VITALITYLIFE PLAN PROVISIONS

VitalityLife Plan Provisions

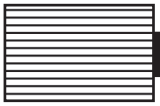
This document is *your plan* provisions. It explains how *your plan* works. It includes details about the covers and options in the *plan*, how *you* pay *your plan premiums*, and how to make a claim if *you* need to. It explains how taking steps to improve *your* health can reduce *your plan premium*.

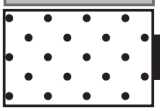
If there is anything that is not clear, please speak to *your* financial adviser, if *you* have one. Or *you* can call *us* on 0345 601 0072. If *you* call *us*, please have *your plan* number to hand. To help *us* improve *our* service, *we* may record or monitor phone conversations with *you*.

In these provisions, *we*, *us* or *our*, means Vitality Life Limited. *You* or *your* means the person or people covered under the *plan*, unless stated otherwise. *We* have put some other words in italics. *We* explain what *we* mean by these words in the Definitions section.

PLEASE ALSO CONTACT US ON 0345 601 0072 OR SPEAK TO YOUR ADVISER IF YOU WOULD LIKE THIS DOCUMENT IN LARGE PRINT OR BRAILLE.

Contents





A. How your plan works

Your plan includes at least one of the core covers. These are:

- *Life Cover*
- Serious Illness Cover
- Income Protection Cover

Your plan schedule shows which core covers *you* have.

A1. Your plan account

The amount of *Life Cover* and Serious Illness Cover *you* have and the amount of *benefit you* could receive are linked to *your plan account*. If *you* only have Income Protection Cover, *you* do not have a *plan account*.

When *you* take out *Life Cover*, or Serious Illness Cover, or both, *we* set up a *plan account* for *you*.

For a *single life plan*, the amount of *your plan account* will be the same as *your* amount of *Life Cover*, if *you* have it. If *you* do not have *Life Cover*, the amount of *your plan account* will be the same as *your* amount of Serious Illness Cover.

For a *joint life plan,* the amount of *your plan account* will be the same as the amount of *Life Cover* held by the *first person covered*. If they do not have *Life Cover*, it will be the same as their amount of Serious Illness Cover.

You cannot have more Serious Illness Cover than *Life Cover*. If *you* have both covers, *you* choose the amount of Serious Illness Cover *you* want as a percentage of *your plan account*. This can be up to 100% of the *plan account*.

If *you* have a *joint life plan*, each *person covered* can choose to have Serious Illness Cover. They can have different amounts of Serious Illness Cover from each other. Each of these amounts is based on a percentage of the *plan account*.

If *we* make payments to *you* as a result of a successful claim for *Life Cover* or Serious Illness Cover, then the value of *your plan account* reduces by the amount *we* have paid *you*. This means that if *you* need to claim again, the value of the covers in *your plan account* will be lower. There are ways to protect the value of the covers in *your plan account*. For more about this, please see the provisions on Protected *Life Cover* provision C12 and the Minimum Protected Account option provision C11.

You can also choose whether the value of *your plan account* increases over time, decreases over time or stays level. For more about this, please see the information on *your ' plan account* structure' below.

Your plan account structure

Your plan account has one of these three structures, as shown in *your plan schedule*:

Your plan account structure	What this means
Level	The value of the *plan account* is designed to stay the same over the life of the *plan*. It will only change if something happens such as *you* make a claim or change a cover.
Indexed	The value of the *plan account* increases on each *plan anniversary*, in line with the *Retail Prices Index* (RPI) rounded to the next 0.25%. Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI figure that applies five months before each *plan anniversary*. *Your plan account* cannot exceed £20,000,000, including any increases as a result of indexation. If *your* cover lasts for the whole of *your* life then the increases will be applied automatically until the *plan anniversary* immediately before *your* 80th birthday. If *your plan* is a *joint life plan* this will be based on the younger of the two *persons covered*. At this point *we* will write to *you* and ask *you* to confirm whether *you* want *your plan account* to continue to be indexed. If *you* do not tell *us* that *you* want *your plan account* to be indexed *we* will automatically change it to a level *plan account*.
Decreasing	The value of the *plan account* decreases over the life of the *plan*. It decreases in the same way that the outstanding capital on a repayment mortgage would if the mortgage had: • A 10% annual equivalent interest rate • The same term as the *plan* *You* can only have a *decreasing account* if *your plan* has a *fixed term*.

Your plan account may change if *we* pay a *benefit*, or because of a change to *your plan*. There is more about changes to *your plan* in provision D.

A2. How other covers work

The other covers *you* may have in *your plan* are not linked to the *plan account*. The amounts of these covers are set individually.

A3. How long your plan lasts

Each cover in *your plan* lasts for a defined term. This term can be up to a fixed date – this is called a *fixed term*. *Life Cover* and Serious Illness Cover can instead be for the whole of *your* life – this is called *whole of life*. *Your plan schedule* shows the date on which each of *your* covers terminates.

If *your plan* has a *decreasing account* structure (see '*Your plan account* structure' above), the following covers must have the same *fixed term*:

- *Life Cover*
- Serious Illness Cover
- Disability Cover

Once *your plan* has started, *you* cannot change the term of any cover from *whole of life* to *fixed term*, or from *fixed term* to *whole of life*.

B. Core Covers

This section provides details of each of the core covers. *Your plan* schedule shows which core covers *you* have.

B1. Life Cover

Life Cover pays a lump sum if the *person covered* dies, or is diagnosed with a *terminal illness*. This cover may be for a *fixed term* or for *whole of life*. *Life Cover* is not available for *children*.

B1.1 When we will pay the benefit

When *we* pay the *benefit* depends on whether *your plan* is a single life or joint life.

Single or joint life?	When we will pay the benefit
Single life plan	*We* will pay the *benefit* if the *person covered* dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit*, the *plan* ends.
Joint life first death	With a *joint life first death plan*, there are two people covered. If both people have Life Cover, *we* will pay the *benefit* if one of those people dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* for one *personcovered*, *we* cancel all the covers for that person. *We* also cancel the Life Cover for the remaining *person covered*. If the remaining person has other covers in the *plan*, the *plan* continues. The remaining person can apply to *us* for new Life Cover under a new *plan*. For more about this, see provision D6.
Joint life second death	This option is only available if *you* have chosen *whole of life* cover, see provision A3. With a *joint life second death plan*, there are two people covered. *We* will pay the Life Cover *benefit* after both of the people covered have died, or have been diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* the *plan* will come to an end.

B1.2 How much we will pay

If both people covered in a *joint life plan* die, and it is not possible to determine who died first, *we* will pay the total amount of the *plan account*.

The maximum amount of *Life Cover we* will pay for each *person covered* under all policies issued by *us* is £20,000,000. In all other circumstances *we* will pay the current *benefit* amount.

B1.3 When we will not pay

We will not pay the *benefit* if the death or diagnosis of *terminal illness* happens after the *Life Cover*'s *date of expiry*. *Your plan schedule* shows this date.

Under certain circumstances, *we* may also not pay the *benefit* if the claim is due to suicide. For more about this, see provision D5.6.

B1.4 What happens if you need to claim while we are still assessing your application for Life Cover

If *you* have applied for *Life Cover* on either a *single life plan* or *joint life first death plan* but *we* are still assessing *your* application, *we* automatically give *you* some limited *Life Cover*. This is called Immediate Cover. Immediate Cover is free of charge.

We will pay a *benefit* under Immediate Cover as long as all of the following apply:

- *We* have received a completed application from *you*
- *We* have received a completed direct debit instruction from *you*
- The claim is for death – *terminal illness* is not covered
- *You* are under 50 when *we* receive *your* application
- *You* are a *resident* of the *United Kingdom*
- *You* are not applying for *Life Cover* with any other company

- *You* answered 'no' to all *our* medical and health questions
- *You* do not take part in any hazardous pursuits or sports or have an *occupation* that *we* would exclude or charge *you* extra for

Immediate Cover stops when one of these happens:

- *We* accept *your* application
- *We* decline *your* application
- *Your* application is cancelled
- 90 days pass since *we* received *your* application

The total amount *we* will pay for Immediate Cover for *Life Cover*, Family Income and Education Cover is the amount *you* applied for, up to a combined maximum of £500,000.

Immediate Cover does not apply to *plans* which have been arranged on a *joint life second death plan* basis.

B1.5 LifestyleCare Cover

LifestyleCare Cover allows *you* to access some or all of *your Life Cover* if *you* are diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision and Appendix 4.

LifestyleCare Cover is only available if *you* have chosen *Whole of Life* Cover. It is available on *single life plans* only.

B1.5.1 When we will pay

Your claim must meet the following criteria before *you* will pay it:

- *You* must be diagnosed with a condition that *we* cover. *Your* condition must meet one of the definitions set out in Appendix 4. *We* will use the criteria in Appendix 4 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *You* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *you* have excluded any conditions from *your* cover. If *you* have, *we* will not pay a claim for that condition.

We will ask *your* General Practitioner, and any *appropriate medical specialists* who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 4. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

Benefits under LifestyleCare Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

B1.5.2 How much we will pay

Your plan schedule shows *your* amount of LifestyleCare Cover. If *your plan account* structure is indexed, *your* LifestyleCare Cover will increase in the same way as the *plan account* at each *plan anniversary*. For more about indexation see provision A1.

The amount *we* will pay depends on:

- How severe *your* condition is, and
- The amount of LifestyleCare Cover *you* have

The lump sum *we* will pay *you* will be a percentage of *your* amount of LifestyleCare Cover. The percentage depends on how severe *your* condition is.

There are two severity levels:

Severity Level	What percentage of your amount of LifestyleCare Cover we pay
Level 1	20%
Level 2	100%

Appendix 4 shows which conditions are covered under Severity Level 1 and Severity Level 2.

B1.5.3 When we will not pay

We will not pay the *benefit* for LifestyleCare Cover if:

- *You* suffer from a condition that *we* do not cover
- *You* suffer from a condition that *we* excluded from *your* cover after assessing *your* application
- *Your* condition does not meet *our* definition for that condition
- *You* are making a subsequent claim that does not meet the criteria for a further payment
- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*
- *We* believe the condition that led to *your* claim was one *you* were already experiencing before *your plan* started and which *you* should have disclosed to *us* when *you* first applied
- *You* have selected LifestyleCare Cover Protector, and *you* do not survive for at least 14 days after the date that *you* meet a severity level 2 definition.

B1.5.4 What happens if you need to make a subsequent claim

We will only make one Severity Level 1 payment.

If *we* have paid *you* a claim under Severity Level 1 *you* can make a subsequent claim for a Severity Level 2 condition. This can be for the same underlying condition, or a different one.

For the subsequent Severity Level 2 condition, *we* will pay the remaining amount of *your* LifestyleCare Cover.

B1.5.5 How your cover continues after a claim for LifestyleCare Cover

The way *your* cover continues after a claim will depend on whether *you* have chosen LifestyleCare Cover Protector.

There are two types of LifestyleCare Cover Protector - LifestyleCare Cover Protector (level 1) and LifestyleCare Cover Protector (level 1 & 2). *Your plan schedule* will indicate whether *you* have selected LifestyleCare Cover Protector and if so which type.

LifestyleCare Cover Protector not selected

If *we* make a payment to *you* for a Severity Level 1 condition, the amount of *your Life Cover* and LifestyleCare Cover will reduce by the amount *we* have paid *you*.

If *we* pay *you* a claim for a Severity Level 2 condition, LifestyleCare Cover will be removed from *your plan*. The amount of *your Life Cover* will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1)

If *you* have chosen LifestyleCare Cover Protector (level 1) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future *Life Cover* or LifestyleCare Cover claims.

If *we* pay *you* a claim under Severity Level 2, LifestyleCare Cover will be removed from *your plan*. The amount of *your Life Cover* will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1 & 2)

If *you* have chosen LifestyleCare Cover Protector (level 1 & 2) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future *Life Cover* or LifestyleCare Cover claims.

If *you* meet the definition for a Severity Level 2 condition and *you* survive for at least 14 days after *you* meet the definition *we* will pay *your* remaining LifestyleCare Cover amount. LifestyleCare Cover will be removed from *your plan*. The amount of *your Life Cover* will not reduce. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

B2. Serious Illness Cover

Serious Illness Cover pays a lump sum if *you* are diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision.

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from levels A to G. For more about severity levels, see 'How much *we* will pay', at provision B2.3. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster the lump sum *we* pay *you* may be increased. For more about Serious Illness Cover Booster please see provision B2.3.

This cover also provides Serious Illness Cover for any children *you* have. For more about this, see provision C1.

Serious Illness Cover may be for a *fixed term* or for *whole of life*. However, if *your plan* also has *Life Cover* and both covers have a *fixed term*, the Serious Illness Cover must have a *date of expiry* on or before *your Life Cover*'s *date of expiry*.

B2.1 When we will pay

Your claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that *we* cover. The *serious illnesses we* cover are specified in Appendix 1. They are grouped into *body system categories* to help *us* assess claims
- *Your* condition must meet any of the definitions set out in Appendix 1 that apply to it. *We* will use the criteria in Appendix 1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have*, we* will not pay a claim for that condition.
- *You* must survive for at least 14 days after the date of the *life-changing event* which causes *you* to claim. If *you* make a *permanent* disability claim, *you* must survive until the date when *we* confirm that *you* are totally and *permanently* disabled. For more about *permanent* disability claims, see Appendix 1.

Benefits under Serious Illness Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

How we will assess your claim if your occupation has changed

You do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed. If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *functional activity tests* to assess *your* claim. For more about *functional activity tests*, see provision D5.4.

Medical evidence

We will ask *your* General Practitioner, and any specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid and, if appropriate, which severity level applies to *your* condition.

B2.2 When we not pay

We will not pay if:	Where to find more information:
You suffer from a condition that *we* do not cover	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application	*Your plan schedule*
Your condition does not meet *our* definition for that condition	Appendix 1
You do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim	Provision B2.1
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment	Provision B2.7
We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim	
We do not receive the medical evidence *we* need from *your* General Practitioner and any specialists who are treating *you*	Provision B2.1
We are not satisfied that the *serious illness* that has lead to *your* claim occurred either while *we* were providing *you* with Education Cover or was disclosed to *us* when *you* applied	
Your Education Cover expires before the *life-changing event* which leads to *your* claim	*Your plan schedule*

B2.3 How much we will pay

The amount *we* will pay depends on:

- How severe *your* condition is
- The type of cover *you* have
- The amount of cover *you* have
- Whether *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster

How severe your condition is

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to G. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster the lump sum *we* pay *you* may be increased. For more about Serious Illness Cover Booster please see below.

Severity level	The percentage of your cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

The type of cover

Your plan schedule shows whether *you* have Primary or Comprehensive Serious Illness Cover.

With Primary cover you are covered for severity levels A, B, C and D. With Comprehensive cover you are covered for all the severity levels - from A to G.

The amount of cover

Your plan schedule shows the amount of Serious Illness Cover *you* have. This is the amount *you* would get if *we* paid 100% of *your* Serious Illness Cover.

Serious Illness Cover Booster

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster the lump sum that *we* pay *you* in the event of a claim for certain *serious illness* conditions may be increased.

The increase in the lump sum *we* pay *you* will depend on the *serious illness* condition.

For the conditions listed in Appendix 2.1 *we* will increase the lump sum *we* pay *you* to 100% of *your* Serious Illness Cover.

For the conditions listed in Appendix 2.2 the increase in the lump sum *we* pay *you* will depend on:

- *Your* age at the time *you* claim; and
- The number of dependent *children* covered under Optional Serious Illness Cover for Children or Education Cover in this *plan*.

The table below shows the percentage of *your* cover that *we* will pay for conditions listed in Appendix 2.2 depending on *your* age at the time *you* claim.

Age attained at date of diagnosis	What percentage of your Serious Illness Cover we will pay	Age attained at date of diagnosis	What percentage of your Serious Illness Cover we will pay
16 - 24	*200*	*45*	*147.5*
25	*197.5*	*46*	*145*
26	*195*	*47*	*142.5*
27	*192.5*	*48*	*140*
28	*190*	*49*	*137.5*
29	*187.5*	*50*	*135*
30	*185*	*51*	*132.5*
31	*182.5*	*52*	*130*
32	*180*	*53*	*127.5*
33	*177.5*	*54*	*125*
34	*175*	*55*	*122.5*
35	*172.5*	*56*	*120*
36	*170*	*57*	*117.5*
37	*167.5*	*58*	*115*
38	*165*	*59*	*112.5*
39	*162.5*	*60*	*110*
40	*160*	*61*	*107.5*
41	*157.5*	*62*	*105*
42	*155*	*63*	*102.5*
43	*152.5*	*64 and older*	*100*
44	*150*		

If *we* accept a claim for a condition that is listed in Appendix 2.2 then, for each *child* that is covered under Optional Serious Illness Cover for Children or Education Cover at the time *you* make *your* claim *we* will pay *you* an additional amount. The additional amount that *we* will pay is 10% of *your* Serious Illness Cover up to a maximum of £25,000 per *child*.

Serious Illness Cover Booster does not apply to claims for Family Income Cover, Education Cover, Core Serious Illness Cover for Children or Optional Serious Illness Cover for Children.

B2.4 What happens if a single life-changing event causes you to claim for more than one serious illness

If a single *life-changing event* causes *you* to have valid claims for more than one *serious illness*, *we* will only pay one claim. *We* will pay the claim for the illness with the highest severity level.

B2.5 What happens if a single life-changing event causes claims for more than one person covered

If a single *life-changing event* causes claims for more than one *person covered* – including any *children* covered – and those claims are each made within three calendar months of the *life-changing event*, then *we* will make more than one *benefit* payment.

We will calculate each payment using the amount of the *plan account* at the time of the *life-changing event*. This means that the total amount *we* pay across all the claims might be more than the value of the *plan account*. If this happens, the *plan account* will reduce to zero – unless *you* have the Minimum Protected Account option. For more about the Minimum Protected Account option, see provision C11.

B2.6 What happens if a single life-changing event means you are eligible for payments under both Serious Illness Cover and Disability Cover

If a single *life-changing event* makes *you* eligible for payments under both Serious Illness Cover and Disability Cover, *we* will make both payments. This applies separately to each *person covered*. If this situation arises and the other *person covered* is also eligible for at least one payment under Serious Illness Cover or Disability Cover, *we* will make a payment for each claim. *We* will calculate the payments simultaneously, rather than reducing *your plan account* by one *benefit* amount before *we* calculate the other one.

B2.7 What happens if you need to make a subsequent claim

If *you* claim once and then claim again, *we* call the second claim a subsequent claim. This can be for the same condition, or a different one. For more about how *we* pay subsequent claims, see the flowcharts in Appendix 5.

When *we* make payments under Serious Illness Cover, the value of *your plan account* reduces by the amount *we* have paid *you*. The maximum amount available for future claims will be the remaining value of the *plan account*. If the amount *we* have paid *you* is equal to or greater than the value of *your plan account, your* Serious Illness Cover will come to an end. This works differently if *you* have the Minimum Protected Account option. For more about this, see provision C11.

Subsequent claims under the same body system category

If *you* have already claimed under a particular body *system category*, *we* will classify any subsequent claims *you* make under this category as either a *progressive claim* or an *unrelated claim*.

Progressive claims	
Definition	A *progressive claim* occurs when: 1. A *person covered* has a *life-changing event* that causes a *serious illness* 2. They make a claim for that *serious illness* 3. They later make a claim for the same illness, or another *serious illness* in the same *body system category* that was caused by the same *life-changing event*
When *we* won't pay	If the severity level of *your progressive claim* is the same as or lower than the severity level of *your* original claim, *we* will not make another payment. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster, *we* will not pay a further amount if the original claim was for a condition listed in Appendix 2.1 and the *progressive claim* is for a condition that is also listed in Appendix 2.1 or is for a severity level A condition.
When *we* will pay	If the severity level of *your progressive claim* is higher than the severity level of *your* original claim, *we* will make another payment. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and the original claim was for a condition listed in Appendix 2.1 *we* will make another payment if the *progressive claim* is for a condition that is also listed in appendix 2.2.
How *we* calculate the amount *we* will pay	*We* will base the amount *we* pay on the increase in severity from the original claim to the new claim. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your progressive claim* is for a condition listed in Appendix 2.2 *we* will calculate the amount *we* will pay as follows: • *We* will calculate the amount *we* pay for a condition listed in Appendix 2.2. When *we* do this *we* will use *your* age at the date *you* meet the definition for the condition for which *you* are making *your progressive claim*; and • *We* will subtract from this the amount *we* have already paid *you* for the original claim. *We* will base the amount *we* pay on the value of *your plan account* prior to the original claim. *We* will also pay interest for the period from the original date of claim to the date *we* pay this *progressive claim*.

Unrelated claims	
Definition	An *unrelated claim* occurs when: 1. A *person covered* has a *life-changing event* that causes a *serious illness* 2. They make a claim for that *serious illness* 3. They later make a claim for another *serious illness* that was caused by a different *life-changing event*
When *we* won't pay	If the severity level of *your unrelated claim* is the same as or lower than the severity level of *your* original claim, and *your unrelated claim* is made within 36 months of the original *life-changing event we* will not make another payment. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *you* make an *unrelated claim* within 36 months of the original *life-changing event* then, *we* will not pay a further amount if the original claim was for a condition listed in Appendix 2.1 and the *unrelated claim* is for a condition that is also listed in Appendix 2.1 or is for a severity level A condition.
When *we* will pay	If *your unrelated claim* is within 36 months of the original *life changing event* then, if the severity level of *your unrelated claim* is higher than the severity level of *your* original claim, *we* will make another payment. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and the original claim was for a condition listed in Appendix 2.1 *we* will make another payment if the *unrelated claim* is for a condition that is listed in appendix 2.2. In addition if the date of the unrelated claim is more than 36 months after the original *life-changing event we* will make another payment.
How *we* calculate the amount *we* will pay	The amount *we* will pay depends on the length of time between the *life-changing event* and the *unrelated claim*. If *your unrelated claim* is within 36 months of the original *life-changing event*, *we* will base the amount *we* pay on: • The increase in severity from the original claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your progressive claim* is for a condition listed in Appendix 2.1 or 2.2 *we* will calculate the amount *we* will pay as follows: – *We* will calculate the amount *we* pay for a condition listed in Appendix 2.1 or 2.2. When *we* do this *we* will use *your* age at the date *you* meet the definition for the condition for which *you* are making *your* progressive claim; and – *We* will subtract from this the amount *we* have already paid *you* for the original claim. • The value of the *plan account* at the time *you* claim If *your unrelated claim* is more than 36 months after the date of the original *life-changing event*, *we* will treat this as a separate claim. That means *we* will base the amount *we* pay on the value of *your plan account* at the time *you* claim and on the severity level of the subsequent claim. *We* will not base the amount *we* pay on the increase in severity from the original claim to the new one, so the severity level of the original claim is not relevant.

Subsequent claims under a different body system category

If *you* claim under a *body system category* that *we* have not made any previous payments for, *we* will treat this as a separate claim. That means *we* will base the amount *we* pay on:

- The value of *your plan account* at the time *you* claim; and
- The severity level that applies to *your* subsequent condition or illness. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* new claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster

There are two types of claim that *we* treat differently:

1. **Subsequent claims under the major organ transplant body system category that are caused by a condition or illness that is named under another body system category**

The underlying cause of a claim under the major organ transplant *body system category* may be a condition or illness named under another category.

- If *we* have previously paid out for that condition – no matter what category it is listed under – *we* will treat *your* claim as a *progressive claim*. For more about *progressive claims*, see the start of this provision.
- If *we* have not previously paid out for that named condition, *we* will treat *your* claim in the same way that *we* treat standard 'subsequent claims under a different *body system category*' – see above.

2. Subsequent permanent disability claims

When *we* use the phrase '*permanent* disability claims', *we* always mean claims under the *body system category* of '*permanent* disability', not claims under Disability Cover. For more about Disability Cover, see provision C3.

If *you* make a claim that is valid under both the *permanent* disability category and another *body system category*, *we* will treat this as a *permanent* disability claim. *We* will manage any subsequent claims on the basis that *we* have already paid a claim under the *permanent* disability category.

- If *we* have made a previous payment for a *permanent* disability claim, and *your* condition then progresses to a higher severity level within that category, *we* will:
  - Pay an amount based on the increase in severity from the original claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster; and
- If *we* have made a previous payment under any *body system category* other than *permanent* disability, and *your* condition then progresses so it becomes valid under the *permanent* disability category, *we* will:
  - Pay an amount based on any increase in severity from the original claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* new claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster; and
  - Manage any subsequent claims on the basis that this was a *permanent* disability claim

The underlying cause of *your permanent* disability claim may be a condition or illness that is named under another *body system category*. *We* will treat *your* subsequent claim as a separate claim if, after making a *permanent* disability claim, *you* go on to make a claim either:

- Under the same *body system category* that the underlying cause of *your permanent* disability claim is listed under – as long as this claim occurs more than 36 months after *your permanent* disability claim
- Under a different *body system category* – irrespective of how long it has been since *your permanent* disability claim

That means that *we* will treat *your* claim in the same way that *we* treat standard 'subsequent claims under a different *body system category*' – see above. However if *you* make an unrelated claim under the same *body system category* that the underlying cause of *your permanent* disability claim is listed under, and *your* subsequent claim occurs less than 36 months after *your permanent* disability claim, *we* will treat this as a standard subsequent claim. In this case, *we* will only pay the subsequent claim if it is of a higher severity level than *your permanent* disability claim.

If *we* pay a severity A claim because *you* fail the relevant *functional activity tests*, *we* will not assess any further claims using these tests – irrespective of which category of illness *your* claim is under.

Once *we* have paid a severity A claim under the *permanent* disability *body system category*:

- *We* will not pay any further claims under this *body system category*
- *We* will only pay a subsequent Serious Illness Cover claim if it is for a condition or illness that it not related to the underlying cause of *your permanent* disability claim

B2.8 How your cover continues after a claim for serious illness

How we calculate your remaining cover – Life Cover and Serious Illness Cover

Usually, payments *we* make under Serious Illness Cover will reduce the value of the *plan account* by that amount. This will affect the amount that is available for future *Life Cover* and Serious Illness Cover claims.

We calculate the amount available for future *serious illness* claims by subtracting the total amount paid for claims under Serious Illness Cover (including Serious Illness Cover Booster) from *your plan account*. The amount of *your* Serious Illness Cover will be a chosen percentage of the *plan account*.

This will work differently if *you* have either:

- The Minimum Protected Account option – for more about this option, see provision C11
- Protected *Life Cover* – this option means that payments *we* make under Serious Illness Cover will not affect the amount that is available for future *Life Cover* claims. For *plans* with protected *life cover we* will calculate the amount available for future *serious illness* claims by subtracting the total amount paid for claims under Serious Illness Cover (including Serious Illness Cover Booster) from *your plan account*. The amount of *your* Serious Illness Cover will be *your* chosen percentage of the *plan account*. *Your Life Cover* amount will not change and may exceed the amount of the *plan account*. For more about this, see provision C12. LifestyleCare Cover Protector (level 1 & 2)

How we calculate your remaining cover – Disability Cover

When *we* make a Disability Cover payment, this does not affect the *plan account*. However, Disability Cover is subject to a maximum amount, so any payments *we* make will reduce the level of Disability Cover available. For more information about Disability Cover, see provision C3.

For joint life plans

Payments *we* make under Serious Illness Cover will reduce the value of *your plan account* by that amount – unless *you* have the Minimum Protected Account option or Protected *Life Cover*. For more about these, see provision C11 and provision C12. If the *plan account* does reduce, then:

- For the *person covered* who made the claim – the premium for covers attached to the *plan account* under the *plan* will stay the same; and
- For the other *person covered* – the premium for covers attached to the *plan account* will reduce in proportion to the reduction in the *plan account*.

What happens if we've paid the maximum amount of Serious Illness Cover benefit

There is a maximum total amount of *benefit you* can receive under Serious Illness Cover (including any payments as a result of Serious Illness Cover Booster). This is the lower of:

- *£3,000,000; and*
- Three times *your* initial amount of Serious Illness Cover – adjusted to reflect:
  - Any indexation increases that occurred up to the date of *your* first *serious illness* claim; and
  - Any changes *you* have made to *your* amount of cover

On *joint life plans* this maximum applies to each *person covered* separately. The maximum *benefit* includes any payments *we* make under Mortgage Incapacity Cover Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a severity A *serious illness*.

If *you* reach this maximum *benefit* amount, *we* will not accept any further *serious illness* claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly.

If *you* are also covered by other policies issued by us, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a severity A *serious illness* is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

This applies separately to each *person covered*. *You* will no longer have to pay a premium for those covers.

If *we* have not yet paid the maximum *benefit*, but a future claim might breach it, *we* might restrict *your* cover.

B3. Income Protection Cover

Income Protection Cover pays *you* a regular income if *you* become incapacitated and cannot work, and *your* incapacity meets *our* definitions. For more information about the different *ways we* define incapacity, see provision B3.1.

If *you* have a *joint life plan* and both people covered have Income Protection Cover, *we* will treat each person's cover separately.

We offer three types of Income Protection Cover – Short Term Income Protection Cover, Primary cover and Comprehensive cover. *Your plan schedule* shows which type of cover *you* have. Unless *we* say otherwise, the following information applies to all levels of cover.

B3.1 When we will pay

We will pay if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. These are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

An *activities of daily living* definition means that *we assess your* incapacity according to a specific set of everyday physical activities. These are designed to help show how able someone is to look after themselves. *We* list these activities in provision D5.4. *We* use this definition to *assess houseperson* claims. For more about this, see provision B3.5.

A special definition means that:

1. For the first 12 months, *we* will pay *you* the full monthly *benefit* if illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. As with the standard definition, these are the duties that are normally needed to do *your* own *occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. *You* must also not be working in any other *occupation* for payment or profit.
2. After 12 months, *we* will assess *you* again. If, at this point, *you* are unable to perform at least three of the activities of daily living without another person's help, *we* will continue to pay *you* the full monthly *benefit*. If *you* do not fail at least three activities of daily living, but are still unable to perform *your own occupation* as described in the paragraph above, *we* will reduce the amount *we* pay *you* to 50% of the monthly *benefit* amount.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

How we will assess your claim

We will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed.

If *we* would not normally use the standard definition of incapacity for that *occupation*, then *we* may use the special definition or activities of daily living definition to assess *your* claim. For more about activities of *daily living* assessments, see provision D5.4.

When we will start paying your claim

Your benefit will be due at the end of *your deferred period*.

The *deferred period* starts on the date *you* become incapacitated according to the definition that applies to *your plan*. It ends when *you* have been continuously incapacitated for one of:

- Seven days (this is only an option if *you* are *self-employed)*
- One month
- Three months
- Six months
- Twelve months

You can choose to set up two *deferred periods* under *your plan*. If *you* have two deferred periods then, when *you* claim, *we* start paying *you* part of *your* monthly *benefit* amount at the end of the first *deferred period*. *We* will start paying *your* full monthly *benefit* amount at the end of *your* second *deferred period*.

Your plan schedule shows which *deferred period* or periods apply to *your* Income Protection Cover.

If *your occupation* is specified as National Health Service General Practitioner (NHS GP) on *your plan schedule* then the following *deferred period* will apply to *your plan*. The *deferred period* varies by the length of *your* service with the NHS and the type of cover *you* have chosen:

Length of NHS service	Comprehensive Cover	Short Term Income Protection Cover and Primary Cover
	Deferred Period	
Up to 3 months	1 month	1 month
Between 3 months and 1 year	1 month	3 months
Between 1 and 2 years	2 months	4 months
Between 2 and 3 years	4 months	8 months
Between 4 and 5 years	5 months	10 months
Over 5 years	6 months	12 months

If *you* continue to receive an income from the NHS after the end of the *deferred period* the *benefit* payable under *your* Income Protection Cover may be reduced, see provision B3.2 for more details.

Telling us that you want to claim

If *you* become incapacitated and need to claim, *you* need to give *us* written notice within a specified period of time. This notification period depends on the *deferred period you* have chosen:

Deferred period	Notification period
7 days	Immediately
1 month	2 weeks
3 months	1 month
6 months	2 months
12 months	2 months

Your plan schedule shows the *deferred period* that applies to *your plan*. If *we* do not receive notice of *your* incapacity within the specified period, *we* may treat the *deferred period* as if it started on the date *we* actually receive notice. If *we* receive notice more than 90 days after the end of the *deferred period, we* may decline *your* claim.

Providing us with evidence for your claim

We will need to be satisfied that *your* claim is valid in order to pay *you* any *benefits* under Income Protection Cover.

When *you* first make *your* claim, *we* will ask for evidence to substantiate it. *We* may also ask for evidence at reasonable intervals to confirm that *you* are still entitled to Income Protection benefits.

This evidence may include, but is not limited to:

- A report from *your* General Practitioner
- Copies of *your* medical records
- A report from any other *appropriate medical specialist*
- *Your* hospital records, including copies of the results of any clinical tests or investigations
- Information from *your* employer, including details of the duties of *your employment*
- *Your* human resources records, including details of sickness absence

We may also need *you* to have a medical examination with an examiner that *we* choose, at *our* expense. *We* may appoint a disability counsellor or someone who represents *us* to talk to *you* about any aspect of *your* claim.

If *you* do not give consent for *us* to *access your* medical information, or to get any other assistance or information that *we* need to assess *your* claim, then *we* may decline, suspend, or stop paying *you* any *benefits* under Income Protection Cover.

Verifying your earnings

When *you* apply for Income Protection Cover, or when *you* ask to increase *your* cover, *you* can ask us to verify *your* earnings. These are *your verified earnings.*

We will then use these earnings to work out the amount of any Income Protection *benefits we* will pay *you* if *you* need to claim.

If *you* do not confirm *your* earnings at one of these stages, then *we* will need information about *your preincapacity earnings* when *you* make a claim

The information *we* need in order to confirm *your verified earnings* may vary depending on whether *you* are *employed, self-employed*, or the director of a limited company.

If you are:	The information we need may include, but is not limited to, things like:
Employed	• *Your* three most recent payslips • *Your* most recent P60
Self-employed	• *Your* three most recent agreed HMRC tax computations and self assessments • A copy of the accounts that relate to these
The director of a limited company	• *Your* three most recent printed payslips • Copies of *your* company accounts that have been submitted to HMRC, for the last three years • Confirmation of the number of employees in the company

We may approach *your* employer, or HM Revenue and Customs, to confirm details of *your* earnings and allowances. However, *we* will ask *you* before *we* do this.

If *you* provide the evidence above, and *we* accept it, then *we* will use these *verified earnings* to assess any claims *you* make under Income Protection Cover. *We* will not need further evidence of *your* earnings before *we* pay *your* claim.

B3.2 How much we will pay

Your plan schedule shows the monthly *benefit you* could receive if *you* claimed under Income Protection Cover. This figure is subject to a maximum amount. The maximum will depend on whether *you* have Short Term Income Protection Cover, Primary cover or Comprehensive Income Protection Cover.

Maximum monthly benefit amount: Short Term Income Protection Cover and Primary cover
For Short Term Income Protection Cover and Primary Cover, *we* calculate the *maximum monthly benefit amount* as the lesser of:

- £10,000 a month, or
- 50% of either *your* verified earnings or *pre-incapacity earnings*, minus the total gross monthly equivalent of:
  - Any *benefits* that are due to *you* under any other insurance against incapacity or illness. These will involve a regular payment to *you* or to a financial institution on *your* behalf. This includes other income protection policies and mortgage payment protection policies;
  - Any salary, wages, income, fees, dividends or commission which *you* continue to receive directly from *employment* or *your* business and
  - Any early retirement pension *you* receive from any office, *employment*, trade, profession or vocation as a result of *your* incapacity. This will be net of any Income Tax or National Insurance contributions that apply.

