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. You can also email us at lifeenquiries@vitality.co.uk or 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

| A1. Your plan account | 4 |
| A2. How other covers work | 5 |
| A3. How long your plan lasts | 5 |

### B. Core covers

| B1. Life Cover | 6 |
| B2. Serious Illness Cover | 9 |
| B3. Income Protection Cover | 17 |

### C. Other covers and options

| C1. Dementia and FrailCare Cover | 31 |
| C2. Core Serious Illness Cover for Children | 35 |
| C3. Optional Serious Illness Cover for Children | 37 |
| C4. Disability Cover | 39 |
| C5. Mortgage Free Cover | 42 |
| C6. Family Income Cover | 44 |
| C7. Education Cover | 52 |
| C8. Waiver of Premium on Incapacity | 59 |
| C9. Waiver of Premium on Serious Illness | 61 |
| C10. Waiver of Premium on Death | 62 |
| C11. Guaranteed Insurability options | 63 |
| C12. Protected Cover | 66 |

### D. Managing your plan

| D1. Paying your premiums | 67 |
| D2. Guaranteed premiums | 69 |
| D3. Reviewable premiums | 70 |
| D4. Changing your covers | 71 |
| D5. Claiming a benefit | 74 |
| D6. How a joint life first death plan continues if one person dies | 79 |
| D7. How a joint life second death plan continues if one person dies | 80 |

### E. How Vitality rewards you for being healthy

| E1. Your Vitality Status | 81 |
| E2. Vitality Optimiser | 81 |
| E3. Wellness Optimiser | 82 |
| E4. Vitality Benefits on your plan | 84 |
| E5. The Vitality commitment | 85 |
### F. General terms and conditions

<table>
<thead>
<tr>
<th>Term</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1. When your plan ends</td>
<td>87</td>
</tr>
<tr>
<td>F2. When we can make changes to your plan</td>
<td>87</td>
</tr>
<tr>
<td>F3. Cancelling your plan</td>
<td>87</td>
</tr>
<tr>
<td>F4. Cash value</td>
<td>88</td>
</tr>
<tr>
<td>F5. Mis-statement of age</td>
<td>88</td>
</tr>
<tr>
<td>F6. Assignment</td>
<td>88</td>
</tr>
<tr>
<td>F7. Payments and currency</td>
<td>88</td>
</tr>
<tr>
<td>F8. Impact on means tested benefits</td>
<td>88</td>
</tr>
<tr>
<td>F9. Complaints</td>
<td>88</td>
</tr>
<tr>
<td>F10. If we can’t meet our obligations</td>
<td>89</td>
</tr>
<tr>
<td>F11. Insurable interest</td>
<td>89</td>
</tr>
<tr>
<td>F12. Law</td>
<td>89</td>
</tr>
<tr>
<td>F13. Data Protection Notice</td>
<td>89</td>
</tr>
</tbody>
</table>

### G. Definitions

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Illnesses and Conditions</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Illnesses and Conditions impacted by Serious Illness Cover Booster</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Disability Cover Illnesses and Conditions</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>LifestyleCare Cover Definitions</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Dementia and FrailCare Cover Definitions</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Subsequent Claims for Serious Illness Cover</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Subsequent Claims for Disability Cover</td>
</tr>
</tbody>
</table>
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 are based on a percentage of the plan account.

If we make a payment 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 Protected Life Cover and the Protected Life and Serious Illness Cover options in provision C12.
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:

<table>
<thead>
<tr>
<th>Your plan account structure</th>
<th>What this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td>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.</td>
</tr>
<tr>
<td>Indexed</td>
<td>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 £18,000,000, 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.</td>
</tr>
</tbody>
</table>
| 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 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.

Certain covers such as Dementia and FrailCare Cover may start once other specific covers terminate. There is more about this in provision C1.

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.

<table>
<thead>
<tr>
<th>Single or joint life?</th>
<th>When we will pay the benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single life plan</td>
<td>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.</td>
</tr>
<tr>
<td>Joint life first death</td>
<td>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 person covered, 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.</td>
</tr>
<tr>
<td>Joint life second death</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 £18,000,000. 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 we 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.
• 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.

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:

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>What percentage of your amount of LifestyleCare Cover we pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>20%</td>
</tr>
<tr>
<td>Level 2</td>
<td>100%</td>
</tr>
</tbody>
</table>

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 C2.

Serious Illness Cover must be for a fixed term. If your plan also has Life Cover for 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 will not pay

We will not pay if:

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

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.

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

The percentage of your cover we will pay

<table>
<thead>
<tr>
<th>Severity level</th>
<th>The percentage of your cover we will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (most severe)</td>
<td>100%</td>
</tr>
<tr>
<td>B</td>
<td>75%</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
</tr>
<tr>
<td>D</td>
<td>25%</td>
</tr>
<tr>
<td>E</td>
<td>15%</td>
</tr>
<tr>
<td>F</td>
<td>10%</td>
</tr>
<tr>
<td>G (least severe)</td>
<td>5%</td>
</tr>
</tbody>
</table>

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 to E. 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.

<table>
<thead>
<tr>
<th>Age attained at date of diagnosis</th>
<th>What percentage of your Serious Illness Cover we will pay</th>
<th>Age attained at date of diagnosis</th>
<th>What percentage of your Serious Illness Cover we will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 24</td>
<td>200</td>
<td>45</td>
<td>147.5</td>
</tr>
<tr>
<td>25</td>
<td>197.5</td>
<td>46</td>
<td>145</td>
</tr>
<tr>
<td>26</td>
<td>195</td>
<td>47</td>
<td>142.5</td>
</tr>
<tr>
<td>27</td>
<td>192.5</td>
<td>48</td>
<td>140</td>
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<td>28</td>
<td>190</td>
<td>49</td>
<td>137.5</td>
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<tr>
<td>29</td>
<td>187.5</td>
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<td>135</td>
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<td>30</td>
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<td>132.5</td>
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<td>31</td>
<td>182.5</td>
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<td>130</td>
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<td>32</td>
<td>180</td>
<td>53</td>
<td>127.5</td>
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<td>33</td>
<td>177.5</td>
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<td>175</td>
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<td>36</td>
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<td>105</td>
</tr>
<tr>
<td>42</td>
<td>155</td>
<td>63</td>
<td>102.5</td>
</tr>
<tr>
<td>43</td>
<td>152.5</td>
<td>64 and older</td>
<td>100</td>
</tr>
<tr>
<td>44</td>
<td>150</td>
<td>65 and older</td>
<td>100</td>
</tr>
</tbody>
</table>

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. Any serious illness, that resulted from a single life-changing event, that progresses will be treated as a progressive claim.

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 Protected Cover option. For more about the Protected Cover option, see provision C12.

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 6.

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 Protected Life and Serious Illness Cover option. For more about this, see provision C12.

Subsequent claims

If you have already claimed we will classify any subsequent claims you make as either a progressive claim or an unrelated claim.

<table>
<thead>
<tr>
<th>Progressive claims</th>
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<tbody>
<tr>
<td><strong>Definition</strong></td>
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<tr>
<td><strong>When we won’t pay</strong></td>
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<tr>
<td><strong>When we will pay</strong></td>
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<tr>
<td><strong>How we calculate the amount we will pay</strong></td>
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</table>
There are four types of claim that we treat differently compared to the table above.

1. **Subsequent claims due to Heart Attack or Stroke**

If you make a valid claim that is caused by a Heart Attack or Stroke, we will treat any subsequent claim of the same or lower severity as an unrelated claim if:

- the subsequent claim is caused by the same life changing event as the previous claim; and
- the Heart Attack or Stroke that causes the subsequent claim occurs at least 30 days after the life changing event that caused the previous valid claim.

Note: Heart Attack and Stroke are treated as two different life changing events.

2. **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 ‘subsequent claims’ - see above.

3. **Subsequent permanent disability claims**

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 previous 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 previous 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, or
- Under a different body system category.

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 is not related to the underlying cause of your permanent disability claim

4. Subsequent claims under the cancer body system category if you have the Cancer Relapse Benefit

This is only applicable to claims under Comprehensive Serious Illness Cover. For more information see provision B2.8 Cancer Relapse Benefit.

B2.8 Cancer Relapse Benefit

Cancer Relapse Benefit pays a lump sum benefit if you are diagnosed with a relapse of cancer and make a subsequent claim under the cancer body system category. Cancer Relapse Benefit is automatically included on Comprehensive Serious Illness Cover.

We will pay a claim under Cancer Relapse Benefit if the condition occurs after a remission* period of at least one year following the life changing event that caused your previous claim.

We will pay out Cancer Relapse Benefit in two ways:

1. We will pay a subsequent claim for the same cancer that recurs at the same or lower severity
2. We will increase the lump sum we pay you by 50%.

*Remission is defined as being cancer free after the completion of chemotherapy, radiotherapy, surgical treatment or biological therapy (if indicated), and confirmed by the subsequent absence of radiological or biochemical (including molecular) evidence of disease. Hormone treatment is not regarded as active treatment for purposes of the remission definition.

B2.8.1 When we will pay the benefit

1. Subsequent claims under Cancer Relapse Benefit

Under Cancer Relapse Benefit we will pay subsequent claims for the relapse of cancer caused by the same life changing event at the same or lower severity level compared to the previous claim. All subsequent claims made under Cancer Relapse Benefit will be calculated using the Plan Account immediately prior to the claim being made.

Please see provision B2.7 for details on how we pay progressive and unrelated subsequent claims.

2. Lump sum increase for subsequent claims

Cancer Relapse Benefit increases the lump sum that we pay you by 50%, in the event of a subsequent claim under the cancer body system category.

Definition of Cancer - For Cancer Relapse Benefit

Cancer Relapse Benefit is only payable if the subsequent claim is for one of the following conditions under the cancer body system category:

- Severity level A condition;
- Severity level C condition;
- Cancer - excluding less advanced cases

Additionally we will only pay Cancer Relapse Benefit if we have previously paid you a claim for one of the above conditions.

See Appendix 1 for a full list of conditions we cover under the cancer body system category.

B2.8.2 When we will not pay the benefit

We will not pay under Cancer Relapse Benefit if the relapse of cancer occurs within a one year remission* period following the previous life changing event that lead to a valid claim under the cancer body system category.

We will pay you a maximum of twice under the Cancer Relapse Benefit over the length of your plan.

B2.8.3 How Cancer Relapse Benefit affects the plan account

When we make a payment under Cancer Relapse Benefit, the value of your plan account will only reduce by the amount we would have paid you before we increased the payment by 50%.
B2.9 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 Protected Life and Serious Illness Cover option – for more about this option, see provision C12
- 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.

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 C4.

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 Protected Life and Serious Illness Cover option or Protected Life Cover. For more about these, see 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 from Cancer Relapse Benefit). This is the lower of:

- £3,000,000; (£4,000,000 if Serious Illness Cover Booster is selected) 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, Dementia and FrailCare 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. Dementia and FrailCare Cover will also not start after your Serious Illness Cover’s date of expiry if you have included it on your plan.

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, Cancer Relapse Benefit, 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.
B2.10 Family Benefit
If you have Serious Illness Cover in your plan, we automatically include Family Benefit.
Family Benefit does not need underwriting. Family Benefit pays a lump sum of £5,000 in the circumstances described in this provision.

B2.10.1 When we will pay the benefit
We will pay Family Benefit if your claim meets one or more of the following criteria:

a. Complications of Pregnancy
We will pay Family Benefit of £5,000 if you, your spouse or your civil partner is diagnosed by a Consultant Obstetrician with one of the following conditions:
- Disseminated Intravascular Coagulation (DIC)*
- Eclampsia (this excludes Preeclampsia)*
- Ectopic Pregnancy*
- Foetal death in utero after at least 20 weeks gestation and confirmed by a death certificate.
- Hydatidiform Mole*
- Placental Abruption*
- Still birth (excluding elective pregnancy termination) after at least 20 weeks gestation.

b. Specified Congenital Conditions
We will pay Family Benefit of £5,000 if any child who was born living, and during the period of cover is diagnosed with any of the following conditions after the start date of the cover:
- Cerebral Palsy - a definite diagnosis of Cerebral Palsy by an appropriate medical specialist
- Cystic Fibrosis - a definite diagnosis of Cystic Fibrosis by an appropriate medical specialist
- Downs Syndrome - a definite diagnosis of Downs Syndrome by an appropriate medical specialist
- Edwards Syndrome - a definite diagnosis of Edwards Syndrome by an appropriate medical specialist
- Osteogenesis Imperfecta - a definite diagnosis of Osteogenesis Imperfecta by an appropriate medical specialist
- Patau Syndrome - a definite diagnosis of Patau Syndrome by an appropriate medical specialist
- Spina Bifida - a definite diagnosis of Spina Bifida by an appropriate medical specialist

c. Children’s Funeral Contribution
We will pay Children’s Funeral Contribution of £5,000 towards the cost of the funeral if any child dies before the date of expiry of your Serious Illness Cover.

The maximum amount of Children’s Funeral Contribution that we will pay following the death of a child across all plans which you hold with VitalityLife is £5,000.

We will only pay Children’s Funeral Contribution in respect of a person who:
- Has not reached the first plan anniversary after their 18th birthday (23rd birthday if they are in full-time education), and
- Is your natural child, adopted child or step-child, and
- Is looked after by or is financially dependent on you, and
- Is a Resident of the United Kingdom.

Children’s Funeral Contribution includes all your children for the term of the cover.

We will only pay the benefit if:
- We receive your written claim form within six months of the life-changing event
- You provide us with any evidence we ask for
- Your child was born living.
B2.10.2 When we will not pay Family Benefit

We will not pay the Family Benefit if:

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

A maximum of one payment will be made under each of the three categories (Complications of Pregnancy, Specified Congenital Conditions and Child Funeral Contribution) for each child across all VitalityLife plans.

For the Complications of Pregnancy conditions listed in section B2.10.1.a that have been marked with an asterisk, we will only make one payment per pregnancy, rather than per child.

In addition, no claim can be made for any Complications of Pregnancy or Specified Congenital Conditions which existed (whether or not a diagnosis was made or any symptoms were evident) within the first 9 months of the start date of your Serious Illness Cover.

B2.10.3 How much we will pay

We will pay £5,000 for each claim for Family Benefit. The total amount that we will pay for all claims under this benefit on all plans which you hold with VitalityLife is £20,000.

Claims we pay for Family Benefit will not reduce your plan account.

B2.10.4. When your Family Benefit will end

Your Family Benefit will end on the earliest of:

- your Serious Illness Cover’s date of expiry, or
- when we have paid a total of £20,000 under Family Benefit, or
- the plan ceasing.

