Group Critical Illness Insurance

Policy Terms and Conditions

Welcome to AIG

American International Group, Inc. (AIG, Inc.) is a leading international insurance organisation serving customers in more than 80 countries and jurisdictions. AIG is the marketing name for the worldwide property-casualty, life and retirement, and general insurance operations of AIG, Inc.

AIG Life Limited is the life insurance arm of AIG in the United Kingdom. We provide financial and practical support for individuals, families and businesses when illness or injury threatens their life, lifestyle or livelihood.

Information about our business, performance and financial position, and details on how we control our business and manage risks can be found in our Solvency and Financial Condition Report available on our website www.aiglife.co.uk.

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Section A

Interpretation

1 Interpretation

1.1 In this Policy Terms and Conditions:

a) save where the context otherwise requires, a reference to a statute or statutory provision shall include a reference:
   i. to that statute or provision as from time to time consolidated, modified, re-enacted or replaced by any statute or statutory provision, and
   ii. any subordinate legislation made under the relevant statute

b) unless otherwise specified, references to Clauses are to clauses of this Policy

c) references to a party, where appropriate, shall include the contracting party or its successors in title from time to time

d) references to any of the masculine, the feminine and the neuter shall include the other genders

e) references to the singular shall include the plural, and vice versa, and

f) the words **'include'**, **'includes'** and **'including'** shall be construed as if they're followed by the words **'without limitation'**.

1.2 The following terms used in this Policy are defined and where used shall have the meanings set out below:

Accounting Period	the period of time from one Data Refresh Date to the next. We use the data provided by You on the Data Refresh Dates to calculate the Premium for the Accounting Period
Adviser	a firm regulated by the Financial Conduct Authority (or other recognised professional body) who acts on behalf of You
Age Specific Rate Table	a table of rates used to calculate the Premium which vary by age as detailed in Your Policy Schedule
Automatic Acceptance Limit	the maximum level of Benefit specified in the Policy Schedule which will be provided in respect of a Member without the need to undergo an Individual Assessment
Benefit	the benefit payable in the event that an Insured Person fulfills the claim conditions set out in Clause 14
Business Day	a calendar day other than a Saturday, Sunday or other statutory holiday in England
Category	a class of Member (or if We've agreed to cover them, a Member's Partner) as stated in the Policy Schedule
Child and Children	a Member's child, step-child or legally adopted child from birth to their 18th birthday (23rd birthday if in full-time education)
Commission Rate	the amount of commission payable to Your Adviser as set out in the Policy Schedule
Data Refresh	the provision of data in accordance with Clauses 2.6 and 2.7
Data Refresh Date	the dates on which You'll give Us the data We require to calculate the Premium
Data Refresh Frequency	the agreed frequency at which You'll give Us the data We require to calculate the Premium

Date Cover Ceases	the date You've agreed with Us being the date at which a Member (and if We've agreed to cover them, a Member's Partner) ceases to be eligible for cover under this Policy as stated in the Policy Schedule
Deposit Premium	a sum calculated by Us which is an estimate of the Premium for the current Accounting Period based on information provided by You, the Premium Rates and any other relevant matters which is payable at the beginning of each Accounting Period in circumstances where the Premium is paid by bank transfer
Effective Date	the date from which the Premium Rates and Policy Terms and Conditions apply
Eligibility Conditions	the conditions that an Eligible Person must satisfy in order to be a Member of the Scheme, as described in each Category outlined in the Policy Schedule
Eligible Person	an individual who meets the Eligibility Conditions
Employee	an individual who is either i. gainfully employed either permanently or for a fixed term by an Employer as evidenced by a United Kingdom contract of employment ii. an Equity Partner in the business of the Employer, or iii. where We've agreed to include such an individual, a worker engaged through a Zero Hours Contract
Employer	an Employer listed in the Policy Schedule, whether it's the Principal Employer or a Participating Employer. Employers must be organisations registered in the United Kingdom with Companies House or a similar body
Equity Partner	a partner in a partnership who is a part owner of the business and is entitled to a proportion of the distributable profits of the partnership
Flexible Benefits Rules	where applicable, outline the rules and requirements governing the particular flexible benefit Scheme
Flexible Benefits Scheme Type	is the basis on which the Scheme is arranged, as stated in the Policy Schedule
HMRC	HM Revenue & Customs
Individual Assessment	an assessment carried out by Us consisting of medical and other lifestyle questions via a secure website, requests for further medical tests and where necessary information from the individual's professional medical advisers
Insured Illness	the illnesses and conditions details of which are set out in Section D. The Policy Schedule will state which apply to Your Policy
Insured Person	any individual covered under this Policy whether they are a Member, a Member's Child or Partner of a Member
Maximum Benefit	the Maximum Benefit payable in respect of Insured Person is as follows: Member: £500,000 Partner (where included in the Policy): the lesser of £250,000 or the Member's Benefit Child: the lesser of £25,000 or 25% of the Member's Benefit
Member	an Employee who satisfies the Eligibility Conditions and is included in the Scheme
Minimum Membership Number	three Members

