Life Insurance+
Policy Conditions

Keep this document safe

These **policy conditions** are written confirmation of your contract with Aviva Life & Pensions UK Limited and should be read together with your **policy schedule** and policy summary.
You may need to refer to these documents in the future if you need to make a claim.

The words in **bold** are defined terms with specific meanings. We explain these in the definitions section.

Any questions?

Call us on:

0800 285 1098

If you're outside the UK, call:

+44 1603 603 479

For our opening hours, please refer to our website **aviva.co.uk**.
Calls may be monitored and will be recorded.

Need to make a claim?

Please read our 'Making a claim' section first, then call us on:

0800 015 1142

For our opening hours, please refer to our website **aviva.co.uk**.

Calls may be monitored and will be recorded.

Make a claim under global treatment

To make a claim, you can call us on 0345 030 8071 and select the option to start a global treatment claim.

Your call will be transferred to **Further**, who will evaluate and process your claim and provide you with any options for overseas treatment.

Further's claims line is open Monday to Friday 8.30am to 5pm. These times are correct at the time of publishing.

Calls to 0800 numbers from UK landlines and mobiles are free. The costs of calls to 03 and +44 1603 prefixed numbers are charged at national call rates (charges may vary dependent on your network provider) and are usually included in inclusive minute plans from landlines and mobiles. Calls from outside the UK may be charged at international rates.

Your cover

Your policy can have life cover or life and critical illness cover.

You can have either a **single policy** for one person or a **joint policy** for two people, usually you and your partner, spouse or civil partner.

Main benefits

Each type of cover offers different **main benefits**. We've shown these in the table below.
If you have a **joint policy**, each person can have a different type of **main benefit**.

Main benefits	Life cover	Life and critical illness cover
Death benefit	✓	✓
Terminal illness benefit	✓	✓
Critical illness benefit	✗	✓

With each type of cover, you can choose at the start to have the **main benefits** paid on a level, decreasing or family income basis.

	Level cover	Decreasing cover	Family income cover
How do we pay the **cover amount** if you make a successful claim?	Cash lump sum	Cash lump sum	Monthly instalments
Does the **cover amount** change over the **policy term**?	Stays the same	Decreases each month using a fixed interest rate.	The monthly instalment stays the same throughout the **policy term**. We pay it from the date we accept a claim until the policy **end date**.

If you have level or family income cover and choose the increasing cover option, your **cover amount** may go up.

The **policy conditions** we send you when you take out the policy will only contain the **main benefits** you've chosen. We'll show these in your **policy schedule**, together with how you've chosen to receive your **main benefits** if we accept your claim.

Optional benefits

You can choose to add optional benefits to your policy when you take it out. Your **policy schedule** will show exactly which optional benefits you've chosen. Your **policy conditions** will include details of all the optional benefits available, including any that you haven't chosen (except fracture cover and/or global treatment, which won't be included if you haven't chosen them).

Additional benefits

You may be eligible for additional benefits. If you are, they'll automatically be added to your policy, at no extra cost.
Your **policy schedule** will show which additional benefits you're eligible for. All additional benefits are outlined in your **policy conditions**.

Contents

Main benefits - Life cover

With life cover, we'll only pay the **main benefit** once, even for **joint policies**. This means the policy – whether **single** or **joint** – will end when we accept a claim for one of the following **main benefits**:

Death benefit

Our criteria

We'll pay this if the **life covered** dies during the **policy term**.

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

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Terminal illness benefit

Our criteria

We'll pay this if the **life covered** is diagnosed with a terminal illness that meets our definition (set out below), during the **policy term**.

Terminal illness – where death is expected within 12 months

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

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

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Main benefits - Life and critical illness cover

With life and critical illness cover, we'll only pay the **main benefit** once, even for joint policies. This means the policy – whether **single** or **joint** – will end when we accept a claim for one of the following **main benefits**. The exception to this is the critical illness benefit where you've chosen extra care cover, as described below.

Death benefit

Our criteria

We'll pay this if the **life covered** dies during the **policy term**.

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

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Terminal illness benefit

Our criteria

We'll pay this out if the **life covered** is diagnosed with a terminal illness that meets our definition (set out below), during the **policy term**.

Terminal illness – where death is expected within 12 months

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

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

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**

Critical illness benefit

Our criteria

We'll pay this if the **life covered** meets the definition for one of our critical illness conditions during the **policy term** and survives for at least 10 days.

See the full list of critical illnesses and our definitions for them, which begin from page 31.

Once we've accepted a claim the policy will end, unless you've chosen extra care cover and the **life covered** claiming under this critical illness benefit is eligible to claim under extra care cover benefit. See page 9 for further details of how extra care cover works.

What do we pay?

We'll pay the **cover amount shown** in the **policy schedule**.

Additional life and critical illness benefits - Life and critical illness cover

Two additional benefits are automatically included for life and critical illness cover: additional critical illness benefit and **children's benefit**. To be able to claim for these additional benefits, you must not have made, nor be eligible to make, a claim for any of the **main benefits**.

If we accept a claim for any of the additional benefits, your policy will continue. That means you can still make a claim for any of the **main benefits** later on to receive the **cover amount**. Also, it won't affect the amount of any payment we make in the future.

Additional critical illness benefit

Our criteria

We'll pay this if the **life covered** meets the definition for one of our additional critical illnesses (set out below) during the **policy term** and survives for at least 10 days.

Additional critical illnesses:

- Less advanced cancer of the breast, and
- Less advanced cancer of the prostate.

See our full definitions for each of the additional critical illnesses which starts on page 31.

Each **life covered** will be able to make one claim for each additional critical illness. After which, that **life covered** won't be able to make another claim for that condition. However, we will still cover them for the other additional critical illness.

It won't affect any of the other benefits chosen under the policy for each **life covered**.

What do we pay?

We'll pay the lower of:

- £25,000, or
- 25% of the **cover amount** shown in the **policy schedule**. For family income cover, we'll multiply this figure by the number of months left on your policy and pay this as a lump sum.

If a claim meets our criteria for critical illness benefit and additional critical illness benefit at the same time, we'll only pay the **cover amount**.

Children's benefit

Our criteria

This includes children's critical illness benefit, hospital benefit and children's death benefit, as described below.

It covers any **child** under the policy.

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

- meet the definition for one of our children's critical illness conditions, or
- stay in hospital, or
- die.

We'll accept a claim for each of the below benefits for each **child**. The cover will then continue for any other **child**.

Children's critical illness benefit

Our criteria

We'll pay this if a **child** meets the definition for one of our children's critical illnesses during the **policy term**, and survives for at least 10 days.

Details of our automatically included children's critical illnesses are in Appendix 1H which starts on page 45.

The illness or condition 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 you.

What do we pay?

We'll pay the lower of:

- £25,000, or
- 50% of the **cover amount** shown in the **policy schedule**. For family income cover, we'll multiply this figure by the number of months left on your policy, and pay this as a lump sum.

Children's hospital benefit

Our criteria

We'll pay this if the **child** is in hospital for more than seven consecutive nights. We pay it from the eighth night's stay, (not the first seven nights).

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

What do we pay?

We'll pay £100 a night for a maximum of 30 nights for each child.

The nights spent in hospital could be over one period, or a number of periods over the **policy term**.

If the **child** is admitted to hospital multiple times for the same or a related reason, they won't have to stay another seven nights before you can claim again.