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 B3.6.

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
- Two months
- 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 you work as a teacher, for a council or for the NHS and you have selected a 12 months deferred period, we may start to pay your monthly benefit according to your employer’s sick-pay structure. For more information please see provision B3.10.

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:

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<tr>
<th>Deferred period</th>
<th>Notification period</th>
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<tr>
<td>7 days</td>
<td>Immediately</td>
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<tr>
<td>1 month</td>
<td>2 weeks</td>
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<tr>
<td>2 months</td>
<td>2 weeks</td>
</tr>
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<td>3 months</td>
<td>1 month</td>
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<tr>
<td>6 months</td>
<td>2 months</td>
</tr>
<tr>
<td>12 months</td>
<td>2 months</td>
</tr>
</tbody>
</table>

If public sector deferred period applies to you then you need to give us written notice within 2 weeks.

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
- Your pre-incapacity earnings evidence

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.

B3.2 How much we will pay

Your plan schedule shows the monthly benefit you have chosen for your Income Protection Cover. If you need to claim, we will pay you the lesser of:

- Your monthly benefit amount, and
- The maximum monthly benefit amount less any continuing income

The maximum monthly benefit amount will depend on whether you have verified your earnings or not as follows:

a) If you have verified your earnings

If you have verified your earnings, your maximum monthly benefit amount is calculated as the greater of:

- 60% of the first £5,000 per month of your verified earnings, plus 50% of your verified earnings between £5,000 and £15,000 per month, and
- 60% of the first £5,000 per month of your pre-incapacity earnings, plus 50% of your pre-incapacity earnings in excess of £5,000 per month

If your Income Protection Cover includes indexation, your monthly benefit amount will increase annually in line with the Retail Prices Index rounded to the next 0.25%. This means you do not need to verify any additional increases due to indexation if you have verified your earnings. Indexation increases will not apply while we are paying a claim under this cover.

For more about this please see ‘How do I verify my earnings’.

b) If you have not verified your earnings

If you have not verified your earnings, your maximum monthly benefit amount is calculated as below:

- 60% of the first £5,000 per month of your pre-incapacity earnings, plus 50% of your pre-incapacity earnings in excess of £5,000 per month

However, you will be eligible for the Earnings Guarantee if your income has reduced since your policy was taken out and:

- Immediately before you claim you have been employed working at least 30 hours a week, or
- Immediately before you claim you have been self-employed working at least 20 hours a week

If you are eligible for the Earnings Guarantee, your maximum monthly benefit amount is calculated as, the greater of:

- 60% of the first £5,000 per month of your pre-incapacity earnings, plus 50% of your pre-incapacity earnings in excess of £5,000 per month, and
- Earnings Guarantee.

Your Earnings Guarantee is the lesser of £1,500 and your monthly benefit amount. If your Income Protection Cover includes indexation, your monthly benefit amount and Earnings Guarantee will both increase annually in line with the Retail Prices Index, rounded to the next 0.25%. Indexation increases will not increase your monthly benefit amount or Earnings Guarantee while we are paying a claim under this cover.
The maximum monthly benefit amount will be reduced by continuing income which is 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;
- 60% of 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.

The maximum monthly benefit amount we will pay is £10,000 a month for Short Term Income Protection Cover and Primary Cover, or £16,666 a month for Comprehensive Cover.

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 B3.6.

How do I verify my earnings

You can ask us to verify your earnings prior to the start of your plan or at any time during the first 6 months your plan starts.

You can verify your earnings according to the following:

- Employed: Your base salary or wages, plus your bonus capped at 20% of your base salary or wages.
- Self-Employed: The lesser of the average of your annual income over the last three years and 120% of the lowest annual income over the three year period.

You are able to verify your earnings for up to £15,000 per month. This will equate to a monthly benefit amount of £8,000. Your pre-incapacity earnings will be used for the monthly benefit amount in excess of £8,000 when you 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.

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<tr>
<th>If you are:</th>
<th>The information we require may include, but is not limited to, items such as:</th>
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</thead>
<tbody>
<tr>
<td>Employed</td>
<td>• Your three most recent payslips and</td>
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<tr>
<td></td>
<td>• Your most recent P60</td>
</tr>
<tr>
<td>Self-employed</td>
<td>• Your three most recent agreed HMRC tax computations and self assessments</td>
</tr>
<tr>
<td></td>
<td>• A copy of the accounts that relate to these</td>
</tr>
<tr>
<td>The director of a limited company</td>
<td>• Your three most recent printed payslips</td>
</tr>
<tr>
<td></td>
<td>• Copies of your company accounts that have been submitted to HMRC, for the last three years</td>
</tr>
<tr>
<td></td>
<td>• Confirmation of the number of employees in the company</td>
</tr>
</tbody>
</table>

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.

If you have been unemployed or on a career break for longer than one month when you claim, we will assess you as a house person. This means we will not use your verified earnings to assess your claims.
Indexation of cover (except during a claim)

Your plan schedule shows whether you have chosen for your benefit amount and Earnings Guarantee 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. The amount by which your premium will increase will depend on the percentage rise in the Retail Prices Index at the time your cover increases.

Your premiums will increase in one of three ways:

<table>
<thead>
<tr>
<th>The percentage increase in the Retail Prices Index</th>
<th>Premium increase amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 0% up to and including 1.75%</td>
<td>Total of the percentage increase in the Retail Prices Index plus 1.5%</td>
</tr>
<tr>
<td>2% up to and including 7.75%</td>
<td>Total of the percentage increase in the Retail Prices Index plus 2.5%</td>
</tr>
<tr>
<td>8% and above</td>
<td>Total of the percentage increase in the Retail Prices Index, to a maximum of 10%, plus 3.5%</td>
</tr>
</tbody>
</table>

If the percentage change in the Retail Prices Index is 0% or less, then there will be no change in your cover amount or premium.

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 determine whether or not we can offer it to you, we may 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.

**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.

**Hospitalisation benefit**

If you have Comprehensive Income Protection Cover, your plan will include a Hospitalisation benefit.

During your deferred period, if you are hospitalised for medically necessary treatment for seven consecutive nights or more, we will provide a benefit of £100 a day from the seventh day onwards for the period that you remain in hospital.

We will pay the Hospitalisation benefit at the end of each month following hospitalisation. You will need to provide us with satisfactory proof of your entitlement to the benefit within 30 days of us asking for it.

We will limit the number of days we pay to an overall maximum of 90 nights. 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 Hospitalisation benefit is £9,000. On joint life plans, this maximum applies to each person covered separately.

We will stop paying you the Hospitalisation benefit on the earliest of:

- You leaving hospital
- The end of your deferred period
- The end of your Income Protection Cover’s date of expiry
- The plan ceasing
- You being removed from the plan
- Your death

**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 benefits to you on a monthly basis. If your benefits 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 When we may not pay or reduce the amount we pay you

If you provided us with inaccurate information at application, this may impact the amount we pay you.

B3.4 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 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
- The benefit payment term

Benefit payment term under Short Term Income Protection Cover

Short Term Income Protection Cover pays you a total of 24 monthly benefit payments for each claim. Once you have received 24 monthly benefit payments, your payments will stop, even if you are still unable to work.

If you have already claimed under Short Term Income Protection, any subsequent claim will be assessed and paid out under the following circumstances:

1. The reason you are unable to work is linked to the same condition as your previous claim and the subsequent claim is made within 6 months of the previous claim.
   We will pay out for this subsequent claim and waive the deferred period. The total combined number of benefit payments for the subsequent and original claim, are limited to 24 monthly benefit payments.

2. The reason you are unable to work is linked to the same condition as your previous claim, the subsequent claims is made after 6 months of the previous claim and you have not returned to work for at least 6 months.
   We will pay out this subsequent claim following the end of your deferred period. The total combined number of benefit payments for the subsequent and original claim, are limited to 24 monthly benefit payments.

3. The reason you are unable to work is linked to the same condition as your previous claim and the subsequent claims is made following 6 months of you going back at work since the previous claim.
   We will pay out this subsequent claim subject to you having returned to work continuously for at least 6 months, working the same amount of hours as you did prior to the claim being made. This means when your claim is accepted, we will start paying your benefit again after the end of your deferred period. We will pay you another total of 24 monthly benefit payments.

4. The reason you are unable to work is not linked to the same condition as your previous claim.
   We will pay out this subsequent claim following the end of your deferred period. The total number of benefit payments for your new claim are limited to 24 monthly benefit payments.

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.

B3.5 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 183 days benefit in any 365 day period. We will also limit the amount we pay to an overall maximum of 365 day benefit.

B3.6 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 per month. This is the maximum even if you had a higher amount of Income Protection Cover in place, or had verified earnings, 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 per month. For more about indexation, see provision B3.2.
We will pay an extra £100 per month for any children that are dependent on you. This amount is per child, but is subject to a monthly maximum of £300 per month 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 your benefit has ended according to provision B3.4
- 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.

**B3.7 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 and you have been unable to work for at least three consecutive months, we will pay you a back to work benefit. We will only pay this benefit once we have stopped paying you a 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 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.

**How long we will pay for**

We will stop paying you benefits under rehabilitation or proportionate benefit if:

- You have selected Short Term Income Protection Cover and your benefit has ended according to provision B3.4.
- Your cover reaches its date of expiry.

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.

**B3.8 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.

**B3.9 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 B3.6 and B3.7.

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 your benefit has ended according to provision B3.4.
- Your 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 C8. 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 C8.1.

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.

B3.10 Public Sector Deferred Period

If you work as a teacher, for a council or for the NHS and you have selected a 12 months deferred period, we may start to pay your monthly benefit that links to your employer’s sick-pay structure. If you have not chosen the 12 months deferred period, the public sector deferred period will not apply to you. The following deferred periods will apply to your plan depending on your occupation. The deferred period varies by the length of your service with your employer:

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<tr>
<th>NHS and Council Employees</th>
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<tbody>
<tr>
<td><strong>Length of Service</strong></td>
<td><strong>50% of monthly benefit amount</strong></td>
<td><strong>100% of monthly benefit amount</strong></td>
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<tr>
<td><strong>Deferred Period</strong></td>
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<td>3 months</td>
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<td>Up to 1 year</td>
<td>2 months</td>
<td>4 months</td>
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<td>Between 1 and 2 years</td>
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<td>8 months</td>
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<td>Between 2 and 3 years</td>
<td>5 months</td>
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<tr>
<td>Between 3 and 5 years</td>
<td>6 months</td>
<td>12 months</td>
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<td>Over 5 years</td>
<td>6 months</td>
<td>12 months</td>
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<table>
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<tr>
<th>Teachers (England, Wales and Northern Ireland)</th>
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<tr>
<td><strong>Length of Service</strong></td>
<td><strong>50% of monthly benefit amount</strong></td>
<td><strong>100% of monthly benefit amount</strong></td>
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<tr>
<td><strong>Deferred Period</strong></td>
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<td>25 days</td>
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<tr>
<td>Up to 4 months</td>
<td>50 days</td>
<td>75 days</td>
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<tr>
<td>Between 4 months and 1 year</td>
<td>50 days</td>
<td>100 days</td>
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<td>Between 1 and 2 years</td>
<td>75 days</td>
<td>150 days</td>
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<tr>
<td>Between 2 and 3 years</td>
<td>100 days</td>
<td>200 days</td>
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<tr>
<td>Over 3 years</td>
<td>100 days</td>
<td>200 days</td>
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<tr>
<td>If your plan has been in force for more than 3 years</td>
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*Based on working days
Who is eligible for the public sector deferred period

To be eligible for the public sector deferred period you must have selected either Primary or Comprehensive Income Protection Cover and be employed in one of the occupations mentioned below throughout your plan and immediately before you claimed. Your sick-pay structure immediately before you claimed must be based on one of the specified structures below.

**Teachers (England and Wales)**

Teachers (including head teachers) who work in schools or in centrally managed LEA services and who are remunerated either on full-time basis or a part-time basis and their sick-pay is set out in the ‘Conditions of Service for School Teachers in England and Wales’, also known as the Burgundy Book.

**Teachers (Scotland)**

Teachers who work in Scotland and are governed by the Scotland Negotiating Committee for Teachers (SNCT) bargaining arrangements and their sick-pay is set out in SNCT Handbook of Conditions of Service.

**Teachers (Northern Ireland)**

Teachers who work in Northern Ireland and their sick-pay is in accordance with the Department of Education, Teachers Terms and Conditions.

**NHS employees**

Employees who work for NHS or one of NHS employers and their sick-pay is based on part 3 section 14 of the NHS Terms and Conditions of Service Handbook, or the equivalent at the time of claim.

**Council employees**

Employees of local authorities or other authorities of equivalent status in the UK and their sick-pay is set out based on National Joint Council for Local Governments Services’ “National Agreement on Pay And Conditions of Service” booklet, also known as Green Book.

**Linked Deferred Period**

To align your deferred period to your sick-pay structure, you do not need to be continuously off-work. We will take into account the total time you have been off work in any year for the same condition to work out when we will start paying your claim. A year refers to a calendar year except for teachers (England, Wales and Northern Ireland) where a year is regarded as beginning on 1st April and ending on 31st March the following year.
B3.11 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. Dementia and FrailCare Cover

Dementia and FrailCare 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. We set these out in this provision and Appendix 5. Your plan schedule shows if you have included the Dementia and FrailCare Cover on your plan.

C1.1 When your Dementia and FrailCare Cover starts

Dementia and FrailCare Cover automatically starts after your Serious Illness Cover’s date of expiry. You are able to cancel the Dementia and FrailCare Cover at any time if you do not wish for it to automatically start after the expiry of your Serious Illness Cover.

Dementia and FrailCare Cover is only available if your plan includes Serious Illness Cover and either Vitality Optimiser or Wellness Optimiser.

Once the cover has started, it cannot be added to your plan again, or any other plan you are covered under, if it was removed or your plan was cancelled.

C1.2 How much we will pay

If you are diagnosed with an illness or condition that we cover, the amount we will pay depends on:

- How severe your condition is, and
- The amount of Dementia and FrailCare Cover you have.

How severe your condition is

The lump sum we will pay you will be a percentage of your amount of Dementia and FrailCare Cover between 25% and 100%. The percentage depends on how severe your condition is, based on a scale from A to D.

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<thead>
<tr>
<th>Severity Level</th>
<th>The percentage of your cover we will pay</th>
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<tr>
<td>A</td>
<td>100%</td>
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<tr>
<td>B</td>
<td>75%</td>
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<tr>
<td>C</td>
<td>50%</td>
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<tr>
<td>D</td>
<td>25%</td>
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</table>

Appendix 5.1 shows which severity levels apply to which conditions.