Parent Company	the legal entity that owns or controls AIG Life Limited as defined by the laws applicable to the jurisdiction within which the legal entity resides
Participating Employer	an Employer stated as such in the Policy Schedule
Partner	at the date cover starts: a) a person to whom the Member is married b) a person with whom the Member has entered into a contractual partnership formally recognised by law under the Civil Partnership Act 2004, or c) a person who isn't a relative of the Member, or married to or a civil partner of the Member at the date cover starts and when cover starts is in a relationship resembling marriage with the Member and has the same main residence as the Member and has done so for at least six months and is either: i. financially dependent on the Member, or ii. in a relationship of mutual financial dependence with the Member
Policy	this document and the Policy Schedule
Policy Anniversary Date	the date stated as such in the Policy Schedule
Policy Schedule	at any given date, the latest Policy Schedule which We've posted in the Policyholder area on Our secure website or otherwise issued to You
Policy Start Date	the Policy Start Date stated in the Policy Schedule. This is the date when the insurance cover starts
Policy Terms and Conditions Reference	the reference to the version of the Policy Terms and Conditions that should be read in conjunction with the Policy Schedule
Policyholder	the legal owner of the Policy, as stated in the Policy Schedule
Premium	the sums payable by You pursuant to Clause 2
Premium Payment Frequency	the frequency stated in the Policy Schedule with which Premium will be paid by You
Premium Rates	either the Age Specific Rate Table or the Unit Rate, whichever's set out in the Policy Schedule
Principal Employer	the Participating Employer who arranged this insurance contract
Quotation	the Quotation provided to You by Us prior to the Policy Start Date on the basis of detailed information submitted by You and confirmed by Us in Our standard application form
Rate Review	the process whereby We review Our Premium Rates and Policy Terms and Conditions
Rate Review Date	the date We review Our Premium Rates and Policy Terms and Conditions as stated in the Policy Schedule
Related Medical Condition	any medical condition, or symptom, which in the opinion of Our consultant medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the Insured Illness
Scheme	an arrangement under the terms of which the Employer has agreed to make a certain payment to Members in the event that they or another Insured Person suffers an Insured Illness
State Pension Age	the earliest age at which an individual can claim their State Pension

Temporary Cover	shall have the meaning provided in Clause 6.5 of these Policy Terms and Conditions
Unit Rate	the rate that is used to calculate the Premium which is the same for all ages as detailed in Your Policy Schedule
United Kingdom	the United Kingdom consisting of England, Wales, Scotland and Northern Ireland
Voluntary Benefits Rules	where applicable, outline the rules and requirements governing the particular voluntary benefits Scheme
We, Us and Our	AIG Life Limited
You and Your	the Employer(s) for the time being of the Scheme as provide in the application form and identified in the Policy Schedule, and
Zero Hours Contract	a contract between You and a worker whereby You aren't obliged to provide the individual with any minimum working hours and the individual isn't obliged to accept any of the hours offered.

Section B

Premium

2 Calculation and payment of Premium

2.1 By You paying the Premium, We agree to insure You, under the terms of this Policy, against Your responsibility to pay a Benefit to the Member as shown in the Policy Schedule.