Children's death benefit

Our criteria

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.

What do we pay?

We'll pay £5,000.

Optional benefits

Your **policy schedule** will show any optional benefits you've chosen to add to your policy.

Upgraded critical illness benefit

When you take out your life and critical illness cover, you can choose to upgrade it to add **upgraded critical illness** benefit. This means you'll receive upgraded critical illness conditions and upgraded additional critical illness benefit.

Upgraded critical illness conditions

We'll cover you for the upgraded critical illness conditions on top of the critical illnesses covered under your **main benefits**.

Our criteria

We'll pay this if the **life covered** meets the definition for one of our upgraded critical illness conditions during the **policy term**, and survives for at least 10 days.

Please refer to the full list of upgraded critical illnesses and their definitions, which begin from page 31.

Once we've accepted a claim the policy will end, unless you've chosen extra care cover and the **life covered** claiming under this upgraded critical illness benefit is eligible to claim under extra care cover benefit. See page 9 for further details of extra care cover.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Upgraded additional critical illness benefit

We'll replace your additional critical illness benefit with upgraded additional critical illness benefit.

Our criteria

We'll pay this if the **life covered** meets the definition for one of our upgraded additional critical illnesses during the **policy term**, and survives for at least 10 days.

Please refer to our Appendices which start on page 31.

Each **life covered** will be able to make one claim for each upgraded additional critical illness. After which, that **life covered** won't be able to make another claim for that condition. However, we will still cover them for the other upgraded additional critical illnesses.

It won't affect any of the other benefits chosen under the policy for each **life covered**.

What do we pay?

We'll pay the lower of:

- £30,000, or
- 100% of the **cover amount** shown in the **policy schedule**. For family income cover, we'll multiply this figure by the number of months left on your policy, and pay it as a lump sum.

If a claim meets our criteria for critical illness benefit and/or upgraded critical illness conditions, and at the same time meets our criteria for upgraded additional critical illness benefit, we'll only pay the **cover amount**.

Hospital benefit

Our criteria

We'll pay this if the **life covered** is in hospital for more than seven consecutive nights. We pay it from the eighth night's stay (not the first seven nights).

This benefit will apply for each **life covered** under the policy.

What do we pay?

We'll pay £100 a night for a maximum of 30 nights.

The nights spent in hospital could be over one period, or a number of periods over the **policy term**.

If the **life covered** is admitted to hospital multiple times for the same or a related reason, they won't have to stay another seven nights before you can claim again.

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

Upgraded children's benefit

When you take out your life and critical illness cover, you can choose to upgrade it to include **upgraded children's benefit**. This means you'll replace **children's benefit**.

Upgraded children's benefit

This includes upgraded children's critical illness benefit, child extra care cover, advanced illness, upgraded children's hospital benefit and upgraded children's death benefit, as described in more detail separately below.

It covers any **child** under the policy from birth up to their 22nd birthday at the time of their:

- diagnosis with one of our upgraded children's critical illnesses, child extra care cover conditions, or an advanced illness, or
- stay in hospital, or
- death.

We won't pay upgraded children's critical illness benefit, child extra care cover or advanced illness if the illness or condition was due to intentional injury caused by you.

Also, we won't pay if, before the policy **start date** or before the legal adoption of the **child**:

- the symptoms had already started, and/or
- either of the parents received counselling or medical advice in relation to the condition or were aware of the increased risk of the condition.

Upgraded children's critical illness benefit

We'll replace your children's critical illness benefit with upgraded children's critical illness benefit.

Our criteria

We'll pay this if a **child** meets the definition for one of our upgraded children's critical illnesses during the **policy term**, and survives for at least 10 days.

Details of our automatically included children's critical illnesses are in Appendix 1H which starts on page 45.

We'll accept one claim for each **child**, but the cover will continue for any other **child**.

What do we pay?

We'll pay £25,000.

Child extra care cover

Our criteria

We'll pay this if a **child** meets the definition for one of our child extra care cover conditions during the **policy term**, and survives for at least 10 days. The exception to this is loss of independence claims, where the **child** must survive at least 90 days.

Please refer to Appendix 1H which starts on page 45.

We'll only accept one claim for each **child**, but the cover will continue for any other **child**.

Once we've accepted a claim for child extra care cover, that **child** will not be covered for any other benefit under the policy except for upgraded children's hospital benefit and upgraded children's death benefit.

What do we pay?

We'll pay

- £50,000, or
- £25,000 if you've already made a claim for upgraded children's critical illness benefit.

Advanced illness

Our criteria

We'll pay this if a **child** meets our definition of advanced illness (set out below) during the **policy term** and survives for at least 10 days.

Advanced illness:

Confirmation by the **attending consultant of** 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 for each **child**, but the cover will continue for any other **child**.

Once we've accepted a claim for advanced illness, that **child** will not be covered for any other benefit under the policy except for upgraded children's hospital benefit and upgraded children's death benefit.

What do we pay?

We'll pay £10,000.

Upgraded children's hospital benefit

Our criteria

We'll pay this if the **child** is in hospital for more than seven consecutive nights. We pay it from the eighth night's stay (not the first seven nights).

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** under the policy.

What do we pay?

We'll pay £100 a night for a maximum of 30 nights for each **child**.

The nights spent in hospital could be over one period or a number of periods over the **policy term**.

If the **child** is admitted to hospital multiple times for the same or a related reason, they won't have to stay another seven nights before you can claim again.

Upgraded children's death benefit

Our criteria

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

It includes stillbirth where the **child** dies on or after the 24th week of pregnancy.

We'll pay it on top of any benefit we've already paid under **upgraded children's benefit**.

After a claim, the cover will continue for any other **child**.

What do we pay?

We'll pay £5,000.

Extra care cover

This benefit will pay out in one of three different circumstances as set out below.

Extra care cover #1

Our criteria

We'll accept a claim if, during the **policy term**, the **life covered** is totally and permanently unable to routinely perform at least three of the activities of daily living without the continual assistance of someone else, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

The activities of daily living we assess against are listed below.

Activities of daily living:

1. **Washing** – being able to wash and bathe unaided, including getting into and out of the bath or shower.
2. **Dressing** – being able to put on, take off, secure and unfasten all necessary items of clothing.
3. **Feeding** – being able to eat pre-prepared foods unaided.
4. **Continence** – being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances.
5. **Moving** – being able to move from one room to another on level surfaces.
6. **Transferring** – being able to get on and off the toilet, in and out of bed and move from a bed to an upright chair or wheelchair and back again.

Once we've accepted a claim, the policy will end.

We won't pay this if during the **policy term** you've made, or are eligible to make, a claim for:

- a **main benefit**,
- an upgraded critical illness condition, or
- the total permanent disability benefit.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule** and at the same time we'll pay £50,000.

If you've chosen family income cover, we'll pay the £50,000 as a lump sum.

Extra care cover #2

Our criteria

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**).

Once we've accepted a claim, the policy will end.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule** and at the same time we'll pay £50,000.

If you've chosen family income cover, we'll pay £50,000 as a lump sum.

Extra care cover #3

Our criteria

We'll accept a claim, if before the first anniversary of meeting our criteria for critical illness, upgraded critical illness conditions, total permanent disability, (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.

Extra care cover #3 must be claimed within 18 months of meeting our criteria for the "trigger claim".

Once we've accepted a claim, the policy will end.

What do we pay?

