to provide cover, subject to **Section 5 - When cover ceases**, for **members** who are granted a temporary leave of absence from work. Cover under the **Policy** will continue:

- during any period of illness, disablement or **statutory leave**, or
- for up to 3 years for any other reason.

Cover will cease if the **member** ceases to qualify for benefits under the **Policy**.

Where an **insured person's** benefit:

- was insured under another policy immediately before this **Policy** commenced, and
- the **member** was absent from work on the **commencement date**

their cover under this **Policy** will stop on the same date that the cover would have ceased under that other policy, if that policy had remained in force. This will only be applied if the previous policy provided cover during absence for a shorter period than that shown above.

This will also apply if new groups or organisations are brought into the **Policy** after the **commencement date**.

The amount of a **member's scheme salary** during a period of temporary leave of absence from work will be the amount that applied in respect of the **member** immediately before the absence started.

However, we will allow some increases in **scheme salary** to be taken into account during a period of temporary leave of absence.

These increases will be limited to the lesser of:

- the general level of increases in basic salaries or wages awarded by the **member's employer**, and
- the increases in the Average Weekly Earnings Statistic (including bonuses), published by the UK Office for National Statistics

during the period of temporary leave of absence.

1.7 Cover that is provided while a member is outside the UK

Cover will be maintained for an **insured person** or **child** who is outside the UK on holiday and an **insured person** travelling, in connection with their business, other than on **secondment**.

We will cover **members** who are working outside the UK on **secondment** to another country within the **scheduled territories** provided that:

- they would otherwise meet the eligibility conditions for inclusion in the **Policy**, and
- they have a contract of employment with the **employer** or, if they are not employed by the **employer**, they have a contract with the **employer** to provide the benefits described in this **Policy**.

We will cover a **spouse** or **civil partner** who is resident outside the UK or working outside the UK on **secondment** provided this is in a country within the **scheduled territories**.

You can request cover for individuals who are:

- working outside the UK on a permanent basis, or
- working on **secondment** in a country outside the **scheduled territories**.

We will need full details of these individuals before we can agree cover and confirm any further special terms and conditions which may apply. There may be locations and circumstances where we will not provide cover.

For **members** working outside the UK:

- all premiums must be paid in UK currency, and
- all **claim benefits** will be paid by us in UK currency.

If the **member** is not paid in UK currency, **scheme salary** for premium calculation will be converted to UK currency based on the exchange rate, as published by the Bank of England, at the previous **annual revision date** and will be fixed until the next **annual revision date.**

If we require medical evidence for **evidence of insurability** or in support of a claim and it is obtained outside the UK, then:

- any medical evidence must be provided in English, and
- all diagnoses and medical opinions relating to any **insured illness** must be given by a medical specialist who is acceptable to our Medical Officer(s), and whose specialism is appropriate to the cause of the claim.

If we agree to contribute an amount towards the cost of obtaining the evidence this will be equivalent to the cost of obtaining similar evidence in the UK unless otherwise agreed.

1.8 Cover for children

We will pay a **child's** benefit to a **member** if their **child** is diagnosed as suffering from one of the **insured illnesses** and survives for at least the length of the **survival period**.

The maximum **child's** benefit will be the lowest of:

- 25% of the **member's scheme benefit,** or
- 25% of the **member's insured benefit,** and
- £20,000.

Notes:

- The **pre-existing conditions exclusion**, see **Section 4 - What is not covered**, will apply in respect of a **child** at the date on which:
  - the **member** was included this **Policy**, or
  - the **member** was included in a previous group critical illness policy arranged in connection with the **member's** employment with you or another employer, if earlier, or
  - the **child** qualifies for cover, if later.
- the other exclusions as shown in the tables in **Section 2- What is covered**, as shown in the tables in **Section 3 - Optional additional cover** and **Section 4 - What is not covered,** will apply in respect of a **child.**

In addition an **insured illness** intentionally caused by either the **insured person,** a parent or a guardian will be excluded.

A **child** will cease to be included in the **Policy**:

- when a claim for one of the **insured illnesses** has been paid for that **child**, or
- the date the **member** ceases to be included in the **Policy** (if earlier) as shown in **Section 5- When cover ceases**, other than if the **member's** cover ceases due to the **member** having received the maximum number of claims payments for which they are eligible.

Cover for total permanent disability as shown in **Section 3 - Optional additional cover**, will not be applicable in respect of a **child**.

This cover is not available if a benefit was paid in respect of an **insured illness** suffered by the **child** under a previous group critical illness policy arranged in connection with the **member's** employment with you or any other employer.

Section 2
What is covered

The cover included in the **Policy** and the basis of its calculation is shown in your **Policy Particulars**.

2.1 Discretionary benefits

If you ask us to provide a **discretionary benefit** we will either:

- agree to provide cover subject to **evidence of insurability** for the **discretionary benefit**, or
- decline to provide such cover.

Where we agree to provide cover we will tell you what **evidence of insurability** we need. If the evidence provided is satisfactory to us we will issue our **decision letter** and confirm the date on which cover will start.

Any **discretionary benefits** will be shown in our **decision letter** and will not be shown in your **Policy Particulars**.

2.2 Insured Illnesses

If the **insured illness** first occurs (in the case of an event) or is diagnosed (in the case of a medical condition) on or after the **commencement date** of the **Policy** we will pay the **insured benefit** or **child's** benefit if an **insured person** or **child**:

- suffers from one of the following core **insured illnesses**, or
- suffers from one of the additional **insured illnesses**, if also insured, as described in **Section 3 - Optional additional cover**, and
- survives for at least the length of the **survival period**.

2.3 Core Insured Illnesses

These are shown on the following pages and are subject to the exclusions shown in **Section 4** - **What is not covered**.

2.4 Second Claims

If a **member** suffers a different **insured illness** a **second claim** may be payable subject to the terms described in this section, **Section 3 - Optional additional cover** and **Section 4 - What is not covered**.

2.5 Core Illness Definitions

Alzheimer's disease
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
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: • remember, • reason, and • perceive, understand, express and give effect to ideas. **Note: For the above definition, the following is not covered:** • other types of dementia.	Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson's disease, epilepsy, depression, dementia, aphasia, amnesic memory disorder, psychosis, major head trauma.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for Alzheimer's disease where there has been an **earlier claim** in respect of any other **neurological illnesses** or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Cancer
– excluding less advanced cases

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
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 leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin). **Note: For the above definition, the following are not covered:** • All cancers which are histologically classified as any of the following: – pre-malignant, – non-invasive, – cancer in situ, – having either borderline malignancy, or – having low malignant potential. • All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0. • Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A. • Any skin cancer (including cutaneous lymphoma) other than: – malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis, or – basal cell carcinoma or squamous cell carcinoma that has invaded and spread to lymph nodes or metastasised to distant organs.	Malignant, borderline malignant or pre-malignant tumour or condition, leukaemia or lymphomas, plus polyposis coli, carcinoma-in-situ, papilloma of the bladder or gallbladder, chronic inflammatory bowel disease, Barrett's oesophagus.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for cancer where there has been an **earlier claim** in respect any of the following **insured illnesses**:

- cancer, whether or not this is connected to or associated with the subsequent cancer,
- loss of independent existence,
- major organ transplant if this is connected to, or associated with any cancer,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Cardiac Arrest
- followed by surgical implantation of a defibrillator

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
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: • implantable Cardioverter-Defibrillator (ICD), or • cardiac resynchronization device 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, family history of Sudden Cardiac Death of uncertain cause, Wolff-Parkinson-White syndrome. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**,
- **drug abuse**.