2.2 We'll calculate the Premium in respect of each Accounting Period on the basis of information You provide to Us and the Premium Rates.

2.3 We'll ask You for a list of all Members as at the Policy Start Date and You must provide Us with this information within 14 days of Our request. The list should contain in respect of each Member the following details:

a) name
b) National Insurance number or unique identifier (whichever We've agreed with You will be provided)
c) sex
d) date of birth
e) Scheme salary and, if requested by Us, Benefit
f) Category
g) normal working location (postcode if in the United Kingdom or country if outside the United Kingdom)
h) email addresses for Members who require Individual Assessment
i) Members for whom restricted benefits or special terms currently apply
j) where it's stated in the Policy Schedule that cover will be provided for Members who work past the Date Cover Ceases under this Policy, details of any such Members.

You must ensure that the data You give Us accurately reflects any salary basis or limitations that You've agreed with Us or apply to Your Scheme. The duty of fair presentation of risk applies to the provision of the data to Us.

2.4 If We've agreed to cover Members' Partners, We'll ask You for a list of all Partners as at the Policy Start Date and You must provide Us with this information within 14 days of Our request. The list should contain in respect of each Partner the following details:

a) name
b) National Insurance number
c) sex
d) date of birth
e) the Member's Scheme salary and, if requested by Us, the Partner's Benefit
f) Category
g) the Member's normal working location (postcode if in the United Kingdom or country if outside the United Kingdom)
h) email addresses for Partners who require Individual Assessments
i) Partners for whom restricted benefits or special terms currently apply
j) where it's stated in the Policy Schedule that cover will be provided for Partners who are over the Date Cover Ceases under this Policy, details of any such Partners.

You must ensure that the data You give Us accurately reflects any salary basis or limitations that You've agreed with Us or apply to Your Scheme. The duty of fair presentation of risk applies to the provision of the data to Us.

2.5 If We don't receive complete data within 14 days of Our request, We'll request payment based on the estimated annual premium in the Quotation. For annual paying policies that pay Premiums by bank transfer, We'll issue an invoice for the estimated annual premium and payment must be made within 14 days. For annual payment policies that pay Premiums by direct debit, We'll request a payment for the estimated annual premium. For quarterly paying policies that pay Premiums by direct debit, We'll request a payment for 25% of the estimated annual premium. For monthly paying policies that pay Premiums by direct debit, We'll request a payment for 1/12th of the estimated annual premium.

2.6 On each Data Refresh Date You must provide to Us the following:

a) a list of all Members as at the Data Refresh Date. The list should include in respect of each Member the following details:
   i. name
   ii. National Insurance number or unique identifier (whichever We've agreed with You will be provided)
   iii. sex
   iv. date of birth
   v. Scheme salary and, if requested by Us, Benefit
   vi. Category
   vii. normal working location (postcode if in the United Kingdom or country if outside the United Kingdom)
   viii. the dates on which individuals, who've become Members since the last Data Refresh Date, joined the Scheme.
b) the date on which any individual ceased to be a Member.
c) where it's stated in the Policy Schedule that cover will be provided for Members who work past the Date Cover Ceases under this Policy, details of any such Members.

You must ensure that the data You give Us accurately reflects any salary basis or limitations that You've agreed with Us or apply to Your Scheme. The duty of fair presentation of risk applies to provision of the data to Us.

2.7 If We've agreed to cover Members' Partners then on each Data Refresh Date You must provide to Us the following:

a) a list of all Partners as at the Data Refresh Date. The list should include in respect of each Partner the following details:
   i. name
   ii. National Insurance number
   iii. sex
   iv. date of birth
   v. the Member's Scheme salary and, if requested by Us, the Partner's Benefit
   vi. Category
   vii. the Member's normal working location (postcode if in the United Kingdom or country if outside the United Kingdom)
   viii. the dates on which individuals, who've become Partners since the last Data Refresh Date, joined the Scheme.
b) the date on which any individual ceased to be a Partner.
c) where it's stated in the Policy Schedule that cover will be provided for Partners who are over the Date Cover Ceases under this Policy, details of any such Partners.