We'll pay £50,000 in addition to the **cover amount** already paid.

If you've chosen family income cover, we'll pay £50,000 as a lump sum.

Total permanent disability

We may ask you more underwriting questions before accepting your application to include this benefit on your policy.

Total permanent disability

Our criteria

We'll pay this benefit if the **life covered** meets our definition of total permanent disability during the **policy term**. We'll pay the **cover amount** shown in the **policy schedule**.

We have two definitions of total permanent disability (set out below):

- Own occupation, and
- Activities of daily work.

Your **policy schedule** will confirm which one applies to your policy.

Once we've accepted a claim the policy will end, unless you have chosen extra care cover and the **life covered** claiming under this total permanent disability benefit is eligible to claim under extra care cover benefit.

Own occupation definition – unable before age 71 to do your own occupation ever again.

- "Own occupation" means your trade, profession or type of work you do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability.
- We'll pay if the **life covered** loses physical or mental ability, through an illness or injury before age 71, to carry out the material and substantial duties of their own occupation ever again.
- "Material and substantial duties" are those normally required for, and/or forming a significant and integral part of performing the **life covered's** own occupation. They can't reasonably be left out or changed.
- Specialists must reasonably expect the disability will last for life with no prospect of improvement, irrespective of when the cover ends or the **life covered** expects to retire.
- The policy doesn't cover disabilities for which specialists can't give a clear prognosis.
- Your **policy schedule** will confirm the definition applying to your policy is own occupation. However, if the **life covered** was not working (for profit or pay) immediately before the onset of the total permanent disability, we'll use the activities of daily work definition instead.

Activities of daily work definition – unable before age 71 to do three specified work tasks ever again.

- We'll pay this if the **life covered** loses the physical ability, through an illness or injury before age 71, to do at least three of the six work tasks listed ever again.
- The specialists must reasonably expect the disability will last for 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. They must be unable to perform the task on their own, even if using special equipment routinely available to help and having taken any appropriate prescribed medication.
- The policy doesn't cover disabilities for which specialists can't give a clear prognosis.

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.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Fracture cover

Fracture cover

Fracture cover is subject to our acceptance following underwriting.

You (the **life covered**) can only add fracture cover to your policy if you don't already have it on any other policy taken out with Aviva Life & Pensions UK Limited.

We'll cover the **life covered** for the fractures listed opposite. We'll only pay out if the fracture happens at least seven days after the **start date** and before the policy **end date**.

We only pay out a successful claim once in each policy year for the first fracture which occurs in that year. A policy year runs from the **start date** to the day before the **anniversary date** shown in your **policy schedule**.

If the **life covered** suffers from more than one fracture at the same time we'll only pay for one of them. You can choose which one you claim for.

All fractures must be diagnosed by an **attending consultant**.

We won't cover a fracture which is classed 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; or 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.

If you make a claim for this benefit, all medical certificates and results of medical examinations must be provided by an **attending consultant**.

You can cancel the fracture cover option at any time six months after the **start date**. However, you won't be able to reinstate it and we won't refund any premiums.

If we accept a claim under this benefit, it won't affect the other benefits under your policy.

What do we pay?

If the **life covered** suffers from any one of the following bone fractures, we'll pay:

Fracture	Amount
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 (we define the wrist as including the carpal bones, the distal radius or distal ulna)	£2,000
Upper leg	£6,000
Lower leg	£4,000
Ankle (we define the ankle as including the medial, posterior or lateral malleous)	£2,500
Knee	£6,000
Hand (excluding fingers and thumbs)	£1,500
Foot (excluding toes)	£2,000

Global treatment

Global treatment has extra definitions, which we use in this section. These definitions are in **bold** and have specific meanings. We explain these in the definitions for global treatment section.

You can only add the global treatment option to your policy if you don't already have the option on any other policy with an Aviva group company.

This option is provided together with **Further** who will process your claim and provide all services related to overseas treatment.

Global treatment

We'll pay the cost of treatment outside of the **territory** if, during the **policy term**, you or your **child** are diagnosed with any one of the **serious illnesses**, or require a **medical procedure** set out below.

Further will recommend appropriate doctors and treatment centres and manage all necessary medical and administrative arrangements for treatment overseas.

It includes **expenses** that are incurred in relation to the treatment from the date the **preliminary medical certificate** is issued. We cover the medical, **medication**, travel, accommodation and miscellaneous **expenses** set out in the expenses section below.

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

If you're no longer **resident** in the **territory**, we'll cancel this option and your policy will continue without global treatment for you or your **child**. If a **child** is no longer **resident** in the **territory**, they will need to return to the **territory** for confirmation of the initial diagnosis for you to make a claim for them under this option.

What do we pay?

We'll pay a maximum of £1,000,000 (including all **expenses**) in any 12-month period from the date the **preliminary medical certificate** is issued. This limit applies for each **life covered** (and/or any **child**), up to an overall maximum of £2,000,000 over the **policy term**.

Once the maximum limit has been reached, this benefit under the policy will end.

Start and end of cover

Global treatment covers you and your **child** for three years from the **start date**. At the end of this three year period, we'll renew the cover automatically, unless before that next **renewal date**:

(a) the **policy term** ends, in which case it will end on the **end date** of the policy,
or

(b) you turn 85, in which case it will end on your 85th birthday,
or

(c) you have reached the maximum benefit of £2,000,000 available under this option,
or

(d) you can't renew your policy because:

- you are **resident** outside of the **territory**, 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 can no longer offer global treatment.

Renewal of cover

We'll contact you at least 30 days before the **renewal date** and tell you one of the following:

(a) The key features of global treatment won't change. If this happens, we'll automatically renew the option from the next **renewal date**. We'll automatically renew global treatment even if we change the amount you pay for it.

(b) The key features of global treatment will change. If this happens, we'll offer you the opportunity to renew from the **renewal date.** We'll ask you to confirm we can automatically renew the option at further **renewal dates**.

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

If you don't want to renew global treatment, you must tell us before the **renewal date**, so we don't renew the option and charge you for it. You can cancel the option at any time six months after the **start date**. However, you won't be able to reinstate it later and we won't refund your premiums.

Any new premium and changes will come into effect from renewal.

Indemnity period

You could still make a claim after the policy has ended in the following circumstances:

(a) If the policy ends as a result of a successful claim, you can claim under the global treatment option after the policy has ended (for a maximum of 36 months from the date the policy ended). To do this, the **serious illness** or **medical procedure** you're claiming for under this global treatment option must be directly related to the earlier claim under your policy.

(b) If you or your **child** have a **serious illness** or require a **medical procedure** and you have started a global treatment claim for overseas treatment, but the policy subsequently ends as a result of a successful claim, the claim under global treatment 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, so you won't have to pay any premiums.

Provided treatment starts within 36 months of the policy ending, we'll cover the cost of any treatment you receive outside of the **territory** and the travel and accommodation **expenses** associated with that, until you or your **child** return to the UK. We'll cover the cost of any medication **expenses** that are incurred in the **territory** after the return of your **child** to the **territory**, provided they are incurred during the indemnity period.

Serious illnesses and medical procedures

Bone marrow transplant

Bone marrow transplantation (BMT) or peripheral blood stem cell transplantation (PBSCT) of bone marrow cells to you or your **child** originating from:

- you or your **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.

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 you or your **child** receive a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.

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.

What don't we pay for?

