For adviser use only. Not for use with customers.

Your technical guide to protection at Aviva

Life Insurance+, Critical Illness+, Whole of Life Insurance+, Simple Life Insurance, Income Protection+ and Living Costs Protection have no cash in value at any time. If the policyholder stops paying the premiums, we'll stop providing cover and we won't pay any money back. We'll only make a payment if a successful claim is made.

Our protection products

Life Insurance+
Life insurance with the added flexibility of critical illness cover

Critical Illness+
Stand alone critical illness cover

Whole of Life Insurance+
Cover that lasts your entire life

Simple Life Insurance
Straightforward life insurance with no optional benefits

Income Protection+
Protection against a loss of earnings due to illness or injury

Living Costs Protection
Protection against being unable to work due to illness or injury

Should you require any further or full details about the products covered by this document please refer to our policy conditions, which are available on our adviser website.

Benefit paid by us may affect the customer's eligibility for means tested state benefits. State benefits may change at any time. For further information please refer to: https://www.gov.uk/browse/benefits

Cover types explained

Level cover

Pays the cover amount as a cash lump sum on a successful claim. The cover amount stays the same throughout the policy term.

Decreasing cover

Pays the cover amount as a cash lump sum on a successful claim. The cover amount decreases each month, broadly in line with the amount outstanding on a repayment loan, such as a capital and interest mortgage, using a fixed interest rate selected at the start of the policy. Interest rates are available between 4% and 15% and can't be changed once the policy starts.

A lower interest rate means a steeper reduction in the cover amount each month compared to a higher interest rate. Choosing a higher interest rate will make the cover amount stay higher for longer but will result in a more expensive premium.

Family income cover

Pays the cover amount as monthly instalments on a successful claim. The monthly instalment stays the same throughout the policy term and is payable from the date we accept a claim until the policy end date. We'll pay more in total if a claim is made in the early years than towards the end of a policy.

It's possible to change the monthly instalments to a lump sum at any point once a claim has been made. However, if this happens, we'll have to recalculate the benefit and the amount we pay will be less than the total amount that we'd have paid monthly over the term of the policy.

Life Insurance+

Provides life cover and/or life and critical illness cover.

Available as a single or joint policy.

On a single policy, if the life covered dies the policy will end.

For joint polices, we'll only pay out once. So when we've accepted a claim for one life covered, the policy will end.

Includes the following optional benefits at an additional cost:

- Conversion option
- Critical illness
- Extra care cover
- Fracture cover
- Global treatment
- Renewal option
- Total permanent disability
- Upgraded critical illness benefit
- Upgraded children's benefit
- Waiver of premium

Increasing cover can be included at no additional cost at outset.

Available as level, decreasing or family income cover

Available as life of another

Cover types available

- Level cover
- Decreasing cover
- Family income cover

Life cover

Main benefits

When Life Insurance+ is used to provide life cover, the following main benefits are included. We only pay out the main benefit once, so when we've accepted a claim for one of these benefits, the policy will end.

Death benefit

We'll pay the cover amount if the life covered dies during the policy term.

We won't pay if the death of the life covered is caused by suicide or intentional self-inflicted injury within 12 months of the policy start date. If this happens, the policy will end.

Terminal illness benefit

We'll pay the cover amount if, during the policy term, the life covered is diagnosed with a terminal illness that meets our definition. We define a terminal illness as a definite diagnosis of an illness by an attending consultant that has no known cure or has progressed to a point where it cannot be cured; and in the opinion of the attending consultant is expected to lead to death within 12 months.

Eligibility

This product is available to customers who at the time they complete the application, they and the life covered must:

- be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
- consider their main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.

The policyholder needs to tell us if they move outside the UK, the Channel Islands, the Isle of Man or Gibraltar and their main residence is in another territory. Laws in the territory they become resident in may affect their ability to continue to benefit fully from the features of their policy. We may need to change, reduce or remove any of their policy terms. We'll give them details once they've told us. They should seek their own independent advice.

Life and critical illness cover

Main benefits

When critical illness cover is selected, the following benefits are included in addition to the death and terminal illness benefits outlined above.

Critical illness benefit

We'll pay the cover amount if, during the policy term you're diagnosed with one of our list of critical illnesses, and you survive for at least 10 days. Depending on the definition of the critical illness, we may pay on diagnosis only, when the condition has progressed to a specified severity or when named treatments or surgeries are performed. Once we've accepted a claim, the policy will end for all other benefits except extra care cover, if it's been selected.

For a list of critical illnesses we cover, please see Appendices.

Life and critical illness cover

Further benefits

The following benefits are also included on life and critical illness cover if the policyholder has not made, nor is eligible to make, a claim for any of the main benefits.

If a claim is made for any of these further benefits the policy will continue and the policyholder can claim for one of the main benefits. Claiming for these further benefits won't reduce what we'll pay on a successful claim for any other benefit in the future.

Additional critical illness benefit

We'll pay this benefit if, during the policy term, the life covered is diagnosed with a critical illness that meets one of our additional critical illness definitions and survives for at least 10 days.

We'll pay the lower of £25,000 or 25% of the cover amount. For family income cover, we'll pay a cash lump sum of 25% of the monthly cover amount multiplied by the number of months left on the policy, up to a maximum of £25,000.

For joint policies, each life covered can claim for each additional critical illness once. After a claim by one life covered, cover for that condition will only continue for the other life covered. However, further claims can be made for the other additional critical illness and other benefits under the policy.

The additional critical illnesses we cover are less advanced cancer of the breast and less advanced cancer of the prostate. For full details, please see **Appendix 2A.**

Children's benefit	Children's benefit consists of: children's critical illness, children's hospital benefit and children's death benefit. It covers the natural, step, legally adopted, under legal guardianship and/or future children of any life covered or their partner. A child born from surrogacy shall be treated as a child within this definition once the legal parenthood has been transferred to the life covered through a parental order or through legal adoption, at which point we will backdate cover to the date when the child would have been first covered by the policy. We classify a partner as someone the life covered is married to or in a civil partnership with, or someone they have been living with for a minimum of two years as if they were married or in a civil partnership. Children are covered from when they are 30 days old until their 18th birthday (or 21st birthday if in full time education).

Children's critical illness

We'll pay this if, during the policy term, a child is diagnosed with, or undergoes surgery for, a critical illness which meets one of our children's critical illness definitions and survives for at least 10 days. We'll pay this if your child survives for at least 10 days after being diagnosed with one of the definitions they're covered for. Depending on the definition of the critical illness, we may pay on diagnosis only, when the condition has progressed to a specified severity or when named treatments or surgeries are performed.

For a list of the children's critical illnesses covered, please see **Appendix 2I**.

Children are also covered for the two additional critical illnesses – less advanced cancer of the breast and less advanced cancer of the prostate. For details, please see **Appendix 2I**.

We'll accept one claim per child. Once we've accepted a claim the cover will end for that child but the policyholder may make further claims for other children in the future.

Pays the lower of £25,000 or 50% of the cover amount

We'll pay the lower of £25,000 or 50% of the cover amount. For family income cover, we'll pay 50% of the monthly cover amount multiplied by the number of months left on the policy, up to a maximum of £25,000.

For a successful claim to be made under children's critical illness, the illness or conditions must not have been present at birth, whether diagnosed or not. The symptoms must not have started before the policy start date or before the child was covered by the policy.
This includes congenital heart defects requiring corrective surgery. In addition, the illness or condition must not be the result of an intentional injury caused by the policyholder.

Children's hospital benefit

We'll pay this benefit if a child is in hospital for more than seven consecutive nights. We'll pay £100 a night from the eighth night's stay onwards. For this benefit, we cover children from 30 days old to their 18th birthday or 21 if in full time education.

We'll pay for a maximum of 30 nights for each child, over the term of the policy.
This can either be in one period or over multiple shorter periods. For multiple shorter periods, we don't require a further seven consecutive nights' stay if the return to hospital is related to a previous claim.

We won't pay if the stay in hospital is due to the child being born prematurely (before the 37th week of pregnancy).

Children's death benefit

We'll pay £5,000 if a child dies during the policy term. For this benefit, we cover children from 30 days old to their 18th birthday or 21 if in full time education.

We'll pay this in addition to any other benefit we may have paid under the children's benefit. Once we've accepted a claim, the cover will continue for any other child.

Critical Illness+

Upgraded cover available

Provides standalone critical illness cover.

Available as a single or joint policy.

On a single policy, if the life covered dies the policy will end. We may still be able to make a payment if the life covered was eligible to make a claim before their death.

For joint policies, if one of the lives covered dies and was not eligible to make a claim, the policy will continue for the remaining life covered.

Includes the following optional benefits at an additional cost:

- Extra care cover
- Fracture cover
- Global treatment
- Renewal option
- Total permanent disability
- Upgraded critical illness benefit
- Upgraded children's benefit
- Waiver of premium

Increasing cover can be included at no additional cost at outset.

Cover types available

- Level cover
- Decreasing cover
- Family income cover

Main benefits

The following main benefits are included.

Critical illness benefit

We'll pay the cover amount if, during the policy term you're diagnosed with one of our list of critical illnesses, and you survive for at least 10 days. Depending on the definition of the critical illness, we may pay on diagnosis only, when the condition has progressed to a specified severity or when named treatments or surgeries are performed.
Once we've accepted a claim, the policy will end for all other benefits except extra care cover, if it's been selected.

For a list of critical illnesses we cover, please see the **appendices**.

Further benefits

The following benefits are also included if the policyholder has not made, nor is eligible to make, a claim for any of the main benefits.

If a claim is made for any of these further benefits the policy will continue and the policyholder can claim for one of the main benefits. Claiming for these further benefits won't reduce what we'll pay on a successful claim for any other benefit in the future.

Additional critical illness benefit

We'll pay this benefit if, during the policy term, the life covered is diagnosed with a critical illness that meets one of our additional critical illness definitions and survives for at least 10 days.

We'll pay the lower of £25,000 or 25% of the cover amount. For family income cover, we'll pay 25% of the monthly cover amount multiplied by the number of months left on the policy, up to a maximum of £25,000.

Each life covered can claim for each additional critical illness once. After a claim by one life covered, cover for that condition will only continue for the other life covered. However, further claims can be made for the other additional critical illness and other benefits under the policy.

The additional critical illnesses we cover are less advanced cancer of the breast and less advanced cancer of the prostate. For full details, pleases see **Appendix 2A.**

Children's benefit	Children's benefit consists of: children's critical illness, children's hospital benefit and children's death benefit. It covers the natural, step, legally adopted, under legal guardianship and/or future children of any life covered or their partner. A child born from surrogacy shall be treated as a child within this definition once the legal parenthood has been transferred to the life covered through a parental order or through legal adoption, at which point we will backdate cover to the date when the child would have been first covered by the policy. We classify a partner as someone the life covered is married to or in a civil partnership with, or someone they have been living with for a minimum of two years as if they were married or in a civil partnership. Children are covered from when they are 30 days old until their 18th birthday (or 21st birthday if in full time education).
Children's critical illness Pays the lower of £25,000 or 50% of the cover amount	We'll pay this if your child survives for at least 10 days after being diagnosed with one of the definitions they're covered for. Depending on the definition of the critical illness, we may pay on diagnosis only, when the condition has progressed to a specified severity or when named treatments or surgeries are performed. For a list of the children's critical illnesses covered, please see **Appendix 2I**. Children are also covered for the two additional critical illnesses – less advanced cancer of the breast and less advanced cancer of the prostate. For details, please see **Appendix 2I**. We'll accept one claim per child. Once we've accepted a claim the cover will end for that child but the policyholder may make further claims for other children in the future.

We'll pay the lower of £25,000 or 50% of the cover amount. For family income cover, we'll pay 50% of the monthly cover amount multiplied by the number of months left on the policy, up to a maximum of £25,000.

For a successful claim to be made under children's critical illness, the illness or conditions must not have been present at birth, whether diagnosed or not. The symptoms must not have started before the policy start date or before the child was covered by the policy. This includes congenital heart defects requiring corrective surgery. In addition, the illness or condition must not be the result of an intentional injury caused by the policyholder.

Children's hospital benefit

We'll pay this benefit if a child is in hospital for more than seven consecutive nights. We'll pay £100 a night from the eighth night's stay onwards. For this benefit, we cover children from 30 days old to their 18th birthday or 21 if in full time education.

We'll pay for a maximum of 30 nights for each child, over the term of the policy. This can either be in one period or over multiple shorter periods. For multiple shorter periods, we don't require a further seven consecutive nights' stay if the return to hospital is related to a previous claim.

We won't pay if the stay in hospital is due to the child being born prematurely (before the 37th week of pregnancy).

Children's death benefit

We'll pay £5,000 if a child dies during the policy term. For this benefit, we cover children from 30 days old to their 18th birthday or 21 if in full time education.

We'll pay this in addition to any other benefit we may have paid under the children's benefit. Once we've accepted a claim, the cover will continue for any other child.

Eligibility

This product is available to customers who at the time they complete the application, they and the life covered must:

- be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
- consider their main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.

The policyholder needs to tell us if they move outside the UK, the Channel Islands, the Isle of Man or Gibraltar and their main residence is in another territory. Laws in the territory they become resident in may affect their ability to continue to benefit fully from the features of their policy. We may need to change, reduce or remove any of their policy terms. We'll give them details once they've told us. They should seek their own independent advice.

Regardless of what is set out elsewhere in these terms we will not be obliged to exercise any of our rights and/or comply with any of our obligations under this policy, if to do so would cause, or be reasonably likely to cause, us to breach any law or regulation in any territory.

Whole of Life Insurance+

Pays the cover amount on the death of a life covered.

Available as a single or joint policy.

- For joint policies, we can pay the cover amount on the first or second death.

It can also be set up on a 'life of another' basis to cover someone else, such as a spouse or civil partner.

Cover lasts throughout life

Available as life of another

Cover types available

- Level cover

Main benefit

Death benefit

We'll pay the cover amount on the death of a life covered.

We won't pay a claim if the life covered dies as a result of suicide or intentional self-inflicted injury in the first 12 months of the policy. If this happens, the policy will end.

Once we've paid out, the policy will end.

Optional benefits:

- Increasing cover - RPI, 3% or 5%
- Waiver of premium

Eligibility

This product is available to customers who at the time they complete the application, they and the life covered must:

- be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
- consider their main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.

The policyholder needs to tell us if they move outside the UK, the Channel Islands, the Isle of Man or Gibraltar and their main residence is in another territory. Laws in the territory they become resident in may affect their ability to continue to benefit fully from the features of their policy. We may need to change, reduce or remove any of their policy terms. We'll give them details once they've told us. They should seek their own independent advice.

Simple Life Insurance

Pays the cover amount on the death of the life covered.

Available as a single or joint policy.

On a single policy, if the life covered dies the policy will end.

For joint policies, we'll only pay out once. So if we accept a claim for one life covered, the policy will end.

Cover types available

- Level cover
- Decreasing cover

Main benefit

Death benefit

We'll pay the cover amount if the life covered dies during the policy term.

