Group Critical Illness

Policy wording
Reference: GR03005 – 08/2022
This policy is intended for schemes with more than 5 lives.
Welcome to Group Protection from Aviva

What the policy wording explains
This policy wording tells you:

● what to do if you need to claim.
● what is covered.
● explanations of some of the terms used in this document.

We’ve tried to make this document as easy to understand as possible, but if you have any questions or queries about the policy please contact us and we will be pleased to help you.

How the policy works
If you provide us with the information we ask for, when we ask for it and pay the premiums when they are due, we will cover members and children for their insured benefits, and pay these benefits should a member or child be diagnosed with a critical illness or undergo an operation covered by the policy.

Outline of the Policy
This policy wording, along with the policy schedule and any endorsements, sets out details of the cover we have agreed to provide to you. It is evidence of a legal contract between you and us. We recommend you keep this document somewhere safe.

Some terms of the policy depend upon the information provided by you. Failing to disclose information, giving false information or failing to tell us where any facts have changed since they were provided where done deliberately or recklessly gives us the right to cancel the policy. If the information was given carelessly or the failure to disclose the information was careless then we will have the right to amend the policy to be consistent with what the terms should have been based on the correct information (or cancel the policy if we would not have offered any terms for the policy applied for).

If you fail to comply with all of the policy terms and conditions, we may not pay claims. We may also cease to accept further premiums, meaning cover under the policy will cease.

The policy will not have or accrue any surrender value.
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**1 Conditions covered**

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

**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 asterix.

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 9 (What is not covered) for the full details of the policy exclusions.

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<th>Critical illness/operation</th>
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| 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  
● lymphoma (except cutaneous lymphoma - lymphoma confined to the skin).  
For the above definition, the following are not covered:  
● All cancers which are histologically classified as any of the following:  
   - pre-malignant;  
   - non-invasive;  
   - cancer in situ;  
   - having either borderline malignancy; or  
   - having low malignant potential.  
● All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above, or having progressed to at least TNM classification T2bN0M0.  
● Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.  
● Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).  
● All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0. | Polyposis Coli, papilloma of the bladder or any cancer in situ. |
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| **Cancer – Second and subsequent** | For this benefit to be payable the following conditions must be met:  
  - The **member** or **eligible** person 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 **policy start date** or during the 120 days following the **policy start date**, and  
  - The new cancer was not **pre-existing** prior to the **member** or **eligible** person joining the **scheme** or during the 120 days following the date they joined the **scheme**, and  
  - The **member** or **eligible** person 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, 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. | None |
| **Cardiac Arrest** | 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, 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. |
<p>| <strong>Coronary artery by-pass grafts – with surgery to divide the breastbone</strong> | The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts. | Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease |</p>
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<td>Creutzfeldt-Jakob disease (CJD) – resulting in permanent symptoms</td>