The amount of cover

When Dementia and FrailCare Cover starts, the cover amount depends on the Serious Illness Cover amount at its date of expiry and the Dementia and FrailCare Cover Cap.

The Dementia and FrailCare Cover amount is calculated as the lesser of:

- The amount of Serious Illness Cover at the date of expiry multiplied by 50%, and
- The Dementia and FrailCare Cover Cap.

Your Serious Illness Cover amount at its date of expiry will reflect any changes due to indexation or any claims you may have made under Serious Illness Cover. For more about how a claim affects your Serious Illness Cover, see provision C1.8. For more about indexation, see provision A1.

C1.2.1 Dementia and FrailCare Cover Cap

The Dementia and FrailCare Cover Cap is the maximum amount that continues as the cover amount at your Serious Illness Cover’s date of expiry. The Cap increases on the first working day in January each year, 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%. Your plan schedule shows the amount of your Dementia and FrailCare Cover Cap at the start of your Serious Illness Cover.
C1.3 When we will pay the benefit

Your claim must meet the following criteria before we 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 5.1. We will use the criteria in Appendix 5.1 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.
- Your Dementia and FrailCare Cover must have started.

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 or conditions. For more about this, see Appendix 5.1. Our Chief Medical Officer will use this evidence to determine whether your claim is valid.

Benefits under Dementia and FrailCare Cover will be due when we confirm that the claim is valid – irrespective of when the claim is made.

If you are covered by more than one policy issued by us, Dementia and FrailCare Cover will only be paid on one policy.

C1.4 When we will not pay

We will not pay under Dementia and FrailCare Cover if:

- You suffer from a condition we do not cover.
- Your condition does not meet our definition for that condition.
- The claim is due to a condition what we have excluded from your Life Cover or Serious Illness Cover when your plan started.
- 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.
- You do not survive for at least 14 days after the date of the life-changing event which caused you to claim.
- You have already claimed for a related condition under your Serious Illness Cover. Please see provision C1.8.1 for more information on this.

C1.5 Changes to Dementia and FrailCare Cover following a claim

Once you have made a successful claim under Dementia and FrailCare Cover, indexation will be removed from the cover. This means your premium and cover amount for Dementia and FrailCare Cover will no longer change due to indexation.

C1.6 What happens if your claim meets multiple definitions at one time

If your claim meets multiple definitions at one time, we will only pay out for one definition. We will payout based on the definition with the highest severity at that time.
C1.7 What happens if you need to make a subsequent claim

If you have already claimed under Dementia and FrailCare Cover, any subsequent claims will be paid as below.

<table>
<thead>
<tr>
<th>Subsequent claims under Dementia and FrailCare Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>When we won’t pay</td>
</tr>
<tr>
<td>No further payment will be made if the severity level of your subsequent claim is the same as or lower than the severity level of your previous claim.</td>
</tr>
<tr>
<td>When we will pay</td>
</tr>
<tr>
<td>If the severity level of your subsequent claim is higher than the severity level of your previous, most recent, claim.</td>
</tr>
<tr>
<td>How we calculate the amount we pay</td>
</tr>
<tr>
<td>We will base the amount we pay on the increase in severity from the previous claim to the new claim. The pay-out will be based on the value of your Dementia and FrailCare Cover amount prior to the previous claim.</td>
</tr>
</tbody>
</table>

C1.8 What happens if you claim for a condition during your Serious Illness Cover term

Any claims made under Serious Illness Cover will reduce the plan account and the remaining Serious Illness Cover amount. Therefore any claims made under Serious Illness Cover may reduce the Dementia and FrailCare Cover amount. This works differently if you have a Protected Cover option. For more about the Protected Cover options, see provision C12.

C1.8.1 What happens if you claim for a related condition during your Serious Illness Cover term

If you have claimed for a condition under Serious Illness Cover that is also covered by Dementia and FrailCare Cover, you will not be able to claim for that condition, or any related conditions, under Dementia and FrailCare Cover.

All related conditions are listed in Appendix 5.2.

C1.9 Your Dementia and FrailCare Cover premium

Once Dementia and FrailCare Cover starts, your Serious Illness Cover premium will continue to be payable. Your premium will be subject to the following adjustments after your Serious Illness Cover’s date of expiry:

- Removal of Serious Illness Cover Booster premium
- Removal of a Protected Cover option premium
- Reducing your premiums in proportion to the reduction in your cover amount due to the Dementia and FrailCare Cover Cap. See provision C1.9.1 for more information about this.

If your plan account includes indexation, your Dementia and FrailCare Cover will continue to be indexed. This means both your cover amount and premium will continue to increase with indexation. The amount by which your premium will increase will depend on your age and the percentage rise in the Retail Prices Index at the time your cover increases. For more about how indexation could affect your premiums, see provisions D1.3.

You can remove indexation from your plan at any time.

Your Dementia and FrailCare Cover premiums will continue to change by either your Vitality Status or both your Vitality Status and Wellness Status. This works differently if you have made a successful claim under Dementia and FrailCare Cover. Please see provision C1.12 for more information on this.

C1.9.1 What happens to your premium when your cover amount is reduced due to the Dementia and FrailCare Cover Cap

If your cover amount is reduced due to the Dementia and FrailCare Cover Cap, we will reduce your premium at the start of the cover. The reduction to your premium will be proportional to the reduction in your cover amount.

C1.10 When your Dementia and FrailCare Cover will end

Your Dementia and FrailCare Cover will end when the first of the following occurs:

- You have claimed the full Dementia and FrailCare Cover amount
- You have claimed the full Funeral Cover amount
- Once Dementia and FrailCare Cover has started, it is removed from your plan
- You cancel your plan
- Your death.
C1.11 Funeral Cover
If you selected Dementia and FrailCare Cover on your plan and your plan includes Term Life Cover, your cover will also include Funeral Cover.

C1.11.1 When your Funeral Cover starts
Funeral Cover will automatically start after your Life Cover’s date of expiry.

C1.11.2 How much we will pay
Funeral Cover pays a lump sum when you die. The cover amount depends on the Life Cover amount at its date of expiry and the Funeral Cover Cap.

The Funeral Cover amount is calculated as the lesser of:
- The amount of Life Cover at the date of expiry multiplied by 10%, and
- The Funeral Cover Cap.

Any claims made under Serious Illness Cover will reduce the plan account and the remaining Life Cover amount. Therefore any claims made under Serious Illness Cover may reduce the Funeral Cover amount. This works differently if you have a Protected Cover option. For more about the Protected Cover options, see provision C12.

Your Life Cover amount at its date of expiry will reflect any changes due to indexation or any claims you may have made under Serious Illness Cover. For more about indexation, see provision A1.

C1.11.3 Funeral Cover Cap
The Funeral Cover Cap is the maximum amount that continues as Funeral Cover at your Life Cover’s date of expiry. The Cap increases on the first working day in January each year, 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%. Your plan schedule shows the amount of your Funeral Cover Cap at the start of your Life Cover.

C1.11.4 Your Funeral Cover premium
If your Funeral Cover amount is reduced due to the Funeral Cover Cap, we will reduce your premium at the start of your Funeral Cover. The reduction to your premium will be proportional to the reduction in your cover amount.

If your plan account includes indexation, your Funeral Cover will continue to be indexed. This means both your cover amount and premium will continue to increase with indexation. The amount by which your premium will increase will depend on your age and the percentage rise in the Retail Prices Index at the time your Funeral Cover increases. For more about how indexation could affect your premiums, see provisions D1.3. You can remove indexation from your plan at any time.

Your Funeral Cover premium will continue to change by either your Vitality Status or both your Vitality Status and Wellness Status. This works differently if you have made a successful claim under Dementia and FrailCare Cover. Please see provision C1.12 for more information on this.

C1.11.5 When your Funeral Cover will end
Your Funeral Cover will end when the first of the following occurs:
- Once Dementia and FrailCare Cover has started, it is removed from your plan
- You cancel your plan
- Your death.

C1.12 What happens if you claim under Dementia and FrailCare Cover
Any pay out under Dementia and FrailCare Cover does not impact your Funeral Cover. This means that if you claim under Dementia and FrailCare Cover, your Funeral Cover will not reduce. Both your Dementia and FrailCare Cover and Funeral Cover premium will continue to be payable until you have claimed your full Dementia and FrailCare Cover amount.

If you make a successful claim under Dementia and FrailCare Cover, we will not increase your plan premium by either your Vitality Status or both your Vitality Status and Wellness Status. However, if you are eligible for a premium reduction, we will continue to apply this to your plan premium.

Once you have claimed your full Dementia and FrailCare Cover amount, the cover will end. However, your Funeral Cover will continue and your Funeral Cover premium will continue to be payable.

If your plan includes indexation, your Funeral Cover will continue to be indexed following a Dementia and FrailCare Cover claim.
C1.13 What happens if I claim the full Serious Illness Cover amount during my plan term

Dementia and FrailCare Cover will only be available if you have any remaining Serious Illness Cover amount at the end of your Serious Illness Cover term. Therefore, if you have claimed the full Serious Illness Cover amount, you will not be eligible to continue with Dementia and FrailCare Cover. This also means you will not be eligible to continue with Funeral Cover, if your plan included Term Life Cover.

C1.14 What happens if your Serious Illness Cover and Life Cover have different terms

If your Serious Illness Cover ends before your Life Cover, Dementia and FrailCare Cover will start as described in provisions C1.1 and C1.2. Your Life Cover will continue until it reaches its date of expiry where it will then continue as Funeral Cover. Premiums will be payable for Dementia and FrailCare Cover and Funeral Cover once each individual cover starts. For more information about this, see provision C1.12.

If you cancel your Life Cover once your Dementia and FrailCare Cover has started, your Dementia and FrailCare Cover also be cancelled.

C1.15 How Dementia and FrailCare Cover works on joint life plans

Dementia and FrailCare Cover is only available if your plan includes Serious Illness Cover and either Vitality Optimiser or Wellness Optimiser.

For joint life plans, each life will only be eligible for Dementia and FrailCare Cover if they each have Serious Illness Cover and either Vitality Optimiser or Wellness Optimiser selected. Your plan schedule shows if you have included Dementia and FrailCare Cover on your plan and for which life the cover is available on.

Dementia and FrailCare Cover automatically starts after your Serious Illness Cover’s date of expiry. For joint life plans this means that the cover will automatically start for each life on the date of expiry for their Serious Illness Cover. Each life will have their own separate plan with Dementia and FrailCare Cover. Each life is able to cancel their respective covers at any time if they do not wish for the cover to automatically start after the expiry of their Serious Illness Cover.

If you selected Dementia and FrailCare Cover on your plan and your plan includes Term Life Cover, your cover will also will include Funeral Cover. For joint life plans, Funeral Cover will only be included for each life if they have both Life Cover and Serious Illness Cover. For each person covered, each life’s Funeral Cover will automatically start on the date of expiry of their Life Cover.

Premiums will continue to be payable for Dementia and FrailCare Cover for each person covered when their cover starts. Similarly, premiums will continue to be payable for Funeral Cover for each person covered when their Funeral Cover starts.

C1.16 How changes made to my plan during the term can impact Dementia and FrailCare Cover

Dementia and FrailCare Cover is only available if your plan includes Serious Illness Cover and either Vitality Optimiser or Wellness Optimiser.

If you make any changes during the term of your plan to either remove Serious Illness Cover, Vitality Optimiser or Wellness Optimiser, you will not be eligible for Dementia and FrailCare Cover.

Funeral Cover is only available if your plan includes Term Life Cover and Serious Illness Cover and either Vitality Optimiser or Wellness Optimiser.

If you make any changes during the term of your plan to remove Serious Illness Cover, Life Cover or either Vitality Optimiser or Wellness Optimiser, you will not be eligible for Funeral Cover.

Additionally, if you reduce your Serious Illness Cover term below the minimum required plan term, you will not be eligible for Dementia and FrailCare Cover or Funeral Cover.

C2. 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 from their birth, unless we say otherwise for a specific condition. 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 Serious Illness 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 C3.
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.

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:
  - 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

If your claim is for a serious illness we will usually assess using functional activity tests, or that is defined as total permanent disability (unable to do your own occupation ever again) we will assess your child’s disability level based on the reports from the consultant in charge of monitoring your child’s progress.

See Appendix 1 for a list of conditions which require the use of functional activity tests to assess claims.

C2.2 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.

<table>
<thead>
<tr>
<th>Severity level</th>
<th>The percentage of your Core Serious Illness Cover for Children we will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (most severe)</td>
<td>100%</td>
</tr>
<tr>
<td>B</td>
<td>75%</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
</tr>
<tr>
<td>D</td>
<td>25%</td>
</tr>
<tr>
<td>E</td>
<td>15%</td>
</tr>
<tr>
<td>F</td>
<td>10%</td>
</tr>
<tr>
<td>G (least severe)</td>
<td>5%</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Your plan</th>
<th>The kind of Serious Illness Cover you have</th>
<th>Your Core Serious Illness Cover for Children includes these severity levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single life plan</td>
<td>Primary</td>
<td>A to E</td>
</tr>
<tr>
<td></td>
<td>Comprehensive</td>
<td>A to G</td>
</tr>
<tr>
<td>Joint life plan</td>
<td>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.</td>
<td>A to E</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>A to G</td>
</tr>
</tbody>
</table>

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.

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 Serious Illness Cover’s date of expiry; or
- The claim is due to a pre-existing medical condition.

C2.4 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.

C3. 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. Children can be covered from 30 days after their birth, unless we say otherwise for a specific condition. 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 C2. 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.
C3.1 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:
  - 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

If your claim is for a serious illness we will usually assess using functional activity tests, or that is defined as total permanent disability (unable to do your own occupation ever again) we will assess your child’s disability level based on the reports from the consultant in charge of monitoring your child’s progress.

See Appendix 1 for a list of conditions which require the use of functional activity tests to assess claims.

C3.2 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.

<table>
<thead>
<tr>
<th>Severity level</th>
<th>The percentage of your Optional Serious Illness Cover for Children we will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (most severe)</td>
<td>100%</td>
</tr>
<tr>
<td>B</td>
<td>75%</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
</tr>
<tr>
<td>D</td>
<td>25%</td>
</tr>
<tr>
<td>E</td>
<td>15%</td>
</tr>
<tr>
<td>F</td>
<td>10%</td>
</tr>
<tr>
<td>G (least severe)</td>
<td>5%</td>
</tr>
</tbody>
</table>

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 to E.

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.

C3.3 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

C3.4 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.

C3.5 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.

C3.6 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.

C4. 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.

C4.1 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

C4.2 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 C8 to C10.

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.
C4.3 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.