We won't pay a claim if the life covered dies as a result of suicide or intentional self-inflicted injury in the first 12 months of the policy. If this happens, the policy will end.

Terminal illness benefit:

We'll pay the cover amount if, during the policy term, the life covered is diagnosed with a terminal illness that meets our definition.

We define a terminal illness as a definite diagnosis of an illness by an attending consultant that has no known cure or has progressed to a point where it cannot be cured; and in the opinion of the attending consultant and our Medical Officer, is expected to lead to death within 12 months.

Eligibility

This product is available to customers who at the time they complete the application, they and the life covered must:

- be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
- consider their main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.

The policyholder needs to tell us if they move outside the UK, the Channel Islands, the Isle of Man or Gibraltar and their main residence is in another territory. Laws in the territory they become resident in may affect their ability to continue to benefit fully from the features of their policy. We may need to change, reduce or remove any of their policy terms. We'll give them details once they've told us. They should seek their own independent advice.

Income Protection+

Pays a percentage of the policyholder's income if, during the policy term, they can't work and suffer a loss of earnings due to illness or injury.

Available as a single policy only.

Includes the following optional benefits at an additional cost.

- Fracture cover
- Global treatment
- Increasing cover

Waiver of premium is included as standard.

This policy will not pay a benefit as a result of being made unemployed.

100% own occupation

Two year limited payment term available

Cover types available

- Full cover to term – No limit on the length of a claim or the number of claims the policyholder can make.
- Limited payment term – Limits the payment of benefit to a maximum of 24 months for each successful claim. There's no limit on the number of claims the policyholder can make.

Eligibility

In order to apply the policyholder:

- be aged between 18 and 59
- be working either employed or self employed
- needs to have been working for at least the last 12 months and have proof of their earnings for that period.
- needs to have been registered with a doctor in the UK, the Channel Islands, the Isle of Man or Gibraltar for at least the past 2 years and/or able to provide a minimum of the last 2 years medical history from a doctor in the UK, the Channel Islands, the Isle of Man or Gibraltar.

This product is available to customers who at the time they complete the application, must:

- be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
- consider their main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.
- and they are legally permitted to work in the UK, the Channel Islands, the Isle of Man or Gibraltar.

The policyholder needs to tell us if they move outside the UK, the Channel Islands, the Isle of Man or Gibraltar and their main residence is in another territory. Laws in the territory they become resident in may affect their ability to continue to benefit fully from the features of their policy. We may need to change, reduce or remove any of their policy terms. We'll give them details once they've told us. They should seek their own independent advice.

Benefits

We'll cover 65% of the first £60,000 of gross earnings, plus 45% of gross earnings above £60,000, up to a maximum benefit amount of £240,000 pa or £20,000 pm.

We'll pay the benefit amount, subject to our maximum yearly amount, after the deferred period ends, if the policyholder:

- was following an occupation immediately before incapacity (unless restricted benefit applies, see below)
- can't perform the duties of their occupation
- is not following any other occupation.

Deferred periods are available of 4, 8, 13, 26, 52 or 104 weeks. Dual deferred periods are available to dovetail with sick pay arrangements. If the 2 year limited benefit option is taken on a dual deferred then a maximum of 24 benefit payments in total will be made for each successful claim.

We'll look at the duties of every occupation in the 12 months before their illness or injury, their ability to do them and whether adjustments can be made to help the policyholder.

If the policyholder has a second occupation which accounts for less then 10 hours a week then this will be disregarded in respect of their ability to do that 2nd occupation in determining their incapacity.

The policyholder can still claim benefit if they are incapacitated during the first 52 weeks of their maternity, parental or adoption leave, or for the first 3 months following unemployment. We will assess their claim on their occupation and earnings they were receiving in the 12 months before they stopped working.

If the policyholder is incapacitated whilst not working and this is not within the first 52 weeks of their maternity, parental of adoption leave or the first 3 months of unemployment, restricted benefit will apply. Please see below for full details.

Restricted benefit

We'll pay this benefit if the policyholder satisfies all three of the following:

- they weren't working immediately before incapacity
- the deferred period has ended
- after incapacity, they were not following an occupation.

We'll assess the claim on the policyholder's occupation and earnings in the 12 months before they stopped working.

We'll pay the full benefit amount, subject to our maximum yearly amount, less any income from continuing sources for a maximum of 12 months. Then the claim will end. The policy will continue and premiums will restart. The policyholder won't be able to make a further claim until they have returned to work for at least 6 consecutive months.

How long will we pay benefit

We'll pay benefit until the:

- policy ends; or
- incapacity ends; or
- end of the restricted benefit term; or
- end of the limited payment term; or
- policyholder is no longer suffering a loss of earnings; or

- policyholder dies; or
- policyholder is remanded in custody; or
- policyholder no longer satisfies the requirements of the back to work benefit.

Back to work benefit

We'll pay reduced benefit once the deferred period has ended, if the policyholder was in a paid occupation before incapacity and their earnings are now reduced because they:

- are in a different occupation due to their continued incapacity; or
- return to their occupation but the illness or injury that caused incapacity restricts the scope of their duties or hours they can work.

Hospital benefit

We'll pay £100 per night each night the policyholder is hospitalised due to incapacity during the deferred period. We'll pay £100 per night provided the policyholder has spent at least six consecutive nights as a patient in hospital. We'll pay for a maximum of 90 nights during the policy term.

Trauma benefit

We'll make one payment of six times the benefit amount or £40,000, whichever is lower, if the policyholder suffers one of six traumatic events.

For a list of the traumatic events, please see **Appendix 1**.

Deferred period arrangement for NHS doctors, surgeons, nurses and midwives

If the policyholder is a doctor, surgeon, nurse or midwife employed directly by the NHS we'll start paying benefit to cover their NHS earnings when their sick pay reduces or stops. The policyholder will need to take out a policy with a deferred period of 52 weeks. We'll use our usual benefit calculation to work out the maximum benefit the policyholder can have based on their earnings in the 12 months before incapacity. We'll also take into account any sick pay received from the NHS, as well as any other payments received from other sources. This arrangement does not apply if the customer is employed by a GP Practice and the appropriate deferred period will be needed on the policy in line with their sick pay arrangements.

Benefit guarantee

This guarantee helps provide peace of mind if the policyholder's earnings have reduced since taking out the policy.

The customer needs to have been working at least 16 hours a week prior to incapacity.

If the benefit amount is up to £1,500 a month we'll guarantee the amount of benefit shown on the policy schedule.

If the benefit amount is over £1,500 a month we'll calculate the maximum benefit amount based on the earnings in the 12 months before incapacity. If this means the benefit the policyholder is entitled to is equal to, or more than, 90% of the amount shown on the policy schedule, we'll guarantee the amount of benefit shown on the policy schedule.

If, following the calculation of the maximum benefit amount, the policyholder is entitled to less than 90% of the amount shown on their policy schedule, we'll pay the new calculated benefit amount or £1,500 per month, whichever is higher.

We'll deduct any continuation of earnings or income that the policyholder continues to receive, after we've applied the benefit guarantee.

Waiver of premium

If we accept the policyholder's claim we'll pay their premiums 13 weeks after they stop working due to incapacity, or when their deferred period ends, whichever is sooner.
The policyholder will need to start paying their premiums again when the claim ends.

Living Costs Protection

Pays a fixed monthly benefit amount of between £500 and £1,500 for a maximum of 12 months for each successful claim if the policyholder is unable to work due to illness or injury.

Available as a single policy only.

Includes the following options at an additional cost:

- Fracture cover
- Global treatment

Waiver of premium is standard on Living Costs Protection with no additional cost.

This policy will not pay a benefit as a result of being made unemployed.

Cover types available

- Level cover

Benefits

We'll pay the benefit amount selected of between £500 and £1,500 per month, after the deferred period ends, if the policyholder:

- was following an occupation (working at least 16 hours a week)
- can't perform the duties of their occupation
- is not following any other occupation

Deferred periods are available of 4, 8, 13 and 26 weeks.

We'll look at the duties of every occupation in the 12 months before their illness or injury, their ability to do them and whether adjustments can be made to help the policyholder.

The policyholder can still claim benefit if they are incapacitated during the first 52 weeks of their maternity, parental or adoption leave, We will assess their claim on their occupation they were doing in the 12 months before they stopped working.

There is no financial assessment so we will not look at what the policyholder is earning and what income they continue to receive when they are ill or injured.
If the claim is successful we will pay the amount shown on their policy schedule.

Benefit is paid for a maximum of 12 months for each successful claim. The policyholder can claim again for the same or a different illness or injury provided that they have returned to work for at least 6 consecutive months for at least 16 hours a week. A new deferred period will apply.

We'll pay benefit until the:

- policy ends; or
- incapacity ends; or
- we've made 12 monthly benefit payments, including any back to work benefit; or
- policyholder dies; or
- policyholder is remanded in custody

Eligibility

In order to apply the policyholder:

- be aged between 18 and 59
- be working either employed or self employed
- be working at least 16 hours a week
- needs to have been working for at least the last 12 months and have proof of their earnings for that period
- needs to have been registered with a doctor in the UK, Channel Islands, Isle of Man or Gibraltar for at least the past 2 years and/or be able to provide a minimum of the last 2 years medical history from a doctor in the UK, Channel Islands, Isle of Man or Gibraltar.

This product is available to customers who at the time they complete the application, must:

- be in the UK, the Channel Islands, the Isle of Man or Gibraltar, with a legal right to live in that jurisdiction, and
- consider their main home as being in the UK, the Channel Islands, the Isle of Man or Gibraltar and have no current intention of moving anywhere else permanently.
- and they are legally permitted to work in the UK, the Channel Islands, the Isle of Man or Gibraltar.

The policyholder needs to tell us if they move outside the UK, the Channel Islands, the Isle of Man or Gibraltar and their main residence is in another territory. Laws in the territory they become resident in may affect their ability to continue to benefit fully from the features of their policy. We may need to change, reduce or remove any of their policy terms. We'll give them details once they've told us. They should seek their own independent advice.

Back to work benefit

We'll pay one month's benefit if the policyholder was in a paid job but their illness or injury means they're earning less because:

- they've changed their occupation; or
- they've had to restrict their duties or hours worked.

Any payment made under back to work benefit will be included in the 12 month maximum claim period.

Waiver of premium

If we accept the policyholder's claim we'll pay their premiums 13 weeks after they stop working due to incapacity, or when their deferred periods ends, whichever is sooner.

The policyholder will need to start paying their premiums again when the claim ends.

Optional benefits

Our protection products include a range of optional benefits so you can tailor the cover to meet your customers' needs.

This guide includes an overview of each one. For a more detailed explanation, please see the policy conditions.

Upgraded critical illness benefit

✔ Life Insurance+
✔ Critical Illness+

Upgraded critical illness benefit enhances our critical illness cover by offering some financial protection against further full and additional payment conditions, please see the policy conditions to find out more.

It's available on all cover types. It can only be selected on a policy where Critical Illness has been selected, at outset and at an extra cost.

Upgraded full payment conditions

In addition to the full payment conditions covered, we'll also provide cover for an extra 15 upgraded full payment conditions.

Covers an **extra 15 full payment** conditions

We'll pay the cover amount if, during the policy term the life assured is diagnosed with one of our list of upgraded critical illnesses, and you survive for at least 10 days. Depending on the definition of the critical illness, we may pay on diagnosis only, when the condition has progressed to a specified severity or when named treatments or surgeries are performed. Once we've accepted a claim, the policy will end for all other benefits except extra care cover, if it's been selected.

For a list of critical illnesses we cover, please see **appendices**.

Upgraded additional critical illness benefit

We'll replace the additional critical illness benefit with an upgraded additional critical illness benefit which provides financial protection for 26 conditions.

Covers **26 additional critical illness conditions**

We'll pay the cover amount if, during the policy term the life assured is diagnosed with one of our list of upgraded additional benefit critical illnesses, and you survive for at least 10 days. Depending on the definition of the critical illness, we may pay on diagnosis only, when the condition has progressed to a specified severity or when named treatments or surgeries are performed.

We'll accept one claim for each upgraded additional critical illness for each life covered. Once we've accepted a claim, the life covered who claimed will no longer be covered for that condition. However, they'll be covered for the other upgraded additional critical illnesses. This benefit will also continue for any other life covered.

We'll pay the lower of:

- £30,000, or
- the cover amount shown in the policy schedule.

For family income cover, we'll pay the monthly cover amount multiplied by the number of months left on the policy, up to a maximum of £30,000.

If a claim meets the definition for critical illness, and/or an upgraded full payment condition and at the same time, meets our definition of upgraded additional critical illness, we will only pay the cover amount.

For a list of the upgraded additional critical illnesses, please see **appendices**.

Hospital benefit

We'll pay this benefit if a life covered is in hospital for more than seven consecutive nights. We'll pay £100 from the eighth night's stay for a maximum of 30 nights for each life covered.

The 30 nights can be either in one period or over multiple shorter periods. For multiple shorter periods, we don't require a further seven consecutive nights' stay if the return to hospital is related to a previous claim.

If a claim meets the definition for critical illness, and/or an upgraded full payment condition and at the same time, meets our definition of hospital benefit, we will only pay the cover amount.

Upgraded children's benefit

✔ Life Insurance+
✔ Critical Illness+

Upgraded children's benefit enhances the cover available for children by extending the eligibility, increasing the benefit amount and providing some financial protection against even more conditions.

It's available on all cover types. It can only be selected on a policy where Critical Illness has been selected, at outset and at an extra cost.

Upgraded children's benefit replaces the children's benefit. It covers the children of any life covered from birth up to their 22nd birthday and includes the following benefits:

- Upgraded children's critical illness
- Child extra care cover
- Advanced illness
- Children's hospital benefit
- Children's death benefit

In order for a successful claim to be made under upgraded children's critical illness, child extra care cover and advanced illness:

- the symptoms must not have started, and/or
- diagnosis of the illness or condition must not have occurred, and/or
- neither parent must have received counselling or medical advice in relation to the condition or have been aware of the increased risk of the condition

before the policy start date or before the legal adoption of the child. The illness or condition must not have been a result of intentional injury caused by the policyholder.

Upgraded children's critical illness

Upgraded children's critical illness provides some financial protection against 50 conditions in total - made up of the children's critical illness conditions and 11 upgraded children's critical illness conditions.

We'll pay £25,000 if, during the policy term, a child is diagnosed with, or undergoes surgery for, a critical illness that meets one of our children's critical illness or upgraded children's critical illness definitions and survives for at least 10 days.

We'll accept one claim per child. Once we've accepted a claim, the cover will continue for any other child.

For details of the 11 additional upgraded children's critical illness benefit conditions, please see **appendices**.

A further 11 conditions payable at **£25,000**

Child extra care cover

We'll pay this benefit if, during the policy term, a child is diagnosed with, or undergoes surgery for, a condition that meets one of our child extra care cover definitions and survives for at least 10 days (or 90 days in the case of loss of independence).

