Group Critical Illness

Policy Conditions

These Policy Conditions are introduced from 4 November 2015
Your Policy

The contractual terms of the Policy are set out in:

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

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

The terms of the Policy are dependent upon the information we are provided with. If this is mis-stated, or has changed since the information was provided, we may amend, discontinue or void the Policy.

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

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

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

This Policy will not have or accrue any surrender value.

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

Any person or company who is not a party to this Policy does not and shall not have or acquire any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Policy. But after a claim has been made by the policyholder, the member to which the claim relates can pursue that claim as if they were the policyholder.
The **member** can also, for any complaint or dispute in connection with that claim, pursue their complaint or grievance through our normal complaints procedures. If they remain dissatisfied, they can then refer the matter to the Financial Ombudsman Service before seeking a remedy at law.

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

Signed for and on behalf of Canada Life Limited:

Ian McMullan  
Managing Director, Group Insurance

Doug Brown  
UK Division Chief Executive Officer

**Please read this Policy carefully, and then keep it in a place of safety for future reference.**
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Terms and Expressions we use

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

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

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

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

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

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

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

**Child:**
any natural or legally adopted child of the member who is more than 30 days old and under 18 years old, at the time they suffer an insured illness.

**Circulatory system illnesses:**
for the purposes of assessment of a claim the following are all considered to be circulatory system illnesses:
• aorta graft surgery,
• balloon valvuloplasty,
• cardiomyopathy,
• coronary artery bypass grafts,
• heart attack,
• heart transplant,
• heart valve replacement or repair,
• open heart surgery,
• primary pulmonary hypertension,
• pulmonary artery surgery, and
• stroke.

**Civil partner:**
a person who is the member’s civil partner, for the purposes of Section 1 of the Civil Partnership Act 2004, at the time they suffer an insured illness.
Claim benefit:
the amount of insured benefit or child’s benefit that we have agreed to pay following:

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

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

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

For the purpose of this definition this will include:

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

Discretionary benefit:
a benefit you want us to provide

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

Discretionary entrant:
someone:

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

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

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

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

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

Eligible employee:
as shown in your Policy Particulars.

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

Evidence of insurability:
yany documentary or medical evidence that we may reasonably require to include someone for benefits in the Policy.
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**Existed:**
an **insured illness** or related condition is said to have **existed** if it was:

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

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

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

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

**HMRC:**
HM Revenue & Customs.

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

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

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

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

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

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

- Blindness, Deafness, Liver failure, Loss of independent existence, Loss of speech and Paralysis of limbs.

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

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

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

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

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

- on the first day that they meet the entry conditions shown in your **Policy Particulars**, and
- for their **scheme benefit**.
Normal inclusion date:
the first day that an eligible employee qualifies for inclusion in the Policy. The day is explained in your Policy Particulars.

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

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

Permanent:
an insured illness that is expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person or child expects to retire.

This definition is associated with the following insured illnesses:
Alzheimer’s disease, Aplastic anaemia, Bacterial meningitis, Benign brain tumour, Blindness, Cardiomyopathy, Coma, Creutzfeldt-Jakob disease, Deafness, Dementia/Pre-senile dementia, Encephalitis, Kidney failure, Liver failure, Loss of hands or feet, Loss of independent existence, Loss of speech, Motor neurone disease, Parkinson’s disease, Primary pulmonary hypertension, Progressive supranuclear palsy, Stroke and Traumatic brain injury.

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

Dysfunction of the nervous system includes:
• numbness,
• hyperaesthesia (increased sensitivity),
• paralysis,
• localised weakness,
• dysarthria (difficulty with speech),
• aphasia (inability to speak),
• dysphagia (difficulty in swallowing),
• visual impairment,
• difficulty in walking,
• lack of coordination,
• tremor,
• seizures,
• dementia,
• delirium, and
• coma.

The following are not covered:
• an abnormality seen on brain or other scans without definite related clinical symptoms,
• neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms,
• symptoms of psychological or psychiatric origin.

This definition is associated with the following insured illnesses:
Bacterial meningitis, Benign brain tumour, Coma, Encephalitis, Stroke and Traumatic brain injury.
Group Critical Illness Policy Conditions

Policy:
This is comprised of:

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

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

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

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

Policyholder:
As shown in your Policy Particulars.

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

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

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

Scheme benefit:
as shown in your Policy Particulars.

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

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

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

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

State pension age:
the age at which the insured person is first entitled to receive the basic state pension or any benefit that may replace it.
Statutory leave:
any leave taken from employment due to an entitlement to:

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

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

The 14 day period starts:

- on the day of surgery for:
  - aorta graft surgery;
  - balloon valvuloplasty;
  - a coronary artery bypass graft;
  - a heart valve replacement or repair;
  - open heart surgery; or
  - pulmonary artery surgery.

- for a major organ transplant, on the earlier of:
  - the date the **insured person** or **child** is included on an official UK transplant waiting list for a heart, liver, lung, kidney, pancreas or bone marrow; or
  - the actual date of surgery.

- for any other **insured illness**, on the date the **insured illness** was diagnosed.

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

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

**War and civil commotion**
Where an **insured illness** arises as a result of war, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
Section 1
Who is covered

1.1 Normal entrants
We will include a normal entrant as a member:

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

Your Policy Particulars will show what conditions apply.