C4.4 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.

C4.5 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.

C4.6 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 C4.2.

C4.7 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.

C4.8 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 7 shows how we deal with further claims. If you have a joint life plan, this applies separately to each person covered.

C4.9 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 tell you how much Serious Illness Cover this premium will give you.

C5. 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.

C5.1 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

C5.2 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.

C5.3 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.

C5.4 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

C5.5 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
C6. 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.

C6.1 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 C6.2.

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 C6.2.

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 elected 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 C6.2.

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.

C6.2 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. You have an option to select a guaranteed payment term of either five or ten years.

If you have not selected a guaranteed payment term, a one year period will apply to Primary Family Income Cover and a two year period will apply to Comprehensive Family Income Cover.

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.

<table>
<thead>
<tr>
<th>Severity level</th>
<th>Benefit payment term</th>
</tr>
</thead>
</table>
| 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

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

**C6.3 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:

<table>
<thead>
<tr>
<th>We will not pay if:</th>
<th>Where to find more information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have not selected Family Income Cover that provides cover on diagnosis of a serious illness</td>
<td>Provision C6.1</td>
</tr>
<tr>
<td>You suffer from a condition that we do not cover</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>You suffer from a condition that we excluded from your cover after assessing your application</td>
<td><em>Your plan schedule</em></td>
</tr>
<tr>
<td>Your condition does not meet our definition for that condition</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>You do not survive for at least 14 days after the date of the <em>life-changing event</em> which caused you to claim</td>
<td>Provision C6.1</td>
</tr>
<tr>
<td>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</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>You are making a subsequent claim that does not meet the criteria for a further payment</td>
<td>Provision C6.8</td>
</tr>
<tr>
<td>We do not receive written notice that you want to claim within six months of the <em>life-changing event</em> which causes you to claim</td>
<td></td>
</tr>
<tr>
<td>We do not receive the medical evidence we need from your General Practitioner and any specialists who are treating you</td>
<td>Provision C6.1</td>
</tr>
<tr>
<td>We are not satisfied that the <em>serious illness</em> 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</td>
<td></td>
</tr>
<tr>
<td>Your Family Income Cover expires before the <em>life-changing event</em> which leads to your claim</td>
<td><em>Your plan schedule</em></td>
</tr>
</tbody>
</table>

**C6.4 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 C6.5.

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.
C6.5 Indexed Cover

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

<table>
<thead>
<tr>
<th>Level or indexed?</th>
<th>What this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td>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.</td>
</tr>
<tr>
<td>Indexed</td>
<td>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.</td>
</tr>
</tbody>
</table>

C6.6 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.

C6.7 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.

C6.8 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 we will classify any subsequent claims you make as either a *progressive claim* or an *unrelated claim*.

### Progressive claims

<table>
<thead>
<tr>
<th>Definition</th>
<th>A progressive claim occurs when:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. A person covered has a life-changing event that causes a serious illness</td>
</tr>
<tr>
<td></td>
<td>2. They make a claim for that serious illness</td>
</tr>
<tr>
<td></td>
<td>3. They later make a claim for the same illness, or another serious illness that was caused by the same life-changing event</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When we won’t pay</th>
<th>If the severity level of your progressive claim is the same as or lower than the severity level of your previous claim, we will not make another payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>When we will pay</td>
<td>If the severity level of your progressive claim is higher than the severity level of your previous claim, we will make another payment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How long the claim will be paid for</th>
<th>We will pay the claim for the period of time equal to the difference between:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The benefit payment term had the condition been diagnosed at the higher severity level when the previous claim was accepted</td>
</tr>
<tr>
<td></td>
<td>• The length of time that we have already paid the claim for the previous condition</td>
</tr>
</tbody>
</table>

### Unrelated claims

<table>
<thead>
<tr>
<th>Definition</th>
<th>An unrelated claim occurs when:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. A person covered has a life-changing event that causes a serious illness</td>
</tr>
<tr>
<td></td>
<td>2. They make a claim for that serious illness</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If a claim is made after the end of a previous benefit payment term</th>
<th>If the benefit payment term for the previous 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a subsequent claim is made while the benefit is being paid due to a previous claim</td>
<td>If the benefit payment term for the previous 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.</td>
</tr>
<tr>
<td></td>
<td>If this benefit payment term is longer than the period until which the benefit for the previous claim will be paid, the benefit will be paid until the end of the benefit payment term for the subsequent claim.</td>
</tr>
<tr>
<td></td>
<td>If this benefit payment term is shorter than the period until which the benefit for the previous claim will be paid, the benefit will be paid until the end of the benefit payment term for the previous claim.</td>
</tr>
</tbody>
</table>

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

1. **Subsequent claims due to Heart Attack or Stroke**

If you make a valid claim that is caused by a Heart Attack or Stroke, we will treat any subsequent claim of the same or lower severity as an unrelated claim if:

- the subsequent claim is caused by the same life changing event as the previous claim; and
- the Heart Attack or Stroke that causes the subsequent claim occurs at least 30 days after the life changing event that caused the previous valid claim.

Note: Heart Attack and Stroke are treated as two different life changing events.
2. 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 subsequent claims - see table above

3. 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 C4.

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.

C6.9 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.

C6.10 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.

C6.11 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 C6.3 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 C2).

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.

<table>
<thead>
<tr>
<th>Severity level</th>
<th>Benefit payment term</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (most severe)</td>
<td>100% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
<tr>
<td>B</td>
<td>75% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
<tr>
<td>C</td>
<td>50% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
<tr>
<td>D</td>
<td>25% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
<tr>
<td>E</td>
<td>15% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
<tr>
<td>F</td>
<td>10% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
<tr>
<td>G (least severe)</td>
<td>5% of the longer of:</td>
</tr>
<tr>
<td></td>
<td>• From date of diagnosis until the date of expiry</td>
</tr>
<tr>
<td></td>
<td>• Guaranteed payment term</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Your plan</th>
<th>The kind of Family Income Cover you have</th>
<th>Your Family Income Cover for child serious illness claims includes these severity levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single life plan</td>
<td>Primary</td>
<td>A to E</td>
</tr>
<tr>
<td></td>
<td>Comprehensive</td>
<td>A to G</td>
</tr>
<tr>
<td>Joint life plan</td>
<td>Both people covered have Primary Family Income Cover or one person covered has Primary Family Income Cover and the other person has no Family Income Serious Illness Cover.</td>
<td>A to E</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>A to G</td>
</tr>
</tbody>
</table>

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 C2) 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.

C6.12 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

C6.13 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 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.

### C7. Education 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.

#### C7.1 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 C7.8.

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.

C7.2 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 C7.8.

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.

C7.3 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 C7.8.

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
C7.4 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.

C7.5 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.

C7.6 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 E.

<table>
<thead>
<tr>
<th>Severity level</th>
<th>The percentage of your cover we will pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (most severe)</td>
<td>100%</td>
</tr>
<tr>
<td>B</td>
<td>75%</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
</tr>
<tr>
<td>D</td>
<td>25%</td>
</tr>
<tr>
<td>E</td>
<td>15%</td>
</tr>
</tbody>
</table>

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.

C7.7 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 Cover is the amount you applied for, up to a combined maximum of £500,000.

**C7.8 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.

**C7.9 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

<table>
<thead>
<tr>
<th>We will not pay if:</th>
<th>Where to find more information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You suffer from a condition that we do not cover as a severity A serious illness</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>You suffer from a condition that we excluded from your cover after assessing your application</td>
<td>Your plan schedule</td>
</tr>
<tr>
<td>Your condition does not meet our definition for that condition</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>You do not survive for at least 14 days after the date of the life-changing event which caused you to claim</td>
<td>Provision C7.8</td>
</tr>
<tr>
<td>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</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>We do not receive written notice that you want to claim within six months of the life-changing event which causes you to claim</td>
<td></td>
</tr>
<tr>
<td>We do not receive the medical evidence we need from your General Practitioner and any specialists who are treating you</td>
<td>Provision C7.8</td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Your Education Cover expires before the life-changing event which leads to your claim</td>
<td>Your plan schedule</td>
</tr>
</tbody>
</table>

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.

C7.10 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.

C8. 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.

C8.1 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 C8.6.

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
- Two months
- 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 or two months, 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.

C8.2 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 C8.1.

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 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

C8.3 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, Wellness Optimiser, Premium Optimiser or Interest Rate 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.

C8.4 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.

C8.5 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 previous claim
- Within three months of the original waiver of premium ending

C8.6 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 C8.1.

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

C8.7 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

C8.8 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.

C9. 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 Protected Life and Serious Illness Cover 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 Protected Life and Serious Illness Cover 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.
C9.1 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

C9.2 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.

C9.3 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, Wellness Optimiser, Premium Optimiser or Interest Rate 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

C9.4 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

C10. Waiver of Premium on Death
This cover is only available if you have a joint life plan.

C10.1 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.

C10.2 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.

C10.3 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, Wellness Optimiser, Premium Optimiser or Interest Rate 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

C10.4 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

C11. Guaranteed Insurability options

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

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

Guaranteed Insurability options are automatically included in your plan 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.

C11.1 When can you use Guaranteed Insurability options

<table>
<thead>
<tr>
<th>Event</th>
<th>Life Cover</th>
<th>Serious Illness Cover</th>
<th>Disability Cover</th>
<th>Income Protection Cover</th>
<th>Family Income Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childbirth or adoption</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>–</td>
<td>●</td>
</tr>
<tr>
<td>Marriage or Civil Partnership</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>–</td>
<td>●</td>
</tr>
<tr>
<td>New or increased mortgage</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Promotion or change of job leading to a salary increase</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>●</td>
<td>–</td>
</tr>
<tr>
<td>Every third plan anniversary</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>●</td>
<td>–</td>
</tr>
<tr>
<td>Increase in value of estate leading to an increase in inheritance tax liability*</td>
<td>●</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Legislative change leading to an increase in inheritance tax liability*</td>
<td>●</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

* Only available where Life Cover is arranged on a whole of life basis.
You can apply to increase your cover amount 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 amount 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 amount 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 amount 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 amount 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.

**Splitting a joint life plan into two single life plans upon divorce or dissolution of a civil partnership**

You can split a joint life first death plan into two separate single life plans upon getting divorced or dissolving your civil partnership.
You can apply to split your joint life plan using the Guaranteed Insurability option at any time, as long as your application meets all of the following criteria:

- You, your spouse or your civil partner must be both persons covered under the original plan
- The original plan was used for the purpose of protecting a mortgage where:
  - The mortgage has been rearranged to be in the name of just you, your spouse or your civil partner, or
  - You, your spouse or your civil partner have taken out a new mortgage
- The divorce or dissolution of civil partnership has happened in the last three months, and you can provide necessary evidence we request
- You have not made a successful claim under your plan, apart from under Serious Illness Cover for Children
- Your plan is not suspended. For more about how this can happen, see provision D1.1
- The two new plans must each meet our minimum premium requirements

The two new plans will be subject to all the provisions that applied to the original plan and each plan term must be at least as long as our minimum term requirements. Additionally, the amount of cover and term must not be greater than the amount of cover and term you had on the original 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 or both your Vitality Status and your Wellness Status
- Any premium increases as a result of indexation
- Any changes to your premium due to Premium Optimiser or Interest Rate Optimiser

If either person covered wants to add to or increase their cover or increase the date of expiry they had under the original plan, we will need to underwrite their request. The plan premium will be calculated using premium rates applicable at the time of the request.

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
- Remove the Protected Life and Serious Illness Cover 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.

C11.2 Limits to using Guaranteed Insurability options

If you use Guaranteed Insurability options to increase a cover amount 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 cover amounts by, and the number of times you can increase them:

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Whole of Life Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislative change leading to an increase in IHT liability</td>
<td>The limit is 50% of the initial cover amount 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.</td>
</tr>
</tbody>
</table>
| Increase in value of estate option                         | The limit is the lower of:  
- 50% of the initial cover amount 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. |

If you use a Guaranteed Insurability option to split a joint life first death plan into two single life plans upon divorce or dissolution of a civil partnership, the maximum cover for the second person covered is £500,000.

The maximum number of times that you can increase any of your cover amounts 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 cover amount, 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.

C11.3 How using Guaranteed Insurability options affects your plan

If you use Guaranteed Insurability options to increase a cover amount, 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 Protected Life and Serious Illness Cover 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 the cover amount as those we applied when that cover was added to your plan.

C11.4 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, divorce or dissolution of 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

C12. Protected Cover

C12.1 Protected Life and Serious Illness Cover

You can apply to add the Protected Life and Serious Illness Cover 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 Protected Life and Serious Illness Cover option.

C12.1.1 How the Protected Life and Serious Illness Cover option works

If we pay you a benefit under Serious Illness Cover, your plan account will reduce by the amount of that benefit. If your plan includes the Protected Life and Serious Illness Cover option, we will top it back up. We do this as soon as we have paid all the benefits that are due as a result of your claim.

C12.1.2 When Protected Life and Serious Illness Cover ends

If your plan no longer has Serious Illness Cover, we will remove the Protected Life and Serious Illness Cover 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.

C12.2 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 Protected Life and Serious Illness Cover 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.

If you have Dementia and FrailCare Cover, premiums will continue to be paid after your Serious Illness Cover and Life Cover ends. Please see provision C1.9 for information on how your premiums will continue.

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 cover increases. 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 amount by which we increase your premiums will also depend on the percentage rise in the Retail Prices Index, rounded to the next 0.25% at the time your cover increases.

Your premiums will increase in one of three ways:

<table>
<thead>
<tr>
<th>The percentage increase in the Retail Prices Index</th>
<th>Premium increase amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 0% up to and including 1.75%</td>
<td>Total of the percentage increase in the Retail Prices Index plus 1.5%</td>
</tr>
<tr>
<td>2% up to and including 7.75%</td>
<td>Total of the percentage increase in the Retail Prices Index plus 2.5%</td>
</tr>
<tr>
<td>8% and above</td>
<td>Total of the percentage increase in the Retail Prices Index, to a maximum of 10%, plus 3.5%</td>
</tr>
</tbody>
</table>

If the percentage change in the Retail Prices Index is 0% or less, then there will be no change in your cover amount or premium.
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, Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser. For more about healthy living programme, see provision E. For more about how your premiums change with Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser, see provision D.

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 ask us not to apply indexation in any year. If you decline indexation, then your premium and cover amount will not increase due to indexation for that year. If you do this for three consecutive years for any individual cover, we will cancel the indexation for that cover.

If your cover continues beyond your 80th birthday, 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 and cover amounts will no longer increase due to indexation.

There will be no change to your premiums or your cover amounts if we cancel indexation at any time.