We'll accept one claim per child. Once we've accepted a claim, that child will only be covered for children's hospital benefit and children's death benefit. However, child extra care cover, and all other benefits under the upgraded children's benefit, will continue for any other child.

We'll pay:

- £50,000; or
- £25,000 if the policyholder has already claimed for upgraded children's critical illness.

For a list of the conditions covered by child extra care cover, please see **appendices**.

Advanced illness

We'll pay £10,000 if, during the policy term, a child meets our definition of advanced illness and survives for at least 10 days.

We define an advanced illness as one where an attending consultant has confirmed either:

- a definite diagnosis of cancer that has reached an advanced stage and meets the following:
  - treatment has failed to achieve remission of the condition as evidenced by medical investigations; and
  - there are no curative treatments available that will prevent further progression of the condition; or
- a definite diagnosis of an advanced or rapidly progressing and incurable condition with a life expectancy of no greater than 12 months.

We'll accept one claim per child. Once we've accepted a claim, that child will no longer be covered for any other benefit under the policy except for children's hospital benefit and children's death benefit. However, advanced illness and all other benefits under upgraded children's benefit will continue for any other child.

Children's hospital benefit

We'll pay this benefit if a child is in hospital for more than seven consecutive nights. We'll pay £100 from the eighth night's stay for a maximum of 30 nights for each child.

The 30 nights can be either in one period or over multiple shorter periods. For multiple shorter periods, we don't require a further seven consecutive nights' stay if the return to hospital is related to a previous claim.

We won't pay if the stay in hospital is due to the child being born prematurely (before the 37th week of pregnancy).

This benefit applies for each child covered by the policy.

Children's death benefit

Under upgraded children's benefit, children are covered for this benefit from the 24th week of pregnancy. We'll pay £5,000 if a child dies during the policy term. We'll pay this in addition to any other benefit that may have been paid under the upgraded children's benefit. This benefit applies for each child covered by the policy.

Extra care cover

✔ Life Insurance+
✔ Critical Illness+

Extra care cover provides an additional level of financial protection against illnesses which have severe and permanent symptoms.

It's available on all cover types. It can only be selected at outset and comes at an extra cost.

Extra care cover is available with life and critical illness cover and critical illness cover.

Once we've accepted a claim for extra care cover, the policy will end.

To make a successful claim, the life covered must meet one of the following three conditions:

An extra **£50,000** of financial support

Claim period	Extra care cover conditions
During the policy term	We'll pay if the life covered is suffering from the total and permanent loss of the ability to routinely perform at least three of the specified six activities of daily living without the continual assistance of someone else, even with the use of special equipment which is available to help and having taken any appropriate prescribed medication. The activities of daily living we use are: • Washing – being able to wash and bathe unaided, including getting into and out of the bath or shower. • Dressing – being able to put on, take off, secure and unfasten all necessary items of clothing. • Feeding – being able to eat pre-prepared foods unaided. • Continence – being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances. • Moving – being able to move from one room to another on level surfaces. • Transferring – 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. We'll pay an amount equivalent to the cover amount plus £50,000. For family income cover, the £50,000 will be payable as a lump sum. We won't pay if the life covered has made, or is eligible to make, a claim for a main benefit, an upgraded full payment condition or total permanent disability benefit.

Claim period	Extra care cover conditions
During the policy term and the life covered is under 55	We'll accept a claim if, during the **policy term**, the **life covered** is under age 55 when they either: • meet our critical illness criteria for dementia, kidney failure, liver failure, Parkinson's disease, motor neurone disease or respiratory failure, or • meet our criteria for Parkinson's plus syndrome or heart failure (if you've chosen **upgraded critical illness benefit**). We'll pay the cover amount plus £50,000. For family income cover, the £50,000 will be payable as a lump sum.
Before the first anniversary of a successful claim	We'll accept a claim, if before the first anniversary of meeting our criteria for critical illness, upgraded critical illness conditions, total permanent disability, accelerated surgery or upgraded accelerated surgery (if chosen) (the "trigger claim"), the **life covered** is suffering from: **Permanent loss of independence** The total and permanent loss of the ability to perform routinely at least three of the six activities of daily living detailed in the extra care cover #1 section above, 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 claim must be as a direct result of the previous claim. We'll pay £50,000 in addition to the cover amount already paid. For family income cover, this £50,000 will be payable as a lump sum. All claims must be made within 18 months of meeting our definition of critical illness, upgraded full payment condition or total permanent disability (if selected).

Fracture cover

✔ Life Insurance+
✔ Critical Illness+
✔ Income Protection+
✔ Living Costs Protection

Fracture cover enhances the financial protection on offer by paying a lump sum if the life covered suffers from one of 18 specified fractures during any 12 month period.

It's available on all cover types. It can only be selected at outset and comes at an extra cost.

Fracture cover is available if the policyholder:

- doesn't already have it on any other policy with Aviva Life & Pensions UK Limited
- is also a life covered.

Cover for **18** injuries

	If the life covered suffers from one of the following bone fractures, we'll pay:	
	Type of fracture	**Fracture cover amount**
Fracture	Skull (open fracture)	£6,000
	Skull (closed fracture)	£4,000
	Cheekbone	£1,500
	Jaw	£3,000
	Collar bone	£1,500
	Shoulder blade	£2,000
	Sternum	£2,000
	Arm	£3,500
	Ribs	£1,500
	Vertebra	£2,500
	Pelvis	£2,500
	Wrist*	£2,000
	Upper leg	£6,000
	Lower leg	£4,000
	Ankle*	£2,500
	Knee	£6,000
	Hand (excluding fingers and thumbs)	£1,500
	Foot (excluding toes)	£2,000

* We define a fracture of the wrist as including the carpal bones, the distal radius or the distal ulna.
We define a fracture of the ankle as including the medial, posterior or lateral malleolus.

We'll only pay one claim in each policy year. A policy year runs from the start date to the day before the anniversary date shown in the policy schedule and then each subsequent year thereafter.

If the life covered suffers from more than one fracture at the same time, we'll only pay for one of them. They can choose which one they claim for. The life covered will only be able to claim for the first fracture that happens during the policy year.

All fractures must be diagnosed by an attending consultant.

We won't cover for a fracture which is classified as fatigue, stress, hairline, avulsion, chip or microfracture.

We won't cover a fracture that happens when taking part in any of the following; mountain biking or BMX; boxing, cage fighting or martial arts; rugby or Gaelic football; horse riding; any form of motor cycle sport or event including practice, competing or track days, or motor cycling off-road, trail riding or green-lane riding.

We will only pay a claim if the fracture happens at least seven days after the policy start date and before the policy end date.

Global treatment

✔ Life Insurance+
✔ Critical Illness+
✔ Income Protection+
✔ Living Costs Protection

Global treatment offers access to overseas medical treatment for the life covered and their eligible children.

It's available on all cover types. It can only be selected at outset and comes at an extra cost.

Global treatment is available if the life covered:

- hasn't already selected the option on any other policy with an Aviva group company.
- is also the policyholder
- is a resident of England, Northern Ireland, Scotland, Wales, Jersey, Guernsey, the Isle of Man or Gibraltar (referred to here as the territory).

Global Treatment is provided in conjunction with Further Underwriting International SLU.

It covers the cost of overseas treatment if, during the policy term, the life covered or any eligible child is diagnosed with a serious illness or requires a medical procedure that meets our definition. It includes a concierge service which recommends appropriate doctors and treatment centres and manages all necessary medical and administrative arrangements for treatment overseas.

It covers the children of any lives covered from birth to their 18th birthday (or 21st birthday if in full time education) at the date of starting the global treatment claim.

To make a successful claim for global treatment for a child:

- the symptoms must not have started; and/or
- diagnosis of the illness or condition must not have occurred; and/or
- neither parent must have received counselling or medical advice in relation to the condition, or have been aware of the increased risk of the condition

before the policy start date or before the legal adoption of the child.

We'll pay up to £1 million in any one year per life covered. The maximum we'll pay over the policy term is £2 million per life covered. Once this limit is reached the benefit will end.

Access to **expert medical minds**

Global treatment continued...

Serious illnesses and medical procedures we cover

Bone marrow transplant

Bone marrow transplantation (BMT) or peripheral blood stem cell transplantation (PBSCT) of bone marrow cells to the life covered or their child originating from:

- the life covered or their child (autologous bone marrow transplant); or
- a living compatible donor

Cancer treatment

The treatment of:

- any malignant tumour including leukaemia, sarcoma and lymphoma, characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissues;
- any in situ cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues;
- all cancers which are histologically classified as any of the following:
  - pre-malignant;
  - having borderline malignancy;
  - having low malignant potential

Coronary artery bypass surgery

The undergoing of surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

We will not provide cover for any correction of narrowing or blockage of coronary arteries which is treated using techniques other than bypass surgery e.g. angioplasty surgery.

Heart valve replacement or repair

The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.

Live-donor organ transplant

A surgical transplant in which the life covered or their child receive a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.

We will not cover any of the following:

- any live-donor organ transplant that involves stem cell treatment
- any organ transplant when the transplant is conducted as a self-transplant
- any transplant when the life covered or their child is a donor for a third party, unless the recipient is also insured under global treatment
- if the transplant is made possible by the purchase of donor organs
- any disease which has been caused by an organ transplant, unless it is a serious illness or requires a medical procedure.

For clarity, complications directly associated with transplant surgery covered by the global treatment option occurring during surgery or post-surgery recovery outside of the territory will be covered as it will be considered a continuation of the transplant procedure.

Neurosurgery

Any surgical intervention, including minimally or non-invasive techniques of:

- the brain (or any intracranial structures); or
- benign tumours located in the spinal cord.

Illnesses and surgeries we don't cover

In addition to the above specific serious illness exclusions, we won't pay for any:

- treatment that isn't medically necessary
- experimental treatment
- medical procedures in connection with or derived from cosmetic surgery.

Medical expenses we cover

Hospital charges

We'll pay for hospital charges relating to:

- accommodation, meals and general nursing services provided during the life covered's, or their child's stay in a room, ward or section of the hospital or in an intensive care or monitoring unit;
- other hospital services including those provided by a hospital outpatient department, as well as expenses relating to the cost of an extra or travelling companion's bed if the hospital provides this service;
- the use of an operating room and all related services.

Day clinic

We'll pay for day clinic or independent welfare centre expenses, but only if the treatment, surgery or prescription would have been covered by us if provided in hospital.

Consultant treatment

We'll pay any consultant expenses relating to examination, treatment, medical care or surgery.

Hospitalisation

We'll pay any expenses relating to consultant visits during the life covered's, or their child's hospitalisation.

Medication

We'll pay for medication applied by medical prescription while the life covered or their child are hospitalised for treatment of a covered illness or medical procedure. Medication prescribed for post-operative treatment is covered for 30 days from the date the life covered or their child has completed the treatment received outside of the territory and only when these are purchased prior to returning to the territory.

Please see below for separate benefits for medication expenses incurred in the territory.

Hospital transfers

We'll pay for transfers and transportation by ground or air ambulance for the life covered or their child where their use is indicated and prescribed by a consultant and preapproved by Further.

Medical treatments

We'll pay any expenses relating to the following medical and surgical services including reconstructive surgery, treatments or prescriptions:

- for anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist;
- laboratory analysis and pathology;
- x-rays for diagnostic purposes;
- radiotherapy;
- radioactive isotopes;
- chemotherapy;
- electrocardiograms (ECG);
- echocardiography (ECHO);
- myelograms;
- electroencephalograms (EEG);
- angiograms;
- computerised tomography (CT scan);
- other similar tests and treatments required for the diagnosis and treatment of a covered illness or medical procedure, when performed by a consultant or under medical supervision;
- blood transfusions;
- administration of plasma and serum;
- expenses relating to the use of oxygen, application of intravenous solutions and injections.

Living donor

We'll pay for services provided to a living donor during the process of removal of an organ or tissue to be transplanted to the life covered or their child arising from:

- the investigation procedure for the location of potential donors;
- hospital services provided to the donor, including accommodation in a hospital room, ward or section, meals, general nursing services, regular services provided by hospital staff, laboratory tests and use of equipment and other facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted);
- surgery and medical services for the removal of a donor's organ or tissue to be transplanted to the life covered or their child.

Bone marrow transplant

We'll pay for services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to the life covered or their child.

Medical expenses we don't cover

We won't pay for:

Any medical expenses (with the exception of medication expenses set out below) that are incurred in the territory
Any treatment that is not arranged under the preliminary medical certificate.
Expenses incurred in the purchase or hire of any of the following equipment or similar items: • orthopaedic appliances; corsets; bandages; crutches; artificial members or organs; wigs (even where their use is considered necessary during chemotherapy treatment); orthopaedic footwear; trusses; or other similar equipment or items. • wheelchairs; special beds; air conditioning appliances; air cleaners; or any other similar equipment or items.
Any type of prosthesis that: • are not fully inserted into the body; and • are not required as a direct result of the damage to a structure made by the medical procedure(s) arranged under this global treatment option.
Alternative medicine: Any charges made for the use of alternative medicine, even where specifically prescribed by a consultant.
Any expense incurred in a different hospital from the authorised hospital stated in the preliminary medical certificate.
Any expense incurred in respect of confinement services, home health care, or services provided in a convalescence centre or institution, hospice or nursing home, even where such services are required or necessary as a result of a serious illness or medical procedure.
Cerebral syndrome or impairment: Any charges for medical attention or confinement, regardless of the status of their development, in cases of: • cerebral syndrome (presence of a cerebral disorder or damage to the brain resulting in the partial or total impairment of the brain functions); or • senility; or • cerebral impairment regardless of the status of their development.

Medication expenses in the territory

We'll pay for the cost of medication purchased in the territory, up to a maximum of £50,000 over the policy term following treatment of any of the serious illnesses or medical procedures which are paid for under this global treatment option, which resulted in a stay in hospital for three nights or more.

We will only cover the medication expenses on the following basis:

- the medication must be recommended through Further by the international consultant that treated the life covered or their child, as necessary for on-going treatment;
- the medication recommended by the international consultant has been licensed and approved by the corresponding medical authority or agency in the territory and its prescription and administration is regulated;
- the medication must be available for purchase in the territory;
- the medication must require prescription by a consultant in the territory;
- no single prescription must exceed a dose for consumption longer than two months.

We won't pay for:

- the cost of medication which is funded by the NHS or that is covered by any other insurance policy held by the life covered.
- any costs associated with the administration of the medication.
- any medication expenses which the life covered incurred which have not been sent to us within 180 days of the purchase.
- any medication that is not medically necessary.

Other expenses we cover

Travel and accommodation

We'll pay for expenses for travel, in economy class, to and from the agreed hospital indicated in the preliminary medical certificate, and any necessary accommodation, arranged by us for:

- the life covered and a travelling companion; or
- the life covered, their child, and another travelling companion (if it is their child that is receiving the treatment under the global treatment option); and/or
- a living donor (if applicable).

We'll also pay £100 for each day the life covered or their child receive medical services in a hospital outside of the territory in respect of treatment arranged under the preliminary medical certificate, whether these are on an in or out-patient basis, subject to a maximum of 60 consecutive days for each successful claim made under the global treatment option under the policy.

