Group Critical Illness for Voluntary and Flexible Benefits Policies

Technical Guide

Reference: GR03002 - 05/2024

This policy is intended for schemes with more than 250 potential members or 50 insured members.

Aviva

By choosing Aviva, part of the UK's largest insurance group, you benefit from our financial strength. Together with millions of customers worldwide you can feel certain of your choice whether you invest for the future, provide against the unexpected, or protect the things that are important to you.

Our size and efficiency give us the strength to deliver an extensive range of value for money, quality products – investments, retirement, protection and healthcare – designed to meet your needs, both now and in the future.

This Technical Guide has been produced based on the standard format recommended by the Group Risk Development group (GRiD) and The Association of British Insurers (ABI).

This Technical Guide will tell you the main features and benefits about our Group Critical Illness voluntary and flexible benefits policies. It should be read alongside the quotation with which it was issued. **It does not form part of the policy contract**. Full details of the contract terms can be found in the Policy wording.

You are responsible for deciding if the cover meets your needs, and periodically reviewing the cover to make sure it continues to meet your needs.

If you have any existing cover, we recommend you seek financial advice before deciding whether to cancel your existing arrangements. We also recommend you seek financial advice if you are unsure whether this cover is right for you. If you haven't got a financial adviser and you would like to speak to one, you can find one in your area by using www.unbiased.co.uk. An adviser may charge a fee for this service.

Contents

Please note

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

'You' or 'your' refers to the **policyholder** named in the **policy schedule**.

'We', 'our' or 'us' means Aviva Life & Pensions UK Limited.

Policy aims

This is a non-complex **policy**. The aim of the **policy** is to meet the demands and needs of an **employer** who wishes to:

- provide insurance to cover a **lump sum benefit** if a **member** or their **child** is diagnosed with one of the **critical illnesses** or undergoes an **operation** which the **policy** covers and survives for at least 14 days
- choose whether to cover a **default benefit** funded by you or;
- only provide a **voluntary/flexible benefit** for **members** to choose an element of cover that's right for their individual needs and budget
- choose the number of **critical illnesses** or **operations** they wish to cover, we call these standard or extended
- choose whether to cover an **employee's partner** as well.

It also offers the following optional benefits:

- Total **Permanent** Disability cover
- A Cancer Drugs Fund benefit

We will pay a **lump sum benefit** for a **critical illness** or **operation** to your **employee** provided it is to a UK, Channel Islands or Isle of Man bank account. If covered, we will pay a claim for cancer drugs fund benefit to the **member's** local NHS trust.

This document will tell you which **critical illnesses** and **operations** can be covered. It will also tell you the circumstances when **members** or **children** will not be eligible to receive a **lump sum benefit**, even if they have suffered a **critical illness** or undergone an **operation** set out in the **policy**.

The **policy** is suited to UK, Channel Islands or Isle of Man registered **employers** with more than 250 potential **members** or 50 insured **members**.

An **employer** will need to have a suitable flexible benefits platform in place to administer the **benefits** provided by the **policy**.

The **policy** is not designed to support the following:

- **employers** with less than 250 potential **members** or 50 insured **members**
- **employers** or partnerships who are not registered in the UK, Channel Islands or Isle of Man
- **employers** with **members** who are not in the UK, Channel Islands or Isle of Man or one of our **standard territories**, unless otherwise agreed
- **employers** who wish to **cover critical illness definitions** or **operations** not covered under those we list
- the self-employed (other than Equity Partners).

There is no medical underwriting needed for **members**, although the product is subject to a **pre-existing** and **associated conditions** exclusion. This means that we will not pay a claim for a **critical illness** or **operation** that existed before they joined the **employer's scheme**. In addition, we will not pay a claim that occurs within two years of joining that is **related** to an insured condition due to treatment, symptoms, advice or awareness.

The **policy** will not have or accrue a surrender value.

Your commitment

You agree to inform us straight away:

- if you want to change the cover; or
- if you want to change the **eligibility** criteria for membership;
- about any claims;
- about any significant changes to the **employer**
- when any member moves **overseas** to a location which is not listed in our **standard territories** or any additional locations detailed in your **policy schedule**.

You agree to:

- pay premiums when requested or as agreed;
- comply with the terms and conditions of the **policy**.

You also agree to provide us with all of the information we need:

- when you apply for the **policy**;
- at review/**anniversary dates**;
- when you make a claim;

and tell us if these details change.

In order to make a claim, you must tell us within 3 months of a **member** or **child**:

- being diagnosed with a **critical illness**; or
- undergoing an **operation**.

Risk factors

- Cover may stop if you don't comply with the terms and conditions of the **policy** or if you stop paying premiums. This will mean you will have no cover in place with us for future **lump sum benefits** and may result in an uninsured liability. We will continue to assess claims for **critical illnesses** that were diagnosed and **operations** that took place before the **policy** was cancelled.
- We recommend that a lawyer considers the content of your **employees'** contracts for you in the light of this **policy**, and any requirements you may have for offering the benefits to your **employees**.

- We usually guarantee the rate(s) for two years after the start of the **policy**.

The guarantee may not apply if:

- during the period of the **rate guarantee**, there is any change to the total **core benefit, default benefit** or sum insured upon which our illustration is based of 25% or more;
- the number of **members** who are covered falls below 50 (if this happens we reserve the right to cancel the **policy**);
- there is a change to the (or any new) legislation, regulation or taxation affecting the **policy**;
- there is a change to the:
  - benefit basis;
  - **eligibility**;
  - nature of business; or
  - companies included within the **policy**.

Critical illnesses and operations, and their associated conditions

There are two levels of cover – Standard and Extended. The level of cover you have chosen is shown on the **policy schedule**. If you have chosen Extended cover, this includes the **critical illnesses** and **operations** shown in Standard cover. Your **policy schedule** will also show if you have selected one of the optional benefits listed. No other **critical illnesses** or **operations** are covered.

We adhere to the Association of British Insurers (ABI) minimum standards for critical illnesses that have been defined by them. Some of our definitions are more generous than the ABI model wording definition. The definitions that are defined by the ABI are marked with an asterisk.

The right hand column shows the **associated conditions** for each **critical illness** or **operation** - these **associated conditions** are used in a **policy** exclusion - see section 8 (What is not covered) for the full details of the **policy** exclusions.

Critical illness/ operation	Definition	Associated conditions
Standard		
*Alzheimer's disease – *resulting in **permanent** symptoms*	A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be **permanent** clinical loss of the ability to do all of the following: • remember; • reason; and • perceive, understand, express and give effect to ideas. For the above definition, the following are not covered: • other types of dementia.	Head injury, pure amnesia, depression, psychosis, dementia
* Cancer – *excluding less advanced cases*	Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes: • leukaemia • sarcoma, and lymphoma except those that arise from or are confined to the skin (including cutaneous lymphomas and sarcomas). • pseudomyxoma peritonei • merkel cell cancer For this definition of cancer, the following are not covered: • All cancers which are histologically classified as any of the following: – non-invasive; – pre-malignant; – cancer in situ; – having 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 TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate). • Neuroendocrine tumours without lymph node involvement or distant metastases unless classified as WHO Grade 2 or above. • Gastrointestinal stromal tumours without lymph node involvement or distant metastases unless classified by either AFIP/Miettinen and Lasota as having a moderate or high risk of progression, or as UICC/TNM8 stage II or above. • All urothelial tumours unless histologically classified as having progressed to at least TNM classification T1N0M0.	Polyposis Coli, papilloma of the bladder or any cancer in situ.