If we have removed indexation, you can apply for us to reintroduce it. However, we will need to repeat the underwriting process for all the persons 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 or both your Vitality Status and Wellness Status affect your plan premiums**

Your plan premium may change as a result of your Vitality Status or both your Vitality Status and Wellness 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, or both your Vitality Status and Wellness Status, after any changes that result from indexation, a review of your premiums, or if you have chosen Premium Optimiser or Interest Rate Optimiser.

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.

For more about how Wellness Optimiser may affect your premium, see provision E3.

**D1.6 Premium Optimiser**

Premium Optimiser is only available if you have selected Whole of Life Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Premium Optimiser your initial Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium starts lower than an equivalent Whole of Life premium that does not include Premium Optimiser.

At each plan anniversary your Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium will increase by 2.5%. 

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Managing your plan
We will apply any change in your Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium as a result of Premium Optimiser before any change as a result of indexation or your Vitality status or both your Vitality Status and Wellness Status. Your Plan Schedule indicates whether you have chosen Premium Optimiser.

**D1.7 Interest Rate Optimiser**

Interest Rate Optimiser is only available if you have selected Whole of Life Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Interest Rate Optimiser your initial Whole of Life Cover or Whole of Life Cover with LifestyleCare Cover premium, starts lower than an equivalent Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium that does not include Interest Rate Optimiser.

At each plan anniversary your Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium will increase.

Your Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium increase will depend on the Long Term Interest Rate that is published on the first working day of the calendar quarter 65 days before your plan anniversary e.g. 1st January.

The table below shows how your annual Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premiums can change:

<table>
<thead>
<tr>
<th>Long Term Interest Rate</th>
<th>Premium Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2% or lower</td>
<td>2.75%</td>
</tr>
<tr>
<td>2.25%</td>
<td>2.6875%</td>
</tr>
<tr>
<td>2.50%</td>
<td>2.625%</td>
</tr>
<tr>
<td>2.75%</td>
<td>2.5625%</td>
</tr>
<tr>
<td>3%</td>
<td>2.5%</td>
</tr>
<tr>
<td>3.25%</td>
<td>2.375%</td>
</tr>
<tr>
<td>3.50%</td>
<td>2.25%</td>
</tr>
<tr>
<td>3.75%</td>
<td>2.125%</td>
</tr>
<tr>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>4.25%</td>
<td>1.875%</td>
</tr>
<tr>
<td>4.50%</td>
<td>1.75%</td>
</tr>
<tr>
<td>4.75%</td>
<td>1.625%</td>
</tr>
<tr>
<td>5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>5.25%</td>
<td>1.375%</td>
</tr>
<tr>
<td>5.50%</td>
<td>1.25%</td>
</tr>
<tr>
<td>5.75%</td>
<td>1.125%</td>
</tr>
<tr>
<td>6% or higher</td>
<td>1%</td>
</tr>
</tbody>
</table>

We will apply any change in Whole of Life Cover, or Whole of Life Cover with LifestyleCare Cover, premium as a result of Interest Rate Optimiser before any change as a result of Indexation, your Vitality Status or your Wellness Status.

Your Plan Schedule indicates whether you have chosen Interest Rate Optimiser. Further information regarding the Long Term Interest Rate can be found at vitality.co.uk/wholeoflife.

**D2. Guaranteed premiums**

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

**D2.1 A guaranteed premium is one that will only change;**

- If you change your plan
- If you make a claim
• Depending on your Vitality Status, or both your Vitality Status and Wellness Status (See provision E)
• If your premiums are indexed
• At each plan anniversary if you have chosen either Premium Optimiser (See D1.6) or Interest Rate Optimiser. (See D1.7)

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, any of our Optimiser options, or indexation, 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.

<table>
<thead>
<tr>
<th>If your premium needs to:</th>
<th>You can choose to:</th>
<th>What you need to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase</td>
<td>Accept the increased premium</td>
<td>You do not need to do anything</td>
</tr>
<tr>
<td></td>
<td>Keep your current premium and have less cover</td>
<td>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.</td>
</tr>
<tr>
<td>Cancel your cover</td>
<td></td>
<td>For how to cancel a cover, see provision F</td>
</tr>
</tbody>
</table>

| 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 person covered from a joint life plan
- Change the fixed term of your covers
- Change your deferred period
- Lower your premiums because of a change in your circumstances
- Remove Vitality Optimiser
- Remove Wellness Optimiser
- Remove Premium Optimiser
- Remove Interest Rate 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
- You cannot increase your Dementia and FrailCare Cover amount once it has started and you cannot add it on more than one policy you are covered on
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, or both your Vitality Status and your Wellness Status
- Any changes to your premium due to Premium Optimiser or Interest Rate Optimiser
- Any changes to your premium due to indexation

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, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser see provision D4.6, D4.7 and D4.8.

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, both your Vitality Status and your Wellness Status, Premium Optimiser, Interest Rate Optimiser, 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 Protected Life and Serious Illness Cover option, if you have it, so that it reflects the new value of the plan account
- Remove the Protected Life and Serious Illness Cover 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 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
Managing your plan

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. Additionally, if you have Dementia and FrailCare Cover and reduce your Serious Illness Cover term below the minimum required plan term, you will not be eligible to continue with Dementia and FrailCare Cover.

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.

D4.5 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.

D4.6 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 or Vitality Lite. For more information on Vitality Plus or Vitality Lite please see your separate terms and conditions. If your Vitality Plus or Vitality Lite 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.

If you have Vitality Lite and you remove Vitality Optimiser, your Vitality Lite will also be removed from your plan.

If you have Vitality Plus and remove Vitality Optimiser from your plan, your Vitality Plus will continue in place, unless you separately cancel it. The fee charged for Vitality Plus may also change.

In addition to above, if you have Dementia and FrailCare Cover and remove Vitality Optimiser from your plan, your cover will be affected as follows:

- If you remove Vitality Optimiser during your Serious Illness Cover term, Dementia and FrailCare Cover will not start at the end of your Serious Illness Cover term.
- If you remove Vitality Optimiser after your Dementia and FrailCare Cover started, the plan will continue subject to an increase in the premium.

D4.7 Removing Wellness Optimiser

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

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

If Wellness Optimiser is removed, your plan will change as follows:
• You can keep your premium at the same level and reduce your level of cover
• You can keep your cover amounts at the same level and your premium will increase.

If you have Vitality Lite and you remove Wellness Optimiser, your Vitality Lite will also be removed from your plan.

If you have Vitality Plus and remove Wellness Optimiser from your plan, your Vitality Plus will continue in place, unless you separately cancel it. The fee charged for Vitality Plus may also change.

In addition to above, if you have Dementia and FrailCare Cover and remove Wellness Optimiser from your plan, your cover will be affected as follows:

• If you remove Wellness Optimiser during your Serious Illness Cover term, Dementia and FrailCare Cover will not start at the end of your Serious Illness Cover term.
• If you remove Wellness Optimiser after your Dementia and FrailCare Cover started, the plan will continue subject to an increase in the premium.

D4.8 Removing Premium Optimiser or Interest Rate Optimiser

If your plan schedule shows that you have chosen Premium Optimiser or Interest Rate Optimiser, you can apply to remove these options at any time.

If Premium Optimiser or Interest Rate Optimiser are removed your premiums will change as follows:

• If you want to keep your premium for Whole of Life Cover or Whole of Life Cover with LifestyleCare Cover at the same level, the level of cover will be reduced.
• If you want to keep your Whole of Life Cover or Whole of Life Cover with LifestyleCare Cover benefit at the same level, the premium will increase.

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, Family Income Cover or Childrens Funeral Contribution 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 a claim recipient 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

<table>
<thead>
<tr>
<th>Tasks designed to assess whether you can look after yourself ever again (also called activities of daily living)</th>
<th>How we define this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washing</td>
<td>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</td>
</tr>
<tr>
<td>Getting dressed and undressed</td>
<td>The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances</td>
</tr>
<tr>
<td>Feeding yourself</td>
<td>The ability to feed yourself when food has been prepared and made available</td>
</tr>
<tr>
<td>Maintaining personal hygiene</td>
<td>The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function</td>
</tr>
<tr>
<td>Getting between rooms</td>
<td>The ability to get from room to room on a level floor</td>
</tr>
<tr>
<td>Getting in and out of bed</td>
<td>The ability to get out of bed into an upright chair or wheelchair and back again.</td>
</tr>
</tbody>
</table>

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

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.

If your claim is for your child under Core or Optional Serious Illness Cover for Children, we will assess your child’s disability level based on the reports from the appropriate medical specialist in charge of monitoring your child’s progress.

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
- Dementia and FrailCare 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.

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 Income Protection Cover

We will not pay the benefit if the life-changing event that causes you to claim happens before the start date of your Income Protection 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 C5, B1.4, C6.6 and C7.7. 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.

Exclusions for Family Benefit
We will not pay the benefit if:
- The claim is due to a pre-existing medical condition, or
- The life-changing event that causes you to claim happens after your Serious Illness Cover’s date of expiry.

In addition, no claim can be made for Complications of Pregnancy or Specified Congenital Conditions until your Serious Illness Cover has been in force for at least nine months.

Exclusions for Dementia and FrailCare Cover
Appendix 5 explains the exclusions that apply to claims for specific illnesses under Dementia and FrailCare Cover.
We will not pay a benefit for any illness or condition that is not listed in Appendix 5.1. 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.

If you claim for a condition under Serious Illness Cover, you will not be able to claim for that condition, or any related conditions, under Dementia and FrailCare Cover. Related conditions are listed in Appendix 5.2.

We may have excluded specific conditions from your Dementia and FrailCare Cover. If we have, and you make a claim, we will not pay a benefit if our Chief Medical Officer believes that your illness or condition 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. Additionally, we will base any benefit on the cover amount that was in force at the time the condition, which you are claiming for, occurred.

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, both your Vitality Status and your Wellness Status, Premium Optimiser, Interest Rate Optimiser, 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 C10.

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 Protected Life and Serious Illness Cover 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

Serious Illness Cover will continue for the surviving person covered if the plan account has not reduced to zero after the Life Cover claim. The Serious Illness Cover amount for the surviving person covered will be calculated by subtracting the total amount paid for the Life Cover claim from the plan account immediately prior to the claim. The amount of Serious Illness Cover will be the chosen percentage of the plan account.
If the surviving person wants to increase their cover, we will need to underwrite their request. The plan premium will be calculated using premium rates applicable at the time of the request. Additionally, the plan will be subject to the provisions applicable at the time of the 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. This request is subject to 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 C10.
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.

The healthy living programme is provided to you by Vitality Corporate Services Limited.

Please refer to the separate terms and conditions for more information on the healthy living programme.

E1. Your Vitality Status

When you take steps to look after your health, you could improve your Vitality Status. There are four Vitality Statuses:

<table>
<thead>
<tr>
<th>Vitality status</th>
<th>Effort threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>You start at this level on your plan’s start date. You may return to this level on each anniversary of your plan, depending on the Vitality Status rules at that time</td>
</tr>
<tr>
<td>Silver</td>
<td>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</td>
</tr>
<tr>
<td>Gold</td>
<td>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</td>
</tr>
<tr>
<td>Platinum</td>
<td>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</td>
</tr>
</tbody>
</table>

E2. 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.

Vitality Optimiser can be added at any time during the term of your plan and once added, will automatically include Vitality Benefits - either Vitality Plus or Vitality Lite on your plan. Please see provision E4 for more information on Vitality Benefits.

We will recalculate your plan premium on each plan anniversary until the date of expiry of each cover.

E2.1 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:

<table>
<thead>
<tr>
<th>Vitality status</th>
<th>Premium change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>+2%</td>
</tr>
<tr>
<td>Silver</td>
<td>+1%</td>
</tr>
<tr>
<td>Gold</td>
<td>No change</td>
</tr>
<tr>
<td>Platinum</td>
<td>-1%</td>
</tr>
</tbody>
</table>

If the premiums for your covers change, the premiums for any waiver or premium cover could also change (see provision D1).

The premium changes in this table do not apply if you have Wellness Optimiser and you are below age 70. For more information on how Wellness Optimiser affects your premiums, see provision E3. After the person covered reaches age 70, their plan premium will change in the same way that a plan with Vitality Optimiser would change.
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, Premium Optimiser, Interest Rate Optimiser 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. For more information about how Premium Optimiser or Interest Rate Optimiser could affect your premiums, see provision D1.6 and D1.7.

The maximum amount your premium can reduce

The maximum premium reduction you can have due to Vitality Optimiser on each of your covers, over their respective terms, is 5%. This means your plan premium for each cover can only ever reduce by a maximum of 5% compared to your plan premium at the start of your cover with Vitality Optimiser. If you have a joint life plan, this will apply to each person covered.

If you have included Dementia and Frail Care Cover on your plan, Serious Illness Cover and Dementia and Frail Care Cover are regarded as one cover and Life Cover and Funeral Cover are regarded as one cover.

This maximum premium reduction only applies to premium changes due to Vitality Optimiser. It excludes:

- The upfront discount you receive due to Vitality Optimiser
- Any changes you make to your cover or plan
- Any premium changes that may also apply due to indexation, a review of your premium, or if you have chosen Interest Rate Optimiser or Premium Optimiser
- Any proportional premium reductions that may apply due to your Dementia and Frail Care Cover or Funeral Cover Caps.

E2.2 Premium Discounts

If your plan includes Vitality Optimiser or Wellness Optimiser, Premium Discounts will not apply to your plan. Your plan schedule will indicate whether you have chosen these options. If your plan does not include Vitality Optimiser or Wellness 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:

<table>
<thead>
<tr>
<th>Vitality status</th>
<th>Premium change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>No change</td>
</tr>
<tr>
<td>Silver</td>
<td>-1%</td>
</tr>
<tr>
<td>Gold</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Platinum</td>
<td>-3%</td>
</tr>
</tbody>
</table>

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, Premium Optimiser, Interest Rate Optimiser 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. For more information about how Premium Optimiser or Interest Rate Optimiser could affect your premiums, see provision D1.6 and D1.7.

We will allow your plan premium to reduce below our normal allowable minimum if the reduction is a result of Premium Discounts.
E3. Wellness Optimiser

With Wellness Optimiser, your initial plan premium starts lower than the premium of an equivalent plan that does not include Wellness Optimiser.

Wellness Optimiser can be added at any time during the term of your plan and once added, will automatically include Vitality Benefits - either Vitality Plus or Vitality Lite on your plan. Please see provision E4 for more information on Vitality Benefits.

At each plan anniversary your premiums will change according to both your:

- Wellness Status, and
- Vitality Status

Please see provision E1 for details regarding your Vitality Status.