You must ensure that the data You give Us accurately reflects any salary basis or limitations that You've agreed with Us or apply to Your Scheme. The duty of fair presentation of risk applies to provision of the data to Us.

2.8 For Policies where the Premium is paid by bank transfer, the terms and conditions of payment are set out in Clauses 2.9 to 2.18. For Policies where the Premium is paid by direct debit, the terms and conditions of payment are set out in Clauses 2.19 to 2.27.

Policies where Premium is paid by bank transfer

2.9 The Deposit Premium payable in respect of the first Accounting Period will be the amount set out in the Quotation. We'll issue an invoice to You and it will be payable by bank transfer within 14 days of the date on which the invoice was issued.

2.10 We'll then use the information given to Us pursuant to Clauses 2.3 and 2.4 to check the calculation of the Deposit Premium for the first Accounting Period. If it's different to the amount stated in the Quotation and paid by You then We'll make an adjustment.

2.11 We'll notify You within 30 days of receiving the information of any adjustment made.

2.12 Any additional Premium required must be paid by You within 14 days of the date of Our notification pursuant to Clause 2.11.

2.13 Any refund due to You will be refunded to You within 14 days of the date of Our notification pursuant to Clause 2.11.

2.14 Subsequent Deposit Premiums will be based on the final premium agreed for the previous Accounting Period. We'll issue an invoice for subsequent Deposit Premiums 30 days before the Data Refresh Date and this will be payable within 14 days of Our request.

2.15 We'll use the information given to Us pursuant to Clauses 2.6 and 2.7 to:

a) confirm that You've paid the correct Premium for the Accounting Period which is about to expire, and
b) re-calculate the Deposit Premium payable for the next Accounting Period.

2.16 We'll notify You within 30 days of receiving the data required under Clauses 2.6 and 2.7 of:

a) any additional Premium payable by You in respect of the Accounting Period which expired on the Data Refresh Date in question or any refund of Premium due to You in respect of that Accounting Period, and
b) the actual Deposit Premium payable in respect of the Accounting Period commencing on the Data Refresh Date. This will be based on the revised Premium Rates notified to You pursuant to Clause 3.9 where the Deposit Premium is payable in respect of an Accounting Period commencing on a Rate Review Date.

2.17 We'll add any additional Premium payable by You to the Deposit Premium payable in respect of the next Accounting Period.

2.18 We'll deduct any refund of Premium due to You from the Deposit Premium payable in respect of the next Accounting Period.

Policies where Premium is paid by direct debit

2.19 We'll use the information given to Us pursuant to Clauses 2.3 and 2.4 to calculate the Premium for the first Accounting Period.

2.20 We'll notify You within 30 days of receiving the information of the amount of Premium payable in respect of the first Accounting Period. This amount will be collected by Us by direct debit at regular intervals as detailed in the Policy Schedule.

2.21 The same amount of Premium will be payable for subsequent Accounting Periods until notice is given by Us pursuant to Clause 2.22 or Clause 3.2 or Clause 3.9.

2.22 We'll use the information given to Us pursuant to Clauses 2.6 and 2.7 to:

a) confirm that You've paid the correct Premium for each Accounting Period to date, and
b) calculate the Premium payable for subsequent Accounting Periods.

2.23 Where the information You provide to Us shows that You've paid too much or too little Premium in respect of any Accounting Period We'll notify You of the relevant amount and, where additional Premium is owed by You, details of when We'll collect payment from You pursuant to Clause 2.22.

2.24 Any additional Premium required will be collected by Us by direct debit.

2.25 Where the information You provide to Us shows that You have paid too much Premium, We'll normally reduce the Premium We'll collect at the next payment date. However, if the Premium is payable annually We'll refund the overpayment.

2.26 We'll notify You within 30 days of receiving the data pursuant to Clauses 2.6 and 2.7 of the amount of Premium payable in respect of subsequent Accounting Periods. This will be based on the revised Premium Rates notified to You pursuant to Clause 3.9 where the Premium is payable in respect of an Accounting Period commencing on a Rate Review Date. This amount will be collected by Us by direct debit.