State benefits, non-*employment* related dividends, income from renting property or goods, and any waiver of premium *benefits* will not reduce *your maximum monthly benefit amount*.

Maximum monthly benefit amount: Comprehensive cover
For Comprehensive cover, *we* calculate the *maximum monthly benefit amount* as the lesser of:

- £16,666 a month, or
- 60% of the first £2,500 of *your verified earnings* or pre-incapacity earnings, plus 50% of *your* earnings or *pre-incapacity earnings* in excess of £2,500, minus the total gross monthly equivalent of:
  - Any *benefits* that are due to *you* under any other insurance against incapacity or illness. These will involve a regular payment to *you* or to a financial institution on *your* behalf. This includes other income protection policies and mortgage payment protection policies;
  - Any salary, wages, income, fees, dividends or commission which *you* continue to receive directly from *employment* or *your* business; and
  - Any early retirement pension *you* receive from any office, *employment*, trade, profession or vocation as a result of *your* incapacity. This will be net of any Income Tax or National Insurance contributions that apply.

State *benefits*, non-*employment* related dividends, income from renting property or goods, and any waiver of premium *benefits* will not reduce *your maximum monthly benefit amount*.

For Short Term, Primary and Comprehensive Income Protection Cover
If, when *you* claim, *your verified earnings* or *pre-incapacity earnings* are not sufficient to support the monthly *benefit* shown on *your plan schedule*, *we* will pay *you* the *maximum monthly benefit amount*.

If *you* are receiving Income Protection Cover payments and category C Disability Cover payments at the same time, *we* will not allow the sum of these to exceed the *maximum monthly benefit amount*. In this situation *we* would reduce *your* total *benefit* payments to the maximum amount. *We* will always reduce or cancel Disability Cover payments before *we* reduce any Income Protection Cover payments.

A different *maximum monthly benefit amount* will apply if *we* are assessing *your* claim under the *houseperson* category. For more about this, see provision B3.5.

Indexation of cover (except during a claim)

Your plan schedule shows whether *you* have chosen for *your benefit* amount to:

- Remain level throughout the term of the cover; or
- Increase annually in line with the *Retail Prices Index* rounded to the next 0.25%

You can choose to have indexed Income Protection Cover irrespective of whether *your plan account* is indexed, as Income Protection Cover is not linked to the value of *your plan account*.

Any annual increase in *your* cover will result in an increase in *your* Income Protection Cover premium by the total of:

- The percentage rise in the *Retail Prices Index*, from a minimum of 0% to a maximum of 10%, and
- 2.5%

You can choose indexed Income Protection Cover when *you* take *your plan* out, or *you* can add it during *your* term. The only times when *you* cannot add indexed Income Protection Cover are:

- When *you* are incapacitated and not working
- During the *deferred period*
- When *we* are paying *you* a *benefit* under *your* Income Protection Cover

We cannot guarantee to offer indexed Income Protection Cover to everyone. To decide whether or not *we* can offer it to *you*, *we* might need to underwrite *your* request.

Indexation increases will not increase *your benefit* amount while *we* are paying a claim under this cover – unless *your* cover includes the escalation of claims in payment option. For more about this, see 'Escalation of claims in payment' below. Once *we* stop making payments, *you* can ask for any increases *you* missed to be added to *your* future *benefit* amount.

Escalation of claims in payment

If *your* cover includes the escalation of claims in payment, *your* Income Protection Cover *benefit* will increase annually while *we* are paying an Income Protection claim.

Increases due during a claim will be added to *your benefit* amount annually, on the anniversary of the date *we* made the first Income Protection payment to *you*. *We* will calculate each increase using the *Retail Prices Index* that applies exactly five months before the date *we* add the increase.

The amount that *your benefit* will increase by depends on whether *you* have Short Term, Primary, or Comprehensive Income Protection Cover.

With Short Term and Primary Income Protection Cover, the increase in *your benefit* amount will be in line with the *Retail Prices Index* rounded to the next 0.25%. This is subject to an annual minimum of 0% and maximum of 10%.

With Comprehensive cover *you* have two options. The increase in *your benefit* amount can be either:

- In line with the *Retail Prices Index*, rounded to the next 0.25%, subject to an annual minimum of 0% and maximum of 10%; or
- In line with the *Retail Prices Index*, rounded to the next 0.25%, plus 2%. This is subject to an annual minimum of 2% and maximum of 12%

Your plan schedule shows which level of cover *you* have. If *you* have Comprehensive cover, it also shows which percentage increase *you* have chosen from the options above.

You can choose to add the escalation of claims in payment option when *you* take *your plan* out, or *you* can add it during *your* term. The only times when *you* cannot add it are:

- When *you* are incapacitated and not working
- During the *deferred period*
- When *we* are paying *you* a *benefit* under *your* Income Protection Cover

We cannot guarantee to offer this option to everyone. To decide whether or not *we* can offer it to *you*, *we* might need to *underwrite your* request.

Permanent disability increase

If *you* have Comprehensive Income Protection Cover, *we* will increase *your* monthly *benefit* amount if *you* become *permanently* disabled. *We* will increase it if *you* are *permanently* unable to perform at least three of the *activities of daily living* without another person's help. For more about *activities of daily living*, see provision D5.4.

A *permanent* disability increase adds 10% to *your* monthly *benefit*, subject to the annual maximum *benefit* of £200,000. For more about the maximum *benefit*, see provision B3.2.

If *we* have already confirmed that *you* are eligible for standard *benefit* payments, *we* will pay these while *we* assess whether *you* are eligible for a *permanent* disability increase.

Once *we* are satisfied that *you* are eligible for the increase, *we* will start paying *you* the increased monthly *benefit* amount from the date of *your* next *benefit* payment.

Recovery benefit

The recovery *benefit* gives *you* access to a range of services that can help *you* recover from *your* incapacity. *We* do not pay the *benefit* directly to *you*. Instead, *we* work with *you* to organise services to help *you* recover. These services might include, but are not limited to:

- Medical support – including private medical care, physiotherapy, osteopathy, psychotherapy and cognitive behavioural therapy
- Assisted care – including assisted devices, modifying a house or car, and a carer or nursing support
- Educational support – including further education qualifications and CV writing

The services *you* access through the recovery *benefit* must be related to the incapacity that has caused *your* claim. An appropriate medical specialist must agree to any medical support and assisted care *you* receive.

We will provide the recovery *benefit* either:

- At the end of *your deferred period*
- If *your* deferred period is less than three months – when *you* have been continuously incapacitated for three months, to an extent that meets the definition of incapacity that applies to *your plan*

The amount of the Recovery *Benefit we* will provide depends on whether *you* have Short Term, Primary or Comprehensive Income Protection Cover. The amount is fixed when *you* set up *your plan*.

For Short Term and Primary Income Protection Cover, *we* will provide a *benefit* that is equal to *your* first full monthly *benefit* payment under Income Protection Cover – up to a maximum of £1,000.

For Comprehensive Cover, *we* will provide a *benefit* that is equal to double *your* first full monthly *benefit* payment under Income Protection Cover – up to a maximum of £2,000.

When *you* use *your* recovery *benefit*, the amount available will reduce by the cost of the services *you* have used.

In some cases *we* may pay the *benefit* directly to *you*. *You* will need to demonstrate that this will go towards the cost of other services that will help *you* recover from *your* incapacity.

Payments for partial months

We will pay *your benefit* or *benefit* to *you* on a monthly basis. If *your benefit* do not stop for any other reason, *we* will pay *you* the final monthly *benefit* on the first day of the month that follows *your* Income Protection Cover's *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover.

Your first and last *benefit* payments may be for partial months. If they are, they will be fractions of the monthly amount.

We calculate *your* first monthly *benefit* payment by:

1. Determining the number of days between the end of the *deferred period* and the date of the first payment
2. Multiplying this number by 12
3. Dividing it by 365
4. Multiplying the result by the amount of monthly *benefit you* are due to get

We will calculate *your* final monthly *benefit* payment in the same way except that, for the first step, *we* will determine the number of days between *your* second last payment and *your* Income Protection Cover's *date of expiry*.

If the end of the *deferred period* and the *date of expiry* for *your* Income Protection Cover are within the same month, *we* will only make one payment. *We* will calculate it as above except that, for the first step, *we* will determine the number of days between the end of the *deferred period* and *your* cover's *date of expiry*.

What happens if we overpay your claim

If, for any reason, *we* pay *you* more under *your* Income Protection Cover than the *benefit* amount *you* are entitled to, *we* may recover the excess amount from *you*. *We* will do this either by offsetting the overpayment against *your* future *benefit*, or by asking *you* to return the excess amount to *us*.

B3.3 How long we will pay for

When your benefit will start

We will start paying *your benefit* on the day after *your deferred period* ends. For more about the *deferred period*, see provision B3.1.

Retrospective payments if you are self-employed

If *you* are *self-employed* – and have a seven-day or one-month *deferred period* – payments will still start at the end of the *deferred period*. However, *we* may make retrospective Income Protection *benefit* payments, backdated to the date *you* became incapacitated.

You must be continuously incapacitated throughout the *deferred period* to get retrospective payments. *You* must also undergo or suffer from one of of the following treatments or conditions during the *deferred period*, and it must be directly related to the cause of *your* claim:

- Any hospital outpatient treatment, excluding Accident and Emergency department consultations.
- Hospitalisation as an inpatient, for a continuous period of at least 24 hours
- Medical quarantine, imposed by a doctor for an infectious disease such as chicken pox or measles but excluding a common cold, influenza and stomach problems or gastro-enteritis
- Back problems where an MRI scan shows clear medical evidence of a condition such as a prolapsed intervertebral disc
- Anxiety, stress or depression that meant *you* were referred to a hospital psychiatric unit
- Courses of chemotherapy or radiotherapy

When your benefit will end

If *you* have selected *Primary* or *Comprehensive Income Protection Cover*, *we* will stop paying *you benefits* on the cover's *date of expiry*. *Your plan schedule* shows this date. If *you* have selected Short Term Income Protection Cover, *we* will stop paying *you benefits* under Income Protection Cover on the earlier of:

- The cover's *date of expiry*; and
- When *we* have paid *you* a total of 24 monthly *benefit* payments for all claims caused by the same life-changing event.

For Short Term, Primary and Comprehensive Income Protection Cover, *we* will stop paying *you benefits* earlier if any of the following occurs:

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work
- *You* are no longer suffering any loss of income from *your own occupation*, despite *your* illness or injury
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury
- *You* refuse reasonable modifications or adjustments – for example to *your* working environment or working practices – that would mean *you* were able to carry out the essential duties of *your occupation*
- *You* fail to provide *us* with satisfactory proof of *your* entitlement to *benefit* payments within 30 days of *us* asking for it
- *You* do not have a physical examination and medical tests – at *our* expense – when *we* ask
- *You* fail to provide *us* with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*.
- *You* are removed from the *plan*. For more about how this happens, see provision D
- *Your* death

You need to tell us if either of the following occurs while *we* are paying *benefits* to *you* under Income Protection Cover:

- *You* return to work and start earning again
- *You* start receiving an income or benefits under any other insurance because of *your* incapacity, including mortgage payment protection policies or any other type of policy that pays a *benefit* to *you* or to a financial institution on *your* behalf

If *you* do not tell *us* about any other income or *benefits*, *we* might cancel *your* Income Protection Cover claim and stop paying *your benefit*.

Reviewing your claim

We might review *your* claim at any time while *we* are paying *benefits* under Income Protection Cover, to make sure *you* continue to be eligible for the *benefit*. This means that *you* might periodically need to fill out claim forms.

B3.4 What happens if you live abroad

If *you* live or are travelling in the *United Kingdom* or *permitted countries*, *we* will pay *your* Income Protection *benefits* as normal. If *you* live or are travelling within other countries while *we* are paying *you benefits*, **we** will limit the amount *we* pay *you* to the equivalent of 26 weeks' *benefit* in any 52-week period. *We* will also limit the amount *we* pay to an overall maximum of 52 weeks' *benefit*.

B3.5 What happens if you are not in employment when you make a claim or you have chosen Houseperson Cover

If you are unemployed or on a career break

If *you* become *unemployed* – or take a *career break* – and claim under Income Protection Cover within a month of leaving work, *we* will assess *your* claim against *your* previous *own occupation*.

If *you* claim more than one month after leaving work, *we* will assess *you* as a houseperson. *We* may also change the *deferred period* that applies to *your* Income Protection Cover. For more about the *deferred period*, see provision B3.1.

Houseperson claims

We will use the *houseperson* category to assess claims for anyone who is:

- A *houseperson*
- A student
- Retired
- Working less than 16 hours a week
- *Unemployed* – and has been for at least one month

When we will pay

If *you* become ill or injured to the extent that *you* cannot perform three out of the *six activities of daily living*, *we* will *pay you* a *benefit*. For more about *activities of daily living*, see provision D5.4. *You* will not need to give *us* details of *your* earnings when *you* claim.

How much we will pay

The maximum monthly *benefit* amount is £1,500. This is the maximum even if *you* had a higher amount of Income Protection Cover in place before *you* became eligible under the *houseperson* category. If *you* become *unemployed* or become a *houseperson*, *you* may want to reduce *your* cover so that it does not exceed this maximum.

If *your* Income Protection Cover is indexed, indexation increases can raise the *maximum monthly benefit amount* for *houseperson* claims over £1,500. For more about indexation, see provision B3.2.

We will pay an extra £100 a month for any children that are dependent on *you*. This amount is per child, but is subject to a monthly maximum of £300 or 20% of *your* monthly *benefit* amount – whichever is lower.

How long we will pay for

We will stop paying *you* benefits under the houseperson category if:

- *You* start work in any *employment* or *occupation* for profit or *reward*
- *You* no longer fail three out of the six *activities of daily living*
- *You* have selected Short Term Income Protection Cover and *we* have paid *you* a total of 24 monthly *benefit* payments for all claims caused by the same *life-changing event*
- *Your* cover reaches its *date of expiry*

If *you* start or return to work for profit or reward *you* need to tell *us* immediately. If *you* originally had full Income Protection Cover, *you* can ask *us* to reinstate this when *we* stop paying *you* benefits under the houseperson category.

If *you* were originally covered as a *houseperson*, *you* can ask to increase *your* cover to full Income Protection Cover. Any increase will be subject to all the provisions in these *plan* provisions that relate to Income Protection Cover. *We* will need details of *your employment* or *occupation* and evidence about *your* health before *we* can increase *your* cover. *We* will also need evidence of *your* earnings or what *you* expect to earn so *we* can make sure *your* cover would not exceed the *maximum monthly benefit amount*.

B3.6 What happens if you go back to work

In the same capacity as before you were ill or injured

If *you* recover sufficiently to go back to work in *your own occupation* or another *occupation*, in a capacity that means *you* are no longer suffering any loss of income, and *you* have a *deferred period* of seven days or one month, *we* will stop paying all Income Protection *benefits* to *you*.

Back to work benefit

If *you* recover sufficiently to go back to work in *your own occupation* or another *occupation*, in a capacity that means *you* are no longer suffering any loss of income, and *you* have a *deferred period* of three, six or 12 months, *we* will pay *you* a back to work *benefit*. *We* will only pay this *benefit* once *we* have stopped paying *you benefit* under Income Protection Cover, including rehabilitation *benefit* and proportionate *benefit*. For more about these, see 'In a reduced capacity' below.

The amount of back to work *benefit we* will pay depends on whether *you* have Short Term, Primary, or Comprehensive Income Protection Cover.

- Short Term and Primary Cover:
  - One month after *we* pay *your* last monthly *benefit*, *we* will pay *you* an amount equal to 25% of *your* last full monthly *benefit* payment
  - Two months after *we* pay *your* last monthly *benefit*, *we* will pay *you* an amount equal to 10% of *your* last full monthly *benefit* payment
- Comprehensive Cover:
  - One month after *we* pay *your* last monthly *benefit*, *we* will pay *you* an amount equal to 50% of *your* last full monthly *benefit* payment
  - Two months after *we* pay *your* last monthly *benefit*, *we* will pay *you* an amount equal to 25% of *your* last full monthly *benefit* payment

If *you* make any subsequent claims under Income Protection Cover, *we* will only pay a back to work *benefit* for *your* subsequent claim if it occurs more than six months after *we* paid the last *benefit* for *your* previous claim.

In a reduced capacity

If *you* go back to work in a reduced capacity – with lower earnings – *we* will continue to pay *you* some of *your benefit*.

Working in your own occupation for lower earnings: rehabilitation benefit
If *you* go back to *your* own *occupation*, but are unable to undertake it to the same extent that *you* were immediately before becoming incapacitated – and can prove this to *our* satisfaction – *we* will pay *you* a rehabilitation *benefit*. This is a fraction of *your* full *benefit* amount, based on how much *you* earn on *your* return to work.

We will pay the rehabilitation *benefit* for a maximum of 52 weeks. *We* may ask *you* to have medical treatment or supervision to help *you* recover *your* former level of capacity.

Working in a different occupation for lower earnings: proportionate benefit
If *you* go back to work, but *your* new job is not in *your* own *occupation* and provides *you* with lower earnings, *we* will pay *you* a proportionate *benefit*. This is a fraction of *your* full *benefit* amount, based on how much *you* earn on *your* return to work. *We* must be satisfied that *your* incapacity makes *you* unable to continue in *your* own *occupation*.

We calculate the amount of rehabilitation or proportionate *benefit we* will pay in the following way:

1. *We* take *your* reduced earnings (how much *you* earn on *your* return to work) away from *your* verified earnings or pre-incapacity earnings (depending on which amount *we* have used to assess *your* claim)
2. *We* divide the result by *your* verified earnings or pre-incapacity earnings
3. *We* then multiply that result by *your* monthly Income Protection *benefit*

If *you* do not tell us that *you* have returned to work, *we* might cancel *your* Income Protection Cover claim and stop paying *your benefit*.

B3.7 What happens if you need to claim again

If *you* recover and return to work but then need to make another Income Protection Cover claim, *we* will waive the deferred period for this subsequent claim. This waiver only applies if the two claims are linked to the same condition, and *you* make the second claim within six months of the original *benefit* payments ending.

If *we* determine that *your* claims are linked to the same condition, and *your* level of Income Protection Cover has increased due to indexation of cover since *you* returned to work, *we* will not apply any increases to the amount *we* pay for *your* subsequent claim. Instead *we* will reduce *your* level of Income Protection Cover to the level that applied to the first of *your* linked claims.

B3.8 Waiver of Income Protection Cover premiums

We will waive *your* Income Protection Cover premiums while *we* are paying *you* any benefits under that cover. This includes payments under the houseperson category, rehabilitation *benefit* and, proportionate *benefit*. For more about these, see, provisions B3.5 and B3.6.

We will continue to waive *your* premiums until the first of the following happens:

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work
- *You* are no longer suffering any loss of income from *your* own *occupation*, despite *your* illness or injury
- *You* perform any kind of work for profit or reward – except if *we* are paying *you* rehabilitation or proportionate *benefit*
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury
- *You* fail to provide us with satisfactory proof of *your* entitlement to the *benefit* within 30 days of us asking for it, or *you* do not have a physical examination and medical tests – at *our* expense – when *we* ask
- *You* fail to provide us with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*.
- *You* Income Protection Cover reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover
- *You* have selected Short-Term Income Protection Cover and *we* have paid *you* a total of 24 monthly *benefit* payments for all claims caused by the same life-changing event
- *You* death

Waiver of Premium on Incapacity

The Waiver of Income Protection Cover premiums described above is separate from the Waiver of Premium on Incapacity explained in provision C7. Waiver of Premium on Incapacity means that *we* will waive the *plan* premiums for *your* whole *plan* – not just for Income Protection Cover – if *you* become incapacitated and *your* incapacity meets one of *our* definitions. For more about the definitions of incapacity that apply, see provision C7.1.

If *you* have Comprehensive Income Protection Cover plus at least one other cover as part of *your plan*, Waiver of Premium on Incapacity is automatically included. If *you* have Short Term or Primary Income Protection Cover plus at least one other cover, *you* can choose to add it to *your plan*. *Your plan schedule* shows if Waiver of Premium on Incapacity is part of *your plan*.

If *you* have a VitalityHealth policy which provides *you* with private medical cover and which started at least six months before the date *you* became incapacitated, *we* will waive the premiums for that policy or scheme. *We* will waive them from the date *you* became incapacitated, for a maximum of six months.

If *your* VitalityHealth premiums increase while *we* are waiving them, *we* will not waive the increase. *We* will only waive VitalityHealth premiums up to a maximum value of 10% of the monthly amount *you* are receiving under Income Protection Cover.

B3.9 When your cover will end

Your Income Protection Cover will end on the earliest of:

- *Your* cover's *date of expiry*, less the deferred period. For example, if *you* have a deferred period of three months, *your* cover will end three months before its *date of expiry*. The deferred period may not apply if *you* are making a subsequent claim. For more about this, see provision B3.7.
- *You* being removed from the *plan*
- The *plan* ceasing
- *Your* death

C. Other covers and options

C1. Core Serious Illness Cover for Children

Core Serious Illness Cover for Children pays a lump sum if *your* child suffers from a serious illness that *we* cover. If *you* have Serious Illness Cover in *your plan*, *we* automatically include Core Serious Illness Cover for Children. Serious Illness Cover Booster is not available on Core Serious Illness Cover for Children.

This cover does not need *underwriting*. It includes all *your* children, for the term of the cover.

If *you* want to increase the level of cover for *your* children above the level that Core Serious Illness Cover for Children provides, *you* can apply for Optional Serious Illness Cover for Children. For more about this, see provision C2.

As well as the following information, all of the information in provision B2 about medical evidence, severity levels, and the definitions *we* use to assess serious illnesses apply to Core Serious Illness Cover for Children. Serious Illness Cover Booster does not apply to Core Serious Illness Cover for Children.

C1.1 When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- *Your child* is diagnosed with a serious illness as defined in Appendix 1, except for:
  - An illness that is defined as total permanent disability - unable, before 70, to do *your* own *occupation* ever again.
  - An illness that *we* would assess using *functional activity tests* in the permanent disability category
  - Insulin dependent (type1) Diabetes Mellitus
- The child *you* are claiming for survives for at least 14 days after the life-changing event or the diagnosis of the life-changing event
- *We* receive *your* written claim within six months of the life-changing event
- *You* give us any evidence *we* ask for, as set out in provision B2
- *Your* claim meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated

C1.2 How much cover do I have?

The amount of Core Serious Illness Cover for Children for each child is:

- 50% of *your* current Serious Illness Cover if *you* have a *single life plan*
- 50% of the combined current Serious Illness Cover for both people covered if *you* have a *joint life plan*; or
- £25,000, whichever is the lower

The maximum total amount *we* will pay for the same child under this cover is £25,000. If the child is covered for core Serious Illness Cover for Children by more than one policy issued by us, this maximum applies to the total of all payments under these policies and not each policy separately.

For information about how *your* Serious Illness Cover can change, see provision B2.
The amount *we* will pay depends on:

- The amount of Core Serious Illness Cover for Children for *your* child; and
- How severe the serious illness is; and
- The type of Serious Illness Cover *you* have

If *your* child is diagnosed with a serious illness that *we* cover *we* will calculate the amount that *we* pay as follows:
First *we* will calculate *your* child's amount of Core Serious Illness Cover for Children (described above). Then *we* multiply this amount by the percentage relevant to the severity of *your* child's claim.

Severity level	The percentage of your Core Serious Illness Cover for Children we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

How severe the serious illness is

We will pay a percentage of *your* Core Serious Illness Cover for Children, depending on how severe the serious illness is, based on a scale from A to G.

Your plan	The kind of Serious Illness Cover you have	Your Core Serious Illness Cover for Children includes these severity levels
Single life plan	Primary	A, B, C and D
	Comprehensive	A, B, C, D, E, F and G
Joint life plan	Both people covered have Primary Serious Illness Cover, or one *person covered* has Primary Serious Illness Cover and the other person has no Serious Illness Cover.	A, B, C and D
	At least one *person covered* has Comprehensive Serious Illness Cover – the other person could have Primary Serious Illness Cover, Comprehensive Serious Illness Cover or no Serious Illness Cover.	A, B, C, D, E, F and G

The severity levels you are covered for

This table shows how the kind of *plan you* have and the kind of Serious Illness Cover *you* have determine which severity levels are included in *your* Core Serious Illness Cover for Children.

Your plan schedule shows whether *you* have Primary or Comprehensive Serious Illness Cover.

Some serious illnesses are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

C1.3 When we will not pay

We will not pay the *benefit* if:

- The life-changing event that causes *you* to claim happens after *your* Serious Illness Cover's *date of expiry*; or
- The claim is due to a pre-existing medical condition.

C1.4 What happens if you claim for more than one serious illness at a time

If a single life-changing event results in a child being diagnosed with more than one serious illness, *we* will only pay a *benefit* for the illness with the highest severity level.

However, if one of the serious illnesses is a neurological condition that started after the *start date* of the Core Serious Illness Cover for Children, *we* will assess it as a separate claim. *We* will base *our* assessment on reports from the consultant in charge of monitoring progress.

C2. Optional Serious Illness Cover for Children

Optional Serious Illness Cover for Children pays a lump sum if *your* child suffers from a serious illness that *we* cover. It can provide a higher level of cover than Core Serious Illness Cover for Children. *Your plan schedule* shows if *you* have Optional Serious Illness Cover for Children. Serious Illness Cover Booster does not apply to Optional Serious Illness Cover for Children.

This cover does not need *underwriting*. It includes any of *your* children that *you* have asked us to cover. *We* pay any benefits under this cover to the planholder.

You don't have to have Serious Illness Cover to have this cover. If *you* do have Serious Illness Cover, *you* automatically have Core Serious Illness Cover for Children. For more about this, see provision C1. If *you* have Optional Serious Illness Cover for Children as well, there may be times when both covers pay a *benefit* for the same claim. In that case, *we* will pay both benefits, not just one.

C2.1 When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- *Your child* is diagnosed with a serious illness as defined in Appendix 1, except for:
  - An illness that is defined as total permanent disability - unable, before 70, to do *your* own *occupation* ever again.
  - An illness that *we* would assess using *functional activity tests* in the permanent disability category
  - Insulin dependent (type1) Diabetes Mellitus
- The child *you* are claiming for survives for at least 14 days after the life-changing event or the diagnosis of the life-changing event
- *We* receive *your* written claim within six months of the life-changing event
- *You* give us any evidence *we* ask for, as set out in provision B2
- *Your* claim meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated

C2.2 How much we will pay

How much *we* will pay depends on:

- How severe *your* child's condition is
- The type of cover *you* have; and
- The amount of cover for *your* child

How severe your child's condition is

We will pay a percentage of *your* Optional Serious Illness Cover for Children, depending on how severe the serious illness is, based on a scale from A to G:

Some serious illnesses are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

Severity level	The percentage of your Optional Serious Illness Cover for Children we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

The type of cover you have

If *you* have Optional Serious Illness Cover for Children, *your plan schedule* shows whether it is at Primary or Comprehensive level.

If *you* have Comprehensive cover, *your* Optional Serious Illness Cover for Children includes all severity levels, from A to G.

If *you* have Primary cover, *your* Optional Serious Illness Cover for Children only includes severity levels A, B, C and D.

You can change the type of *your* cover from Primary to Comprehensive, or from Comprehensive to Primary, at any time, unless *we* are assessing a claim under this cover. The type of *your* cover must be the same for all named children under the cover.

The amount of cover

Your plan schedule shows the amount of Optional Serious Illness Cover for each child.

The maximum total amount of benefit

The maximum total amount of *benefit* that *we* will pay for each named child under this cover over the term of the *plan* is £100,000.

If the child is covered by more than one of *our* policies, this maximum applies to the total of all payments under these policies and not to each policy separately. This includes where a *joint life plan* has been split.

C2.3 When we will not pay

We will not pay the *benefit* if:

- The life-changing event that causes *you* to claim happens after *your* Optional Serious Illness Cover for Children's *date of expiry*, or
- The claim is due to a pre-existing medical condition

C2.4 What happens if a single life-changing event causes you to claim for more than one serious illness

If a single life-changing event results in a child being diagnosed with more than one serious illness, *we* will only pay a *benefit* for the illness with the highest severity level.

However, if one of the serious illnesses is a neurological condition that started after the *start date* of the Optional Serious Illness Cover for Children, *we* will assess it as a separate claim. *We* will base *our* assessment on reports from the consultant in charge of monitoring progress.

C2.5 How your cover continues after a claim

When *we* make payments under this cover, the amount of cover available for future claims for that child will reduce by the amount *we* have paid *you*. If *you* claim once and then again *we* may make a further payment. The circumstances in which *we* may make a further payment are outlined in provision B2.7. How *we* calculate the amount *we* will pay is also outlined in provision B2.7, however the calculation will be based on *your* amount of Optional Serious Illness Cover for Children rather than the *plan* account. Serious Illness Cover Booster does not apply to Optional Serious Illness Cover for Children.

C2.6 Indexed Cover

Your plan schedule will show whether *your* Optional Serious Illness Cover for Children is on a level or an indexed basis.

Level

The amount of Optional Serious Illness Cover for Children will stay the same over the life of the *plan*. It will only change if something happens such as *you* change the cover.

Indexed

The amount of Optional Serious Illness Cover for Children *benefit* increases on each *plan anniversary,* in line with the *Retail Prices Index* (RPI rounded to the next 0.25%). Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI figure that applies five months before each *plan anniversary*.

C3. Disability Cover

Disability Cover pays one or more lump sums if *you* become disabled because of an accident or illness. *You* can be covered for several different categories of disability, from temporary disability that stops *you* working in the short term, to severe disability that affects *you* for the rest of *your* life.

When *we* use the phrase 'Disability Cover', *we* always mean the cover described in this provision, not the permanent disability category that is part of Serious Illness Cover. For more about this, see provision B2.

The level of your Disability Cover

When *you* take out Disability Cover, *you* choose the level of cover *you* want. There are three levels to choose from. Each level includes certain categories of disability:

- Level 1 means *you* can claim for categories A and D
- Level 2 means *you* can claim for categories A, B and D
- Level 3 means *you* can claim for categories A, B, C and D

We explain these categories below, in 'The category of *your* claim'.

Your plan schedule shows if *you* have Disability Cover, and which level *you* have.

Who can get Disability Cover?

To get Disability Cover, each *person covered* needs to have *Life Cover* or Serious Illness Cover or both. If *you* have a *joint life plan*, *you* can add this cover for both people covered, or just one. Children cannot have this cover.

C3.1 When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- The illness or condition that led to *your* claim is in a category that *you* are covered for
- The illness or condition that led to *your* claim started after the *start date* of *your* Disability Cover, or *you* told us about it before *your plan* started
- *You* give us any information and documents that *we* reasonably ask for as evidence for *your* claim
- *Your* employer, GP and any appropriate medical specialist treating *you* give us any medical information *we* reasonably ask for as evidence for *your* claim
- *Our* Chief Medical Officer decides *your* claim is valid and, if appropriate, decides the severity level of *your* illness or condition
- The life-changing event which causes *your* claim occurs before the *date of expiry* of *your* Disability Cover
- *You* live longer than the relevant survival period for *your* illness or condition

C3.2 How much we will pay

How much *we* will pay depends on:

- How much Disability Cover *you* have
- The category of *your* claim

How much Disability Cover you have

Your plan schedule shows *your* initial amount of Disability Cover.

Disability Cover is subject to a maximum amount, so any payments *we* make will reduce the amount of Disability Cover available for future claims.

The category of your claim

We pay different amounts depending on the category of *your* claim. There are four categories: A, B, C and D.

Category A

You can make a category A claim if *your* claim meets all of the following criteria:

- *You* meet the category A criteria for any of the illnesses or conditions in Appendix 3, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated
- *You* survive for at least 14 days after the diagnosis of the life-changing event
- *We* receive *your* written claim within six months of the life-changing event

The *benefit* is 100% of *your* Disability Cover. If *we* pay this, *your* Disability Cover will end, and *we* reduce *your* premiums accordingly.

Category B

You can make a category B claim if *your* claim meets all of the following criteria:

- *You* have level 2 or level 3 Disability Cover
- *You* meet the category B criteria for any of the illnesses or conditions in Appendix 3, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated
- *You* survive for at least 14 days after the diagnosis of the life-changing event
- *We* receive *your* written claim within six months of the life-changing event

Category C

You can make a category C claim if *your* claim meets all of the following criteria:

- *You* have level 3 Disability Cover

- *Your* illness or injury means *you* lose at least 80% of *your* own *occupation* income for four months in a row
- *We* receive *your* written claim within three months of the life-changing event

The *benefit* is a lump sum of 2.5% of *your* Disability Cover.

You can make a further category C claim for the same disability every four months, if *your* claim meets the criteria above. *We* will make up to six of these *benefit* payments for the same disability.

You cannot make a category C claim if:

- *You* have already had a category A or B *benefit* for the same illness or condition
- It is less than four months before the *date of expiry* of *your* Disability Cover

The monthly equivalent of this *benefit* is one quarter of the lump sum. This monthly equivalent, together with any *benefit we* are paying *you* under Income Protection Cover, must not be more than *your* Income Protection Cover's maximum monthly *benefit* amount. For more about this, see provision B3.2. If it is more than that, *we* will reduce *your* total *benefit* payments to the maximum amount. *We* will always reduce or cancel Disability Cover payments before *we* reduce any Income Protection Cover payments.

If *we* pay *you* any category C *benefit*, *you* must continue to pay *your* Disability Cover premiums, unless:

- It is less than four months before *your* Disability Cover's *date of expiry*, or
- *You* are covered by a waiver of premium. There is more about premium waivers in provisions C7 to C9.

Category D

You can make a category D claim if *your* claim meets all of the following criteria:

- An illness or injury causes *you* to meet *our* definition of total permanent disability - unable, before 70, to do *your* own *occupation* ever again
- *You* survive at least until the date when *we* agree that *you* are totally and permanently disabled
- *We* receive *your* written claim within six months of the life-changing event

The *benefit* is 100% of *your* Disability Cover. If *we* pay this, *your* Disability Cover will end, and *we* will reduce *your* premiums accordingly.

Maximum benefit amounts

The maximum amount of Disability Cover *you* can have is £500,000. This maximum applies to *your* initial amount of cover and to any increases *you* make to *your* cover.

For claims as a result of a serious illness, the maximum combined Education Cover, Family Income Cover, Disability Cover and Serious Illness Cover *benefit* (including any payments as a result of Serious Illness Cover Booster) *we* will pay for a *person covered* over the life of the *plan* is £3,000,000.

If *you* reach this maximum *benefit* amount, *we* will not accept any further serious illness claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly.

If *you* are also covered by other policies issued by us, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a serious illness and Education Cover payable on diagnosis of a severity A serious illness is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

Other covers and options

If *we* haven't yet paid the maximum *benefit*, but a future claim might breach it, *we* might restrict *your* cover.

If *you* have a *joint life plan*, all of these points apply to each *person covered* separately.

C3.3 What happens if you make another claim

If *we* pay *you* a category B *benefit*, *you* cannot make another category B claim for the same condition.

However, if the condition has got worse, *you* may be able to make a category A claim for the same condition.

If *we* pay *you* a category B *benefit* and *you* make a successful claim for a different condition in the same illness category, *we* will upgrade *your* new *benefit* to category A.

C3.4 How will we assess your incapacity

If *you* make a claim, *we* will assess *your* incapacity by referring to *your* own *occupation*. If *we* don't normally give an own *occupation* definition for *your* particular *occupation*, *we* may assess *your* incapacity by referring to the activities of daily living. For more about activities of daily living, see provision D5.4.