In addition we will not pay a subsequent claim for cardiac arrest where there has been an **earlier claim** in respect of any other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Coronary artery bypass grafts
– with surgery to divide the breastbone

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.	Coronary artery anomalies, coronary vasospasms and myocardial bridging. All obstructive or occlusive arterial disease such as arteriosclerosis, coronary artery dissection or haematoma, coronary ectasia, diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,** for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for coronary artery bypass grafts where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Creutzfeldt-Jakob disease (CJD)
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist. There must be **permanent** clinical loss of the ability to do all of the following: • remember, • reason, and • perceive, understand, express and give effect to ideas.	Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson's disease, epilepsy, depression, dementia, aphasia, amnesic memory disorder, psychosis, major head trauma.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for Creutzfeldt-Jakob disease where there has been an **earlier claim** in respect of any other **neurological illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**

Dementia/Pre-senile dementia
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of dementia or pre-senile dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be **permanent** and progressive clinical loss of the ability to do all of the following: • remember, • reason, and • perceive, understand, express and give effect to ideas. **Note: For the above definition, the following is not covered:** • dementia secondary to alcohol or drug abuse.	Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson's disease, epilepsy, depression, aphasia, amnesic memory disorder, psychosis, stroke, brain tumour, hydrocephalus, Creutzfeld-Jacob disease and major head trauma.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,**
- **related condition exclusions**.

In addition we will not pay a subsequent claim for dementia/pre-senile dementia where there has been an **earlier claim** in respect of any other **neurological illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Heart attack
– of specified severity

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction: • typical clinical symptoms (for example, characteristic chest pain). • new characteristic electrocardiographic changes. • the characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher: – Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L) – Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L) The evidence must show a definite acute myocardial infarction. **Note: For the above definition, the following are not covered:** • other acute coronary syndromes, • angina without myocardial infarction.	Familial Hyperlipidaemia, coronary artery anomalies, coronary vasospasms and myocardial bridging, all obstructive or occlusive arterial disease such as arteriosclerosis, coronary artery dissection or haematoma, coronary ectasia, diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,** for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**,
- **drug abuse**.

In addition we will not pay a subsequent claim for a heart attack where there has been an **earlier claim** in respect of any other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness,

For further information see **Section 4 – What is not covered**.

Kidney failure
– requiring permanent dialysis

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Chronic and end-stage failure of both kidneys to function, as a result of which regular dialysis is **permanently** required.	Polycystic kidney disease, pyelonephritis or Glomerulonephritis, diabetes mellitus or any chronic renal disorder. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for a Kidney failure where there has been an **earlier claim** for or any of the following **insured illnesses**:

- loss of independent existence,
- major organ transplant of the kidney,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Major organ transplant
– from another person

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
The undergoing as a recipient of a transplant from another person of bone marrow or of a complete heart, kidney, liver, lung or pancreas, or inclusion on an official UK waiting list for such a procedure. **Note: For the above definition, the following is not covered:** • transplant of any other organs, parts of organs, tissues or cells.	Cystic fibrosis, leukaemia, diabetes mellitus, aplastic or hypoplastic anaemia, immunological defects or disease, cardiomyopathy, coronary artery disease, cardiac failure, chronic lung disease, chronic kidney disease, chronic liver disease, chronic pancreatitis or pulmonary hypertension.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **alcohol abuse**,
- **drug abuse**.

In addition we will not pay a subsequent claim for major organ transplant where there has been an **earlier claim** for any of the following **insured illnesses**:

- aplastic anaemia,
- cancer, if this is connected to or associated with the subsequent major organ transplant,
- kidney failure,
- liver failure,
- any major organ transplant,
- loss of independent existence,
- respiratory failure
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Motor neurone disease
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist: • 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.	Any chronic neurological symptoms that would be attributable to or known to motor neurone disease.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for a motor neurone disease where there has been an **earlier claim** in respect of any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Multiple sclerosis
– with persisting symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months.	Any form of neuropathy, encephalopathy or myelopathy (disorders of function of the nerves); abnormal sensation (numbness) of 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 and abnormal MRI scan.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for multiple sclerosis where there has been an **earlier claim** in respect of any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Parkinson's disease
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered - Related Conditions
A definite diagnosis of Parkinson's disease by a Consultant Neurologist or Consultant Geriatrician. There must be **permanent** clinical impairment of motor function with associated tremor and muscle rigidity. Note: For the above definition, the following is not covered: • Parkinsonian syndromes/Parkinsonism.	Tremor, rigidity of limbs, slurred speech, dementia, extra pyramidal disease. Secondary parkinsonism.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **alcohol abuse**.

In addition we will not pay a subsequent claim for a Parkinson's disease where there has been an **earlier claim** in respect of any other **neurological illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Stroke
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in **permanent neurological deficit with persisting clinical symptoms**. Note: For the above definition, the following are not covered: • transient ischaemic attack (TIA). • traumatic injury to brain tissues or blood vessels. • death of tissue of the optic nerve or retina/eye stroke.	Any disease or disorders of the heart, including arrhythmia, valve disorder, cardiac tumour and obstructive or occlusive arterial disease such as arteriosclerosis. Transient ischaemic attack (TIA), intracranial aneurysm or vascular disorder, such as dissection. Anticoagulation treatment, thrombophilia and diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,** for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness
- **related condition exclusions**.

In addition we will not pay a subsequent claim for a stroke where there has been an **earlier claim** in respect of any other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Cardiovascular Risk Table

If the **insured person** or **child** has had:

- 2 or more recorded blood pressure readings, either the diastolic or systolic, taken at least 7 days apart, or
- 2 or more recorded cholesterol readings taken at least 7 days apart

that exceeded the levels shown in the table below, in the two years prior to:

- inclusion in this **Policy**, or
- inclusion in a previous group critical illness policy arranged in connection with the **member's** employment with you or any other **employer**, if earlier, or
- the date of increase in **insured benefit** or **child's** benefit,

these will be treated as **related conditions** in respect of the **insured illnesses** cardiac arrest, coronary artery bypass grafts, heart attack, kidney failure and stroke.

Age bands (at date of reading)	Up to 50	51-60	61 and over
Blood Pressure	160/90	170/95	175/95
Total Cholesterol	5.5 mmol/l	6.5 mmol/l	7.5 mmol/l

Section 3 Optional additional cover

Your **Policy Particulars** will state any additional cover that is included under the **Policy**, the basis of its calculation and the method used to calculate the premiums for additional cover.

3.1 Additional insured illnesses

If you have selected to insure these, the additional **insured illnesses** covered are listed below. Exclusions may apply and these are shown below and in **Section 4 - What is not covered**

3.2 Additional Illness Definitions

Aorta graft surgery
– for disease

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Undergoing surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. **Note: For the above definition, the following are not covered:** • any other surgical procedure, for example the insertion of stents or endovascular repair. • surgery following traumatic injury to the aorta.	Marfan's syndrome, Ehlers-Danlos syndrome, bicuspid aortic valve, congenital malformation of the heart or aorta, coarctation of aorta, known previous aneurysms/dissection/ectasia of aorta, arteriosclerosis of aorta.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for aorta graft surgery where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Aplastic anaemia
– with permanent bone marrow failure

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Permanent bone marrow failure which results in all of anaemia, neutropenia and thrombocytopenia, requiring treatment with at least one of the following: • blood transfusion. • marrow stimulating agents. • immunosuppressive agents. • bone marrow transplant.	Any history of symptoms or abnormal blood tests that would be attributable to or known to aplastic anaemia.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,**
- **related condition exclusions**.