Critical illness/ operation	Definition	Associated conditions
* Cancer – *excluding less advanced cases* (continued)	• Malignant melanoma skin cancers that are confined to the epidermis (outer layer of skin). • Any non-melanoma cancer that arises from or is confined to one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin (including cutaneous lymphomas and sarcomas) unless it has spread to lymph nodes or distant organs. • All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0.	
Cancer – *Second and subsequent*	For this benefit to be payable the following conditions must be met: • The **member** has previously had a cancer that met the "Cancer – excluding less advances cases" definition above, whether a claim was paid or not, and • The new cancer meets the definition of cancer – excluding less advanced cases (above), and • The new cancer was not **pre-existing** prior to the **member** joining the **scheme** or during the 120 days following the date they joined the **scheme**, and • The **member** has been treatment free for a period of 5 years from the date of the previous and most recent diagnosis of cancer, and • There is no evidence, confirmed by appropriate up-to-date investigations and tests, of any continuing presence, recurrence or spread of any previous cancer, and • The new cancer: – Affects an organ that is physically and anatomically separate to any previous cancer, and – Is not secondary cancer or histologically related to any previous cancer; or – For haematological cancers, the new cancer is categorised or divided according to defined cell characteristics in a distinctly different manner to any previous cancer. Treatment includes chemotherapy, radiotherapy, monoclonal antibody therapy, immunotherapy, and invasive or non-invasive surgery, but does not include long term maintenance hormone treatment. In addition, we will not pay the amount of any increase in **lump sum benefit** if prior to the date of the increase: • There was an **associated condition** relating to the new cancer, or • The new cancer was **pre-existing**. We will still consider the claim for the pre-increase amount.	
Cardiac arrest – *with insertion of a defibrillator*	Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted: • Implantable Cardioverter-Defibrillator (ICD); or • Cardiac Resynchronization Therapy with Defibrillator (CRT-D)	Coronary artery disease, heart failure and cardiomyopathy, left ventricular hypertrophy, hyperlipidaemia, myocarditis, hypertrophic cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy, Brugada syndrome, idiopathic VF (also called primary electrical disease), congenital or acquired long QT syndrome, familial SCD of uncertain cause, Wolff-Parkinson-White syndrome.

Critical illness/ operation	Definition	Associated conditions
*Coronary artery by-pass surgery	The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.	Any disease or disorder of the heart, diabetes mellitus, any obstructive/occlusive arterial disease or hyperlipidaemia.
Creutzfeldt-Jakob disease (CJD)	A definite diagnosis of CJD by a Consultant Neurologist.	Organic brain disease, disease of the central nervous system, Parkinson's disease, depression, epilepsy, dementia, amnesic memory disorder, aphasia, psychosis.
* Dementia including Alzheimer's disease of specified severity	A definite diagnosis of dementia, including Alzheimer's disease, by a Consultant Geriatrician, Neurologist, Neuropsychologist or Psychiatrist supported by evidence including neuropsychometric testing. There must be **permanent** cognitive dysfunction with progressive deterioration in the ability to do all of the following: • remember • reason • perceive, understand, express and give effect to ideas. For the above definition, the following are not covered: • Mild Cognitive Impairment (MCI)	Stroke, cerebrovascular disease, organic brain disease, brain tumours, disease of the central nervous system, hydrocephalus, Alzheimer's disease, Creutzfeldt-Jakob disease, Parkinson's disease, depression, epilepsy, pure amnesia, aphasia, psychosis.
*Heart attack - of specified severity	A definite diagnosis of acute myocardial infarction with death of heart muscle as evidenced by all of the following: • Typical clinical symptoms (for example, characteristic chest pain). • New characteristic electrocardiographic changes or new diagnostic imaging 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. For the above definition, the following are not covered: • Myocardial injury without infarction. • Angina without myocardial infarction.	Any disease or disorder of the heart, diabetes mellitus, hypertension, hyperlipidaemia or any obstructive/occlusive arterial disease.
*Kidney failure – *requiring **permanent** dialysis*	Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.	Familial polycystic kidney disease, diabetes mellitus or any chronic renal disease or disorder
*Major organ transplant – *from another donor where applicable*	The undergoing as a recipient a transplant of: • bone marrow, or • haematopoietic stem cells preceded by total bone marrow ablation, or • a complete heart, kidney, liver, lung, or pancreas from another donor, or • a whole lobe of the lung or liver from another donor, or inclusion on an official UK waiting list for such a procedure. The following are not covered: • transplant of any other organs, parts of organs, tissues or cells.	Cardiomyopathy, coronary artery disease, cardiac failure, chronic liver disease, chronic pancreatitis, pulmonary hypertension, cystic fibrosis, chronic lung disease or chronic kidney disease

Critical illness/ operation	Definition	Associated conditions
*Motor neurone disease – *resulting in **permanent** symptoms*	A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist: • Amyotrophic lateral sclerosis (ALS) • Primary lateral sclerosis (PLS) • Progressive bulbar palsy (PBP) • Progressive muscular atrophy (PMA). There must also be **permanent** clinical impairment of motor function.	Progressive muscular atrophy, primary lateral sclerosis, progressive bulbar palsy
*Multiple sclerosis – *where there have been symptoms*	A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must have been clinical impairment of motor or sensory function caused by multiple sclerosis.	Any form of neuropathy, encephalopathy or myelopathy (disorders or functions of the nerves) including but not restricted to the following: abnormal sensation (numbness) of the extremities, trunk or face/weakness or clumsiness of a limb/double vision/partial blindness/ocular palsy/vertigo (dizziness)/ difficulty of bladder control/optic neuritis/ spinal cord lesion/abnormal MRI scan
*Parkinson's disease – *resulting in **permanent** symptoms*	A definite diagnosis of Parkinson's disease by a Consultant Neurologist or a Consultant Geriatrician. There must be **permanent** clinical impairment of motor function with associated tremor and muscle rigidity. The following are not covered: • Parkinsonian syndromes/Parkinsonism.	Treatment with dopamine antagonist, tremor, extra pyramidal disease
Progressive supranuclear palsy – *resulting in **permanent** symptoms*	A definite diagnosis of progressive supranuclear palsy by a Consultant Neurologist or a Consultant Geriatrician. There must be **permanent** clinical impairment of eye movements and motor function.	Organic brain disease, disease of the central nervous system, Parkinson's disease, treatment with dopamine antagonist, tremor, extra pyramidal disease, depression, epilepsy, dementia, amnesic memory disorder, aphasia, psychosis.
*Stroke or spinal cord stroke - resulting in permanent symptoms	Death of brain tissue or spinal cord tissue due to inadequate blood supply or haemorrhage within the skull or spinal cord resulting in either: • permanent neurological deficit with persisting clinical symptoms; or • definite evidence of death of tissue or haemorrhage on a brain or spinal cord scan; and • neurological deficit with persistent clinical symptoms lasting at least 24 hours. The following are not covered: • transient ischaemic attack (TIA) • death of tissue of the optic nerve or retina/eye stroke.	Atrial fibrillation, transient ischaemic attack, diabetes mellitus, hypertension, intracranial aneurysm or occlusive arterial disease

Critical illness/ operation	Definition	Associated conditions
Childcover benefit Included in standard cover		
Cerebral palsy	We will pay **childcover benefit** if the **child** receives a definite diagnosis of cerebral palsy made by an attending Consultant.	
Children's intensive care benefit – *requiring mechanical ventilation for 7 days*	We will pay **childcover benefit**, if during the period of cover, a **child** due to sickness or injury is requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) unless it is as a result of the **child** being born prematurely (before 37 weeks).	
Cystic fibrosis	We will pay **childcover benefit** if the **child** receives a definite diagnosis of cystic fibrosis made by an attending Consultant.	
Down's syndrome	We will pay **childcover benefit** if the **child** receives a definite diagnosis of Down's syndrome made by an attending Consultant.	
Edwards' syndrome	We will pay **childcover benefit** if the **child** receives a definite diagnosis of Edwards's syndrome made by an attending Consultant.	
Hydrocephalus – *Treated* by surgery	We will pay **childcover benefit** if the **child** suffers hydrocephalus if the hydrocephalus is treated by surgery.	
Loss of independent existence	We will pay **childcover benefit** if in the opinion of a **specialist** the **child** will not at 18 be able to perform routinely at least three of the specified six activities of daily living without the continual assistance of someone else, even with the use of special devices or equipment. The following are activities of daily living: • Washing – this means being able to wash and bathe unaided, including getting into and out of the bath or shower. • Dressing – this means being able to put on, take off, secure and unfasten all necessary items of clothing. • Feeding – this means being able to eat pre-prepared foods unaided. • Continence – this means being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances. • Moving – this means being able to move from one room to another on level surfaces. • Transferring – this means being able to get on and off the toilet, in and out of bed and move from a bed to an upright chair or wheelchair and back again. The loss of independence must be entirely due to illness or injury, and not as a result of the age of the **child**. Having met our definition, the **child** must survive for 90 days.	
Muscular dystrophy	We will pay **childcover benefit** if the **child** receives a definite diagnosis of muscular dystrophy made by a Consultant Neurologist.	
Osteogenesis imperfecta	We will pay **childcover benefit** if the **child** receives a definite diagnosis of osteogenesis imperfecta by an attending Consultant. For the above definition, the following isn't covered: • Type 1 osteogenesis imperfecta.	