C3.5 What happens if a single life-changing event causes you to claim for more than one condition

If a single life-changing event causes *you* to have more than one condition, *you* might qualify for more than one *benefit* under Disability Cover. If this happens, *we* will only pay the most valuable *benefit*.

C3.6 What happens if a single life-changing event means you are eligible for payments under Disability Cover, Serious Illness Cover, Family Income Cover or Education Cover

If a single life-changing event makes *you* eligible for benefits under Disability Cover, Serious Illness Cover, Family Income Cover or Education Cover, *we* will pay all benefits. This is subject to a maximum amount. For more about the maximum, see provision C3.2.

C3.7 What happens if both people covered claim

If *you* have a *joint life plan* and both people covered claim, *we* will treat each claim separately. If *we* pay a *benefit* for both claims, the two benefits will also be separate.

C3.8 What happens to your cover after a successful claim

Disability Cover is subject to a maximum amount, so any payments *we* make will reduce the amount of Disability Cover available for future claims. Appendix 6 shows how *we* deal with further claims. If *you* have a *joint life plan*, this applies separately to each *person covered*.

C3.9 What happens when you reach the age of 70

Your Disability Cover will end when *you* reach the age of 70, unless *you* have chosen a shorter term. *Your plan schedule* shows the *date of expiry* for this cover. If *you* have a *whole of life plan* account, *you* can choose to convert *your* Disability Cover to a limited version of Serious Illness Cover at this point.

This version of Serious Illness Cover will only provide cover for serious illnesses with severity A or B. *We* exclude the following body system categories or conditions from this version of Serious Illness Cover:

- Ear
- Eye
- Respiratory diseases
- Permanent disability: mental and behavioural disorders
- Permanent disability: total permanent disability - unable, before 70, to do *your* own *occupation* ever again
- Loss of manual dexterity
- Loss of muscle power
- Persistent vegetative state

If *you* choose to convert to Serious Illness Cover, *your* Disability Cover premium will stay the same. *We* will tellyou how much Serious Illness Cover this premium will give *you*.

C4. Mortgage Free Cover

Mortgage Free Cover is temporary *Life Cover* or Serious Illness Cover or both, that covers *you* before *your plan* starts. It may be relevant to *you* if:

- *Your plan* is to cover a loan to buy or improve *your* home
- *You* do not want *your plan* to start until *you* start paying back *your* loan

We offer *you* Mortgage Free Cover in this situation because *you* might be legally committed to the loan before *you* start paying it back – for example, if *you* have exchanged contracts to buy a new home.

Mortgage Free Cover only provides Serious Illness Cover for conditions of severity level A or B. For more about how severity levels apply for Serious Illness Cover, see provision B2.3.

We do not charge *you* any premium for Mortgage Free Cover.

C4.1 When you are eligible for Mortgage Free Cover

To be eligible for Mortgage Free Cover, *your plan* application must meet all of the following criteria:

- *You* are using *your plan* to cover a loan arranged through a recognised financial institution
- *You* are using *your* loan to buy or improve *your* home
- *You* are not using *your* loan to pay for a remortgage
- *Your* loan is not covered by another life assurance policy or free cover arrangement like this one
- *You* have applied for *Life Cover* or Serious Illness Cover or both, and *we* have accepted *your* application and told *you* which of *your* covers the Mortgage Free Cover applies to
- The period from when *you* applied for *your plan* to when *you* are legally committed to a loan for buying or improving *your* home – for example when *you* exchange contracts – is less than four months
- *You* and any other *person covered* must be younger than 50 on the date *we* issue *your* acceptance letter
- *You* have a *single life plan* or a *joint life first death plan*

C4.2 When Mortgage Free Cover starts

Mortgage Free Cover starts when either of the following events happen:

- *We* issue *your* acceptance letter
- *You* become legally committed to a loan for buying or improving *your* home – for example this might be when *you* exchange contracts

You can only have Mortgage Free Cover in the period immediately before *your plan* starts. *You* cannot have it when *you* are changing *your plan* at a later stage.

C4.3 When we will pay

If *you* need to make a claim under *Life Cover* while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision B1.

If *you* need to make a severity A or B claim under Serious Illness Cover while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision B2. *We* will not pay out under Mortgage Free Cover for conditions of lower severity levels.

You must claim within six months of the life-changing event.

C4.4 How much we will pay

The amount of *Life Cover* or Serious Illness Cover *benefit we* pay will be the lowest of:

- The amount of cover that *we* state on *your* acceptance letter
- The amount of *your* mortgage or loan; and
- £300,000

C4.5 When the cover ends

The *date of expiry* of Mortgage Free Cover is when the first of any of these events happen:

- Three months pass since *we* issued *your* acceptance letter
- *Your* mortgage starts
- *Your plan* starts; or
- *You* are no longer legally committed to the loan, for any reason

C5. Family Income Cover

Family Income Cover pays a regular monthly *benefit* for a fixed period of time if *you* die or are diagnosed with a *terminal illness*. If *you* have selected Family Income Cover that provides a *benefit* on diagnosis of a serious illness, a *benefit* will also be paid if *you* are diagnosed with a serious illness that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision.

We offer two types of Family Income Cover – Primary cover and Comprehensive cover. *Your plan schedule* shows which type of cover *you* have. Unless *we* say otherwise, the following information applies to both levels of cover.

C5.1 When we will pay the benefit

Death or diagnosis of a terminal illness

If the cover is single life *we* will pay the regular monthly *benefit* if the *person covered* dies, or is diagnosed with a *terminal illness* that meets *our* definition. The regular monthly *benefit* will be paid until the end of the Family Income Cover *date of expiry* or for the guaranteed payment term if this is longer – for more information about the guaranteed payment period see provision C5.2.

If the cover is *joint life first death we* will pay the regular monthly *benefit* if one of the people covered dies, or is diagnosed with a *terminal illness* that meets *our* definition.

The regular monthly *benefit* will be paid until the end of the Family Income Cover *date of expiry* for the *person covered*, or for the guaranteed payment term if this is longer – for more information about the guaranteed payment period see provision C5.2.

When *we* have paid this *benefit* for one *person covered*, *we* cancel all the covers for that person. *We* also cancel the Family Income Cover for the remaining *person covered*. If the remaining person has other covers in the *plan*, the *plan* continues.

The remaining person can apply to us for new Family Income Cover under a new *plan*. For more about this, see provision D6.

Serious Illness

If *you* have selected Family Income Cover that provides a *benefit* on diagnosis of a serious illness *your* claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that *we* cover. The serious illnesses *we* cover are specified in Appendix 1. They are grouped into body system categories to help us assess claims.
- *Your* condition must meet any of the definitions set out in Appendix 1 that apply to it. *We* will use the criteria in Appendix 1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have, *we* will not pay a claim for that condition.
- *You* must survive for at least 14 days after the date of the life-changing event which causes *you* to claim. If *you* make a permanent disability claim, *you* must survive until the date when *we* confirm that *you* are totally and permanently disabled. For more about permanent disability claims, see Appendix 1.

Regular monthly *benefit* payments under Family Income Cover will start to be paid when *we* confirm that the claim is valid – irrespective of when the claim is made.

The fixed period of time for which *we* pay *you* the *benefit* will depend on how severe *your* illness is – based on a scale from levels A to G. For more about severity levels, see 'How long *we* will pay the *benefit* for', at provision C5.2.

How we will assess your claim if your occupation has changed

You do not need to tell us if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed. If *we* would not normally use an own *occupation* definition for that *occupation*, then *we* may use *functional activity tests* to assess *your* claim. For more about *functional activity tests*, see provision D5.4.

Medical evidence

We will ask *your* General Practitioner, and any specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid and, if appropriate, which severity level applies to *your* condition.

C5.2 How long we will pay the benefit for

Guaranteed payment term

Family Income Cover will be paid for a minimum period – this is known as the guaranteed payment term. *Your plan schedule* will show the guaranteed payment term which applies to *your plan*.

Death or diagnosis of a terminal illness

If *you* die or are diagnosed with a *terminal illness* the *benefit* will be paid until the Family Income Cover *date of expiry*, or for the guaranteed payment term if this is longer.

Serious illness

The period for which *we* will pay after diagnosis of a serious illness depends on:

- How severe *your* condition is,
- The type of cover *you* have, and
- The guaranteed payment term

How severe your condition is

The period for which *we* will pay the regular monthly *benefit* will depend on how severe *your* illness is – based on a scale from A to G.

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

Severity level	Benefit payment term
A (most severe)	Longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
B	75% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
C	50% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
D	25% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
E	15% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
F	10% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
G (least severe)	5% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term

The type of cover

Your plan schedule shows whether *you* have Primary or Comprehensive Family Income Cover. With Primary cover *you* are covered for severity levels A, B, C and D. With Comprehensive cover *you* are covered for all the severity levels - from A to G.

C5.3 When we will not pay

We will not pay the *benefit* if the death or diagnosis of *terminal illness* happens after the Family Income Cover *date of expiry*. *Your plan schedule* shows this date.

Under certain circumstances, *we* may also not pay the *benefit* if the claim is due to suicide. For more about this, see provision D5.6.

For claims following the diagnosis of a serious illness *we* will not pay if:

We will not pay if:	Where to find more information:
You have not selected Family Income Cover that provides cover on diagnosis of a *serious illness*	Provision C5.1
You suffer from a condition that *we* do not cover	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application	*Your plan schedule*
Your condition does not meet *our* definition for that condition	Appendix 1
You do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim	Provision C5.1
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment	Provision C5.8
We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim	
We do not receive the medical evidence *we* need from *your* General Practitioner and any specialists who are treating *you*	Provision C5.1
We are not satisfied that the *serious illness* that has lead to *your* claim occurred either while *we* were providing *you* with Family Income Cover, or was disclosed to *us* when *you* applied	
Your Family Income Cover expires before the *life-changing event* which leads to *your* claim	*Your plan schedule*

C5.4 How much we will pay

Your plan schedule shows the amount of Family Income Cover *you* have. This is the regular monthly *benefit* amount that *we* will pay *you* in the event of a claim. If *your* cover is indexed it will increase at each *plan anniversary* – see provision C5.5.

If both people covered in a *joint life plan* die, and it is not possible to determine who died first, or if both people suffer from a serious illness *we* will pay the higher Family Income Cover amount.

C5.5 Indexed Cover

Your plan schedule will show whether *your* Family Income Cover is on a level or an indexed basis.

Level or indexed?	What this means
Level	The amount of Family Income Cover will stay the same over the life of the *plan*. It will only change if something happens such as *you* change the cover.
Indexed	The amount of Family Income Cover *benefit* increases on each *plan anniversary*, in line with the *Retail Prices Index* (RPI rounded to the next 0.25%). Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI figure that applies five months before each *plan anniversary*. The RPI increase will continue during a claim.

C5.6 What happens if you need to claim while we are still assessing your application for Family Income Cover

If *you* have applied for Family Income Cover, but *we* are still assessing *your* application, *we* automatically give *you* some limited *Life Cover*. This is called Immediate Cover. Immediate Cover is free of charge.

We will pay a *benefit* under Immediate Cover as long as all of the following apply:

- *We* have received a completed application from *you*
- *We* have received a completed direct debit instruction from *you*
- The claim is for death - *terminal illness* is not covered
- *You* are under 50 when *we* receive *your* application
- *You* are a resident of the *United Kingdom*
- *You* are not applying for *Life Cover* or Family Income Cover with any other company
- *You* answered 'no' to all *our* medical and health questions
- *You* do not take part in any hazardous pursuits or sports or have an *occupation* that *we* would exclude or charge *you* extra for

Immediate Cover stops when one of these happens:

- *We* accept *your* application
- *We* decline *your* application
- *Your* application is cancelled
- 90 days pass since *we* received *your* application

The total amount *we* will pay for Immediate Cover for *Life Cover*, Family Income Cover and Education Cover is the amount *you* applied for, up to a combined maximum of £500,000.

C5.7 What happens if more than one person covered needs to claim

If one person dies or is diagnosed with a *terminal illness* the *benefit* will be paid until the *date of expiry*, or the guaranteed payment term if this is longer. The Family Income Cover for the remaining *person covered* will be cancelled.

If one person is diagnosed with a serious illness and, while *we* are paying a claim the other life is diagnosed with a serious illness, *we* will pay the *benefit* for whichever claim is eligible for the longest payment period. If the regular monthly *benefit* amount for the person with the longest payment period is lower than the amount for the person with the shorter payment period, *we* will pay the higher *benefit* amount until the end of the shorter payment period. At the end of this period *we* will pay the lower monthly *benefit* amount until the end of the longest payment period.

C5.8 What happens if you need to make a subsequent claim

If *you* claim once and then claim again, *we* call the second claim a subsequent claim. This can be for the same condition, or a different one.

Subsequent claims

If *you* have already claimed under a particular body system category, *we* will classify any subsequent claims *you* make under this category as either a progressive claim or an unrelated claim.

Progressive claims	
Definition	A *progressive claim* occurs when: 1. A *person covered* has a *life-changing event* that causes a *serious illness* 2. They make a claim for that *serious illness* 3. They later make a claim for the same illness, or another *serious illness* in the same *body system category* that was caused by the same *life-changing event*
When *we* won't pay	If the severity level of *your progressive claim* is the same as or lower than the severity level of *your* original claim, *we* will not make another payment
When *we* will pay	If the severity level of *your progressive claim* is higher than the severity level of *your* original claim, *we* will make another payment
How long the claim will be paid for	*We* will pay the claim for the period of time equal to the difference between: • The *benefit* payment term had the condition been diagnosed at the higher severity level when the original claim was accepted • The length of time that *we* have already paid the claim for the original condition

Unrelated claims	
Definition	An *unrelated claim* occurs when: 1. A *person covered* has a *life-changing event* that causes a *serious illness* 2. They make a claim for that *serious illness* 3. They later make a claim for another *serious illness* that was caused by a different *life-changing event* or one that is under a different *body system category*
If a claim is made after the end of a previous *benefit* payment term	If the *benefit* payment term for the original claim has ended and *we* are no longer paying the regular monthly *benefit* amount *we* will treat the *unrelated claim* as a new claim. *We* will calculate the *benefit* payment term based on the severity of the *serious illness* which has caused the *unrelated claim*.
If a subsequent claim is made while the *benefit* is being paid due to a previous claim	If the *benefit* payment term for the original claim has not yet ended and *we* are still paying the regular monthly *benefit* amount *we* may extend the *benefit* payment term. *We* will calculate the *benefit* payment term based on the severity of the *serious illness* which has caused the *unrelated claim*. If this *benefit* payment term is longer than the period until which the *benefit* for the original claim will be paid, the *benefit* will be paid until the end of the *benefit* payment term for the subsequent claim. If this *benefit* payment term is shorter than the period until which the *benefit* for the original claim will be paid, the *benefit* will be paid until the end of the *benefit* payment term for the original claim.

There are two types of claim that we treat differently to the scenarios set out above:

1. Subsequent claims under the major organ transplant body system category that are caused by a condition or illness that is named under another body system category

The underlying cause of a claim under the major organ transplant body system category may be a condition or illness named under another category.

- If *we* have previously paid out for that condition – no matter what category it is listed under – *we* will treat *your* claim as a progressive claim. For more about progressive claims, see the start of this provision.
- If *we* have not previously paid out for that named condition, *we* will treat *your* claim in the same way that *we* treat unrelated claims – see above

2. Subsequent permanent disability claims

When *we* use the phrase 'permanent disability claims', *we* always mean claims under the body system category of 'permanent disability', not claims under Disability Cover. For more about Disability Cover, see provision C3.

If *you* make a claim that is valid under both the permanent disability category and another body system category, *we* will treat this as a permanent disability claim. *We* will manage any subsequent claims on the basis that *we* have already paid a claim under the permanent disability category.

C5.9 What happens if you claim for a severity A serious illness

When *we* have paid a severity A serious illness claim for Family Income Cover no further Family Income Cover claims can be made for the *person covered*.

C5.10 Maximum benefit amounts

For claims as a result of a serious illness, the maximum combined Education Cover, Family Income Cover, Disability Cover and Serious Illness Cover *benefit* (including any payments as a result of Serious Illness Cover Booster) *we* will pay for a *person covered* over the life of the *plan* is £3,000,000.

If *you* are also covered by other policies issued by us, the overall maximum amount that *we* will ever pay in respect of claims for a *person covered* for Disability Cover for Business, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a serious illness and Education Cover payable on diagnosis of a severity A serious illness is £3,000,000. This overall maximum is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

If *you* reach this maximum *benefit* amount, *we* will not accept any further serious illness claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly.

C5.11 Child Serious Illness Cover

What happens if my child is diagnosed with a serious illness

If *you* have selected Family Income Cover that provides a *benefit* on diagnosis of a serious illness *we* will also pay a *benefit* if any children *you* have are diagnosed with a serious illness.

We will provide a regular monthly *benefit* for a fixed period of time if *your* child is diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision.

This cover does not need *underwriting*. It includes all *your* children, for the term of the cover.

As well as the following information, all of the information in provision C5.3 about medical evidence, severity levels, and the definitions *we* use to assess serious illnesses apply to claims for *your* children.

When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- *Your child* is diagnosed with a serious illness as defined in Appendix 1, except for:
  - An illness that is defined as total permanent disability - unable, before 70, to do *your* own *occupation* ever again.
  - An illness that *we* would assess using *functional activity tests* in the permanent disability category
  - Insulin dependent (type1) Diabetes Mellitus
- The child *you* are claiming for survives for at least 14 days after the life-changing event or the diagnosis of the life-changing event
- *We* receive *your* written claim within six months of the life-changing event
- *You* give us any evidence *we* ask for, as set out in provision B2
- *Your* claim meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated

How much we will pay

- 50% of *your* current Family Income Cover if *you* have a *single life plan*
- 50% of the combined current Family Income Cover if *you* have a *joint life plan*

This is subject to a maximum of £25,000 in total for all benefits paid for the same child under this cover and Core Serious Illness Cover for Children (see provision C1).

If the child is covered by more than one policy issued by us, this maximum applies to the total of all payments under these policies and not to each policy separately - including where a *joint life plan* has been split.

How long we will pay the benefit for

The period for which *we* will pay after diagnosis of a serious illness depends on:

- How severe the condition is
- The type of cover *you* have
- The guaranteed payment term

How severe your condition is

The period for which *we* will pay the regular monthly *benefit* will depend on how severe the serious illness is – based on a scale from A to G:

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

Severity level	Benefit payment term
A (most severe)	100% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
B	75% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
C	50% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
D	25% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
E	15% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
F	10% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
G (least severe)	5% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term

The type of cover

This table shows how the kind of Family Income Cover *you* have determines which severity levels are included in *your* Family Income Cover claims for *your* children.

Your plan	The kind of Family Income Cover you have	Your Family Income Cover for child serious illness claims includes these severity levels
Single life plan	Primary	A, B, C and D
	Comprehensive	A, B, C, D, E, F and G
Joint life plan	Both people covered have Primary Family Cover or one *person covered* has Primary Family Income Cover and the other person has no Family Income Serious Illness Cover.	A, B, C and D
	At least one *person covered* has Comprehensive Family Income Cover – the other *person covered* could have Primary Family Income Cover, Comprehensive Family Income Cover or no Family Income Cover.	A, B, C, D, E, F and G

Your plan schedule shows whether *you* have Primary or Comprehensive Family Income Cover.

Some serious illnesses are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

Once *we* have paid a total of £25,000 for the same child under this cover and Core Serious Illness Cover for Children (see provision C1) no further payments will be made.

When we will not pay

We will not pay the *benefit* if:

- The life-changing event that causes *you* to claim happens after *your* Family Income Cover date of expiry
- The claim is due to a pre-existing medical condition

What happens if you claim for more than one serious illness at a time

If a single life-changing event results in a child being diagnosed with more than one serious illness, *we* will only pay a *benefit* for the illness with the highest severity level.

However, if one of the serious illnesses is a neurological condition that started after the *start date* of the Family Income Cover, *we* will assess it as a separate claim. *We* will base *our* assessment on reports from the consultant in charge of monitoring progress.

C5.12 Funeral Contribution Benefit

When we will pay this benefit

We will pay this *benefit* when one of the people covered dies.

How much we will pay

The amount of Funeral Contribution *Benefit* that *we* will pay will depend on whether *you* have Primary Family Income Cover or Comprehensive Family Income Cover. *Your plan schedule* shows which type of cover *you* have.

- If *you* have Primary Family Income Cover *we* will pay £1,000
- If *you* have Comprehensive Family Income Cover *we* will pay £2,000
- If *you* have selected indexed Family Income Cover these amounts will not increase in line with the *Retail Prices Index*

C5.13 Spend Protector

If *you* have selected Comprehensive Family Income Cover *your plan* will include the Spend Protector.

Spend Protector will pay a regular monthly amount for the first 12 months of a claim for Family Income Cover. This amount will indemnify *you* for the following regular monthly outgoings:

- Mortgage/rent payments
- Utilities bills
- Broadband bills
- Insurances
- Grocery bills
- Car tax/petrol

The regular monthly amount will be paid in addition to *your* Family Income Cover *benefit* amount.

When we will pay this benefit

We will pay this *benefit* when the *person covered* dies or is diagnosed with a *terminal illness*. If *you* have selected Family Income Cover that provides a *benefit* on diagnosis of a serious illness *we* will also pay this *benefit* if *you* are diagnosed with a severity level A serious illness.

Spend Protector will only be payable once for each *person covered* during the period of cover.

How much we will pay

The amount that *we* will pay for Spend Protector will be the lower of:

- 100% of the Family Income *Life Cover* amount being paid for the claim for the *person covered*
- The amount of confirmed expenditure

We will make a maximum of 12 monthly payments.

C6. Family Income Cover

Education Cover provides a range of benefits to cover the expenses associated with *your* child's education. *You* can choose to provide Education Cover for one of *your* children or for more than one child.

The benefits will be paid if the *person covered* dies or is diagnosed with a *terminal illness*. In addition, if *you* have selected Education Cover that pays out on serious illness the benefits will be paid if *you* suffer from a

serious illness that meets *our* definition of a severity A serious illness. *Your plan schedule* shows whether *you* have chosen this option.

We offer different types of Education Cover for children who are at State school, Private school with boarding or Private day school. *Your plan schedule* shows which type of cover *you* have selected. Unless *we* say otherwise, the following information applies to all types of cover.

C6.1 School Fees Benefit

If *you* have selected the Private School with Boarding Education Cover or the Private Day School Education Cover *you* will be entitled to the School Fees *Benefit*. This *benefit* is not available if *you* have selected the State School Education Cover.

The School Fees *Benefit* provides a regular amount at the beginning of each school term to cover the primary and secondary school fees of a child.

When we will pay this benefit

We will pay the School Fees *Benefit* in respect of each child named on *your plan schedule* if the *person covered* dies, or is diagnosed with a *terminal illness*. If *you* have selected Education Cover that also pays out on serious illness the benefits will be paid if *you* suffer from a serious illness that meets *our* definition of a severity A serious illness. *Your* claim also needs to meet other criteria. *We* set these out in provision C6.8.

The School Fees *Benefit* will be paid at the start of each school term. Before *we* will pay the *benefit we* will require evidence of the actual amount of school fees payable for the coming term.

The first *benefit* payment will be payable at the start of the school term immediately following the date of claim.

If *your* child has not yet reached the compulsory school age (as defined by the Education Act 1996) *benefit* payments will only begin once they reach this age.

How much we will pay

At the start of each term *we* will pay an amount equal to the school fees due for each child listed in *your plan schedule* up to a maximum amount.

The maximum amount for the School Fees *Benefit* may change each year. The change will reflect *our* assessment of the change in cost of school fees each year. The maximum amount for the first policy year is shown on *your plan schedule*. The maximum amount for subsequent policy years will be shown on *your* anniversary schedule.

While *we* are paying a claim for School Fees *Benefit we* will review the amount that *we* will pay each school term for the coming school year on 1st September. The amount which *we* will pay each term for the coming school year will be the lower of:

- The actual amount of school fees payable in respect of the child for the coming school year
- The maximum amount of school fees payable in the previous year increased by the lower of:
  - *Our* assessment of the change in the cost of school fees for the coming year
  - 12%

The last payment *we* will make for this *benefit* will be on the earlier of;

- The child no longer being enrolled at a primary or secondary school
- The start of the school term immediately before their 19th birthday
- The death of the child

If the child leaves a private school and enrols at a state school where no fees are payable, the regular amount of *benefit* will still be paid. The *benefit* amount will be 50% of the last regular *benefit* paid while the child was at a private school.

C6.2 University Fees Benefit

If one or more of the children listed in *your plan schedule* attend a *UK* university *we* will pay an amount towards their university fees each year.

When we will pay this benefit

We will pay the University Fees *Benefit* if the *person covered* dies, or is diagnosed with a *terminal illness*. If *you* have selected Education Cover that also pays out on serious illness the benefits will be paid if *you* suffer from a serious illness that meets *our* definition of a severity A serious illness. *Your* claim also needs to meet other criteria. *We* set these out in provision C6.8.

We will pay the *benefit* if the child is attending a *UK* university and is studying towards one of the following qualifications:

- First degree, such as a Bachelor of Arts, Science or Education
- Foundation Degree
- Certificate of Higher Education
- Diploma of Higher Education
- Higher National Certificate
- Higher National Diploma

Before *we* will pay the *benefit we* will require evidence confirming that the child is attending a *UK* university and is studying towards one of the qualifications above. *We* will also require evidence of the actual fees payable.

University Fees *Benefit* will be payable at the start of each university term.

The first *benefit* payment will be payable at the start of the University term immediately following the date of claim.

How much we will pay

At the start of each term *we* will pay an amount equal to the university fees due for each child listed in *your plan schedule* up to a maximum amount.

The maximum amount for the University Fees *Benefit* may change each year. The change will reflect *our* assessment of the change in cost of university fees each year. The maximum amount for the first policy year is shown on *your plan schedule*. The maximum amount for subsequent policy years will be shown on *your* anniversary schedule.

While *we* are paying a claim for University Fees *Benefit we* will review the amount that *we* will pay each term for the coming university year on 1st September. The amount which *we* will pay each term for the coming university year will be the lower of:

- The actual amount of university fees payable in respect of the child for the coming university year,
- The maximum amount of university fees payable in the previous year increased by the lower of :
  - *Our* assessment of the change in the cost of university fees for the coming year
  - 12%

The last payment *we* will make for this *benefit* will be on the earlier of;

- The child no longer being enrolled at a *UK* university
- The child no longer studying towards a qualification listed above
- The start of the university year immediately before their 25th birthday
- The University Fees *Benefit* having been paid for five years
- The death of the child

How much we will pay if a child does not attend a UK university

If one or more of the children listed in *your plan schedule* has completed their secondary education and attained the age of 18 but does not attend a registered *UK* university *we* will still pay the University Fees *Benefit*. The amount payable will be 33% of the maximum amount payable for the University Fees *Benefit*. The *benefit* will be paid for a maximum of three years.

If the child subsequently decides to attend a *UK* university *we* will reduce the University Fees *Benefit* by an amount equal to the *benefit* which *we* have previously paid.

How much we will pay if a child does not complete their university education

If the University Fees *Benefit* has been paid for more than three years then no further payments will be made.

If the University Fees *Benefit* has been paid for less than three years *we* will pay 33% of the maximum amount for the University Fees *Benefit*. This will be paid until a total of three years *benefit* has been paid (including the period where the child attended university) or until the child reaches the age of 25 if this is earlier.

C6.3 School Expenses Benefit

The School Expenses *Benefit* provides a regular amount at the beginning of each school term to cover expenses associated with going to school (e.g. uniforms, stationery, textbooks and school trips).

When we will pay this benefit

We will pay the School Expenses *Benefit* if the *person covered* dies, or is diagnosed with a *terminal illness*. If *you* have selected Education Cover that also pays out on serious illness the benefits will be paid if *you* suffer from a serious illness that meets *our* definition of a severity A serious illness. *Your* claim also needs to meet other criteria. *We* set these out in provision C6.8.

The School Expenses *Benefit* will be paid at the start of each school term. The first *benefit* payment will be payable at the start of the school term immediately following the date of claim.

If *your* child has not yet reached the compulsory school age (as defined by the Education Act 1996) *benefit* payments will only begin once they reach this age.

How much we will pay

The amount that *we* will pay is shown on *your plan schedule*. This amount will increase at each *plan anniversary* in line with the *Retail Prices Index* rounded to the next 0.25%. Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI value five months before the start of the current school year. If the claim is in payment the *benefit* will continue to increase in line with RPI subject to a minimum of 0% and to a maximum of 10%.

When we will stop paying this benefit

The last payment *we* will make for this *benefit* will be on the earlier of;

- The child no longer being enrolled at a primary or secondary school
- The start of the school term immediately before their 19th birthday
- The death of the child

C6.4 Star Award Benefit

The Star Award *Benefit* provides an amount if *your* child excels in an extracurricular activity. If, while *we* are paying the School Expenses *Benefit* a child listed in *your plan schedule* is:

- Selected for a national sports team
- Achieves Grade 8 level in a musical instrument
- Achieves a Gold Award in the Duke of Edinburgh Awards scheme
- Achieves Gold level in the British Maths Olympiad

we will pay an amount of £1,000.

The Star Award *Benefit* may be paid only once for each child listed in *your plan schedule*.

Before *we* will pay the Star Award *Benefit we* will require satisfactory evidence of the achievement.

C6.5 School Absence Benefit

The School Absence *Benefit* provides an amount if *your* child is unable to attend school for an extended period of time due to illness or injury.

If, while *we* are paying the School Expenses *Benefit* a child listed in *your plan schedule* is either;

- Hospitalised for a period of 10 consecutive days or more
- Unable to attend their school for 20 consecutive full days due to illness

we will pay an amount of £1,000.

We will require written evidence that either of these events has occurred before *we* will pay this *benefit*.

The School Absence *Benefit* may be paid only once for each child listed in *your plan schedule*.

C6.6 Serious Illness Cover for Children

This *benefit* pays a lump sum if one of the children named on *your plan schedule* suffers from a serious illness that *we* cover.

This cover does not need *underwriting*. As well as the following information, all of the information in provision B2 about medical evidence, severity levels, and the definitions *we* use to assess serious illnesses also apply to Serious Illness Cover for Children. Serious Illness Cover Booster does not apply to this *benefit*.

When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- *Your* child is at least one month old and has not reached the first *plan anniversary* after their 23rd birthday
- *Your* child is diagnosed with a serious illness as defined in Appendix 1, except for:
  - An illness that is defined as total permanent disability - unable, before age 70, to do *your* own *occupation* ever again
  - An illness that *we* would assess using *functional activity tests* in the permanent disability category
  - Insulin Dependent Diabetes Mellitus (type1)
- The child *you* are claiming for survives for at least 14 days after the life-changing event or the diagnosis of the life-changing event
- *We* receive *your* written claim within six months of the life-changing event
- *You* give us any evidence *we* ask for, as set out in provision B2
- *Your* claim meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated

How much we will pay

The amount of Serious Illness Cover for Children is £5,000.

The amount *we* will pay depends on how severe the serious illness is.

How severe the serious illness is

We will pay a percentage of *your* Serious Illness Cover for Children depending on how severe the serious illness is, based on a scale from A to D.

Severity level	The percentage of your cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%

Some serious illnesses are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

When we will not pay

We will not pay the *benefit* if:

- The life-changing event that causes *you* to claim happens after the first *plan anniversary* following *your* child's 23rd birthday
- The claim is due to a pre-existing medical condition

What happens if you claim for more than one serious illness at a time

If a single life-changing event results in a child being diagnosed with more than one serious illness, *we* will only pay a *benefit* for the illness with the highest severity level.

However, if one of the serious illnesses is a neurological condition that started after the *start date* of the Education Cover, *we* will assess it as a separate claim. *We* will base *our* assessment on reports from the consultant in charge of monitoring progress.

C6.7 What happens if you die while we are assessing your application for Education Cover?

If *you* have applied for Education Cover but *we* are still assessing *your* application, *we* automatically give *you* some limited cover. This is called Immediate Cover. Immediate Cover is free of charge.

We will pay a *benefit* under Immediate Cover as long as all of the following apply:

- *We* have received a completed application from *you*
- *We* have received a completed direct debit instruction from *you*
- The claim is for death - *terminal illness* and serious illness are not covered
- *You* are under 50 when *we* receive *your* application
- *You* are a resident of the *United Kingdom*
- *You* are not applying for *Life Cover* with any other company
- *You* answered 'no' to all *our* medical and health questions
- *You* do not take part in any hazardous pursuits or sports or have an *occupation* that *we* would exclude or charge *you* extra for

Immediate Cover stops when one of these happens:

- *We* accept *your* application
- *We* decline *your* application
- *Your* application is cancelled
- 90 days pass since *we* received *your* application

The total amount *we* will pay for Immediate Cover for *Life Cover*, Family Income Cover and Education *Life Cover* is the amount *you* applied for, up to a combined maximum of £500,000.

C6.8 What criteria must I meet to receive a benefit on diagnosis of a serious illness

If *you* have selected for Education Cover to provide a *benefit* if the *person covered* is diagnosed with a serious illness then *your* claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that *we* cover as a severity A serious illness. The severity A serious illnesses *we* cover are specified in Appendix 1.
- *Your* condition must meet any of the severity A definitions set out in Appendix 1 that apply to it. *We* will use the criteria in Appendix 1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have, *we* will not pay a claim for that condition.
- *You* must survive for at least 14 days after the date of the life-changing event which causes *you* to claim. If *you* make a permanent disability claim, *you* must survive until the date when *we* confirm that *you* are totally and permanently disabled. For more about permanent disability claims, see Appendix 1.

Benefits will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

How we will assess your claim if your occupation has changed

You do not need to tell us if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed. If *we* would not normally use an own *occupation* definition for that *occupation*, then *we* may use *functional activity tests* to assess *your* claim. For more about *functional activity tests*, see provision D5.4.

Medical evidence

We will ask *your* General Practitioner, and any specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

C6.9 When we will not pay Education Cover benefits

Claims as a result of death or diagnosis of a terminal illness

We will not pay the *benefit* if the death or diagnosis of *terminal illness* happens after the Education Cover *date of expiry*. *Your plan schedule* shows this date.

Under certain circumstances, *we* may also not pay the *benefit* if the claim is due to suicide. For more about this, see provision D5.6.

When *we* have accepted a claim for one *person covered*, *we* cancel all the covers for that person.

We also cancel Education Cover, Family Income Cover and *Life Cover* for the remaining *person covered* under the *plan*. If the remaining person has other covers in the *plan*, the *plan* continues.

Claims as a result of diagnosis of a serious illness

We will not pay if:	Where to find more information:
You suffer from a condition that *we* do not cover as a severity A *serious illness*	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application	*Your plan schedule*
Your condition does not meet *our* definition for that condition	Appendix 1
You do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim	Provision C6.8
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled	Appendix 1
We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim	
We do not receive the medical evidence *we* need from *your* General Practitioner and any specialists who are treating *you*	Provision C6.8
We are not satisfied that the *serious illness* that has lead to *your* claim occurred either while *we* were providing *you* with Education Cover or was disclosed to *us* when *you* applied	
Your Education Cover expires before the *life-changing event* which leads to *your* claim	*Your plan schedule*

How your Education Cover continues after a claim for serious illness cover

When *we* have accepted a Serious Illness Cover claim for Education cover no further premiums will be payable for Education Cover. Education Cover will also be removed for any other *person covered* on the *plan*.

Maximum benefit amounts

For claims as a result of a serious illness, the maximum combined Education Cover, Family Income Cover, Disability Cover and Serious Illness Cover (including any payments as a result of Serious Illness Cover Booster) *benefit we* will pay for a *person covered* over the life of the *plan* is £3,000,000.