In addition we will not pay a subsequent claim for aplastic anaemia where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- major organ transplant of bone marrow,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Bacterial meningitis
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of bacterial meningitis by an appropriate consultant resulting in significant **permanent neurological deficit with persisting clinical symptoms**. Note: For the above definition, the following is not covered: • all other forms of meningitis including viral meningitis.	Chronic ear disease, cerebral shunt related to hydrocephalus, immunodeficiency syndromes.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for bacterial meningitis where there has been an **earlier claim** for any of the following **insured illnesses**:

- encephalitis,
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Balloon valvuloplasty

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
The actual insertion, on the advice of a Consultant Cardiologist, of a balloon catheter through the orifice of one of the valves of the heart, and the inflation of the balloon to relieve valvular abnormalities.	Rheumatic fever, carcinoid syndrome, bicuspid valve, mital valve prolapse, myxomatous or calcified heart valve, cardiomyopathy, Ehlers-Danlos syndrome, Marfan's syndrome.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness.
- **related condition exclusions**.

In addition we will not pay a subsequent claim for balloon valvuloplasty where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Benign brain tumour
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in **permanent neurological deficit with persisting clinical symptoms**. Note: For the above definition, the following are not covered: • tumours in the pituitary gland, • tumours originating from bone tissue • angioma and cholesteatoma.	Pre-existing benign brain tumour, neurofibromatosis (Von Recklinghausen's disease), haemangioma (Von Hippel- Lindau disease), pituitary gland tumours, angioma/haemangioma/meningioma, any malformation of the arteries or veins of the brain.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for benign brain tumour where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Benign spinal cord tumour

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A non-malignant tumour in the spinal canal or spinal cord, resulting in either of the following: • **permanent neurological deficit with persisting clinical symptoms**, or • invasive surgery to remove the tumour Note: For the above definition, the following are not covered: • radiotherapy for any tumour.	Neurofibromatosis, meningomyelocele and syringomyelia

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for Benign spinal cord tumour where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- paralysis of a limb,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Blindness
– permanent and irreversible

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Permanent and **irreversible** loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.	Stroke, transient ischaemic attack (TIA), head trauma, brain tumour, glaucoma, pituitary gland tumour, optic neuropathy, papilloedema, retrobulbar neuritis, sarcoidosis, malignant exophthalmus, diabetes mellitus, uveitis, retinal detachment, macular degeneration or registered blind.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,**
- **related condition exclusions**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for blindness where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Cardiomyopathy
– of specified severity

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis by a Consultant Cardiologist of cardiomyopathy resulting in **permanently** impaired ventricular function such that the ejection fraction is 40% or less for at least six months when stabilised on therapy advised by the Consultant. The diagnosis must also be evidenced by: • electrocardiographic changes, and • echocardiographic abnormalities. The evidence must be consistent with the diagnosis of cardiomyopathy. **Note: For the above definition, the following are not covered:** • all other forms of heart disease and/or heart enlargement. • myocarditis, and • cardiomyopathy related to alcohol or drug abuse.	Any disease or disorders of the heart. This will include congenital malformations, heart valve defects, any obstructive or occlusive arterial disease such as arteriosclerosis or Takotsubo Syndrome. Muscular dystrophy, acromegaly, amyloidosis, haemochromatosis, any previous chemotherapy or diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for cardiomyopathy where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Coma
– with associated permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A state of unconsciousness with no reaction to external stimuli or internal needs which: • requires the use of life support systems for a continuous period of at least 96 hours, and • with associated **permanent neurological deficit with persisting clinical symptoms**. Note: For the above definition, the following are not covered: • medically induced coma, • coma secondary to alcohol or drug abuse.	Self- inflicted injury or misuse of drugs or alcohol, diabetes mellitus, medically induced coma.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for coma where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Deafness
– permanent and irreversible

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
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.	Stroke, transient ischaemic attack (TIA), head trauma, brain tumour, chronic ear infection, acoustic nerve tumour, presbycusis, otosclerosis, congenital deafness.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for deafness where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness,

For further information see **Section 4 – What is not covered**.

Encephalitis
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of encephalitis by a Consultant Neurologist resulting in **permanent neurological deficit with persisting clinical symptoms**. Note: For the above definition, the following is not covered: • encephalitis in the presence of HIV.	Bacterial meningitis, HIV Immuno deficiency syndromes, Lyme disease.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for encephalitis where there has been an **earlier claim** for any of the following **insured illnesses**:

- bacterial meningitis,
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Heart valve replacement or repair

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
The undergoing of surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.	Endocarditis, congenital malformation of the heart, cardiomyopathy, any obstructive or occlusive arterial disease, rheumatic fever, Marfan's syndrome, Ehlers–Danlos syndrome, carcinoid syndrome, bicuspid aortic valve, mitral valve prolapse, myxomatous or calcified heart valve.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for heart valve replacement or repair where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

HIV infection

– caught in the UK, the Channel Islands, the Isle of Man or EU from a blood transfusion, physical assault or at work in an eligible occupation

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Infection by Human Immunodeficiency Virus (HIV) resulting from: • a blood transfusion given as part of medical treatment, • a physical assault, or an incident occurring in the course of performing normal duties of employment from the eligible occupations listed below: – a medical practitioner, – a person employed in a medical facility, – a prison officer, – a dentist, or – a **member** of the fire, police or ambulance emergency services, after the start of the **insured person** or **child's** cover under the **Policy** and satisfying all of the following: • the incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures. • where HIV infection is caught through a physical assault or as a result of an incident 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. • the incident causing infection must have occurred in the UK, the Channel Islands, the Isle of Man or EU. **Note: For the above definition, the following is not covered:** • HIV infection resulting from any other means, including sexual activity or drug abuse.	No **insured benefit** or **child's** benefit will be payable in respect of an **insured person** or **child** who has been infected with any Human Immunodeficiency Virus (HIV) or has demonstrated any antibodies to such virus, at any time prior to the date of inclusion: • in this **Policy**, or • in a previous group critical illness policy arranged by you or any other employer in connection with the **member's** employment, if earlier.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for HIV where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness,

For further information see **Section 4 – What is not covered**.

Liver failure
– irreversible

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of **irreversible** end stage liver failure due to cirrhosis by a Consultant Physician resulting in all of the following: • **permanent** jaundice, • ascites, and • encephalopathy. **Note: For the above definition, the following is not covered:** • liver failure secondary to alcohol or drug abuse.	Chronic liver disease and hepatitis, primary sclerosing cholangitis, cirrhosis of the liver, portal hypertension, hepatic steatosis, autoimmune hepatitis.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for liver failure where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- major organ transplant of the liver,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Loss of a hand or foot
– permanent physical severance

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Permanent physical severance of either a hand or foot at or above the wrist or ankle joint.	Peripheral vascular disease, bone cancer, soft tissue cancer, diabetes mellitus.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **self-inflicted injury**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for the loss of a hand or foot where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness,

For further information see **Section 4 – What is not covered**.