Repatriation expenses

If the life covered or their child or a living donor dies whilst receiving treatment approved by the preliminary medical certificate, we'll pay the costs relating to transporting the body home, as well as the minimum costs necessary for administrative formalities, embalmment and the coffin in which the body is transported back to the territory.

Other expenses we don't cover

We will not pay for:

Any travel arrangements which are not associated with travel from and to a permanent address in the territory.
Any expenses in respect of accommodation or transportation arranged by the life covered, a travelling companion or a living donor.
Any interpreter's fees, telephone and other charges in respect of items for personal use or which are not of a medical nature, or for any other service provided to relatives or travelling companions.
Any breakfast, meals and incidental costs incurred at the hotel. If the life covered pays for an upgrade to their hotel accommodation, they will bear the full cost of the upgrade.

Indemnity period

A claim could still be made after the policy has ended in the following circumstances:

(a) If the policy ends as a result of a successful claim under the policy, the life covered can claim under the global treatment option after the policy has ended (for a maximum of 36 months from the date of that earlier claim) provided that the serious illness or medical procedure for which they are claiming under this global treatment option is directly related to the earlier claim under the policy.

(b) If the life covered or their child has a serious illness or requires a medical procedure and you have started a claim for overseas treatment, but the policy subsequently ends as a result of a successful claim under the policy, the claim under the global treatment option can continue for a maximum of 36 months from the date the policy has ended.

If one of the above indemnity periods applies, all other benefits under the policy will have stopped when the policy ended and the policyholder will not be required to pay premiums.

Provided treatment has started within 36 months of the policy ending as described above, we'll cover the cost of any treatment the life covered and their child receives outside of the territory and the travel and accommodation expenses associated with that until the life covered or their child return to the UK.

We will cover the cost of any medication expenses that are incurred in the territory after the return of the life covered or their child to the territory provided they are incurred during the indemnity period.

Start and end of cover

The global treatment option covers the life covered and their child for three years from the start date.

At the end of this three year period, the global treatment option will be renewed, unless before next renewal date the:

- policy term ends, in which case it will end on the end date of the policy; or
- life covered turns 85, in which case it will end on their 85th birthday; or
- life covered has reached the maximum benefit of £2,000,000; or
- policy cannot be renewed because
  - the life covered is resident outside of the countries listed above; or
  - our relationship with Further comes to an end; or
  - there has been any change of law, regulatory requirement or taxation which means that we are no longer able to offer the global treatment option.

Renewal of cover

We'll contact the policyholder at least 30 days before the renewal date and will tell them that:

(a) the key features of global treatment won't change. If this happens, we'll automatically renew the option from the next renewal date. Please be aware that we will automatically renew global treatment if we change the amount the policyholder pays for it; or

(b) the key features of global treatment will change. If this happens, we'll offer the policyholder the opportunity to renew from the renewal date and we'll ask them to confirm that the option can be automatically renewed at further renewal dates; or

(c) we won't renew the option. If this happens, the policy will continue without inclusion of global treatment and we'll remove the charge for it from the policyholder's premium.

If the policyholder does not wish to renew global treatment, they must tell us before the renewal date and the change will apply from that renewal date.

The policyholder can cancel the option at any time six months after the start date. However, they won't be able to reinstate it later and we won't refund their premiums.

Any new premium and any changes will come into effect upon renewal.

Total permanent disability

✔ Life Insurance+
✔ Critical Illness+

Total permanent disability provides an additional level of financial protection when a life covered suffers a long-lasting disability.

It's available on all cover types. It can only be selected at outset and comes at an extra cost.

Total permanent disability is available when the policyholder takes out life and critical illness cover or critical illness cover. It's subject to our acceptance following underwriting.

Once we've accepted a claim, all benefits under the policy will end except extra care cover if it's been selected.

We'll pay the cover amount if, during the policy term, a life covered meets our definition of total permanent disability. We have two definitions of total permanent disability:

- Own occupation.
- Activities of daily work.

Total permanent disability – unable before age 71 to do your own occupation ever again.

Loss of the physical or mental ability through an illness or injury before age 71 to the extent that the life covered 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 life covered's own occupation that cannot reasonably be omitted or modified.

Own occupation means the trade, profession or type of work the life covered does 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 life covered expects to retire.

Disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

Total permanent disability – unable before age 71 to do 3 specified work tasks ever again.

Loss of the physical ability through an illness or injury before age 71 to do at least three of the six work tasks listed below ever again.

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the life covered expects to retire.

The life covered must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

The work tasks are:

1. Walking –
the ability to walk more than 200 metres on a level surface.

2. Climbing –
the ability to climb up a flight of 12 stairs and down again, using the handrail if needed.

3. Lifting –
the ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.

4. Bending –
the ability to bend or kneel to touch the floor and straighten up again.

5. Getting in and out of a car –
the ability to get into a standard saloon car, and out again.

6. Writing –
the manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

Disabilities for which the relevant specialists can't give a clear prognosis are not covered.

Waiver of premium

✔ Life Insurance+
✔ Critical Illness+
✔ Whole of Life Insurance+
✔ Income Protection+
✔ Living Costs Protection

With waiver of premium we'll pay the premiums if a life covered can't work due to illness or injury so cover can be maintained.

It's available on all cover types. It's included as standard on Income Protection+ and Living Costs Protection and comes at an extra cost on Life Insurance+, Critical Illness+ and Whole of Life Insurance+

Life Insurance+, Critical Illness+ and Whole of Life Insurance+

We'll pay premiums if, due to illness or injury, the life covered:

- is unable to perform the duties of their own occupation; or
- meets the below activities of daily work criteria.

If the life covered stopped performing any occupation (for profit or pay) more than 12 months before the start of the illness or injury, we'll apply the activities of daily work definition.

Own occupation:

The life covered must be unable to perform the material and substantial duties that are normally required for and/or form a significant and integral part of their own occupation that cannot be reasonably omitted or modified.

Activities of daily work:

The life covered must be unable to perform at least two of the work tasks listed below. The life covered must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

For more information about waiver of premium on Income Protection+ and Living Costs Protection, please see pages 16 and 17.

The work tasks are:

1. Walking –
the ability to walk more than 200 metres on a level surface.

2. Climbing –
the ability to climb up a flight of 12 stairs and down again, using the handrail if needed.

3. Lifting –
the ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.

4. Bending –
the ability to bend or kneel to touch the floor and straighten up again.

5. Getting in and out of a car –
the ability to get into a standard saloon car, and out again.

6. Writing –
the manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

Deferred period

After we've accepted a claim, we apply a deferred period of one, three or six months before we start paying premiums. The policyholder must continue to pay the premiums until the end of the deferred period.

The policyholder chooses the deferred period at outset and it can't be changed once the policy has started.

When the deferred period ends, we'll start paying the premiums until the earliest of the:

- (for life and critical illness cover only) policy end date; or
- date the life covered is able to perform the duties of their own occupation or they no longer meet the activities of daily work; or
- date the life covered starts any type of work (for profit or pay); or
- date we accept a claim for the main benefit; or
- (for life and critical illness cover only) date we accept a claim for the main benefit, upgraded critical illness benefit, total permanent disability benefit or extra care cover benefit (if selected).
- (for Whole of Life Insurance+ on a joint life second death basis) death of the life covered claiming under this waiver of premium option.

If the life covered becomes able to perform the duties of their own occupation, no longer meets the activities of daily work definition or starts any type of work, the policyholder will need to resume paying premiums in order to keep the policy in force.

If the life covered (or the eldest life covered for a joint policy) turns 71 during a claim, they will no longer be eligible for waiver of premium. This means the policyholder will need to restart paying premiums to allow the policy to continue.

For Whole of Life Insurance+ on a joint life second death basis, if the life covered claiming under this waiver of premium option dies first, the surviving life covered will need to restart paying premiums.

In order for us to continue paying premiums, we'll need evidence that the life covered is still unable to perform the duties of their own occupation or meets the activities of daily work as described above.

You can't claim waiver of premium if we establish that the life covered is living outside of the following countries for more than 13 consecutive weeks in any 12 month period:

Andorra, Australia, Canada, the Channel Islands, the European Union, the Faroe Islands, Gibraltar, the Isle of Man, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, the UK, USA or the Vatican City.

Income Protection+ and Living Costs Protection

Waiver of premium is automatically included on all policies at no extra cost. If we accept a claim, we'll start paying the premiums 13 weeks after the policyholder stops working due to incapacity, or when the deferred period ends, whichever is sooner. We'll start to collect the premiums again once the claim has ended.

Conversion option

✔ Life Insurance+	The conversion option lets the policyholder convert their policy to a new whole of life policy without us asking any further medical questions. It can only be selected at outset and comes at an extra cost.

The conversion option is available if the policy:

- is accepted on standard terms;
- has level life cover only;
- does not include critical illness
- doesn't include the increasing cover option.

The policyholder can use the conversion option at any time before the policy end date as long as they haven't already made, nor are they eligible to make, a claim for the death benefit or terminal illness benefit.

When the conversion option is used, we'll cancel the original policy.

The new policy must:

- start immediately after the original policy ends; and
- have a cover amount less than, or equal to, the cover amount on the original policy.

The premium for the new policy will be based on the rates available at the time of the request and the age of the life covered. The policy conditions in force at the time will apply to the new policy.

If the original policy:

- is a single policy – the new policy has to be a single policy.
- is a joint policy – the new policy can be either single or joint. Both policyholders need to agree to the new policy.

It's not possible to change the lives covered.

Increasing cover

✔ Life Insurance+
✔ Critical Illness+
✔ Whole of Life Insurance+
✔ Income Protection+

Increasing cover lets the policyholder automatically increase their cover or benefit amount each year without us asking further medical questions.

For Life Insurance+ and Critical Illness+

Increasing cover is not available with decreasing cover or the conversion option.

For life and critical illness cover, the increase will also apply to the amount we pay for the following benefits:

- additional critical illness
- children's benefit (except children's hospital benefit)
- upgraded critical illness benefit (except hospital benefit)
- upgraded children's benefit (except children's hospital benefit)
- total permanent disability benefit (if selected)
- extra care cover (if selected).

For level cover – the policyholder can choose from three options:

- The cover/benefit amount will increase each year in line with the percentage increase in the Retail Prices Index (RPI) over the 12 month period ending 12 weeks before the start of the month of the policy anniversary;
- The cover/benefit amount will increase by 3% on the anniversary date of the policy; or
- The cover/benefit amount will increase by 5% on the anniversary date of the policy.

There is no additional cost for including increasing cover at the start of the policy but premiums will increase each year. We'll calculate the increase in premium by multiplying the percentage increase in the cover/benefit amount by 1.5. We'll then multiply that amount by the current premium to work out what the new premium will be. The factor is determined when a policy starts and won't change over the policy term.

If the policyholder chooses the RPI option:

- The maximum increase in the cover/benefit amount will be 10% each year.
- The premium won't increase by more than 15% unless the policyholder has also chosen reviewable premiums and a combined increase in premium could exceed 15%.
- If the change in RPI is 0% or below, the cover/benefit amount –and the premium – will stay the same.

We'll write to the policyholder at least eight weeks before the anniversary date to tell them how much their cover/benefit amount and premiums will increase by.

The policyholder can decide against the increase up to three times in a row after which we'll remove increasing cover from the policy.

For family income cover – the policyholder can choose from two options:

- The cover amount will increase by 3% on the anniversary date of the policy.
- The cover amount will increase by 5% on the anniversary date of the policy.

The cover amount will continue to increase until the end of the policy, even if we have accepted a claim.

Premiums will not increase and remain the same throughout the policy. This means that it will cost more to include increasing cover on a family income cover policy.

It's not possible to cancel an increase if the policyholder has selected family income cover as the cover type.

Example 1

Jonathan, 40, and Julie, 38, have a £100,000 Life Insurance+ policy with level cover to last 30 years and have selected increasing cover using the Retail Prices Index (RPI). Their main benefit is life cover. They pay £20.00 a month.

After the first year, RPI has increased by 2.5%

Their cover amount increases by 2.5%.

£100,000 x 2.5% = £2,500

£100,000 + £2,500 = £102,500

Their premium increases by the change in RPI and the factor we apply. (1.5)

£20.00 x 2.5% x 1.5 = £0.75

£20.00 + £0.75 = £20.75

Example 2

Rafe, 31, has a £200,000 Critical Illness+ policy with level cover to last 20 years. He has selected the increasing cover option. His premium is £45.00.

After the first year RPI has increased by 1%

His cover amount for the main benefit will increase by 1%

£200,000 x 1% = £2,000

£200,000 + £2,000 = £202,000

The cover amount payable for the other benefits will also increase by 1%

Additional critical illness benefit

Additional critical illness benefit	Children's critical illness	Children's death benefit
£25,000 x 1% = £250	£25,000 x 1% = £250	£5000 x 1% = £50
£25,000 + £250 = £25,250	£25,000 + £250 = £25,250	£5000 + £50 = £5050

His premium will increase by the change in RPI and the factor we apply. (1.5)

£45.00 x 1% x 1.5 = £0.67

£45.00 + £0.67 = £45.67

For Whole of Life Insurance+

Like the level Life Insurance+ the policyholder can choose from the following 3 options:

- the benefit amount will increase a maximum of 10% each year in line with the percentage increase in the Retail Prices Index (RPI) over the 12 month period ending 12 weeks before the start of the month of the policy anniversary date (subject to a maximum increase of 10%); or
- 3% increase in the benefit amount on the anniversary date of the policy; or
- 5% increase in the benefit amount on the anniversary date of the policy

The premiums will increase each year by 2.0 times the percentage increase in the cover amount.

If the change in RPI is 0% or below, the benefit amount, and premium, will stay the same.

We'll write to the policyholder at least eight weeks before the anniversary date to tell them how much their benefit amount and premiums will increase by.

The policyholder can decide against taking the increase, in which case we will offer it again at the next policy anniversary.

If the policyholder declines the annual increase three times in a row, we'll remove increasing cover from the policy.

Example

Karen, 55 has a £100,000 Whole of Life Insurance+ policy.

Her premium is £200 per month and she has selected to increase her cover by a fixed 3% each year.

At her first policy anniversary her original cover amount increases by 3%.

£100,000 x 3% = £3,000

£100,000 + £3,000 = £103,000

Her premium increases by 3% and the factor we apply (2.0)

£200 x 3% x 2.0 = £12.0

So the maximum her premium will increase to is £200 + £12 = £212

For Income Protection+

The policyholder can choose from the following three options:

- the benefit amount will increase each year in line with the percentage increase in the Retail Prices Index (RPI) over the 12 month period ending 12 weeks before the start of the month of the policy anniversary date (subject to a maximum increase of 10%); or
- 3% increase in the benefit amount on the anniversary date of the policy; or
- 5% increase in the benefit amount on the anniversary date of the policy.