1.2 When any benefits need to be underwritten
If a free cover limit does not apply, all of a person’s benefit will be subject to evidence of insurability and acceptance by us.

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

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

1.3 Provision of cover for discretionary and late entrants
We may agree, if specifically requested, to include a discretionary entrant or late entrant.

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

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

1.4 Provision of cover before an underwriting decision has been made
If evidence of insurability is needed by us before we can accept a person’s benefit, we will provide temporary cover. This will apply for up to 120 days, from the date:

• the insured person is first included in the Policy or
• when an increase in an insured person’s benefit applies, or
• when we are notified of a discretionary entrant or late entrant, or
• when we are notified of any discretionary benefits

and will cease when we tell you what our decision is, if earlier. However, temporary cover will not apply:

• if the person has previously had some or all of their benefit declined or postponed, or
• if any additional premiums chargeable following the issue of our decision letter have not been accepted, or
• if a decision letter has not been issued where evidence of insurability has previously been requested, or
• to any part of the member’s benefit that exceeds £250,000, or
• if the insured person suffers an insured illness and that illness has occurred as a result of a related condition.
1.5 Underwriting decisions which can be made
When we have received all the evidence of insurability that we need to decide whether we can accept a person’s benefit our decision letter will be issued showing what cover can be provided and whether any special terms will be applied. We may:

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

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

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

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

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

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

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

Where a insured person’s benefit:

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

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

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

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

However, we will allow some increases in scheme salary to be taken into account during a period of temporary leave of absence.
These increases will be limited to the lesser of:

- the general level of increases in basic salaries or wages awarded by the member’s employer, and
- the increases in the Average Weekly Earnings Statistic (including bonuses), published by the UK Office for National Statistics during the period of temporary leave of absence.

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

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

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

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

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

You can request cover for individuals who are:

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

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

For members working outside the UK:

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

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

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

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

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

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

The maximum child’s benefit will be the lowest of:

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

Notes:

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

- the other exclusions as shown in the tables in Section 2 - What is covered, as shown in the tables in Section 3 - Optional additional cover and Section 4 - What is not covered, will apply in respect of a child.

A child will cease to be included in the Policy:

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

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

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

We will not pay a claim where:

- the child’s condition was present at birth, or
- the symptoms first arose before the child was covered.
Section 2
What is covered

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

2.1 Discretionary benefits
If you ask us to provide a discretionary benefit we will either:

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

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

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

2.1 Insured Illnesses
If the insured illness first occurs or is diagnosed on or after the commencement date of the Policy we will pay the insured benefit or child’s benefit if an insured person or child:

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

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

2.4 Second Claims
If a member suffers a different insured illness a second claim may be payable subject to the terms described in this section, Section 3 - Optional additional cover and Section 4 - What is not covered.
### 2.5 Core Illness Definitions

#### Alzheimer’s disease

**Definition**

A definite diagnosis of Alzheimer’s disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember,
- reason, and
- perceive, understand, express and give effect to ideas.

**Note:** For the above definition, the following is not covered:

- other types of dementia.

#### Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2

- Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson’s disease, epilepsy, depression, dementia, aphasia, amnesic memory disorder, psychosis, major head trauma.

#### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

For further information see **Section 4 – What is not covered.**
### Cancer – excluding less advanced cases

<table>
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<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
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| Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin). **Note:** For the above definition, the following are not covered:  
• All cancers which are histologically classified as any of the following:  
  – pre-malignant,  
  – non-invasive,  
  – cancer in situ,  
  – having either borderline malignancy, or having low malignant potential.  
• All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0.  
• Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.  
• Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin). | Malignant, borderline malignant or pre-malignant tumour or condition, leukaemia or lymphomas, plus polyposis coli, carcinoma-in-situ, papilloma of the bladder or gallbladder, chronic inflammatory bowel disease, Barrett’s oesophagus. |

### Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for cancer where there has been an **earlier claim** in respect any of the following **insured illnesses:**  
• cancer, whether or not this is connected to or associated with the subsequent cancer,  
• loss of independent existence,  
• total permanent disability,  
• terminal illness.

For further information see **Section 4 – What is not covered.**
### Coronary artery bypass grafts

**Definition**
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
Coronary artery anomalies, coronary vasospasms and myocardial bridging. All obstructive or occlusive arterial disease such as arteriosclerosis, coronary artery dissection or haematoma, coronary ectasia, diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

### Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for coronary artery bypass grafts where there has been an **earlier claim** in respect any of the other circulatory system illnesses or any of the following insured illnesses:
- loss of independent existence,
- total permanent disability,
- terminal illness.

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

### Creutzfeldt-Jakob disease (CJD)

**Definition**
A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist. There must be permanent clinical loss of the ability to do all of the following:
- remember,
- reason, and
- perceive, understand, express and give effect to ideas.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson’s disease, epilepsy, depression, dementia, aphasia, amnesic memory disorder, psychosis, major head trauma.

### Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for Creutzfeldt-Jakob disease where there has been an **earlier claim** in respect any of the other neurological illnesses or any of the following insured illnesses:
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered**.
## Dementia/Pre-senile dementia

### Definition

A definite diagnosis of dementia or pre-senile dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be **permanent** and progressive clinical loss of the ability to do all of the following:
- remember,
- reason, and
- perceive, understand, express and give effect to ideas.