<td>A definite diagnosis of CJD by a Consultant Neurologist. There must be permanent clinical impairment of motor function and loss of the ability to:  - remember  - reason, and  - perceive, understand, express and give effect to ideas. For the CJD definition, we do not cover other types of dementia.</td>
<td>Organic brain disease, disease of the central nervous system, Parkinson’s disease, depression, epilepsy, dementia, amnesic memory disorder, aphasia, psychosis.</td>
</tr>
<tr>
<td>Dementia – resulting in permanent symptoms</td>
<td>A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to:  - remember  - reason and  - perceive, understand, express and give effect to ideas. We do not cover dementia secondary to alcohol or drug abuse.</td>
<td>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.</td>
</tr>
<tr>
<td>*Heart attack – of specified severity</td>
<td>Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:  - typical clinical symptoms (for example, characteristic chest pain)  - the characteristic rise of cardiac enzymes or Troponins  - new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests. The evidence must show a definite acute myocardial infarction. The following are not covered:  - other acute coronary syndromes  - angina without myocardial infarction.</td>
<td>Any disease or disorder of the heart, diabetes mellitus, hypertension or any obstructive/occlusive arterial disease.</td>
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<tr>
<td>*Kidney failure – requiring permanent dialysis</td>
<td>Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.</td>
<td>Familial polycystic kidney disease, diabetes mellitus or any chronic renal disease or disorder</td>
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<tr>
<td>*Major organ transplant</td>
<td>The undergoing as a recipient from another person of a:  - transplant of a bone marrow, or  - transplant of a complete heart, kidney, liver, lung or pancreas, or  - transplant of a lobe of liver, or  - transplant of a lobe of lung, or  - inclusion on an official UK waiting list for such a procedure. For the above definition, the following is not covered:  - Transplant of any other organs, parts of organs, tissues or cells.</td>
<td>Cardiomyopathy, coronary artery disease, cardiac failure, chronic liver disease, chronic pancreatitis, pulmonary hypertension, cystic fibrosis, chronic lung disease or chronic kidney disease</td>
</tr>
<tr>
<td>*Motor neurone disease – resulting in permanent symptoms</td>
<td>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.</td>
<td>Progressive muscular atrophy, primary lateral sclerosis, progressive bulbar palsy</td>
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<td>Multiple sclerosis – with persisting symptoms</td>
<td>A definite diagnosis of multiple sclerosis by a consultant neurologist, that has resulted in either of the following: ● clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least three months; or ● two or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on Magnetic Resonance Imaging (MRI). All of the evidence must be consistent with multiple sclerosis.</td>
<td>Any form of neuropathy, encephalopathy or myelopathy (disorders of 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</td>
</tr>
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<td>*Parkinson’s disease – resulting in permanent symptoms</td>
<td>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/Parkinsonian.</td>
<td>Treatment with dopamine antagonist, tremor, extra pyramidal disease</td>
</tr>
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<td>Progressive supranuclear palsy – resulting in permanent symptoms</td>
<td>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.</td>
<td>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.</td>
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<td>*Stroke – resulting in permanent symptoms</td>
<td>Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either: ● permanent neurological deficit with persisting clinical symptoms; or ● definite evidence of death of tissue or haemorrhage on a brain scan; and ● neurological deficit with persistent clinical symptoms lasting at least 24 hours. The following are not covered: ● transient ischaemic attack ● traumatic injury to brain tissue or blood vessels ● death of tissue of the optic nerve or retina/eye stroke.</td>
<td>Atrial fibrillation, transient ischaemic attack, diabetes mellitus, hypertension, intracranial aneurysm or occlusive arterial disease</td>
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**Childcover benefit (Included in Standard cover)**