The premiums will increase each year. We'll take the current premium and multiply it by 1.5 and the rate of the increase. Therefore premiums will increase by a higher percentage than the benefit amount.

The premium won't increase by more than 15% each year (1.5 multiplied by the maximum of 10%). If the change in RPI is 0% or below, the benefit amount, and premium, will stay the same.

We'll write to the policyholder at least eight weeks before the anniversary date to tell them how much their benefit amount and premiums will increase by.

If the policyholder decides against taking the increase this will always be offered again at the next policy anniversary.

Including increasing cover on an Income Protection+ policy will increase the initial cost of the policy.

Example

Susan is a 33 year old Accountant. She chooses a deferred period of 26 weeks and a ceasing age of 65 and has chosen a monthly benefit of £1,500 per month. Her premium is £25 a month and she has selected to increase her cover by the Retail Prices Index (RPI).

After the first year, RPI has increased by 2.5%

Her benefit amount increases by 2.5%

£1,500 x 2.5% = £37.50

£1,500 + £37.50 = £1,537.50

Her premium increases by the change in RPI and the factor we apply (1.5)

£25 x 2.5% x 1.5 = £0.93

£25 + £0.93 = £25.93

Renewal option

✔ Life Insurance+
✔ Critical Illness+

The renewal option lets the policyholder renew their cover on the policy end date without us asking any further medical questions.

It's available on level cover and comes at an extra cost.

The renewal option is available if:

- we accepted the policy on standard terms
- the policy has level life cover, level life and critical illness cover with guaranteed premiums or critical illness cover with guaranteed premiums
- the policy doesn't include increasing cover or reviewable critical illness cover.

The policyholder can use the renewal option as long as they haven't already made, nor are they eligible to make, a claim for one of the main benefits, an upgraded full payment condition, upgraded accelerated surgery benefit, total permanent disability or extra care cover.

The new policy must:

- start immediately after the original policy ends; and
- have a term no longer than the original policy; and
- have a cover amount less than, or equal to, the cover amount on the original policy.

The new policy can include any benefits and options that are on the original policy as long as they're available at the time and any eligibility criteria are met. If waiver of premium is included, the deferred period cannot be shorter than that on the original policy.

If the policyholder has already claimed for additional critical illness, children's benefit or upgraded children's benefit on their original policy, they won't be able to claim for that same condition on the new policy.

If the original policy has:

- life and critical illness cover – the new policy can have the same cover or life cover only
- life cover – the new policy must also be life cover only
- critical illness cover – the new policy must also be critical illness cover only.

If the original policy:

- is a single policy – the new policy has to be a single policy
- is a joint policy – the new policy can be either single or joint. Both policyholders need to agree to the new policy.

It's not possible to change the lives covered.

The premium payable for the new policy will be based on the rates available at the time of the request and the age of the life covered. The policy conditions in force at the time will apply to the new policy.

Additional benefits

Our protection products also include additional benefits to give your customers valuable flexibility at no extra cost.

This guide includes an overview of each additional benefit. For a more detailed explanation, please see the policy conditions

House purchase cover

✔ Life Insurance+

House purchase cover provides free cover during the house buying process.

It's available on level and decreasing cover.

House purchase cover provides a free death benefit of £500,000, the cover amount applied for or the house purchase price, whichever is lower.

The cover starts when we've accepted an application and contracts have been exchanged (in Scotland when missives are completed).

It ends on the earlier of:

- 90 days; or
- the date of completion/date of entry; or
- the policy start date.

The start date of the policy should coincide with the anticipated date of completion. If these conditions aren't met we won't accept a claim.

We also won't pay a house purchase cover claim if death is a result of suicide or self-inflicted injury. If we accept a claim for house purchase cover, the policy will end and no other claims can be made.

Life change benefit

If the policyholder's circumstances change, they may be able to take out more cover without us asking further medical questions.

- ✔ Life Insurance+
- ✔ Critical Illness+
- ✔ Whole of Life Insurance+
- ✔ Income Protection+
- ✔ Living Costs Protection

Life Insurance+ and Critical Illness+

Life change benefit will only be included if:

- we accepted the policy on standard terms; and
- the policyholder is the life covered; and
- the eldest life covered is under age 55 at the policy start date; and
- the policyholder didn't take out the policy under the life change benefit or separation benefit.

After they've had their policy for six months, the policyholder can use the life change benefit in the event of the following life changes:

Life change	Evidence needed
Marriage or civil partnership	Marriage or civil partnership certificate
Divorce, dissolution of civil partnership or separation	Final order (previously known as decree absolute) or dissolution order, evidence of new mortgage, mortgage transfer or new separate addresses
Becoming a parent	Birth or adoption certificate
Increased mortgage due to a house move or purchase, or carrying out home improvements	Evidence of new mortgage or increase on existing mortgage, or builder's receipts for work carried out
20% increase in salary due to change of employer or promotion	Copy of recent payslips dated within 90 days of each other
Increased rental payments imposed by your landlord; or due to moving to a new property; or changing from rental to mortgage payments.	The new rental agreement or the increased cost of the new mortgage payments compared to the rent paid previously

The policyholder can use the life change benefit as many times as they like on the original policy as long as:

- they take out the new policy before the oldest life covered turns 55;
- they take out the new policy within 180 days of the life change happening;
- they send us the evidence we need;
- they haven't already made, nor are they eligible to make, a claim for any benefit except for children's benefit or upgraded children's benefit; and
- the premium of the new policy meets the minimum premium limit that applies at the time.

If the original policy:

- is a single policy – the new policy has to be a single policy.
- is a joint policy – the new policy can be either single or joint. Both policyholders need to agree to the new policy.

It's not possible to change the lives covered. The new policy can include the option and benefits that are on the original policy as long as they're available at the time

The new policy won't include the life change benefit, increasing cover or the conversion, renewal, fracture cover or global treatment options. In addition, it can only have the waiver of premium option if the deferred period on the new policy is no shorter than on the original policy.

The following limits apply depending on the type of cover:

Cover	Limits
Level and decreasing cover	For mortgage increases, the new cover amount can't exceed the mortgage increase. The total cover amount for all the policies taken out using the life change benefit must not exceed the lower of: • £200,000; or • the original cover amount. The new policy must end before the eldest life covered on the original policy turns 70. If due to an increase in rent, the maximum increase allowed is the monetary increase in rent multiplied by the remaining months on the policy capped at a maximum increase of £200,000 or the original cover amount.
Family income cover	The total cover amount for all the policies the policyholder takes out using the life change benefit must not exceed the lower of: • the original cover amount; or • the equivalent of £8,000 a year. The new policy must end on the earlier of: • the end date of the original policy; or • before the oldest life covered turns 70. If due to an increase in rent, the maximum increase allowed is the monetary increase in rent multiplied by the remaining months on the policy capped at a maximum increase of £8,000 a year or the original cover amount.

The premium for any new policy will be based on the rates available at the time of the request and the personal circumstances of the life covered. The policy conditions in force at the time will apply to the new policy.

Whole of Life Insurance+

This benefit will only be included at outset if:

- we accepted the policy on standard terms; and
- the eldest life covered is under age 65 at the policy start date; and
- the policyholder didn't take out the policy under the life change benefit or separation benefit.

Life change	Evidence needed
Marriage or civil partnership	Marriage or civil partnership certificate
Divorce, dissolution of civil partnership or separation	Final order (previously known as decree absolute) or dissolution order, evidence of new mortgage, mortgage transfer or new separate addresses
Becoming a parent	Birth or adoption certificate
Increased mortgage due to a house move or purchase, or carrying out home improvements	Evidence of new mortgage or increase on existing mortgage, or builder's receipts for work carried out
Gift of cash	Evidence of bank statement
Gift of residential property	Evidence of property deeds
Receipt of residential property or inheritance of cash	Evidence of property deeds or confirmation from executor of the will

The policyholder can use the life change benefit as many times as they like as long as they take out the new policy before the eldest life covered turns 65 and as long as the amount of cover does not exceed the maximum cover amount. For mortgage increases, the new cover amount can't exceed the mortgage increase. The total combined amount for all the policies taken out under the life change benefit must not exceed the lower of £200,000 or the original cover amount. If the policyholder has transferred ownership of the policy to someone else, the new policyholder can still use life change benefit provided the life covered's circumstances change in one of the ways described above.

The policyholder can't use it if they have made a claim for any benefit, or if they are eligible to make a claim for any benefit.

For joint life second death policies, they can use it if the first life covered has died.

The premium for the new policy must meet the minimum premium limit that applies at the time.

If the original policy:

- is a single policy - the new policy has to be a single policy.
- is a joint life first death policy – the new policy can be either a single, or joint life first death policy.
- is a joint life second death policy – the new policy can be either a single, joint life first death policy or joint life second death policy.

For joint policies, both policyholders need to agree to the new policy. It's not possible to change the lives covered.

The new policy:

The new policy can include the options and benefits that are on the original policy as long as they're available at the time (and any eligibility criteria are met) except for:

- life change benefit
- increasing cover
- inheritance tax benefit

The new policy can only have the waiver of premium option if the eldest life covered is under age 70 at the policy start date.

The deferred period on the new policy can't be shorter than on the original policy.

The premium for any new policy will be based on the rates available at the time of the request and the personal circumstances of the life covered. The policy conditions in force at the time will apply to the new policy.

Income Protection+

Life change benefit will only be included if we accepted the policy on standard terms.

The increase can be up to 50% of the original benefit amount or £9,000 a year (whichever is lower) for each life change event, subject to the maximum yearly amount applicable at the time extra cover is taken out. If the policyholder's salary increases by 20% or more as a result of one or more pay rises, they can apply for extra cover of up to £20,000 a year. They can do this once during the policy term. This isn't available if the policyholder is self-employed.

After they've had their policy for six months, the policyholder can use the life change benefit in the event of the following life changes:

Taking out or increasing a mortgage	**Evidence needed**
Marriage or civil partnership	Marriage or civil partnership certificate
Divorce, dissolution of civil partnership or separation	Final order (previously known as decree absolute) or dissolution order, evidence of new mortgage, mortgage transfer or new separate addresses
Separation	Evidence of new mortgage, mortgage transfer or new separate addresses.
Becoming a parent	Birth or adoption certificate
Increased mortgage due to a house move or purchase, or carrying out home improvements	Evidence of new mortgage or increase on existing mortgage, or builder's receipts for work carried out
Change of employer or promotion	Copy of payslips dated within 90 days of each other
Increase in rental payment imposed by landlord, or moving to a new rental property	Evidence of increase in rent on rental agreement or bank statements

The policyholder can use the life change benefit as many times as they like on the original policy as long as they:

- take out the new policy before they turn 55
- take out the new policy within 90 days of the life change happening
- send us the evidence we need
- haven't already made a claim.
- are not in claim or eligible to make a claim on your original policy. This includes any accident or illness you've had where you are currently in the deferred period
- take a new policy to end before they turn 71
- are not within the last five years of their original policy end date
- do not take out a new policy with a shorter deferred period than their original policy
- do not take out a new policy with a policy end date more than five years after the original policy
- do not take out a policy with a longer limited payment term than their original policy
- do not have a combined total benefit amount that is more than the maximum yearly amount available against their earnings when they apply for the new policy

Living Costs Protection

Life change benefit will only be included if we accepted the policy on standard terms.

The increase can be up to 2 times the original benefit amount, with a minimum increase of £100 per month for each life change event, subject to the maximum benefit across all Living Costs Protection policies held with Aviva of £1,500 per month.

After they've had their policy for six months, the policyholder can use the life change benefit in the event of the following life changes

Life event	Evidence needed
Increase in mortgage payments due to a house move, remortgage or home improvements	Evidence of new mortgage or increase in existing mortgage, or builders receipts for work carried out
Increase in rental payment imposed by landlord or due to moving to a new rental property	Evidence of increase in rent on rental agreement or bank statements
Change from rental payments to mortgage payments	Rental agreement, mortgage offer and/or bank statement

The policyholder can use the life change benefit as many times as they like as long as they:

- take out the new policy before they turn 55
- take out the new policy to end before they turn 71
- take out their new policy within 90 days of the life change event happening
- send us the evidence we need
- haven't already made a claim
- are not in claim or eligible to make a claim on their original policy. This includes any accident or illness they've had where they are currently in the deferred period
- are not within 5 years of the original policy end date
- do not take out a new policy with a shorter deferred period than their original policy
- do not take out a new policy with a policy end date more than five years after the original policy

Separation benefit

✔ Life Insurance+
✔ Critical Illness+
✔ Whole of Life Insurance+

If joint policyholders separate, they can cancel the policy and each take out a new single policy without answering any further medical questions.

It's available with all types of cover.

Separation benefit will only be included if:

- we accepted the policy on standard terms
- the policyholders are the lives covered
- the eldest life covered is under age 55 or 65 for Whole of Life Insurance+ at the policy start date
- the policyholder didn't take out the policy under the life change benefit (for Life Insurance+ and Critical Illness+)

After they've had their policy for six months, the policyholders can use the separation benefit if they separate or rearrange their mortgage into one name.

Separation	Evidence needed
Divorce, dissolution of civil partnership or separation.	Final order (previously known as decree absolute) or dissolution order.
Mortgage transferred into one name only	Evidence of mortgage transfer.
Moving into a different house	Evidence of new mortgage or new address.

Policyholders can use the separation benefit as long as:

- they both agree to cancel the original policy
- they take out the new policies before the eldest life turns 55 or 65 for Whole of Life Insurance+
- they take out the new policy within 90 days of the separation happening for Whole of Life Insurance+ and 180 days for Life Insurance+ and Critical Illness+ policies
- they send us the evidence we need
- neither of them have already made, nor are they eligible to make, a claim for any benefit except children's benefit or upgraded children's benefit
- the premium of the new policy meets the minimum premium limit that applies at the time.

The new policy:

- can only start when the original policy has been cancelled
- has to have a cover amount which is less than, or equal to, the current cover amount. For Whole of Life Insurance+ the combined cover amount if two policies taken out must not exceed the current cover amount. For family income cover, the new policy can't last longer than the original policy
- has to end before the policyholder turns 70 (for Life and Critical illness policies)
- can include the same options as the original policy as long as they're available at the time
- won't include the life change benefit, or inheritance tax benefit for Whole of Life Insurance+.
- won't include conversion or renewal options

If the new policy includes waiver of premium, the deferred period can't be shorter than that on the original policy.

The separation benefit can only be used once.

Inheritance Tax Benefit

✔ Whole of Life Insurance+

This benefit allows the policyholder to take out more cover through an additional policy without any further health and lifestyle questions being asked, if inheritance tax legislation changes and this results in an increase to the life covered's inheritance tax liability.

If the inheritance tax liability increases because of a change in the band rates of inheritance tax or in the exemptions and reliefs from inheritance tax, the policyholder can increase their cover amount to the lower of:

- the amount by which their potential inheritance tax liability has increased
- £1,000,000, or
- the original cover amount they had at the start of the policy.

It can be used after six months from the start date.

The new policy must be taken out within 90 days of a change in:

- the band rates for inheritance tax; or
- the exemptions from inheritance tax; or
- the reliefs from inheritance tax.