We won't pay for:

- any initial diagnosis from a hospital or **consultant** outside of the **territory**
- any treatment that is not **medically necessary**
- any **experimental treatment**
- any **medical procedures** in connection with or derived from **cosmetic surgery**.

The following limits apply to these specific serious illnesses and **medical procedures**:

Coronary artery bypass surgery

- We won't provide cover for any correction of narrowing or blockage of coronary arteries treated using techniques other than bypass surgery e.g. angioplasty surgery.

Live-donor organ transplant

We won't cover any of the following:

- organs listed under the live-donor organ transplant definition that involves stem cell treatment
- any organ transplant when the transplant is conducted as a self-transplant
- any transplant when you or your **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.

Treatment for your child

To make a successful claim for your **child**:

- the symptoms must not have started, and/or
- the illness or condition must not have been diagnosed, 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**.

Medical expenses

What we cover

Hospital charges

Relating to:

- accommodation, meals and general nursing services provided during your, or your **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

- 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

- **Consultant expenses** relating to examination, treatment, medical care or **surgery**.

Stay in hospital

- **Expenses** relating to **consultant** visits during your, or your **child's** stay in hospital.

Medication

- For **medication** from a medical prescription while you or your **child** are staying in hospital for treatment of a covered illness or **medical procedure**. We cover **medication** prescribed for post-operative treatment for 30 days from the date you or your **child** have completed the treatment received outside of the **territory**.

  However, we only cover these when you buy them before returning to the **territory**. Please see below for separate benefits for **medication expenses** incurred in the **territory**.

Hospital transfers

For transfers and transportation by ground or air ambulance for you or your **child** where their use is indicated and prescribed by a **consultant** and pre-approved by **Further**.

Medical treatments

Expenses relating to the following medical and surgical services including **reconstructive surgery**, treatments or prescriptions:

- administration of plasma and serum
- anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist
- angiograms
- blood transfusions
- chemotherapy
- computerised tomography (CT scan)
- echocardiography (ECHO)
- electrocardiograms (ECG)
- electroencephalograms (EEG)
- **expenses** relating to the use of oxygen, application of intravenous solutions and injections
- laboratory analysis and pathology
- myelograms
- radioactive isotopes
- radiotherapy
- x-rays for diagnostic purposes
- 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.

Living donor

For services provided to a living donor during removal of an organ or tissue to be transplanted to you or your **child**. This includes:

- the investigation procedure for locating 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 you or your **child**.

Bone marrow transplant

For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to you or your **child**.

What we don'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 buying or hiring 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
  - 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 for confinement services, home health care or services provided in a convalescence centre or institution, hospice or nursing home. This is the case, 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 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.

Any charges made for any treatment, service, supply or medical prescription for a disease for which the best treatment is a transplant, is covered by global treatment.

Medication expenses

What we cover

If treatment of any of the **serious illnesses** or **medical procedures**, which are paid for under this option, resulted in a hospital stay for three nights or more, we'll pay the cost of **medication** purchased in the **territory**. The maximum limit for this is £50,000 over the **policy term**.

We'll only cover the **medication expenses** if:

- the **medication** is recommended as necessary for ongoing treatment through **Further** by the international **consultant** who treated you or your **child**
- 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** is available for purchase in the **territory**
- the **medication** requires prescription by a **consultant** in the **territory** and
- no single prescription exceeds a dose for consumption longer than two months.

What we don't pay for

The cost of **medication** funded by the NHS or that is covered by any other insurance policy you hold.

Any costs associated with administering the **medication**.

Any **medication expenses** you build up which you don't send us within 180 days of the purchase.

Any **medication** that is not **medically necessary**.

Travel, accommodation and miscellaneous expenses

What we cover

Travel and accommodation

We'll pay for **expenses** for economy class travel, to and from the agreed hospital indicated in the **preliminary medical certificate**. We'll also arrange and pay for any necessary accommodation for:

- you and a **travelling companion**, or
- you, your **child**, and another **travelling companion** (if your **child** is receiving the treatment under the global treatment option), and/or
- a living donor (if applicable).

We'll also pay £100 for each day you or your **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 you, your **child** or a living donor dies whilst receiving treatment approved by the **preliminary medical certificate**, we'll pay the costs of transporting the body. We'll also pay the minimum costs necessary for administrative formalities, embalmment and the coffin in which the body is transported back to the **territory**.

What we don't pay for

Any travel arrangements not associated with travel from and to a permanent address in the **territory**.

Any **expenses** for accommodation or transportation arranged by you, a **travelling companion** or a living donor.

Any interpreter's fees, telephone and other charges for items for personal use, items not of a medical nature, or for any other service provided to relatives or **travelling companion**s.

Any breakfast, meals and incidental costs incurred at the hotel. If you pay for an upgrade to your hotel accommodation, you'll bear the full cost of the upgrade.

You, your **child** or **travelling companion** to obtain a passport to enable travel outside of the **territory**.

Making a claim under the global treatment option

You can make a claim at any time during the **policy term**, or within the indemnity period described above. You can make a claim even if you've made any other claims under your policy.

To make a claim, you can call us on 0345 030 8071 and select the option to start a global treatment claim.

Your call will be transferred to **Further**, who will evaluate and process your claim and provide you with any options for overseas treatment.

Further's claims line is open Monday to Friday 8.30am to 5pm.

Increasing cover

This benefit allows you to automatically increase your **cover amount** each year without any more health and lifestyle questions being asked.

Increasing cover

If you have life and critical illness cover, this will also increase the benefits payable for:

- additional critical illness
- **children's benefit** (except children's hospital benefit).

And, if selected, it will also increase the benefits payable for:

- **upgraded critical illness benefit** (except hospital benefit)
- **upgraded children's benefit** (except upgraded children's hospital benefit)
- total permanent disability, and
- extra care cover.

Wherever we refer to **cover amount** in this section, it also includes the amount you may be entitled to under any of the above optional benefits.

We won't increase your **cover amount** if it exceeds the maximum we allow at that time.

The way increasing cover applies depends on whether you have level or family income cover:

Level cover

With level cover, you can choose how your **cover amount** will increase from three increasing cover options:

a) Increase your **cover amount** based on the Retail Prices Index

Your **cover amount** will increase based on the percentage increase in the **Retail Prices Index (RPI)** over the 12-month period ending 12 weeks before the start of the month of your policy's **anniversary date**.

If you choose this option:

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

Or

b) Increase your **cover amount** by 3% on each **anniversary date** of your policy.

Or

c) Increase your **cover amount** by 5% on each **anniversary date** of your policy.

If your **cover amount** increases, your premiums will also increase each year. We'll calculate the increase in premium by multiplying the percentage increase in the **cover amount** by 1.5. We'll then multiply that amount by the current premium to work out what the increase in your premium will be.

When will I be told about any increase?

We'll write to you at least eight weeks before the **anniversary date** to tell you how much your **cover amount** and premiums will increase by.

The increase will take effect from the **anniversary date**.

You can choose not to increase your **cover amount** if you don't want to pay the higher premium. If you do this, your **cover amount** and your premiums will stay the same. You must tell us as soon as possible before the **anniversary date** if you want us to cancel the increase. We'll reinstate the increasing cover option the following year.

If you decide against the increase three times in a row, we'll remove increasing cover from your policy. You can't add it again in the future.

Family income cover

With family **income cover**, you can choose from two options how your **cover amount** will increase:

a) Increase your **cover amount** by 3% on each **anniversary date** of your policy.