Loss of independent existence
– permanent and irreversible

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Total, **permanent** and **irreversible** disablement resulting in the inability to perform, even with the use of appropriate assistive devices, at least three of the following six activities without the direct assistance of another person. • **Feeding/eating** – cutting meat, buttering bread, getting food and drink to the mouth using fingers or utensils. • **Dressing** – dressing oneself including fastening of zips and buttons, getting clothes from wardrobes and drawers. • **Bathing/grooming** – turning on taps, getting in and out of the bath or shower, washing face, hands and body, drying oneself, combing hair. • **Continence** – moving into and out of the bathroom, getting on and off the toilet unaided, recognising the need or urge to void bladder or bowel in time to get to the toilet. • **Mobility** – the ability to move indoors from one room to another in the **insured person's** or **child's** own home. • **Transfer** – getting into and out of bed, transferring from one place to another, for example, chair to bed, chair to standing, chair to chair.	Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson's disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Back, neck or joint pain, arthritis, diabetes mellitus.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for loss of independent existence where there has been an **earlier claim** for any other **insured illness**:

For further information see **Section 4 – What is not covered**.

Loss of speech
– total, permanent and irreversible

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Total **permanent** and **irreversible** loss of the ability to speak as a result of physical injury or disease.	Stroke, transient ischaemic attack (TIA), brain injury, brain tumour, motor neurone disease, muscular dystrophy, throat tumour, laryngeal polyps, Alzheimer's disease, Parkinson's disease.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,**
- **related condition exclusions**.

In addition we will not pay a subsequent claim for loss of speech where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness,

For further information see **Section 4 – What is not covered**.

Open heart surgery
– with surgery to divide the breastbone

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct a structural abnormality of the heart.	Endocarditis, congenital malformation of the heart, cardiomyopathy, any obstructive or occlusive arterial disease, rheumatic fever, Marfan's syndrome, Ehlers–Danlos syndrome, carcinoid syndrome, bicuspid aortic valve, mitral valve prolapse, myxomatous or calcified heart valve, tumours of the heart such as myxomas. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for open heart surgery where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Paralysis of a limb
– total and irreversible

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Total and **irreversible** loss of muscle function to the whole of a limb.	Diseases of the central nervous system including multiple sclerosis, motor neurone disease, Parkinson's disease, stroke, transient ischaemic attack (TIA), brain tumour, Alzheimer's disease. Tumours, infections, lesions and malformations of the spinal cord. Muscular dystrophy.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for paralysis of a limb where there has been an **earlier claim** for any other **insured illness**:

For further information see **Section 4 – What is not covered**.

Primary pulmonary hypertension
– of specified severity

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of primary pulmonary hypertension. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in the **permanent** loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity*. *NYHA Class 3: Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.	There are no **related conditions** applicable.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,** for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for primary pulmonary hypertension where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Progressive supranuclear palsy
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis, by a Consultant Neurologist, of progressive supranuclear palsy. There must be **permanent** clinical impairment of eye movement and motor function with associated tremor, rigidity of movement and postural instability.	Motor neurone disease.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for progressive supranuclear palsy where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Pulmonary artery surgery
– with surgery to divide the breastbone

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) 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.	Pulmonary valve disorder, Fallot's tetralogy, patent ductus arteriosus, congenital malformation of the heart and its vessels.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**, for the purposes of this exclusion **circulatory system illnesses** are considered to be the same illness,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for pulmonary artery surgery where there has been an **earlier claim** in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Respiratory failure
– resulting in breathlessness even when resting

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Advanced stage chronic lung disease resulting in: • breathlessness at rest, and • the need for continuous daily oxygen treatment ($PaO2 < 7.3kPa$ when clinically stable as prescribed under British Thoracic Society and NICE guidelines) for at least 12 months.	Chronic obstructive or restrictive pulmonary disease, emphysema.Any disease or disorder of the respiratory system including lung, bronchi and trachea. Tuberculosis or chronic inflammatory diseases. Autoimmune disorders affecting the lung, such as sarcoidosis.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion,**
- **related condition exclusions**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for respiratory failure where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- major organ transplant of a lung,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Rheumatoid arthritis
– of specified severity

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
A definite diagnosis of chronic rheumatoid arthritis by a Consultant Rheumatologist resulting in all of the following: • there must be morning stiffness in the affected joints of at least one-hour duration, • there must be arthritis of at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a physician, • the arthritis must involve two or more of the following sites: – wrists or ankles – hands and fingers – feet and toes • the arthritis must affect both sides of the body, • presence of rheumatoid factor or anti CCP (anticyclic citrullinated protein) antibodies, unless all other criteria are met, • there must be subcutaneous nodules (nodular swelling beneath the skin), • there must be radiographic changes typical of active rheumatoid arthritis plus evidence of clinical deformity. The symptoms must have been present for at least six months before a claim can be submitted and in the opinion of our Medical Officer(s) all appropriate treatments such as disease modifying agents have been prescribed for at least six months.	Inflammatory polyarthropathy, psoriatic arthopathy.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for rheumatoid arthritis where there has been an **earlier claim** for any of the following **insured illnesses**:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Systemic lupus erythematosus
- with severe complication

Definition	**Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions**
A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following: • **permanent neurological deficit with persisting clinical symptoms**, or • the **permanent** impairment of kidney function tests as follows: – Glomerular Filtration Rate (GFR) below 30 ml/min	Hughes syndrome, rheumatoid arthritis, and Sjogren's syndrome

Exclusions applicable to a claim

The following exclusions apply to any claim:
- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for systemic lupus erythematosus where there has been an **earlier claim** for any other **insured illness**:

For further information see **Section 4 – What is not covered**.

Terminal illness
- where death is expected within 12 months

Definition	**Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions**
A definite diagnosis by the attending Consultant of an illness that satisfies both of the following: • 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 12 months.	All core and additional **insured Illnesses**.

Exclusions applicable to a claim

The following exclusions apply to any claim:
- **pre-existing conditions exclusion**,
- **related condition exclusions**.

In addition we will not pay a subsequent claim for terminal illness where there has been an **earlier claim** for any other **insured illness**:

For further information see **Section 4 – What is not covered**.

Third degree burns
– covering 20% of the body's surface area

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.	There are no **related conditions** applicable.

Exclusions applicable to a claim

The following exclusions apply to any claim:
- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **alcohol abuse**,
- **drug abuse**,
- **self-inflicted injury**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for third degree burns where there has been an **earlier claim** for any of the following **insured illnesses**:
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Traumatic brain injury
– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Death of brain tissue due to traumatic injury resulting in **permanent neurological deficit with persisting clinical symptoms**.	There are no **related conditions** applicable.

Exclusions applicable to a claim

The following exclusions apply to any claim:
- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **alcohol abuse**,
- **drug abuse**,
- **self-inflicted injury**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for traumatic head injury where there has been an **earlier claim** for any of the following **insured illnesses**:
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.

Cardiovascular Risk Table

If the **insured person** or **child** has had:

- 2 or more recorded blood pressure readings, either the diastolic or systolic, taken at least 7 days apart, or
- 2 or more recorded cholesterol readings taken at least 7 days apart

that exceeded the levels shown in the table below, in the two years prior to:

- inclusion in this **Policy**, or
- inclusion in a previous group critical illness policy arranged in connection with the **member's** employment with you or any other **employer**, if earlier, or
- the date of increase in **insured benefit** or **child's** benefit,

these will be treated as **related conditions** in respect of the **insured illnesses** cardiomyopathy and open heart surgery.