The policyholder must send us the evidence of the life covered's increased inheritance tax liability.

New Policy

The new policy can include the options and benefits that are on the original policy as long as they're available at the time except for the life change benefit, the inheritance tax benefit or increasing cover.

The new policy can only have the waiver of premium option if the eldest life covered is under age 70 at the new policy start date.

The deferred period on the new policy can't be shorter than on the original policy.

The premium for any new policy will be based on the rates available at the time of the request and the personal circumstances of the life covered. The policy conditions in force at the time will apply to the new policy.

The inheritance tax benefit can be used as many times as the client likes as long as the policy holder takes out the new policy before the eldest life covered turns 85 and as long as the amount of cover does not exceed our maximum cover amount as stated above.

Making changes to a policy

Unless otherwise stated:

- The policyholder can make changes to their policy six months from the start date.
- We'll make the changes without any further medical information.
- We'll use the original premium rates based on the personal circumstances of the life covered.

Any changes will apply from the date the next premium is due.

Life Insurance+ and Critical Illness+

If the policyholder makes any of the following changes, we'll amend the policy:

- Reducing the cover amount.
- Reducing the policy term.
- Increasing the policy term – We'll use the premium rates available when we make the change, based on the personal circumstances of the life covered. We may need to ask some further medical questions. Depending on the answers, we may not be able to carry out the increase. The policy term can't be increased if the policy includes the increasing cover or conversion/renewal options.
- Changing from monthly to yearly premiums, or the other way round.
- Changing from life and critical illness cover to life cover only – This will also remove accelerated surgery benefit, additional critical illness benefit, children's benefit, upgraded critical illness benefit, upgraded children's benefit, extra care cover and total permanent disability from the policy if included.
- Removing any of the options selected at outset – We'll remove the charge for the option from the premium.

If the policyholder increases the cover amount, we'll issue a new policy to go with the original policy, which will remain in force. If we can carry out the change, the policy conditions in force at the time will apply to the new policy.

After any of the above changes, the premium can't be lower than the minimum premium limit which applies at the time we agree to the request.

Whole of Life Insurance+

If the policyholder makes any of the following changes, we'll amend the policy and won't ask any further health and lifestyle questions:

- Reduce cover amount
- Change premium frequency
- Remove selected option

If the policyholder increases the cover amount, their original policy will remain in force and we'll issue a new policy for the further amount.

We may need to ask some further health and lifestyle questions. Depending on the answers, we may not be able to carry out the change. If we can carry out the change, the policy conditions in force at the time will apply to the new policy.

If we can carry out the change, the policy conditions in force at the time will apply to the new policy.

Simple Life Insurance

If the policy holder makes any of the following changes, we'll amend the policy and won't ask any further health and lifestyle questions:

- Reducing the cover amount
- Reducing the policy term

After any of the above changes, the premium can't be lower than the minimum premium limit which applies at the time we agree to the request.

The original policy conditions will continue to apply to the amended policy.

Income Protection+

If the policyholder makes any of the following changes, we'll amend the policy without asking any further medical questions:

- Removing the increasing cover option – Premiums will stay the same for the remainder of the term.
- Reducing the benefit amount – Change available in the first six months.
- Reducing the policy term.
- Increasing the deferred period – Change available in the first six months.
- Removing the shortest deferred period from a policy with dual deferred periods.
- Selecting a dual deferred period so the customer waits longer for benefit to be paid.

Unless stated otherwise, we'll use the premium rates and smoker status when they took out the policy when we make the change, based on the age of the life covered at the start of the policy.

If the policyholder makes any of the following changes, we'll amend the policy:

- Increasing the policy term.
- Decreasing the deferred period.
- Amending the cover by selecting a dual deferred period so that the benefit is paid earlier.
- Removing the longest deferred period from a policy with dual deferred periods.

Unless stated otherwise, we'll use the premium rates and smoker status available when we make the change based on the policyholder's current age.

We may need to ask further medical questions. Depending on the answers provided, we may not be able to carry out the change.

The policyholder does not need to tell us about a change in occupation but we can amend this on the policy if the life covered has moved to a lower risk occupation. We'll use the premium rates and smoker status when they took out the policy when we make the change, based on the age of the life covered at the start of the policy.

If the policyholder increases the benefit amount, we'll issue a new policy to go with the original policy, which will remain in force. We may need to ask further medical questions. The policy conditions in force at the time will apply to the new policy.

After any of the above changes, the premium can't be lower than the minimum premium limit which applies at the time we agree to the request.

Living Costs Protection

The policyholder can reduce the benefit amount (subject to the minimum benefit of £500 per month) without the need to answer any medical questions. We'll use the premium rates and smoker status when they took out the policy when we make the change, based on the age of the life covered at the start of the policy.

The policyholder does not need to tell us about a change in occupation but we can amend this on the policy if the life covered has moved to a lower risk occupation. We'll use the premium rates and smoker status when they took out the policy when we make the change, based on the age of the life covered at the start of the policy.

After either of these changes, the premium can't be lower than the minimum premium limit which applies at the time we agree to the request.

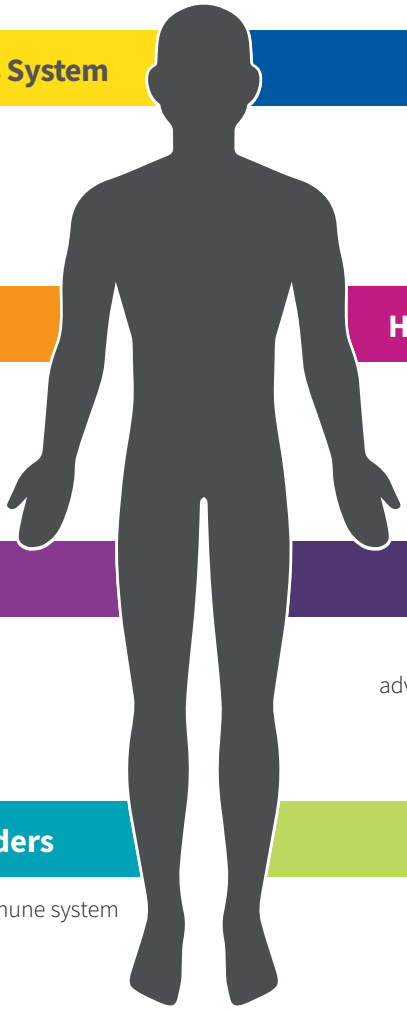
Appendix 1:

Traumatic events covered by the trauma benefit

- Blindness – permanent and irreversible loss of sight to the extent that 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 the visual field is reduced to 20 degrees or less of an arc as certified by an ophthalmologist.
- Deafness – 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.
- Loss of hand or foot – permanent physical severance of a hand or foot at or above the wrist or ankle joint.
- Loss of speech – total, permanent and irreversible loss of the ability to speak as a result of a physical injury or disease.
- Paralysis of limb – total and irreversible loss of muscle function to the whole of the limb.
- Loss of independence – total and permanent loss of the ability 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.

Appendix 2

We'll be presenting the critical illnesses we cover using groupings. Each group represents what the illness or condition relates to using a simple body picture as shown below. You can see at a glance the types of conditions you are covered for and can find more detail in the following pages.



Brain & Central Nervous System

The brain controls all body functions including movement. Conditions covered here either affect the brain directly or as a result of a condition, the functionality of the brain is affected.

Mental Health

We cover specific mental health disorders. These are included within our upgraded critical illness benefit.

Senses

We cover conditions of different severity around touch, feel, hearing and sight.

Heart & Circulatory System

We cover specific heart conditions, surgeries and conditions which affect the flow of blood around the body.

Organs

We cover several organ failures as well as transplants.

Cancer

We cover invasive cancer, as well as several less advanced cancers which might pay a smaller sum of money due to specific treatment.

Auto-immune Disorders

Auto-immune disorders are where the body's immune system attacks and destroys healthy body tissue.
We cover several of these conditions.

Children's Cover

We offer children's cover as standard, with an option to add on and take more extensive cover.

Terminal illness

Where death is expected within 12 months.

We cover a number of types of conditions, illnesses and treatments. This table sets out which appendices you should refer to for each of type of condition or illness.

Appendix 2A - Cancer
Appendix 2B - Brain and the central nervous system
Appendix 2C - Heart and the circulatory system
Appendix 2D - Organs
Appendix 2E - Auto-immune disorders
Appendix 2F - Senses
Appendix 2G - Mental Health
Appendix 2H - Terminal Illness
Appendix 2I - Children's Cover
Appendix 3 - Our products at a glance

Appendix 2A - Cancer

Cancer

Critical illness benefit (full payment)

Cancer

Critical illness benefit (additional benefits)

Less advanced cancer of the breast	Less advanced cancer of the prostate

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded critical illness benefit (additional benefits)

Less advanced cancer of the breast	Less advanced cancer of the urinary bladder
Less advanced cancer of the larynx	Less advanced cancer in situ – with surgery
Less advanced cancer of the ovary	Less advanced tumour of gastrointestinal stromal (GIST) or Neuroendocrine (NET) types – with surgery
Less advanced cancer of the prostate	
Less advanced cancer of the renal pelvis and ureter	Skin cancer (not including melanoma)
Less advanced cancer of the testicle	

Critical Illness Benefit (full payment)

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 and are confined to the skin (including cutaneous lymphomas and sarcomas)
- pseudomyxoma peritonei
- Merkel cell cancer

The following are not covered:

- all cancers which are histologically classified as any of the following:
  - pre-malignant
  - non-invasive
  - cancer in situ
  - having borderline malignancy
  - having low malignant potential
- all tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification 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
- malignant melanoma skin cancer that is 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.

Critical Illness Benefit (additional benefits)

For the following two definitions we will pay out the lower of £25,000 or 25% of the cover amount. If Upgraded Critical Illness is included, the calculation will change to that shown below.

Less advanced cancer of the breast – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ or neuroendocrine tumour (NET) of low malignant potential of the breast with surgery to remove the tumour.

Less advanced cancer of the prostate – of specified severity and treatment

Tumours of the prostate histologically classified as having a Gleason score between 2 and 6 inclusive providing the tumour has progressed to a clinical TNM classification between T1N0M0 and T2aN0M0 and the tumour has been treated by one of the following:

- external beam or interstitial implant therapy
- cryotherapy
- hormone therapy
- high intensity focused ultrasound.

The following is not covered:

- prostate cancers where the treatment is not one of the specified treatments above, or active surveillance or watchful waiting only is required.

If Upgraded Critical Illness Benefit is taken, we will pay the lower of £30,000 or the cover amount for these two definitions.

Upgraded Critical Illness Benefit (additional benefits)

The below definitions will pay the lower of £30,000 or the cover amount.

Less advanced cancer of the larynx – with specified treatment

A positive diagnosis with histological confirmation of cancer in situ of the larynx treated with surgery, laser or radiotherapy.

Less advanced cancer of the ovary – with surgical removal

A positive diagnosis with histological confirmation of ovarian tumour of borderline malignancy or low malignant potential which has resulted in surgical removal of an ovary.

The following is not covered:

- removal of an ovary due to a cyst.

Less advanced cancer of the renal pelvis or ureter – of specified severity

A positive diagnosis with histological confirmation of cancer in situ of the renal pelvis or ureter.

The following are not covered:

- non-invasive papillary carcinoma
- tumours of TNM classification stage Ta.

Less advanced cancer of the testicle – with specified surgery

A positive diagnosis with histological confirmation of intratubular germ cell neoplasia unclassified (ITGCNU) or benign testicular tumour resulting in orchidectomy (removal of a testicle).

Less advanced cancer of the urinary bladder – of specified severity

A positive diagnosis with histological confirmation of cancer in situ of the urinary bladder.

The following are not covered:

- non-invasive papillary carcinoma
- TNM classification stage Ta bladder cancer.

Less advanced cancer in situ – with surgery

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

The following are not covered:

- any skin cancer (including melanoma)
- tumours treated with radiotherapy, laser therapy, cryotherapy, cone biopsy, LLETZ (large loop excision of the transformation zone), diathermy treatment or topical therapy.

For this definition, you can claim more than once as long as the in situ cancer is of a separate site to one previously claimed for and also is not covered under any of the less advanced cancer definitions of named sites.

Less advanced tumour of gastrointestinal stromal (GIST) or Neuroendocrine (NET) types – with surgery

- neuroendocrine tumours that are WHO Grade 1 or less, or
- gastrointestinal stromal tumours classified by either AFIP/ Miettinen and Lasota as having a very low or low risk of progression, or as UICC/TNM8 stage I

which have been treated by surgery.

The following are not covered:

- tumours treated with radiotherapy, laser therapy, cryotherapy, diathermy treatment or topical therapy.

Skin cancer (not including melanoma)

Non-melanoma skin cancer diagnosed with histological confirmation that the tumour is larger than 2 centimetres across and has at least one of the following features:

- tumour thickness of at least 4 millimetres (mm)
- invasion into nerves in the skin (perineural invasion)
- poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope); or
- has recurred despite previous treatments.

Appendix 2B - Brain and central nervous system

Brain and the central nervous system

Critical illness benefit (full payment)

Bacterial meningitis	Encephalitis
Benign brain tumour	Motor neurone disease
Brain injury due to trauma, anoxia or hypoxia	Multiple sclerosis
Coma	Paralysis of a limb
Creutzfeldt-Jakob disease	Parkinson's disease
Dementia	Stroke or spinal cord stroke

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded critical illness benefit (full payment)

Benign spinal cord tumour	Neuromyelitis optica (Devic's disease)
Brain abscess	Parkinson's plus syndromes
Intensive care	Syringomyelia or syringobulbia

Upgraded critical illness benefit (additional benefits)

Cauda equina syndrome	Drug resistant epilepsy
Cerebral spinal aneurysm	Non-malignant pituitary adenoma
Cerebral or spinal arteriovenous malformation	

Critical Illness Benefit (full payment)

Bacterial meningitis – resulting in permanent symptoms

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.

Benign brain tumour – resulting in permanent symptoms or undergoing defined treatments

A non-malignant tumour or cyst originating in the brain, cranial nerves or meninges within the skull, 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:

- tumours in the pituitary gland
- angiomas.

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.

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; and
- results in associated permanent neurological deficit with persisting clinical symptoms.

Creutzfeldt-Jakob disease

A definite diagnosis of Creutzfeldt-Jakob disease by a consultant neurologist.

Dementia – 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; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

- mild cognitive impairment (MCI).

Encephalitis – resulting in permanent symptoms

A definite diagnosis of encephalitis by a consultant neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

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)
- Kennedy's disease
- primary lateral sclerosis (PLS)
- progressive bulbar palsy (PBP)
- progressive muscular atrophy (PMA)
- spinal muscular atrophy (SMA).

There must also be permanent clinical impairment of motor function.

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.

Paralysis of a limb – total and irreversible

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

Parkinson's disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a consultant neurologist or geriatrician. There must be permanent clinical impairment of motor function with associated tremor or muscle rigidity.