Critical illness/ operation	Definition	Associated conditions
Patau syndrome	We will pay **childcover benefit** if the **child** receives a definite diagnosis of Patau syndrome made by an attending Consultant.	
Spina bifida	We will pay **childcover benefit** if the **child** receives a definite diagnosis of spina bifida myelomeningocele or rachischisis by a Paediatrician. The following are not covered: • spina bifida occulta, and • spina bifida with meningocele.	
Extended		
*Aorta graft surgery	The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the affected aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. For the above definition, the following is not covered: • any other surgical procedure, for example the insertion of stents or endovascular repair.	Any disease or disorder of the heart or any obstructive/occlusive arterial disease.
Aplastic anaemia – *with **permanent** bone marrow failure*	A definite diagnosis of aplastic anaemia by a Consultant Haematologist. There must be **permanent** bone marrow failure with anaemia, neutropenia and thrombocytopenia.	Polyposis Coli, papilloma of the bladder or any cancer in situ.
Bacterial meningitis – *resulting in **permanent** symptoms*	A definite diagnosis of bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in **permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be confirmed by a Consultant Neurologist. The following are not covered: • all other forms of meningitis including viral meningitis.	Chronic ear disease or hydrocephalus
*Benign brain tumour – *resulting in **permanent** symptoms or undergoing defined treatments*	A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in either of the following: • **permanent neurological deficit with persisting clinical symptoms** • undergoing invasive surgery to remove part or all of the tumour; or • undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells. The following are not covered: • tumours in the pituitary gland • angiomas.	Neurofibromatosis (von Recklinghausen's disease), haemangioma (von Hippel- Lindau disease)

Critical illness/ operation	Definition	Associated conditions
Benign spinal cord tumour – *resulting in **permanent** symptoms or undergoing defined treatments*	• A non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges, resulting in any of the following: • **Permanent neurological deficit with persisting clinical symptoms;** or • Undergoing invasive surgery to remove part or all of the tumour; or • Undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells. The following are not covered: • granulomas, haematomas, abscesses, disc protrusions and osteophytes.	Neurofibromatosis, meningomyelocele, and syringomyelia.
*Blindness – ***permanent** and **irreversible***	**Permanent** and **irreversible** loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 20 degrees or less of an arc, as certified by an Ophthalmologist.	Stroke or transient ischaemic attack. No **lump sum benefit** will be payable under the blindness **critical illness** in respect of an insured **member** or **child** who at any time prior to the date of entry into the **policy** has been registered blind
*Coma – *with associated **permanent** symptoms*	A state of unconsciousness with no reaction to external stimuli or internal needs which: • requires the use of life support systems for a continuous period of at least 96 hours; and • with associated **permanent neurological deficit with persisting clinical symptoms**. For the above definition, the following is not covered: • medically induced coma.	
Coronary angioplasty – *with specified treatment*	Percutaneous coronary intervention (PCI) to correct narrowing or blockages of the left main stem artery, or two or more main coronary arteries. Multiple vessels must be treated at the same time or as part of a planned stage procedure within 60 days of the first PCI. The main coronary arteries for this purpose are defined as right coronary artery, left anterior descending artery, circumflex artery, or their branches. PCI is defined as any therapeutic intra-arterial catheter procedure including balloon angioplasty and/or stenting. The following are not covered: • diagnostic angioplasty • two angioplasty procedures to a single main artery or branches of the same artery.	Any disease or disorder of the heart, diabetes mellitus, hyperlipidaemia, or any obstructive/occlusive arterial disease
*Deafness – ***permanent** and **irreversible***	**Permanent** and **irreversible** loss of hearing to the extent that the quietest sound that can be heard in the better ear is 70 decibels across all frequencies using a pure tone audiogram.	Acoustic nerve tumour, neurofibromatosis (von Recklinghausen's disease)
Encephalitis – *resulting in **permanent** symptoms*	A definite diagnosis of encephalitis by a Consultant Neurologist. There must be **permanent neurological deficit with persisting clinical symptoms**.	There are no **associated conditions** for encephalitis
*Heart valve replacement or repair	The undergoing of surgery including balloon valvuloplasty on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.	Any disease or disorder of the heart, or any obstructive/occlusive arterial disease.

Critical illness/ operation	Definition	Associated conditions
HIV infection – *caught from a blood transfusion, a physical assault or at work in an eligible occupation*	Infection by Human Immunodeficiency Virus resulting from: • a blood transfusion given as part of medical treatment; • a physical assault; or • an incident occurring during the course of performing normal duties of employment from the eligible occupations listed below; – ambulance workers – chiropodists – dental nurses – dental surgeons – district nurses – fire brigade firefighters – general practitioners – hospital caterers – hospital cleaners – hospital doctors, surgeons and consultants – hospital laboratory technicians – hospital laundry workers – hospital nurses – hospital porters – midwives – nurses employed by general practitioners – occupational therapists – paramedics – physiotherapists – podiatrists – policemen and policewomen – prison officers – radiologists – refuse collectors – social workers after the start of 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 occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident • there must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus For the above definition, the following is not covered: • HIV infection resulting from any other means, including sexual activity or drug abuse.	

Critical illness/ operation	Definition	Associated conditions
Liver failure – *of advanced stage*	Liver failure due to cirrhosis and resulting in: • **permanent** jaundice • ascites, and • encephalopathy.	Chronic liver disease, including but not limited to hepatitis B & C, primary sclerosing cholangitis, and portal hypertension
*Loss of hand or foot – ***permanent*** *physical severance*	**Permanent** physical severance of hand or foot at or above the wrist or ankle joint.	Diabetes mellitus, peripheral vascular disease, bone and soft tissue cancer.
Loss of independent existence – ***permanent*** *and* ***irreversible***	The total and **permanent** loss of the ability to perform routinely at least three of the six activities of daily living without the continual assistance of someone else, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. The activities of daily living we assess against are listed below. Activities of daily living: 1. Washing – being able to wash and bathe unaided, including getting into and out of the bath or shower. 2. Dressing – being able to put on, take off, secure and unfasten all necessary items of clothing. 3. Feeding – being able to eat pre-prepared foods unaided. 4. Continence – being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances. 5. Moving – being able to move from one room to another on level surfaces. 6. Transferring – being able to get on and off the toilet, in and out of bed and move from a bed to an upright chair.	Multiple sclerosis, muscular dystrophy, motor neurone disease, or any disease or disorder of the brain, spinal cord or column
*Loss of speech – *total,* ***permanent*** *and* ***irreversible***	Total **permanent** and **irreversible** loss of the ability to speak as a result of physical injury or disease.	Stroke, transient ischaemic attack, motor neurone disease, brain or throat tumour, laryngeal polyps.
*Paralysis of limb – *total and* ***irreversible***	Total and **irreversible** loss of muscle function to the whole of any limb.	Multiple sclerosis, muscular dystrophy, motor neurone disease or any disease or disorder of the brain, spinal cord or column.
Primary cardiomyopathy – *of specified severity or undergoing a defined treatment*	A definite diagnosis by a Consultant Cardiologist of primary cardiomyopathy. The disease must result in at least one of the following: • left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months by an MRI scan. • marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months. • implantation of a Cardioverter Defibrillator (ICD) on the specific advice of a Cardiologist for the prevention of sudden cardiac death. The following are not covered: • any secondary cardiomyopathy • all other forms of heart disease, heart enlargement and myocarditis.	Any disease or disorder of the heart, diabetes mellitus or any obstructive/ occlusive arterial disease