If *you* are also covered by other policies issued by us, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a serious illness and Education Cover payable on diagnosis of a Severity A serious illness is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

If *you* reach this maximum *benefit* amount, *we* will not accept any further serious illness claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly.

C6.10 How your Education Cover premiums change each year

Your premium for Education Cover may change at each *plan anniversary*. The change will reflect any change in education costs. *We* will not look at *your* individual circumstances but at the change in education costs to everyone *we* insure.

Each year *we* will assess the change in the cost of education by considering:

- Changes in private school fees
- Changes in university tuition fees
- Changes in school expenses with reference to the *Retail Prices Index*

We will not review *your* premium with reference to:

- *Your* individual health circumstances

- *Our* claims experience, or the experience of the whole insurance industry, and
- The potential future costs to us of settling claims.

Before each *plan anniversary we* will send *you* an updated schedule showing *your* new premium for Education Cover.

Any change in *your* Education Cover premium could affect other covers in *your plan*. For more about this, see provision D1.

- Three months pass since *we* issued *your* acceptance letter
- *Your plan* starts
- *You* are no longer legally committed to the loan, for any reason

C7. Waiver of Premium on Incapacity

Waiver of Premium on Incapacity means that if *you* become incapacitated, *we* stop charging the *plan* premium for *your plan*.

- If *you* have a *single life plan*, *you* can choose to add this cover
- If *you* have a *joint life plan*, *you* can choose to add this cover for just one *person covered*, or both people can have it separately

Your plan schedule shows if *your plan* includes this cover. *You* can add or remove this cover at any time. If *you* apply to add it, *we* will underwrite *your* request.

C7.1 When we will waive your premiums

We will waive *your plan* premium if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your* own *occupation*. These are the duties that are normally needed to do *your* own *occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

A special definition means the loss of the physical ability through an illness or injury to do at least three of the six tasks designed to assess whether *you* can look after yourself. *We* list these tasks in provision D5.4. *We* use this definition to assess houseperson claims, see provision C7.6.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

When we will start waiving your plan premium

We will start waiving *your plan* premium on the day after *your* deferred period ends.

The deferred period starts on the date *you* become incapacitated according to the definition that applies to *your plan*. It ends when *you* have been continuously incapacitated for one of:

- Seven days (this is only an option if *you* are self-employed)
- One month
- Three months
- Six months
- Twelve months

You choose *your* deferred period when *you* set up this cover. If *you* have a *joint life plan*, each *person covered* can choose their own deferred period. For some own occupations *you* cannot choose a deferred period of seven days or one month. *We* will tell *you* if this applies to *you*.

Your plan schedule shows which deferred period applies to *your* Waiver of Premium on Incapacity.

Telling us that you want to claim

If *you* become incapacitated and need to claim, *you* need to give us written notice within a specified period of time. This notification period depends on the deferred period *you* have chosen. If *you* have a deferred period of:

- Seven days, *you* should notify us immediately
- One month, *your* notification period is two weeks
- Three, six or twelve months, *your* notification period is two months

If *we* don't receive notice of *your* incapacity within the specified period, *we* may treat the deferred period as if it started on the date *we* actually receive notice.

If *we* receive notice more than 90 days after the end of the deferred period, *we* may decline *your* claim.

Providing us with evidence for your claim

We will need to be satisfied that *your* claim is valid in order to waive *your plan* premium.

When *you* first make *your* claim, *we* will ask for evidence to substantiate it. This evidence may include, but is not limited to:

- A report from *your* General Practitioner
- Copies of *your* medical records
- A report from any other appropriate medical specialist
- *Your* hospital records, including copies of the results of any clinical tests or investigations
- Information from *your* employer, including details of the duties of *your employment*
- *Your* human resources records, including details of sickness absence

We may also need *you* to have a medical examination with an examiner that *we* choose, at *our* expense. *We* may appoint a disability counsellor or someone who represents us to talk to *you* about any aspect of *your* claim.

At reasonable intervals *we* may also ask *you* to fill in a claim form, to confirm that *you* are still entitled to Waiver of Premium on Incapacity.

If *you* do not give consent for us to access *your* medical information, or to get any other assistance or information that *we* need to assess *your* claim, then *we* may decline, suspend, or stop paying *you* any benefits under Waiver of Premium on Incapacity Cover.

C7.2 How long we will waive your plan premium for

When we will start waiving your plan premium

We will start waiving *your plan* premium on the day after *your* deferred period ends. For more about the deferred periods, see provision C7.1.

When we stop waiving your plan premium

We will continue to waive *your plan* premium until the first of the following occurs:

- *You* become able to start work in *your* own *occupation* again. *We* will base this on *your* ability to work, not the availability of work.
- *You* are no longer suffering any loss of income from *your* own *occupation*, despite *your* illness or injury
- *You* perform any kind of work for profit or reward
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury
- *You* fail to provide us with satisfactory proof that *you* are entitled to the *benefit* within 30 days of us asking for it, or *you* do not have a physical examination and medical tests – at *our* expense – when *we* ask
- *You* fail to provide us with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*.
- *Your* Waiver of Premium on Incapacity reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover
- *You* are removed from the *plan*
- The *plan* is cancelled
- *Your* death

C7.3 Which plan premium increases we will waive

While *we* are waiving *your plan* premium, *we* will waive any increases that happen because:

- *You* have an indexed *plan* account
- *Your plan* premium increases as a result of Vitality Optimiser
- *We* review *your plan* premium

While *we* are waiving *your plan* premium, *you* will have to pay any increases that happen because:

- *You* add more covers to *your plan*
- *You* increase the amount of any of *your* covers

C7.4 When we will not waive your plan premium

We will not waive *your plan* premium if the life-changing event which causes *your* claim occurs after the *date of expiry* for this cover.

C7.5 What happens if you need to claim again

If *you* recover and return to work but then need to make another claim under this cover, *we* will waive the deferred period for this subsequent claim. This waiver only applies if the subsequent claim is:

- Caused by the same life-changing event as the original claim
- Within three months of the original waiver of premium ending

C7.6 What happens if you are not in employment when you make a claim

If you are unemployed or on a career break

If *you* become unemployed – or take a career break – and claim under Waiver of Premium on Incapacity Cover within a month of leaving work, *we* will assess *your* claim against *your* previous own *occupation*.

If *you* claim more than one month after leaving work, *we* will assess *you* as a houseperson. *We* may also change the deferred period that applies to *your* Waiver of Premium on Incapacity Cover. For more about the deferred period for Waiver of Premium on Incapacity Cover, see provision C7.1.

Houseperson claims

We will use the houseperson category to assess claims for anyone who is:

- A houseperson
- A student
- Retired
- Working less than 16 hours a week
- Unemployed – and has been for at least one month

When we will accept your claim

If *you* become ill or injured to the extent that *you* cannot perform three out of the six activities of daily living, *we* will accept *your* claim. For more about activities of daily living, see provision D5.4. *You* will not need to give us details of *your* earnings when *you* claim.

How long we will pay for

We will stop waiving *your* premiums under the houseperson category if:

- *You* start work in any *employment* or *occupation* for profit or reward
- *You* no longer fail three out of the six activities of daily living

C7.7 What happens if you start to earn an income

If *you* start or return to work for profit or reward *you* need to tell us immediately. If *you* don't do this, *we* may:

- Stop waiving *your plan* premium
- Cancel *your plan*

C7.8 What happens if you change your occupation

You do not need to tell us if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed.

If *we* would not normally use an own *occupation* definition for that *occupation*, then *we* may use activities of daily living to assess *your* claim. For more about activities of daily living assessments, see provision D5.4.

C8. Waiver of Premium on Serious Illness

Waiver of Premium on Serious Illness means that if *you* get a serious illness that *we* class as severity A, *we* stop charging the *plan* premium for *your plan*.

You do not need to have Serious Illness Cover to have this waiver. However, unless *you* have the Minimum Protected Account option, *you* cannot add this waiver to *your plan* if *you*:

- Only have Serious Illness Cover, at 100% of *your plan account*
- Only have *Life Cover* plus Serious Illness Cover at 100% of *your plan account*

This is because plans set up as above and without the Minimum Protected Account option will end if *you* get a severity A Serious Illness Cover payment – so there will be no *plan* premium left to waive.

If *you* have a *joint life plan*, *you* can choose to add this cover for just one *person covered*, or both people can have it separately. *You* can add or remove this cover at any time. If *you* apply for this cover, *we* will underwrite *your* request.

Your plan schedule shows if *your plan* includes this cover.

C8.1 When we will waive your plan premium

We will waive all further *plan* premiums if *your* claim meets all of the following criteria:

- *You* are diagnosed with a serious illness that meets *our* definition and which is classed as severity level A. For more about the illnesses *we* cover, see Appendix 1.
- *We* receive written notice of *your* claim within six months of the life-changing event that caused the claim
- *Your* GP and any relevant specialist treating *you* give us any medical evidence *we* ask for.
- *You* survive for at least 14 days from the date of the life-changing event. *We* may waive this condition under some circumstances.
- If *your* claim is in the permanent disability category, *you* survive to the date when *we* agree that *you* are totally and permanently disabled

C8.2 When we will start waiving your plan premium

We will start waiving *your plan* premium 15 days from the date of the life-changing event that caused *your* claim. However, if *your* claim is under the permanent disability category, *we* will start waiving *your plan* premium when *we* agree that *you* are totally and permanently disabled.

C8.3 Which premium increases we will waive

While *we* are waiving *your plan* premium, *we* will waive any increases that happen because:

- *You* have an indexed *plan account*
- *Your plan* premium increases as a result of Vitality Optimiser
- *We* review *your* premiums

While *we* are waiving *your plan* premium, *you* will have to pay any increases that happen because:

- *You* add more covers to *your plan*
- *You* increase the amount of any of *your* covers

C8.4 When we will stop waiving your plan premium

We will stop waiving *your plan* premium when any of the following events happen:

- *Your* Waiver of Premium on Serious Illness reaches its *date of expiry*
- All the covers that *we* are waiving the premiums for reach their dates of expiry
- *You* are removed from the *plan*
- The *plan* is cancelled
- *Your* death

C9. Waiver of Premium on Death

This cover is only available if *you* have a *joint life plan*.

C9.1 When we will waive your plan premium

Waiver of Premium on Death means that if one *person covered* dies or is diagnosed with a *terminal illness*, *we* stop charging *plan* premiums for the other *person covered* by *your plan*. *You* can include this cover for either or both people covered.

Your plan schedule shows if *your plan* includes this cover and who is covered for Waiver of Premium on Death.

C9.2 When we will start waiving your plan premium

We will start waiving *your plan* premiums from the date the *person covered* dies, or the date of the diagnosis of a *terminal illness*. However, *we* will not waive *your plan* premiums if this date is after the *date of expiry* of the Waiver of Premium on Death.

C9.3 Which premium increases we will waive

While *we* are waiving *your plan* premiums, *we* will waive any increases that happen because:

- *You* have an indexed *plan account*
- *Your plan* premium increases as a result of Vitality Optimiser
- *We* review *your* premiums

While *we* are waiving premiums, *you* will have to pay any increases that happen because:

- *You* add covers to *your plan*
- *You* increase the amount of *your* cover

C9.4 When we will stop waiving your plan premium

We will stop waiving *your plan* premiums when any of the following events happen:

- The Waiver of Premium on Death reaches its *date of expiry*
- All the covers that *we* are waiving the premiums for reach their dates of expiry
- The *plan* is cancelled
- The death of the remaining *person covered*

C10. Guaranteed Insurability options

Guaranteed Insurability options allow *you* to increase certain covers when particular events happen in *your* life, without giving us any more information about *your* health. The covers *you* can increase are:

- *Life Cover*
- Family Income Cover
- Serious Illness Cover
- Income Protection Cover
- Disability Cover

We include this feature in *your plan* automatically as long as:

- *We* accepted *you* and any other *person covered* at normal rates
- *We* have not added any special exclusions to *your plan*

Your plan schedule shows if *your plan* includes Guaranteed Insurability options.

C10.1 When you can use Guaranteed Insurability options

Event	The cover you can increase					
	Life Cover	Serious Illness Cover	Disability Cover	Income Protection Cover		Family Income Cover
				Short Term or Primary	Comprehensive	
Childbirth or *adoption*	●	●	●	–	●	●
Marriage or *Civil Partnership*	●	●	●	–	●	●
New or increased mortgage	●	●	●	●	●	●
Promotion or change of job leading to a salary increase	–	–	–	●	●	–
Every third *plan anniversary*	–	–	–	–	●	–
Increase in value of estate leading to an increase in inheritance tax liability*	●	–	–	–	–	–
Legislative change leading to an increase in inheritance tax liability*	●	–	–	–	–	–

* Only available where *Life Cover* is arranged on a *whole of life* basis.

You can apply to increase *your* cover using Guaranteed Insurability options at any time, as long as *your* application meets all of the following criteria:

- *You* already have the relevant cover
- One of the events shown in the table above has happened in the last three months
- *You* give us the evidence *we* ask for to show that the event has happened within the last three months
- *You* have not made a successful claim under *your plan*, apart from under Serious Illness Cover for Children
- *You* have not reached the *plan* anniversary immediately before *your* 55th birthday for;
  - Childbirth or *adoption*
  - *Marriage* or *Civil Partnership*
  - New or increased mortgage
  - Promotion or change of job leading to a salary increase
  - Every third *plan anniversary*
- *You* have not reached *your* 70th birthday for;
  - Legislative change leading to increase in inheritance tax liability
  - Increase in value of estate leading to an increase in inheritance tax liability options
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1
- If *you* apply to increase Income Protection Cover or Disability Cover, *you* give us proof of *your* earnings

If *you* have a *joint life plan*, and either *person covered* wants to increase their Income Protection Cover or Disability Cover, the increase must take place on a *plan anniversary* that occurs at least a year before the Guaranteed Insurability options expire. This means that the increase cannot take place on the *plan anniversary* immediately before that person's 55th birthday.

If *you* want to use a Guaranteed Insurability option to increase *your* cover in line with an increase in *your* mortgage, *your* application must meet all of the following criteria:

- *You* are using *your plan* to cover a mortgage or mortgages on *your* main residence
- *Your* mortgage has increased, or *you* have taken out a new mortgage
- Any increase in *your* total mortgage payments is solely to pay for a new main residence or to improve *your* existing main residence

We will increase *your* cover as soon as *we* have accepted *your* application.

Legislative change leading to an increase in inheritance tax liability

If *your plan* has been arranged on a *whole of life* basis, *you* can also increase *your Life Cover* if a change in legislation increases the inheritance tax (IHT) liability on *your* estate. A legislative change is limited to a change in inheritance tax rate, inheritance tax rate bands, inheritance tax reliefs and exemptions.

In order to exercise this option there must be evidence that the death *benefit* under the *plan* is in force to cover the potential IHT liability on *your* estate.

VitalityLife will reserve the right to request evidence of the increased potential IHT liability.

Increase in value of estate option

If *your plan* has been arranged on a *whole of life* basis, *you* can also increase *your Life Cover* if the potential IHT liability on *your* estate increases as a result of an increase in the value of the estate due to receipt of a gift or inheritance.

VitalityLife will reserve the right to request evidence of the event and the increase in IHT liability before allowing the Guaranteed Insurability *benefit* to be exercised.

C10.2 Limits to increases using Guaranteed Insurability options

If *you* use Guaranteed Insurability options to increase a cover that is attached to *your plan account*, the amount of *your plan account* may increase. This will depend on the covers *you* have.

- The maximum *you* can increase *your plan account* by, using Guaranteed Insurability options, is £150,000. This maximum applies across the whole life of *your plan*.
- The maximum *you* can increase Disability Cover by, using Guaranteed Insurability options, is £150,000
- The maximum *you* can increase Family Income Cover by, using Guaranteed Insurability options, is the amount that would lead to a total payout over the term of the cover of £150,000. This maximum applies across the whole life of *your* cover.

There are also limits to the amount *you* can increase certain covers by, and the number of times *you* can increase them:

Event	Life Cover	Serious Illness Cover	Disability Cover	Income Protection Cover	Family Income Cover
Childbirth or *adoption*	The limit is 50% of the initial level of cover. *You* cannot increase it more than twice.			The limit is 50% of the initial level of cover, and no more than £8000 a year. *You* cannot increase it more than twice.	The limit is 50% of the initial level of cover up to a maximum of £8000 a year. *You* cannot increase it more than twice.
Marriage or *Civil Partnership*	The limit is 50% of the initial level of cover. *You* cannot increase it more than once.			The limit is 50% of the initial level of cover, and no more than £8000 a year. *You* cannot increase it more than once.	The limit is 50% of the initial level of cover up to a maximum of £8000 a year. *You* cannot increase it more than once.
New or increased mortgage	The limit is the amount of the new mortgage or the increase in the mortgage.			The limit is the amount of *your* increased regular mortgage payment, and no more than £8000 a year, and no more than 50% of the initial level of cover.	The limit is the amount of *your* increased regular mortgage payment, and no more than £8000 a year, and no more than 50% of the initial level of cover.
Promotion or change of job leading to a salary increase				The limit is the lower of 50% of the initial level of cover, the increase in *your* salary or £8000 a year.	

Event	Whole of Life Cover
Legislative change leading to an increase in IHT liability	The limit is 50% of the initial level of cover or the increase in the IHT liability on the portion of *your* estate covered by the *plan* which is a direct result of the legislative change.
Increase in value of estate option	The limit is the lower of: • 50% of the initial level of cover or • The increase in the IHT liability on the portion of *your* estate covered by the *plan*. This increase must be as a direct result of the receipt of the gift or inheritance, or • £50,000 This option can only be exercised once.

The maximum number of times that *you* can increase any of *your* covers using these options over the period of cover is three.

In addition to these limits, *you* can increase Comprehensive Income Protection Cover by up to 10% of the current level of cover, on every third *plan anniversary*.

You can only increase Income Protection Cover a maximum total of three times over the life of *your plan*, whatever the event.

C10.3 How using Guaranteed Insurability options affects your plan

If *you* use Guaranteed Insurability options to increase a cover, *we* will increase *your* premium for that cover. *We* will work out the amount of the premium increase using *your* age and the rates that applied at the time of the increase.

If *your plan* includes the Minimum Protected Account option or any waiver of premium covers, *we* work out new premiums for these. *We* do this using the rates that apply at the time of the increase.

We will apply the same provisions to an increase in cover as those *we* applied when that cover was added to *your plan*.

C10.4 When your Guaranteed Insurability options end

If you make a claim

If *you* make a successful claim under any cover except Serious Illness Cover for Children, *we* will cancel *your* Guaranteed Insurability options. If *you* have a *joint life plan*, the other *person covered* can still use their Guaranteed Insurability options, but only for covers that are not attached to the *plan account*.

Date of expiry

Your Guaranteed Insurability options end on the *plan anniversary* immediately before *your*:

- 55th birthday for childbirth or *adoption*, *marriage* or *Civil Partnership*, new or increased mortgage options, promotion or change of job leading to a salary increase, every third *plan anniversary*
- 70th birthday for legislative change leading to increase in inheritance tax liability or, increase in value of estate leading to an increase in inheritance tax liability options

C11. The Minimum Protected Account option

The Minimum Protected Account option is available for single and *joint life plans*.

If *you* make a successful claim under Serious Illness Cover, the Minimum Protected Account option tops up *your plan account* to a minimum level. *You* choose this minimum level when *you* add this option to *your plan*.

You can apply to add the Minimum Protected Account option to *your plan* if *you* have Serious Illness Cover.

You can apply to add this option to *your plan* at any time. *We* will underwrite *your* request. *You* can remove this cover from *your plan* at any time.

Your plan schedule shows if *your plan* includes the Minimum Protected Account option.

C11.1 How the Minimum Protected Account option works

When *you* add the Minimum Protected Account option to *your plan*, *you* choose how much of *your plan account you* want to protect. This amount must be between 25% and 100% of the value of *your plan account* at the time.

- If *you* have a level *plan account*, the amount of the Minimum Protected Account option will stay the same for the life of *your plan*
- If *you* have a decreasing or indexed *plan account,* the amount of the Minimum Protected Account option will decrease or increase at the same rate as the covers in *your plan account*

If *we* pay *you* a *benefit* under Serious Illness Cover, *your plan account* will reduce by the amount of that *benefit*. If it reduces to below the amount that *you* have protected using the Minimum Protected Account option, *we* will top it back up to that amount. *We* do this as soon as *we* have paid all the benefits that are due as a result of *your* claim.

C11.2 When the Minimum Protected Account option ends

If *your plan* no longer has Serious Illness Cover, *we* will remove the Minimum Protected Account option from *your plan*. As a result, *we* will reduce the premium for *your plan*. For more about how *your* Serious Illness Cover may end, see provision B2.

C12. Protected Life Cover

If *you* have Serious Illness Cover as well as *Life Cover*, *you* have the option to include Protected *Life Cover* in *your plan*. This means that *your Life Cover* will not reduce if *you* claim under Serious Illness Cover.

D. Managing your plan

D1. Paying your premiums

Your plan premium is made up of the individual premiums for each of the covers in *your plan*. *Your plan schedule* shows the details of *your plan premium*.

You pay *your plan* premiums either monthly or annually, in advance. *Your* selected payment frequency is shown in *your plan schedule*. If *you* have selected monthly, *your plan* premiums will be paid by direct debit. If *you* have selected annually, the *plan premium* will be paid for by either direct debit, Electronic Fund Transfer (EFT) or Telegraphic Transfer (TT).

The premiums for any waiver of premium covers depend on the premiums *you* pay for the other covers *you* have in *your plan*.

If *you* have the Minimum Protected Account option, the individual premium for this will depend on the amount of *Life Cover* and Serious Illness Cover *you* have.

D1.1 What happens if you do not pay your plan premium

If *you* do not pay *your plan premium* by the due date, *we* will suspend all the covers in *your plan*. However, *you* can ask *us* to reinstate *your plan* within thirteen months of the date of the first unpaid *plan premium* as long as:

- *You* pay all of the outstanding *plan premium*. If *your* premium would have increased in the time that *you* have not been paying it, *you* will need to pay the increased amounts.
- *You* provide *us* with a new direct debit instruction so *we* can collect future *plan premium*.
- *You* and any other *person covered* by the *plan* completes a reinstatement application form. This is so that *we* can underwrite *your* request. *We* may offer *you* revised terms, or decline *your* request. If *your plan* is reinstated, *we* will not pay any child's claim for a condition that was pre-existing at the time of reinstatement.

D1.2 When your premiums end

Your plan schedule shows the *date of expiry* of each of *your* covers. It also shows whether *your* premium will increase automatically. The *date of expiry* will be different for each *person covered* by the *plan*.

We will collect *your* final premium for each cover on the last due date before the *date of expiry*.

D1.3 Indexed premium increases

If the *benefit* for *your* cover is indexed, *we* will increase *your* premiums annually. The amount by which *we* will increase *your* premiums will depend on *your* age at the time *your* covers increase. For *joint life plans* this will be based on the age of the younger of the two people covered.

If *you* have not reached the *plan anniversary* immediately before *your* 80th birthday the premiums will increase by the total of:

- The percentage rise in the *Retail Prices Index* rounded to the next 0.25%, from a minimum of 0% to a maximum of 10%; and
- 2.5%

Once *you* have reached the *plan anniversary* immediately before *your* 80th birthday the premiums will increase by the total of:

- The percentage rise in the *Retail Prices Index* rounded to the next 0.25%, from a minimum of 0% to a maximum of 10%; and
- 5%

If the *Retail Prices Index* is not suitable, *we* will use another index that measures retail price inflation.

We will increase indexed premiums on each anniversary of *your plan*. *We* will send *you* a new *plan schedule* one month before the increase is due to take effect. The *plan schedule* will show *you* how much the premiums are going to increase by. It will also show any changes to *your* premiums as a result of *healthy living programme*. For more about *healthy living programme*, see provision E.

You do not have to accept the increase to *your* premiums. However, if *you* do not want to accept them, *you* need to notify us before the date that the increases are due to take effect. *You* can also ask us not to apply indexation in any year. If *you* do this for three consecutive years for any individual cover, *we* will cancel the indexation for that cover.

If *your* cover lasts for the whole of *your* life then at the *plan* anniversary immediately before *your* 80th birthday (for *joint life plans* this will be based on the age of the younger of the two people covered) *we* will write to *you* and ask *you* to confirm whether *you* want *your* covers to continue to be indexed. If *you* do not tell us that *you* want *your* covers to be indexed *we* will cancel indexation on *your plan* and *your* premiums will no longer increase due to indexation.

If *we* have cancelled indexation, *you* can apply for us to re-introduce it. However, *we* will need to repeat the *underwriting* process for all the people covered.

D1.4 How making a claim affects your premiums

Your premiums may be affected if *you* make a claim.

For *single life plans*, *your* premiums will stay the same after *you* have made a claim, except when the cover ends after a claim. In this case, *you* will no longer have to pay the premium for that cover.

For *joint life plans*, *we* will reduce *your* premium if *you* make a claim for Serious Illness Cover. *We* do this because the claim reduces the amount of *your* benefits. *We* reduce the premium in proportion to the reduction in *your* benefits. *We* will reduce the premium for the person who did not claim if their cover reduces.

We will allow *your plan* premium to fall below *our* normal minimum *plan* premium if the reduction is because of a claim.

D1.5 How your Vitality Status affects your plan premiums

Your plan premium may change as a result of *your Vitality Status*. *We* will apply these changes on *your plan anniversary* in addition to any other changes that are due. *We* apply any changes as a result of *your Vitality Status* after any changes that result from indexation or a review of *your* premiums.

We will tell *you* if *your plan* premium is going to change at least one month before *your plan anniversary*.

For more about how *your Vitality Status* may affect *your* premium, see provision E2.

D2. Guaranteed premiums

A guaranteed premium is one that will only change as a result of choices that *you* make. Without this option, *we* would review *your* premiums regularly and potentially change them. For more about reviewable premiums, see provision D3.

If *you* have a:

- *Whole of life plan account* with Serious Illness Cover *you* cannot guarantee *your* premiums
- *Fixed term* for *your plan account* or a *whole of life plan account* with no Serious Illness Cover, *you* can choose to have guaranteed premiums for Disability Cover and any of the covers in *your plan account*

You can also have a guaranteed premium for Family Income Cover and Income Protection Cover. However, *you* need to choose this option separately.

Your plan schedule shows whether any of *your* covers have guaranteed premiums.

If *you* choose guaranteed premiums, *we* work out *your* premiums by making assumptions that cover the full duration of the *plan*.

Even if *you* choose guaranteed premiums, the amount *you* pay will not necessarily stay the same for the duration of the *plan*. *Your* premiums could change:

- If *you* change *your plan*
- If *you* make a claim
- Depending on *your Vitality Status* (See provision E); or
- If *your* premiums are indexed

D3. Reviewable premiums

We will review *your* premiums periodically if *your plan schedule* shows that any of *your* covers have reviewable premiums.

D3.1 How we review your premiums

When *we* review *your* premiums, *we* do not look at *your* individual circumstances such as *your* health. *We* look at the premiums *we* are charging to everyone *we* insure.

We will look at:

- *Our* claims experience, and the experience of the whole insurance industry
- Medical trends and advances, including treatments and diagnostic techniques that could affect *our* claims experience for any of the covers that *we* provide
- The potential future costs to *us* of settling claims
- Changes in applicable law or taxation

A review will affect each type of cover in *your plan* separately. It will apply to the full amount for each cover in *your plan*, including any changes *you* have made to *your* cover since *you* set *your plan* up. The date for each review will be based on the *start date* of the cover for each *person covered*, even if *you* have made later additions to the cover.

For some premiums, any change following a review could affect other covers in *your plan*. For more about this, see provision D1.

If *your* premium changes because of the *healthy living programme*, this does not count as a review.

D3.2 Reviewing premiums for a Whole of Life plan account

Unless *your plan* schedule shows that *you* have guaranteed premium rates *we* will review *your* premiums for each of the covers in *your whole of life plan account* on the tenth anniversary of that cover. *We* may then review them every year. However, if *we* change one of *your* premiums as a result of a review, *we* will not review that premium again for another ten years. The exceptions to this are:

- For Serious Illness Cover, *we* will also review the premium on the 70th birthday of each *person covered*. Even if *we* change the premium, *we* will then review it each subsequent year.
- For *Life Cover*, *we* will also review the premium on the 75th birthday of each *person covered*. Even if *we* change the premium, *we* will review it each subsequent year.

If *you* have a *joint life plan*, *we* will review the premiums for each *person covered* separately.

There is no limit on the amount *we* might increase or reduce *your* premium by after a review.

D3.3 Reviewing premiums for a fixed term plan account, Disability Cover, Family Income Cover and Income Protection Cover

If *you* did not choose guaranteed premiums on a *fixed term plan account*, Disability Cover, Family Income Cover or Income Protection Cover, *we* will review *your* premiums on the fifth anniversary of *your plan*. *We* may then review them every year.

However, if *we* change one of *your* premiums as a result of a review, *we* will not review that premium again for another five years. If *you* have a *joint life plan*, *we* will review the premiums for each *person covered* separately.

There is no limit on the amount *your* premium could increase or reduce by after a review.

D3.4 Telling you if your premium needs to change

If *your* premium needs to change as a result of a review, *we* will tell *you* at least one month before the date the change is due to take effect. *We* will also explain *your* options.

D3.5 Your options if your premium needs to change as a result of a review

This table shows *your* options if *your* premium needs to change as the result of a review.

If your premium needs to:	You can choose to:	What you need to do:
Increase	Accept the increased premium	*You* do not need to do anything
	Keep *your* current premium and have less cover	Tell *us* in writing within 30 days of receiving *our* notification. If *your* current premium is below *our* allowable minimum, *we* will ask *you* to increase *your* premium to the minimum level.
	Cancel *your* cover	For how to cancel a cover, see provision F
Decrease	Accept the decreased premium	*You* do not need to do anything
	Ask to keep *your* current premium and have more cover	Apply to *us* in writing within 30 days of receiving *our* notification. *We* may need to *Underwrite your* request.
	Cancel *your* cover	For how to cancel a cover, see provision F

D4. Changing your covers

There are several ways *you* can change *your* covers. *You* can:

- Add or increase covers
- Remove or reduce covers
- Remove a *erson covered* from a *joint life plan*
- Split a *joint life plan* into two *single life plans*
- Change the *fixed term* of *your* covers
- Change *your deferred period*
- Lower *your* premiums because of a change in *your* circumstances
- Remove Vitality Optimiser

We explain below when and how *you* can make these changes.

If *you* want to make a change, *you* need to make it on the same day of the month as the *start date* of *your plan*. If *your plan* is suspended, *you* cannot make any changes to it.

D4.1 Adding or increasing covers

You can apply to add covers to *your plan*, or increase *your* existing levels of cover, at any time – subject to the restrictions explained below. *We* will increase *your* premium based on the increase in cover and the age of the *person covered* at the time the change is made.

Any addition or increase *you* make will be subject to *our* terms and conditions when *you* make the change.

Restrictions on adding or increasing covers

- *You* cannot make an addition or increase if it would be beyond the limits that apply to *your plan*
- *We* may subject *your* request for an addition or increase to *underwriting*
- *You* cannot add or increase covers if *you* are *resident* outside the *United Kingdom*
- *You* cannot add *Life Cover* if Serious Illness Cover is the only cover in *your plan account.* For *joint life plans, you* also cannot add *Life Cover* if *we* have previously paid *you* a claim for *Life Cover*.

- *You* cannot increase *your* Income Protection Cover or Family Income Cover while *we* are paying *you* a *benefit* under that cover
- If *your plan* premiums are being waived at the time *you* ask to add or increase covers, *you* will need to pay the premium for the increased amount

D4.2 Removing or reducing covers

You can apply to remove covers from *your plan*, or reduce *your* existing levels of cover, at any time. *You* can do this as long as *you* leave at least one of the following covers in *your plan*:

- *Life Cover*
- Serious Illness Cover
- Income Protection Cover

We will reduce *your* premium to take into account:

- What it would have been if *you* had the reduced cover when that cover started
- Any premium reviews *we* have carried out
- Any changes to *your* premium due to *your Vitality Status*

Reducing a cover might also reduce other covers in *your plan*. *Your* premiums might also change. For more about this, see provision D1. For information on how *your* premium will change if *you* remove Vitality Optimiser see provision D4.7.

If *your plan* premium drops below the minimum *plan* premium *we* allow, *we* may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher premium.

D4.3 Removing a person covered from a joint life plan

If *you* have a *joint life first death plan*, *you* can remove either of the people covered from it. If *you* do, the *plan* will continue as a *single life plan* for the remaining *person covered*, as long as that person has at least one of the following covers:

- *Life Cover*
- Serious Illness Cover
- Income Protection Cover

If the remaining person has:

- *Life Cover*, this will set the amount of the *plan account*. Their Serious Illness Cover cannot be higher than this amount
- Serious Illness Cover but no *Life Cover*, this will set the amount of the *plan account*
- Neither *Life Cover* nor Serious Illness Cover, they will not have a *plan account*

When *we* remove a person from *your plan*, *we* will remove all the covers from the *plan* that apply to that person. *We* will recalculate the premium payable as the amount that would have applied if the *plan* had originally been taken out as a *single life plan*, adjusted for any premium reviews or changes in premium as a result of *your Vitality Status* or indexation premium increases.

If *your* new *plan* premium drops below the minimum *plan* premium *we* allow, *we* may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher *plan* premium.

We will also:

- Remove any Waiver of Premium on Death
- Remove any Waiver of Premium on Serious Illness if the only remaining covers are *Life Cover* and Serious Illness Cover at 100%, or just Serious Illness Cover at 100%
- Reduce any remaining Optional Serious Illness Cover for Children so that it does not exceed the total amount in the *plan account*
- Adjust the Minimum Protected Account option, if *you* have it, so that it reflects the new value of the *plan account*
- Remove the Minimum Protected Account option altogether if *Life Cover* is the only cover left in the *plan account*

This option is not available on *joint life second death plan*.

D4.4 Splitting a joint life plan into two single life plans

You can split a *joint life first death* into two separate *single life plans*. The new *plans* can have the same covers, levels of cover and term as the existing *joint life plan*.

We will adjust the *plan premium* for each *plan*, to take into account:

- What it would have been if *you* had taken out a *single life plan* when *your plan* started
- Any premium reviews *we* have carried out
- Any changes to *your* premium due to *your Vitality Status*
- Any premium increases as a result of indexation

If neither person wants to add to or increase a cover or increase the *date of expiry* they had under the original *plan*, *we* will not need any additional medical evidence.

If either person's new *plan* premium drops below the minimum *plan* premium *we* allow, *we* may ask them to maintain it at a higher level. If *we* do, they will receive a level of cover that reflects that higher *plan* premium.

We will also:

- Remove any Waiver of Premium on Death
- Remove any Waiver of Premium on Serious Illness if the remaining covers are *Life Cover* and Serious Illness Cover at 100%, or just Serious Illness Cover at 100%
- Reduce any remaining Optional Serious Illness Cover for Children so that it does not exceed the total amount in the *plan account*
- Adjust the Minimum Protected Account option, if *you* have it, so that it reflects the new value of the *plan account*
- Remove the Minimum Protected Account option altogether if *Life Cover* is the only cover left in the *plan account*

We will include any remaining Optional Serious Illness Cover for Children in the *plan* of whoever was the *first person covered* in the original *plan*. If *you* would like us to include it in the other person's *plan*, or would like us to split it evenly between the two plans, *you* will need to write to us. The maximum cover under Optional Serious Illness Cover for Children for any one child across all plans held with us is £100,000.

The two new plans will be subject to all the provisions that applied to the original *plan*. This option is not available on a *joint life second death plan*.