The following are not covered:

- Parkinsonian syndromes
- Parkinsonism.

Stroke or spinal cord stroke

Death of brain 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 is not covered

- Transient ischaemic attacks (TIA)
- Death of tissue of the optic nerve or retina/eye stroke.

Upgraded Critical Illness Benefit (full payment)

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.

Brain abscess – undergoing defined treatments

A definite diagnosis of an intracerebral abscess within the brain tissue by a consultant neurologist, resulting in either of the following:

- surgical removal; or
- surgical drainage of the abscess

Intensive care – requiring mechanical ventilation for 10 consecutive days

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

Neuromyelitis optica (Devic's disease) – where there have been symptoms

A definite diagnosis of neuromyelitis optica or neuromyelitis optica spectrum disorder (Devic's disease) by a consultant neurologist. There must have been clinical impairment of motor or sensory function caused by neuromyelitis optica.

Parkinson's plus syndromes – resulting in permanent symptoms

A definite diagnosis of one of the following Parkinson's plus syndromes by a consultant neurologist or geriatrician.

- multiple system atrophy
- progressive supranuclear palsy
- Parkinsonism-dementia-ALS complex
- diffuse lewy body disease
- corticobasal degeneration.

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

- motor function; or
- eye movement disorder; or
- postural instability; or
- dementia.

The following are not covered:

- other Parkinsonian syndromes
- Parkinsonism.

Syringomyelia or syringobulbia – requiring surgery

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

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Upgraded critical illness benefit (additional benefits)

The below definitions will pay the lower of £30,000 or the cover amount.

Cauda equina syndrome – with permanent symptoms

Compression of the lumbosacral nerve roots (cauda equina) resulting in all of the following:

- permanent bladder dysfunction; and
- permanent weakness and loss of sensation in the legs.

The diagnosis must be supported by appropriate neurological evidence.

Cerebral or spinal aneurysm – with specified surgery

The undergoing of either of the following surgical procedures:

- surgical correction via craniotomy (surgical opening of the skull) or embolisation treatment using coils or other materials, in order to treat a cerebral aneurysm; or
- surgical resection, wrapping, clipping or embolisation of a spinal aneurysm.

Cerebral or spinal arteriovenous malformation – with specified surgery

The undergoing of either of the following surgical procedures:

- surgical correction via craniotomy (surgical opening of the skull) or endovascular treatment using coils or other materials, in order to treat a cerebral arteriovenous malformation; or
- surgical correction or embolisation of a spinal arteriovenous malformation.

Drug resistant epilepsy – with specified surgery

The undergoing of invasive surgery to brain tissue in order to control epilepsy that cannot be controlled by oral medication.

The following is not covered:

- deep brain stimulation.

Non-malignant pituitary adenoma – with specified treatment

A non-malignant pituitary tumour requiring radiotherapy or surgical removal.

The following is not covered:

- non-malignant tumours of the pituitary gland treated by any other method.

Appendix 2C - Heart and the circulatory system

Heart and the circulatory system

Critical illness benefit (full payment)

Aorta graft surgery	Primary Cardiomyopathy
Cardiac arrest	Pulmonary arterial hypertension
Coronary artery bypass grafts	Pulmonary artery surgery
Heart attack	Structural heart surgery
Heart valve replacement or repair	

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded critical illness benefit (full payment)

Heart failure	Peripheral vascular disease

Upgraded critical illness benefit (additional benefits)

Aortic aneurysm	Central retinal artery or vein occlusion
Carotid artery stenosis	Coronary angioplasty

Critical Illness Benefit (full payment)

Aorta graft surgery

The undergoing of surgery 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.

The following are not covered:

- any other surgical procedure, for example, the insertion of stents or endovascular repair.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Cardiac arrest – with insertion of a defibrillator

Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and either of the following devices being surgically implanted:

- implantable cardioverter-defibrillator (ICD); or
- cardiac resynchronisation therapy with defibrillator (CRT-D).

Coronary artery bypass graft

The undergoing of surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Heart attack

A definite diagnosis of acute myocardial infarction with death of heart muscle as evidenced by all of the following:

- new characteristic electrocardiographic changes or new diagnostic imaging changes
- the characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- angina without myocardial infarction
- myocardial injury without infarction.

Heart valve replacement or repair

The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

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.

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).

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; or
- pulmonary endarterectomy.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Structural heart surgery

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist to correct any structural abnormality of the heart.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Upgraded Critical Illness Benefit (full payment)

Heart failure – of specified severity

A definite diagnosis by a consultant cardiologist of failure of the heart to function as a pump which is evidenced by all of the following:

- permanent and irreversible limitation of function to at least class III on the New York Heart Association (NYHA) classification of functional capacity (i.e. heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain)
- permanent and irreversible ejection fraction of 39% or less.

Peripheral vascular disease – requiring bypass surgery

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

The following is not covered:

- angioplasty.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Upgraded critical illness benefit (additional benefits)

The below definitions will pay the lower of £30,000 or the cover amount.

Aortic aneurysm – with endovascular repair

The undergoing of endovascular repair of an aneurysm of the thoracic or abdominal aorta with a graft.

The following is not covered:

- procedures to any branches of the thoracic or abdominal aorta.

Carotid artery stenosis – with surgical repair

The undergoing of endarterectomy or angioplasty with or without stent on the advice of a consultant physician to treat severe symptomatic stenosis in a carotid artery. This operation must be to treat:

- at least 50% diameter narrowing; and
- angiographic evidence will be required.

Central retinal artery or vein occlusion – with permanent visual impairment

Death of the optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in permanent visual impairment of the affected eye.

The following are not covered:

- branch retinal artery or vein occlusion or haemorrhage
- traumatic injury to tissue of the optic nerve or retina.

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 for 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.

Appendix 2D - Organs

Organs

Critical illness benefit (full payment)

Kidney failure	Respiratory failure
Liver failure	Third degree burns
Major organ transplant	

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded critical illness benefit (full payment)

Crohn's disease – treated with two resections	Pneumonectomy
Interstitial lung disease	Ulcerative colitis
Necrotising fasciitis	

Upgraded critical illness benefit (additional benefits)

Crohn's disease – one intestinal resection	Removal of one or more lobe(s) of the lung
Less severe third degree burns	

Critical Illness Benefit (full payment)

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.

Liver failure

Chronic liver disease, being end stage liver failure due to cirrhosis and resulting in all of the following:

- permanent jaundice
- ascites
- encephalopathy.

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 is not covered:

- transplant of any other organs, parts of organs, tissues or cells.

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.

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% of the body's surface area or covering at least 20% of the surface area of the face or head.

Upgraded Critical Illness Benefit (full payment)

Crohn's disease – treated with two intestinal resections or total colectomy

A definite diagnosis by a consultant gastroenterologist of Crohn's disease, resulting in either:

- surgical intestinal resection to remove part of the small intestine or bowel on at least two separate occasions; or
- total colectomy (removal of entire large bowel).

Interstitial lung disease – of specified severity

A definite diagnosis of interstitial lung disease by a consultant respiratory physician resulting in all of the following:

- radiological evidence of pulmonary fibrosis
- permanent and irreversible DLCO (diffusing capacity of the lung for carbon monoxide) below 40% of predicted.

Necrotising fasciitis

A definite diagnosis of necrotising fasciitis or gas gangrene by a consultant physician, requiring surgery to remove necrotic tissue and intravenous antibiotic treatment.

For the above definition, the following is not covered:

- all other forms of gangrene or cellulitis.

Pneumonectomy

The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung due to disease or traumatic injury.

The following is not covered:

- other forms of surgery to the lungs including removal of a lobe of the lungs (lobectomy) or lung resection.

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Ulcerative colitis – with total colectomy

A definite diagnosis of ulcerative colitis by a consultant gastroenterologist, which is treated with total colectomy (removal of entire large bowel).

We will make an advance payment of the cover amount if you are placed on an NHS waiting list for this surgical treatment.

Upgraded critical illness benefit (additional benefits)

The below definitions will pay the lower of £30,000 or the cover amount.

Crohn's disease – treated with one intestinal resection

A definite diagnosis by a consultant gastroenterologist of Crohn's disease, which has been treated with surgical intestinal resection.

Removal of one or more lobe(s) of the lung

The undergoing of surgery for the removal of one or more lobes of the lung due to underlying disease or trauma. The surgery must be carried out on the advice of a consultant physician.

Third degree burns – covering at least 5% of the body's surface area or 10% of the face or head.

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area or covering at least 10% of the surface area of the face or head.

Appendix 2E - Auto-immune disorders

Auto-immune disorders

Critical illness benefit (full payment)

Aplastic anaemia – with bone marrow failure	Systemic lupus erythematosus

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded critical illness benefit (full payment)

Rheumatoid arthritis

Upgraded critical illness benefit (additional benefits)

Aplastic anaemia – of specified severity	Guillain-Barre syndrome
Diabetes mellitus type 1	

Critical Illness Benefit (full payment)

Aplastic anaemia – with 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.

Systemic lupus erythematosus – of specified severity

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
- permanent impairment of kidney function with glomerular filtration rate (GFR) below 30 ml/min.

Upgraded Critical Illness Benefit (full payment)

Rheumatoid arthritis – of specified severity

Severe chronic rheumatoid arthritis evidenced by widespread joint destruction and deformity of at least three major joint groups, resulting in the inability to do three of the following:

- bend or kneel to pick up an object from the floor
- use hands or fingers to pick up or manipulate small objects such as cutlery or a pen
- lift or carry an everyday object such as a kettle
- walk a distance of 200m on flat ground with or without the use of a walking stick and without experiencing severe discomfort.

Upgraded critical illness benefit (additional payments)

The below definitions will pay the lower of £30,000 or the cover amount.

Aplastic anaemia – of specified severity

A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be bone marrow hypocellularity confirmed by biopsy with at least two of the following:

- absolute neutrophil count (ANC) <0.5 x 10^9/L
- platelet count <20 x 10^9/L
- Hb <100 g/L (<10g/dL)

The following is not covered:

- other types of anaemia.

Diabetes mellitus type 1

A definite diagnosis of type 1 diabetes mellitus, requiring the permanent use of insulin injections.

The following are not covered:

- gestational diabetes
- type 2 diabetes (including type 2 diabetes treated with insulin).

Guillain-Barre syndrome – with persisting clinical symptoms

A definite diagnosis of Guillain-Barre syndrome by a consultant neurologist. There must be clinical impairment of motor or sensory function which must have persisted for a continuous period of at least six months.

Appendix 2F - Senses

Senses

Critical illness benefit (full payment)

Blindness	Loss of hand or foot
Deafness	

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded critical illness benefit (additional benefits)

Severe visual loss

Critical Illness Benefit (full payment)

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, certified by an ophthalmologist.

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.

Loss of hand or foot – permanent physical severance

Permanent physical severance of a hand or foot at or above the wrist or ankle joint.

Upgraded critical illness benefit (additional benefits)

The below definitions will pay the lower of £30,000 or the cover amount.

Significant visual loss – 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 6/24 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 45 degrees or less of an arc, as certified by an ophthalmologist.

Appendix 2G - Mental Health

Mental Health

Upgraded critical illness benefit (full payment)

Psychosis and bipolar affective disorder

The below definitions are included if you have chosen to include upgraded critical illness benefit at extra cost to your premium.

Upgraded Critical Illness Benefit (full payment)

Psychosis and bipolar affective disorder – of specified severity

A definite diagnosis by a consultant psychiatrist of any of the following:

- bipolar affective disorder; or
- delusional disorder; or
- schizo-affective disorder; or
- schizophrenia,

  which has resulted in at least three of the following occurring within one year:

  - being under the care of a psychiatrist, psychiatric nurse, community mental health team or approved social worker
  - chronic symptoms lasting at least a year or requiring continuous therapy or medication to control them
  - in-patient admission to a psychiatric ward for at least 14 consecutive nights, or continuous home care by a Crisis Resolution and Home Treatment Team for 14 consecutive days, requiring at least 2 visits per day
  - a court order being made by the Court of Protection under the Mental Capacity Act.

For the above definition the following are not covered:

- delirium where there is no underlying psychiatric disorder
- conditions caused by or exacerbated by alcohol or drug misuse.

Appendix 2H - Terminal Illness

Terminal illness

Terminal illness – where death is expected within 12 months

A definitive diagnosis by the **attending consultant** of an illness that satisfies both the following:

- the illness has no known cure or has progressed to the point where it cannot be curred, and
- in the opinion of the **attending consultant**, the illness is expected to lead to death within 12 months.

Terminal illness is not included under children's cover.

Appendix 2I - Children's cover

Children's Benefit

For our children's cover, all conditions covered under critical illness benefit are automatically included for children, with cover from 30 days old to their 18th birthday or 21 if in full time education.
These conditions pay out 50% of the cover amount, capped at £25,000. The definitions below are what children are automatically covered for and the full definition wording can be found in the previous appendices.
Please note children are not covered for terminal illness benefit.

Cancer
Cancer
Brain and the central nervous system
Bacterial meningitis
Benign brain tumour
Brain injury due to trauma, anoxia or hypoxia
Coma
Creutzfeldt-Jakob disease
Dementia
Encephalitis
Motor neurone disease
Multiple sclerosis
Paralysis of a limb
Parkinson's disease
Stroke or spinal cord stroke
Heart & the circulatory system
Aorta graft surgery
Cardiac arrest
Coronary artery bypass grafts
Heart attack
Heart valve replacement or repair
Primary cardiomyopathy
Pulmonary arterial hypertension
Pulmonary artery surgery
Structural heart surgery
Organs
Kidney failure
Liver failure
Major organ transplant
Respiratory failure
Third degree burns
Auto-immune disorders
Aplastic anaemia – with bone marrow failure
Systemic lupus erythematosus
Senses
Blindness
Deafness
Loss of hand or foot

For the critical illness definitions noted above, please see the relevant previous sections. In addition to the above noted definitions, less advanced cancer of the breast and less advanced cancer of the prostate are included.

Full details of the below automatically included benefits can be found on page 6.

Your child spends more than a week in hospital

This is called children's hospital benefit.

We'll pay this benefit if your child spends more than seven consecutive nights in hospital. From the eighth night onwards we'll pay £100 a night. We'll pay that for up to 30 nights for each child over the policy term.

For this benefit, we cover children from 30 days old to their 18th birthday or 21 if in full time education.

Your child dies

This is called children's death benefit.

We'll pay £5,000.

We'll pay this if a **child** dies during the **policy term**.

Children are covered between the age of 30 days until their 18th birthday (or 21st if in full time education). They must be between these ages at the time they die.

Upgraded Children's benefit

The below conditions are at extra cost. Upgraded children's benefit can be added at additional cost. It covers children under the policy from birth up to their 22nd birthday. This includes the automatically included conditions on the previous page which will pay out £25,000 unless stated otherwise below. The definitions below are included if this option is added.