Critical illness/ operation	Definition	Associated conditions
Pulmonary arterial hypertension – *of specified cause and severity*	A definite diagnosis of one of the following by a Consultant Cardiologist or Consultant Respiratory Physician of either: • idiopathic pulmonary arterial hypertension • chronic thrombo-embolic pulmonary hypertension. There must be all of the following: • a systolic pulmonary arterial pressure (PAP) of greater than 50mmHg (mm of mercury) for more than a year • **permanent** and **irreversible** right ventricular dilatation and hypertrophy on echocardiogram and electrocardiogram (ECG).	Any disease or disorder of the heart, diabetes mellitus or any obstructive/ occlusive arterial disease.
Pulmonary artery surgery	The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) or thoracotomy on the advice of a Consultant Cardiologist for one of the following procedures: • Pulmonary artery surgery to excise and replace the diseased pulmonary artery with a graft. • Pulmonary endarterectomy.	Pulmonary valve stenosis, pulmonary atresia, truncus arteriosus, Fallot's tetralogy, patent ductus arteriosus.
Respiratory failure – *of specified severity*	Confirmation by a Consultant Physician of severe lung disease with **permanent** impairment of lung function resulting in all of the following: • the need for daily oxygen therapy for a minimum of 15 hours per day for at least six months • forced expiratory volume at one second (FEV1) below 50% of normal • forced vital capacity (FVC) below 50% of normal.	Any disease or disorder of the respiratory system including the lungs, bronchi and trachea.
Rheumatoid arthritis – *chronic and severe*	A definite diagnosis of rheumatoid arthritis by a Consultant Rheumatologist: • there must be morning stiffness in the affected joints lasting for at least one hour • there must be arthritis of at least three joint groups, with soft tissue swelling or fluid observed by a physician • the arthritis must involve at least the: – wrists or ankles – hands and fingers, or – feet and toes • there must be symmetrical arthritis • there must be radiographic changes typical of rheumatoid arthritis.	Inflammatory polyarthropathy.
Structural heart surgery	The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) or thoracotomy on the advice of a Consultant Cardiologist, to correct any structural abnormality of the heart.	Any disease or disorder of the heart, diabetes mellitus, hyperlipidaemia, or any obstructive/occlusive arterial disease.
Systemic lupus erythematosus – *with severe complications*	A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following: • **permanent neurological deficit with persisting clinical symptoms**; or • the **permanent** impairment of kidney function tests as follows: – Glomerular Filtration Rate (GFR) below 30 ml/min.	Hughes syndrome, rheumatoid arthritis, and Sjogren's syndrome.

Critical illness/ operation	Definition	Associated conditions
Terminal illness – *where death is expected within 12 months*	A definite diagnosis by the attending Consultant of an illness that satisfies both of the following: • the illness either has no known cure or has progressed to the point where it cannot be cured; and • in the opinion of the attending Consultant, the illness is expected to lead to death within the earlier of 12 months and the **member's cease age**.	Any medical condition that is listed as a **critical illness** condition.
*Third degree burns – *of specified severity*	Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20 percent of the body's surface area or 20 percent loss of surface area of the face which for the purposes of this definition includes the forehead and ears.	
*Traumatic brain injury due to trauma, anoxia or hypoxia – *resulting in specified symptoms*	Death of brain tissue due to traumatic injury or reduced oxygen supply (anoxia or hypoxia) resulting in **permanent neurological deficit with persisting clinical symptoms**.	
Optional Cover		
In addition to the **critical illnesses** or **operations** covered under the Standard and Extended schemes, subject to agreement by Aviva, you may be able to include cover for the Cancer drugs fund benefit and/or total **permanent** disability. These options will result in an extra cost under both Standard and Extended schemes.		
Cancer drugs fund benefit	If this option is selected, following the diagnosis of cancer for which we have paid a **lump sum benefit**, we will pay for the cost of drugs recommended by the **member's** NHS **specialist** up to a maximum of £100,000 to treat their cancer if their NHS **specialist's** submission for the provision of cancer drugs is rejected by their local **commissioning body** on financial grounds. A treatment plan must also have been agreed by the NHS multi-disciplinary team (MDT). We will only pay for drugs recommended by the NHS **specialist** for cancer treatment if they are: • proven or established within common UK practice, such as a drug used within the terms of its licence or approved by NICE for use in the NHS, and • supported by published, peer- reviewed clinical evidence that proves the treatment has positive clinical outcomes, and • recognised as acceptable clinical practice and practised widely by UK **specialists**. We will pay the cost of cancer drugs, and the charges for administering those drugs, up to a maximum of £100,000. If the treatment costs exceed this the **member** will have to pay the extra costs themselves.	

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

Your questions answered

1 How does the policy work?

- For new policies, we need a minimum of 250 **employees** who are **eligible** to be covered under the **voluntary/flexible benefits policy.** For existing **voluntary/flexible benefits polices**, we need a minimum of 50 **employees** in the **policy** to be able to offer terms.
- The **policy** will pay a **lump sum benefit** to the **employee** if they (or their **partner** and/or a **child** covered by the **policy**):
  - is diagnosed with one of the **critical illnesses**, or
  - undergoes one of the **operations**

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

- You decide:
  - the level of benefit
  - the type of cover (Standard or Extended)
  - whether or not to cover **members' partners**.
  - whether or not to include Cancer Drugs Fund benefit or Total permanent disability benefit.
- You pay the premium to us, although you will need to collect any relevant premiums from your employees. Please see the tax considerations section on page 26 for details about how premiums and benefits are treated.
- We will not cancel the **policy** as a result of paying valid claims. If the **policy** is cancelled we will still pay valid claims for diagnoses that were made and **operations** that **members** or **children** underwent whilst the **policy** was in force.
- You make claims on behalf of the **member** or **child**, and you must give us the information that we need to be able to assess the claim.
- If a claim is valid, we will pay a **lump sum benefit** for a **critical illness** or **operation** to your **employee** provided it is to a UK, Channel Island or Isle of Man bank account. We will pay a claim for cancer drug fund benefit to the **member's** local NHS trust. The **lump sum benefit** is tax free under current tax rules.
- All premiums and benefits will be in pounds sterling.

2 What factors should be considered in deciding what benefits to provide?

Aviva's Group **Critical Illness policy** has a number of options to help you create a **policy** that fits your business needs and the needs of your workforce.

2.1 Who can be covered?

Employees with a current UK, Channel Islands or Isle of Man contract of employment with an **employer** covered by the **policy** and who meet the **eligibility**.

Cover for **employees' children** is automatically included and you can also choose to cover **members' partners** at an additional cost.

2.2 Can cover be provided for members who are not in the UK, Channel Islands or Isle of Man?

We will maintain cover for **members** who are travelling outside of the UK, Channel Islands or Isle of Man whilst on holiday, or on company business for example; attending conferences, company meetings, or visiting clients.

We will cover **members** who are working or residing outside of the UK, Channel Islands and the Isle of Man, provided that:

- they are working or residing in one of the listed **standard territories** or any additional locations detailed in your **policy schedule**; and
- the **employee** still has a UK, Channel Islands or Isle of Man contract of employment with an **employer** covered under this **policy**; and
- the premium to cover **members** based **overseas** is paid in sterling by you; and
- they are still eligible for cover under the **policy**

You can ask us to cover individuals who are working or residing in a country outside of the **standard territories**. In order to consider cover, we will require full details of these individuals including their location and the duration they expect to be located **overseas** before we can agree cover. There may be circumstances where we are unable to provide cover. Any additional locations will be detailed in your illustration or **policy schedule.**

You must tell us about any **members** who are working **overseas** at the **policy** start date or **rate guarantee date**. You must also tell us the countries that they will be working in.

Special terms and conditions may apply for cover to an **overseas member**.

You should seek your own independent advice if you wish to continue to provide cover for any **members** who move to another territory.

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

2.3 What are the eligibility conditions?

You will have to decide the **eligibility** conditions. These can include:

- the minimum and maximum ages that **members** can join the **policy**. We allow membership for people who are 69 and younger (we will automatically cancel membership when a **member** reaches 70 years old). **Children** from date of birth up to the age of 18 years old (or 23rd birthday if in full time education) will be automatically covered (we will no longer cover **children** when they reach 18 years old (or 23 years if in full time education), or when the **employee** reaches 70 years old if this happens earlier).