**Note:** For the above definition, the following is not covered:
- dementia secondary to alcohol or drug abuse.

### Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2

- Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson’s disease, epilepsy, depression, aphasia, amnesic memory disorder, psychosis, stroke, brain tumour, hydrocephalus, Creutzfeld-Jacob disease and major head trauma.

## Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for dementia/pre-senile dementia where there has been an **earlier claim** in respect of any other **neurological illnesses** or any of the following **insured illnesses**:
- loss of independent existence,
- total permanent disability,
- terminal illness.

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

### Definition

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- typical clinical symptoms (for example, characteristic chest pain).
- new characteristic electrocardiographic changes.
- the characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
  - Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L)
  - Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L)

The evidence must show a definite acute myocardial infarction.

**Note:** For the above definition, the following are not covered:

- other acute coronary syndromes,
- angina without myocardial infarction.

### Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2

Familial Hyperlipidaemia, coronary artery anomalies, coronary vasospasms and myocardial bridging, all obstructive or occlusive arterial disease such as arteriosclerosis, coronary artery dissection or haematoma, coronary ectasia, diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

For further information see **Section 4 – What is not covered**.
Kidney failure
– requiring permanent dialysis

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic and end-stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.</td>
<td>Polycystic kidney disease, pyelonephritis or Glomerulonephritis, diabetes mellitus or any chronic renal disorder. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.</td>
</tr>
</tbody>
</table>

Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

For further information see **Section 4 – What is not covered**.
## Major organ transplant

**– from another donor**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The undergoing as a recipient of a transplant from another donor of bone marrow or of a complete heart, kidney, liver, lung or pancreas, or inclusion on an official UK waiting list for such a procedure. <strong>Note: For the above definition, the following is not covered:</strong> • transplant of any other organs, parts of organs, tissues or cells.</td>
<td>Cystic fibrosis, leukaemia, diabetes mellitus, aplastic or hypoplastic anaemia, immunological defects or disease, cardiomyopathy, coronary artery disease, cardiac failure, chronic lung disease, chronic kidney disease, chronic liver disease, chronic pancreatitis or pulmonary hypertension.</td>
</tr>
</tbody>
</table>

### Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for major organ transplant where there has been an earlier claim for any of the following insured illnesses:
- aplastic anaemia
- kidney failure,
- liver failure,
- any major organ transplant,
- loss of independent existence,
- respiratory failure
- total permanent disability,
- terminal illness.

For further information see Section 4 – What is not covered.
**Motor neurone disease**  
- resulting in permanent symptoms

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
</table>
| A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist.  
• Amyotrophic lateral sclerosis (ALS)  
• Primary lateral sclerosis (PLS)  
• Progressive bulbar palsy (PBP)  
• Progressive muscular atrophy (PMA)  
There must also be permanent clinical impairment of motor function. | Any chronic neurological symptoms that would be attributable to or known to motor neurone disease. |

**Exclusions applicable to a claim**

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

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

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

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

---

**Multiple sclerosis**  
- with persisting symptoms

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months.</td>
<td>Any form of neuropathy, encephalopathy or myelopathy (disorders of function of the nerves); abnormal sensation (numbness) of extremities, trunk or face; weakness or clumsiness of a limb; double vision; partial blindness; ocular palsy; vertigo (dizziness); difficulty of bladder control; optic neuritis, spinal cord lesion and abnormal MRI scan.</td>
</tr>
</tbody>
</table>

**Exclusions applicable to a claim**

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

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

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

For further information see **Section 4 – What is not covered.**
### Parkinson’s disease
- resulting in permanent symptoms

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A definite diagnosis of Parkinson’s disease by a Consultant Neurologist. There must be <strong>permanent</strong> clinical impairment of motor function with associated tremor and muscle rigidity.</td>
<td>Tremor, rigidity of limbs, slurred speech, dementia, extra pyramidal disease. Secondary parkinsonism.</td>
</tr>
<tr>
<td><strong>Note</strong>: For the above definition, the following is not covered:</td>
<td></td>
</tr>
<tr>
<td>• Parkinsonian syndromes/Parkinsonism.</td>
<td></td>
</tr>
</tbody>
</table>

#### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

For further information see **Section 4 – What is not covered.**
**Stroke – resulting in permanent symptoms**

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

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**Exclusions applicable to a claim**

The following exclusions apply to any claim:

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

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

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

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

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**Cardiovascular Risk Table**

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

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

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

- inclusion in this **Policy**, or
- inclusion in a previous group critical illness policy arranged in connection with the **member’s employment with you** or any other **employer**, if earlier, or
- the date of increase in **insured benefit** or **child’s benefit**, these will be treated as **related conditions** in respect of the **insured illnesses** coronary artery bypass grafts, heart attack, kidney failure and stroke.