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<th>Condition</th>
<th>Description</th>
<th>None</th>
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<td>Cerebral palsy</td>
<td>We will pay childcover benefit if the child receives a definite diagnosis of cerebral palsy made by an attending consultant.</td>
<td>None</td>
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<td>Children’s intensive care benefit - requiring mechanical ventilation for 7 days</td>
<td>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).</td>
<td>None</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>We will pay childcover benefit if the child receives a definite diagnosis of cystic fibrosis made by an attending consultant.</td>
<td>None</td>
</tr>
<tr>
<td>Hydrocephalus - Treated with the insertion of a shunt</td>
<td>We will pay childcover benefit if the child suffers hydrocephalus if the hydrocephalus is treated with an insertion of a shunt.</td>
<td>None</td>
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<tr>
<td>Critical illness/operation</td>
<td>Definition</td>
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<td>Loss of independent existence</td>
<td>We will pay <strong>childcover benefit</strong> if in the opinion of a <strong>specialist</strong> the <strong>child</strong> will not at 18 years old be able to perform routinely at least three of the following six tasks without the assistance of another person, even with the use of special devices or equipment. The tasks are: 1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. 2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances. 3. Feeding yourself – the ability to feed yourself when food has been prepared and made available. 4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function. 5. Getting between rooms – the ability to get from room to room on a level floor. 6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.</td>
<td>None</td>
</tr>
<tr>
<td>Muscular dystrophy</td>
<td>We will pay <strong>childcover benefit</strong> if the <strong>child</strong> receives a definite diagnosis of muscular dystrophy made by a <strong>Consultant Neurologist</strong>.</td>
<td>None</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>We will pay <strong>childcover benefit</strong> if the <strong>child</strong> receives a definite diagnosis of spina bifida myelomeningocele or rachischisis by a <strong>paediatrician</strong>. The following are not covered: ● spina bifida occulta, and ● spina bifida with meningocoele.</td>
<td>None</td>
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<tr>
<td><strong>Extended</strong></td>
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<td><em>Aorta graft surgery – for disease</em></td>
<td>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.</td>
<td>None</td>
</tr>
<tr>
<td><strong>Aplastic anaemia – with permanent bone marrow failure</strong></td>
<td>A definite diagnosis of aplastic anaemia by a <strong>Consultant Haematologist</strong>. There must be permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.</td>
<td>Polyposis Coli, papilloma of the bladder or any cancer in situ.</td>
</tr>
<tr>
<td><strong>Bacterial meningitis – resulting in permanent neurological deficit with persisting clinical symptoms</strong></td>
<td>A definite diagnosis of bacterial meningitis resulting in <strong>permanent neurological deficit with persisting clinical symptoms</strong>. <strong>We do not cover any other form of meningitis, only meningitis caused by bacterial infection.</strong></td>
<td>Chronic ear disease or hydrocephalus</td>
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| *Benign brain tumour – resulting in permanent symptoms or removed via craniotomy | 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  
- removal of the tumour by craniotomy (surgical opening of the skull).  
For the above definition the following are not covered:  
- Tumours in the pituitary gland.  
- Tumours originating from bone tissue.  
- Angioma and cholesteatoma.  | Neurofibromatosis (von Recklinghausen’s disease), haemangioma (von Hippel-Lindau disease) |
| Benign spinal cord tumour | A non-malignant tumour in the spinal canal or spinal cord, resulting in either of the following:  
- permanent neurological deficit with persisting clinical symptoms  
- invasive surgery to remove the tumour.  
For the above definition, the following is not covered:  
- Radiotherapy for any tumour. | 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 |
| Cardiomyopathy – of specified severity | A definite diagnosis of cardiomyopathy by a Consultant Cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classification’s of functional capacity\(^\text{a}\).  
For the cardiomyopathy definition, we do not cover:  
- cardiomyopathy secondary to alcohol or drug abuse.  
- any other form of heart disease, heart enlargement and myocarditis.  
\(^\text{a}\) NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain. | Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease |
| *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, and  
- coma secondary to alcohol or drug abuse. | Self inflicted injury or misuse of drugs or alcohol |
<p>| Coronary angioplasty – to 2 or more coronary arteries | The undergoing of balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of two or more coronary arteries as a single procedure. | Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease |
| *Deafness – permanent and irreversible | Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram. | Acoustic nerve tumour, neurofibromatosis (von Recklinghausen’s disease) |</p>
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<td><strong>Encephalitis – resulting in permanent symptoms</strong></td>