- any service qualification period – for example stating that an **employee** must have worked for at least 6 months in order to qualify for the **policy**. Part-time **employees** and **employees** on fixed-term contracts can also be included on the **policy**.
- any categories of membership, for example 'managers', 'office staff', 'sales teams'. If **employees** need to be members of a pension scheme in order to be **eligible** for the **policy**, you will need to specify the **eligibility** criteria for the pension scheme.
- when new **employees** can join the **policy** – for example at the **anniversary date**, the first day of each month or as soon as they become **eligible**.
- when **members'** benefits can increase – for **voluntary/flexible benefits policies** this will be on the **anniversary date** of the **policy** or at a **lifestyle event** (if a chosen feature).

We will also need to agree:

- the levels of benefit. We allow a maximum **lump sum benefit** of five times the **employee's salary** (although this is capped – we will pay no more than £500,000 per claim for an **employee**. **Partners** of **employees** can receive a maximum of £250,000. **Children** can receive up to 25% of the **employee's** benefit with a cap of £25,000).
- what definition of **salary** to use. You may need to take into account bonuses, commissions and overtime if they form part of **employees'** regular salaries.

For **voluntary/flexible benefits policies**:

- **employees** can increase their benefit and that of their **partner's** by an agreed number of steps at each **anniversary date** or **lifestyle event**. A new **pre-existing conditions** exclusion will apply to the increased benefit from that **anniversary date** or **lifestyle event**;
- **members** can decrease their benefit at an **anniversary date** or **lifestyle event**;
- **members** may not have adequate cover if they do not adjust their choices at the **anniversary date** or a **lifestyle event**. Any increase or decrease in benefit must be effective on the **anniversary date** or within two months of the **lifestyle event** taking place.
- each **policy year**, **members** can only increase benefit once at the **anniversary date** and once on a **lifestyle event**. The **lifestyle events** are applicable in respect of the **employee** only. Other **lifestyle events** may be approved on request. We may require evidence of **lifestyle events** for a **member** in the event of a claim.

Discretionary entrants

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

TUPE transfers

You may add **members** to the **policy** at any time however cover will not be backdated. For any **TUPE** or other group employment transfer, **employees** and **employee's partners** will be treated as **members** switching cover from another insurer. Please refer to section 11 for our switch terms to see how these **members** would be treated.

2.4 Can different Group Critical Illness policies be linked?

It is possible to link different Aviva Group Critical Illness policies taken out by the **employer** or parent/subsidiary of the **employer**. This will be for the purpose of sharing premiums rates and is subject to prior agreement by us.

2.5 When will cover stop for a member or child?

All cover will stop when the **policy** is cancelled or the premiums are not paid.

You choose the **policy cease age**, which can be **state pension age (SPA)** or any fixed age up to a maximum of 70.

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

Cover will stop for an **employee**, when they;

- are no longer employed by you;
- are no longer **eligible** for the **policy**;
- reaches the **cease age**; or
- move **overseas** to a location not listed in our **standard territories** or any additional locations detailed in your **policy schedule**, unless otherwise agreed; or
- dies.

We will cancel cover for a **partner** of an **employee**;

- when they are no longer **eligible** for the **policy**;
- when the **employee** reaches the **cease age**.
- when they move **overseas** to a location not listed in our **standard territories** or any additional locations detailed in your **policy schedule**, unless otherwise agreed;
- when they die; or
- if the **employee** leaves the **policy**, for whatever reason.

We will cancel cover for a **child** of an **employee**;

- when they are no longer **eligible** for the **policy**;
- when they reach the **cease age** (18 years old (23 if in full time education);
- when the **employee** reaches the **cease age**.
- if they or the **employee** moves **overseas** to a location not listed in our **standard territories** or any additional locations detailed in your **policy schedule**, unless otherwise agreed; or
- when they die; or
- if the **employee** leaves the **policy**, for whatever reason.

2.6 What types of cover are available?

We have two levels of cover – Standard and Extended. The **policy schedule** will show if you have selected optional cover for cancer drugs fund and/or total permanent disability. We adhere to the Association of British Insurers (ABI) minimum standards for all

critical illnesses that have been defined by them. These definitions are marked with an asterisk in the **critical illnesses** and **operations** table on page 7. Within the **critical illness** definitions there are four words or phrases that have very specific meanings. These are also defined by the ABI and are:

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

You can also choose whether or not to include:

– Cancer Drugs Fund benefit

– Total **permanent** disability benefit

– cover for **partners** of your employees.

2.7 What happens if someone is temporarily absent?

Where an **employee** is off work due to illness or injury, the cover for the **employee** (and if applicable the **employees' partner**) can continue up to the **cease age** providing premiums continue, the member is included in the membership data whenever it is provided and a UK, Channel Islands or Isle of Man contract of employment is maintained.

Where absence is due to any other reason, such as statutory absence (for example maternity leave, paternity leave, shared parental leave, adoption leave or Armed Forces Reserves call up), then cover can continue to be provided for a maximum of 36 months, providing premiums continue and a UK, Channel Islands or Isle of Man contract of employment is maintained.

3 How is the policy set up?

3.1 What do we need to set up the policy?

If you have received an illustration, all the details are correct and nothing has changed, and you have answered any outstanding information in respect of caveats, then we can start cover if you ask us to in writing within three months of when the illustration was issued.

We will need, within 30 days of the start of the **policy**:

- a fully completed application form, together with any additional information that the form asks for, and
- the deposit premium and/or direct debit mandate returned

We will not backdate cover under any circumstances.

The **policy schedule**, along with our **policy** wording will form the basis of the cover.

In order to prepare an illustration, we will need to know **employees'**:

- genders;
- dates of birth;
- salaries and benefits;
- occupations;
- work postcode locations or;
- countries of residence if outside the UK, Channel Islands or Isle of Man.

together with previous policy and claims history (if you have had a policy insured before). Any additional information will be requested if required.

3.2 Does any evidence of health have to be provided before members are covered?

We do not need any evidence of health about the **members** or **children** before the **policy** begins. If you need to make a claim, we will investigate whether or not:

- the illness;
- a **related** illness; or
- an **associated condition**;

existed before the **policy** started, and then assess the claim.

3.3 What happens if a claim arises before an underwriting decision has been made?

As we do not medically underwrite **members**, everyone who is **eligible** is covered once the **policy** begins.

4 What premiums will be charged for the cover?

We calculate the premium rate(s) using a number of different factors. These include, but are not limited to, the:

- level of benefits insured (for example **salary** x 5);
- level of cover that you choose (for example Standard or Extended, or if chosen, cover for a Cancer Drugs Fund benefit and/or which definition of total permanent disability you wish to use);
- **cease age**;
- **eligibility** and entry conditions (for example, whether or not **partners** will be covered);
- age and gender of the **members**;
- occupations of **employees** and the location(s) where they are based; and
- claims history (if you have had a policy insured before).

4.1 How will premiums be calculated?

Core/default benefit (if applicable)

Premiums will be calculated based on a unit rate, and shown per £1,000 of benefit.

The premium is calculated based upon the total **core** or **default benefits** for **members** at the **start date** or **anniversary date**.

Voluntary/flexible benefits

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

4.2 Will there be any unexpected extra premiums?

We usually guarantee the rate(s) for two years after the start of the **policy**.

Terms and conditions

We can change the rates, any other term or condition of the **policy**, or cancel cover from the **start date** if:

- during the period of the **rate guarantee**, there is any change to the total **core benefit**, **default benefit** or sum insured upon which our illustration is based of 25% or more;
- the number of **members** who are covered falls below 50 (if this happens we reserve the right to cancel the **policy**);
- any further information you give us affects the terms offered by us;
- there is a change to the (or any new) legislation, regulation or taxation affecting the **policy**;
- there is a change to the:
  - benefit basis
  - **eligibility**
  - nature of business, or
  - companies included within the **policy**; or
- the premium or application form requirements are not met (if the application form and premium requirements are not met within 30 days of the **start date**, we reserve the right to cancel the contract from the **start date** – this means that the **policy** will never have existed and your **members** will have no cover).