<table>
<thead>
<tr>
<th>Age bands (at date of reading)</th>
<th>Up to 50</th>
<th>51-60</th>
<th>61 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>160/90</td>
<td>170/95</td>
<td>175/95</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>5.5 mmol/l</td>
<td>6.5 mmol/l</td>
<td>7.5 mmol/l</td>
</tr>
</tbody>
</table>
Section 3
Optional additional cover

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

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

3.2 Additional Illness Definitions

<table>
<thead>
<tr>
<th>Aorta graft surgery</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
</table>
| **Definition**      | Undergoing surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. **Note: For the above definition, the following are not covered:**  
  • any other surgical procedure, for example the insertion of stents or endovascular repair.  
  • surgery following traumatic injury to the aorta. |
|                     | Marfan’s syndrome, Ehlers-Danlos syndrome, bicuspid aortic valve, congenital malformation of the heart or aorta, coarctation of aorta, known previous aneurysms/dissection/ectasia of aorta, arteriosclerosis of aorta. |

**Exclusions applicable to a claim**

The following exclusions apply to any claim:
• **pre-existing conditions exclusion**, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
• **related condition exclusions**.

In addition we will not pay a subsequent claim for aorta graft surgery where there has been an earlier claim in respect of any of the other circulatory system illnesses or any of the following insured illnesses:
• loss of independent existence,
• total permanent disability,
• terminal illness.

For further information see Section 4 – What is not covered.
### Aplastic anaemia — with permanent bone marrow failure

**Definition**
- Permanent bone marrow failure which results in all of anaemia, neutropenia and thrombocytopenia, requiring treatment with at least one of the following:
  - blood transfusion.
  - marrow stimulating agents.
  - immunosuppressive agents.
  - bone marrow transplant.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
- Any history of symptoms or abnormal blood tests that would be attributable to or known to aplastic anaemia.

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

In addition we will not pay a subsequent claim for aplastic anaemia where there has been an earlier claim for any of the following insured illnesses:
- loss of independent existence,
- major organ transplant of bone marrow,
- total permanent disability,
- terminal illness.

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

### Bacterial meningitis — resulting in permanent symptoms

**Definition**
- A definite diagnosis of bacterial meningitis by an appropriate consultant resulting in significant permanent neurological deficit with persisting clinical symptoms.

**Note: For the above definition, the following is not covered:**
- all other forms of meningitis including viral meningitis.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
- Chronic ear disease, cerebral shunt related to hydrocephalus, immunodeficiency syndromes.

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

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

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

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The actual insertion, on the advice of a Consultant Cardiologist, of a balloon catheter through the orifice of one of the valves of the heart, and the inflation of the balloon to relieve valvular abnormalities.</td>
<td>Rheumatic fever, carcinoid syndrome, bicuspid valve, mital valve prolapse, myxomatous or calcified heart valve, cardiomyopathy, Ehlers-Danlos syndrome, Marfan’s syndrome.</td>
</tr>
</tbody>
</table>

**Exclusions applicable to a claim**

The following exclusions apply to any claim:

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

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

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

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

---

**Benign brain tumour – resulting in permanent symptoms**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms. <strong>Note:</strong> For the above definition, the following are not covered:</td>
<td>Pre-existing benign brain tumour, neurofibromatosis (Von Recklinghausen’s disease), haemangioma (Von Hippel- Lindau disease), pituitary gland tumours, angioma/haemangioma/meningioma, any malformation of the arteries or veins of the brain.</td>
</tr>
<tr>
<td>• tumours in the pituitary gland,</td>
<td></td>
</tr>
<tr>
<td>• tumours originating from bone tissue</td>
<td></td>
</tr>
<tr>
<td>• angioma and cholesteatoma</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusions applicable to a claim**

The following exclusions apply to any claim:

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

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

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

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

- **permanent and irreversible**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent</strong> and <strong>irreversible</strong> 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.</td>
<td>Stroke, transient ischaemic attack (TIA), head trauma, brain tumour, glaucoma, pituitary gland tumour, optic neuropathy, papilloedema, retrobulbar neuritis, sarcoidosis, malignant exophthalmus, diabetes mellitus, uveitis, retinal detachment, macular degeneration or registered blind.</td>
</tr>
</tbody>
</table>

## Exclusions applicable to a claim

The following exclusions apply to any claim:
- pre-existing conditions exclusion,
- related condition exclusions,
- war and civil commotion.

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

For further information see **Section 4 – What is not covered**.
### Cardiomyopathy – of specified severity

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

### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

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

**Definition**
A state of unconsciousness with no reaction to external stimuli or internal needs which:
- requires the use of life support systems for a continuous period of at least 96 hours, and
- with associated permanent neurological deficit with persisting clinical symptoms.

**Note:** For the above definition, the following are not covered:
- medically induced coma,
- coma secondary to alcohol or drug abuse.

**Exclusions applicable to a claim**
The following exclusions apply to any claim:
- **pre-existing conditions exclusion,**
- **related condition exclusions,**
- **war and civil commotion.**

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

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

### Deafness

**Definition**
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.

**Exclusions applicable to a claim**
The following exclusions apply to any claim:
- **pre-existing conditions exclusion,**
- **related condition exclusions,**
- **war and civil commotion.**

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

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

**Definition**
A definite diagnosis of encephalitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

**Note:** For the above definition, the following is not covered:
- encephalitis in the presence of HIV.
- Bacterial meningitis, HIV Immuno deficiency syndromes, Lyme disease.

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

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

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

### Heart valve replacement or repair

**Definition**
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
Endocarditis, congenital malformation of the heart, cardiomyopathy, any obstructive or occlusive arterial disease, rheumatic fever, Marfan’s syndrome, Ehlers–Danlos syndrome, carcinoid syndrome, bicuspid aortic valve, mitral valve prolapse, myxomatous or calcified heart valve.