<td>A definite diagnosis of encephalitis by a Consultant Neurologist. There must be permanent neurological deficit with persisting clinical symptoms.</td>
<td>There are no associated conditions for encephalitis.</td>
</tr>
<tr>
<td><strong>Heart valve replacement or repair</strong></td>
<td>The undergoing of surgery including balloon valvuloplasty on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.</td>
<td>Any disease or disorder of the heart, or any obstructive/occlusive arterial disease.</td>
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</table>
| **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 | **We will not pay a lump sum benefit** for HIV infection to a member who, at any time before joining the scheme, has been infected with any Human Immunodeficiency Virus (HIV) or has demonstrated any antibodies to such virus. |
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<tr>
<td>Liver failure – of advanced stage</td>
<td>Liver failure due to cirrhosis and resulting in:</td>
<td>Chronic liver disease, including but not limited to hepatitis B &amp; C, primary sclerosing cholangitis, and portal hypertension</td>
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<td></td>
<td>● permanent jaundice</td>
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<td>● ascites, and</td>
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<td>● encephalopathy</td>
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<tr>
<td></td>
<td>We do not cover liver disease secondary to alcohol or drug abuse.</td>
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<tr>
<td></td>
<td>Permanent physical severance of hand or foot or above the wrist or ankle joint.</td>
<td></td>
</tr>
<tr>
<td>*Loss of hand or foot – permanent physical severance</td>
<td>Permanent physical severance of hand or foot at or above the wrist or ankle joint.</td>
<td>Diabetes mellitus, peripheral vascular disease, bone and soft tissue cancer.</td>
</tr>
<tr>
<td>Loss of independent existence – permanent and irreversible</td>
<td>The permanent loss of the ability to perform routinely at least three of the following six tasks without the assistance of another person, even with the use of special devices or equipment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Feeding yourself – the ability to feed yourself when food has been prepared and made available.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Getting between rooms – the ability to get from room to room on a level floor.</td>
<td></td>
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<tr>
<td></td>
<td>6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.</td>
<td></td>
</tr>
<tr>
<td>*Loss of speech – total, permanent and irreversible</td>
<td>Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.</td>
<td>Stroke, transient ischaemic attack, motor neurone disease, brain or throat tumour, laryngeal polyps.</td>
</tr>
<tr>
<td>Open Heart Surgery – with surgery to divide the breastbone</td>
<td>The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist, to correct any structural abnormality of the heart.</td>
<td>Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease.</td>
</tr>
<tr>
<td>*Paralysis of limb – total and irreversible</td>
<td>Total and irreversible loss of muscle function to the whole of any limb.</td>
<td>Multiple sclerosis, muscular dystrophy, motor neurone disease or any disease or disorder of the brain, spinal cord or column</td>
</tr>
<tr>
<td>Critical illness/operation</td>
<td>Definition</td>
<td>Associated conditions</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
</tbody>
</table>
| Primary pulmonary arterial hypertension | A definite diagnosis of pulmonary arterial hypertension of unknown cause. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity (marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain). The following is not covered:  
  - Pulmonary hypertension secondary to any other known cause i.e. not primary | Any disease or disorder of the heart, diabetes mellitus or any obstructive/occlusive arterial disease. |
| Pulmonary artery graft surgery | The undergoing of surgery on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft. For the pulmonary artery graft surgery definition, we do not cover any other surgical procedure, for example endovascular repairs or the insertion of stents. | Pulmonary valve stenosis, pulmonary atresia, truncus arteriosus, Fallot’s tetralogy, patent ductus arteriosus |
| Respiratory failure – of advanced stage | Advanced stage emphysema or other chronic lung disease, resulting in:  
  - the need for regular oxygen treatment on a permanent basis; and  
  - the permanent impairment of lung function tests where Forced Vital Capacity (FVC) and Forced Expiratory Volume at 1 second (FEV1) are less than 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 polyarthritis |
| 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 |
<table>
<thead>
<tr>
<th>Critical illness/operation</th>
<th>Definition</th>
<th>Associated conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminal illness</td>
<td>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</td>
<td>Any medical condition that is listed as a critical illness condition</td>
</tr>
<tr>
<td><em>Third degree burns – covering 20% of the body’s surface area or 30 percent loss of surface area to the face</em></td>
<td>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 30 percent loss of surface area of the face which for the purposes of this definition includes the forehead and ears.</td>
<td>There are no associated conditions for third degree burns</td>
</tr>
<tr>
<td><em>Traumatic brain injury – resulting in permanent symptoms</em></td>
<td>Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.</td>
<td>There are no associated conditions for traumatic head injury</td>
</tr>
</tbody>
</table>