We also reserve the right to change the terms and conditions at the **rate guarantee date**.

4.3 What commission is included within the premium?

Commission payments to your intermediary are a percentage of the premium. The **policy** illustration will show the rate of commission we pay on your **policy**.

In addition to any commission, the premium could also reflect the fact that our staff are salaried and may receive an annual bonus based upon the overall performance of the Aviva Group. Some members of staff may also receive an additional bonus a proportion of which relates to their sales performance.

4.4 Is there a discount for good claims experience?

Claims experience is a factor in assessing a unit rate and premium for a **policy**, and therefore a good claims history will usually be reflected in the rate and premiums charged.

5 How does the policy accounting work?

The **policy** runs on one year accounting periods. The premium must be paid in advance monthly or annually by direct debit, or any other method agreed with us.

Non-annual payment

Where premiums are paid monthly by BACS, cheque or direct transfer, we will issue an invoice for the premium due for that month. Premiums should be paid within 30 days of the date they become due.

Where premiums are paid monthly by Direct Debit, we will collect a level premium based on the membership at the **start date** or **anniversary date**. We will then record the accurate premiums based on the monthly data supplied, and produce a final account at the end of the **policy year** (unless otherwise agreed). We will then advise you of any additional premiums due before they are collected, or issue a refund for any over payment that has been made. We may also offer to offset against the following year.

Annual payment

Where premiums are paid annually, we will charge a deposit premium based on the membership at the **start date** or **anniversary date**. We will then record the accurate premiums based on the monthly data supplied, and produce a final account at the end of the **policy year** (unless otherwise agreed). We will then issue an invoice for any premiums due, or issue a refund for any over payment that has been made.

5.1 What information is needed for accounting purposes?

Unless otherwise agreed with us, we will require full and accurate membership data to be sent to us in electronic spreadsheet format every month and at each **anniversary date**. This should include:

- names;
- genders;
- dates of birth;
- **salary** or benefit;
- **default benefits**;
- **flexible benefits**;
- details of any **member** increasing or decreasing their benefit due to a **lifestyle event**;
- dates of joining for any new **members**;
- **policy** category (if more than one is covered);
- any other relevant information such as **members** who are located **overseas**.

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

5.2 How are accounts adjusted for members who join, leave or have benefit changes during the year?

As we receive monthly data, we will calculate a premium adjustment to make sure that we charge the correct premium for the amount and length of the cover that we actually provide.

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

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

Cover for **members** that are eligible to join the **policy** part way through the month will start immediately with premiums becoming payable at beginning of the following month. Premiums for **members** that leave part way through the month will not be refunded.

6 How are claims made?

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

6.1 How are claims submitted?

If you need to submit a claim, or have questions about a claim, please contact us:

email: groupciclaims@aviva.com, or

phone: 0800 015 7523,

Online claim form

write to us at:
Aviva Group Protection
PO Box 3240
Norwich
Norfolk
NR1 3ZF

Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

We will then advise you what will happen next and what information we require.

6.2 When is a claim paid?

In order to make a claim, an **employee** (or their **partner** or **child**) covered by the **policy** must have:

- been diagnosed with a **critical illness**; or
- undergone one of the **operations**;

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

6.3 What might be needed to assess a claim?

Once we have received the information we require:

- we will assess the claim to see if the medical evidence confirms that the **member** or **child** has suffered a **critical illness** or undergone one of the **operations** that the **policy** covers.
- if we need more medical information we will ask for it. If we ask for any other medical information that comes from the UK (for example a medical report), we will pay for it. In some circumstances we may ask for an independent medical examination.

Depending on who and what the claim is for, we may need to see birth or adoption certificates, marriage certificates or civil partnership certificates, or see evidence of an applicable **lifestyle event**. If we need any more information, we will contact the people that we need to in order to get it (provided that we have the appropriate consent to do this).

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

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

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

6.4 To whom can payments be made?

If we accept a claim we will pay a **lump sum benefit** for a **critical illness** or **operation** to your **employee** provided it is to a UK, Channel Island or Isle of Man bank account. We will pay a claim for cancer drug fund benefit to the **member's** local NHS trust.

All payments will be in pounds sterling.

6.5 Can another claim be made in the future?

- Subsequent claims for cancer drugs fund benefit in respect of **partners** of an **employee** will only be considered if:
  - the **employee** remains a **member** of the **policy**, and
  - the claim for cancer drugs fund benefit relates to the diagnosis of cancer for which we paid a **lump sum benefit**.
- If a **member** or **child** has been paid a **lump sum benefit** by your **policy** and then suffers another **critical illness** or undergoes a further **operation** covered by the **policy**, we may pay a **lump sum benefit** subject to the exclusions details in section 8.
- We will not pay a **lump sum benefit** for any illness or **operation** covered by this **policy** if the **member** or **child** has previously claimed for
  - total permanent disability;
  - paralysis of limb; or
  - loss of independent existence, or
  - terminal illness;

and that claim was paid even if the first payment was from a previous insurer of your **policy**. We would cancel cover for the **employee**, their **partner** and any **child** covered by the **policy** once a **lump sum benefit** has been paid in respect of the **employee** for any of these **critical illnesses.**

- We will not pay a **lump sum benefit** for
  - total permanent disability; or
  - paralysis of limb; or
  - loss of independent existence, or
  - terminal illness;

if the **member** or **child** has previously received a **lump sum benefit** for any other **critical illness** or **operation**.

7 When can the policy be changed or cancelled?

7.1 When a change can be made by you

Requests to change the **policy** can be made by you at any time.

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

You need to inform us immediately if:

- you want to change the cover or **eligibility** criteria for the membership; or
- there are any material changes to the **employer**; or
- a **TUPE** or group employment transfer takes place (either into or out of the **policy**); or
- the business location of an **employer** or group of **employees** changes; or
- any **member** moves **overseas** to a location which is not listed in our **standard territories** or any additional locations detailed in your **policy schedule**; or
- there is a change in the nature of an **employer's** business; or
- you want to include any additional cover; or
- you want to add any other **lifestyle events** to the **policy**; or
- the total sum insured increases/decreases by 25% from the last **rate guarantee date** (or **start date** if rate review not yet happened); or
- you want to cancel the **policy**.

However, we will reserve the right to cancel the **policy** if;

- the business location of an **employer** or group of **members** changes; or; there is a change in the nature of an **employer's** business or;
- you do not give us the information and documentation that we need to administer the **policy**;
- the number of **employees** covered drops below fifty;
- If the provision of cover would cause, or be reasonably likely to cause, us to breach any law or regulation in the given territory we reserve the right to cease cover within that territory.

7.2 When can you cancel the policy?

You may cancel the **policy** at any time. Cover for all benefits under the **policy** will stop on the agreed date, and a premium will be due for the cover we have provided.

If the **policy** is cancelled for any reason, we will produce a final account based on the cover we provided up to the date you cancel the **policy**. We will pay you a refund if you have made any overpayments or request payment for any premiums due.

We will not backdate cancellations.

7.3 When we can make changes to the policy

a. We may, at each **rate guarantee date**, or at any time if required, make reasonable changes to the terms and conditions provided for in this **policy** and any linked policy which, are needed to:
   - respond in an appropriate manner to changes in the way we administer policies of this type;
   - respond in an appropriate manner to changes in technology or general practice in the insurance industry;
   - respond in an appropriate manner to changes in taxation, the law or interpretation of the law, decisions or recommendations of a Court, Ombudsman, Regulator or similar person, or any code of practice with which we intend to comply; or
   - correct errors that need correcting and it is reasonable to do so.

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

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

b. We may at any time (and retrospectively where appropriate) cancel the **policy** or cover in respect of a **member**, reclaim benefits paid in respect of a **member's** claim, or apply different terms in line with reasonable underwriting and insurance practice if a **member** or you have at any time:
   - deliberately or recklessly failed to disclose information to us, given false information to us or failed to tell us where any facts have changed since they were provided
   - defrauded/attempted to defraud us;
   - agreed to any attempt by someone else to defraud us;
   - failed to observe the terms and conditions of this **policy**.