2.27 The same amount of Premium will be payable in the same manner for each subsequent Accounting Period until notice is given by Us pursuant to Clause 2.26.

3 Variations to the Policy Terms and Conditions

3.1 We reserve the right to revise at Our discretion (prospectively or retrospectively) the Policy Terms and Conditions and the Premium Rates at any time if:

a) the number of Members (and if We've agreed to cover them, Member's Partners) or the total of all Members' salaries is changed by more than 30% from that notified to Us prior to the Policy Start Date or prior to the last Rate Review Date, whichever is the later
b) there are fewer Members than the Minimum Membership Number
c) We agree to include a new Employer or a TUPE (Transfer of Undertaking (Protection of Employment) Regulations 2006) transfer
d) an Employer is disposed of or the closure of part of an Employer's business
e) We agree to the inclusion of a new Category
f) We agree to change the terms of this Policy following a request from You
g) there's a change in the nature of the business carried on by any Employer
h) more than 30% of the total number of Members or total salary change location
i) there's no longer an Adviser acting for You in connection with this Policy
j) there's is a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this Policy, or
k) You didn't make a fair presentation of the risk when setting up the Policy or at any subsequent review of the terms.

These matters define the risk as a whole.

3.2 In the event that We wish to change any of the Policy Terms and Conditions or the Premium Rates pursuant to Clause 3.1 We'll give You one calendar month's notice of the change in writing. At the end of the one calendar month period We'll issue an amended version of the Policy Terms and Conditions and a new Policy Schedule. The notice period won't affect the effective date of the change.

3.3 Where there has been a delay in You providing the information We need to review the Policy Terms and Conditions or Premium Rates of this Policy, We'll backdate any change to the appropriate date.

3.4 In addition, the Policy Terms and Conditions and the Premium Rates may be varied by Us for any reason at any Rate Review Date.

Rate Review

3.5 At least 12 weeks before each Rate Review Date, We'll ask You to provide Us with the information We reasonably require to assess whether any changes should be made to the Policy Terms and Conditions or the Premium Rates. The duty of fair presentation of risk applies to provision of the information to Us.

3.6 You must provide this information to Us within six weeks of Our request.

3.7 Where We haven't received the requested information, We'll base any changes We intend to make to the Policy Terms and Conditions or the Premium Rates on the Rate Review Date on the information available to Us.

3.8 If You provide information after the Rate Review has been completed and it means We make a change to the Policy Terms and Conditions or the Premium Rates, these changes will be effective from the Data Refresh Date immediately prior to when You gave us the information.

3.9 In the event that We wish to change any of the Policy Terms and Conditions or the Premium Rates pursuant to Clause 3.4, We'll give You one calendar month's notice of the change in writing. We'll issue an amended version of the Policy Terms and Conditions and a new Policy Schedule once the Rate Review is completed. This notice period won't affect the effective date of the change.

Section C

The Critical Illness Insurance Cover

4 Cover from the Policy Start Date

4.1 Subject to Clause 4.4, each Member is covered under this Policy up to the Automatic Acceptance Limit on and from the Policy Start Date.

4.2 Subject to Clause 4.3, in respect of any Member where cover in excess of the Automatic Acceptance Limit is sought, We shall be entitled in Our sole discretion to require an Individual Assessment of the Member to enable Us to consider whether to grant the requested excess cover. For the avoidance of doubt, such Member will be covered up to the Automatic Acceptance Limit regardless of the decision made by Us following the Individual Assessment. While the Individual Assessment is being conducted, the cover provided will be as set out in Clause 6.

4.3 If, immediately prior to the Policy Start Date, the Members were insured under a group critical illness insurance policy, any Member whose cover was limited to below the Automatic Acceptance Limit following an assessment or for non-provision of medical evidence, will have their cover under this Policy limited to match the terms of the cover under the previous policy. Benefit in excess of this limited level of cover will be subject to an Individual Assessment.