Or

b) Increase your **cover amount** by 5% on each **anniversary date** of your policy.

Your **cover amount** will continue to increase until the end of the policy, even if we've accepted a claim.

Your premiums won't increase.

Renewal option

This option is only available if you have level cover and we accept your policy on **standard terms**.

It's not available if you have reviewable premiums or if you've taken out the increasing cover option.

Renewal option

This benefit allows you to renew your cover on your policy **end date** without us asking any more health and lifestyle questions.

You can use this option if you haven't already made, or you're not eligible to make, a claim for the **main benefit**.

For life and critical illness cover, you can't use the renewal option if you've made, or you're eligible to make a claim for an upgraded critical illness condition, total permanent disability or extra care cover.

The new policy

The new policy must:

(a) start immediately after your original policy ends

(b) have a **policy term** no longer than your original policy

(c) have a cover amount less than, or equal to, the **cover amount** on your original policy.

The new policy can include any of the benefits and options that were on your original policy, as long as they are available at the time and you meet any eligibility criteria. You can only have the waiver of premium option if the **deferred period** on your new policy is not shorter than on your original policy.

If you've already claimed for an additional critical illness, upgraded additional critical illness, **children's benefit** or **upgraded children's benefit** under your original policy, you won't be able to claim for that same condition on your new policy.

Your new policy will be based on the policy conditions in force at the time of the request. We'll base the premium you pay on the personal circumstances of the **life covered** and the rates available at the time.

If your original policy:

- has life and critical illness cover › you can have the same cover on the new policy, or you can choose life cover only
- has life cover › the new policy must also be life cover only
- 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.

You can't change the **lives covered** on the new policy.

Waiver of premium

We may ask you more health and lifestyle questions before accepting your application to add this benefit to your policy.

This option is only available until the **life covered**, or the eldest **life covered** for a **joint policy**, turns 71.

Waiver of premium option

We'll pay your premiums if the **life covered**:

- is unable to perform the duties of their own occupation (as set out below) because of their illness or injury, or
- meets the below activities of daily work criteria.

We'll consider the **life covered's** ability to perform their own occupation, unless they stopped performing any occupation (for profit or pay) more than 12 months before the start of the illness or injury. In these circumstances, we'll apply the activities of daily work definition.

Own occupation

We'll pay your premiums if the **life covered** is unable to perform the material and substantial duties of their own occupation.

"Material and substantial duties" are those normally required for, and/or forming a significant and integral part of performing the **life covered's** own occupation. These duties can't reasonably be left out or changed.

Activities of daily work:

We'll pay this if the **life covered** is unable to perform at least two of the work tasks listed below.

The **life covered** must need the help or supervision of another person. They must be unable to perform the task on their own, even if using 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.

What happens when we accept a claim for waiver of premium?

After we've accepted a claim, there is a **deferred period** before we start paying your premiums. So you'll need to carry on paying your premiums until the end of the **deferred period**.

When the **deferred period** ends, we'll pay your premiums until the earliest of:

- the policy **end date**
- the date the **life covered** is able to perform the duties of their own occupation or they no longer meet the activities of daily work criteria as described above
- the date the **life covered** starts any type of work (for profit or pay)
- the date we accept a claim for the **main benefit**, **upgraded critical illness benefit**, total permanent disability benefit and extra care cover benefit (if selected)
- the **life covered** turns 71. For joint policies this will be when the eldest **life covered** turns 71.

If we stop paying your premiums and your policy has not ended, you will need to restart paying them to keep your policy in force.

For us to continue paying your premiums, we'll need evidence that the **life covered** is still unable to perform their own occupation or meet the activities of daily work criteria.

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.

Optional benefits - Life cover

Your **policy schedule** will show any optional benefits you've chosen to add to your policy.

Conversion option

This option is only available if you have level cover and your policy is accepted on **standard terms**.

This option is not available if you have life and critical illness cover or if you've taken out the increasing cover option.

Conversion option

This benefit lets you convert your policy to a new whole of life policy without answering any more medical questions. Your original policy will be cancelled.

You can use this option at any time before the policy **end date** if you haven't already made, or are not eligible to make, a claim for the **main benefit**.

The new policy

The new policy must:

(a) start immediately after your original policy ends, and

(b) have a cover amount less than, or equal to, the **cover amount** on your original policy.

The premium you'll pay 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.

If your 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**.

Additional benefits

House purchase cover

This benefit is not available if you have family income cover.

House purchase cover

We'll give you free cover when you are purchasing a property. This benefit will provide cover only where the **life covered** dies.

Your free cover starts when we've accepted your application for the policy and after you've exchanged contracts (in Scotland, when missives are completed). You must give us a future **start date** for your policy which coincides with the completion of your house purchase (or date of entry in Scotland).

The free cover ends on the earlier of:

- 90 days from the date the free cover starts, or
- the completion date/date of entry of the property, or
- the policy **start date**.

Once we've accepted a claim under house purchase cover, the policy will end and you won't be able to make another claim.

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

What do we pay?

We'll pay the lower of:

- £500,000, or
- the purchase price of the house (as confirmed when contracts are exchanged/missives are completed), or
- the **cover amount** shown in the **policy schedule**.

Life change benefit

This benefit will only be included from the start of your policy if:

- we accepted your policy on **standard terms**
- the eldest **life covered** is under age 55 at the policy **start date**
- you are the policyholder as well as the **life covered**
- you didn't take out your policy under the life change benefit or separation benefit.

Life change benefit

This benefit lets you take out more cover through an additional policy without answering any more health and lifestyle questions, if the life covered's circumstances change in one of the ways described below.

You can use this benefit six months from the **start date**.

You must take out the new policy within 180 days of the life change happening and you must send us the evidence we need.

Life change	Evidence needed
Marriage or civil partnership	Marriage or civil partnership certificate
Divorce or dissolution of civil partnership	Final order (Decree absolute) or dissolution order
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
At least 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.

You can use the life change benefit as many times as you like as long as you take out the new policy before the eldest **life covered** turns 55.

If the policyholder has transferred ownership of the policy to someone else, you can still use life change benefit provided the life covered's circumstances change in one of the ways described above.

You can't use it if you've made a claim for any benefit except for hospital benefit, **children's benefit** or **upgraded children's benefit**.

You can't use it if you are eligible to make a claim for any benefit.

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

If your 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.

You can't change the **lives covered**.

The new policy

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

- the life change benefit
- the renewal option
- increasing cover
- fracture cover
- the conversion option
- global treatment.

You can only have the waiver of premium option on the new policy if the **deferred period** is not shorter than the one on your original policy.

If the original policy was on a family income basis, the new policy must also be on a family income basis. Otherwise, you can set up the new policy on a level or decreasing basis.

We'll base the premium you'll pay for any new policy 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. You also need to meet the eligibility criteria in force at the time you apply for the new policy.

There are certain limits on life change benefit, depending on whether you have level, decreasing or family income cover:

For level cover or decreasing cover:

For mortgage increases, the new cover amount can't be more than the mortgage increase.

The total cover amount for all the policies you take out using the life change benefit must not be more than the lower of:

- £200,000, or
- the original **cover amount**.

The new policy must end before the eldest **life covered** on your 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, whichever is lower.

For family income cover:

The total cover amount for all the policies you take out using the life change benefit must not be more than 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
- the day 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, whichever is lower.