7.4 When we can cancel the policy

We can cancel the **policy** if:

- the number of **employees** covered falls below 50; or
- you do not pay us the premiums when due; or
- you do not provide us with membership data, other information or documentation that we need to administer the **policy**; or
- the business location of an **employer** or group of **members** changes; or
- there is a change in the nature of an **employer's** business; or
- if the provision of cover would cause, or be reasonably likely to cause, us to breach any law or regulation in the given territory we reserve the right to cease cover within that territory.

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

If we cancel the **policy** we will give you at least 30 days' notice.

Sanction Checking

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

7.5 Does the policy have a surrender value?

There is no surrender value if the **policy** is cancelled at any time.

7.6 What happens to premiums if the policy is cancelled mid-year?

If the **policy** is cancelled mid-year, we will produce a final account based on the date you cancel the **policy**. We will pay you a refund if you have made any overpayments or request payment for any premiums due.

7.7 What happens if the policy is cancelled before a claim is paid?

If the **policy** is cancelled, we will continue to assess claims for **critical illnesses** that were diagnosed and **operations** that took place whilst the **policy** was in force. If a **member's** date of diagnosis is after the **policy** was cancelled, we will not be liable to pay the claim.

8 What is not covered?

A **lump sum benefit** for each **critical illness** or **operation** covered by the **scheme**, will only be paid once in respect of each **member** or **child**.

The insurer who insured the **scheme** at the time the definition of the **critical illness** or **operation** was first met should consider the claim.

If the definition of a **critical illness** or **operation** insured by this **policy** has changed, any claim will be considered against the definition of the **critical illness** or **operation** at the time the **member** or **child** was diagnosed or underwent the **operation**.

If a claim has been paid for a **member** or **child**, for a **critical illness** or **operation**, under a previous group critical illness **policy**, that claim will be treated by us as a first claim under this **policy**.

If any new **critical illnesses** or **operations** are added, the exclusions detailed in this section will apply to them from the date they were added to this **policy**.

8.1 Pre-existing conditions

We will not pay a **lump sum benefit** for a **member** or **child** if the **critical illness** or **operation** being claimed for:

- was **pre-existing** at any time prior to the date their cover commenced under the **scheme** or;
- has, prior to the current claim, previously met the definition for that **critical illness** or **operation**.

For example, if the **member** or **child** had a lung transplant (major organ transplant), we will not consider a claim for another major organ transplant.

We will not pay the amount of any increase in **lump sum benefit** (except increases which are in-line with standard company pay awards which are limited to a maximum of 7% per **policy year**) if the **critical illness** or **operation** was **pre-existing** at any time prior to the date of each increase. We will still consider the claim for the pre-increase amount.

8.2 Related conditions

We will not pay a **lump sum benefit** for a **member** or a **child** who has a **critical illness** or **operation** that is **related** to:

- another **critical illness** or **operation** which was **pre-existing** at any time prior to the date their cover commenced under the **scheme** or;
- another **critical illness** or **operation** which at any time has previously met the definition.

Please be aware that for this **policy** the following **critical illnesses** and **operations** are **related** to each other:

- Aorta graft surgery
- Cardiac arrest
- Coronary angioplasty
- Coronary artery by-pass surgery
- Heart attack
- Heart transplant
- Heart valve replacement or repair
- Primary cardiomyopathy
- Pulmonary arterial hypertension
- Pulmonary artery surgery
- Stroke or spinal cord stroke
- Structural heart surgery

For example, if the **member** or **child** experienced kidney failure, we will not pay a **lump sum benefit** if they have a kidney transplant in the future.

Also, if the **member** has previously had a heart attack, we will not pay a **lump sum benefit** if they have a stroke in the future.

8.3 Associated conditions

We will not pay a **lump sum benefit** for a **member** or a **child** if they had an **associated condition** at any time prior to the date their cover commenced under the **scheme**.

We will also not pay the amount of any increase in **lump sum benefit** (except increases which are in-line with standard company pay awards which are limited to a maximum of 7% per **policy year**) if the **member** or **child** had an **associated condition** at any time prior to the increase. We will still consider the claim for the pre-increase amount.

This exclusion applies indefinitely in respect of claims for:

- Total Permanent Disability

- Loss of independent existence
- Paralysis of limb

For all other **critical illnesses** and **operations**, if the **member** or **child** has not had a **critical illness** or **operation** during the first two years after joining the **scheme**, or their increase in **lump sum benefit**, this exclusion will no longer apply.

For example, if the **member** or **child** experienced a numb hand before their cover started and they are diagnosed with Multiple Sclerosis within two years of joining the **scheme**, we will not pay a **lump sum benefit** as the numbness is an **associated condition**.

Also, if the **member** or **child** experienced reduced hearing or vision after their cover started but before an increase to their **lump sum benefit** and they are diagnosed with brain tumour within two years after the increase, we will cap the **lump sum benefit** at the pre-increase level as the reduced hearing or vision is an **associated condition**.

8.4 Exclusion for children

We will not pay **a lump sum benefit** for a **child** if symptoms first arose, the underlying condition was first diagnosed, or the **member** or **child** received counselling or medical advice in relation to the condition:

- before the **member** joined the **scheme**; or
- before the **member's** legal adoption or legal guardianship of the **child**; or
- if the **critical illness** or **operation** was brought about by intentional harm inflicted on the **child** by the **member**

We will not pay a **lump sum benefit** for a **child** for:

- total permanent disability; or
- cancer drug fund.

8.5 Terminal illness

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

8.6 Self-inflicted injury

We will not pay a claim if the **critical illness or operation** is a direct or indirect result of an intentionally self-inflicted injury.

8.7 Alcohol or drug abuse

We will not pay a **lump sum benefit** if the **critical illness** or **operation** is a direct or indirect result of the inappropriate use of alcohol or drugs, including but not limited to:

- Consuming too much alcohol
- Taking an overdose of drugs, whether lawfully prescribed or otherwise
- Taking Controlled Drugs (as defined by the Misuse of Drugs Act 1971) otherwise than in accordance with a lawful prescription.

9 What are the tax considerations?

All references to taxation are based on our understanding of current tax law and practices. Tax law and practices could change in the future. You should get professional advice from your own tax advisers.

9.1 What are the tax considerations for payment of premiums?

An **employer** normally pays the whole premium for the **policy**. In this situation HMRC will generally agree to this being allowed as a trading expense and can be offset against Corporation Tax. The **employer** is liable for Class 1A National Insurance Contributions on the premiums.

The premiums are a 'benefit in kind' for the **members** and are taxed under the PAYE system. HMRC does not normally grant tax relief on premiums paid for any **employees** with a proprietary interest in the company. However, they may sometimes grant tax relief provided that a substantial number of other **employees** are entitled to similar benefits.

Equity Partners

Each Equity Partner pays for their own cover, although Aviva will collect the premium from the **employer**. There is no tax relief on the premium paid.

9.2 What are the tax considerations for payment of benefits?

Under current tax rules **lump sum benefits** to an **employee** are not taxable.

10 Continuation option

There is no continuation option available for **members** or **children** who are no longer **eligible** for your **policy**.

11 Transferring underwriting from another insurer

Although we do not medically underwrite **members**, we will need the full underwriting details for anyone who was underwritten by your previous insurer.

If your policy transfers to Aviva and:

- there is an increase in benefit compared to the previous insurer;

the **pre-existing conditions** exclusion will apply to the increase in benefit from the date cover started with Aviva.

- there is a **critical illness** or **operation** on the Aviva **policy** that was not previously covered by the policy;

the **pre-existing conditions** exclusion will apply to that condition from the date cover started with Aviva.

- there is a **pre-existing conditions** exclusion with the current insurer, for benefits and conditions that are the same on both policies;

the **pre-existing conditions** exclusion will apply from the date(s) the previous insurer had applied.

- there is a benefit underwritten and accepted with a medical exclusion;

we will continue to apply that exclusion and the **pre-existing conditions** exclusion will not apply to that benefit.