4.4 If, immediately prior to the Policy Start Date, the Members were insured under a group critical illness insurance policy with an identical benefit structure to this Policy and there hasn't been a material change in the number of Members or the Eligibility Conditions, then We'll accept the previously insured level of Benefit in respect of each Member, up to the Automatic Acceptance Limit subject to Clauses 4.3 and 4.5. Any previously insured level of Benefit in excess of the Automatic Acceptance Limit will be accepted subject to:

a) You providing satisfactory evidence of the level of cover and the details of any special terms and conditions to Us, and
b) Our right to conduct an Individual Assessment pursuant to Clause 6 and to impose special terms where We consider it appropriate to do so.

4.5 Where We have agreed to transfer cover for Members the following will apply:

a) Our pre-existing Insured Illnesses, Related Medical Conditions exclusions and additional exclusion in relation to Children as defined in Clause 18 will apply from the date the Member joined the Scheme and to any increase in Benefit that has occurred since joining the Scheme, and
b) any Insured Illness that We cover that wasn't covered by the previous insurer will be subject to our pre-existing Insured Illnesses, Related Medical Conditions exclusions and additional exclusion in relation to Children as defined in Clause 18 from the Policy Start Date.

5 Individuals becoming Members of the Scheme after the Policy Start Date

5.1 Subject to Clause 6, cover in respect of individuals who become Members after the Policy Start Date but as soon as they meet the Eligibility Conditions will commence on the date they join the Scheme. Cover will be subject to the pre-existing Insured Illness, Related Medical Conditions exclusions and additional exclusion in relation to Children as outlined in Clause 18.

6 Individual Assessments and Temporary Cover

6.1 In circumstances where:

a) You seek cover in excess of the Automatic Acceptance Limit (or no Automatic Acceptance Limit applies) in respect of any Insured Person, or
b) You ask Us to change the terms of the Policy and We've identified Insured Persons whose increase is subject to Individual Assessment

the Insured Person in question must undergo an Individual Assessment and We reserve the right to refuse to provide the cover sought.

6.2 You must give Us written notice immediately if You're seeking cover of the type described in Clause 6.1 a) to b). If You fail to notify Us of individuals who meet the criteria in Clause 6.1 these individuals may not be covered for any or all of their Benefit.

6.3 The cost of any medical examination and any tests requested by Us will be paid for by Us. We won't be liable for any costs incurred by You or the Insured Person in attending a medical examination, undergoing any tests or in supplying any other information.

6.4 Where Insured Persons are outside the United Kingdom, and provision of their Benefit is subject to Individual Assessment, if after this further medical information is required to enable Us to complete Our assessment, the Insured Person will be responsible for arranging and paying for the tests to be conducted. Examinations, tests or reports may only be arranged or conducted at a centre or provider with prior approval from Us otherwise We won't be liable for any costs and the Insured Person may be required to undertake another set of tests with an approved centre or provider. This may include returning to the United Kingdom to undergo the necessary tests.

We'll reimburse the Insured Person for the tests We've requested, to a maximum of the amount We would pay for the same test in the United Kingdom. Reimbursement will be in pounds sterling to a United Kingdom bank account and the exchange rate used for reimbursement will be Our banker's rate of exchange on the date of reimbursement. All results and/or reports must be provided in English.

Benefit in respect of Insured Persons who require Individual Assessment

6.5 Where You seek cover that is subject to Individual Assessment in respect of any Insured Person, then subject to Clauses 6.6 to 6.9, You'll have cover in respect of the Insured Person in question until the completion of the Individual Assessment. Subject to Clause 4.3, Your cover will be the higher of the Automatic Acceptance Limit and their previously accepted level of Benefit. In addition, You'll receive Temporary Cover equivalent to the additional cover being sought subject to the following:

a) the pre-existing Insured Illness and Related Medical Conditions exclusions as set out in Clause 18
b) an individual won't be given Temporary Cover if You've previously had a request for Benefit in respect of the Insured Person declined, restricted due to failure to provide medical evidence, postponed or accepted on non-standard terms, and
c) no Temporary Cover will be available to Insured Persons beyond the Date Cover Ceases who require Individual Assessment because the Policy has an Automatic Acceptance Limit of £0, or any Insured Person We've identified as needing to be Individually Assessed before benefiting from any change to the cover under the Policy.