E3.1 Your Wellness Status

There are three Wellness Statuses:

- Select
- Healthy
- Everyday

Your Wellness Status is based on your clinical health factors. Please see your Vitality Terms and Conditions for information on how we define your Wellness Status.

E3.2 How your Wellness Status and Vitality Status affect your plan premium

The following table shows you how your plan premium can change each year depending on your Wellness Status and your Vitality Status.

<table>
<thead>
<tr>
<th>Wellness Status</th>
<th>Vitality Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bronze</td>
</tr>
<tr>
<td>Select</td>
<td></td>
</tr>
<tr>
<td>Healthy</td>
<td></td>
</tr>
<tr>
<td>Everyday</td>
<td></td>
</tr>
</tbody>
</table>

Your plan premium will change at each plan anniversary depending on both your Vitality Status and your Wellness Status until the plan anniversary immediately before your 70th birthday. After your 70th birthday, your plan premium will only change by your Vitality Status at each plan anniversary. If you have a joint life plan, this will affect each person separately. This means for each person covered, their Wellness Optimiser premiums will only change by their Vitality Status at each plan anniversary after their 70th birthday. This will work the same way as Vitality Optimiser works. Please see provision E2.1 ‘How we calculate the change in your plan premium’ for more information on this.

If you have Optional Serious Illness Cover for Children, premium changes due to Wellness Optimiser for this cover will be based on the planholder’s Wellness Status and Vitality Status. If you have a joint life plan, the planholder is the first person covered.

The maximum amount your premium can reduce

The maximum premium reduction you can have due to Wellness Optimiser on each of your covers, over their respective terms, is 5%. This means your plan premium for each cover can only ever reduce by a maximum of 5% compared to your plan premium at the start of your cover with Wellness Optimiser. If you have a joint life plan, this will apply to each person covered.

If you have included Dementia and FrailCare Cover on your plan, Serious Illness Cover and Dementia and FrailCare Cover are regarded as one cover and Life Cover and Funeral Cover are regarded as one cover.

This maximum premium reduction only applies to premium changes due to Wellness Optimiser. It excludes:

- The upfront discount you receive due to Wellness Optimiser
- Any changes you make to your cover or plan
• Any premium changes that may also apply due to indexation, a review of your premium, or if you have chosen Interest Rate Optimiser or Premium Optimiser
• Any proportional premium reductions that may apply due to your Dementia and FrailCare Cover or Funeral Cover Caps.

E3.3 When your premium will not increase

If you get a serious illness that we class as Severity A, we will not increase your plan premium due to Wellness Optimiser. However, if you are eligible for a premium reduction, we will continue to apply this to your plan premium. You do not need to have Serious Illness Cover for this to apply.

Your plan premium may continue to increase if you have selected indexation, Premium Optimiser or Interest Rate Optimiser, or due to a review of your premiums.

Please see Appendix 1 for a full list of the severity A serious illnesses we cover. Please see provision D1.3 for more information on how your plan premium changes due to indexation, D1.6 for how your plan premiums change due to Premium Optimiser, or D1.7 for how your plan premium changes due to Interest Rate Optimiser. Please see provision D3 for more information on reviewable premiums.

E4. Vitality Benefits on your plan

E4.1 Vitality Benefits for plans without Vitality Optimiser or Wellness Optimiser

For plans without Vitality Optimiser or Wellness Optimiser, you are able to add Vitality Plus to your plan. 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.

You will be subject to a minimum plan premium to add Vitality Plus to your plan. Please contact your financial advisor for further details.

E4.2 Vitality Benefits for plans with Vitality Optimiser or Wellness Optimiser

For both Vitality Optimiser and Wellness Optimiser your plan will automatically include Vitality Benefits - either Vitality Plus or Vitality Lite. Your plan schedule indicates whether your plan includes Vitality Plus or Vitality Lite.

Your initial plan premium will define which Vitality Benefits your plan includes, either Vitality Plus or Vitality Lite. If your initial plan premium is:

• Below £30* for a single life plan or £40* for a joint life plan then Vitality Lite will automatically be included on your plan,
• £30* or above for a single life plan or £40* or above for a joint life plan then Vitality Plus will automatically be included on your plan.

* This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Lite) you will receive on your plan. This applies to all plans that have selected Vitality Optimiser or Wellness Optimiser now. If you later choose to add Vitality Optimiser or Wellness Optimiser, the premium requirements which determine your Vitality Benefits may have changed.

E4.3 How my Vitality Benefits may change during the duration of my plan

There will be no change to your Vitality Benefits as a result of a change to your premiums for any of the following:-

• Vitality status premium adjustments, or
• Wellness status premium adjustments, or
• Indexation, or
• Premium Optimiser adjustments, or
• Interest Rate Optimiser adjustments, or
• Review of your premiums, or
• Existing covers expire, or
• A valid claim on existing cover.

However, the Vitality Benefits you have access to may change if you make one or more of the following changes to your plan:-

• Add or increase covers,
• Remove or reduce covers,
• Remove a person covered from a joint life plan or add a person covered to your existing plan,
• Split a joint life plan into two single life plans,
• Change the fixed term of your covers,
• Change your deferred period,
• Reduce your premiums because of a change in your circumstances.

The Vitality Benefits you have access to will only change if, as a result of one of the above, your plan premium changes. This will only happen in one of following ways:-

1. Your plan is a Vitality Optimiser or Wellness Optimiser plan including Vitality Lite and you make a change to your plan such that your plan premium increases to £30* (single life) or £40* (joint life) or more. In this case Vitality Lite would be removed from your plan and replaced with Vitality Plus.

2. Your plan is a Vitality Optimiser or Wellness Optimiser plan including Vitality Plus and you make a change to your plan such that your plan premium reduces below £30* (single life) or £40* (joint life). In this case Vitality Plus would be removed from your plan and replaced with Vitality Lite.

3. Your plan includes Vitality Plus (and is not a Vitality Optimiser or Wellness Optimiser plan) and you make a change to your plan such that your plan premium reduces below £30* (single life) or £40* (joint life). In this case Vitality Plus would be removed from your plan.

* This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Lite) you will receive on your plan. This applies to all plans that have selected Vitality Optimiser or Wellness Optimiser now. If you later choose to add Vitality Optimiser or Wellness Optimiser, the premium requirements which determine your Vitality Benefits may have changed.

E4.4 Cancelling your Vitality Benefits

E4.4.1 Vitality Lite

If your Vitality Lite is cancelled, Vitality Optimiser or Wellness Optimiser will be removed from your plan and your premiums will change as described in provision D4. Please refer to the separate terms and conditions for more information on the healthy living programme.

If you cancel Vitality Lite, you may not be able to add it again to your plan after it has been cancelled.

E4.4.2 Vitality Plus

If your plan is not a Vitality Optimiser or Wellness Optimiser plan and Vitality Plus is cancelled, it will be removed from your plan and there will be no change to your premiums.

If your plan is a Vitality Optimiser or Wellness Optimiser plan and your Vitality Plus is cancelled, Vitality Optimiser or Wellness Optimiser will be removed from your plan and your premiums will change as described in provision D4. If you remove Vitality Optimiser or Wellness Optimiser from your plan, your Vitality Plus will continue in place, unless you separately cancel it. The fee charged for Vitality Plus may also change. Please refer to the separate terms and conditions for more information on the healthy living programme.

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 or Wellness Optimiser to your plan again after it has been removed.
E5. 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 F3.

If you would like details 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 Protected Life and Serious Illness Cover 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
- You cancel your plan

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 is 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 within 30 days of receiving your plan details, we will refund your plan premium, as long as you have not made a claim.

If you pay your premiums monthly and you cancel your plan after 30 days, we will not refund your plan premium.

If you pay your premiums annually and you cancel your plan after 30 days, we will calculate your premium as though it were monthly and will refund you for the remainder of the plan year from the cancellation date.

To cancel your plan, you will need to contact us via one of the following methods:

<table>
<thead>
<tr>
<th>Phone:</th>
<th>0800 030 4903</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:VitalityLife_CreditControl@vitality.co.uk">VitalityLife_CreditControl@vitality.co.uk</a></td>
</tr>
<tr>
<td>Post:</td>
<td>VitalityLife, Sheffield, S95 1BW</td>
</tr>
</tbody>
</table>

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.
OTHER REASONS
The Financial Conduct Authority (FCA) publishes an Insurance 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, Sheffield, S95 1BW.

We will not change who is entitled to benefits under your plan until we receive this notice.

F7. Payments and currency
All payments we make to you will be to a bank account registered in the United Kingdom. In addition, all payments made to us must be from a bank account registered in the United Kingdom. You must also be the registered account holder of the bank account; alternatively there must be an insurable interest between you and the registered account holder of this bank account.

We cannot make any payments to you, nor accept any payments from you if the bank account is registered outside the United Kingdom.

All payments must be in pound sterling (GBP).

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, Sheffield, S95 1BW

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:

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Enquiry line: 0800 023 4567</td>
</tr>
<tr>
<td>Fax number: 020 7964 1001</td>
</tr>
<tr>
<td>Website: <a href="http://www.financial-ombudsman.org.UK">www.financial-ombudsman.org.UK</a></td>
</tr>
<tr>
<td>Email: <a href="mailto:complaint.info@financial-ombudsman.org.UK">complaint.info@financial-ombudsman.org.UK</a></td>
</tr>
</tbody>
</table>

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 (FSCS). You may be entitled to compensation from the scheme if we cannot meet our obligations. Whether or not you are able to claim and how much you may be entitled to will depend on the specific circumstances at the time.

For further information about the scheme please contact the FSCS at: www.fscs.org.uk.

F11. Insurable interest

You must have an insurable interest in the person covered when you take out the plan. If insurable interest does not exist, your plan will become void.

F12. 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.

Sanctions

We will not be responsible or liable to make any payment to you or any third party covered under your plan howsoever arising (including, but not excluding, payment of any benefit) when doing so would put us in breach of any applicable economic sanctions, laws and regulations of the European Union, the United Kingdom, the United Nations or any other legal regime or code of practise we may consider applicable.

Economic sanctions are subject to changes and include prohibiting the transfer of funds to a sanctioned country, freezing the assets of a government, the corporate entities and residents of a sanctioned country, or freezing the assets of specific individuals or corporate entities.

If you, or any third party who is covered under your plan, are the subject of sanctions, we may not be able to provide cover under your plan and we may terminate your plan with us.

F13. Data Protection Notice

Why should you read this notice?

We think it is important for all of our members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that we comply with the data protection legislations. The following is a summary of our Privacy Policy. For details of the full Privacy Policy (effective from 25 May 2018) please visit vitality.co.uk/privacy.

Who Vitality are

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of Vitality Health Limited (“VitalityHealth”), Vitality Life Limited (“VitalityLife”) and (“VitalityInvest”). Together “Vitality” arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. Vitality Corporate Services Limited is the data controller for the management of interactions between us and you; VitalityHealth and VitalityLife and
VitalityInvest respectively are the data controllers for the personal data and special category data that you or your representative provide to us.

Sharing your personal data
We may need to share your personal data for legal or regulatory purposes, with your authorised representative where you have appointed an insurance or financial adviser or with other companies in order provide our products and services.

Processing claims
In the event of a claim we may require a medical report from your GP. Such a report will only be requested with your consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from your GP will be limited to only the information relevant to your claim. You have the right to request to see the GP’s report and to request any amendments be made by the GP where you consider the data to be inaccurate. The GP may agree to this at his/her discretion. You will be informed about the AMRA process at the time we request your consent to enable us to ask your GP for a report. We may have to give some information about your plan and about your health or medical status to those involved in your treatment or care, (and/or your representative if you have consented to us doing this). Any such disclosure will be done confidentially unless you specifically instruct us otherwise. If the claimant is aged 13 or over we will address any correspondence to the claimant in order to protect their right to confidentiality. The planholder will be informed only that a claim has been made and the value of the payment we have made; no details about the medical condition or treatment provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform us at the time the claim is made. 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 data to that other insurer so that we can ensure we only pay our proportion of the claim. 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.

Marketing
Vitality Corporate Services Limited would like to send you information about our products and future products, which currently include health and life insurance, investments and general insurance. We are focused on bringing exciting new products to you and to enhance those already available by offering improved services and benefits as a Vitality member.

When you purchase a product from Vitality you will be provided with access to the Member Zone where you can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time.

You can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time by calling our customer services team.

Data protection complaints
We want all of our members to be happy with the way their personal data, health data and medical information has been processed by us. If you are unhappy about the way we have managed your personal data we would like to know about it as we are constantly striving to ensure we do the right thing and we would like to be able to put things right.

You’ll find the contact details for our complaints teams at:
vitality.co.uk/legal/complaints

However, if you are still dissatisfied you have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at:
ico.org.uk

You can also call the ICO on 0303 123 1113 or 01625 545 745, or write to them at:
Information Commissioner’s Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

If you have any queries in respect of your data protection rights or the way your personal data is processed by Vitality, please call us on 0207 133 8600, or write to us at:

<table>
<thead>
<tr>
<th>Data Protection Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitality</td>
</tr>
<tr>
<td>70 Gracechurch Street</td>
</tr>
<tr>
<td>London</td>
</tr>
<tr>
<td>EC3V 0XL</td>
</tr>
</tbody>
</table>

All information about data protection and privacy can be found at vitality.co.uk/privacy.
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:
- Has not reached the first plan anniversary after their 18th birthday (23rd birthday if they are in full-time education), and
- Is your natural child, adopted child or step-child, and
- 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.
Definitions

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 in value 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.

Insurable interest
The following conditions must be satisfied for an insurable interest to exist:

- The person taking out the plan must stand to be financially worse off if the life assured dies or becomes seriously ill (to a degree capable of valuation); and
- There must be a legally recognised relationship between the person taking out the plan and the life assured.

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.

Legally recognised relationship
A legally recognised relationship includes:

- An individual has an unlimited insurable interest in their own life;
- Legally married couples, or registered civil partners, have unlimited insurable interest in each other’s lives;
- Employee/employer relationship provided there would be detrimental financial impact to an employer in the event that the employee dies or becomes seriously ill;
- A partner, of a partnership, has insurable interest in the life of a co-partner;
- Trustees accountable to pay the inheritance tax on the death of a beneficiary have an insurable interest in that beneficiary; and
- Creditor on the life of a debtor, however, only up to the amount of the debt.

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.
**Long Term Interest Rate**
The 20 year rate from the Bank of England’s UK government liability nominal spot rate curve. This is the rate which is used to determine annual premium changes if the Interest Rate Optimiser option is selected.