D4.5 Changing the fixed term of your covers

You can change the *fixed term* of *your* covers at any time, as long as *your* new *plan* premium does not drop below *our* minimum allowable *plan* premium. If *you* have a decreasing *plan account*, *you* cannot change the term of individual covers within it; all the covers must have the same term.

If *you* reduce a *fixed term*, *your* new *plan* premium will be the same as or less than the one *you* are currently paying.

If *you* want to increase a *fixed term*, *we* will need to underwrite *your* request. *Your* new premium will be calculated using the rates applicable at the time of the change.

If a *fixed term* cover pays a lump sum, *you* cannot extend the *fixed term* beyond the *date of expiry* of *your plan account*.

If *you* make a change to certain covers, other covers in *your plan* could be affected. For more about this, see provision D1.

Changing your deferred period

You can change *your* deferred period for any cover that has one, except Disability Cover.

If *you* increase *your* deferred period, *your* new premium will be the same as or less than the one *you* are currently paying. If *you* want to decrease *your* deferred period, *we* will need to underwrite *your* request.

D4.6 Lowering your premiums because of a change in your circumstances

If a change in *your* circumstances could lead to a lower premium, it is in *your* interest to tell *us*. *We* will then offer *you* a new premium, as long as:

- *You* complete a declaration of health form, if *we* ask *you* to, that confirms *you* are in good health
- The new *plan premium* is lower than *your* current one

Examples of changes in circumstances that *we* will consider are giving up smoking or stopping hazardous activities.

D4.7 Removing Vitality Optimiser

If *your plan schedule* shows that *you* have chosen Vitality Optimiser, *you* can apply to remove this option at any time.

You are only eligible for Vitality Optimiser under this *plan* if *you* also have *Vitality Plus*. For more information on *Vitality Plus* please see *your* separate terms and conditions. If *your Vitality Plus* is cancelled, Vitality Optimiser will be removed from *your plan*.

If Vitality Optimiser is removed *your* premiums will change as follows:

If *you* want to keep *your* premium at the same level until the *date of expiry*, the level of cover will be reduced. *We* will calculate the new level of cover for each of the covers in *your plan*.

If *you* want to keep *your benefit* at the same level until the *date of expiry*, the premium will increase. *We* will calculate the premium for each of the covers in *your plan* based on *your* age and *our* rates at the time *you* remove Vitality Optimiser.

If *you* remove Vitality Optimiser from *your plan*, *your Vitality Plus* will remain in place, unless *you* separately cancel it.

D5. Claiming a benefit

This provision explains:

- How and when *you* can claim a *benefit* under *your plan*
- Who *we* will pay the *benefit* to
- The exclusions to claiming a *benefit*

D5.1 Who we will pay the benefit to

We will pay the *benefit* to the person legally entitled to receive it.

D5.2 Telling us about a claim

If a claim needs to be made under *your* cover, *we* need *you* to tell *us* as soon as possible. *We* describe the exact notification requirements for each type of cover in the individual cover sections of these *plan* provisions.

D5.3 What we need before we can settle a claim

For a *Life Cover* claim or Family Income Cover claim, *we* will need proof that the *person covered* has died. If *your plan* is arranged on a *joint life second death* basis *we* will need proof that both people covered have died. *We* may also need proof of the age(s) of the person(s) covered, if *we* have not already received it.

If *your plan* has been placed in trust, *we* will require a copy of the original trust deed. Please ensure that the trustees keep this in a safe place.

For any claim under either Core or Optional Serious Illness Cover for Children or Education Cover, *we* will need to see a birth certificate. *We* may also need proof of *your* relationship to the child if their birth certificate does not provide this.

For each type of cover, *we* describe what *we* need before *we* can settle a claim in the individual cover sections of these *plan* provisions.

For the purposes of complying with *our* Anti-Money Laundering obligations, *we* may require the claimant to give us satisfactory proof of their identity.

D5.4 Confirming that you are incapacitated

For some types of cover, *we* may need to assess whether *you* are incapacitated. To make this assessment, *we* will need an appropriate medical specialist to confirm that *you* have an ongoing inability to perform a series of *functional activity tests*. *You* must need the help or supervision of another person and be unable to

perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. *We* explain these tests below. The individual cover sections in these provisions will explain which tests are relevant to a claim under that cover.

There are two types of *functional activity tests:*

- Tasks designed to assess whether *you* can look after yourself (*we* also refer to these as activities of daily living in these *plan* provisions)
- Work tasks

Types of functional activity tests

Tasks designed to assess whether you can look after yourself ever again (also called activities of daily living)	How we define this activity
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.

Work tasks	How we define this activity
Walking	The ability to walk more than 200 metres on a level surface
Climbing	The ability to climb up a flight of 12 stairs and down again, using the handrail if needed
Lifting	The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table
Bending	The ability to bend or kneel to touch the floor and straighten up again
Getting in and out of a car	The ability to get into a standard saloon car, and out again
Writing	The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard

For the above definitions, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

Knowing which tests are relevant to your claim

The specific tests *you* need to take will depend on the cover *you* are claiming under.

Serious Illness Cover

If *you* are aged between 16 and 65 when *you* make *your* claim *we* will assess *your* claim based on whether *you* can perform activities of daily living or work tasks. When *we* assess whether *you* are incapacitated there will be no accumulation of the number of failures for tasks designed to assess whether *you* can look after yourself and work tasks. *We* will assess each set of tasks separately and after *you* have taken the tests *we* will use the results that are most favourable to *you* to assess whether *you* are incapacitated.

If *you* are aged 65 or over when *you* make *your* claim *we* will assess *your* claim based on whether *you* can perform activities of daily living.

Income Protection, Waiver of Premium on Incapacity or Disability Cover

If *you* have the special definition of incapacity or *you* are a houseperson then *we* will assess *your* claim based on whether *you* can perform activities of daily living.

The tests *you* will need to take are also explained in the individual cover sections of these provisions.

For any claim, *your* inability to perform a particular activity needs to have been caused by a condition that arose after the *start date* of *your plan*."

D5.5 Making a claim when you are abroad

If *you* are outside the *United Kingdom*, the Channel Islands or the Isle of Man when *you* make a claim for anything other than *Life Cover*, *we* will need an *appropriate medical specialist* to confirm all *your* information and *your* diagnosis. *We* will consider information from *appropriate medical specialists* in *permitted countries*.

D5.6 Exclusions

General exclusions

If the illness, condition or procedure *you* are claiming for is a consequence of an excluded condition, *we* will not pay any *benefit* under any of these covers:

- Serious Illness Cover
- Family Income Cover (payable on diagnosis of a serious illness)
- Family Income Cover (Serious Illness Cover for Children)
- Education Cover (payable on diagnosis of a Severity A serious illness)
- Education Cover (Serious Illness Cover for Children)
- Optional Serious Illness Cover for Children
- Core Serious Illness Cover for Children
- Disability Cover
- Income Protection Cover
- Mortgage Free Cover
- Waiver of Premium on Serious Illness
- Waiver of Premium on Incapacity
- LifestyleCare Cover

This applies to the excluded conditions in the definitions of named conditions or any exclusions that were included in *your* acceptance terms at the start of the *plan*.

For the covers listed below *we* will not pay any benefits in the following circumstances:

Unreasonable failure to follow medical advice

Unreasonable failure to seek or follow medical advice.

- Serious Illness Cover
- Family Income Cover (payable on diagnosis of a serious illness)
- Family Income Cover (Serious Illness Cover for Children)
- Education Cover (payable on diagnosis of a Severity A serious illness)
- Education Cover (Serious Illness Cover for Children)
- Optional Serious Illness Cover for Children
- Core Serious Illness Cover for Children
- Disability Cover
- Mortgage Free Cover
- Waiver of Premium on Serious Illness
- Waiver of Premium on Incapacity
- LifestyleCare Cover

Exclusions for Life Cover, Family Income Cover and Education Cover

Exclusions for suicide

We will not pay a claim for *Life Cover*, Family Income Cover or Education Cover if one of the people covered dies as a result of suicide within 12 months of:

- The *start date* of the *Life Cover*, Family Income Cover or Education Cover
- The date they were added to the *plan*
- The date the *plan* was re-instated if it was suspended because *your plan* premiums were not paid

If *you* have increased the *Life Cover* or Family Income Cover under *your plan*, and one of the people covered dies as a result of suicide within 12 months of the increase, *we* will not normally pay the additional amount as part of the claim.

Exclusions for Serious Illness Cover, Family Income Cover (payable on diagnosis of a serious illness) and Education Cover (payable on diagnosis of a severity A serious illness)

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Serious Illness Cover or Family Income Cover (payable on diagnosis of a serious illness) or Education Cover (payable on diagnosis of a severity A serious illness).

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* Serious Illness Cover, Family Income Cover or Education Cover. If *we* have, and *you* make a claim for another body system category, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that the illness is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to us when *you* applied for cover.

Exclusions for LifestyleCare Cover

Appendix 4 explains the exclusions that apply to claims for specific illnesses under LifestyleCare Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 4. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* LifestyleCare Cover. If *we* have, and *you* make a claim, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that *your* illness is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to us when *you* applied for cover.

Exclusions for Mortgage Free Cover and Immediate Cover

Mortgage Free Cover and Immediate Cover provide limited *Life Cover* or Serious Illness Cover or both, depending on *your plan*. For more about these, see provision C4, B1.4, C5.6 and C6.7. The exclusions that apply to *Life Cover* and Serious Illness Cover, Family Income Cover and Education Cover apply in the same way to Mortgage Free Cover and Immediate Cover, as appropriate.

Exclusions for Optional Serious Illness Cover for Children, Core Serious Illness Cover for Children, Family Income Cover (Serious Illness Cover for Children) and Education Cover (Serious Illness Cover for Children)

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Optional Serious Illness Cover for Children and Core Serious Illness Cover for Children, Family Income Cover (Serious Illness Cover for Children) and Education Cover (Serious Illness Cover for Children).

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

Exclusions for Disability Cover

Appendix 3 explains the exclusions that apply to Disability Cover claims. These exclusions apply even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* Disability Cover. If *we* have, and *you* make a claim for another body system category, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that the illness is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to us when *you* applied for cover.

If the person making the claim is:

- Permanently based outside the *permitted countries*, *we* will not pay any *benefit* under Category C Disability Cover
- Temporarily based outside the *permitted countries*, *we* will only pay a maximum of three consecutive *benefit* payments for Disability Cover

Exclusions under Waiver of Premium on Incapacity

If the person making the claim is temporarily based outside the *permitted countries*, *we* will only waive a maximum of 12 months' *plan* premiums for Waiver of Premium on Incapacity.

Exclusions under Waiver of Premium on Death

We will not waive a *plan* premium under Waiver of Premium on Death if one of the people covered dies, as a result of suicide, within 12 months of:

- The *start date* of the cover for that person
- The date the *plan* was re-instated if it was suspended because *your plan* premiums were not paid

Exclusions for Guaranteed Insurability options

If *you* used *your* Guaranteed Insurability options to increase or add to *your* cover, *we* will not pay a claim if the illness or disability causing the claim:

- Was known when *you* used *your* Guaranteed Insurability options, or
- Would have resulted in us paying a *benefit* before *you* used *your* Guaranteed Insurability options, or
- Would have been in the deferred period of an Income Protection Cover claim before *you* used *your* Guaranteed Insurability options

D6. How a joint life first death plan continues if one person dies

If one of the people covered on a *joint life first death plan* dies *we* will remove all the covers that apply to the person who has died from the *plan*.

The *plan* will continue for the surviving person as described below

D6.1 How the premiums change

For the surviving *person covered*, *we* will recalculate their *plan* premium:

- Based on what they would have been if *you* had originally applied for a *single life plan* instead of a *joint life plan*.
- Using their age, the term and the premium rates that applied when any covers were added or changed.
- Allowing for:
  - Any premium reviews of *your joint life plan*
  - Any changes *you* made to *your joint life plan*
  - Any annual changes to *your* premium as a result of *your Vitality Status* or indexation

If the new *plan* premium drops below the minimum *plan* premium *we* allow, *we* may ask the surviving person to maintain it at a higher level. If that happens, the surviving person will receive a level of cover that reflects that higher *plan* premium.

If the person who died had Waiver of Premium on Death, *we* will stop charging premiums for the surviving person. For more about Waiver of Premium on Death, see provision C9.

D6.2 How the covers change

For the surviving *person covered*, the following covers will continue without any changes to the *benefit*:

- Disability Cover
- Income Protection Cover

However, *we* will:

- Remove *Life Cover*, Family Income Cover or Education Cover for the remaining person if *we* have made a *Life Cover* payment, including for a *terminal illness*
- Reduce any remaining Optional Serious Illness Cover for Children so that it does not exceed the amount of any remaining Serious Illness Cover
- Remove Optional Serious Illness Cover for Children if there is no Serious Illness Cover left in the *plan account*.
- Remove the Minimum Protected Account option if there is no Serious Illness Cover left in the *plan account*
- Remove any Waiver of Premium on Death
- Remove Waiver of Premium on Serious Illness if Serious Illness Cover is the only cover remaining

If the surviving person wants to increase their cover, *we* will need to underwrite their request.

If the surviving person wants further *Life Cover*, Family Income Cover or Education Cover they will need to set up a new *plan*. *We* will base any new *Life Cover*, Family Income Cover or Education Cover on the age of the person and the premium rates that apply when they set up the new *plan*. *We* may also need to subject the request to limited *underwriting*. The premium for any new *Life Cover*, Family Income Cover or Education Cover will not be covered by any Waiver of Premium on Death.

D7. How a joint life second death plan continues if one person dies

If one of the people covered on a *joint life second death plan* dies the policy will continue and the *plan* premium will continue at the same level. If the person who died had Waiver of Premium on Death, *we* will stop charging *plan* premiums. For more about Waiver of Premium on Death, see provision C9.

E. How Vitality rewards you for being healthy

The *healthy living programme* helps *you* improve *your* health – and saves *you* money at the same time. It encourages *you* to be healthy by offering all adults on the *plan* discounts with a range of health partners. By taking steps to look after *your* health, *you* can increase *your Vitality Status*. To begin with, this is Bronze. Then as *you* make an effort to be healthy, *you* can increase *your* Status to Silver, Gold or even Platinum. The higher *your* status, the greater the discounts and rewards. Some Vitality rewards and benefits are only available to those who are over the age of 18.

Vitality Plus

You are only eligible for Vitality Optimiser under this *plan* if *you* also have *Vitality Plus*. If *your Vitality Plus* is cancelled, Vitality Optimiser will be removed from *your plan* and *your* premiums will change as described in provision C4.5. If *you* remove Vitality Optimiser from *your plan*, *your Vitality Plus* will continue in place, unless *you* separately cancel it. Please refer to the separate terms and conditions for more information on the *healthy living programme*.

You can choose to include *Vitality Plus* on *your plan* from the *plan*'s *Start date*, or within three months of the *plan*'s *Start date*. Outside of this period, *Vitality Plus* can only be added at each anniversary of the *plan*.

If *you* cancel *Vitality Plus you* can apply to add it again at a future *plan anniversary*, provided that *you* do this at least six months after the date *Vitality Plus* was cancelled. However, *you* may not be able to add Vitality Optimiser to *your plan* again after it has been removed.

E1. Your Vitality Status

When *you* take steps to look after *your* health, *you* could improve *your Vitality Status*. There are four *Vitality Statuses*:

Vitality status	Effort threshold
Bronze	*You* start at this level on *your plan*'s *Start date*, or when *you* are added to the *plan*. *You* may return to this level on each anniversary of *your plan*, depending on the *Vitality Status* rules at that time
Silver	*You* will be able to achieve Silver *Vitality Status* between *plan* anniversaries if *you* make a moderate but regular effort to look after *your* health
Gold	*You* will be able to achieve Gold *Vitality Status* between *plan* anniversaries if *you* make a strong and regular effort to look after *your* health
Platinum	*You* will be able to achieve Platinum *Vitality Status* between *plan* anniversaries if *you* make a very strong and regular effort to look after *your* health

E2. How your Vitality Status affects your premiums

E2.1 Vitality Optimiser

With Vitality Optimiser *your* initial *plan* premium starts lower than an equivalent *plan* that does not include Vitality Optimiser and *your plan* premium may change on each *plan anniversary*: *Your plan* schedule indicates whether *you* have chosen Vitality Optimiser.

We will recalculate *your plan* premium on each *plan anniversary* until the earliest of:

- The *date of expiry* of each cover, and
- The *plan anniversary* immediately before *your* 80th birthday (for *joint life plans* this will be based on the age of the younger of the two people covered)

E2.1.1 How we calculate the change in your plan premium

Where *you* have chosen Vitality Optimiser, *we* will recalculate *your plan premium* based on *your Vitality Status* at each *plan anniversary*. The following table shows *you* how *your plan premium* can change:

Vitality status	Premium change
Bronze	+2%
Silver	+1%
Gold	No change
Platinum	-1%

If the premiums for *your* covers change, the premiums for any waiver or premium cover could also change (see provision D1).

We will apply any change in premium as a result of Vitality Optimiser after any changes as a result of indexation or a review of *your* premiums. For more about how indexation could affect *your* premiums, see provisions D1.3. For more about how a review of *your* premiums could affect *your* premiums, see provision D3.

We will allow your plan premium to reduce below our normal allowable minimum if the reduction is a result of Vitality Optimiser.

E2.1.2 Vitality Plus

You are only eligible for Vitality Optimiser under this *plan* if *you* also have *Vitality Plus*. If *your Vitality Plus* is cancelled, Vitality Optimiser will be removed from *your plan* and *your* premiums will change as described in provision C4.5. If *you* remove Vitality Optimiser from *your plan*, *your Vitality Plus* will continue in place, unless *you* separately cancel it. Please refer to the separate terms and conditions for more information on the *healthy living programme*.

You can choose to include *Vitality Plus* on *your plan* from the *plan's start date*, or within three months of the *plan's start date*. Outside of this period, *Vitality Plus* can only be added at each anniversary of the *plan*.

If *you* cancel *Vitality Plus you* can apply to add it again at a future *plan anniversary*, provided that *you* do this at least six months after the date *Vitality Plus* was cancelled. However, *you* may not be able to add Vitality Optimiser to *your plan* again after it has been removed.

E2.2 Premium Discounts

If *your plan* includes Vitality Optimiser, Premium Discounts will not apply to *your plan*. *Your plan* schedule will indicate whether *you* have chosen Vitality Optimiser. If *your plan* does not include Vitality Optimiser, Premium Discounts will apply.

If *your plan* includes Premium Discounts *your plan premiums* may decrease at each *plan anniversary*.

How we calculate the decrease in your plan premium

We will recalculate *your plan premium* based on *your Vitality Status* at *plan anniversary*. The following table shows *you* how *your plan premium* can change:

Vitality status	Premium change
Bronze	No change
Silver	-1%
Gold	-1.5%
Platinum	-3%

If the premiums for *your* covers change, the premiums for any waiver or premium cover could also change (see provision D1).

We will apply any change in premium because of *your Vitality Status* after any changes as a result of indexation or a review of *your* premiums. For more about how indexation could affect *your* premiums, see provision D1.3. For more about how a review of *your* premiums could affect *your* premiums, see provision D3.

We will allow *your plan premium* to reduce below *our* normal allowable minimum if the reduction is a result of Premium Discounts.

E3. The Vitality commitment

The *healthy living programme* will give *you* access to discounts and rewards for the duration of *your plan*. Because *your plan* could last many years,the discounts and rewards offered to *you* may need to be revised from time to time.

As new opportunities and technologies emerge, the way *you* are rewarded for being healthy will change over time. The discounts and rewards depend on relationships with third party providers and the range of services these providers offer.

Please refer to the separate terms and conditions for more information on the *healthy living programme*. This includes changes to the way *you* are awarded *healthy living programme* points, the eligible activities, incentives and partners offered, and how *your Vitality Status* could change as a result.

If *you're* not satisfied with the changes, *you* may cancel *your plan* in accordance with the information in provision F2.

If *you* would like discounts of the incentives and rewards that are in effect at any time, *you* can call *us* on 0345 601 0072.

F. General terms and conditions

F1. When your plan ends

Your plan will end when the first of the following occurs:

- The death of the *person covered* in a *single life plan*, or the death of one *person covered* in a *joint life first death plan* (see provision D6), or both *persons covered* in a *joint life second death plan* (see provision D7)
- *Your plan account* reduces to zero after a claim, and *you* also do not have the Minimum Protected Account or Protected *Life Cover* options, or any Disability Cover, Income Protection Cover or LifestyleCare Cover Protector as part of *your plan* at that time
- All covers under *your plan* have reached their *date of expiry*

F2. When we can make changes to your plan

We may change the terms of *your plan* for any of the following reasons:

a. To respond, in a proportionate manner, to changes in the way *we* administer plans of this type.

b. To respond, in a proportionate manner, to changes in technology or general practice in the life and pensions industry.

c. To respond, in a proportionate manner, to changes in taxation, the law or interpretation of the laws of England and Wales, decisions or recommendations of an Ombudsman, regulator, *UK* Court, the European Court of Justice, or similar person, or any code of practice with which *we* intend to comply (with the exception of Guaranteed Premiums, unless such change in required by the Financial Services Regulator from time to time).

If *we* consider any variation to these conditions is to *your* advantage or is necessary to meet regulatory requirements, *we* may make the change immediately and will tell *you* at a later date.

We will tell *you* in writing of any change *we* consider is to *your* disadvantage (other than any change necessary to meet regulatory requirements) at least 60 days before the change becomes effective, unless it is not possible for *us* to do this, in which case *we* will give *you* as much notice as *we* can.

F3. Cancelling your plan

When you may cancel your plan

You can cancel *your plan* at any time.

If *you* cancel it within 30 days of receiving *your plan* details, *we* will refund *your plan premium*, as long as *you* have not made a claim. To do this, please contact *us* by post at:

VitalityLife, Stirling, FK9 4UE
Or by phone on: 0345 601 0072

If *you* cancel *your plan* after 30 days, *we* will not refund *your plan premium*. *You* can either contact *us* to cancel it, or just cancel *your* direct debit.

When we may cancel your plan

FRAUD

We may cancel *your plan* if *you*:

- Make any untrue statements to *us*
- Fail to disclose any material facts relevant to *your plan* or a claim
- Act fraudulently in any other way

If *we* cancel *your plan* because of fraud, *your plan* will become void. If this happens, *we* will return all the *plan* premiums *you* have paid.

OTHER REASONS

The Financial Conduct Authority (FCA) publishes a Conduct of Business Sourcebook that sets out the rules to do with when it is reasonable for a company to cancel a *plan* like this one. *We* will apply these rules to *your plan*. *We* will apply these rules to the *plan* as a whole, rather than to each type of cover separately.

The FCA may update their rules during the life of *your plan*. For the latest rules, please contact the FCA at consumer.queries@fca.org.*uk* or by phoning 0800 111 6768. *You* can also download the Conduct of Business Sourcebook at www.fca.org.uk.

F4. Cash value

Your plan does not have any cash value.

F5. Mis-statement of age

If any *person covered* under the *plan* did not state their age accurately when they applied, *we* will change the terms of the *plan* in a way that *we* consider to be just and reasonable.

F6. Assignment

If *you* assign any of *your* legal rights under the *plan* to someone else, including changing who is entitled to the *plan*, *you* need to give us written notice. Please do this by writing to: Vitality Life Limited, Stirling, FK9 4UE.

We will not change who is entitled to benefits under *your plan* until *we* receive this notice.

F7. Currency

All payments *we* make to *you* and all payments made to *us* must be in the lawful currency of the *United Kingdom*.

F8. Impact on means tested benefits

Payments of benefits from this *plan*, including LifestyleCare Cover may affect *your* entitlement to receive means tested benefits from the government or *your* local authority. *We* recommend that *you* seek professional advice if *you* are concerned about this.

F9. Complaints

Our commitment to you

We understand that sometimes things can go wrong. *You* are important to us, so if *you* have reason to complain *we* want to know. *We* will try to resolve *your* complaint quickly in a professional and helpful way.

How to contact us

You can contact us by letter, phone or email. It will help if *you* give *your* name, address and *plan* number. Either send us a secure message via *our* Member Zone, or call us on the number shown on *your* certificate of insurance. Or *you* can write to us at:

VitalityLife Customer Services, Stirling, FK9 4UE

How we will deal with your complaint

The time it takes to resolve *your* complaint will depend on how complex it is and how much investigation *we* have to do. *We* will always try to resolve *your* complaint as quickly as possible, keeping *you* informed of *our* progress.

We will:

- Acknowledge *your* complaint promptly
- Tell *you* who is dealing with *your* complaint so contacting us is easier. This person will be a trained complaint handler not directly involved with *your* case before the complaint
- Fully investigate *your* complaint and send *you* a detailed report about *our* findings. *We* will clearly explain the reasons behind *our* decision and what action *we* will take to put things right, if appropriate
- Update *you* every four weeks if the investigation is not complete and explain the reason for the delay

What to do if you are still not happy with the outcome

We want to resolve complaints to *your* satisfaction whenever possible. If *we* cannot reach agreement with *you*, *you* can refer *your* complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms. If *you* are going to ask the Financial Ombudsman to review *your* case, *you* should do so within six months of *our* giving *you our* final decision on *your* complaint.

You can contact the Financial Ombudsman in the following ways:

The Financial Ombudsman Service, Exchange Tower, London, E14 9SR
Enquiry line: 0800 023 4567
Fax number: 020 7964 1001
Website: www.financial-ombudsman.org.UK
Email: complaint.info@financial-ombudsman.org.UK

If *you* contact the Financial Ombudsman Service, this does not affect *your* right to take legal action if *you* are dissatisfied with and do not accept the outcome of the review.

F10. If we cannot meet our obligations

We are covered by the Financial Services Compensation Scheme. This means that *you* may be entitled to financial help up to 90% of the value of *your* loss if *we* cannot meet *our* obligations.

For more information about the Financial Services Compensation Scheme, please contact them by email: enquiries@fscs.org.uk or by phone: 0800 678 1100.

F11. Law

We will govern and interpret *your plan* according to the applicable laws and regulations of England and Wales. Where *we* are required to change *your plan* under these laws and regulations *we* will do so. *Your plan* will be subject to the exclusive jurisdiction of the English courts.

Anyone who is not party to this contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this *plan*. *We* include the planholder and any other *person covered* as party to the *plan*.

F12. Data Protection Notice

Why should you read this notice?

We think it's important for all *our* customers to be made aware of what information Vitality Group* holds about them and to have the reassurance of knowing that *we* comply with the Data Protection Act.

How we use your personal information

The Vitality Group will use *your* information (including information provided about *your* dependants) for *underwriting* and administration purposes. By taking out a *plan* with us, *you* agree to us processing *your* personal information and sensitive personal information (e.g. health information). *We* will also use *your* information for statistical data analysis, management information and fraud prevention purposes.

If *you* wish to make a claim on *your plan*, this will inevitably mean that *you* will have to provide us with information regarding *your* medical condition which *we* will then process in order to administer *your* claim. Calls to VitalityLife may be recorded and may be monitored.

Who we may give personal information to

We may disclose *your* personal information to *our* business associates, agents and service providers for the purposes above. *Your* information may be processed by service providers in a country outside the European Economic Area, which may not have the same standard of data protection as in the *UK*. *We* will ensure appropriate safeguards are in place to protect *your* information. *We* will pass *your* information to any legal or regulatory body if required to do so. *We* may also use *your* information or give it to others, for research, statistical purposes or to improve *our* services, but *we* will remove *your* name and address from this first.

If *you* have appointed an insurance adviser *we* will send them copies of correspondence relating to the *plan* and any renewal documentation. *We* may disclose information about a claim to them, although no medical information will be provided without *your* consent. *Your* information, and that of others also covered by the *plan*, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Processing claims

In the event of a claim *we* may have to give some information to those involved in *your* treatment or care, and/or *your* representative (if *you* have chosen one). This will be done confidentially.

An insured dependant over the age of 16 has the right to confidentiality in relation to their claims and information. In order for them to exercise this right please contact customer services. If *you* have another insurance *plan* that covers the same costs that *you* are claiming from *us*, then *we* may also disclose *your* relevant personal information to that other insurer so that *we* can ensure *we* only pay *our* proportion of the claim.

VitalityLife's marketing policy and your right to opt out from future communications

The Vitality Group*, *our* business associates, service providers and agents may use *your* personal information to inform *you* of other services and products that may be of interest to *you* by telephone, post, email or text. If *you* haven't already, *you* can exercise *your* right to opt out of communications about products and services not directly related to *your plan* by contacting *our* customer services team.

Obtaining a copy of the information we hold about you

You have the right to request a copy of the information *we* hold about *you* (for which *we* may charge a fee) and to have any inaccurate information corrected by writing to *us* at the below address. Where information has been supplied by a medical practitioner, *you* should be aware that *we* need their consent before *we* can supply this to *you*, or alternatively *you* can request such information direct from the practitioner.

Data Protection Officer
Vitality Corporate Services Limited
Marshall Point
4 Richmond Gardens
Bournemouth
BH1 1JD

Disposal of information

We will continue to hold information about *your plan* for a reasonable period of time after it has ended. *We* will then dispose of *your* personal information in a responsible way to maintain *your* confidentiality.

Changing this Data Protection Notice

This Data Protection Notice may change from time to time and *you* should review the contents regularly. *We* will notify *you* of any changes where *we* are required to do so by law.

* The Vitality Group includes Vitality Health Limited and Vitality Health Insurance Limited, both trading as VitalityHealth, and Vitality Corporate Services Limited trading as VitalityHealth and/or VitalityLife.

G. Definitions

Acceptance letter
The letter *we* send *you* when *we* accept the application for a *plan* that names *you* as a *person covered*. This letter includes the terms of the *plan*, and any special conditions.

Activities of daily living (also referred to as *tasks designed to assess whether you can look after yourself*)
A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4.

Adoption
For a *single life plan*, the legal *adoption* of a child or children by the *Person Covered*.

For a *joint life plan*, the legal *adoption* of a child or children by both people covered.

Alcohol or drug abuse
Inappropriate use of alcohol or drugs, including but not limited to:

- Drinking too much alcohol
- Taking controlled drugs as defined by the Misuse of Drugs Act 1971, unless they are legally prescribed
- Taking an overdose of drugs, whether legally prescribed or not

Appropriate medical specialist
Someone who is:

- A medical consultant or equivalent at a hospital in the *United Kingdom* or any of the *permitted countries*
- A specialist appropriate to the cause of the claim
- Registered in the *United Kingdom* or any of the *Permitted countries*
- Not related by blood or *marriage* to the person or people covered
- Accepted by *our* Chief Medical Officer

Benefit
Money *we* pay to *you* if *you* make a successful claim under the *plan*.

Body system category
The category of serious illnesses that affect a particular body system, as outlined in the appendices.

Career break
A specific period that *you* take away from *your* own *occupation*, after which *you* intend to return to the same position.

Child/children
A person who:

- Is at least one month old.
- Has not reached the first *plan anniversary* after
- Their 18th birthday (23rd birthday if they are in full-time education)
- Is *your* natural child, adopted child or step-child
- Is looked after by, or financially dependent on, *you*

Childbirth
For a *single life plan*, the birth of a child or children to the *person covered*.

For a *joint life plan*, the birth of a child or children to both people covered.

Civil partnership
This applies to same sex marriages only, registered in terms of the Civil Marriages Act 2004. For a *single life plan*, a partnership between the *person covered* and another person, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

For a *joint life plan*, a partnership between the two people covered, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

Confirmed expenditure
This is the expenditure *we* will take into account when determining the Spend Protector *Benefit* which *we* will pay *you* in the event of a claim. *We* reserve the right to ask for documentary evidence at the time of *your* claim to enable us to calculate the amount of Spend Protector *Benefit* that *we* will pay *you*.

Documentary evidence includes, but is not limited to:

- Copies of bills for regular household expenditure.
- 3 months bank statements covering the period immediately before *your* claim.

If *we* have not received documentary evidence *we* will calculate the confirmed expenditure with reference to the most recent edition of the Family Spending survey, published by the Office for National Statistics.

Current benefit amount
The current *benefit* amount is the amount on which *we* would base any payments for a successful claim.

The current *benefit* amount can change over time. It can change because *you* have chosen an *Indexed account* or a *Decreasing account*. It can also change because *you* have made a successful claim or because *you* have asked *us* to change *your plan*.

The current *benefit* amount will be shown on the most recent *plan schedule*, servicing schedule or anniversary letter.

Date of expiry
The date a cover ends. The *date of expiry* of each of *your* covers is shown on the *plan schedule*.

Decreasing account
A *plan account* that decreases in value over the life of the *plan*. It decreases in the same way as a repayment mortgage that has a 10% annual equivalent interest rate. If the *plan* is *fixed term*, *you* can choose to have a *decreasing account*. If *you* have Disability Cover, *you* can also choose for it to decrease in this way.

Deferred period
The period during which an insured person must be ill or disabled before *we* will pay any *benefit*.

Employed/employment
Paid work under a contract of *employment* and paying Class 1 National Insurance contributions.

First person covered
For a *single life plan*, this is the insured person. For a *joint life plan*, this is the insured person with the highest amount of *Life Cover* when the *plan* starts. If there is no *Life Cover* in the *plan*, then it is the insured person with the highest amount of Serious Illness Cover or Income Protection Cover when the *plan* starts. If the amounts of these covers are the same for both people, the *first person covered* is the first person named on the application form.

Fixed term
The term of a cover is how long the cover lasts. A *fixed term* has a defined *date of expiry*.

Functional activity tests
Specific sets of everyday physical or functional activities that help to show how able someone might be to work or look after themselves. The two kinds of tests are called work tasks and activities of daily living (sometimes *we* refer to these as tasks designed to assess whether *you* can look after yourself ever again). *We* may refer to these activities if *you* make a claim to do with incapacity.

Full-time occupation
An *occupation* that normally takes up at least 16 hours a week on a regular basis.

Healthy living programme
The discounts and rewards available to all adults on the *plan*. These are provided by Vitality Corporate Services Limited. Please refer to the separate terms and conditions for more information.

Houseperson
A person who has a *full-time occupation* maintaining the home or caring for one or more dependants

Indexed account
A *plan account* that is designed to increase invalue on each *plan anniversary*. The increase is a percentage of the current *plan account*. This percentage will be equal to the *Retail Prices Index* that applies exactly five months before the *plan anniversary*, subject to a maximum of 10% and a minimum of 0%.

If *you* have Optional Serious Illness Cover for Children, Disability Cover or Income Protection Cover or Family Income Cover, *you* can also choose for any of these covers to increase in this way.

Irreversible
Cannot be reasonably improved by medical treatment and/or surgical procedures used by the National Health Service in the *United Kingdom* at the time of the claim.

Joint life plan
A *plan* that provides cover for two people. *We* call these two people the *first person covered* and the *second person covered*.

Joint life first death
A cover where the payment is made when the first of the *persons covered* dies or is diagnosed with a *terminal illness*.

Joint life second death
A cover where the payment is made when the last of the *persons covered* dies or is diagnosed with a *terminal illness*.

Level account
A *plan account* that stays the same unless *you* make a successful claim or change a cover. If *you* have Optional Serious Illness Cover for Children, Disability Cover or Income Protection Cover, *you* can also choose one or more of these covers to stay level in this way.

Life-changing event
A single identifiable event or condition that causes *you* to make a claim.

Marriage
For a single life plan, the marriage of the person covered, excluding re-*marriage* to a former spouse.

For a *joint life plan*, the *marriage* of the two people covered to each other, excluding their re-*marriage*.

Maximum monthly benefit amount
- Income Protection Cover
- Income Protection Cover and Category C Disability Cover combined

The actual amount depends on whether *you* have Short Term or Primary or Comprehensive Income Protection Cover. There is more about this in provision B3.2.