Age bands (at date of reading)	Up to 50	51-60	61 and over
Blood Pressure	160/90	170/95	175/95
Total Cholesterol	5.5 mmol/l	6.5 mmol/l	7.5 mmol/l

3.3 Total permanent disability

A benefit will only be payable under the **Policy** as a result of total permanent disability if the **insured person**:

- survives for more than six months from the date of total permanent disability, and the **cease age** is not reached during this period, and
- suffers total permanent disability throughout this period.

The definitions of total permanent disability are shown in the tables below.

Unable to do their own occupation ever again – (own occupation)	
Definition	**Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions**
Loss of the physical or mental ability through an illness or injury before the **cease age** to the extent that the **member** 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 person's own occupation that cannot reasonably be omitted or modified. Own occupation means the **member**'s trade, profession or type of work done for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability. 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 **member** expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.	Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson's disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Also back, neck or joint pain, arthritis and diabetes mellitus.
Exclusions applicable to a claim	
The following exclusions apply to any claim: • **pre-existing conditions exclusion**, • **related condition exclusions**, • **alcohol abuse**, • **drug abuse**, • **self-inflicted injury**, • **war and civil commotion**. In addition we will not pay a subsequent claim for total permanent disability where there has been an **earlier claim** for any other **insured illness**. For further information see **Section 4 – What is not covered**.	

Unable to do a suited occupation ever again – (suited occupation)

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Loss of the physical or mental ability through an illness or injury before the **cease age** to the extent that the **member** 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. A suited occupation means any work the **member** 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. 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 **member** expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.	Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson's disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Also back, neck or joint pain, arthritis and diabetes mellitus.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **alcohol abuse**,
- **drug abuse**,
- **self-inflicted injury**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for total permanent disability where there has been an **earlier** claim for any other **insured illness**.

For further information see **Section 4 – What is not covered**.

Unable to look after yourself ever again

Definition	Related Conditions relevant in the use of the Policy exclusion shown in Section 4.1.2 What is not covered – Related Conditions
Loss of the physical ability through an illness or injury before the **cease age** to do at least 3 of the 6 tasks listed below ever again. 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 **insured person** expects to retire. The **insured person** must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. 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. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.	Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson's disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Also back, neck or joint pain, arthritis and diabetes mellitus.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- **pre-existing conditions exclusion**,
- **related condition exclusions**,
- **alcohol abuse**,
- **drug abuse**,
- **self-inflicted injury**,
- **war and civil commotion**.

In addition we will not pay a subsequent claim for total permanent disability where there has been an **earlier claim** for any other **insured illness**.

For further information see **Section 4 – What is not covered**.

3.3.1 Exclusions for total permanent disability, on an own occupation or suited occupation basis

Exclusion applies to	Exclusion
any **member** who has to hold a licence or certificate that is dependant on them being certified as medically, physically or mentally fit to be able to perform their occupation, for example but not limited to, LGV drivers, PSV drivers, aircraft pilots, aircrew and Merchant Navy personnel.	a benefit will not be payable unless the **member** has suffered loss of the physical or mental ability through an illness or injury before the **cease age** to the extent that the **member** is unable to do the material and substantial duties of any occupation at all 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 occupation that cannot reasonably be omitted or modified. Any occupation means any type of work at all irrespective of location and availability. 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 **member** expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

3.4 Cover for spouse or civil partner

Cover for a **member's spouse** or **civil partner** up to the **cease age**, or the date at which the **member's** cover ceases if earlier.

Benefits will be paid if their **spouse** or **civil partner** is diagnosed as suffering from one of the **insured illnesses** and survives for at least the length of the **survival period**.

The maximum benefit will be the lower of:

- the **scheme benefit** of the **member** (or, where no further benefits are payable in respect of the **member**, the **scheme benefit** to which the **member** would otherwise be entitled) and
- £150,000.

3.4.1 Terms of Cover

The **pre-existing conditions exclusion** as described in **Section 4 - What is not covered**, will apply in respect of a **spouse** or **civil partner** at the date:

- the **member** was included in this **Policy**; or
- the **member** was included in a previous group critical illness policy arranged by you or any other employer in connection with the **member's** employment, or
- the **spouse** or **civil partner** qualifies for cover, if later, or
- benefit levels which are applicable to the **spouse** or **civil partner** increase.

The other exclusions as described in **Section 4 - What is not covered** will also apply in respect of a **spouse** or **civil partner**.

Where total permanent disability is insured, the 'total permanent disability – unable to look after yourself ever again' basis will apply in respect of a **spouse** or **civil partner**.

The following elements of **Section 1 – Who is covered**, will also apply:

- When any benefits need to be underwritten (**Section 1.2)**.
- Provision of cover or discretionary entrants and late entrants (**Section 1.3**).
- Provision of cover before an underwriting decision has been made (**Section 1.4**).
- Underwriting decisions which can be made (**Section 1.5**).

This cover is not available if an **earlier claim** has been paid in respect of a **spouse** or **civil partner**.

The **discretionary benefits** element of **Section 2 - What is covered**, will also apply.

A **member's spouse** or **civil partner** will cease to be included in the **Policy**:

- when a claim for one of the **insured illnesses** has been paid for that **person**, or
- from the date the **member** ceases to be included in the **Policy** (if earlier) as shown in **Section 5.1** other than if the **member's** cover ceases due to the **member** having received the maximum number of claims payments for which they are eligible.

Section 4
What is not covered

4.1 Exclusions

4.1.1 Pre-existing conditions

No benefit will be payable for an **insured illness** (or a repeat of the same **insured illness**) which **existed** prior to the date of inclusion:

- of the **insured person** or **child** in this **Policy**, or
- in a previous group critical illness policy arranged by you or any other employer in connection with the **member's** employment, or
- of the illness in the **Policy**, if later.

No increase in benefit will be payable if selected by the **member** or you and the **insured illness existed** prior to the date of any increase in benefit.

For the purposes of **Section 4.1.1** the following will be treated as the same **insured illness**:

- aorta graft surgery,
- balloon valvuloplasty,
- cardiac arrest,
- cardiomyopathy,
- coronary artery bypass grafts,
- heart attack,
- heart transplant,
- heart valve replacement or repair,
- open heart surgery,
- primary pulmonary hypertension,
- pulmonary artery surgery, and
- stroke.

If an **insured person** or **child** has suffered any form of cancer, as defined in **Section 2 - What is covered**, then no benefit will be payable in respect of any subsequent cancer whether or not the earlier cancer is connected to or associated with the subsequent cancer.

4.1.2 Related conditions

4.1.2.1 Insured Illnesses where a related conditions exclusion applies indefinitely

No benefit will be payable for:

- loss of independent existence,
- paralysis of a limb,
- terminal illness or
- total permanent disability

where any **related condition** (see tables in **Section 2 - What is covered** and **Section 3 - Optional additional cover**), **existed** at any time prior to:

- the **insured person** or **child's** inclusion in this **Policy**, or
- the **insured person** or **child's** inclusion in a previous group critical illness policy arranged by you or any other employer in connection with the **member's** employment, if earlier, or
- the date of inclusion of the **insured illness** in the **Policy**, if later, or
- the date of any increase in benefit which has been selected by the **member** or you.

4.1.2.2 Insured Illnesses where a related conditions exclusion is applied for a period of 2 years.

No benefit will be payable for any **insured illness** not detailed in **section 4.1.2.1** where any **related condition** (see tables in **Section 2 - What is covered** and **Section 3 - Optional additional cover**), **existed** at any time prior to:

- the **insured person** or **child's** inclusion in this **Policy**, or
- the **insured person** or **child's** inclusion in a previous group critical illness policy arranged by you or any other employer in connection with the **member's** employment, if earlier, or
- the date of inclusion of the **insured illness** in the **Policy**, if later.