**Exclusions applicable to a claim**
The following exclusions apply to any claim:
- **pre-existing conditions exclusion,** for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- **related condition exclusions.**

In addition we will not pay a subsequent claim for heart valve replacement or repair where there has been an earlier claim in respect any of the other circulatory system illnesses or any of the following insured illnesses:
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see **Section 4 – What is not covered.**
### HIV infection
- caught in the EU, the Channel Islands or the Isle of Man from a blood transfusion, physical assault or at work in an eligible occupation

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection by Human Immunodeficiency Virus (HIV) resulting from: • a blood transfusion given as part of medical treatment, • a physical assault, or an incident occurring in the course of performing normal duties of employment from the eligible occupations listed below: – a medical practitioner, – a person employed in a medical facility, – a prison officer, – a dentist, or – a member of the fire, police or ambulance emergency services, after the start of the insured person or child’s cover under the Policy and satisfying all of the following: • the incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures. • where HIV infection is caught through a physical assault or as a result of an incident during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident. • there must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus. • the incident causing infection must have occurred in the EU, the Channel Islands or the Isle of Man. <strong>Note:</strong> For the above definition, the following is not covered: • HIV infection resulting from any other means, including sexual activity or drug abuse.</td>
<td>No insured benefit or child’s benefit will be payable in respect of an insured person or child who has been infected with any Human Immunodeficiency Virus (HIV) or has demonstrated any antibodies to such virus, at any time prior to the date of inclusion: • in this Policy, or • in a previous group critical illness policy arranged by you or any other employer in connection with the member’s employment, if earlier.</td>
</tr>
</tbody>
</table>

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

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

For further information see Section 4 – What is not covered.
### Liver failure

**Definition**

A definite diagnosis of **Irreversible** end stage liver failure due to cirrhosis by a Consultant Physician resulting in all of the following:

- permanent jaundice,
- ascites, and
- encephalopathy.

**Note:** For the above definition, the following is not covered:
- liver failure secondary to alcohol or drug abuse.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**

- Chronic liver disease and hepatitis, primary sclerosing cholangitis, cirrhosis of the liver, portal hypertension, hepatic steatosis, autoimmune hepatitis.

---

### Loss of hands or feet

**Definition**

**Permanent** physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**

- Peripheral vascular disease, bone cancer, soft tissue cancer, diabetes mellitus.

---

**Exclusions applicable to a claim**

The following exclusions apply to any claim:

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

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

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

For further information see **Section 4 – What is not covered**.
## Loss of independent existence

### Definition

Total, **permanent** and **irreversible** disablement resulting in the inability to perform, even with the use of appropriate assistive devices, at least three of the following six activities without the direct assistance of another person.

- **Feeding/eating** – cutting meat, buttering bread, getting food and drink to the mouth using fingers or utensils.
- **Dressing** – dressing oneself including fastening of zips and buttons, getting clothes from wardrobes and drawers.
- **Bathing/grooming** – turning on taps, getting in and out of the bath or shower, washing face, hands and body, drying oneself, combing hair.
- **Continence** – moving into and out of the bathroom, getting on and off the toilet unaided, recognising the need or urge to void bladder or bowel in time to get to the toilet.
- **Mobility** – the ability to move indoors from one room to another in the **insured person’s or child’s own** home.
- **Transfer** – getting into and out of bed, transferring from one place to another, for example, chair to bed, chair to standing, chair to chair.

### Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2

Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson’s disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Back, neck or joint pain, arthritis, diabetes mellitus.

### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

For further information see **Section 4 – What is not covered.**
## Loss of speech
- total, permanent and irreversible

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total <strong>permanent</strong> and <strong>irreversible</strong> loss of the ability to speak as a result of physical injury or disease.</td>
<td>Stroke, transient ischaemic attack (TIA), brain injury, brain tumour, motor neurone disease, muscular dystrophy, throat tumour, laryngeal polyps, Alzheimer’s disease, Parkinson’s disease.</td>
</tr>
</tbody>
</table>

### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

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

## Open heart surgery
- with surgery to divide the breastbone

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct a structural abnormality of the heart.</td>
<td>Endocarditis, congenital malformation of the heart, cardiomyopathy, any obstructive or occlusive arterial disease, rheumatic fever, Marfan’s syndrome, Ehlers–Danlos syndrome, carcinoid syndrome, bicuspid aortic valve, mitral valve prolapse, myxomatous or calcified heart valve, tumours of the heart such as myxomas. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.</td>
</tr>
</tbody>
</table>

### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

For further information see Section 4 – What is not covered.
## Paralysis of limbs

- **Definition**: Total and *irreversible* loss of muscle function to the whole of any two limbs.

### Related conditions

## Exclusions applicable to a claim

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

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

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

## Primary pulmonary hypertension

- **Definition**: A definite diagnosis of primary pulmonary hypertension. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in the *permanent* loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity*.

*NYHA Class 3: Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

### Related conditions
- There are no **related conditions** applicable.

## Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for primary pulmonary hypertension where there has been an earlier claim in respect any of the other **circulatory system illnesses** or any of the following **insured illnesses**:
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 4 – What is not covered.
### Progressive supranuclear palsy

**Definition**
A definite diagnosis, by a Consultant Neurologist, of progressive supranuclear palsy. There must be permanent clinical impairment of eye movement and motor function with associated tremor, rigidity of movement and postural instability.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
Motor neurone disease.