Separation benefit

This benefit only applies if you have a **joint policy**.
It will be included in your policy if:

- we accepted your policy on **standard terms**
- the eldest **life covered** is under age 55 at the policy **start date**
- you are the policyholder as well as the **life covered**.

Separation benefit

This benefit lets you split your **joint policy** and take out a new **single policy** if you separate, without having to answer any more health and lifestyle questions. Either one or both of the policyholders can take out a new **single policy**.

You can use this benefit six months from the **start date**.

You must take out the new policy within 180 days of the separation. You must also send us the evidence we need.

Separation	Evidence needed
Divorce or dissolution of civil partnership	Final order (Decree absolute) or dissolution order
Separation	Evidence of new mortgage, mortgage transfer or new separate addresses
Mortgage transferred into one name only	Evidence of mortgage transfer
Moving into a different house	Evidence of new mortgage or new address

In addition, you can use the separation benefit as long as:

- you and the other **life covered** agree to cancel the original policy, and
- you take out the new policy before the eldest **life covered** turns 55.

You can't use it if you have made a claim for any benefit except for hospital benefit, **children's benefit** or **upgraded children's benefit**.

You can't use it if you are eligible to make a claim for any benefit.

You can't use it if the policy is placed under trust.

You can only use the separation benefit once.

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

The new policy can only start when your original policy has been cancelled. It has to end before you turn 70 and have a cover amount which is less than, or equal to, the current **cover amount**. If you have family income cover, the new policy can't last longer than your original policy.

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

- the life change benefit
- the renewal option
- separation benefit
- the conversion option.

You can only have the waiver of premium option if the **deferred period** on your new policy is not shorter than the one on your original policy.

If the original policy was on a family income basis, the new policy must also be on a family income basis. Otherwise, you can set up the new policy on a level or decreasing basis.

We'll base the premium you'll pay for any new policy 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.

Making changes to your policy

You can make certain changes to your policy from six months after the **start date**, unless you're claiming or eligible to make a claim. If you make any changes, they will apply from the date your next premium is due.

We've set out the changes you can make in the table below. Depending on the type of change, we may either amend your existing policy or issue you with a new policy.

Type of change	Amend existing policy	Issue a new policy
Reduce **cover amount**	✓	✘
Increase **policy term**	✓	✘
Change premium frequency	✓	✘
Remove selected option	✓	✘
Increase **cover amount**	✘	✓
Reduce the **policy term**	✓	✘

Changes needing an amendment to your policy

The following applies to the above changes which require an amendment to your existing policy:

- We won't ask you any more health and lifestyle questions, unless you want to increase the **policy term**.
- If you want to increase the **policy term**, we may need to ask you some further health and lifestyle questions. Depending on the answers, we may not be able to change your policy. You can't increase the **policy term** if your policy includes the increasing cover or conversion/renewal options. We'll use the premium rates available when we make the change, based on the **personal circumstances** of the **life covered**.
- For all other changes, we'll use the original premium rates based on the **personal circumstances** of the **life covered**.
- If you want to remove an option, we'll remove the charge for that option from your premium.
- After you've made any of the above changes, your premium can't be lower than the minimum premium limit which applies at the time we agree to your request.
- If you have family income cover and you chose the increasing cover option, you can't later remove it from the policy.
- These **policy conditions** will continue to apply to your amended policy.

Increasing your cover amount

If you increase the **cover amount**, your original policy will remain in force and we will issue a new policy for the further amount.

We may need to ask you some more 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.

For life and critical illness cover only

In addition to the above, you can also change the policy to become a life cover only policy. However, this will also remove the additional critical illness benefit, **children's benefit, upgraded critical illness benefit, upgraded children's benefit,** extra care cover and total permanent disability.

Making a claim

If you need to make a claim, call us on **0800 015 1142**
from outside of the UK, please call **+44 1603 603 479**.
For our opening hours, please refer to our website **aviva.co.uk**.

Calls may be monitored and will be recorded.

For claims under the global treatment option, please read that section of these **policy conditions**. Or you can call us on 0345 030 8071 and select the option to start a global treatment claim. Your call will be transferred to **Further**, who will evaluate and process your claim and provide you with any options for overseas treatment. **Further's** claims line is open Monday to Friday 8.30am to 5pm. These times are correct at the time of publishing.

Before we can pay a claim we need to assess it

To do this, we'll ask for some important information. If we ask for information from third parties, we'll pay for it. If you want to, you can provide additional evidence at your own expense.

The kind of information we need includes, but isn't limited to:

- Proof that the event giving rise to the claim has happened
- Proof that a **child** has died or met our definition for **children's benefit** or **upgraded children's benefit**
- Proof of who legally owns the policy

- Written consent that lets us:
  - access the medical records or reports of the **life covered** or **child**
  - receive the results of any medical examinations or tests of the **life covered**
  - Conversations with, and reports from, third parties such as coroners, **attending consultants**, employers and the police.

If you make a claim, all medical certificates and results of medical examinations must be provided by medical practitioners. These practitioners must be resident and practising in one of these places: 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.

For extra care cover, total permanent disability and waiver of premium claims, we may ask the **life covered** to have regular medical examinations. If we do, we'll appoint a medical examiner to carry them out.

For waiver of premium claims, the **life covered** must take all necessary steps to help their recovery.

If you have family income cover and we accept a claim, you can decide to take the **cover amount** as a cash lump sum instead of monthly instalments at any time. However, if you do, we'll have to recalculate your benefit. This means it will be less than the total amount of the monthly instalments. We'll calculate the reduction fairly and reasonably so it reflects how much it costs us to pay out in advance.

If we accept a claim for the **main benefit** under the policy, that doesn't automatically mean you'll be eligible to claim under the global treatment option. We'll assess claims for global treatment in their own right, as described in the global treatment option section (if selected).

When we assess a claim, we rely on the information we're given. If any of the information is untrue or incomplete, it could affect whether we pay a claim or not, and may mean we won't pay a claim. It may also mean we can reclaim the money if we've already paid a claim. If this happens, we won't make any further payments. We may also cancel the policy without refunding any premiums.

This doesn't affect any other legal rights we have.

If we accept a claim, we'll make any relevant payment to the person who is legally entitled to receive it.

We won't be able to pay anything if:

- your policy has ended because you haven't paid your premiums
- you've cancelled your policy
- you're diagnosed with, or have surgery for, something that isn't defined in the policy
- you're diagnosed with a terminal illness and you're expected to live longer than 12 months
- you're not covered for the benefit you claim for
- you die in the first 12 months of the policy term because of suicide or intentional, self-inflicted injury
- you get ill outside the policy term, or
- you die outside the policy term

This isn't the kind of policy that you can 'cash in' – so you don't get any money if you cancel it.

Your premiums

You need to pay your premiums to keep your policy in force.

You can pay premiums yearly or monthly by direct debit. All direct debits need to come from a bank or building society in the UK, the Channel Islands, the Isle of Man or Gibraltar, in the currency of the UK.

Your **policy schedule** will show the initial premium you'll pay, together with the date it and subsequent premiums are due. You have 60 days from each due date to pay your premium. If you have to make a claim during this period, we'll deduct the unpaid premium from any benefit we pay.

If you have an unpaid premium and we ask you to pay that unpaid premium, we'll only accept payment from a debit card. We'll also need you to provide new bank account details to ensure that your regular premium payments can continue.