The **related conditions** exclusion will not be applied if the **insured illness** occurs 2 or more years following any of the dates listed above.

4.1.2.3 Application of the related conditions exclusion to increases in benefit.

No increase in benefit selected by the **member** or you will be payable for any insured illnesses not detailed in **Section 4.1.2.1** where any **related condition** (see tables in **Section 2 - What is covered** and **Section 3 - Optional additional cover**), **existed** at any time prior to that increase in benefit.

The **related conditions** exclusion will not be applied if the **insured illness** occurs 2 or more years following the date of the increase in benefit.

This 2 year period will also be applied to any new increase in benefit each time that any further increases in benefit take place.

4.2 Other exclusions

The following exclusions also apply to certain **insured illnesses** suffered by an **insured person** or **child** and no benefit will be payable. The definitions of the **insured illnesses** detailed in **Section 2 - What is covered and Section 3 - Optional additional cover** will show whether these apply:

- **alcohol**
- **drug abuse**
- **self-inflicted injury**
- **war and civil commotion**

4.2.1 Exclusions as a result of underwriting

Where exclusions for claims arising from certain specified medical conditions or in specified circumstances have been imposed on individual **insured persons'** benefits as a result of **underwriting**.

4.3 Circumstances where a second claim will not be allowed

If a **member** suffers a second, different **insured illness** then a second claim may be payable, subject to the **pre-existing conditions exclusion** and other exclusions as shown in this section and the tables in **Section 2 - What is covered** and **Section 3 - Optional additional cover**.

If a **member** has previously received benefits in respect of an **earlier claim**, this will count as the first claim for the **member**.

Once a second claim has been paid for a **member** then a subsequent claim will not be payable in respect of that **member**.

Once a first claim has been paid for a **spouse**, **civil partner** or **child** then a subsequent claim will not be payable in respect of that **spouse**, **civil partner** or **child**.

4.4 Other illnesses where we will not pay a second claim

Details of these can be found in the tables in **Section 2 - What is covered** and **Section 3 - Optional additional cover**.

Section 5
When cover ceases

5.1 When cover ceases for a member

Cover for a **member** will cease on whichever of the following events is first to occur:

- on reaching the **cease age** you have agreed with us, or
- on ceasing to satisfy the eligibility conditions shown in your **Policy Particulars**, or
- on ceasing to be actively employed by an **employer** for any reason, other than during a period of temporary leave of absence, or
- on reaching the end of the period allowed under the **Policy** for a period of temporary leave of absence and having not returned to active employment, or
- on ceasing to work in the **scheduled territories**, unless otherwise agreed, or
- on reaching the end of their employment contract, or
- for a **member** who is a **partnership partner**, on ceasing to be a **partnership partner**, or
- having received the maximum number of claim payments for which they are eligible.

Cover for a **spouse** or **civil partner** or **child** may be maintained if the **member's** cover ceases due to the **member** having received the maximum number of claim payments for which they are eligible.

In all other circumstance where the **member's** cover ceases **spouse** or **civil partner** or **child's** cover will also cease.

Where the **cease age** is linked to **state pension age** and **state pension age** for a **member** changes, the **cease age** will be the **member's** new **state pension age**.

5.2 When we can cease cover under a Policy

We reserve the right to cease this **Policy** if:

- you cancel an **associated policy**, or
- you do not pay premiums requested within 30 days of the date they were due, as shown in **Section 7.4.3**, or
- new legislation or regulations are introduced, or changes are made to existing legislation which affect group critical illness policies or this **Policy**.
- you or any **employer** becomes a **restricted person**.

Section 6 Policy limitations

The maximum **scheme benefit** available to a **member** is £500,000.

The maximum **scheme benefit** in respect of a **spouse** or **civil partner** is the lower of:

- the **member's scheme benefit** and
- £150,000

Where a second claim has been paid in respect of the member, the **member's scheme benefit** used in the assessment of maximum **scheme benefit** available to a **spouse** or **civil partner** will be the **scheme benefit** to which the **member** would otherwise be entitled.

The maximum benefit in respect of a **child** is the lowest of:

- 25% of the **member's scheme benefit**, or
- 25% of the **member's insured benefit,** and
- £20,000.

Where a second claim has been paid in respect of the **member**, the **member's scheme benefit** used in the assessment of the maximum **scheme benefit** available to a **child** will be the **scheme benefit** to which the **member** would otherwise be entitled.

Section 7 Premiums

7.1 How we calculate your premiums

The basis we will use to calculate your premiums depends on how many **members** are covered at the **commencement date** under this **Policy** and any **associated policies** (or the last **periodic review date**, if later). We use either our single premium basis or our unit rate basis.

The single premium basis is used where there are up to and including 19 **members**.

The unit rate basis is used where there are 20 or more **members**.

Your **Policy Particulars** will show which basis applies.

The minimum total annual premium for the **Policy** for any **policy year** will be £1,000. This minimum will be applied as a total across this **Policy** and any **associated policies**.

7.1.1 Single premium basis

We calculate separate premium rates for each individual **insured person** based on a rate using their age, gender, location and occupation. The **insured person's insured benefit** is multiplied by this rate.

This method will also be used to calculate any additional premiums which have been shown in our **decision letter** for an individual **insured person** regardless of the method used to calculate premiums for the **Policy**.

Separate premiums will be calculated for each **insured person** on the **commencement date** and on each subsequent **annual revision date**. These will be shown on the statement of account and the total premium charged will include any **policy fee**.

An additional premium will be calculated if someone becomes an **insured person** or has an increase in **insured benefit** other than on the **commencement date** or an **annual revision date**.

If an **insured person's insured benefit** ceases or decreases we will calculate a refund at the next **annual revision date.**

Any premiums, additional premiums or premium refunds will be for the period from the date on which any of the events described above takes place until the next **annual revision date**. Where the period is not a complete year, the premiums will be based on the number of days from the date on which any of the events described above takes place to the next **annual revision date**. We will produce one set of accounts for each **policy year** which will include any adjustments required.

7.1.2 Unit rate basis

We calculate these premiums by multiplying the relevant total **members' insured benefits** by the unit rate that applies at that date.

If the period from the **commencement date** to the next **annual revision date** is not a complete year, we will charge premiums for the number of days for which cover is provided.

At each **annual revision date**, we will calculate a premium adjustment to allow for any increases or decreases in **insured benefits** or changes in membership since the **commencement date** (or last **annual revision date**, if later).

When calculating premiums we will assume that all these changes occur half way through the **policy year**.

If there has been any change to the basis of cover, eligibility, **employers** or groups of people included, legislation or unit rate during that period, we will calculate adjustments for the periods before and after that change took place.

Total premiums will be shown on the statement of account and any **policy fee** will already be included in the unit rate.

7.2 Revision of premium rates and basis

Premium rates and **policy conditions** are reviewed at each **periodic review date** and any changes will be effective from that **periodic review date**.

We reserve the right to review the basis on which we calculate your premiums where:

- the total number of **members**, or
- the total number of **insured persons**, or
- the total **insured benefit**

increases or decreases by more than 25% in comparison with the same totals that were applicable on the **commencement date** (or on the last **periodic review date**, if later), across all **associated policies** (if any).

This may result in us changing the premium rates, **Policy** terms and **policy fee** for the **Policy**.

7.3 The information we need to calculate your premiums

All data should be provided in electronic spreadsheet format.