#### Exclusions applicable to a claim

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

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

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

### Pulmonary artery surgery

**Definition**
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**
Pulmonary valve disorder, Fallot’s tetralogy, patent ductus arteriosus, congenital malformation of the heart and its vessels.

#### Exclusions applicable to a claim

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

In addition we will not pay a subsequent claim for pulmonary artery surgery where there has been an earlier claim in respect any of the other circulatory system illnesses or any of the following insured illnesses:
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 4 – What is not covered.
### Respiratory failure

**– resulting in breathlessness even when resting**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced stage chronic lung disease resulting in: • breathlessness at rest, and • the need for continuous daily oxygen treatment (PaO2&lt; 7.3kPa when clinically stable as prescribed under British Thoracic Society and NICE guidelines) for at least 12 months.</td>
<td>Chronic obstructive or restrictive pulmonary disease, emphysema. Any disease or disorder of the respiratory system including lung, bronchi and trachea. Tuberculosis or chronic inflammatory diseases. Autoimmune disorders affecting the lung, such as sarcoidosis.</td>
</tr>
</tbody>
</table>

### Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

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

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

*– of specified severity*

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A definite diagnosis of chronic rheumatoid arthritis by a Consultant Rheumatologist resulting in all of the following:</td>
<td>Inflammatory polyarthritis, psoriatic arthropathy.</td>
</tr>
<tr>
<td>• there must be morning stiffness in the affected joints of at least one-hour duration,</td>
<td></td>
</tr>
<tr>
<td>• there must be arthritis of at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a physician,</td>
<td></td>
</tr>
<tr>
<td>• the arthritis must involve two or more of the following sites:</td>
<td></td>
</tr>
<tr>
<td>– wrists or ankles</td>
<td></td>
</tr>
<tr>
<td>– hands and fingers</td>
<td></td>
</tr>
<tr>
<td>– feet and toes</td>
<td></td>
</tr>
<tr>
<td>• the arthritis must affect both sides of the body,</td>
<td></td>
</tr>
<tr>
<td>• presence of rheumatoid factor or anti CCP (anticyclic citrullinated protein) antibodies, unless all other criteria are met,</td>
<td></td>
</tr>
<tr>
<td>• there must be subcutaneous nodules (nodular swelling beneath the skin),</td>
<td></td>
</tr>
<tr>
<td>• there must be radiographic changes typical of active rheumatoid arthritis plus evidence of clinical deformity.</td>
<td></td>
</tr>
<tr>
<td>The symptoms must have been present for at least six months before a claim can be submitted and in the opinion of our Medical Officer(s) all appropriate treatments such as disease modifying agents have been prescribed for at least six months.</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusions applicable to a claim**

The following exclusions apply to any claim:

• pre-existing conditions exclusion.

• related condition exclusions.

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

• loss of independent existence,

• total permanent disability,

• terminal illness.

For further information see Section 4 – What is not covered.
### Terminal illness
- where death is expected within 12 months

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
</table>
| A definite diagnosis by the attending Consultant of an illness that satisfies both of the following:  
  • the illness either has no known cure or has progressed to the point where it cannot be cured, and  
  • in the opinion of the attending Consultant the illness is expected to lead to death within 12 months. | All core and additional insured illnesses. |

### Exclusions applicable to a claim
The following exclusions apply to any claim:  
• pre-existing conditions exclusion,  
• related condition exclusions.
In addition we will not pay a subsequent claim for terminal illness where there has been an earlier claim for any other insured illness:
For further information see Section 4 – What is not covered.

### Third degree burns
- covering 20% of the body’s surface area

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

### Exclusions applicable to a claim
The following exclusions apply to any claim:  
• pre-existing conditions exclusion,  
• related condition exclusions,  
• alcohol abuse,  
• drug abuse,  
• self-inflicted injury,  
• war and civil commotion.
In addition we will not pay a subsequent claim for third degree burns where there has been an earlier claim for any of the following insured illnesses:
• loss of independent existence,  
• total permanent disability,  
• terminal illness.
For further information see Section 4 – What is not covered.
### Traumatic brain injury

**Definition**

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

**Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2**

### Exclusions applicable to a claim

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

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

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

### Cardiovascular Risk Table

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

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

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

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

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

<table>
<thead>
<tr>
<th>Age bands (at date of reading)</th>
<th>Up to 50</th>
<th>51-60</th>
<th>61 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>160/90</td>
<td>170/95</td>
<td>175/95</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>5.5 mmol/l</td>
<td>6.5 mmol/l</td>
<td>7.5 mmol/l</td>
</tr>
</tbody>
</table>
Group Critical Illness Policy Conditions

3.2 Total permanent disability – before the greater of age 65 and state pension age (or cease age if earlier)

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

- survives for more than six months from the date of total permanent disability, and
- suffers total permanent disability throughout this period.