**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
- Hypoesthesia (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, Vitality Optimiser or Wellness 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:
• The last 12 months’ payslips or the last P60 certificate.*
• 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.
• 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.

*(Please note that if you make a claim for Income Protection Cover and you have not verified your earnings we will require your last 12 months, payslips or your most recent P60 certificate as evidence of your income.)

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

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 183 days in any 365 day 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
Definitions

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.

Suicide
An event where, in our reasonable opinion, the life insured took their own life voluntarily and intentionally or through intentional self-inflicted injury.

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/underwritten
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 C7.2.

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 Benefits
Vitality Benefits are the additional benefits provided to you under the healthy living programme. They are either Vitality Plus or Vitality Lite and are automatically included if you have Vitality Optimiser or Wellness Optimiser.

Vitality Lite
Vitality Lite provides the opportunity to earn additional points and a number of rewards when you look after your health. Vitality Lite is provided by Vitality Corporate Services Limited and is separate from this plan and has its own terms and conditions.

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.

Wellness Status
Your Wellness Status is a measure of your current health. There are three statuses: Everyday, Healthy and Select. We work out your Wellness Status at plan anniversary using the valid results of the health checks you have recorded between each plan anniversary - the healthier your results, the higher your status.

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.

Work tasks
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.
Illnesses and Conditions – Definitions for Serious Illness Cover
(see provision B2).

This plan follows the ABI Guide to Minimum Standards for Critical Illness Cover (2018). 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 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 7th edition of the International Union against Cancer (pub.Wiley-Liss).

For the above definition the following are not covered:
- Stage II non-melanoma skin cancer

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.

Borderline Ovarian Cancer
A diagnosis of an ovarian tumour of borderline malignancy or low malignant potential which has been positively diagnosed with histological confirmation, resulting in surgical removal of an ovary.

For the above definition, the loss of an ovary due to a cyst is excluded.

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)
Appendix 1 - Cancer

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 - treated with surgery to remove the tumour
Carcinoma in-situ diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of organs and that has been treated by surgery to remove the tumour.

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
- For cervical carcinoma in-situ - loop excision, laser surgery, conisation and cryosurgery are not covered
- For carcinoma in-situ of the colon or rectum - local excision and polypectomy are not covered
- Non-invasive papillary bladder carcinoma, TA bladder carcinoma
- Basal cell and squamous cell carcinoma of the skin
- Tumours treated with only radiotherapy, laser therapy, cryotherapy or diathermy treatment
- Procedures that are solely for diagnostic purposes.

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 with surgery to remove the tumour.

For the above definition the following are excluded:
- Barrett’s 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 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 Carcinoma in-situ.

Moderately Severe Aplastic Anaemia
There must be bone marrow cellularity less than 30% plus 2 of the following present for a minimum of six months:
- Neutrophils less than 1 x 10⁹/L
- Platelets less than 50 x 10⁹/L
- Reticulocytes less than 20 x 10⁹/L

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.
Appendix 1 - Cancer

Non-Melanoma Skin Cancer - of specified severity
The presence of one or more of any 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
• Non-melanoma skin cancer that is larger than 2 centimetres (cm) across and has at least one of the following features:
  - tumour thickness of at least 4 millimetres (mm);
  - invasion into subcutaneous tissue (Clark level V);
  - invasion into nerves in the skin (perineural invasion);
  - poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope); or
  - has recurred at the site of previous treatment.

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

Severe Aplastic Anaemia
There must be bone marrow cellularity less than 25% plus two of the following present for a minimum of three months:
• Neutrophils less than 0.5 x 10^9/L
• Platelets less than 20 x 10^9/L
• Reticulocytes less than 20 x 10^9/L

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 7th 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 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:
• Acute Lymphoblastic Leukaemia
• Acute Myeloid Leukaemia
• Advanced cancer classified as a TNM Group Stage III tumour or above
• Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
• Advanced Hodgkin’s Disease classified as Ann-Arbor Stage III or above
• Advanced Non-Hodgkin’s Lymphoma classified Ann-Arbor Stage III or above
• Chronic Myeloid Leukaemia
• Multiple Myeloma
• Severe 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
- 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
- Moderately Severe Aplastic Anaemia
- Mastectomy for Carcinoma in-situ of the Breast

**Severity Level E:**
- Borderline Ovarian Cancer
- Carcinoma in-situ – treated with surgery to remove the tumour
- Lumpectomy for Carcinoma in-situ of the Breast
- Myelodysplasia classified as Low risk on the International Prognostic Scoring System

**Severity Level G:**
- Carcinoma in Situ
- Non-Melanoma Skin Cancer – of specified severity

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**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, vulval or prostatic intraepithelial neoplasia (dysplasia) with histology showing CIN-1, CIN-2, VAIN-1, VAIN-2, VIN-1, VIN-2, PIN-1 or PIN-2
- 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

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**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 Angioplasty – with specified treatment
Percutaneous coronary intervention (PCI) to correct narrowing or blockages of the left main stem artery, or two or more main coronary arteries. Multiple vessels must be treated at the same time or as part of a planned stage procedure within 60 days of the first PCI.

The main coronary arteries for this purpose are defined as right coronary artery, left anterior descending artery, circumflex artery, or their branches.

PCI is defined as any therapeutic intra-arterial catheter procedure including balloon angioplasty and/or stenting.

The following are not covered:
- Diagnostic angioplasty
- Two angioplasty procedures to a single main artery or branches of the same artery.

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
- 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 > 200 ng/L (0.2 ng/ml or 0.2 µg/L)
  - Troponin I > 500 ng/L (0.5 ng/ml or 0.5 µg/L)

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

• Other acute coronary syndromes
• 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) 1 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 thoroscope 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 Defibrillator Insertion due to Cardiac Arrest**
The permanent insertion of an automatic implantable defibrillator as a result of a cardiac arrest.

**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**
A definite diagnosis of peripheral vascular disease by a consultant cardiologist or vascular surgeon with objective evidence from imaging of obstruction in the arteries requiring bypass graft surgery to an artery of the legs.

The following is not covered:

• Angioplasty
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 or bypass of symptomatic stenosis of the carotid artery.

For the above definition the following are excluded:
• Surgery using intravascular techniques

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 or by using endovascular techniques.

Surgical repair of a Structural Abnormality 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 abnormality 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 Abnormality of the Heart
• Heart Valve Replacement or Repair
• Endovascular Repair of an Aortic Aneurysm
• Permanent Defibrillator Insertion due to Cardiac Arrest

Severity Level E:
• Coronary Angioplasty - with specified treatment
• Iliac Artery Aneurysm Repair
• Femoral Artery Aneurysm Repair
• Keyhole Coronary Artery Bypass Surgery
• 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
• 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 creatine 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.

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

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.

Bacterial Meningitis – resulting in permanent symptoms
Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis resulting in permanent neurological deficit with persisting clinical symptoms. 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.

Brain Injury due to anoxia or hypoxia
Death of brain tissue due to reduced oxygen supply (anoxia or hypoxia) resulting in permanent neurological deficit with persisting clinical symptoms.

Coma
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

**Devic's Disease (Neuromyelitis Optica)**
A definite diagnosis of Devic's disease by a Consultant Neurologist resulting in current symptoms.

**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).

**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).

**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) 1, 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 a limb**
Total and irreversible loss of muscle function to the whole of any limb.

**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.

**Parkinson’s plus syndromes**
A definite diagnosis of one of the following Parkinson-plus syndromes by a consultant neurologist:

- Multiple system atrophy
- Parkinsonism-Dementia-ALS complex
- Lewy body disease
- Corticobasal degeneration

There must also be permanent clinical impairment of at least one of the following:

- Motor function; or
- Eye movement disorder; or
- Postural instability; or
- Dementia.

For the above definition, the following are not covered:

- Other 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 aneurysm or arteriovenous malformation
The undergoing of surgical resection, wrapping, clipping or embolisation of a spinal aneurysm or arteriovenous malformation.

Spinal Stroke
Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in permanent neurological deficit with persisting clinical symptoms.

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 histopathological 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 that results in persisting clinical symptoms lasting for at least 24 hours. For the above definition, the following are not covered:

- Transient ischaemic attack
- 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.

Syringomyelia or syringobulbia
The undergoing of surgery to treat a syrinx in the spinal cord or brain stem.

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 permanent 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
- Paralysis of a limb

**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*
- Bacterial Meningitis – resulting in permanent symptoms
- Benign Brain Tumour – resulting in permanent symptoms or surgery*
- Brain Injury due to anoxia or hypoxia
- Coma*
- Craniotomy
- Craniotomy to treat a Cerebral Arteriovenous Malformation
- Creutzfeldt-Jakob Disease - resulting in permanent symptoms*
- Devic’s Disease (Neuromyelitis Optica)
- Dementia – resulting in permanent symptoms*
- Drainage of Brain Abscess by Craniotomy
- Encephalitis - resulting in permanent symptoms*
- Functional Surgery for Movement Disorders
- Motor Neurone Disease*
- Multiple Sclerosis*
- Muscular Dystrophy*
- Parkinson’s Disease – resulting in permanent symptoms*
- Parkinson’s plus syndromes*
- Progressive Supra-nuclear Palsy – resulting in permanent symptoms*
- Shunt Insertion for Hydrocephalus (restricted to one payment only)
- Spinal Stroke
- Spinal Tumour
- Stroke*
- Syringomyelia or syringobulbia
- 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:**
- Endovascular treatment of a Cerebral Arteriovenous Malformation
- Spinal aneurysm or arteriovenous malformation
- Surgical Repair of Depressed Skull Fracture

**Severity Level F:**
- Alzheimer’s Disease
- Bacterial Meningitis
Appendix 1 Gastrointestinal

- Benign Brain Tumour
- Creutzfeldt-Jakob Disease
- Dementia
- Encephalitis
- Parkinson's 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

Bowel Ischaemia requiring surgery
Death of intestinal tissue as a result of impaired blood supply caused by one of the following conditions;

- Acute mesenteric ischaemia
- Chronic mesenteric ischaemia
- Ischaemic colitis

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 chronic Hepatitis 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 or Ulcerative Colitis
A definite diagnosis of Crohn’s Disease or Ulcerative Colitis by a Consultant Gastroenterologist. To meet the definition of moderate, at least one of deep tissue intestinal tract must be affected by continued or relapsing inflammation, with one or more flare-ups each year.

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 strictureing 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
Appendix 1: Connective Tissue Diseases

Surgical Repair of a Tracheo-Oesophageal 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 Gastrointestinal Disease - requiring hospitalisation
- Severe Inflammatory Crohn's Disease

Severity Level D:
- Bowel Ischaemia requiring surgery
- Chronic Pancreatitis
- 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 or Ulcerative Colitis

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, sero-negative rheumatoid 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 Erythematosus (SLE)**
The definite diagnosis of Systemic Lupus Erythematosus (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 Rheumatic 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 erythematosus, 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 erythematosus, 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 erythematosus, 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 erythematosus, 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.
Appendix 1 – Urogenital Tract and Kidney

Severity Level F:
• A definite diagnosis of giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosi, 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 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. 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 Arterial 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
Chronic hypoxaemia on a *permanent* basis with a concentration of oxygen in the arteries of less than 8 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.

Pulmonary Arterial Hypertension - of specified cause and severity or requiring surgery
A definite diagnosis of one of the following by a consultant cardiologist or consultant respiratory physician:

- idiopathic pulmonary arterial hypertension
- chronic thrombo-embolic pulmonary hypertension

With either:

- The measurement reported at the average level measured by cardiac catheterisation at 30mmHG (mm of mercury) or higher at rest. There must also be right ventricular dilation and hypertrophy on echocardiogram with characteristic ECG changes; or
- The undergoing of surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist for the disease of the pulmonary artery to excise and replace the disease pulmonary artery with a graft.
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
- Home Oxygen Therapy
- Cor Pulmonale
- Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

Severity Level C:
- 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

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 Human Immunodeficiency Virus (HIV) category – meeting specified criteria

1. DEFINITIONS

HIV infection
Infection by HIV 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
- An organ transplant

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 one of the countries in the list of permitted countries

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse.

2. SEVERITY LEVELS

Severity Level A:
HIV infection 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
- An 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.

We will require evidence of a negative HIV test within 5 days of the incident and the subsequent positive HIV 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
- 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)
Appendix 1 – Musculoskeletal Trauma

1. DEFINITIONS

Amputation of Two or More Fingers or Thumbs
*Permanent* physical severance of two or more fingers or thumbs at the metacarpal bone.

Intensive care for 10 days continuous duration
Any sickness or injury resulting in the person covered requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an intensive care unit in a UK hospital.

For the above definition the following are not covered:
- *Children* under the age of 30 days
- Sickness or injury as a result of drug or alcohol intake or other self-inflicted means

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.

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.

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:
- Intensive Care of 10 days continuous duration
- 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.

Central Retinal Occlusion
Death of optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in permanent visual impairment of the affected eye.
For the above definition, the following are not covered:
- Branch retinal artery or vein occlusion or haemorrhage

Corneal Transplant
Replacement of a portion or entire cornea with a healthy cornea as a result of disease, accident or trauma. The surgery must be performed by a consultant ophthalmic surgeon or ophthalmologist.
For the above definition, the following are not covered:
- Any corneal transplant surgery for vision correction in the absence of damage, disease or injury to the cornea.

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.
Appendix 1 - Ear

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
• Central Retinal Occlusion
• Tunnel Vision
• Surgical Removal of one Eye

Severity Level F:
• Corneal Transplant
• 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 F:
• 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

1.1 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 1 ng/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.
Appendix 1 – Major Organ Transplant

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) 1.
- 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, pancreas; or of a lobe of lung or liver from another donor; 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.