Non-invasive

A description of malignant or cancerous cells that have not spread into surrounding healthy cells or tissue.

Optimal therapy
Therapy that is currently recommended by:

- The National Institute for Clinical Excellence
- NHS Prodigy Guidelines
- British (or European) Cardiac or Hypertension Societies

Occupation

A trade, profession or type of work undertaken for profit or pay. It is not a specific job with any particular employer and is independent of location and availability.

Own occupation
The *full-time occupation you* had immediately before the start of the illness or injury (or incapacity for the purposes of Income Protection Cover).

Permanent/permanently
Expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

Permanent neurological deficit with persisting clinical symptoms
Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout *your* life. Symptoms that are covered include:

- Numbness
- Hyperaesthesia (increased sensitivity)
- Paralysis
- Localised weakness
- Dysarthria (difficulty with speech)
- Aphasia (inability to speak)
- Dysphagia (difficulty in swallowing)
- Visual impairment
- Difficulty in walking
- Lack of coordination
- Tremor
- Seizures
- Lethargy
- Dementia
- Delirium
- 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.

Permitted countries
Andorra, Australia, Austria, Belgium, Canada, Channel Islands, Denmark, Finland, France, Germany, Gibraltar, Greece, Isle of Man, Italy, Liechtenstein, Luxembourg, Malta, Monaco, The Netherlands, New Zealand, Norway, Portugal, Republic of Ireland, San Marino, Spain, Sweden, Switzerland, *United Kingdom* and United States of America.

Person Covered
The *first person covered* or the *second person covered* as appropriate.

Plan
The VitalityLife *plan*.

Planholder
The owner of the *plan*.

Plan account
An amount that determines how much *we* can pay out if *you* make a claim under *Life Cover* or Serious Illness Cover. There are special rules for simultaneous claims under Serious Illness Cover. For more about this, see provisions B2.4 to B2.6.

Plan anniversary
The anniversary of the *start date* of the *plan*.

Plan premium
This is the total premium payable in respect of the covers in your plan. This does not include any fee which you may be charged for *Vitality Plus* or Vitality Optimiser in accordance with the separate Vitality terms and conditions for the healthy living part of your plan.

Plan schedule
A document that shows:

- The cover or covers in the *plan*
- The amount of each cover
- The premium for each cover
- The *date of expiry* of each cover, unless the cover is *whole of life*
- Any special conditions

Pre-existing medical condition
A medical condition (whether or not a diagnosis was made or any symptoms were evident) which existed before any of these dates, as appropriate:

- The *start date* of the *plan*
- The *start date* of the relevant cover
- The relevant child reaching the age of one month (only for Optional Serious Illness Cover for Children, Core Serious Illness Cover for Children, Family Income Cover (Serious Illness Cover for Children) and Education Cover (Serious Illness Cover for Children)
- The legal *adoption* of the relevant child (only for Optional Serious Illness Cover for Children, Core Serious Illness Cover for Children, Family Income Cover (Serious Illness Cover for Children) and Education Cover (Serious Illness Cover for Children)
- The date that the *plan* is reinstated following non-payment of *plan* premiums

Pre-incapacity earnings
This depends on whether *you* are employed or self-employed, as explained below:

If you are employed

Your average gross monthly earnings for PAYE purposes from *your* own *occupation* in the 12 months before the incapacity. This includes:

- Salary before any tax or national insurance contributions have been taken off.
- Regular commission or bonus payments.
- Regular overtime payments.
- P11D benefits in kind as long as these will be lost in the event of incapacity, and
- Dividend income from this *employment* as long as:
  - It is paid directly to *you* in lieu of salary
  - It ceases in the event of incapacity
  - It is consistent with the salary, and
  - The company's trading position reasonably allows *you* to receive it on a continuing basis.

If you are self-employed

Your average gross monthly taxable earnings from *your* business in the 12 months before the incapacity. *You* can take off from this figure any amounts allowable as expenses against income tax. *You* must not take off from this figure any income tax or national insurance contributions.

When *you* work out *your* pre-incapacity earnings, do not include any of these:

- Income from savings
- Income from rental of property or goods
- Dividends which are not included in the box above

Pre-malignant
A description of abnormal or cancerous cells that might develop into a malignant tumour but have not yet done so.

Progressive claim
A second claim that happens in the following way:

1. A *person covered* has a life-changing event that causes a serious illness
2. They make a first successful claim for that serious illness
3. They later make a second claim which is for the same serious illness or another serious illness that was caused by the same life-changing event
4. The two illnesses are in the same body system category. The body system categories are set out in Appendix 1

Promotion or change in job leading to a salary increase
An increase in basic salary as a direct result of one of these single events:

- A promotion
- The award of a recognised professional qualification
- A change of both *employment* and employer

Resident of the United Kingdom
A person who legally lives in the *United Kingdom* for at least 40 weeks in any 52 week period during the life of the *plan*.

Retail Prices Index
The measure of *UK* inflation known as the *Retail Prices Index* (all items), as published by the Office for National Statistics. If the *UK* Government replaces that index with another index of *UK* retail price increases, *we* shall use that replacement index.

Second person covered
If two people are insured on a *plan*, this is the insured person who is not the *first person covered*. This person cannot be a child.

Self-employed

- Actively working alone, with others in a partnership, or as a member of a limited liability partnership
- Paying Class 2 National Insurance contributions
- Assessable for income tax under Schedule D Case I or II

Serious illness
An illness or condition that:

- Is defined in Appendix 1
- Meets *our* criteria for that illness or condition

The serious illnesses are divided into body system categories. These categories are set out in Appendix 1.

Simultaneous claims
Two or more serious illness claims that meet all of the following criteria:

- They are being made by more than one *person covered* or child under a *plan*
- They are a result of the same life-changing event
- They are within three calendar months of that life-changing event

Single life plan
A *plan* that provides cover for one person only, referred to in this *plan* as the *person covered*. This does not include any cover provided for children.

Start date

The date when cover under the whole *plan* begins or, where relevant, when a particular cover begins.

Survival period
The period after an insured event that the insured person has to survive before a claim becomes valid.

Tasks designed to assess whether you can look after yourself ever again
A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4. *We* also call these activities of daily living.

Terminal illness - where death is expected within 12 months
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;
- In the opinion of the attending Consultant, the illness is expected to lead to death within 12 months.

Underwrite/underwriting
The process *we* use to assess *your* application to include or change a cover. *Underwriting* may lead *us* to:

- Accept *your* application
- Reject *your* application
- Amend one or more terms

Unemployed/unemployment
Ceasing to follow *your own occupation* for more than one month, and not following any other *occupation*.

United Kingdom/UK
The *United Kingdom* of Great Britain and Northern Ireland. This excludes the Channel Islands and the Isle of Man.

Unrelated claim
A second claim that happens in the following way:

1. A *person covered* has a life-changing event that causes a serious illness
2. They make a first claim for that serious illness
3. They later make a second claim for another serious illness that was caused by a different lifechanging event

UK university
Any tertiary education institution which offers a recognised *UK* qualification that meets the criteria listed in provision C6.2.

Verified earnings
A figure for *your* earnings that *we* verify when *you* make *your* application for Income Protection Cover or, where appropriate, for an increase to this cover. *You* may need to provide us with evidence of these earnings. There is more information about this in provision B3.1.

Vitality Plus
Vitality Plus provides the opportunity to earn additional points and rewards when *you* look after *your* health. *Vitality Plus* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

Vitality Status
Your Vitality Status is a measure of how much *you*'ve done to look after *your* health. There are four statuses: Bronze, Silver, Gold and Platinum. *We* work out *your Vitality Status* using the activities *you*'ve recorded between each *plan anniversary* - the harder *you* work, the higher *your* status.

We/us/our
Vitality Life Limited.

Whole of life
The term of a cover that lasts from the cover's *start date* to the death of the insured person for *joint life first death* or the death of both *persons covered* for *joint life second death*.

Whole of life
A specific set of everyday physical or functional activities that help to show how able someone is to work. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4.

You/your
The person named on the *plan schedule* as the *person covered*. For a *joint life plan*, either or both people covered, as appropriate.

This page has been left blank

Appendix 1

Illnesses and Conditions – Definitions for Serious Illness Cover

(see provision B2).

This *plan* follows the ABI Statement of Best Practice for Critical Illness Cover (December 2014). All model illness definitions are included and the amount *we* pay *you* ranges from 25% to 100% depending upon their severity. However, some conditions at a lower level of severity may qualify for an increased payment if, or when, their severity increases.

For example cancer is included at a minimum severity of 25%, although higher staged tumours may qualify for an increased payment. The ABI model wording has been used however for the purpose of this *plan we* also provide cover for low grade prostate cancers that have a Gleason score of between 2 and 6 inclusive or a TNM classification of T1N0M0.

The full definitions of the illnesses covered and the circumstances in which *you* can claim are given in this Appendix. These definitions typically use medical terms to describe the illnesses and severities and how they are measured. In some cases the cover may be limited, for example some types of cancer are not covered and to make a claim for some illnesses, *you* need to have permanent symptoms.

1.a Cancer category – specified conditions of defined severity

1. DEFINITIONS

Advanced Aplastic anaemia
Aplastic anaemia is the reduction of circulating red cells, white cells and platelets. For the purposes of this *plan* pancytopenia, causing a reduction to 10% of the normal number of white cells and platelets as well as 50% of the normal levels of red cells, must be present. All lines of blood production must be depressed as demonstrated by bone marrow examination and abnormalities persisting on blood tests for a minimum of three months.

Advanced Cancer
An advanced malignant tumour that has progressed to at least Group Stage II of the TNM Classification of Malignant Tumours as described in the 6th edition of the International Union against Cancer (pub.Wiley-Liss).

Advanced Chronic Lymphocytic Leukaemia
For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood. Chronic Lymphocytic Leukaemia is covered when it has progressed to Binet Stage C.

Advanced Hodgkin's Disease
This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver characterised by Reed-Sternberg cells in the abnormal lymph tissue. The staging must have progressed to at least Stage II of the Ann-Arbor system.

Advanced Non-Hodgkin's Lymphoma
This is an advanced malignant condition of the reticuloendothelial system, which includes the lymph nodes, spleen and liver. The staging must have progressed to at least Stage II of the Ann-Arbor system.

Cancer – excluding less advanced cases
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, Merkel Cell Carcinoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

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 borderline malignancy
  - 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 TNM classification T2N0M0

- 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 (outer layer of skin)

Carcinoma in situ

Any pre-malignant, non-invasive cell growth positively diagnosed and histologically confirmed as carcinoma in situ.

For the above definition, the following are not covered:

- Any dysplasia, hyperplasia, metaplasia, intraepithelial neoplasia or low grade squamous intraepithelial lesions not histologically classified as carcinoma in situ
- Polycystic dysplasia or disease
- Polyps at any site not histologically classified as carcinoma in situ
- Non-invasive papillary bladder carcinoma, TA bladder carcinoma
- Basal cell and squamous cell carcinoma of the skin

Carcinoma in-situ of the Oesophagus requiring surgery

A definite diagnosis, which has been supported by histological evidence, of carcinoma in-situ of the oesophagus which has been treated surgically by removal of a portion, or all of the oesophagus.

Low Grade Prostate Cancer

Low-Grade Prostate Cancer means any malignant tumour of the prostate characterised by uncontrolled growth and spread of malignant cells and invasion of tissue which is histologically classified as having a Gleason score of between 2 and 6 inclusive or having progressed to a TNM classification of T1N0M0.

Lumpectomy for Ductal Carcinoma in-situ of the Breast

The undergoing of a lumpectomy, cystectomy or partial mastectomy for the removal of a tumour in one breast which has been histologically classified as Ductal Carcinoma in-situ (DCIS).

Marrow Aplasia

The reduction of circulating red cells, white cells or platelets causing a reduction to 25% of the normal number of one cell line of the red cells, white cells or platelets as well as 75% of the normal levels of red cells, must be present. The line of blood production must be depressed as demonstrated by bone marrow examination and abnormalities persisting on blood tests for a minimum of six months.

Mastectomy for Carcinoma in-situ of the Breast

Total removal of all the tissue of one breast for the treatment of carcinoma in-situ in the removed breast. Prophylactic mastectomy without histological evidence of cancer in-situ is not covered. *We* only cover mastectomy, any other surgical procedures such as lumpectomy and partial mastectomy are also excluded.

Multiple Myeloma

A malignant proliferation of plasma cells in the bone marrow with destruction of surrounding tissue on bone marrow examination. It must also cause a high level of abnormal proteins in the blood called paraproteinaemia demonstrated on protein electrophoresis. Monoclonal gammopathy of unknown significance will be excluded.

Myelodysplasia

Myelodysplasia is a clonal disorder of at least one cell line of the bone marrow causing insufficient number of normal blood cells.

Non-Melanoma Skin Cancer – Squamous Cell and Basal Cell Carcinomas of specified severity

The presence of one or more of either of the following malignant skin lesions;

- Basal cell carcinoma as determined by histological examination that is greater than 5cm in diameter requiring either Mohs' micrographic surgery or standard excision
- Squamous cell carcinoma as determined by histological examination that is greater than 2cm in diameter

For the above definition, the following are not covered:

- Gorlin's Syndrome
- Skin Cancers secondary to Xeroderma Pigmentosa
- Skin Cancers secondary to Albinism
- Bowen's Disease

2. SEVERITY LEVELS

How is severity measured?

The severity level determines the payment(s) *we* make. The severity of cancer is measured by staging at diagnosis, so the higher the stage at diagnosis the higher the initial *benefit*. If a cancer progresses, *we* will assess the progression of the cancer using the same staging criteria as will be used at diagnosis.

For example, if *you* are diagnosed with stage 1 breast cancer, this is stage 1 disease at diagnosis. If this metastasises (spreads, or invades different organs or parts of the body) *we* will reclassify the staging, even if *your* medical records still state 'stage 1 but with metastases to the bones'. In this example *we* will reclassify the claim as stage 4. Please tell us if *you* believe that the cancer has spread to other organs or parts of the body, *we* will then liaise with *your* Oncologist and/or other specialist.

For the purpose of this *plan we* will assess the staging of cancer using The International Union against Cancer TNM Classification of Malignant Tumours 6th edition (Pub.Wiley-Liss). *We* will use the group stages 1–4 as defined within this reference book to allocate the severities.

Leukaemia: The severity of Chronic Lymphocytic

Leukaemia is measured by the Binet classification which covers stages A to C.

Hodgkin's Disease and Non-Hodgkin's Lymphomas:

The severity is measured by staging and uses the Ann-Arbor system which covers stages I to IV.

Myelodysplasia:

The severity is assessed using the International Scoring System for Prognosis in Evaluating Myelodysplasia syndromes as published by Greenberg et al, in the Journal 'Blood' 1997: 6; p 2079-2088. The prognostic score and details must be provided by the Consultant Haematologist supervising the monitoring or treatment of the patient. If no prognostic score is available *our* Chief Medical Officer will assess the most likely severity in conjunction with the Haematologist monitoring the patient. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified Ann-Arbor Stage III or above
- Acute Myeloid Leukaemia
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Chronic Myeloid Leukaemia
- Acute Lymphoblastic Leukaemia
- Advanced Aplastic Anaemia

Severity Level C:

- Advanced cancer classified as a TNM Group Stage II tumour
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage II
- Advanced Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage II
- Multiple Myeloma
- Myelodysplasia classified as Intermediate 1 under the International Prognostic Scoring System

Severity Level D:

- Cancer - excluding less advanced cases
- Carcinoma in-situ of the Oesophagus requiring surgery
- Low-Grade Prostate Cancer
- Marrow Aplasia
- Mastectomy for Carcinoma in-situ of the Breast

Severity Level E:

- Myelodysplasia classified as Low risk on the International Prognostic Scoring System

Severity Level F:

- Lumpectomy for Ductal Carcinoma in-situ of the Breast

Severity Level G:

- Carcinoma in Situ
- Non-Melanoma Skin Cancer – Squamous Cell and Basal Cell Carcinomas of specified severity

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Confirmation of the diagnosis by an appropriate medical specialist and copies of the specialist and hospital reports
- Relevant CT/MRI scans, histological evidence and Full Blood Count results where appropriate

4. SPECIFIC EXCLUSIONS

- All tumours which are histologically described as pre-malignant, as non-invasive or cancer in situ (other than those stated as covered in this document and *your plan schedule*)
- Cervical, vaginal or prostatic intraepithelial neoplasia (dysplasia) with histology showing CIN-1 to CIN-3, VIN-1 to VIN-3 or PIN-1 to PIN-3, each inclusive
- Lesions where there has been no invasion of tissue including, but not limited to, papillary micro-carcinoma of the thyroid or papillary cancer of the bladder histologically described as TisN0M0,TaN0M0 or of lesser classification (other than those stated as covered in this document and *your plan schedule)*
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.b Heart and Artery category – specified conditions of defined severity

1. DEFINITIONS

Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty)
PTCA or other percutaneous coronary artery procedures performed by a Consultant Cardiologist to dilate and treat a coronary artery stenosis. The procedure may or may not involve the use of a stent.

Angioplasty to correct Carotid Artery Stenosis
Therapeutic angioplasty with or without stent to correct symptomatic stenosis of the carotid artery.

Any Cardiac Condition resulting in a Reduced Ejection Fraction
Any cardiac condition causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

Aorta Graft Surgery
The undergoing of surgery for disease or traumatic injury to the aorta with excision and surgical replacement of a portion of the diseased or injured aorta with a graft.

The term aorta includes the thoracic and abdominal aorta but not its branches. For the above definition, the following are not covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair

Balloon Valvuloplasty
The dilation of a stenotic valve of the heart by percutaneous balloon procedure performed by a Consultant Cardiologist.

By-pass Graft Surgery to 3 or more Coronary Arteries
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage to three or more coronary arteries with by-pass grafts.

Cardiomyopathy resulting in a Reduced Ejection Fraction
A disease of the heart muscle causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

Cardioversion for Cardiac Arrhythmia
The intentional therapeutic medically supervised application of an electrical shock, using at least 40 joules, to correct a documented and recorded arrhythmia of the heart.

Congestive Heart Failure
The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and optimal therapy must have been established for at least 6 months. There must be at least 4 signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound
- Jugular venous pressure above 6 cms
- Rales present in both bases on auscultation
- Cardiomegaly on chest x-ray
- Grade 3, or gross ascites, associated with marked abdominal distension
- Severe oedema to a level above the knee

Coronary Artery By-pass Grafts
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 by-pass grafts.

Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation
Documented Ventricular Tachycardia or Ventricular Fibrillation requiring admission to hospital for the treatment of intra-venous antiarrhythmic therapy.

Endovascular Repair of Aortic Aneurysm
The repair through endovascular methods of an aortic aneurysm with the replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

Femoral Artery Aneurysm Repair
Surgical repair of an aneurysm of the femoral artery by surgery or by endovascular techniques.

Heart Attack
Death of heart muscle, due to inadequate blood supply that has resulted in the following:

- Definite Diagnosis of an acute Myocardial Infarction by a Consultant Cardiologist, which is supported by current medical reports, tests and investigations, as defined by the recognised international standard* prevailing at the time of claim.

For the above definition, the following are not covered:

- Other acute coronary syndromes including but not limited to angina without myocardial infarction.
- Myocardial Infarctions that meet the international standard that occurred before cover commenced

*(International standard defined by the European Society of Cardiology or the universal standard definition of Myocardial Infarction.)

Heart Attack - of specified severity
Death of heart muscle, due to inadequate blood supply, that has resulted in the following evidence of acute myocardial infarction:

- New characteristic electrocardiographic changes, and
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
  - Troponin T > 0.5 ng/ml
  - AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes including but not limited to angina without myocardial infarction.

Heart Valve Replacement or Repair
The undergoing of surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

Heart Attack resulting in a Reduced Ejection Fraction
A heart attack causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. The measurement must be performed at least one month after an acute heart attack. The heart attack must have been diagnosed according to the criteria stated under the Heart Attack definition in provision 1 b) i above for a claim to be considered.

Hypertrophic Cardiomyopathy - of specified severity
A disease of the heart muscle which results in thickening and enlargement of the interventricular septum or any myocardial segment. There must be a maximal LV wall thickness of at least 15mm in any myocardial segment confirmed via cardiac imaging and the diagnosis of hypertrophic cardiomyopathy must be confirmed by a consultant cardiologist.

For the above definition the following are not covered:

- Cardiomyopathy secondary to alcohol or drug misuse

Iliac Artery Aneurysm Repair
Surgical repair of an aneurysm of the iliac artery by surgery or by endovascular techniques.

Infective Endocarditis
Endocarditis is the infection on the valves of the heart with vegetations (clumps of small clot and bacteria) visible on the echocardiogram.

There must be echocardiographic evidence of vegetation on the valves of the heart, and blood cultures must show bacterial growth in at least two samples taken at the same time. Endocarditis as a result of drug misuse is not covered.

Keyhole Coronary Artery Bypass Surgery
The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts via a thorascope or mini thoracotomy.

Pericardectomy
The surgical excision of part of the pericardium surrounding the heart via thoracotomy or sternotomy to relieve a constriction of the heart. Biopsy and aspiration of pericardial effusion is excluded.

Permanent Defibrillator Insertion
The permanent insertion of an automatic implantable defibrillator after the occurrence of ventricular tachycardia or ventricular fibrillation.

Permanent Pacemaker Insertion
The permanent insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to us.

Severe Peripheral Vascular Disease
There must be severe restriction of blood flow through the arteries below the knee as measured by doppler readings of less than 30 per cent of normal and a claudication distance of 20 metres. Surgery must have failed to reverse this or be contraindicated for reasons as agreed by *our* Chief Medical Officer.

Severe Vascular Disease affecting Multiple Systems
Severe vascular disease affecting the heart, kidney and/or brain. There must be at least 2 of the following:

- Stroke*
- Left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3
- Renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/lGrade 4 retinopathy

combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase greater than 110mmHg on optimal therapy.

*For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be residual deficit with a Modified Rankin Scale of 2 or above.

Surgery for Cardiac Arrhythmia
The surgical or endovascular division or ablation of abnormal conduction pathways to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to us.

Surgery to correct Carotid Artery Stenosis
Therapeutic correction by open surgical techniques with endarterectomy of symptomatic stenosis of the carotid artery.

Surgical repair of an Atrial or Ventricular Septal Defect
The surgical closure of a defect in the interatrial or interventricular septum. This can be performed through a thoracotomy, a sternotomy or by using endovascular techniques.

Surgical repair of a Structural Lesion of the Heart
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to repair a structural lesion of the heart.

2. SEVERITY LEVELS

How is severity measured?

Reduction in ejection fraction:
The ejection fraction is a measure of the efficiency of the pumping action of the heart; in a healthy heart this is typically greater than 50%. Damage to the muscle of the heart (myocardium) such as that sustained during myocardial infarction or cardiomyopathy, impairs the heart's ability to eject blood and therefore reduces ejection fraction. Where a severity is measured by the permanent reduction in ejection fraction it is measured by the percentage of the contents of the left ventricle that is expelled in each contraction of the ventricle. This can be measured by echocardiography or through radioisotope measurements. It must be measured in a cardiac laboratory, which has regular quality control audits available to us, and be supervised by a Consultant Cardiologist.

The disease or disorder causing the reduction in ejection fraction must be established as being permanent and irreversible and the measurement must be taken whilst the patient is on optimal treatment.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Cardiomyopathy resulting in a permanent ejection fraction of 39% or less whilst on optimal therapy*
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25 mm
- Heart attack resulting in a permanent ejection fraction of 39% or less whilst on optimal therapy*
- Any other cardiac condition resulting in a permanent ejection fraction of 39% or less whilst on optimal therapy*
- At least 4 signs of congestive heart failure on optimal therapy for at least 6 months
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 110mmHg on optimal therapy
- Severe peripheral vascular disease

Severity Level B:

- Cardiomyopathy resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy*
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of between 15mm and 25mm
- Heart attack resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy*
- Any other cardiac condition resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy*
- Aorta Graft Surgery
- By-pass Graft Surgery to three or more Coronary Arteries

*See 'How is severity measured?' (above) for details as to how a reduction in ejection fraction is measured.

Severity Level C:

- Coronary Artery By-pass Grafts
- Heart Attack - of specified severity

Severity Level D:

- Heart Attack
- Surgical Repair of a Structural Lesion of the Heart
- Heart Valve Replacement or Repair
- Endovascular Repair of an Aortic Aneurysm

Severity Level E:

- Iliac Artery Aneurysm Repair
- Femoral Artery Aneurysm Repair
- Balloon Valvuloplasty
- Pericardectomy
- Surgery to correct Carotid Artery Stenosis

Severity Level F:

- Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty) with or without stent
- Angioplasty to correct Carotid Artery Stenosis
- Keyhole Coronary Artery Bypass Surgery

- Permanent Pacemaker Insertion
- Permanent Defibrillator Insertion
- Surgery for Cardiac Arrhythmia
- Infective Endocarditis
- Surgical Repair of an Atrial or Ventricular Septal Defect
- Cardioversion for Cardiac Arrhythmia
- Emergency Intravenous Anti-arrhythmic therapy
- for Ventricular Tachycardia or Fibrillation

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- History of signs and symptoms compatible with the condition claimed
- Full cardiologist's, cardiothoracic, neurosurgeon or vascular surgeon's assessment and operation notes
- Relevant electrocardiographs, angiograms, aortograms, thallium scans, echocardiograms, X-rays, CT scans or any other relevant test results and reports
- Cardiac enzyme results for heart attacks. Raised serum CKMB fraction or positive Troponin-T or I, if performed. Raised creatinine kinase and LDH alone are not considered.

4. SPECIFIC EXCLUSIONS

- Any Acute coronary syndromes which do not completely satisfy any of the definitions listed in the Definitions section of this illness category including, but not limited to, angina
- Alcoholic Cardiomyopathy
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Any second claim at any time under any of the Severity Level F procedures listed in provision 1 b) 2 above
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.c Stroke and Nervous System category– specified conditions of defined severity

1. DEFINITIONS

Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of previous or current symptoms (these symptoms do not need to be permanent).

For the above definition, the following are not covered:

- Other types of dementia.

Alzheimers Disease - resulting in permanent symptoms

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
- Perceive, understand, express and give effect to ideas

For the above definition, the following are not covered:

- Other types of dementia

Bacterial Meningitis

Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis. All other forms of meningitis, including viral, are not covered.

Benign Brain Tumour
A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull. For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angioma and cholesteatoma

Benign Brain Tumour - resulting in permanent symptoms or surgery
A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in either surgical removal or permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angioma and cholesteatoma

Bilateral Hemianopia
Permanent and irreversible loss of vision in one half of the visual field of both eyes.

Coma - with associated permanent symptoms
A state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems.

The following is not covered:

- Coma secondary to alcohol or drug abuse

Craniotomy
Any surgical treatment of brain tissue via craniotomy by a Consultant Neurosurgeon for any of the following:

- Intracranial infections
- Subdural, Intracerebral and Epidural Haematomas or Subarachnoid bleeds
- Traumatic Brain Injury

For the above definition, the following are not covered:

- Burr Holes procedures
- Insertion of deep brain stimulators

Craniotomy to treat a Cerebral Arteriovenous Malformation
Surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or aneurysm.

Creutzfeldt-Jakob Disease
A definite diagnosis of Creutzfeldt-Jakob Disease by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of current or previous symptoms (these symptoms do not need to be permanent).

This must have been reported the National CJD Monitoring Unit as a confirmed case.

Creutzfeldt-Jakob Disease - resulting in permanent symptoms
A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist, Psychiatrist or Geriatrician. This must have been reported to the National CJD Monitoring Unit as a confirmed case. There must be permanent clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Dementia
A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of current or previous symptoms (these symptoms do not need to be permanent).

Dementia - resulting in permanent symptoms
A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Drainage of Brain Abscess by Craniotomy
The surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

Encephalitis
A definite diagnosis of Encephalitis by a Consultant Neurologist with evidence of current or previous symptoms (these symptoms do not need to be permanent).

Encephalitis – resulting in permanent symptoms
A definite diagnosis of Encephalitis by a Consultant Neurologist, resulting in permanent neurological deficit with persisting clinical symptoms.

Endovascular Treatment of a Cerebral Arteriovenous Malformation
Endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or aneurysm.

Functional Surgery for Movement Disorders
Undergoing of surgery, in the form of deep brain stimulation, to treat tremor, parkinsonism, dyskinesia, or dystonia.

Guillain-Barré Syndrome
A definite diagnosis of Guillain-Barré Syndrome by a Neurologist, confirmed by electromyography and lumbar puncture. There must be evidence of continual and permanent weakness or numbness being present for a minimum period of 2 years, which is supported by appropriate neurological evidence. The residual deficit must measure at least 3 on the Modified Rankin Scale.

Loss of Manual Dexterity to age 70
Total and irreversible loss of the ability to use the hands and fingers with precision to perform daily activities of work such as picking up or manipulating small objects, operating a range of equipment manually or communicating through writing or typing. The disability must be permanent and supported by appropriate neurological evidence.

Loss of Muscle Power resulting in the inability to grip to age 70
Total and irreversible loss of all muscle power in both hands resulting in the inability to grip any tool, utensil or assistive device. The disability must be permanent and supported by appropriate neurological evidence.

Loss of Speech
Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.

Motor Neurone Disease
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 evidence of current or previous symptoms (these symptoms do not need to be permanent).

Motor Neurone Disease – resulting in permanent symptoms

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.

Multiple Sclerosis
A definite diagnosis of multiple sclerosis by a Consultant Neurologist with evidence of previous or current symptoms (even if these are not permanent).

Multiple Sclerosis - resulting in current symptoms
A definite diagnosis of Multiple Sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function.

Muscular Dystrophy
The definite diagnosis of Muscular Dystrophy by a Consultant Neurologist which must be supported by typical changes on muscle biopsy.

Neurological Diseases
For the purpose of this *plan* this includes any permanent irreversible disease affecting the basal ganglia, cerebellum, neurones, horn cells or myelin sheaths that produce identifiable permanent neurological deficit. If the disease, disability or symptom is not defined as a named condition in this provision 1 c) i, benefits will be paid only when there is an inability to perform the *functional activity tests* see provision D5.4. Alcohol or drug abuse is excluded.

Paralysis of limbs
Total and irreversible loss of muscle function to the whole of any two limbs.

Parkinson's Disease
A definite diagnosis of Parkinson's disease by a Consultant Neurologist with evidence of current or previous symptoms (these symptoms do not need to be permanent).

For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist.

There must be permanent clinical impairment of motor function with associated tremor and muscle rigidity.

For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Persistent Vegetative State to age 70
A severe neurological condition of decreased consciousness where there must be all of the following:

- The loss of an awareness of surroundings
- The lack of speech
- The lack of response to commands
- The lack of any purposeful movements

This condition must be permanent and supported by appropriate neurological evidence.

Progressive Supra-nuclear Palsy
Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supra-nuclear Palsy with evidence of current or previous symptoms (these symptoms do not need to be permanent).

Progressive Supra-nuclear Palsy – resulting in permanent symptoms
Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supranuclear Palsy. There must be permanent clinical impairment of motor function.

Shunt Insertion for Hydrocephalus
Surgical insertion of a permanent drainage shunt for the treatment of hydrocephalus. There must be enlargement of the ventricles which has been confirmed by a radiologist.

Spinal Tumour
A primary tumour of the spinal cord resulting in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must be supported by CT, MRI or histiopathological evidence. For the above definition, only the following tumours are covered:

- Meningioma
- Neurofibroma
- Astrocytoma
- Ependymoma
- Chordoma

Stereotactic Brain Surgery
Undergoing stereotactic surgery to the brain performed by a Consultant Neurosurgeon for neurological disease. Biopsy of brain tissue is specifically excluded.

Stroke
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull. For the above definition, the following are not covered:

- Transient ischaemic attack
- Traumatic injury to brain tissue or blood vessels
- Death of tissue of the optic nerve or retina/eye stroke

Stroke - resulting in permanent symptoms
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Transient ischaemic attack
- Traumatic injury to brain tissue or blood vessels
- Death of tissue of the optic nerve or retina/eye stroke

Surgery for Drug Resistant Epilepsy
Undergoing of surgery to brain tissue in order to control epilepsy that cannot be controlled by oral medication.

Surgical Repair of Depressed Skull Fracture
Undergoing surgery to correct a depression in the skull as a result of an accidental traumatic fracture or break in the cranial bone.

Traumatic Brain Injury - with clinical symptoms

Death of brain tissue due to traumatic injury resulting in clinical symptoms that have persisted for a continuous period of at least 2 weeks (these symptoms do not need to be permanent).

For the above definition the following is not covered:

- Traumatic Brain injury secondary to alcohol or drug abuse

Traumatic Brain Injury – resulting in permanent symptoms
Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

2. SEVERITY LEVELS

How is severity measured?

Modified Rankin Scale:
Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

Functional Activity Tests (FATs):
For neurological diseases (including those not specifically stated under this *benefit*) *we* will pay a *benefit* if *you* become permanently unable to perform certain *functional activity tests* due to the disease.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- A Stroke with a residual deficit measuring 4 or above on the Modified Rankin Scale
- Any Neurological Disease causing the permanent and irreversible inability to perform four out of six *functional activity tests*. See provision D5.4.
- Loss of Speech
- Paralysis of limbs
- Loss of Manual Dexterity
- Loss of muscle power resulting in the inability to grip
- Persistent Vegetative State

Severity Level B:

- A Stroke with a residual deficit measuring at least 3 on the Modified Rankin Scale
- Any Neurological Disease causing the permanent and irreversible inability to perform three out of six *functional activity tests*. See provision D5.4.
- Bilateral Hemianopia
- Guillain-Barré Syndrome with a residual deficit measuring at least 3 on the Modified Rankin Scale

Severity Level C:

- A Stroke with a residual deficit measuring at least 2 on the Modified Rankin Scale
- Any Neurological Disease causing the permanent and irreversible inability to perform two out of six *functional activity tests*. See provision D5.4
- Surgery for Drug Resistant Epilepsy

Severity Level D:

- Alzheimer's disease – resulting in permanent symptoms*
- Benign Brain Tumour – resulting in permanent symptoms or surgery*
- Coma – with associated permanent symptoms*
- Craniotomy
- Craniotomy to treat a Cerebral Arteriovenous Malformation
- Creutzfeldt-Jakob Disease – resulting in permanent symptoms*
- Dementia – resulting in permanent symptoms*
- Drainage of Brain Abscess by Craniotomy
- Encephalitis - resulting in permanent symptoms*
- Functional Surgery for Movement Disorders
- Motor Neurone Disease – resulting in permanent symptoms*
- Multiple Sclerosis* – resulting in current symptoms*
- Muscular Dystrophy*
- Parkinson's Disease – resulting in permanent symptoms*
- Progressive Supra-nuclear Palsy – resulting in permanent symptoms*
- Shunt Insertion for Hydrocephalus (restricted to one payment only)
- Spinal Tumour
- Stroke*
- Stroke - resulting in permanent symptoms*
- Traumatic Brain injury* - resulting in permanent symptoms

*these conditions can be continually re-assessed as they progress in severity by use of the Modified Rankin Scale or *functional activity tests* (FATs) as described in 'How is severity measured' above. Please also refer to provision B2.7.