At each **annual revision date** (including a **periodic review date**) we will ask you for a complete list of **members**.

The list must include for each **member**:

- individual identifier (this can be name but should not be National Insurance Number),
- date of birth,
- gender,
- **scheme salary** or benefit (if the **member's** benefit is a fixed benefit), reflecting the definition agreed with us and taking into account any limitations which may apply,
- benefit category,
- occupation,
- postcode of normal work location, or home postcode if the **member** normally works from home, or overseas location (if appropriate), and
- details of any regular business travel taken in the last 12 months, or anticipated in the next 12 months, outside the UK, the EU or North America.

For cases where the single premium basis applies we will also require:

- date of joining or leaving, if appropriate, and
- date of increase in **scheme salary**, if allowed, if the increase was not on the **annual revision date**, and
- name, date of birth and gender for the **spouse** or **civil partner** of a **member**, if this cover is insured under the **Policy**.

Limitations may include the following:

- any salary cap which you choose to apply and have agreed with us,
- any maximum benefit limits which apply to the **Policy**, or
- any limits applied to benefits following the issue of our **decision letter**, or
- any restrictions on increases permitted during a period of temporary leave of absence.

You must also clearly show all **members**:

- who have been granted a period of temporary leave of absence from work under the terms shown in **Section 1.6** (including those who are temporarily working outside the UK), and/or
- who are not **actively at work** on the **annual revision date** (or **periodic review date**) including any who are in receipt of disability benefits, and/or
- for whom benefits are not fully covered, and/or
- whose benefits exceed the **free cover limit** which was granted at the previous **annual revision date**, and/or
- for whom any special terms apply,

as this may affect the calculation of premiums and the value of any **claim benefit**.

You must ensure that the data you give us accurately reflects any salary basis or limitations that you have agreed with us. We will use the agreed salary basis (where applicable) to determine the amount of any **claim benefit** payable, not the data provided.

7.4 When premiums are payable

The premiums are payable by you to us in advance.

Premiums are due on the **commencement date** and on each subsequent **annual revision date**.

Premiums are payable annually, but you may choose to pay your premiums monthly by direct debit. If you choose this payment method your premiums will increase by 2%.

7.4.1 What we will do

We will send you a statement of account setting out the total premiums due in respect of the **insured persons** at the **commencement date** and at each subsequent **annual revision date**.

A deposit premium will be charged at each **annual revision date**, due immediately, in order to ensure cover is maintained.

When you provide us with complete accurate information we will send you a revised statement of account for the updated premiums. We will then either send you a refund for excess premium paid, or request the balance of any premiums you owe us.

Where premiums are payable annually by cheque or electronic funds transfer (other than by Direct Debit) we will also issue an invoice for premiums due.

If the single premium basis applies the statement of account will include individual premiums for each **insured person**.

7.4.2 How you can pay your premiums

You may pay your premiums:

- annually by electronic funds transfer, or
- by Direct Debit (this will increase your premiums by 2%).

7.4.3 What will happen if you do not pay your premiums

You must pay your premiums within 30 days of the date they are due.

If you do not pay your premiums, we may:

- reject your claims, or
- delay the payment of any new claims until any outstanding premium debts have been resolved, or
- withdraw cover completely.

If we cease your cover, we will tell you the date that cover ceases in writing. Premiums will be due for the period of cover up to that date.

Any agreement made by us to extend the 30 day payment period will be subject to additional terms and conditions.

If premiums remain unpaid after 30 days, or any agreed extension to the payment period, we reserve the right to start debt collection proceedings against you.

If you wish to cease your **Policy**, you should contact us in writing and not simply stop payment of your premiums.

Section 8 Alterations to the Policy cover

8.1 Keeping the Policy up to date

You can request an alteration to the **Policy** cover at any time but you must tell us in writing what you want to change before you want the alteration to take place. We have to agree to any changes you require to your cover before they can be applied to your **Policy**. If you do not tell us the cover insured under the **Policy** will remain unchanged.

We will confirm to you any additional requirements that we will need to be able to make the change.

If benefit levels increase as a result of a change that you have requested any increase will be subject to the **pre-existing conditions exclusion** described in **Section 4 - What is not covered**, and this will be applied at the agreed date of change.

Any agreement to:

- add cover for additional **insured illnesses** as shown in **Section 3 - Optional additional cover**, to the **Policy**, and/or
- the introduction of new **insured illnesses** not currently included under either core or additional **insured illnesses**

will be subject to the **pre-existing conditions exclusion** described in **Section 4 - What is not covered**, and this will be applied at the agreed date of change.

Only changes which have been agreed by us will be acceptable and we will write to you to confirm when the change has been made and the date on which it will become effective

8.2 Alterations which may affect your premiums and/or terms and conditions

You must tell us immediately, if:

- you wish to change the cover or the way in which benefits are calculated, or
- you wish to include (or remove) any optional additional cover, or
- you wish to change the **cease age** of the **Policy**, or
- you wish to include a company, partnership, organisation or a group of people in the **Policy** (including new categories, new companies or transfers to new contracts of employment), or
- you wish to remove an **employer** or a group of people from the **Policy**, or
- changes are made to an **employer's** pension scheme, to which the membership, or levels of benefit which are insured under this **Policy**, are linked, or
- there are any changes in the structure or legal status of any of the **employers** included in the **Policy**, or
- you appoint, change or dismiss your intermediary.

These changes can have a direct effect on the premiums and/or terms and conditions that we can apply to the **Policy**. New terms and conditions and premium rates can be applied to the **Policy** from the date any changes take place.

8.3 Changes to the nature of your business or the locations where members work

You must tell us immediately if there is a change in:

- an **employer's** normal place(s) of business, or
- the locations where **members** travel on business, or

the nature of an **employer's** business which results in the occupation of any **member** becoming more hazardous

If you do not tell us, claims arising as a result of a more hazardous occupation or location will be declined.

These changes can have a direct effect on the premiums and/or terms and conditions that we can apply to the **Policy**. New terms and conditions and premium rates can be applied to the **Policy** from the date any changes take place.

8.4 When we can make alterations

We can apply new terms and conditions and premium rates to the **Policy** at the **periodic review date**.

In addition we also reserve the right to apply new terms and conditions and rates to the **Policy** at any time:

- if new legislation or regulations are introduced, or changes are made to existing legislation (including any relating to **state pension age**), and
- if changes are made to **HMRC** practice which affects the tax treatment of your premiums and/or benefits for you, the **members** or us, and
- if an **associated policy** is altered or cancelled.

8.5 How you can cancel the Policy

You must tell us before the date when you want to cancel the **Policy** and confirm the request in writing. The **Policy** will continue until we receive your instructions.

We will not backdate cancellation of cover and will charge for the time we have been providing cover.

Section 9
Making a claim

9.1 When you should tell us about a claim

A completed claim form and a completed personal statement must be submitted as soon as possible after an **insured person** or **child** suffers an **insured illness**.

In order for us to pay any **insured benefit** or benefit for a **child**, or any additional amounts of **insured benefit** or benefit for a **child**, we must receive a completed claim form and a completed personal statement, in respect of the benefit being claimed within 2 years of the date an **insured person** or **child** suffers an **insured illness**.

You should send completed forms and documentation to:

Claims Management Services
Canada Life Limited Group Insurance
3 Rivergate,
Temple Quay,
Bristol BS1 6ER

Fax: 01707 671 100
E-mail: ipclaims@canadalife.co.uk

9.2 What we need to assess a claim

We must be provided with:

- a current claim form fully completed by an official of the **policyholder**, and
- a current personal statement fully completed by the **insured person**.