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

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 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
- Myelodysplasia, classified as Intermediate 1 under the International Prognostic Scoring System

Connective Tissue Disease
For the following conditions which result in the permanent inability to perform at least 3 out of 6 functional activity tests:
- Giant Cell Arteritis
- Polyarteritis nodosa
- Polymyositis
- Rheumatoid Arthritis
- Systemic Lupus Erythematos
- Systemic Sclerosis (Scleroderma)
- Wegener’s Granulomatosis

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
- 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
- Permanent Defibrillator Insertion due to Cardiac Arrest
- Surgical repair of a structural lesion of the heart

Musculoskeletal trauma
- Intensive Care for 10 days continuous duration
- 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

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
- Bacterial Meningitis – resulting in permanent symptoms
- Benign brain tumour - resulting in permanent symptoms or surgery
- Bilateral hemianopia
- Coma
- Creutzfeldt-Jakob disease - resulting in permanent symptoms
- Dementia - resulting in permanent symptoms
- Devic's Disease (Neuromyelitis Optica)
- Encephalitis - resulting in permanent symptoms
- Guillain-Barre Syndrome with a residual deficit measuring at least 3 on the Modified Rankin Scale
- Motor neurone disease
- Multiple Sclerosis
- Muscular Dystrophy
- Paralysis of a limb
- Parkinsons Disease - resulting in permanent symptoms
- Progressive Supra-nuclear palsy - resulting in permanent symptoms
- Spinal Stroke
- Spinal Tumour
- Stroke
- 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 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
For the following conditions which result in the permanent inability to perform at least 4 out of 6 functional activity tests:
- Giant Cell Arteritis
- Polyarteritis nodosa
- Polymyositis
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus
- Systemic Sclerosis (Scleroderma)
- Wegener’s Granulomatosis

Eye
- Blindness
- Severe visual impairment
Appendix 2 – Illnesses and conditions impacted by Serious Illness Cover Booster

**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 the 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 C4).

1.a Advanced Cancer category - specified conditions of defined severity

1. DEFINITIONS

Severe aplastic anaemia
There must be bone marrow cellularity less than 25% plus two of the following present for a minimum of three months:
- Neutrophils less than 0.5 x 10^9/L
- Platelets less than 20 x 10^9/L
- Reticulocytes less than 20 x 10^9/L

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 7th edition of the International Union against Cancer (pub.Wiley-Liss).
For the above definition the following are not covered:
- Stage II non-melanoma skin cancer

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 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

Category 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
- Severe Aplastic Anaemia

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C4.1 and D5.
Any or all of the following may apply to any claim under this category:
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, 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.

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
Severe Peripheral Vascular Disease
A definite diagnosis of peripheral vascular disease by a consultant cardiologist or vascular surgeon with objective evidence from imaging of obstruction in the arteries requiring bypass graft surgery to an artery of the legs.

The following is not covered:
• Angioplasty

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 three 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 C4.1 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 creatine 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 a lobe of 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 C4.1 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 C4.1 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 erythematosus, 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 Erythematosus (SLE)
The definite diagnosis of Systemic Lupus Erythematosus (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 impairment

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C4.1 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 must be 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 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

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 a Limb
Total and irreversible loss of muscle function to the whole of any limb.

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 lasting for at least 24 hours. For the above definition, the following are not covered:
- Transient ischaemic attack
- 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:
- Bilateral hemianopia*
- Dementia
- Loss of eye-hand co-ordination
- Loss of use of a leg
- Loss of use of a whole hand
- Paralysis of a limb
- 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.
Appendix 3 – Renal Disease and Respiratory System

*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 C4.1 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 permanently required.

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 C4.1 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 Arterial 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).

Home Oxygen Therapy
Chronic hypoxaemia on a permanent basis with a concentration of oxygen in the arteries of less than 8 kPa. Supplemental oxygen therapy must be used at home for at least 13 hours each day.

Lung Transplant
The undergoing as a recipient of a transplant of lung, a lobe 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 whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery
A definite diagnosis of one of the following by a consultant cardiologist or consultant respiratory physician:
- Idiopathic pulmonary arterial hypertension
- Chronic thrombo-embolic pulmonary hypertension

With either:
- The measurement reported at the average level measured by cardiac catheterisation at 30mmHG (mm of mercury) or higher at rest. There must also be right ventricular dilation and hypertrophy on echocardiogram with characteristic ECG changes; or
The undergoing of surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist for the disease of the pulmonary artery to excise and replace the disease pulmonary artery with a graft.

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
- Home Oxygen Therapy
- Lung, or Heart and Lung transplant
- Inclusion on an official UK waiting list for the transplantation of a lung, or a heart and lung
- Pulmonary Arterial Hypertension - of specified cause and severity or requiring surgery
- 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 C4.1 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 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.

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 C4.1 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
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:
- Follow simple instructions
- perform simple daily tasks including eating, drinking and washing; and
- 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
• 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

Ilnesses and conditions impacted by Dementia and FrailCare Cover.

Appendix 5.1

1. DEFINITIONS

**Advanced Alzheimer’s disease**
A definite diagnosis of Alzheimer’s disease by a consultant neurologist, psychiatrist or geriatrician resulting in permanent inability to perform 2 or more Cognitive Tasks. 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

**Advanced Dementia**
A definite diagnosis of dementia by a consultant neurologist, psychiatrist or geriatrician resulting in permanent inability to perform 2 or more Cognitive Tasks. 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

**Nursing Home Care (for at least 3 months) – of specified cause**
Permanently (full time) residing in a nursing home for at least 3 months or been receiving support from a nurse or carer at home for at least 5 hours a day for at least 3 months, due to one of the following conditions:
- Permanent inability to perform 4 out of 6 activities of daily living
- Advanced Alzheimer’s Disease with permanent inability to perform 4 out 6 Cognitive Tasks
- Advanced Dementia with permanent inability to perform 4 out 6 Cognitive Tasks
- Parkinson’s disease resulting in the permanent inability to perform 4 out of 6 ADLs
- Stroke with a residual deficit measuring 4 or above on the Modified Rankin Scale
For the purposes of this definition:
- A nursing home is defined as a residential care facility with registered nursing staff permanently on duty
- A carer is defined as a trained care worker, or group of care workers, in order to assist with nursing or care needs
- All nursing staff must be CQC trained (or equivalent)

**Parkinson’s disease resulting in the permanent inability to perform 2 or more out of 6 ADLs**
A definite diagnosis of Parkinson’s disease by a Consultant Neurologist resulting in the permanent inability to perform 2 or more out 6 ADLs. For the above definition, the following is not covered:
- Parkinsonian syndromes/Parkinsonism.

**Permanent inability to perform activities of daily living (ADL)**
The permanent loss of physical ability through illness or injury to do a specified number of tasks designed to assess whether you can look after yourself ever again
The relevant specialist must reasonably expect that the disability will last throughout life with no prospect of improvement.
You must need the help of supervision of another person and be unable to perform the task on your own, even with the use of specialist equipment routinely available to help and having taken any appropriate prescribed medication.
These specified tasks (we also refer to these tasks as *activities of daily living*) are:

- **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. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.
- **Maintaining personal hygiene** - The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

The above tasks will be assessed through standardised testing in place at the time of the claim.

### Residential Home Care (for at least 3 months) - of specified cause

*Permanently* (full time) residing in a residential care home on a *permanent* basis for at least 3 months due to one of the following conditions:

- Permanent inability to perform 4 out of 6 *activities of daily living*
- Advanced Alzheimer’s Disease with permanent inability to perform 4 out 6 Cognitive Tasks
- Advanced Dementia with permanent inability to perform 4 out 6 Cognitive Tasks
- Parkinson’s disease resulting in the permanent inability to perform 4 out 6 ADLs
- Stroke with a residual deficit measuring 4 or above on the Modified Rankin Scale

For the purposes of this definition:-

- A residential care home is defined as a residential care facility with trained care assistants *permanently* on duty
- All residential staff must be CQC trained (or equivalent)

### Stroke with a residual deficit measuring 3 or more on the Modified Rankin Scale

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting clinical symptoms lasting for at least 24 hours and measuring 3 or more or above on the Modified Rankin Scale.

For the above definition, the following are not covered:

- Transient ischaemic attack
- Death of tissue of the optic nerve or retina / eye stroke

## 2. SEVERITY LEVELS

### How is severity measured?

To assess the severity of Advanced Alzheimer’s disease and Advanced Dementia, the following cognitive tasks will be used.

### Cognitive Tasks

The *permanent* loss of cognitive ability through illness or injury to do a specified number of tasks *designed to assess whether you can look after yourself ever again*

The relevant specialist must reasonable expect that he disability will last throughout life with no prospect of improvement.

You must need the help of supervision of another person and be unable to perform the task on your own and having taken any appropriate prescribed medication.

The specific tasks are:

- **Feeding** - Demonstrate the cognitive ability to eat regular meals without being prompted
- **Washing** - Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence washing by any means, with the use of assistive devices where applicable
- **Dressing** - Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence, putting on and taking off of all necessary garments, with the use of assistive devices where applicable
- **Communication** - Demonstrate the ability to present rational ideas and to reason clearly
• Orientation - Demonstrate the cognitive ability to recognise people commonly known to you or to recognise when and where you are in time and location
• Continence - Demonstrate the cognitive ability to recognise, initiate and sequence the task of bowel and bladder functions such that an adequate level of personal hygiene can be maintained

The above cognitive tasks will be assessed through standardised testing in place at the time of the claim.

**Severity Level A:**
- Nursing Home Care (for at least 3 months) - of specified cause
- Residential Home Care (for at least 3 months) - of specified cause

**Severity Level B:**
- Permanent inability to perform 4 or more activities of daily living
- Stroke with a residual deficit measuring 4 on the Modified Rankin Scale
- Parkinson’s Disease resulting in the permanent inability to perform 4 out of 6 ADLs
- Advanced Alzheimer’s Disease resulting in the permanent inability to perform 4 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the permanent inability to perform 4 out of 6 Cognitive Tasks

**Severity Level C:**
- Permanent inability to perform 3 or more activities of daily living
- Parkinson’s Disease resulting in the permanent inability to perform 3 out of 6 ADLs
- Advanced Alzheimer’s Disease resulting in the permanent inability to perform 3 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the permanent inability to perform 3 out of 6 Cognitive Tasks

**Severity Level D:**
- Permanent inability to perform 2 or more activities of daily living
- Stroke with a residual deficit measuring 3 on the Modified Rankin Scale
- Parkinson’s Disease resulting in the permanent inability to perform 2 out of 6 ADLs
- Advanced Alzheimer’s Disease resulting in the permanent inability to perform 2 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the permanent inability to perform 2 out of 6 Cognitive Tasks

3. **EVIDENCE REQUIRED IN THE EVENT OF A CLAIM**

This should be read in addition to and in connection with provision C1.3 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 claim to be paid, we will require that the extent of permanency has been established to our satisfaction.

4. **SPECIFIC EXCLUSIONS**

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this Appendix, 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 during your Serious Illness Cover term
Appendix 5.2

If you claim for the below conditions under Serious Illness Cover, you will not be able to claim for that condition, or any related conditions, under Dementia and FrailCare Cover.

<table>
<thead>
<tr>
<th>Serious Illness Cover conditions</th>
<th>Related conditions under Dementia and FrailCare Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total permanent disability</td>
<td>• Failure of 2 or more activities of daily living</td>
</tr>
<tr>
<td>• Any Neurological Disease causing the permanent and irreversible inability to perform two or more functional activity tests</td>
<td>• Nursing Home Care</td>
</tr>
<tr>
<td>• Any connective tissue disease causing the permanent inability to perform one or more functional activity tests</td>
<td>• Residential Home Care</td>
</tr>
<tr>
<td>• A Stroke with a residual deficit measuring at least 2 on the Modified Rankin Scale</td>
<td>• A Stroke with a residual deficit measuring at least 3 on the Modified Rankin Scale</td>
</tr>
<tr>
<td>• Alzheimer’s disease - resulting in permanent symptoms</td>
<td>• Parkinson’s disease resulting in the permanent inability to perform 2 or more out of 6 ADLs</td>
</tr>
<tr>
<td>• Alzheimer’s disease</td>
<td>• Advanced Alzheimer’s Disease</td>
</tr>
<tr>
<td>• Dementia - resulting in permanent symptoms</td>
<td>• Advanced Dementia</td>
</tr>
<tr>
<td>• Dementia</td>
<td>• Nursing Home Care</td>
</tr>
<tr>
<td>• Persistent Confusional State</td>
<td>• Residential Home Care</td>
</tr>
<tr>
<td>• Parkinson’s Plus syndromes</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 5 – Dementia and FrailCare Cover
Appendix 6 (i) - Subsequent Claims for Serious Illness Cover

Assessment of subsequent claims for permanent disability

Before following this flowchart please note:
1. Once a severity A claim, which is assessed by failure of functional activity tests has been paid, no further claims assessed by failure of functional activity tests will be considered, regardless of an illness category under which claims are paid.

2. If a condition that leads to a permanent disability claim also falls under another illness category, then only the permanent disability claim will be paid or deemed to have been paid with regard to subsequent claims.

Full claim will be paid irrespective of the length of time between claims

Is the current claim a permanent disability claim?

Follow Serious Illness chart (Appendix 6ii) ignoring the Permanent Disability claim

Is the underlying cause of the permanent disability claim an unrelated claim to all other claims?

Define the permanent disability claim as the named condition with a severity A payout of 100% and follow Serious Illness chart (Appendix 6ii).

Are any of the previous claims a severity C permanent disability claim?

Were any of the previous claims a severity B permanent disability claim?

Follow Serious Illness chart (Appendix 6ii)

Is this or any one of the previous claims severity A permanent disability claims?

No more benefit will be paid.

Is the underlying cause of the permanent disability claim a named condition under one of the other illness categories?

No more benefit will be paid.

Are any of the previous claims assessed by failure of functional activity tests?

Full claim will be paid irrespective of the length of time between claims
Appendix 6 (ii) - Subsequent Claims for Serious Illness Cover

Assessment of subsequent progressive or subsequent unrelated serious illness cover claims

The full claim will be paid based on the severity of the subsequent claim and the current value of the plan account.

Is the subsequent claim due to a condition defined as “progressive”?  

Is the severity higher than the previous highest claim for this condition?  

Claim paid as the difference between the new and the previous severity based on value of plan account prior to previous claim. (If your plan schedule indicates that you have selected Serious Illness Cover Booster this calculation will include any increase in the amount we pay out as a result of Serious Illness Cover Booster.)

No more benefit will be paid.

Is this a major organ transplant claim?

Is the claim a consequence of another named condition in any Body System category which resulted in any previous payment?

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.

Note: this does not apply to Heart Attack and Stroke. Please refer to Appendix 6 (iii)
ASSESSMENT OF SUBSEQUENT CLAIMS FOR HEART ATTACK OR STROKE

Note: Heart Attack and Stroke are treated as two different life changing events.
**Appendix 6 (iv) - Subsequent Claims for Cancer under Cancer Relapse Benefit**

**ASSESSMENT OF SUBSEQUENT CLAIMS FOR CANCER UNDER CANCER RELAPSE BENEFIT**

*Remission is defined as being cancer free after the completion of chemotherapy, radiotherapy, surgical treatment or biological therapy (if indicated), and confirmed by the subsequent absence of radiological or biochemical (including molecular) evidence of disease. Hormone treatment is not regarded as active treatment for purposes of the remission definition.*
Appendix 7 - Subsequent Claims for Disability Cover

This is a visual aid overview. Other relevant information and full details of the exclusions can be found in C4 and D5.6 of these provisions.