Severity Level E:

- Surgical Repair of Depressed Skull Fracture
- Endovascular treatment of a Cerebral Arteriovenous Malformation

Severity Level F:

- Alzheimers Disease
- Bacterial Meningitis
- Benign Brain Tumour
- Creutzfeldt-Jakob Disease
- Dementia
- Encephalitis
- Motor Neurone Disease
- Multiple Sclerosis
- Parkinsons Disease
- Progressive Supra-nuclear Palsy
- Stereotactic Brain Surgery
- Traumatic Brain Injury - with clinical symptoms

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results
- Diagnosis made by an appropriate medical specialist
- Loss of neurological function compatible with area of damage of the brain involved

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1c) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Chronic Fatigue Syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free Disease.
- Pituitary tumours – specified treatments are covered within the Endocrine *benefit*
- Transient Ischaemic Attacks
- Benign intracranial hypertension

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.d Gastrointestinal category – specified conditions of defined severity

1. DEFINITIONS

Chronic Inflammatory Hepatitis
An inflammation of the liver which has been present for at least one year. There must be all of the following:

- Abnormal liver function tests including liver enzymes called transaminases to at least three times normal laboratory range throughout this period
- Moderate plate necrosis or severe focal cell necrosis on liver biopsy
- Periportal or septal fibrosis on liver biopsy. Causes of this condition can include chronicHepatitis B or C or Autoimmune Disease.

Chronic Pancreatitis
Chronic Inflammation of the pancreas with calcification throughout the body and tail of the gland. There must also be all of the following:

- Proof of calcification on CT scan
- Evidence of failure of secretion of pancreatic enzymes
- Evidence of chronic inflammation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP)

Cirrhosis of the Liver
A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy.

Fulminant Hepatic Necrosis
Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

Loss of the use of more than one third of the tongue
Loss of the use of more than one third of the tongue through loss of motor function, traumatic amputation or through surgery.

Moderately Severe Inflammatory Crohn's Disease
A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To meet the definition of moderate, at least 2 sites of deep tissue intestinal tract must be affected by continued or relapsing inflammation, with 2 or more flare-ups each year. Each flare up must require courses or increased dosages of either oral or intravenous steroids or immunosuppressants.

Partial Hepatectomy
The surgical excision of at least 25% of the liver mass by laparotomy. Liver biopsy and donation are specifically excluded.

Permanent Faecal Incontinence to age 70
There must be permanent incontinence of faeces with constant soiling, despite optimal therapy for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

Permanent Rectal Fistula
A permanent abnormal tract or connection between the rectum and the skin, bladder or vagina due to a disease of the rectum. There must be radiological evidence of the abnormal tract or connection. Fistula in ano is specifically excluded.

Portal Vein Thrombosis
The thrombosis of the portal vein causing ascites and enlargement of the spleen. There must be radiological evidence of the blockage to the portal vein as well as proof of oesophageal varices as a complication.

Sclerosing Cholangitis
An inflammation of the bile ducts proven on cholangiography, with abnormal liver function tests. There must be diagnostic appearances with irregular stricturing and dilatation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP).

Severe Cirrhosis of the Liver
A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy. To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/litres;
- Abnormal protein production marked by decreased albumin levels below 27 G/L;
- Abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR) test above 2.0

Severe Gastrointestinal Disease - requiring Hospitalisation
Objective evidence of severe gastrointestinal disease with all of the following:

- Disturbance of bowel function at rest with severe persistent pain for a minimum of 3 consecutive months
- Limitation of activity with continued restriction of diet and no response to medical therapy for a minimum of 3 months
- There have been 2 hospital admissions to treat this condition in the 12 months prior to claim

For the above definition, the following are not covered:

- Any hospitalisation for diagnostic purposes
- Any hospitalisation for other conditions
- Any hospitalisation relating to alcohol or drug misuse
- Irritable Bowel Syndrome

Severe Inflammatory Crohn's Disease
A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To be considered as severe, symptoms must not have responded to optimal therapy while under the continued supervision of a Gastroenterologist.

There must also be evidence of continued inflammation with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital
- Fistula formation between loops of bowel or bowel to another organ
- At least one resection of a segment of small bowel

Surgical Repair of a Tracheo-Oesophogeal Fistula
The surgical repair of an abnormal tract between the trachea and oesophagus as demonstrated by radiological methods.

Total Colectomy
Removal of the whole of the colon creating an opening on the abdomen joining the small intestine to the abdomen wall called an Ileostomy. This procedure is covered if it is established that the ileostomy is permanent in the opinion of both a Consultant Gastroenterologist and *our* Chief Medical Officer.

2. SEVERITY LEVELS

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level A:

- Fulminant Hepatic Necrosis
- Permanent Faecal Incontinence
- Severe Cirrhosis of the Liver

Severity Level C:

- Sclerosing Cholangitis
- Severe Inflammatory Crohn's Disease

Severity Level D:

- Chronic Pancreatitis
- Severe Gastrointestinal Disease - requiring hospitalisation
- Total Colectomy

Severity Level E:

- Cirrhosis of the Liver
- Chronic Inflammatory Hepatitis
- Partial Hepatectomy
- Portal Vein Thrombosis
- Loss of use of more than one third of the Tongue

Severity Level F:

- Surgical Repair of a Tracheal-Oesophageal Fistula
- Permanent Rectal Fistula
- Moderately Severe Inflammatory Crohn's Disease

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Diagnosis and treatment by an appropriate medical specialist
- Relevant investigations, results, copies of hospital and histology reports signed by suitably qualified Consultant Histopathologist

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1d) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Alcohol or drug abuse
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.e Connective Tissue Diseases category – specified conditions of defined severity

1. DEFINITIONS

For the purposes of this *plan* other diseases which are not specifically named such as sero-negative arthritis, psoriatic arthritis or osteoarthritis are not covered by this *plan*, but complications of these diseases may be paid out should criteria be met under any of the other categories of illnesses.

Giant Cell Arteritis
The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Pemphigus Vulgaris
A chronic, relapsing autoimmune skin disease that causes blisters and erosions of the skin and mucous membranes. For the purpose of this *plan* only Pemphigus Vulgaris is covered, with the diagnosis supported by a biopsy and presence of PV auto-antibodies in the blood.

Polyarteritis Nodosa
The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Polymyositis
Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this illness category there must be all of the following:

- Elevated serum muscle enzymes (CK, aldolase)
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM)
- Muscle biopsy findings typical of PM or DM (as defined immediately above)
- Compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation

Rheumatoid Arthritis
The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Lupus Erythematosis (SLE)
The definite diagnosis of Systemic LupusErythematosis (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Sclerosis (Scleroderma)
The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Wegener's Granulomatosis
The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rhematic Diseases.

2. SEVERITY LEVELS

How is severity measured?

Connective Tissue Diseases:

Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. For the purposes of this *plan* the severity of Connective Tissue Diseases will be determined by the permanent inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the permanent inability to perform at least four out of six *functional activity tests*. See provision D5.4.

Severity Level B:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the permanent inability to perform at least three out of six *functional activity tests*. See provision D5.4.

Severity Level C:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the permanent inability to perform at least two out of six *functional activity tests*. See provision D5.4.

Severity Level D:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the permanent inability to perform at least one out of six *functional activity tests*. See provision D5.4.

Severity Level F:

- A definite diagnosis of giant cell arteritis,
- polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis
- Pemphigus Vulgaris

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant blood tests and tissue biopsies which satisfy the relevant defined diagnostic criteria
- Histological proof of the presence of the disease

4. SPECIFIC EXCLUSIONS

- Fibromyalgia, or any synonym including, but not limited to, fibromyositis, fibrositis, muscular rheumatism, myofascial pain syndrome
- Osteoarthritis, wear and tear or any other subjective, non-diagnosed condition
- Chronic fatigue syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free disease
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*

1.f Urogenital Tract and Kidney category – specified conditions of defined severity

1. DEFINITIONS

Acute Renal Dialysis
Undergoing more than two treatments of haemodialysis over a three week period or a cumulative total of more than 24 hours haemofiltration due to a rapid decline of renal function leading to renal failure.

Bilateral Orchidectomy
The therapeutic surgical removal of all of both testicles due to trauma or for the treatment of a disease of the testicles or of the blood vessels supplying the testicles.

Bladder Fistula
The abnormal connection or tract between the bladder and the skin, vagina or rectum due to disease of the bladder. This must be proven by radiological evidence.

Chronic Renal Impairment
The impairment in kidney function such that the estimated glomerular filtration rate is below 25 mls/litre/min/1.73 m2 surface area persistently for a period of six months or more.

Cystectomy
The surgical removal of the complete organ of the bladder with the construction of a urostomy or nephrostomies to allow urine to be collected external to the body. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

Kidney Failure
Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.

Nephrectomy
Undergoing the surgical removal of a complete kidney as a result of documented renal disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

Partial Cystectomy
Undergoing the surgical removal of at least 50% of the bladder, measured by surface area, as a result of documented disease or trauma. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

Partial Nephrectomy
Undergoing the surgical removal of at least 30% of the mass of one kidney as a result of documented disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below. Biopsy is excluded.

Severe Chronic Renal Impairment
The impairment in renal function such that the estimated glomerular filtration rate is below 15 mls/ litre/ min/1.73 m2 surface area persistently for a period of six months or more.

Surgical Repair of a Kidney
Surgical repair of acute damage to the kidney as a result of trauma. Keyhole surgery, including laparoscopic surgery, is specifically excluded.

2. SEVERITY LEVELS

How is severity measured?

Renal function:
Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Kidney Failure

Severity Level B:

- Severe Chronic Renal Impairment

Severity Level C:

- Chronic Renal Impairment
- Cystectomy

Severity Level D:

- Acute Renal Dialysis
- Nephrectomy
- Partial Cystectomy

Severity Level E:

- Partial Nephrectomy
- Bilateral Orchidectomy
- Surgical repair of a Kidney

Severity Level F:

- Bladder Fistula

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5

Any or all of the following may apply to any claim under this category

- Diagnosis and treatment by an appropriate medical specialist
- Copies of all available specialist reports
- Details of current and historic renal function tests
- Histology of biopsies and any other relevant investigations must be available

4. SPECIFIC EXCLUSIONS

- Kidney transplant. This is covered in the Major Organ Transplant category
- Kidney donation
- Elective gender reassignment
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.g Respiratory Disease to Age 70 category – specified conditions of defined severity

1. DEFINITIONS

Chronic Obstructive Pulmonary Disease

A disease of the airways of the lung causing obstruction to the exhalation of air. There must be permanent and irreversible reduction of the maximum volume of air expelled in one second (FEV1) of less than 50% of predicted.

There must be permanent and irreversible obstruction to airflow demonstrated by a FEV1/ FVC ratio of less than 50% and there must be less than 5% variation in three repeated measurements, (which must be performed under the direction of a specialist respiratory physician) whilst on optimal therapy. They must be measured in a respiratory laboratory, which has regular quality control audits available to us.

These measurements must be repeated after an interval of at least three months and must also satisfy the criteria mentioned above for a claim to be considered.

Only the following severities are covered:

- Stage III – where FEV1 is between 31% and 49% of predicted
- Stage IV – where FEV1 is 30% or less of predicted

When both Chronic Obstructive Pulmonary Disease and Fibrotic Lung Disease co-exist, only one payment will be made for the condition which is at the highest severity level.

Cor Pulmonale

Irreversible right ventricular failure due to a lung disease producing raised pulmonary artery pressure (Pulmonary Hypertension). There must be evidence of raised pulmonary artery pressure of at least 30mmHG (mm of mercury) and there must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

Fibrotic Lung Disease

For the purpose of this *plan* fibrotic lung disease is defined as one of the following only:

- Sarcoidosis
- Fibrosing Alveolitis
- Aspergilosis

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

There must be radiological evidence of fibrosis and there must be a permanent and irreversible restriction of Vital Capacity (VC), the maximum total volume of air that can be expelled from the lung after maximum inhalation, to below 75% of predicted. There must also be a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 55% of predicted or less.

These tests must be performed under the direction of a specialist respiratory physician whilst on optimal therapy. They must be measured in a respiratory laboratory, which has regular quality control audits available to us, and be supervised by the treating specialist. When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made (for the condition which is at the highest severity level).

Home Oxygen Therapy

Severe obstructive lung disease with a FEV1 of less than 1 litre present for at least 1 year as well as a concentration of oxygen in the arteries of less than 7.3 kPa. Supplemental oxygen therapy must be used at home for at least 13 hours each day.

Mechanical Ventilatory Support for Near Drowning

Mechanical ventilatory support for at least 24 hours following full resuscitation as a consequence of near drowning.

Pleurectomy

The therapeutic surgical excision of the pleura (the membrane covering the lungs) for documented disease.

Primary Pulmonary Hypertension

The presence of irreversible raised pressure in the Pulmonary arteries. The measurement reported must be the average level measured by cardiac catheterisation and be at least 30mmHG (mm of mercury) at rest. There must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

Pulmonary Embolus

The blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs) or an angiography.

Removal of One Lobe of the Lungs

The therapeutic surgical removal of one lobe of the lungs for documented disease or trauma.

Removal of Two or more Lobes of the Lungs

The therapeutic surgical removal of two or more lobes of the lungs for documented disease or trauma.

Surgical Drainage of a Lung Abscess

The surgical drainage of an abscess in the parenchyma of the lung using a thoracotomy.

Surgical Drainage of Empyema

The collection of pus in the pleural space. This is the space between the lung and the ribcage. The empyema must have been drained using a thoracotomy operation to qualify for this *benefit*.

2. SEVERITY LEVELS

How is severity measured?

Chronic Obstructive Pulmonary Disease:

Severity is assessed by the measurement of:

1. Vital Capacity (VC). This is the maximum total volume of air that can be expelled from the lung after maximum inhalation.
2. The Forced Expiratory Volume 1 (FEV1). The maximum volume of air expelled in one second.
3. The ratio of the two measurements. Fibrotic Lung Disease: The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor. The amount of the claim depends on the severity of the illness *you* suffer.

The following levels apply:

Severity Level A:

- Fibrotic Lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less
- Cor Pulmonale
- Primary Pulmonary Hypertension

Severity Level C:

- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 35% and 39% of predicted
- Home Oxygen Therapy
- Stage IV Chronic Obstructive Pulmonary Disease
- Removal of two or more lobes of the lungs

Severity Level D:

- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 40% and 49% of predicted
- Stage III Chronic Obstructive Pulmonary Disease
- Removal of one lobe of the lungs

Severity Level E:

- Surgical Drainage of a Lung Abscess
- Surgical Drainage of Empyema
- Pleurectomy
- Pulmonary Embolus

Severity Level F:

- Mechanical Ventilatory Support for Near Drowning
- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 50% and 55% of predicted

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Must be diagnosed and treated by an appropriate medical specialist
- Relevant pulmonary and cardiac investigations must be done and be available
- Histology report must be available if needed

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1g) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.h Accidental HIV category – meeting specified criteria

1. DEFINITIONS

HIV infection

Infection by Human Immunodeficiency Virus resulting from:

- A blood transfusion given as part of medical treatment
- A physical or sexual assault

- An incident occurring during the course of performing normal duties of *employment* from the eligible occupations listed below;

after the start of the *plan* 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 or sexual assault or as a result of an incident occurring during the course of performing normal duties of *employment*, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus
- The incident causing infection must have occurred in the *United Kingdom*, the Channel Islands, the Isle of Man or the Republic of Ireland

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse

The eligible *occupations* covered by this *benefit* are as follows:

- Ambulance Workers
- Chiropodists
- Dental Nurses
- Dental Surgeons
- District Nurses
- Fire Brigade Fire-fighters
- General Practitioners
- Hospital Caterers
- Hospital Cleaners
- Hospital Doctors, Surgeons and Consultants
- Hospital Laboratory Technicians
- Hospital Laundry Workers
- Hospital Nurses
- Hospital Porters
- Midwives
- Nurses employed by General Practitioners
- Occupational Therapists
- Paramedics
- Physiotherapists
- Podiatrists
- Policemen and Policewomen
- Prison Officers
- Radiologists
- Refuse Collectors
- Social Workers

2. SEVERITY LEVELS

HIV infection resulting from:

- A blood transfusion given as part of medical treatment
- or a physical or sexual assault
- or an incident occurring during the course of performing normal duties of *employment* from the list of eligible *occupations*

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

We will require evidence of a negative HIV test within 5 days of the incident and the subsequent positive HIV (Human Immunodeficiency Virus) antibody test with a confirmatory Western Blot test within 12 months of the incident.

4. SPECIFIC EXCLUSIONS

- Any method of infection of HIV or AIDS that is not stated above
- Transmission through occupational duties for any *occupation* other than those specified above in provision 1 h) i
- No cover under this *benefit* is effective unless there is shown to be a negative HIV test within five days of the incident causing the claim
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.i Musculoskeletal Trauma category – specified conditions of defined severity

1. DEFINITIONS

Amputation of Two or More Fingers or Thumbs
Permanent physical severance of two or more fingers or thumbs at the metacarpal bone.

Le Fort III Reconstruction
This is a form of surgical repair of the maxillofacial bones for severe facial trauma.

Less Extensive Third Degree Burns – covering 15% of the body's surface area
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 15% of the body's surface area.

Less Extensive Third Degree Burns – covering 10% of the body's surface area
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 10% of the body's surface area.

Less Extensive Third Degree Burns – covering 5% of the body's surface area
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area.

Loss of a single hand or foot
The permanent physical severance of either hand or either foot at or above the wrist or ankle joints.

Loss of a single limb
The permanent physical severance of a single limb from above the knee or elbow joint or the total loss of motor power to the entire limb.

Loss of hands or feet
Permanent physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

Loss of the use of a Whole Hand
Total and irreversible loss of muscle function or sensation to the whole of a hand due to trauma. The disability must be permanent and supported by appropriate neurological evidence.

Surgical Re-attachment of an Amputated Limb
Surgery to re-attach a limb following amputation at or above the wrist or ankle joint.

Third Degree Burns
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.

2. SEVERITY LEVELS

How is severity measured?

Third Degree Burns:
Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area. Adding up the injured areas provides an assessment of burn percentage.

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level A:

- Third degree burns
- Loss of hands or feet

Severity Level B:

- Loss of a single limb
- Less extensive Third degree burns covering 15% of the body's surface area

Severity Level C:

- Less extensive Third degree burns covering 10% of the body's surface area
- Loss of use of a whole hand
- Loss of a single hand or foot

Severity Level D:

- Surgical Re-attachment of an Amputated Limb

Severity Level E:

- Le Fort III Reconstruction
- Less extensive Third Degree Burns covering 5% of the body's surface area

Severity Level F:

- Amputation of two or more fingers or thumbs at the metacarpal bone

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Either or both of the following may apply to any claim under this category:

- Must be diagnosed and treated by an appropriate medical specialist
- Appropriate investigations and reports must be available

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.j Eye to Age 70 category – specified conditions of defined severity

1. DEFINITIONS

Blindness
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.

Blindness in one eye
Total permanent and irreversible loss of all sight in one eye.

Central Blindness
Permanent and irreversible loss of central vision of 20 degrees from the centre of the horizontal plane of the visual field. The measurement of this must be supervised by a Consultant Ophthalmologist.

Severe Visual Impairment
Permanent and irreversible reduction in the sight of both eyes such that the Snellen rating is less than 6/36 after correction.

Significant Visual Impairment
Permanent and irreversible reduction in the sight of both eyes such that the Snellen rating is less than 6/18 after correction.

Surgical Removal of one eye
Surgical removal of a complete eyeball for disease or trauma.

Surgical Repair of a Detached Retina
The surgical repair of a detached retina by a Consultant Ophthalmologist. Laser surgery is specifically excluded.

Tunnel Vision
Permanent and irreversible loss of peripheral vision such that the total field of vision is 90 degrees or less in the horizontal plane with both eyes open. The measurement of this must be supervised by a Consultant Ophthalmologist.

2. SEVERITY LEVELS

How is severity measured?

Visual acuity:
The Snellen rating is the measurement of visual acuity using a standard Snellen chart at 6 metres. This must be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at 6 metres letters that people with normal vision can read at 18 or 36 metres.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Blindness
- Severe Visual Impairment

Severity Level C:

- Significant Visual Impairment

Severity Level D:

- Central Blindness

Severity Level E:

- Blindness in one Eye
- Tunnel Vision
- Surgical Removal of one Eye

Severity Level F:

- Surgical repair of a detached retina

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Signs and symptoms must be compatible with the condition claimed
- The Consultant Ophthalmologist's report must be available with details of corrected visual acuity
- Relevant investigations must be performed

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1j) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Any temporary reduction in sight
- If a Consultant considers that a device or implant could result in the improvement of sight
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.k Ear to Age 70 category – specified conditions of defined severity

1. DEFINITIONS

Deafness
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.

Radical Mastoid Surgery
The surgical drainage and excision of chronically infected bony tissue from the mastoid area of the skull. There must have been radiological proof of bony destruction of the mastoid bones by infection.

Significant Hearing Loss in Both Ears
Permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram. There should be at least two measurements over a period of six months in order for a claim to be considered.

2. SEVERITY LEVELS

How is severity measured?

Hearing loss:
Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Deafness

Severity Level C:

- Significant hearing loss in both ears

Severity Level D:

- Radical Mastoid Surgery

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant investigations and reports must be available
- Must be diagnosed and treated by an appropriate medical specialist
- Must have relevant signs and symptoms

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1k) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.l Endocrine and Metabolic Diseases category – specified conditions of defined severity

1. DEFINITIONS

The following conditions are covered (only one payment will be made for each):

Acromegaly
A disease of the pituitary gland with production of excess growth hormone which cannot be suppressed below 2 ng/ml after a 75 Gram oral glucose load.

Addison's Disease
Primary Adrenal insufficiency is a disease in an individual who has never taken steroids without pituitary disease. There must be low levels of circulating steroids and high levels of Adrenocorticotrophic hormone. This must be present for at least six months.

Adrenalectomy
The therapeutic surgical removal of the complete adrenal gland for documented disease.

Conn's Syndrome
A disease of the adrenal glands with persistently raised aldosterone levels and reduced rennin levels. There must be evidence of low serum levels of potassium of less than 3 Mmol/L, rennin levels of less than 1ng/ml/Hr and a plasma aldosterone level of greater than 15 nG/dl.

Cushing's Syndrome
A disease in an individual who has never taken steroids with raised cortisol on 24 hour urine collection and confirmatory testing such as dexamethasone test or imaging of the adrenal and/or pituitary glands. This must be present for at least six months.

Diabetes Insipidus
The permanent inability of the body to concentrate urine. This must be permanent and be caused by either the lack of the hormone vasopressin to be secreted or the failure of the kidney to respond to vasopressin. This is not Diabetes Mellitus (Sugar Diabetes).

Insulin dependent Diabetes Mellitus (Type I)
Diagnosis of Diabetes Mellitus (Type 1), characterised by absolute insulin deficiency requiring on going treatment with exogenous insulin for survival.

For the above definition, the following are not covered:

- Gestational Diabetes
- Type 2 Diabetes (including Type 2 Diabetes treated with insulin)
- Latent Autoimmune Diabetes of Adulthood

This condition is not covered under core Serious Illness Cover for Children or Optional Serious Illness Cover for Children.

Insulinoma
A tumour of the pancreas producing high levels of insulin causing recurrent attacks of hypoglycaemia. The insulinoma must be diagnosed by MRI or CT scan.

Pheochromocytoma
A tumour of the adrenal gland producing high levels of adrenal hormones. The secretion can be demonstrated by high levels of urinary vanillyl mandelic acid and is associated with a compatible complication such as raised blood pressure.

Radiotherapy to the Pituitary Gland
Radiotherapy to the pituitary gland for the treatment of a documented pituitary adenoma.

Sheehan's Syndrome
Evidenced by radiological evidence of infarction of the pituitary gland, a serum prolactin of less than 5 ng per ml and evidence of failure of the pituitary to secrete other hormones.

Simmond's Disease
An irreversible failure of the pituitary to secrete normal levels of hormones. There must be all of the following: low T4 hormone levels, low T3 resin uptake, low testosterone levels and low prolactin levels. These must be present for at least six months and require replacement therapy.

Surgical Removal of the Pituitary Gland
The surgical removal of the pituitary gland for the treatment of a documented pituitary adenoma.

Thyrotoxic Crisis
A clinical condition in someone who has never taken thyroid hormones, with fever, rapid heart rate of over 130, delirium and coma. These symptoms must result in admission to hospital for at least seven days. There must be recorded levels of circulating thyroid hormones at least three times the normal level.

2. SEVERITY LEVELS

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level E:

- Diabetes Insipidus
- Insulin dependent Diabetes Mellitus (Type 1)
- Sheehan's Syndrome
- Thyrotoxic Crisis

Severity Level F:

- Conn's Syndrome
- Cushing's Syndrome
- Addison's Disease
- Pheochromocytoma
- Surgical Removal of the Pituitary Gland
- Radiotherapy to the Pituitary Gland
- Insulinoma
- Simmond's Disease
- Adrenalectomy
- Acromegaly

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant signs and symptoms must be present compatible with the condition claimed
- Investigations must be available
- Diagnosis and treatment must be by an appropriate medical specialist

4. SPECIFIC EXCLUSIONS

- Any claim for Non-Insulin dependent Diabetes Mellitus (Sugar Diabetes)
- Any claim for Insulin Dependent Diabetes Mellitus (type 1) under Core Serious Illness Cover for Children or Optional Serious Illness Cover for Children
- Any second claim at any time under any of the illnesses listed above in provision 1 l) i.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.m Major Organ Transplant category

1. DEFINITIONS

Major Organ Transplant

The undergoing as a recipient of a transplant 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. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells

Only one procedure is covered for transplants of the heart and/or both lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

2. SEVERITY LEVELS

Severity Level A:

- Major Organ Transplant

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Must be diagnosed and treated by an appropriate medical specialist
- Relevant investigation results and any other supporting specialist reports required
- Histology report must be available if needed

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.n Permanent Disability

1. DEFINITIONS

Cauda equina

The compression of the nerve roots in the lumbar spine causing the loss of sensation and movement to the bladder, bowel and both legs. The disability must be permanent and supported by appropriate neurological evidence.

Mental and Behavioural Disorder: Persistent Confusional State to age 70

An individual shall be considered to be in a persistent confusional state where the individual cannot:

i) Follow simple instructions
ii) perform simple daily tasks including eating, drinking and washing
iii) have any insight into his or her disability

AND

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force.

Mental and behavioural disorder: total lack of social interaction to age 70

An individual shall be considered to have a total lack of social interaction where the individual has:

- Ongoing medical treatment from a psychiatrist for more than two years
- And more than two in-patient admissions, each greater than one week
- And total lack of social interaction of any kind
- And the permanent inability to carry out all of the following:
  - Answering the telephone
  - Holding a face to face conversation for at least five minutes
  - Travelling fifty metres outside using all available aids

Total permanent disability

Your plan schedule indicates which of the following definitions apply.

a) Total permanent disability – own occupation

i) Total permanent disability – unable before age 70 to do your own occupation ever again

Loss of the physical or mental ability through an illness or injury before age 70 to the extent that *you* are unable to do the material and substantial duties of *your* 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 *your* own *occupation* that cannot reasonably be omitted or modified.

Own *occupation* means *your* trade, profession or type of work *you* do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability.

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 *you* expect to retire.

b) Total permanent disability – permanent failure of functional activity

i) Total permanent disability Unable, before age 65 to do a specified number of work tasks ever again (listed in provision D5.4).

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 *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii) Total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again

Loss of the physical ability through an illness or injury to do a specified number of tasks designed to assess whether *you* can look after yourself ever again (listed in provision D5.4).

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 *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

2. SEVERITY LEVELS

How is severity measured for total permanent disability – unable before age 65, to do a specified number of work tasks ever again or total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again?

The severity of a condition claimed under either of these benefits will be determined by the permanent inability to perform a number of tasks ever again. These tasks are listed in provision D5.4.

The inability to perform a particular task or number of tasks has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

Severity Level A:

- Cauda equina
- Mental and behavioural disorder – persistent confusional state to age 70
- Mental and behavioural disorder – total lack of social interaction to age 70
- Total permanent disability – unable before age 70 to do *your* own *occupation* ever again
- Total permanent disability – unable, before age 65, to do at least four work tasks ever again
- Total permanent disability – unable to do at least four tasks designed to assess whether *you* can look after yourself ever again

Severity Level C:

- Total permanent disability – unable, before age 65, to do at least two work tasks ever again
- Total permanent disability – unable to do at least two tasks designed to assess whether *you* can look after yourself ever again

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any of the following may apply to any claim under this category:

- Must be diagnosed and treated by an appropriate medical specialist
- Relevant investigations and reports must be available
- Signs and symptoms must be compatible with the condition claimed

In order for a total permanent disability claim to be paid, *we* will require that the extent of permanency has been established to *our* satisfaction.

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1n) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Any diagnosis. disease. disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion within the definition of any named condition
- Any exclusion applied specifically to *your plan*

Appendix 2

Illnesses and conditions impacted by Serious Illness Cover Booster

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster, the lump sum that *we* pay *you* in the event of a claim for certain serious illness conditions may be increased. This Appendix lists the conditions to which Serious Illness Cover Booster applies (see Provision B2.3). For details of the definitions for these conditions please refer to Appendix 1.

Appendix 2.1

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster then in the event of a claim for a Serious Illness Cover condition listed in Table 1 below *we* will increase the lump sum *we* pay *you* to 100% of *your* Serious Illness Cover.

CONDITION

Cancer

- Advanced Hodgkin's disease, classified as Ann-Arbor Stage II
- Advanced Non-Hodgkin's Lymphoma, classified as Ann-Arbor Stage II
- Advanced Cancer classified as a TNM group stage II tumour
- Cancer - excluding less advanced cases
- Multiple Myeloma
- Myelodysplasia, classified as Intermediate 1 under the International Prognostic Scoring System

Connective Tissue Disease

- Giant Cell Arteritis, Polyarteritis nodosa, Polymyositis, Rheumatoid Arhthritis, Systemic Lupus Erythematosis, Systemic Sclerosis (Scleroderma) or Wegener's Granulomatosis casuing the permanent inability to perform at least 3 out of 6 *functional activity tests*

Heart and artery

- Any other cardiac condition resulting in permanent ejection fraction of between 40% and 45% whilst on optimal therapy
- Aorta graft surgery
- Cardiomyopathy resulting in permanent ejection fraction of between 40% and 45% whilst on optimal therapy
- By-pass graft surgery to three or more coronary arteries
- Coronary artery by-pass grafts
- Heart Attack of specified severity
- Heart Attack resulting in permanent ejection fraction of between 40% and 45% whilst on optimal therapy
- Heart valve replacement or repair
- Hypertrophic Cardiomyopathy - resulting in maximal LV wall thickness between 15mm and 25mm
- Surgical repair of a structural lesion of the heart

Musculoskeletal trauma

- Less extensive third degree burns covering 15% of the body's surface area
- Loss of a single hand or foot
- Loss of a single limb
- Loss of use of a whole hand

Respiratory

- Stage IV Chronic obstructive pulmonary disease
- Fibrotic lung disease with transfer factor (or diffusing capacity) for carbon monoxide of between 35% and 39% of predicted
- Home oxygen therapy

Stroke and nervous systems

- Any neurological disease causing permanent and irreversible inability to perform 3 out of 6 *functional activity tests*
- Alzheimer's disease - resulting in permanent symptoms
- Benign brain tumour - resulting in permanent symptoms or surgery
- Bilateral hemianopia
- Coma - with associated permanent symptoms
- Creutzfeldt-Jakob disease - resulting in permanent symptoms
- Dementia - resulting in permanent symptoms
- Encephalitis - resulting in permanent symptoms
- Guillain-Barre Syndrome with a residual deficit measuring at least 3 on the Modified Rankin Scale
- Motor neurone disease - resulting in permanent symptoms
- Multiple Sclerosis - resulting in current symptoms
- Muscular Dystrophy
- Parkinsons Disease - resulting in permanent symptoms
- Progressive Supra-nuclear palsy - resulting in permanent symptoms
- Spinal Tumour
- Stroke – resulting in permanent symptoms
- Stroke with a residual deficit measuring at least 3 on the Modified Rankin Scale
- Stroke with a residual deficit measuring at least 2 on the Modified Rankin Scale
- Surgery for drug resistant epilepsy
- Traumatic Brain injury - resulting in permanent symptoms

Urogenital and kidney

- Severe chronic renal impairment

Appendix 2.2

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster then in the event of a claim for a Serious Illness condition listed in Table 2 below *we* will increase the lump sum *we* pay *you*. The increase in lump sum will depend on *your* age at the time *you* claim and the number of dependent children covered under Optional Serious Illness Cover for Children or Education Cover in this *plan*. The way the increase in lump sum is calculated is described in provision B2.3.

CONDITION

Connective Tissue Diseases

- Giant Cell Arteritis, Polyarteritis nodosa, Polymyositis, Rheumatoid Arthritis, Systemic Lupus Erythematosis, Systemic Sclerosis (Scleroderma) or Wegener's Granulomatosis causing the permanent inability to perform at least 4 out of 6 *functional activity tests*

Eye

- Blindness
- Severe visual impairment

Gastrointestinal

- Permanent faecal incontinence

Musculoskeletal trauma

- Loss of hands or feet
- Third degree burns

Permanent disability

- Cauda Equina
- Total and permanent disability - unable to do at least four tasks designed to assess whether *you* can look after yourself ever again.
- Total and permanent disability - unable before age 65 to do at least four work tasks ever again
- Mental and Behavioural disorder - persistent confusional state to age 70
- Total and permanent disability - unable before age 70 to do *your* own *occupation* ever again
- Mental and Behavioural disorder - total lack of social interaction to age 70

Stroke and nervous systems

- Any neurological disease causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Alzheimer's disease causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Benign Brain Tumour causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Coma causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Creutzfeldt-Jakob disease - causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Dementia causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Encephalitis causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Loss of manual dexterity
- Loss of muscle power resulting in the inability to grip
- Loss of speech
- Motor Neurone Disease causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Multiple Sclerosis causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Muscular Dystrophy causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Paralysis of limbs
- Parkinson's Disease causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Persistent vegetative state
- Progressive Supra-nuclear palsy causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*
- Stroke with residual deficit measuring 4 or above on the modified rankin scale
- Traumatic Brain Injury - causing permanent and irreversible inability to perform 4 out of 6 *functional activity tests*

Appendix 3

Disability Cover Illnesses and Conditions

Illnesses and Conditions – Definitions for Disability Cover (see provision C3).

1.a Advanced Cancer category – specified conditions of defined severity

1. DEFINITIONS

Advanced aplastic anaemia
Aplastic anaemia is the reduction of circulating red cells, white cells and platelets. For the purposes of this *plan* pancytopenia causing a reduction to 10% of the normal number of white cells and platelets as well as 50% of the normal levels of red cells, must be present. All lines of blood production must be depressed as demonstrated by bone marrow examination and abnormalities persisting on blood tests for a minimum of three months.

Advanced Cancer
An advanced malignant tumour that has progressed to at least Group Stage III of the TNM Classification of Malignant Tumours as described in the 6th edition of the International Union against Cancer (pub.Wiley-Liss).

Advanced Chronic Lymphocytic Leukaemia
For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood.

Chronic Lymphocytic Leukaemia is covered when it has progressed to Binet Stage C.

Advanced Hodgkin's Disease
reticulo-endothelial system, which includes the lymph nodes, spleen and liver characterised by Reed-Sternberg cells in the abnormal lymph tissue. The staging must have progressed to at least Stage III of the Ann-Arbor system.

Advanced Non-Hodgkin's Lymphoma
This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver. The staging must have progressed to at least Stage III of the Ann- Arbor system.

Bone Marrow Transplant
The undergoing as a recipient of a transplant of bone marrow or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells

Leukaemia
For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood. Acute leukaemias and Chronic Myeloid Leukaemia are covered under this *benefit*.