If the **insured person** is not physically or mentally able to sign the personal statement, it can be signed by any person who has been granted a Lasting Power of Attorney for health and care decisions, or a valid Enduring Power of Attorney. If either of the above Powers of Attorney are not in place then we should be contacted immediately.

Telephone: 0117 9164463
E-mail: ipclaims@canadalife.co.uk

If the person who has suffered an insured illness is a **child** the personal statement may have to be completed by the **child** and not a parent or guardian.

Where the claim is for a **child** we will require original copies (not a photocopy) of:

- the **child's** birth certificate, or
- adoption certificate (if applicable), and

If the claim is for a step child we will also require original copies (not a photocopy) of the **member's**:

- marriage certificate, or
- civil partnership certificate.

Where the claim is for a **spouse** or **civil partner**, we will also need original copies (not a photocopy) of the respective marriage or civil partnership certificates.

Where the claim is for total permanent disability on either an own occupation or suited occupation basis we will require a copy of the **member's** job description, including details of the duties undertaken.

Our claims guides and current claim forms can be downloaded from our website: https://www.canadalife.co.uk/group-insurance/group-critical-illness/group-critical-illness-how-to-make-a-claim

9.3 Claim assessment outcomes

We request the information detailed in **Section 9.2** above so that we can ensure that it matches the agreed basis of cover provided under the **Policy**.

If the information provided on the claim form matches the agreed basis of cover provided under the **Policy** we will proceed with our assessment of your claim.

We will require medical evidence in support of a claim. We will obtain details of the **insured person** or **child's** medical condition including treatment and medical history from any relevant medical professional.

The personal statement includes a consent that provides us with the authority to obtain further information from any relevant medical professional that has attended the **insured person** or **child**, as required under the Access to Medical Reports Act.

The medical evidence, all diagnoses and any medical opinions relating to any **insured illness** must be given by a medical specialist who:

- holds an appointment as a Consultant at a hospital in the United Kingdom, and
- whose specialism is appropriate to the cause of the claim.

The evidence provided must also be acceptable to our Medical Officer(s).

If the information provided matches the agreed basis of cover and the medical evidence supports your claim we will accept it and payment will be made as shown in **Section 9.5**.

If we need to request further information this may include but will not be limited to:

- medical records relating to the person who has suffered an **insured illness**, and
- any employment records deemed necessary, for example recruitment records and/or evidence of earnings relating to the **member**.

If the information provided

- shows that the **Insured person** or **child** has not been correctly included in the Policy, and/or
- does not match the agreed basis of cover provided under the **Policy**, and/or
- the medical evidence does not support your claim

we may not pay the claim.

If we do decline the claim we will tell you the reasons for our decision.

If you do not submit the fully completed claim form within the time period detailed in **Section 9.1** we will not proceed with our assessment of the claim.

9.4 What we need if a member suffers an insured illness outside the UK

If any medical evidence is obtained outside the UK:

- any medical evidence must be provided in English, and
- all diagnoses and medical opinions relating to any **insured illness** must be given by a medical specialist who is acceptable to our Medical Officer(s).

If we agree to contribute an amount towards the cost of obtaining the evidence this will be equivalent to the cost of obtaining similar evidence in the UK unless otherwise agreed.

9.5 How your claim benefits will be paid

Claim benefits are payable by us in UK currency.

If your claim is accepted in respect of an **insured person** or **child**, the **claim benefit** will be made to the **member**.

Section 10
Further information

10.1 The Company

This **Policy** is issued by Canada Life Limited, an incorporated company limited by shares, whose Head Office is in the United Kingdom. The address is:

Canada Life Limited
Canada Life Place,
Potters Bar,
Hertfordshire EN6 5BA

10.2 Queries and complaints

If you have any questions about either the **Policy** or your cover please contact your intermediary in the first instance. You should also contact your intermediary if you wish to complain about the service you have received. If you do not have an intermediary or if the matter is not resolved, please write to:

Customer Services
Canada Life Limited Group Insurance,
3 Rivergate,
Temple Quay,
Bristol BS1 6ER

You can also email:
groupcsc@canadalife.co.uk
or ring **0345 223 8000**.
Lines are open
Monday to Friday, 9am to 5pm
(Thursday 9.30am to 5pm).

If we are not able to resolve your complaint you may contact the Financial Ombudsman Service in writing or by telephone. Their address, telephone number and email address are as follows:

The Financial Ombudsman Service
Exchange Tower,
London E14 9SR

Telephone: **0800 0234 567** or,
for mobile phone users **0300 123 9 123**
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk
Your right to take legal action will not be affected if you contact this service.

10.3 Compensation

If we are unable to meet our liabilities, you may be able to claim compensation from the Financial Services Compensation Scheme. Further information is available from the Financial Conduct Authority and the Financial Services Compensation Scheme.

Section 11
General Information

11.1 Confidentiality

We will treat the information that you give us in connection with this **Policy** as confidential as long as it:

- was not rightly in our possession before you gave it to us;
- was or is not already public knowledge;
- is not trivial or obvious; or
- is not required to be disclosed to a legal or regulatory authority.

We will not disclose your confidential information to any person other than our reinsurers, professional advisers and auditors, employees and employees of other companies in our group.

11.2 Intellectual Property

We will not use your company name, logo or other intellectual property marks for any reason other than administration of the **Policy** without your written permission.

11.3 Bribery and Slavery

We will comply with all applicable laws, regulations, codes and sanctions relating to anti-bribery and anti-corruption including the Bribery Act 2010 and those relating to anti-slavery and human trafficking including the Modern Slavery Act 2015.

Our full Modern Slavery Act Statement is published here:
http://documents.canadalife.co.uk/modern-%20slavery-%20act.pdf

11.4 Money Laundering

We will comply with all applicable laws, regulations, codes and sanctions relating to money laundering including the Money Laundering Regulations 2007.

11.5 Data Protection

We will comply with all applicable laws, regulations, codes and sanctions relating to data protection including the Data Protection Act 2018 (incorporating the General Data Protection Regulation)

Our full Data Protection Notice is published here:
https://www.canadalife.co.uk/data-protection-notice

About Us

We provide support when it's needed most

We are Canada Life Group Insurance, the UK's largest provider of group insurance.
We have over 45 years' experience covering thousands of businesses throughout the UK.

Our mission is to help people when they need it most, so we specialise in three products that help employers do exactly that – Life Assurance, Income Protection and Critical Illness cover.

We've grown considerably since we first arrived in the UK in 1903. We now support over 24,000 employers, covering 2.8 million employees for over £260 billion of benefits. This makes us the largest provider of group insurance in the UK.

Find out more

We are dedicated to helping more employers support their employees when they need it most. Use our website to find out more about our products or feel free to contact us on **0345 223 8000**.

Our forms are available to download from our website: www.canadalife.co.uk/group

Canada Life Limited, registered in England no. 973271. Registered Office: Canada Life Place, Potters Bar, Hertfordshire EN6 5BA.

CLFIS (UK) Limited, registered in England no. 04356028 is an associate company of Canada Life Limited. Registered Office: Canada Life Place, Potters Bar, Hertfordshire EN6 5BA.

Canada Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

PGCISTD0319

Canada Life
Group Insurance

Canada Life Limited
3 Rivergate, Temple Quay, Bristol BS1 6ER
Telephone 0345 223 8000