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

<table>
<thead>
<tr>
<th>Unable to do their own occupation ever again – (own occupation)</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td></td>
</tr>
<tr>
<td>Loss of the physical or mental ability through an illness or injury before the greater of age 65 and state pension age (or cease age if earlier) to the extent that the member is unable to do the material and substantial duties of their own occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of the person’s own occupation that cannot reasonably be omitted or modified. Own occupation means the member’s trade, profession or type of work done for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the member expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.</td>
<td>Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson’s disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Also back, neck or joint pain, arthritis and diabetes mellitus.</td>
</tr>
</tbody>
</table>

Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

For further information see Section 4 – What is not covered.
**Unable to do a suited occupation ever again**  
– (suited occupation)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of the physical or mental ability through an illness or injury before the greater of age 65 and state pension age (or cease age if earlier) to the extent that the member is unable to do the material and substantial duties of a suited occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of a suited occupation that cannot reasonably be omitted or modified. A suited occupation means any work the member could do for profit or pay, taking into account their employment history, knowledge, transferable skills, training, education and experience, and is irrespective of location and availability. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the member expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.</td>
<td>Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson’s disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Also back, neck or joint pain, arthritis and diabetes mellitus.</td>
</tr>
</tbody>
</table>

**Exclusions applicable to a claim**

The following exclusions apply to any claim:

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

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

For further information see Section 4 – What is not covered.
Unable to look after yourself ever again

<table>
<thead>
<tr>
<th>Definition</th>
<th>Related conditions which will be considered in the application of the exclusion shown in Section 4.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of the physical ability through an illness or injury before the greater of age 65 and state pension age (or cease age if earlier) to do at least 3 of the 6 tasks listed below ever again. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire. The insured person must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances. Feeding yourself – the ability to feed yourself when food has been prepared and made available. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function. Getting between rooms – the ability to get from room to room on a level floor. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.</td>
<td>Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson’s disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Also back, neck or joint pain, arthritis and diabetes mellitus.</td>
</tr>
</tbody>
</table>

Exclusions applicable to a claim

The following exclusions apply to any claim:

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

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

For further information see Section 4 – What is not covered.
Exclusions for total permanent disability, on an own occupation or suited occupation basis

<table>
<thead>
<tr>
<th>Exclusion applies to</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>any member who has to hold a licence or certificate that is dependant on them being certified as medically, physically or mentally fit to be able to perform their occupation, for example but not limited to, LGV drivers, PSV drivers, aircraft pilots, aircrew and Merchant Navy personnel.</td>
<td>a benefit will not be payable unless the member has suffered loss of the physical or mental ability through an illness or injury before the greater of age 65 and state pension age (or cease age if earlier) to the extent that the member is unable to do the material and substantial duties of any occupation at all ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of the occupation that cannot reasonably be omitted or modified. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the member expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.</td>
</tr>
</tbody>
</table>
3.4 Cover for spouse or civil partner

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

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

The maximum benefit will be the lower of:

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

3.4.1 Terms of Cover

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

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

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

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

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

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

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

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

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

- when a claim for one of the insured illnesses has been paid for that person, or
- from the date the member ceases to be included in the Policy (if earlier) as shown in Section 5.1 other than if the member’s cover ceases due to the member having received the maximum number of claims payments for which they are eligible.
Section 4
What is not covered

4.1 Exclusions
4.1.1 Pre-existing conditions
No benefit will be payable for an insured illness (or a repeat of the same insured illness) which existed prior to the date of inclusion:

• of the insured person or child in this Policy, or

• in a previous group critical illness policy arranged by you or any other employer in connection with the member’s employment, or

• of the illness in the Policy, if later.

For the purposes of Section 4.1.1 circulatory system illnesses will be treated as the same insured illness

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

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

4.1.2 Related conditions
4.1.2.1 Insured illnesses where a related conditions exclusion applies indefinitely
No benefit will be payable for:

• loss of independent existence,

• paralysis of limbs,

• terminal illness or

• total permanent disability

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

• the insured person or child’s inclusion in this Policy, or

• the insured person or child’s inclusion in a previous group critical illness policy arranged by you or any other employer in connection with the member’s employment, if earlier, or

• the date of inclusion of the insured illness in the Policy, if later, or

• the date of any increase in benefit which has been selected by the member or you.
4.1.2.2 Insured Illnesses where a related conditions exclusion is applied for a period of 2 years.

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

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

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

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

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

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

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

4.2 Other exclusions

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

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

4.2.1 Exclusions as a result of underwriting

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

4.3 Circumstances where a second claim will not be allowed

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

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

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

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

4.4 Other illnesses where we will not pay a second claim

Details of these can be found in the tables in Section 2 - What is covered and Section 3 - Optional additional cover.
Section 5
When cover ceases

5.1 When cover ceases for a member
Cover for a member will cease on whichever of the following events is first to occur:

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

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

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

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

5.2 When we can cease cover under a Policy
We reserve the right to cease this Policy if:

• you cancel an associated policy, or
• you do not pay premiums requested within 30 days of the date they were due, as shown in Section 7.4.3, or
• new legislation or regulations are introduced, or changes are made to existing legislation which affect group critical illness policies or this Policy.
Section 6
Policy limitations

The maximum scheme benefit available to a member is the lower of:

- £500,000 and
- 5 times the member's salary.

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

- the member’s scheme benefit and
- £150,000

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

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

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

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

Section 7
Premiums

7.1 How we calculate your premiums

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

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

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

Your Policy Particulars will show which basis applies.

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

7.1.1 Single premium basis

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

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

Separate premiums will be calculated for each insured person on the commencement date and on each subsequent annual revision date. These will be shown on the statement of account and the total premium charged will include any policy fee.
An additional premium will be calculated if someone becomes an **insured person** or has an increase in **insured benefit** other than on the **commencement date** or an **annual revision date**.