- there is a benefit underwritten and accepted with no special terms ie. ordinary rates;

we will not apply the **pre-existing conditions** exclusion.

- there is a benefit underwritten and a loading has been applied;

we will not apply the **pre-existing conditions** exclusion, and we will not apply a loading (even if the previous insurer did apply a loading).

- there is a benefit underwritten and benefits have been restricted or declined;

we remove the restriction and cover the **member** for their full benefit entitlement, subject to a new **pre-existing conditions** exclusion to the increase in cover.

12 Further information

If you need to contact us, please have your **policy** number to hand and you can contact us:

email: groupprotection@aviva.com

phone: 0800 051 3472

write to us at:
Aviva Group Protection
PO Box 3240
Norwich
Norfolk
NR1 3ZF

Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

However, if you feel it is specific advice that you need, we recommend that you speak to a financial adviser.

If you do not have a financial adviser, one can be found at www.unbiased.co.uk.

Third Party Rights

Only we and the policyholder will have any rights under these **policies**. Any person or persons who are not a party to these **policies** shall have no rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any terms under this **policy**. Reference to, or the consent of, any person who is not a party to the **policy** is not required for any changes to it or its rescission.

Except in the event of a disputed claim where the **member** may, either in conjunction with (unless you inform us otherwise in advance) or instead of you, enforce such claim to the extent that you may enforce it (including the pursuit of a complaint to the Financial Ombudsman Service (FOS) if within FOS jurisdiction).

It is your legal responsibility to inform **members** of their rights in regards to the FOS in the event of any dispute, for example that any notification must be received within appropriate timescales. Aviva Life & Pensions UK Ltd will not be liable for any failure by you to inform **members**.

Compensation

The Financial Services Compensation Scheme (FSCS) may cover your **policy**. It will cover you if Aviva becomes insolvent and we are unable to meet our obligations under the **policy**.

For this type of **policy**, the FSCS will cover you for 100% of the total amount of an existing claim. The FSCS will also provide a refund of 100% of the premiums that have not been used to pay for cover whether you are making a claim under the **policy** or not.

For further information, see fscs.org.uk or telephone 0800 678 1100.

Currency and jurisdiction

All payments made to or by us under this **policy** will be made in pounds sterling.

The policies are issued on England and subject to English Law.

Insurer

The Group Critical Illness Insurance Policies are underwritten by Aviva Life and Pensions UK Limited.

The Head Office of Aviva Life and Pensions UK Limited is Wellington Row, York, YO90 1WR, United Kingdom. Aviva Life and Pensions UK Limited is a wholly owned subsidiary of Aviva plc.

If you have any cause for complaint

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

Group Protection Complaints
PO Box 3240
Norwich
Norfolk
NR1 3ZF

Telephone: 0800 1582714

E-mail: gpcomplaints@aviva.com

Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

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

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Telephone: 0800 023 4567
Email: complaint.info@financialombudsman.org.uk
Website: financial-ombudsman.org.uk.

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

Data Protection

Aviva Life and Pensions UK Limited is the data controller responsible for processing any personal information you provide us.

As the **policyholder** our understanding is that you are not required to obtain individual consent from **employees** before providing us with any personal data we require to set up, administer and assess any claims under the **policy**. However you will need to ensure that you comply with data protection law and regulation and ensure that the appropriate information has been provided to data subjects to explain how the information will be processed and shared. If we need to obtain personal data from anyone covered under the **policy**, we will contact them and if necessary obtain their consent before collecting and using their information.

We will record and store any information provided to us accurately and securely.

Details of our full Privacy Policy is available at aviva.co.uk/privacypolicy or you can request a copy by contacting us at Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD. If you have any questions about how we use personal information, please contact our Data Protection Officer by writing to them at Data Protection Officer, Aviva, Level 4, Pitheavlis, Perth, PH2 0NH.

Solvency and Financial Condition Report

Every year we publish a Solvency and Financial Condition report which provides information about our performance, governance, risk profile, solvency and capital management. This report is available for you to read on our website at aviva.com/investors/regulatory-returns/

Definitions

Throughout this document certain words are shown in bold type. These are defined terms and have specific meanings when used in this document.

We've set out the meanings of these words below.

'You' or 'your' refers to the **policyholder** named in the **policy schedule**.

'We', 'our' or 'us' means Aviva Life & Pensions UK Limited.

Anniversary date

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

Associated conditions

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

- recognised by reasonable **specialist** medical opinion to be related to the occurrence of a **critical illness or operation**, or
- is listed in the "associated conditions" column of the **critical illness/operation** table which begins on page 7.

Cease age

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

Child/Children

Any **employee's** child from date of birth to the age of 18 years (or 23 years old if in full time education). (This includes adopted children and step-children.)

Childcover benefit

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

Commissioning body

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

Core/minimum benefit

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

Critical illness(es)

An illness covered by this **policy**. The **policy schedule** will show whether you have chosen Standard or Extended and whether Total Permanent Disability cover and/or Cancer drugs fund benefits is included.

Data Controller, Data Subject, Personal Data Breach, Process/Processing and Supervisory Authority

Will be the same meaning as in the **Data Protection Laws**.

Data Protection Laws

Means the General Data Protection Regulation (EU) 2016/679 (GDPR) (together with laws implementing or supplementing the GDPR in Member States, in each case as amended and superseded from time to time), and/or all applicable laws, rules, regulations, regulatory guidance, regulatory requirements from time to time.

Default benefit

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

Discretionary entrant

An **employee** or an **employees' partner**:

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

Eligible/Eligibility

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

Employee(s)

A person employed by you (or other participating **employer**) or an equity partner, who is covered under the **policy**.

Employer

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

Irreversible

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

Lifestyle event

A lifestyle event allowing a **member** to change their benefit level.

The lifestyle events are detailed in the **policy schedule**.

Lump sum benefit

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

Member

An **employee**, their **partner** or an equity partner who is covered by the **policy**.

Occupation

A trade, profession or type of work undertaken for profit or pay. It is not a specific job with any particular employer and is independent of location and availability.

Operation(s)

An operation covered by this **policy**. The **policy schedule** will show whether you have chosen Standard or Extended cover.

Overseas

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

Partner

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

An **employee's** civil partner is registered under the Civil Partnership Act 2004.

An unmarried partner is the person the **employee** nominates as their partner, regardless of that person's gender or marital status; whom:

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

Permanent

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

Permanent neurological deficit with persisting clinical symptoms

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the **member's** life. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma. The following are not covered:

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

Personal Data

Means any personal data, as defined in the **Data Protection** Laws, disclosed by you or us to the other in the performance of that party's rights or obligations under the **policy**.

Policy

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

Policy schedule

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

Policy year

The period between:

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

Pre-existing condition

A **critical illness** is pre-existing if the **member** or **child** had:

- received medication, advice, treatment, diagnostic tests or
- experienced symptoms that have resulted in the **critical illness**.

An **operation** is pre-existing if the **member** or **child** had:

- received medication, advice, treatment or diagnostic tests for the condition that led to the **operation** or;
- experienced symptoms of the condition that led to the **operation** whether the need for the **operation** was known or not.

Rate guarantee/Rate guarantee date

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

Related

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

Salary

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

Scheme

Your group critical illness policy whether held by us or a previous insurer.

Specialist

A registered medical practitioner who:

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

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

Standard Territories

All European Union (EU) countries, Andorra, Australia, Canada, Gibraltar, Hong Kong, Iceland, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Singapore, Switzerland, UAE, USA and the Vatican City.

Start date

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

State Pension age (SPA)

The earliest age at which the **member** is entitled to receive their State pension.

The maximum state pension age we will cover is 70.

The **cease age** selected for each category will be shown in the **policy schedule**.

TUPE

Transfer of Undertaking (Protection of Employment) Regulations 2006.

Voluntary/flexible benefit(s)

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

Need this in a different format?

Please get in touch if you'd prefer this document **(GR03002 05/2024)** in large print, braille, or as audio.

0800 051 3472

groupprotection@aviva.co.uk

aviva.co.uk

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Aviva Life & Pensions UK Limited.

Registered in England No 3253947. Aviva, Wellington Row, York, YO90 1WR.
Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Firm Reference Number 185896.

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