**Optional Cover**

In addition to the conditions 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 and/or total permanent disability. These options will result in an extra cost under both Standard and Extended schemes.

**Cancer drugs fund**

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.
<table>
<thead>
<tr>
<th>Critical illness/operation</th>
<th>Definition</th>
<th>Associated conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total permanent disability – unable to do a suited occupation ever again</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Total permanent disability – unable to do your own occupation ever again</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
2 What benefits are covered

The purpose of this policy is to pay a lump sum benefit if a member or child is:

● diagnosed with a critical illness; or
● undergoes an operation, and survives for 14 days from the day:
● that the member or child was diagnosed with the critical illness; or
● of the operation.

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. No other conditions or operations are covered. 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 in section 1 above. 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.

3 Who is 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 employees’ partners at an additional cost.

The policy schedule will tell you the categories of employees who are eligible, and whether or not their partners are covered by the policy.

New entrants will be included in the policy as a member:

● on the policy start date, if they joined the policy on or before that date; or
● from the date they joined the policy if later.

The policy begins on the start date shown on the policy schedule, and cover for each member begins on the date that they join the policy. The eligibility conditions for joining the policy are shown on the policy schedule.

3.1 Discretionary entrants

You may add members 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 the exclusions detailed in section 9 from the date their cover commenced.

3.2 TUPE transfers and group employment 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 employees’ partners will be treated as members switching cover from another insurer.

3.3 Temporary absence

Where an employee is off work due to illness or injury, the cover for the employee (and if applicable cover for the employees’ partner) can continue up to the cease age providing premiums continue 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, including any premiums continue and a UK, Channel Islands or Isle of Man contract of employment is maintained.

Any increases in lump sum benefit during this period will need to be in line with standard company pay awards and will be limited to a maximum of 7% per policy year.

3.4 Overseas cover

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.

We will maintain cover for members who are working outside of the UK, Channel Islands or Isle of Man whilst on holiday, or travelling overseas 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 must tell us immediately about any members who are working in a country that is not part of the UK, Channel Islands or Isle of Man, in a country not listed in our standard territories or any additional locations detailed in your policy schedule. 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.

Special terms and conditions may apply for cover to overseas members.
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.

4 When cover ceases
This depends on the policy cease age you have chosen, which can be the member’s state pension age (SPA) or any fixed age up to a maximum age 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 membership category.

Cover will stop when an employee,
  ● is no longer employed by you; or
  ● is no longer eligible for the policy; or
  ● reaches the cease age; or
  ● moves 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 or child of an employee,
  ● if we pay a claim for them (see section 8.5 - second claims regarding claims for cancer drugs fund benefit); or
  ● when they are no longer eligible for the policy; or
  ● when they reach the cease age (for children, when they reach 18 years old (21 if in full time education)); or
  ● 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 the employee reaches the cease age; or
  ● when they die; or
  ● if the employee leaves the policy, for whatever reason.

5 Policy limitations
5.1 Benefit limits
The policy schedule will show details of how we calculate the lump sum benefit.

If a claim is for an employee, the maximum lump sum benefit that we will pay is five times their salary, up to a maximum of £500,000.

If a claim is for an employees’ partner, the maximum lump sum benefit that we will pay is five times the employee’s salary, up to a maximum of £250,000. This cover is also subject to being lower than or equal to the employee’s lump sum benefit.

If a claim is for a child, the maximum lump sum benefit that we will pay is 25% of the employee’s benefit, up to a maximum of £20,000.

6 Calculation of premiums
The basis of how we calculate your premium depends on the number of lives covered by this policy and any linked policies.

The single premium basis is usually for policies covering up to 19 lives.

The unit rate basis is usually for policies covering 20 or more lives.

Single premium basis
Premiums calculated on the single premium basis are calculated for each member using our current premium rates. These underlying rates are normally guaranteed for two years. We will calculate premiums each year, and the rates are dependent upon the age and gender of the members at the anniversary date. Premium rates generally increase with age.

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 for the period from the relevant date to the next anniversary date. Where the period is not a complete year the premiums will be adjusted proportionally.

Unit rate basis
We calculate these premiums by multiplying the total members’ benefits by the unit rate that applies at that date. The unit rates are expressed as a rate per £1,000 of benefit.

We will calculate a premium adjustment to allow for changes during the previous policy year. The adjustment will take into account new members, leavers and any changes in benefit and will be payable at the end of the policy year.

Minimum premium
The minimum premium we will charge is £600.

6.1 What information is needed to calculate your premiums
The premium for the policy will be recalculated on the anniversary date.

Before that date, we will tell you the information we will need to recalculate the premium payable for that policy year.

You do not need to tell us about new entrants during the policy year who have met the eligibility conditions. We also do not need details of children covered by the policy.