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

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

### 7.1.2 Unit rate basis

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

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

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

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

If there has been any change to the basis of cover, eligibility, **employers** or groups of people included, legislation or unit rate during that period, we will calculate adjustments for the periods before and after that change took place. Total premiums will be shown on the statement of account and any **policy fee** will already be included in the unit rate.

### 7.2 Revision of premium rates and basis

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

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

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

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

This may result in us changing the premium rates, **Policy terms** and **policy fee** for the **Policy**.
7.3 The information we need to calculate your premiums

All data should be provided in electronic spreadsheet format.

At each annual revision date (including a periodic review date) we will ask you for a complete list of members. The list must include for each member:

- name,
- date of birth,
- gender,
- **scheme salary** or benefits (if the member’s benefit is a fixed benefit), reflecting the definition agreed with us and taking into account any limitations which may apply,
- benefit category,
- occupation,
- postcode of normal work location, or home postcode if the member normally works from home, or overseas location (if appropriate), and
- details of any regular business travel taken in the last 12 months, or anticipated in the next 12 months, outside the UK, the EU or North America.

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

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

Limitations may include the following:

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

You must also clearly show all members:

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

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

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

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

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

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

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

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

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

7.4.2 How you can pay your premiums
You may pay your premiums:

• annually by cheque payable to Canada Life Limited, or

• by electronic funds transfer, or

• by Direct Debit (this will increase your premiums by 2%).

7.4.3 What will happen if you do not pay your premiums
You must pay your premiums within 30 days of the date they are due.

If you do not pay your premiums, we may:

• reject your claims, or

• delay the payment of any new claims until any outstanding premium debts have been resolved, or

• withdraw cover completely.

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

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

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

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

Section 8
Alterations to the Policy cover

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

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

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

Any agreement to:

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

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

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

8.2 Alterations which may affect your premiums and/or terms and conditions
You must tell us immediately, if:

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

These changes can have a direct effect on the premiums and/or terms and conditions that we can apply to the Policy. New terms and conditions and premium rates can be applied to the Policy from the date any changes take place.
8.3 Changes to the nature of your business or the locations where members work
You must tell us immediately if there is a change in:

- an employer’s normal place(s) of business, or
- the locations where members travel on business, or
- the nature of an employer’s business which results in the occupation of any member becoming more hazardous.

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

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

8.4 When we can make alterations
We can apply new terms and conditions and rates to the Policy at the periodic review date.

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

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

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

We will not backdate cancellation of cover and will charge for the time we have been providing cover.
Section 9
Making a claim

9.1 When you should tell us about a claim
A completed claim form and a completed personal statement must be submitted as soon as possible after an insured person or child suffers an insured illness.

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

You should send original completed forms and documentation to:

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

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

9.2 What we need to assess a claim
We must be provided with:

• an original current claim form fully completed by an official of the policyholder, and
• an original, current personal statement fully completed by the insured person.

If the insured person is not physically or mentally able to complete the personal statement, it can be completed by their spouse, civil partner or partner.

If the person who has suffered an insured illness is a child the personal statement must be completed by a parent or guardian.

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

• the child’s birth certificate, or
• adoption certificate (if applicable).

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

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

Our claims guides and current claim forms can be downloaded from our website: www.canadalife.co.uk/group/default.asp

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

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

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

The personal statement includes a consent that provides us with the authority to obtain further information from any relevant medical professional that has attended the insured person or child, as required under the Access to Medical Reports Act.
The medical evidence, all diagnoses and any medical opinions relating to any **insured illness** must be given by a medical specialist who:

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

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

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

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

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

If the information provided

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

we may not pay the claim.

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

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

9.4 What we need if a member suffers an insured illness outside the UK, the Channel Islands or the Isle of Man

If any medical evidence is obtained outside the UK:

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

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

9.5 How your claim benefits will be paid

**Claim benefits** are payable by us in UK currency.

If your claim is accepted in respect of an **insured person** or **child**, the **claim benefit** will be made to the **member**.
Section 10
Further information

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

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

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

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

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

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

The Financial Ombudsman Service
Exchange Tower,
London E14 9SR

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

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

Canada Life in the UK
We have been in the Group Risk market for over 40 years and are the UK’s largest provider of group insurance products for intermediaries and their corporate clients. Our experience and expertise in our three core product sectors - Group Life Assurance, Group Income Protection and Group Critical Illness – is recognised in the market and we cover approximately 2.75 million employees through our group schemes.

A Culture of Excellence
We are committed to providing the best customer experience in the industry. Through our culture of personal ownership and responsibility, our aim is to make working with us as easy as possible. Whether through the comprehensive portfolio management provided by our CLASS e-portal or simply by ensuring you are able to reach the person you want to speak to on the telephone, we take this commitment very seriously. We are enormously proud of the accolades we receive that recognise our service excellence.

Expertise
Business placed with Canada Life is in the safe hands of Group Risk specialists who understand your requirements in every way. Our dedicated Bristol office manages every aspect of group policies, from quotations and customer service support to underwriting and claims handling. We have an ongoing commitment to continuous improvement and the development of administration technology that will enhance the support of our customers.

More Information can be found at www.canadalife.co.uk