2. CATEGORY LEVELS

Sategory Level A:

- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Hodgkin's Disease classified as Ann- Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage III or above
- Acute Myeloid Leukaemia
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Chronic Myeloid Leukaemia
- Acute Lymphoblastic Leukaemia
- Bone marrow transplant as a recipient
- Inclusion on an official *UK* waiting list for the transplantation of bone marrow
- Advanced Aplastic Anaemia

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Copies of the histology and staging reports of the tissue removed or biopsied. Serum markers or radiological evidence alone are not acceptable for the diagnosis of cancer under the terms of this *plan*
- Confirmation of the diagnosis by an appropriate medical specialist and copies of the specialist and hospital reports
- Relevant CT/MRI scans, bone marrow histology and Full Blood Count results where appropriate

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.b Cardiovascular System category – specified conditions of defined severity

1. DEFINITIONS

Any Cardiac Condition resulting in a Reduced Ejection Fraction
Any cardiac condition causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

Cardiomyopathy resulting in a Reduced Ejection Fraction
A disease of the heart muscle causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

Congestive Heart Failure
The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and optimal therapy must have been established for at least six months. There must be at least three signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound
- Jugular venous pressure above 6 cms
- Rales present in both bases on auscultation
- Cardiomegaly on chest x-ray
- Grade 3, or gross ascites, associated with marked abdominal distension – severe oedema to a level above the knee

Heart Attack resulting in a Reduced Ejection Fraction
A heart attack causing permanent reduction in the efficiency of the heart to act as a pump. There must be permanent reduction in the ejection fraction to at least 45% or less. The measurement must be performed at least one month after an acute heart attack.

Heart Transplant
The undergoing as a recipient of a transplant of a complete heart or a heart and lung, or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, partsof organs, tissues or cells

Only one procedure is covered for transplants of the heart and/or both lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

Hypertrophic Cardiomyopathy - of specified severity
A disease of the heart muscle which results in thickening and enlargement of the interventricular septum or any myocardial segment. There must be a maximal LV wall thickness of at least 15mm in any myocardial segment confirmed via cardiac imaging and the diagnosis of hypertrophic cardiomyopathy must be confirmed by a consultant cardiologist.

For the above definition the following are not covered:

- Cardiomyopathy secondary to alcohol or drug misus

Severe Peripheral Vascular Disease

There must be severe restriction of blood flow through the arteries below the knee as measured by doppler readings of less than 30 per cent of normal and a claudication distance of 20 metres. Surgery must have failed to reverse this or be contraindicated for reasons as agreed by *our* Chief Medical Officer.

Severe Vascular Disease affecting Multiple Systems

Severe vascular disease affecting the heart, kidney and/or brain. There must be at least two of the following:

- Stroke*
- left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3
- Renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/l
- Grade 4 retinopathy; combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase, as specified in Category Levels A and B below

*For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be residual deficit with a Modified Rankin Scale of 2 or above.

2. CATEGORY LEVELS

How is severity measured?

Reduction in ejection fraction:

The ejection fraction is a measure of the efficiency of the pumping action of the heart; in a healthy heart this is typically greater than 50%. Damage to the muscle of the heart (myocardium) such as that sustained during myocardial infarction or cardiomyopathy, impairs the heart's ability to eject blood and therefore reduces ejection fraction. Where a severity is measured by the permanent reduction in ejection fraction it is measured by the percentage of the contents of the left ventricle that is expelled in each contraction of the ventricle. This can be measured by echocardiography or through radioisotope measurements. It must be measured in a cardiac laboratory, which has regular quality control audits available to us, and be supervised by a Consultant Cardiologist.

The disease or disorder causing the reduction in ejection fraction must be established as being permanent and irreversible and the measurement must be taken whilst the patient is on optimal treatment.

Stroke:

Severity is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored form 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

Congestive heart failure:

Severity is measured by presence of at least three signs of congestive heart failure.

Category Level A:

- Cardiomyopathy resulting in a permanent ejection fraction of 39% or less whilst on optimal therapy
- Heart attack resulting in a permanent ejection fraction of 39% or less whilst on optimal therapy
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25 mm
- Any other cardiac condition resulting in a permanent ejection fraction of 39% or less whilst on optimal therapy
- Heart, or heart and lung transplant
- Inclusion on an official *UK* waiting list for the transplantation of a heart, or a heart and lung transplant
- At least four signs of congestive heart failure on optimal therapy for at least six months
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 110mmHg on optimal therapy
- Severe peripheral vascular disease

Category Level B:

- Cardiomyopathy resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy
- Heart attack resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy

- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of between 15mm and 25 mm.
- Any other cardiac condition resulting in a permanent ejection fraction of between 40% and 45% whilst on optimal therapy
- At least these signs of congestive heart failure on optimal therapy for at least six months
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 100mmHg on optimal therapy

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Full cardiologist's, cardiothoracic, neurosurgeon or vascular surgeon's assessment and operation notes
- Relevant electrocardiographs, angiograms, aortograms, thallium scans, echocardiograms, X-rays, CT scans or any other relevant test results and reports
- Cardiac enzyme results for heart attacks. Raised serum CKMB fraction or positive Troponin-T or I, if performed. Raised creatinine kinase and LDH alone are not considered
- History of signs and symptoms compatible with the condition

4. SPECIFIC EXCLUSIONS

- Any Acute coronary syndromes which do not completely satisfy any of the above definitions including, but not limited to, angina
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Alcoholic Cardiomyopathy
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.c Digestive System category – specified conditions of defined severity

1. DEFINITIONS

Fulminant Hepatic Necrosis

Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

Liver Transplant

The undergoing as a recipient of a transplant of a complete liver or inclusion on an official *UK* waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells

If, in the opinion of *our* Chief Medical Officer, alcohol or drug abuse is a significant contributing factor as a cause of liver disease necessitating a transplant, the claim will be declined.

Pancreas Transplant

The undergoing as a recipient of a transplant of a complete pancreas or inclusion on an official *UK* waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells

If, on the balance of probabilities, alcohol or drug abuse is a significant contributing factor as a cause of pancreatic disease necessitating a transplant, the claim will be declined.

Permanent Faecal Incontinence

There must be permanent incontinence of faeces with constant soiling, despite optimal therapy, for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

Severe Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy.

To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/litre, and abnormal protein production marked by decreased albumin levels below 27 G/L
- Abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR) above 2.0

If, in the opinion of *our* Chief Medical Officer, alcohol or drug abuse is a significant contributing factor as a cause of severe cirrhosis of the liver, the claim will be declined.

Severe Inflammatory Crohn's Disease

A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To be considered as severe, symptoms must not have responded to optimal therapy while under the continued supervision of a Gastroenterologist.

There must also be evidence of continued inflammation with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital
- Fistula formation between loops of bowel or bowel to another organ, and
- At least one resection of a segment of small bowel

2. CATEGORY LEVELS

Category Level A:

- Fulminant Hepatic Necrosis
- Severe Cirrhosis of the Liver
- Transplantation of a liver
- Inclusion on an official *UK* waiting list for the transplantation of a liver
- Transplantation of a pancreas
- Inclusion on an official *UK* waiting list for the transplantation of a pancreas
- Permanent faecal incontinence

Category Level B:

- Severe Inflammatory Crohn's disease

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Diagnosis and treatment by an appropriate medical specialist
- Relevant investigations, results, copies of hospital and histology reports signed by a suitably qualified Consultant Histopathologist
- Appropriate signs and symptoms compatible with the condition claimed

4. SPECIFIC EXCLUSIONS

- Alcohol or drug abuse
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.d Mental and Behavioural Disorders category – specified conditions of defined severity

1. DEFINITIONS

Legally institutionalised

Compulsory admission under the Mental Health Act, 1983. There must be ongoing medical treatment from a psychiatrist for more than two years.

Persistent Confusional State
An individual shall be considered to be in a persistent confusional state where the individual cannot:

i) Follow simple instructions
ii) perform simple daily tasks including eating, drinking and washing
iii) have any insight into his or her disability; and a Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force

Total lack of Social Interaction
An individual shall be considered to have a total lack of social interaction where the individual has:

- Ongoing medical treatment from a psychiatrist for more than two years; and more than two in-patient admissions, each greater than one week; and total lack of social interaction of any kind
- The permanent inability to carry out all of the following:
  - Answering the telephone
  - Holding a face to face conversation for at least five minutes
  - Travelling fifty metres outside using all available aids

2. CATEGORY LEVELS

Category Level A:

- Persistent confusional state
- Total lack of Social Interaction

Category Level B:

- Legally institutionalised

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Diagnosis and treatment by an appropriate medical specialist
- Copies of all available specialist reports

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.e Musculoskeletal System category – specified conditions of defined severity

1. DEFINITIONS

Cauda equina
The compression of the nerve roots in the lumbar spine causing the loss of sensation and movement to the bladder, bowel and both legs. The disability must be permanent and supported by appropriate neurological evidence.

Connective Tissue Diseases
Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. Connective tissue diseases are specifically diagnosed by certain criteria and for the purposes of this *plan* only the following diseases will be covered: giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) and Wegener's granulomatosis.

The full definitions for these are listed below. Other diseases such as sero-negative arthritis, psoriatic arthritis or osteoarthritis are not covered.

Giant Cell Arteritis
The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

Polyarteritis Nodosa
The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

Polymyositis
Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this *plan* there must be all of the following:

- Elevated serum muscle enzymes (CK, aldolase)
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM)
- Muscle biopsy findings typical of PM or DM (as defined above)
- Compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria

Rheumatoid Arthritis
The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

Systemic Lupus Erythematosis (SLE)
The definite diagnosis of Systemic Lupus Erythmatosis (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

Systemic Sclerosis (Scleroderma)
The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

Wegener's Granulomatosis
The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

Less Extensive Third Degree Burns
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 10% of the body's surface area.

Loss of a single hand or foot
Permanent physical severance of either hand or either foot at or above the wrist or ankle joint.

Loss of a single limb
Permanent physical severance of a single limb from above the knee or elbow joint.

Loss of hands or feet
Permanent physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

Radiculopathy and Significant Extremity Impairment
A disease of the spinal nerve roots resulting in significant impairment of the nerves in the legs.

There must be all of the following:

- Muscle biopsy findings typical of PM or DM Loss of the ability to raise the affected leg straight to more than 30 degrees; Muscle biopsy findings typical of PM or DM atrophy of affected muscles;
- Muscle biopsy findings typical of PM or DM loss of reflexes, and
- Muscle biopsy findings typical of PM or DM numbness (loss of all sensation of touch and pinprick) in the corresponding dermatome

The disability must be permanent and supported by appropriate neurological evidence.

Third Degree Burns
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.

2. CATEGORY LEVELS

How is severity measured?

Connective Tissue Diseases:
For the purposes of this *plan* the severity of Connective Tissue Diseases will be determined by the permanent inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

Third Degree Burns:
Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area. Adding up the injured areas provides an assessment of burn percentage.

Category Level A:

- Third degree burns covering at least 20% of the body's surface area
- Loss of Hands or Feet
- Cauda equina
- Connective Tissue Diseases causing the permanent inability to perform at least four out of six *functional activity tests*. See provision D5.4

Category Level B:

- Less extensive third degree burns covering at least 10% of the body's surface area
- Loss of a single hand or foot
- Loss of a single limb
- Connective Tissue Diseases causing the permanent inability to perform at least two out of six *functional activity tests*. See provision D5.4
- Radiculopathy and significant extremity mpairment

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Must be diagnosed and treated by an appropriate medical specialist
- Appropriate investigations and reports mustbe available

4. SPECIFIC EXCLUSIONS

- Fibromyalgia, or any synonym including, but not limited to, fibromyositis, fibrositis, muscular rheumatism, myofascial pain syndrome
- Osteoarthritis, wear and tear or any other subjective, non-diagnosed condition
- Chronic fatigue syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free disease
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.f Nervous System category – specified conditions of defined severity

1. DEFINITIONS

Bilateral Hemianopia
Permanent and irreversible loss of vision in one half of the visual field of both eyes.

Blindness
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.

Deafness
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.

Dementia
A definite diagnosis of dementia by a ConsultantNeurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Loss of Eye-Hand Co-ordination
Total and irreversible loss of all eye-hand coordination such that the subject is incapable of being able to do all of the following:

- Write
- Feed by bringing a fork or spoon to mouth
- Drink unaided from a cup, glass or mug

Loss of Manual Dexterity
Total and irreversible loss of the ability to use the hands and fingers with precision to perform daily activities of work such as picking up or manipulating small objects, operating a range of equipment manually or communicating through writing or typing. The disability must be permanent and supported by appropriate neurological evidence.

Loss of Muscle Power resulting in the inability to grip
Total and irreversible loss of all muscle power in both hands resulting in the inability to grip any tool, utensil or assistive device. The disability must be permanent and supported by appropriate neurological evidence.

Loss of Use of a Leg
Total and irreversible loss of muscle function or sensation to the whole of a leg as a result of injury or disease. The disability must be permanent and supported by appropriate neurological evidence.

Loss of Use of a Whole Hand
Total and irreversible loss of muscle function or sensation to the whole of a hand as a result of injury or disease. The disability must be permanent and supported by appropriate neurological evidence.

Neurological Diseases
Several neurological diseases not specifically stated under this *benefit* can still cause a significant impact to *your* daily activities. To cover these conditions *we* will pay a *benefit* if *you* become permanently unable to perform certain *functional activity tests* due to a neurological disease. The neurological system comprises the system of cells, tissues and organs that regulate the body's responses to internal and external stimuli and consists of the brain, spinal cord, nerves, ganglia and parts of the receptor and effector organs. See provision D5.4 for full details of these *functional activity tests*.

Paralysis of Limbs
Total and irreversible loss of muscle function to the whole of any two limbs.

Persistent Disabling Monoplegia
Total and irreversible loss of muscle function or sensation to the whole of one arm or leg as a result of injury or disease. The disability must be permanent and supported by appropriate neurological evidence.

Persistent Vegetative State
A severe neurological condition of decreased consciousness where there must be all of the following:

- The loss of an awareness of surroundings
- The lack of speech
- The lack of response to commands
- The lack of any purposeful movements

This condition must be permanent and supported by appropriate neurological evidence.

Severe Visual Impairment
Permanent and irreversible reduction in the sight of both eyes such that the Snellen rating is less than 6/36, after correction in the better eye.

Significant Hearing Loss in Both Ears
Permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram.

There must be at least two measurements over a period of six months in order for a claim to be considered.

Significant Visual Impairment
Permanent and irreversible reduction in the sight of both eyes such that the Snellen rating is less than 6/18, after correction in the better eye.

Stroke (with a residual deficit measuring 4 or above on the Modified Rankin Scale)

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms. For the above definition, the following are not covered:

- Transient ischaemic attack
- Traumatic injury to brain tissue or blood vessels
- Death of tissue of the optic nerve or retina/eye stroke

Total Aphasia
The total lack of the ability to speak. The disability must be permanent and supported by appropriate neurological evidence.

2. CATEGORY LEVELS

How is severity measured?

Modified Rankin Scale:
Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

Neurological diseases:
The severity will be determined by the permanent inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

Visual acuity:
The Snellen rating is the measurement of visual acuity using a standard Snellen chart at six metres. This should be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at six metres letters that people with normal vision can read at 18 or 36 metres.

Hearing loss:
Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry.

Category Level A:

- Blindness*
- Deafness*
- Loss of manual dexterity
- Loss of muscle power resulting in the inability to grip
- Paralysis of limbs
- Persistent vegetative state
- Severe visual impairment*
- Stroke (with a residual deficit measuring 4 or above on the Modified Rankin Scale)
- Any neurological disease causing the permanent inability to perform at least four out of six *functional activity tests* (FATs). See provision D5.4.

Category Level B:

- Dementia
- Loss of eye-hand co-ordination
- Loss of use of a leg
- Loss of use of a whole hand
- Bilateral hemianopia*
- Persistent disabling monoplegia
- Significant hearing loss in both ears*
- Significant visual impairment*
- Total aphasia*
- Any neurological disease causing the permanent inability to perform at least two out of six *functional activity tests* (FATs). See provision D5.4

*Hearing, speech and sight measurements are not limited to causes within the nervous system, but to any anatomical or functional impairment causing these outcomes. All measurements are with appropriate aids.

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results
- Diagnosis made by an appropriate medical specialist
- Appropriate signs and symptoms must be present and compatible with the condition claimed
- Loss of neurological function compatible with area of damage of the brain involved

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.g Renal Disease category – specified conditions of defined severity

1. DEFINITIONS

Chronic Renal Impairment
The impairment in kidney function such that the estimated glomerular filtration rate is below 25 mls/litre/min/1.73 m2 surface area persistently for a period of six months or more.

Kidney Failure
Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

Kidney Transplant
The undergoing as a recipient of a transplant of a complete kidney or inclusion on an official *UK* waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

2. CATEGORY LEVELS

How is severity measured?

Renal function:
Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter.

Category Level A:

- Kidney failure
- Transplantation of a kidney as a recipient
- Inclusion on an official *UK* waiting list for the transplantation of a kidney, as a recipient

Category Level B:

- Chronic renal impairment

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Diagnosis and treatment by an appropriate medical specialist
- Copies of all available specialist reports.
- Details of current and historic renal function tests
- Histology of biopsies and any other relevant investigations must be available

4. SPECIFIC EXCLUSIONS

- Kidney donation
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.h Respiratory System category – specified conditions of defined severity

1. DEFINITIONS

Chronic Obstructive Pulmonary Disease

A disease of the airways of the lung causing obstruction to the exhalation of air. There must be permanent and irreversible reduction of the maximum volume of air expelled in one second (FEV1) of less than 50% of predicted. There must be permanent and irreversible obstruction to airflow demonstrated by a FEV1/FVC ratio of less than 50% and there must be less than 5% variation in three repeated measurements, (which must be performed under the direction of a specialist respiratory physician) whilst on optimal therapy. They must be measured in a respiratory laboratory which has regular quality control audits available to us. These measurements must be repeated after an interval of at least three months and must also satisfy the criteria mentioned above for a claim to be considered. Only the following severity is covered:

- Stage IV – where FEV1 is 30% or less of predicted.

When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made for the condition which is at the highest severity level.

Cor Pulmonale

Irreversible right ventricular failure due to a lung disease producing raised pulmonary artery pressure (Pulmonary Hypertension). There must be evidence of raised pulmonary artery pressure of at least 30mmHG (mm of mercury) and there must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

Fibrotic Lung Disease

For the purpose of this *plan* fibrotic lung disease is defined as one of the following only:

- Sarcoidosis
- Fibrosing Alveolitis
- Aspergilosis

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

These tests must be performed under the direction of a specialist respiratory physician whilst on optimal therapy. They must also be measured in a respiratory laboratory, which has regular quality control audits available to us, and be supervised by the treating specialist.

When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made (for the condition which is at the highest severity level).

Lung Transplant

The undergoing as a recipient of a transplant of lung or a heart and lung, or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells. Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whetherthe procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

Primary Pulmonary Hypertension

The presence of irreversible raised pressure in the pulmonary arteries. The measurement reported must be the average level measured by cardiac catheterisation and be at least 30mmHG (mm of mercury) at rest. There must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

Removal of Two or more Lobes of the Lungs

The therapeutic surgical removal of two or more lobes of the lungs for documented disease or trauma.

2. CATEGORY LEVELS

How is severity measured?

Chronic Obstructive Pulmonary Disease:

The severity is assessed by the measurement of:

1. Vital Capacity (VC). This is the maximum total volume of air that can be expelled from the lung after maximum inhalation
2. The Forced Expiratory Volume 1 (FEV1). The maximum volume of air expelled in one second.
3. The ratio of the two measurements. Fibrotic Lung Disease: The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor.

Category Level A:

- Fibrotic lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less
- Lung, or Heart and Lung transplant
- Inclusion on an official *UK* waiting list for the transplantation of a lung, or a heart and lung
- Primary Pulmonary Hypertension
- Cor Pulmonale

Category Level B:

- Fibrotic lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 35% and 39% of predicted
- Stage IV Chronic Obstructive Pulmonary Disease
- Removal of two or more lobes of the lungs

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Must be diagnosed and treated by an appropriate medical specialist
- Relevant pulmonary and cardiac investigations must be done and be available
- Histology report must be available if needed
- Appropriate signs and symptoms compatible with the condition being claimed

4. SPECIFIC EXCLUSIONS

- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.i Permanent failure of functional activity

i) Total permanent disability – unable, before age 65, to do a specified number of work tasks ever again

Loss of the physical ability through an illness or injury to do a specified number of work tasks (listed in provision D5.4) 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 *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii) Total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again.

Loss of the physical ability through an illness or injury to do a specified number of tasks designed to assess whether *you* can look after yourself (listed in provision D5.4) 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 *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

Appendix 4

2. SEVERITY LEVELS

How is severity measured for total permanent disability – unable, before age 65, to do a specified number of work tasks ever again or total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again?

The severity of a condition claimed under either of these benefits will be determined by the permanent inability to perform a number of tasks ever again. These tasks are listed in provision D5.4.

The inability to perform a particular task or number of tasks has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

Category Level A:

- Total permanent disability – unable, before age 65, to do at least 4 work tasks ever again
- Total permanent disability – unable to do at least 4 tasks designed to assess whether *you* can look after yourself ever again

Category Level C:

- Total permanent disability – unable, before age 65, to do at least 2 work tasks ever again
- Total permanent disability – unable to do at least 2 tasks designed to assess whether *you* can look after yourself ever again

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Must be diagnosed and treated by an appropriate medical specialist
- All relevant investigations must be done and the results available
- All histology reports must be available if needed
- Appropriate signs and symptoms compatible with the condition claimed

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

LifestyleCare Cover definitions

1. DEFINITIONS

Severity Level 1

The amount of the claim depends on the severity of the illness *you* suffer. In order to meet the criteria for Severity Level 1, *you* must meet one of the following definitions:

Alzheimer's Disease - resulting in permanent symptoms

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
- Perceive, understand, express and give effect to ideas

For the above definition, the following are not covered:

- Other types of dementia

Dementia - resulting in permanent symptoms

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor and muscle rigidity. For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism

Severity Level 2

In order to meet the criteria for Level 2, *you* must meet one of the following three definitions:

i) Permanent Inability to perform 3 out of 6 tasks designed to assess whether you can look after yourself ever again.

There must be permanent clinical loss of the ability to perform three or more of the following tasks. To make this assessment *we* will need an appropriate medical specialist to confirm that *you* are permanently unable to perform these tasks. *You* must need the help or supervision of another person and be unable to perform the task on *your* 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
- Getting between rooms - The ability to get from room to room on a level floor
- Feeding yourself – The ability to feed yourself when food has been prepared and made available
- Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again.
- Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function

For the above definitions, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii) Persistent Confusional State

An individual shall be considered to be in a persistent confusional state where the individual cannot:

i) Follow simple instructions

ii) perform simple daily tasks including eating, drinking and washing; and

iii) have any insight into his or her disability

AND

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property

iii) Severe stroke - resulting in permanent symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in a permanent residual neurological deficit measuring 4 or above on the Modified Rankin Scale

For the above definition, the following are not covered:

- Transient Ischaemic Attack
- Traumatic Injury to brain tissue or blood vessels
- Death of tissue of the optic nerve or retina/eye stroke

2. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results

- Diagnosis made by an appropriate medical specialist
- For conditions affecting the nervous system any loss of neurological function should be compatible with the area of damage of the brain involved.

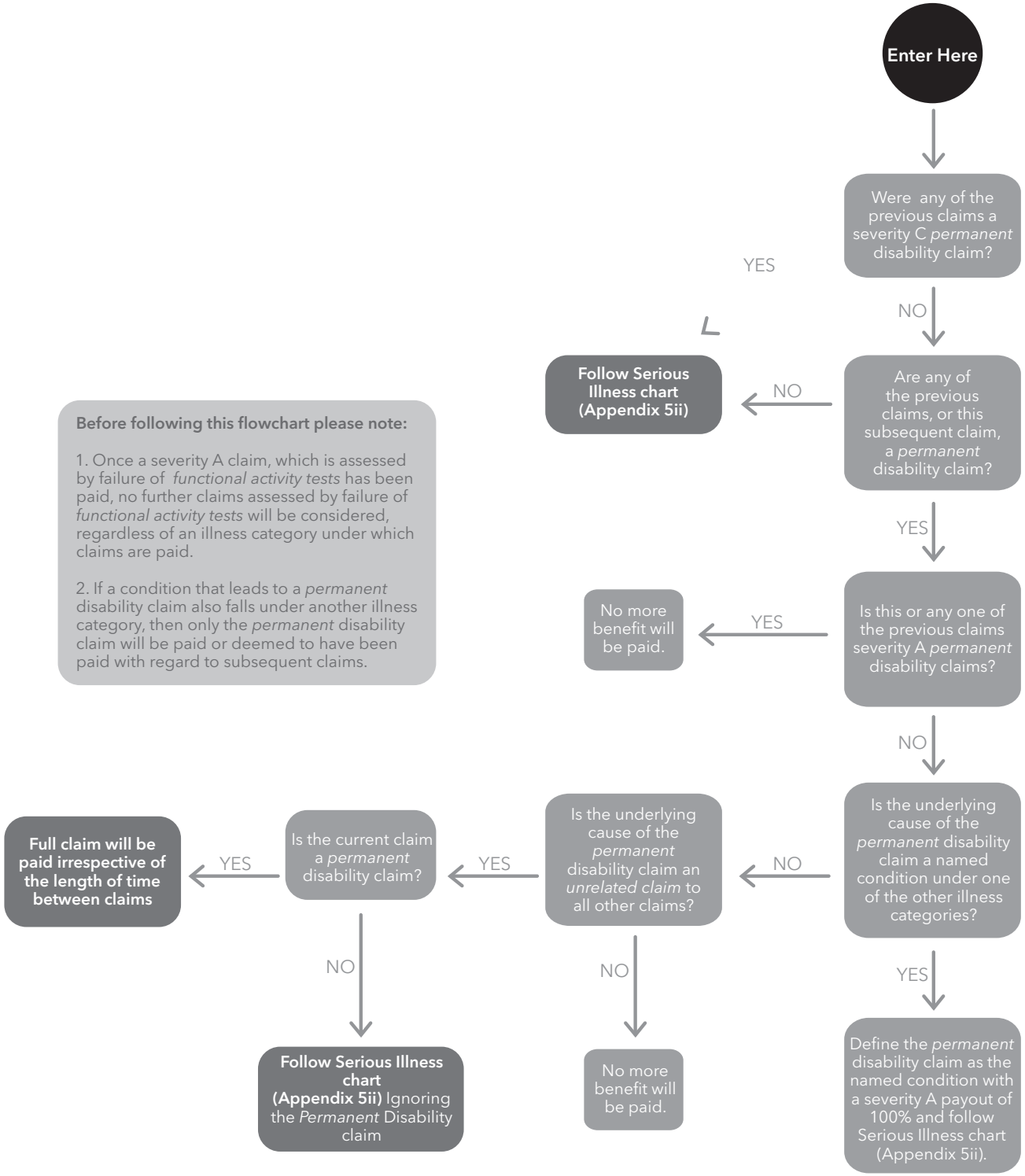
We will use the Modified Rankin Scale (van Swieten et al. 1988) to measure the severity of a Stroke. This is an internationally accepted measure of disability for Stroke, It is scored from 0 to 5 with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

3. SPECIFIC EXCLUSIONS

- Any condition stated in section 1 above where the required permanence has not been established before the cover terminates
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

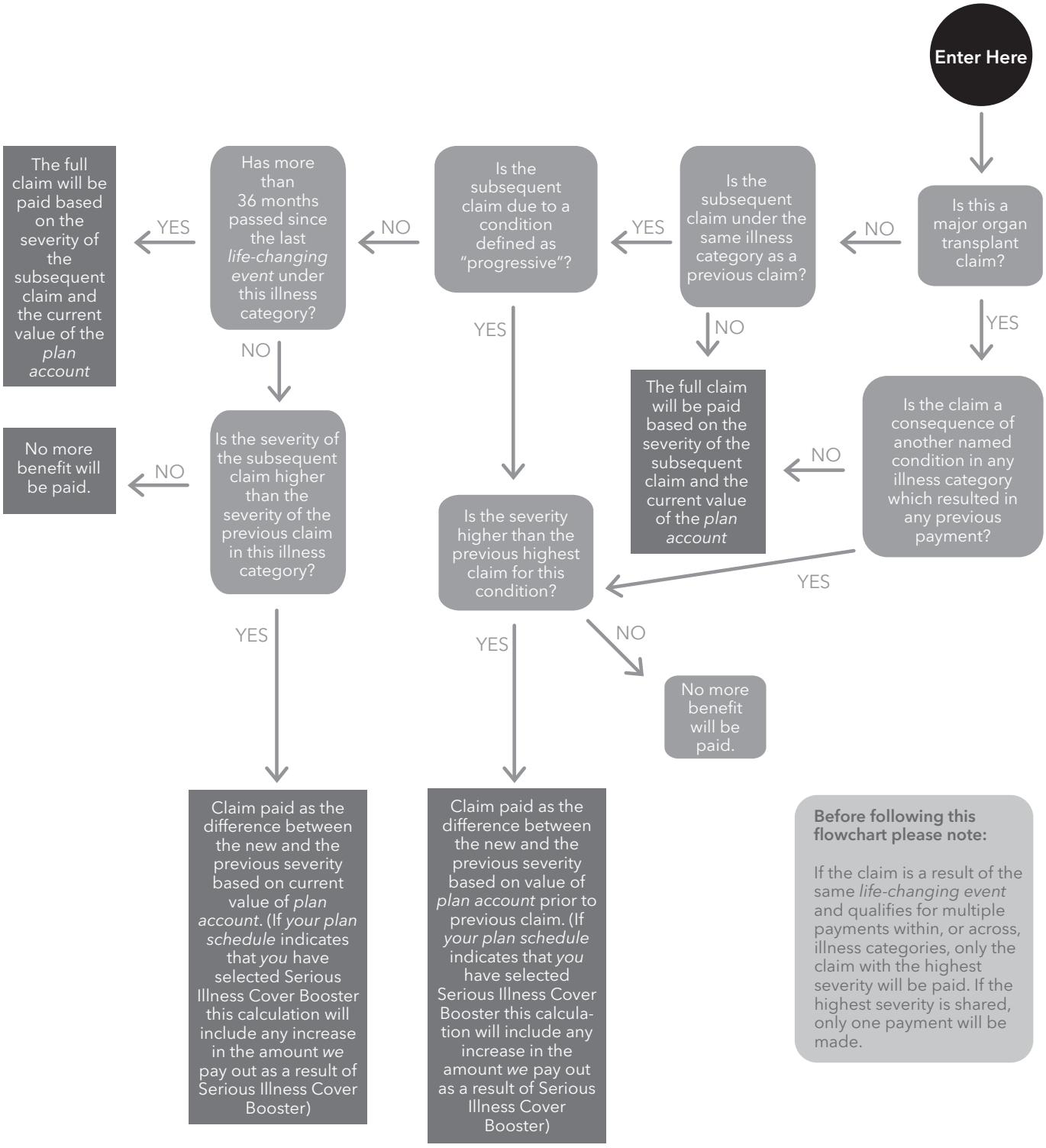
Appendix 5 (i) - Subsequent Claims for Serious Illness Cover

Assessment of subsequent claims for permanent disability



Appendix 5 (ii) - Subsequent Claims for Serious Illness Cover

Assessment of subsequent progressive or subsequent unrelated serious illness cover claims

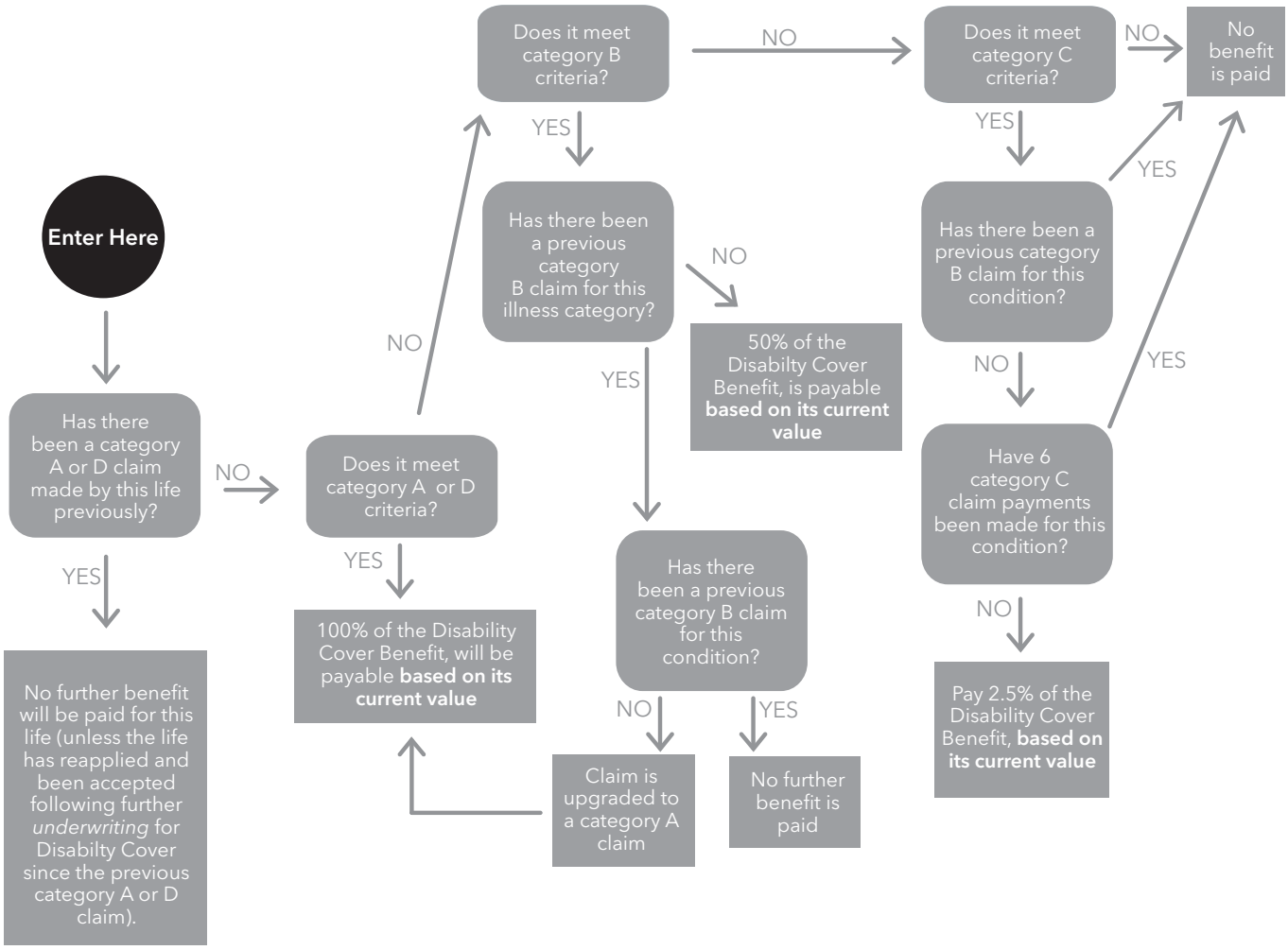


Before following this flowchart please note:

If the claim is a result of the same *life-changing event* and qualifies for multiple payments within, or across, illness categories, only the claim with the highest severity will be paid. If the highest severity is shared, only one payment will be made.

Appendix 6 - Subsequent Claims for Disability Cover

This is a visual aid overview. Other relevant information and full details of the exclusions can be found in C3 and D5.6 of these provisions.



PRUPT11998_01/2016_J0445

Discovery

Part of the Discovery Group