For both single premium and unit rate policies, 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.

6.2 When premium rates are reviewed
The rates used to calculate premiums are guaranteed from the start date until the rate guarantee date and are then reviewed. The policy schedule will show the rate guarantee date.
The guarantee may not apply if there is:

- a change of 25% or more (50% for policies with 19 or less employees) in the total sum insured from the last rate guarantee date (or start date if a rate review has not yet happened);
- any change to the benefit basis;
- a change to the eligibility criteria; or
- a change in the nature of business or companies included within the policy.

You must inform us promptly if any of these changes take place.

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

The guarantee may also not apply where a change is made to reflect, in a proportionate manner, a change to the law or interpretations of the law, decisions or recommendations of a Court, Ombudsman, Regulator or similar body.

We also reserve the right to change the terms and conditions provided for in this policy at any rate guarantee date.

6.3 Payment of premiums

Premiums are paid to us by you for each member. The premium must be paid in advance monthly, quarterly, half yearly or annually by direct debit, or any other method agreed with us.

6.4 Non-payment of premiums

If we cancel the policy due to non-payment of premiums, new claims will only be considered up to the date of the last premium covered.

We will continue to assess claims for critical illnesses that were diagnosed and operations that took place whilst the policy was in force.

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

7 Policy changes and cancellation

7.1 What we need to know

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
- the total sum insured increases/decreases by 25% (50% for policies with 19 or fewer employees) from the last rate guarantee date (or start date if a rate review has not yet happened);
- 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 to four or below,

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 you can cancel the policy

There is no cooling off period. You may cancel the policy at anytime.

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 premium to us.

All cover under this policy will stop on the date agreed with us. We will continue to assess claims for critical illness that were diagnosed and operations that took place whilst the policy was in force.

We will not backdate cancellation.

7.3 When we can make changes to the policy

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.
7.4 Surrender value
There will be no surrender value under this policy if it is cancelled at any time.

7.5 When we can cancel the policy
We can cancel the policy if:
- the number of employees covered falls below 5.
- you do not pay us the premiums when due; or
- you do not provide us with membership date, other information or documentation that we need to administer the policy, or
- the business location of an employer or group of members changes; 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.
- there is a change in the nature of an employer’s business; or
- 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, its ultimate parent company and its ultimate beneficial owners, 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.

8 Claims

8.1 What information is needed to make a claim
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.

We will ask for confirmation from a specialist:
- of the diagnosis of a critical illness, and the date of that diagnosis; or
- that a member or child has undergone an operation, and the date of that operation.

We will pay the lump sum benefit if, in reasonable specialist medical opinion, the critical illness or operation that the member or child is claiming for meets the policy definition. No other conditions or operations are covered.

Depending on whom the claim is for, and what the claim is for, we may need to see birth or adoption certificates, marriage certificates or civil partnership certificates. 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). We cannot pay a claim if we are not able to get the information that we need to assess the 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 an illness or undergone one of the operations that the policy covers.
- we are not responsible for paying for the evidence that we ask for in order to assess a claim, for example:
  - any charges made by a doctor for completing a claim form
  - the costs of sending information to us
  - the costs of translating information into English.

BUT, 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.

Before we pay a claim we may require documentary evidence of earnings.

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

For total permanent disability claims we will need a copy of the employee’s job description.

If you, an employer or a member gives us incorrect information, or doesn’t give us information that we need, we will not be liable for any mistakes or omissions caused by this. If we pay a claim or pay too much for a claim as a result of you, an employer or a member giving us incorrect information, we will take steps to recover that money from you.

8.2 How to submit a claim
You can submit a claim by telephoning us on 0800 015 7523 or emailing us at groupclaim@aviva.com or completing our online claim form which can be found HERE. We will then advise you what will happen next and what information we require.

8.3 How a claim is paid
We will pay all lump sum payments, except in respect of cancer drugs fund benefit, directly to the employee (even if the claim is for the employee’s partner or child) provided it is to a UK, Channel Islands or Isle of Man bank account. All payments will be in pounds sterling.
We will pay all lump sum payments in respect of claims for cancer drugs fund benefit, direct to the member’s local NHS trust. All payments will be in pounds sterling.