If you don't pay your premiums within the 60 day period, we'll cancel your policy. If this happens, you won't be able to make a claim.

For life cover only, your premiums will be guaranteed.

For life and critical illness cover, your premiums can be guaranteed or reviewable. Your **policy schedule** will show which premiums you have.

Guaranteed premiums won't increase over the **policy term**, unless you:

- make changes to your policy, or
- have selected the increasing cover option, or
- have selected the global treatment option.

Your **policy schedule** will show which options you have.

Reviewable premiums

This applies only where you have chosen life and critical illness cover.

Your **policy schedule** will confirm whether you have reviewable premiums.

We review your premiums every five years over the **policy term** to determine if you're paying the right price for the **cover amount** you've chosen.

If our review shows your premium needs to change, we'll assess the change fairly. We'll use certain assumptions to work out what the new premium should be. We won't look at the **personal circumstances** of the **life covered**.

We'll base our assumptions on our view of the following factors:

- The expected impact of medical advances and trends which may affect our expectation of future claims
- Industry developments and our claims experience
- Changes to legislation, taxation and regulation
- The amount, timing and cost of claims we're paying now, and those we may pay in the future.

Your premium may increase or decrease based on our assumptions at the review date. There are no limits on how much your premium can change by.

Following our five-yearly review, we'll write to you to let you know the outcome of the review at least 30 days before the **anniversary date**. After that, one of the following will happen:

- If the change is less than 2% or 50p, your premium will stay the same
- If your premium goes down, we'll automatically change your direct debit
- If your premium goes up, you have two options:
  (a) you can pay the increased premium and we'll automatically change your direct debit.
  (b) you can keep your premium the same and reduce your **cover amount**. If you want to do this, you need to let us know before the **anniversary date**. If you don't tell us, we'll increase your premium. It's up to you to check that the **cover amount** is right for you.

Any changes to your premium, or your **cover amount**, will apply from the fifth anniversary of your policy and every five years after that.

General

Changing your details

You need to let us know if your contact details, or those of any **life covered**, change.

Acceptance of instructions

We can't accept any instruction, request or notice from you until we receive all the information we need. We'll tell you what kind of information or documentation we need.

Cancelling your policy

You have a 30 day cooling off period to change your mind. If you cancel within this period, we'll refund any premiums you've paid. The cooling off period begins on the later of:

- the day we tell you when your policy will start, and
- the day you receive your policy documents.

You can still cancel the policy after the cooling off period ends, or remove any of the options (six months from the **start date**), but we won't refund your premiums. If you cancel your policy, you won't be able to make a claim.

Eligibility

You must be at least 18 to apply for this policy and, if different, the **life covered** must also be 18.

At the time you complete the application, both you 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 your 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.

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

General conditions

Policy amendments

We may change these **policy conditions** for any of the following reasons:

- To respond, in a proportionate manner, to changes in:
  - the way we administer these type of policies
  - technology or general practice in the life and pensions industry
  - taxation, law or the interpretation of the law, decisions or recommendations of an ombudsman, regulator or similar body, or any code of practice with which we intend to comply.
- To correct errors if it is fair and reasonable to do so.

If we think any change to these **policy conditions** is to your advantage, we'll make it immediately and tell you afterwards. We'll also do this if we have to make the change due to regulatory requirements.

If any change is to your disadvantage, we'll aim to tell you in writing at least 60 days before we make it. However, external factors beyond our control may mean we have to give you less notice.

If you're not happy with any change we make to your policy, you can cancel it.

Incorrect information

If the date of birth of any **life covered** is wrong, we'll base the payment we make for any successful claim on the correct date of birth. We'll tell you if this happens.

If the correct date of birth of any **life covered** when you took out your policy would put them outside our limits, we'll cancel your policy.

We rely on the information provided to us. If any of it is untrue or incomplete and would have affected our decision to provide your policy, we may:

- change the terms of your policy
- change your premiums
- cancel your policy and refund the premiums you've paid (without interest).

If we cancel your policy, you won't be able to make a claim.

Trusts and assignments

If you place the policy under trust or transfer it to someone else (known as 'assigning'), unless otherwise stated generic reference in documents to 'critical illness' shall include:

- critical illness benefit
- additional critical illness benefit
- **children's benefit**, and
- **upgraded critical illness benefit**, **upgraded children's benefit**, extra care cover and total permanent disability if selected.

If you chose to add global treatment and fracture cover to your policy, you can't gift them under trust. Plus you can't transfer global treatment or fracture cover to someone else.

Third party rights

This policy does not give any rights to anyone except you and us.

With your agreement, we may change or cancel this policy without reference to, or consent from, any other person.

Fairness of terms

We'll always act reasonably and treat you and all of our customers fairly.

These **policy conditions** will apply to your policy so long as they are not held by a relevant court, or viewed by the Financial Conduct Authority or by us, to be unfair contract terms. If a term is unfair it will still apply as far as possible, but without any part which makes it unfair.

General

If you want to transfer ('assign') the policy to someone else, you must tell us in writing before we can pay a claim. Where appropriate, words in the singular include the plural and vice versa.

Law

This policy is governed by the law of England. Your contract will be in English and we will always write and speak to you in English.

Definitions

Throughout these **policy conditions** we've highlighted defined terms in **bold** type (except for personal terms like "we" and "you") so you know when they apply.

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

"You" or "your" refers to the policyholder(s) named in the **policy schedule**, or anyone else who becomes the legal owner of the policy.

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

Anniversary date

The anniversary of the **start date** shown in the **policy schedule**.

Attending consultant

A surgeon, anaesthetist or physician who is legally entitled to practice medicine or surgery. They must have attended a recognised medical school and be recognised by the relevant authorities in the country in which any treatment takes place as having a specialised qualification in the particular field.

Child

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.

Children's benefit

This includes children's critical illness benefit, children's hospital benefit and children's death benefit. This only applies if you have life and critical illness cover.

Cover amount

The amount we pay for the **main benefits** under this policy. It also includes the amount we pay for extra care cover #1 (if applicable). The cover amount is shown in your **policy schedule** together with your chosen basis for receiving the amount upon a successful claim (that is, level, decreasing or family income cover). For family income cover, you'll see the cover amount as a monthly figure. Following a successful claim, we'll pay this monthly cover amount for each full month until the policy **end date**.

Deferred period

The number of consecutive months which must pass before the policyholder becomes entitled to receive the benefit provided by the waiver of premium option. The deferred period is shown in your **policy schedule**.

End date

The date that cover under this policy will end. This is shown in your **policy schedule** either as a specific date, or an expiry age. If you have family income cover and have made a successful claim, your monthly instalments will stop on the **end date**.

Joint policy

The policy can cover up to two people. A joint policy will only pay out once following a successful claim for the **main benefit**, total permanent disability benefit, upgraded critical illness or conditions. If you've added extra care cover, the **life covered** who successfully claimed may also be eligible to claim for this after the policy ends.

Life covered (or lives covered)

The person whose life is being covered. There can be more than one if you have a **joint policy**.

Main benefits

For life cover only, the **main benefits** are death benefit and terminal illness benefit. For life and critical illness cover, the **main benefits** are death benefit, terminal illness benefit and critical illness benefit.

Partner

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.

Personal circumstances

These can include the age, smoker status (both previous and current), health and lifestyle of the **life covered**.