Upgraded children's critical illnesses

Benign spinal cord tumour – resulting in permanent symptoms or undergoing defined treatments	Down's syndrome
	Hydrocephalus – treated with the insertion of a shunt
Brain abscess – undergoing defined treatments	Intensive care – requiring mechanical ventilation for 7 consecutive days
Cerebral palsy	
Crohn's disease – treated with two intestinal resections or total colectomy	Third degree burns – covering at least 5% of the body's surface area or 10% of the face or head
Cystic fibrosis	Ulcerative colitis – with total colectomy
Diabetes mellitus type 1	

We'll pay £25,000. After a successful claim we'll no longer cover that child for upgraded children's critical illness. You could still claim for that child for upgraded children's hospital benefit, advanced illness, child extra care cover and upgraded children's death benefit.

Child extra care cover conditions

Blindness – permanent and irreversible	Major organ transplant – from another donor
Cancer – excluding less advanced cases	Motor neurone disease – resulting in permanent symptoms
Kidney failure – requiring permanent dialysis	Muscular dystrophy
Liver failure	Paralysis of two limbs – total and irreversible
Loss of independence	Spina bifida myelomeningocele
Loss of two limbs – permanent physical severance	Third degree burns – of specified severity

We'll pay £50,000, unless you've already made a claim for upgraded children's critical illness cover. Instead we'll only pay £25,000.

After a successful claim, we'll no longer cover that child for child extra care cover, upgraded children's critical illness or advanced illness. You could still claim for that child for upgraded children's hospital benefit and upgraded children's death benefit. More information can be found on page 8.

Your child dies

If you've upgraded, this cover for your children will start from 24 weeks of pregnancy, instead of from when your child is 30 days old. We'll pay £5,000.

Your child spends more than a week in hospital

We'll pay this benefit if your child spends more than seven consecutive nights in hospital. From the eighth night onwards we'll pay £100 a night. We'll pay £100 a night. We'll pay that for up to 30 nights for each child over the policy term. It covers any **child** under the policy from birth up to their 22nd birthday. We won't pay if the stay in hospital is due to the **child** being born prematurely (before the 37th week of pregnancy).

Advanced illness

We'll pay this benefit if your child is diagnosed with an advanced or rapidly progressing illness with a life expectancy of no greater than 12 months and we haven't already paid under child extra care cover for that child.

Once we've accepted a claim for advanced illness we will pay £10,000. That child won't be covered for any other benefit under the policy except for upgraded children's hospital benefit and upgraded children's death benefit.

Upgraded children's critical illnesses

For these definitions, we'll pay out £25,000.

Benign spinal cord tumour – resulting in permanent symptoms or undergoing specified 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.

Brain abscess – undergoing defined treatments

A definite diagnosis of an intracerebral abscess within the brain tissue by a consultant neurologist, resulting in either of the following:

- surgical removal; or
- surgical drainage of the abscess.

Cerebral palsy

A definite diagnosis of cerebral palsy made by an **attending consultant**.

Crohn's disease – treated with two intestinal resections or total colectomy

A definite diagnosis by a consultant gastroenterologist of Crohn's disease, resulting in either:

- surgical intestinal resection to remove part of the small intestine or bowel on at least two separate occasions, or
- total colectomy (removal of entire large bowel).

Cystic fibrosis

A definite diagnosis of cystic fibrosis made by an **attending consultant**.

Diabetes mellitus type 1

A definite diagnosis of type 1 diabetes mellitus, requiring the permanent use of insulin injections.

The following are not covered:

- gestational diabetes
- type 2 diabetes (including type 2 diabetes treated with insulin).

Down's syndrome

A definite diagnosis of Down's syndrome by an attending paediatrician.

Hydrocephalus – treated with the insertion of a shunt

A definite diagnosis of hydrocephalus which is treated by the insertion of a shunt.

Intensive care – requiring mechanical ventilation for 7 consecutive days

Any sickness or injury resulting in a **child** requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more unless it is as a result of the **child** being born prematurely (before 37 weeks).

Third degree burns – covering at least 5% of the body's surface area or 10% of the face or head

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area or covering at least 10% of the surface area of the face or head.

Ulcerative colitis – with total colectomy

A definite diagnosis of ulcerative colitis by a consultant gastroenterologist, which is treated with total colectomy (removal of entire large bowel).

Child extra care cover conditions

For these definitions, we'll pay out £50,000, unless you've already made a claim for upgraded children's critical illness cover for that child. Instead we'll only pay out £25,000.

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, certified by an ophthalmologist.

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 and are confined to the skin (including cutaneous lymphomas and sarcomas)
- pseudomyxoma peritonei
- Merkel cell cancer.

The following are not covered:

- all cancers which are histologically classified as any of the following:
  - pre-malignant
  - non-invasive
  - cancer in situ
  - having borderline malignancy
  - having low malignant potential

- all tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate)
- gastrointestinal stromal tumours and neuroendocrine tumours without lymph node involvement or distant metastases unless they are WHO Grade 2 or above
- all urothelial tumours unless histologically classified as having progressed to at least TNM classification T1N0M0
- malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin)
- any non-melanoma cancer that arises from and 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.

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.

Liver failure

Chronic liver disease, being end stage liver failure due to cirrhosis and resulting in all of the following:

- permanent jaundice
- ascites
- encephalopathy.

Loss of independence

The total and permanent loss of the ability to perform routinely at least two 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.

Loss of two limbs – permanent physical severance

Permanent physical severance of any two limbs at or above the wrist or ankle joint.

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.

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)
- Kennedy's disease
- primary lateral sclerosis (PLS)
- progressive bulbar palsy (PBP)
- progressive muscular atrophy (PMA)
- spinal muscular atrophy (SMA).

There must also be permanent clinical impairment of motor function.

Muscular dystrophy

A definite diagnosis of muscular dystrophy made by a consultant neurologist.

Paralysis of two limbs – total and irreversible

Total and irreversible loss of muscle function to the whole of two limbs.

Spina bifida myelomeningocele

A definite diagnosis of spina bifida myelomeningocele or rachischisis by a consultant paediatrician.

The following are not covered:

- spina bifida occulta
- spina bifida with meningocele.

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% of the body's surface area or covering at least 20% of the surface area of the face or head.

Appendix 3:

Our products at a glance

Life Insurance+

	Life cover only			Life & critical illness cover		
Cover type options	Level cover	Decreasing cover (4-15%)	Family income cover	Level cover	Decreasing cover (4-15%)	Family income cover
Main Benefit	• Death benefit • Terminal illness			• Death benefit • Terminal illness • Critical illness benefit • Accelerated surgery benefit		
Benefits – Further				• Additional critical illness benefit • Children's benefit - Children's critical illness - Children's hospital benefit - Children's death benefit		
Benefits – Optional	• Conversion • Fracture cover • Global treatment • Increasing cover (RPI, 3%, 5%) • Renewal • Waiver of premium	• Fracture cover • Global treatment • Waiver of premium	• Fracture cover • Global treatment • Increasing cover (3%, 5%) • Waiver of premium	• Upgraded critical illness benefit • Upgraded children's benefit • Extra care cover • Fracture cover • Global treatment • Increasing cover (RPI, 3%, 5%) • Renewal • Total permanent disability • Waiver of premium	• Upgraded critical illness benefit • Upgraded children's benefit • Extra care cover • Fracture cover • Global treatment • Total permanent disability • Waiver of premium	• Upgraded critical illness benefit • Upgraded children's benefit • Extra care cover • Fracture cover • Global treatment • Increasing cover (3%, 5%) • Total permanent disability • Waiver of premium
Benefits – Additional	• Protection promise • Life change benefit • Separation benefit • House purchase cover	• Protection promise • Life change benefit • Separation benefit • House purchase cover	• Protection promise • Life change benefit • Separation benefit	• Protection promise • Life change benefit • Separation benefit • House purchase cover	• Protection promise • Life change benefit • Separation benefit • House purchase cover	• Protection promise • Life change benefit • Separation benefit
Premiums	Guaranteed			Guaranteed or reviewable		
Claim payment	Lump sum		Monthly instalments	Lump sum		Monthly instalments
Minimum age at entry	18			18		
Maximum age at entry	• Life cover only: 77 • Waiver of premium: 64 • Conversion: 64 • Renewal: 64 • Fracture cover: 59 • Global treatment: 74 • Increasing cover: 77			• Life and critical illness cover: 64 • Waiver of premium: 64 • Renewal: 59 • Fracture cover: 59 • Global treatment: 64 • Increasing cover: 64 • Total permanent disability: 64		
Maximum age at end	• Life cover only: 90 • Waiver of premium: 70* • Conversion: 70 • Renewal: 70 • Fracture cover: 70** • Global treatment: 84** • Increasing cover: 90			• Life and critical illness cover (guaranteed): 75 • Life and critical illness cover (reviewable): 90 • Waiver of premium: 70* • Renewal: 64 • Fracture cover: 70** • Global treatment: 84** • Increasing cover: 90 • Total permanent disability: 70*		

	Life cover only	Life & critical illness cover
Minimum term	• 1 year (life cover only, waiver of premium, fracture cover, global treatment) • 5 years (renewal, conversion, increasing cover)	• 1 year guaranteed • 6 years reviewable • 5 years renewal or increasing cover
Maximum term	50 years	50 years
Maximum amount of cover	• Life cover only: No maximum • Life & increasing cover: £5,000,000 at outset	• £3,000,000 when total permanent disability not selected • £2,000,000 when total permanent disability selected

* The benefit will end before the eldest life covered turns 71 but the policy may continue.

** The benefit will end independently for each life covered at this age, but the policy may continue.

Critical Illness+

	Critical illness cover		
Cover type options	Level cover	Decreasing cover (4-15%)	Family income cover
Main Benefit	• Critical illness benefit • Accelerated surgery benefit		
Benefits – Further	• Additional critical illness benefit • Children's benefit - Children's critical illness - Children's hospital benefit - Children's death benefit		
Benefits – Optional	• Upgraded critical illness benefit • Upgraded children's benefit • Extra care cover • Fracture cover • Global treatment • Increasing cover (RPI, 3%, 5%) • Renewal • Total permanent disability • Waiver of premium	• Upgraded critical illness benefit • Upgraded children's benefit • Extra care cover • Fracture cover • Global treatment • Total permanent disability • Waiver of premium	• Upgraded critical illness benefit • Upgraded children's benefit • Extra care cover • Fracture cover • Global treatment • Increasing cover (3%, 5%) • Total permanent disability • Waiver of premium
Benefits – Additional	• Life change benefit • Separation benefit		
Premiums	Guaranteed or reviewable		
Claim payment	Lump sum		Monthly instalments
Minimum age at entry	18		
Maximum age at entry	• Critical illness cover: 64 • Waiver of premium: 64 • Renewal: 59 • Fracture cover: 59 • Global treatment: 64 • Increasing cover: 64 • Total permanent disability: 64		

Critical Illness+

	Critical illness cover		
Cover type options	Level cover	Decreasing cover (4-15%)	Family income cover
Maximum age at end	• Critical illness cover (guaranteed): 75 • Critical illness cover (reviewable): 90 • Waiver of premium: 70* • Renewal: 64 • Fracture cover: 70** • Global treatment: 84** • Increasing cover: 90 • Total permanent disability: 70*		
Minimum term	• 5 years (guaranteed) • 6 years (reviewable)		
Maximum term	50 years		
Maximum amount of cover	• £3,000,000 when total permanent disability not selected • £2,000,000 when total permanent disability selected		

* The benefit will end before the eldest life covered turns 71 but the policy may continue.

** The benefit will end independently for each life covered at this age, but the policy may continue.

Whole of Life Insurance+

	Whole of life cover
Cover type	Level cover
Cover Basis	• Single • Joint - first and second death
Main Benefit	Death benefit
Benefits – Optional	• Increasing cover - RPI, 3% or 5% • Waiver of Premium*
Benefits – Additional	• Protection promise • Life change benefit • Separation benefit • Inheritance tax benefit
Premiums	Guaranteed
Claim payment	Lump sum
Maximum age at entry	• 79 • 64 including waiver
Minimum amount of cover	£30,000, and subject to £5 minimum premium
Maximum amount of cover	• £10 million per policy • £5 million at inception if Increasing cover is selected. (higher cover amounts will be considered on a case by case basis).

* The benefit will end on the policy when the life covered turns 71. On a joint life where both lives have waiver, the benefit will end on the policy when the eldest life turns 71.

Simple Life Insurance

	Simple Life Insurance	
Cover type options	Level cover	Decreasing cover (4-15%)
Main benefit	• Death benefit • Terminal illness	
Premiums	Guaranteed	
Claim payment	Lump sum	
Minimum age at entry	18	
Maximum age at entry	59	
Maximum age at end	70	
Minimum term	1 year	
Maximum term	40 years	
Maximum amount of cover	**	

**The maximum amount of cover available is based on how old your client is when they first apply. For joint policies, this will be based on the age of the oldest person. Here are details of what is available:

Age at the start of the policy	Maximum cover amount available
18-39	£750,000
40-49	£400,000
50-54	£300,000
55-59	£200,000

Income Protection+

	Income Protection+	
Cover type options	• Full cover to term	Limited payment term 24 months
Main Benefit	Monthly benefit in the event of being unable to work due to illness or injury	
Benefit – Optional	• Fracture cover • Global treatment • Increasing cover (RPI, 3% or 5%)	
Benefits – Additional	• Hospital benefit • Restricted benefit • Trauma benefit • Benefit guarantee • Back to work benefit • Waiver of premium • Life change benefit • Protection promise • Deferred period for NHS doctors, surgeons, nurses and midwives	
Premiums	Guaranteed or reviewable	
Claim payment	Monthly instalments	
Minimum age at entry	18	

	Income Protection+
Maximum age at entry	59
Maximum age at end	70 (subject to occupation)
Deferred periods	4,8,13,26,52 or 104 weeks (subject to occupation)
Minimum term	5 years subject to minimum ceasing age of 50
Maximum term	52 years
Maximum benefit	65% of the first £60,000 gross earnings and 45% of any gross earnings above £60,000 up to a maximum benefit of £240,000 a year (£20,000 a month)

Living Costs Protection

	Living Costs Protection
Cover type options	Limited payment term 12 months
Main Benefit	Monthly benefit in the event of being unable to work and suffer a loss of earnings due to illness and injury
Benefit – Optional	• Fracture cover • Global treatment
Benefits – Additional	• Back to work benefit • Waiver of premium • Life change benefit • Protection promise
Premiums	Guaranteed
Claim payment	Monthly instalments
Minimum age at entry	18
Maximum age at entry	59
Maximum age at end	70 (subject to occupation)
Deferred periods	4, 8, 13 & 26 weeks (subject to occupation)
Minimum term	5 years
Maximum term	52 years
Minimum benefit	£500 per month
Maximum benefit	£1,500 per month (policyholder can only have one Living Costs Protection policy plus any additional policies taken out under the life change benefit option. The maximum benefit across all Living Costs Protection policies must not exceed £1,500 per month).

Need this in a different format?

Please get in touch if you would prefer these policy conditions (**AL99016**) in large font, braille, or as audio.

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