8.4 When a claim is paid
In order to make a claim and to enable us to pay a lump sum benefit to an employee covered by the policy, they (or their partner or child) must have;
- been diagnosed with one of the critical illnesses, or
- undergone one of the operations, which the policy covers, and have survived for 14 days after the date of the diagnosis or operation.

8.5 Second claims
- We will not pay a second claim for an individual child of an employee. We will cancel their cover when we pay a claim for them.
- We will not pay a second claim for partners of an employee except for claims in respect of cancer drugs fund benefit. We will cease cover in respect of all other critical illnesses and operations when we pay a claim for them.
- Subsequent claims for cancer drugs fund benefit in respect of a partner 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 an employee 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 9.
- We will not pay a lump sum benefit for any critical illness or operation covered by this policy if the member has previously received a lump sum benefit for:
  - total permanent disability;
  - paralysis of limbs;
  - 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;
  - paralysis of limbs;
  - loss of independent existence, or
  - terminal illness;
if the employee has previously received a lump sum benefit for any other critical illness or operation.

If you have any questions about making a claim, you can:
- email: groupciclaims@aviva.com
- phone: 0800 015 7523, or
- write to us at:
  - Aviva Group Protection
  - PO Box 3240
  - Norwich
  - Norfolk
  - NR1 3ZF

9 What is not covered?

9.1 Pre-existing conditions
See section 1 and the definition of Cancer – second and subsequent for an explanation of how this exclusion applies to that benefit.
A claim for each critical illness and each 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 claim conditions for the critical illness or operation were first met should consider the claim.
We will not pay a lump sum benefit for a member or a child who has a critical illness or operation if that same critical illness or operation
- was pre-existing at any time prior to the date their cover commenced under the scheme and;
- has previously met the conditions for a valid claim for that member or child under the scheme.
In addition, 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 member or child has a valid claim for a critical illness or operation which was pre-existing at any time prior to the date of each increase. We will still consider the claim for the pre-increase amount.
For example, if a lump sum benefit is paid for a lung transplant we would not be able to consider a subsequent claim for kidney transplant for the same member or child.

9.2 Related Conditions
This exclusion does not apply to claims for Cancer – second and subsequent.
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:
- any critical illness or operation defined in section 1 (whether covered by the policy or not) and which was pre-existing at any time prior to the date their cover commenced under the scheme, and;
- a critical illness or operation that has previously met the conditions for a valid claim for that member or child under the scheme.
In addition, 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 member or child has a valid claim for a critical illness or operation which is related to a critical illness or operation defined in section 1 (whether covered by the policy or not) at any time prior to the date of each increase. We will still consider the claim for the pre-increase amount.

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

- Aorta graft surgery
- Cardiac arrest
- Cardiomyopathy
- Coronary angioplasty
- Coronary artery by-pass graft
- Heart attack
- Heart transplant
- Heart valve replacement or repair
- Primary pulmonary arterial hypertension
- Open heart surgery
- Pulmonary artery graft surgery
- Stroke

For example, if the member or child experienced kidney failure before their cover started, we would not pay a claim if that same member or child has a kidney transplant in the future. Also, if the employee had a lump sum benefit paid for a heart attack, we would not pay a claim if they suffered a stroke in the future.

9.3 Associated Conditions

We will not pay a lump sum benefit for a member or a child who has a critical illness or operation if they had an associated condition at any time prior to:

- the date their cover commenced under the scheme and;
- the most recent date (prior to the current claim) that they met the conditions for a valid claim for a critical illness or operation under the scheme.

In addition, 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 member or child has a valid claim for a critical illness or operation but had an associated condition at any time prior to the date of each increase. We will still consider the claim for the pre-increase amount.

This exclusion will apply indefinitely in respect of claims for:

- total permanent disability; and
- loss of independent existence – permanent and irreversible; and
- paralysis of limbs – total and irreversible.