Policy conditions

This document forms our contract of insurance with you. The application you made (and which we have accepted) and the **policy schedule** also form part of the contract. You should read these documents together with these **policy conditions**.

Policy schedule

This shows the specific detail of your policy, such as:

- the **life** or lives covered
- the **cover amount**
- whether we'll pay the **main benefits** on a level, decreasing or family income basis

– how much your policy will cost, and
– any optional benefits or additional benefits you've chosen.

"Policy schedule" also includes any subsequent changes to your policy, which we'll confirm to you in writing at the time.

Policy term

This is the period your policy is in force, from the **start date** until the **end date**.

Retail Prices Index (RPI)

The monthly index calculated by the government that demonstrates the movement of retail prices in the UK, or an equivalent replacement of that index.

Single policy

A policy which covers the life of just one person.

Standard terms

The premium and benefits we quote before we complete the underwriting process.

If the premiums and benefits for your policy are the same after the underwriting process, you'll be on **standard terms**. If, following our underwriting process, we can only offer cover with a higher premium than first quoted, or with certain benefits excluded, or both, this would not be **standard terms**. We'll have told you whether you were accepted on **standard terms** when confirming our decision on your application.

Start date

The date on which cover under this policy starts. It's shown in the **policy schedule**.

Upgraded children's benefit

This includes the benefits upgraded children's critical illness, child extra care cover, advanced illness, upgraded children's hospital benefit and upgraded children's death benefit. This only applies if you have life and critical illness cover and you have selected upgraded children's benefit.

Upgraded critical illness benefit

This includes upgraded critical illness conditions, upgraded additional critical illness benefit and hospital benefit. This only applies if you have life and critical illness cover and you have selected upgraded critical illness benefit.

Definitions for global treatment only

In addition to the main definitions in these **policy conditions**, the following definitions apply only in relation to the global treatment option:

Alternative medicine

Includes medical and health care systems, practices and products that are not presently considered to be part of conventional medicine or the standard It includes but isn't limited to acupuncture, aromatherapy, chiropractic medicine, homeopathic medicine, naturopathic medicine and osteopathic medicine.

Consultant

An **attending consultant** with a specialised qualification in the field of, or expertise in the treatment of, the disease or illness.

Cosmetic surgery

Procedures enhancing, reducing, lifting or removing a part of the body performed to improve and correct a structural defect. This includes removal of scars, birthmarks or normal evidence of ageing.

Expenses

Means the medical, **medication**, travel, accommodation and miscellaneous **expenses** we cover under this global treatment option.

Experimental treatment

A treatment, procedure, course of treatment, equipment, medicine or pharmaceutical product, intended for medical or surgical use, which has not been universally accepted as safe, effective and appropriate for the treatment of illnesses or injuries by the various scientific organisations recognised by the international medical community. This includes any of the above which are undergoing study, research, testing or are at any stage of clinical experimentation.

Further

Further Underwriting International SLU. It is a company which specialises in the development of both insurance products and the management of overseas treatment for serious medical conditions. Further Underwriting International SLU at Paseo de Recoletos 12, 28001 Madrid, Spain, registered in the Mercantile Registry in Madrid under hoja m-327635, tomo 18794, folio 76 and tax number (CIF) ESB83644484.

Medically necessary

Health care services and supplies which are:

- necessary to meet your, or your **child's** basic health needs, and
- given in the most medically appropriate manner and type of setting appropriate for the delivery of the health service, taking into account both cost and quality of care, and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of medical, research or health care coverage organisations or governmental agencies that are accepted by **Further**, and
- consistent with the diagnosis of the condition or illness, and
- required for reasons other than the convenience of you, your **child** or **consultant**, and
- demonstrated through prevailing pre-reviewed medical literature to be either:
  - effective for treating or diagnosing the condition or illness for which its use is proposed, or
  - efficient for treating a life threatening condition or illness in a clinically controlled research setting.

Medical procedure

A **medical procedure** which we cover in this global treatment option.

Medication

Any single substance or combination of substances, which may be used or administered to you or your **child** with a view to restoring, correcting or modifying physiological functions.

Preliminary medical certificate

Written approval relating to a claim issued by **Further** and/or us before giving any treatment, services, supplies or prescriptions. The **preliminary medical certificate** will include confirmation of your global treatment benefit and the hospital outside of the **territory** authorised for your, or your **child's** treatment.

Prosthesis

A device which replaces all or part of an organ, or replaces all or part of the function of an inoperative or malfunctioning part of the body.

Reconstructive surgery

Procedures that are intended to rebuild a structure to correct its loss of function where **medically necessary**, exclusively when the structure has been damaged or removed.

Renewal date

The third anniversary of the **start date** and the **end date** of every following three-year period.

Resident

By resident:

- you must be in the **territory**, with a legal right to live in that jurisdiction, and
- your main home is in the **territory** and have no current intention of moving anywhere else permanently.

You need to tell us if you move outside of the UK and your main residence is in another territory. Laws in the territory you become resident in may affect your ability to continue to benefit fully from the features of your policy. We may need to change, reduce or remove any of your policy terms. We'll give you details once you've told us. You should seek your own independent advice to consider your options if you move to another territory.

Serious illness

A **serious illness** which we cover in this global treatment option.

Surgery

All operations with a diagnostic or therapeutic purpose, carried out through incision or other means of internal entry, by a **consultant** at a hospital and which normally requires the use of an operating theatre.

Territory

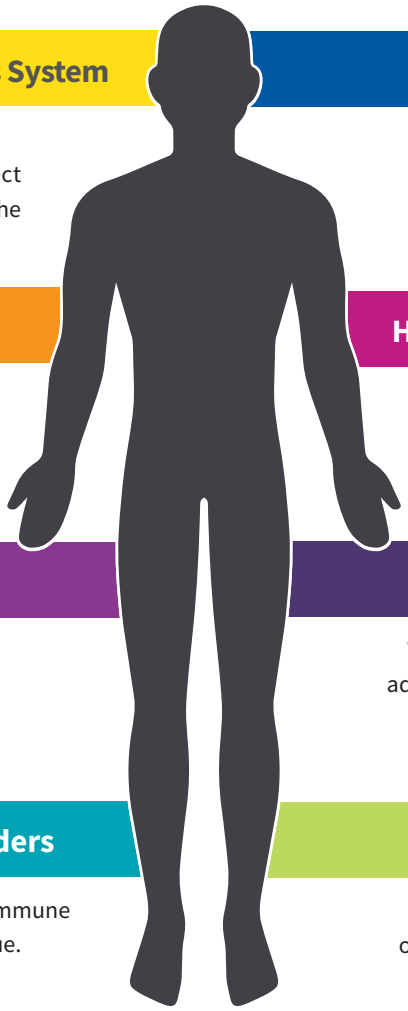
England, Northern Ireland, Scotland, Wales, Jersey, Guernsey, the Isle of Man and Gibraltar.

Travelling companion

The person you choose to accompany you or your **child** while travelling and receiving treatment overseas.

Appendices

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.

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 1A - Cancer
Appendix 1B - Brain and the central nervous system
Appendix 1C - Heart and the circulatory system
Appendix 1D - Organs
Appendix 1E - Auto-immune disorders
Appendix 1F - Senses
Appendix 1G - Mental Health
Appendix 1H - Children's Cover

Appendix 1A - 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 1B - Brain and the 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 1C - 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 1D - 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 1E - 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 1F - 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 1G - 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 1H - 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 9.

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.

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