For all other critical illnesses and operations, the exclusion will no longer apply if the member or child does not have a valid claim for that critical illness or operation within the first two years of the date they joined your scheme. For increases in lump sum benefit the exclusion will no longer apply to the increase in cover if the member or child does not have a valid claim for that critical illness or operation within the first two years of the date of each increase.

For example, if the member or child experienced reduced hearing and vision after their cover started but before an increase to their lump sum benefit and they make a claim within two years of the increase for a brain tumour, we will cap benefit at the pre-increase level of lump sum benefit if the symptoms of reduced hearing or vision are considered to be an associated condition.

9.4 Exclusions 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 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.

9.5 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.

9.6 Self-Inflicted Injury

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

10 Further policy conditions

10.1 Accurate information

We rely on the information given to us. If any of the information you give us is untrue or incomplete, and this might have reasonably affected our decision to provide you with this policy or the terms we offered for the policy, then we may:

- change the terms of this policy; or
- restrict the benefits payable under this policy; or
- cancel this policy.

Where we do any of these, we will refund any overpayment of premium less our reasonable expenses.

10.2 Currency and jurisdiction

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

This policy is issued in England and is subject to English Law.
10.3 Contacting us

If you need to contact us about this policy, please contact us at the address shown in the policy schedule, quoting your policy number. Alternatively call us on 0800 0513472.

10.4 Third party rights

No person other than Aviva Life & Pensions UK Ltd and you will have any rights under this policy. Any person who is not a party to this policy 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 termination.

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 the Policyholder to inform members.

10.5 Data Protection

We and you will act as a separate and independent Data Controller in relation to the Personal Data which is processed for the administration of the policy.

We and you will each comply with their respective obligations under the Data Protection Laws in respect of the processing of Personal Data.

Where Personal Data is disclosed by us or you to the other party, the party disclosing the data will:

- only disclose the Personal Data for one or more defined purposes which are consistent with the terms of the policy (other than to comply with a requirement of applicable law to which a party is subject);
- take all reasonable steps appropriate to provide a fair processing notice to those Data Subject(s) whose Personal Data are to be disclosed under the policy, informing them that their Personal Data will be disclosed for the defined purposes;
- obtain the necessary consents or authorisations required to permit the disclosure of such Personal Data.

Where data is received by you or us, the recipient will notify the other without undue delay following any Personal Data Breach involving the Personal Data and each of us will co-operate with the other, to the extent reasonably requested, in relation to any notifications to Supervisory Authority or to Data Subjects which are required following a Personal Data Breach involving the Personal Data.

Each party shall co-operate with the other, to the extent reasonably requested, in relation to:

- any other communication from a Data Subject concerning the Processing of their Personal Data including requests to exercise their rights; and
- any communication from a Supervisory Authority concerning the Processing of Personal Data, or compliance with the Data Protection Laws.

11 If you have 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 3Z
  - Telephone: 0800 1582714
  - E-mail: gpcomplaints@aviva.com

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: www.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.

Financial services compensation scheme (FSCS)
The Financial Services Compensation Scheme (FSCS) may cover your policy. It’ll 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 www.fscs.org.uk or telephone 0800 678 1100.
12 Definitions

**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 4.

**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 21 years 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

**Critical illness(es)**
An illness listed in section 1 and 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.

**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.

**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 policy schedule.

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

**Operation(s)**
An operation listed in section 1 and 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; and
- 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,
- 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
A critical illness is pre-existing if the member or child had:
- received medication, advice, treatment or diagnostic tests or; experienced symptoms of the critical illness whether the critical illness was diagnosed or not.
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 date
The date until which rates and terms and 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 or child 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 pensionable age (SPA)
The earliest age at which the employee can start to receive the UK basic state pension.
The maximum state pension age we will cover is 68.

TUPE

We/our/us
Aviva Life & Pensions UK Limited.

You/your
The current policyholder of the policy as stated in the policy schedule.
Need this in a different format?

Please get in touch if you’d prefer this document (GR03003 08-2022) in large font, braille or as audio.

How to contact us

0800 051 3472

groupprotection@aviva.com

Aviva.co.uk

Calls may be recorded/monitored for our joint protection.