6.6 The Temporary Cover will commence from the date of receipt by Us of the notice given pursuant to Clause 6.2 and will be in place until the earlier of completion of the Individual Assessment and the expiry of 90 days. If We're unable to complete Our assessment before the Temporary Cover period expires, the individual's cover will be restricted to their previous accepted level of cover.

6.7 The amount of Temporary Cover is limited so that, when added to any existing Benefit the Insured Person may receive under the Policy, their total Benefit entitlement during the period that Temporary Cover operates won't exceed the Maximum Benefit offered.

6.8 If the Insured Person's previous accepted level of cover was provided by another insurer, You must provide satisfactory evidence of the level of cover and any special terms and conditions to Us.

Insured Persons requiring subsequent Individual Assessments

6.9 We reserve the right to require an Insured Person who's previously been Individually Assessed to complete a further Individual Assessment if:

- that Insured Person's Benefit increases as a result of a change in benefit basis, or
- where cover is linked to the Member's Salary, the Member receives an increase in Salary.

7 The Automatic Acceptance Limit

7.1 The Automatic Acceptance Limit will be reviewed and may be changed by Us at any time. We reserve the right to reduce (including to nil) the Automatic Acceptance Limit if:

a) there are fewer than the Minimum Membership Number, or
b) the number of Members reduces by 30% or more from the number of Members at the Policy Start Date or the last Rate Review Date (if later).

7.2 We'll notify You in writing if We make any changes to the Automatic Acceptance Limit and will provide You with an updated Policy Schedule.

7.3 If We determine that the Automatic Acceptance Limit shall be reduced, the level of Benefit which applied to an Insured Person before the reduction becomes effective shall continue to apply.

7.4 If We determine that the Automatic Acceptance Limit shall be increased this will, subject to Clause 7.5, make no difference to the cover of Insured Persons currently insured hereunder unless and until their Benefit increases in which case the new Automatic Acceptance Limit will apply.

7.5 If We determine that the Automatic Acceptance Limit shall be increased the increased level won't apply to those Insured Persons whose cover has been restricted due to failure to provide medical evidence, declined, postponed or accepted on non-standard terms. Their cover shall remain unchanged.

8 Temporary absence from work

8.1 Where a Member is absent from work due to ill health, their cover continues until the date on which cover would otherwise cease pursuant to Clause 17.

8.2 Where a Member is absent from work as a result of statutory leave, cover will remain in place whilst they're still considered a Member unless cover ceases pursuant to Clause 17.

8.3 Where a Member in engaged through a Zero Hours Contract, cover during periods of ill health will cease on the earlier of:

a) the end of the contract in force when the Member was first absent
b) when that contract is terminated, or
c) three years form the start of the ill health

unless cover ceases pursuant to Clause 17.

8.4 Where a Member is absent from work due to any other reason which is agreed with the Member's Employer, cover will remain in place until the earlier of three years from the first date of absence and the date on which cover would otherwise cease pursuant to Clause 17.

8.5 If We agree to cover a Member beyond the Date Cover Ceases, their cover during periods of temporary absence can be until age 70 if absence is due to ill health and for up to 12 months for any other reason unless cover ceases pursuant to Clause 17.

8.6 If a Member is on a fixed term contract, cover during periods of temporary absence won't continue beyond the end of the contract in force at the date the Member was first absent.

8.7 Whilst the Member is absent, Benefit will be based on the Member's Benefit immediately prior to the start of the absence. However, where the basis of cover is a multiple of salary, cover can increase in line with average company pay awards up to a maximum of 5% per annum (the 5% maximum will be waived where the Member's entitlement to a larger increase is enshrined in law).

9 Insured Persons working outside the United Kingdom

9.1 Each Insured Person working outside the United Kingdom temporarily or on a secondment will be covered under this Policy provided:

a) the Member satisfies the Eligibility Conditions of the Scheme
b) the Member has a United Kingdom contract of employment or for services with a Participating Employer
c) there's the intention to return to the United Kingdom, and
d) the country of secondment is declared for each Insured Person at the Policy Start Date and at each Data Refresh.

9.2 Where an Insured Person is working outside the United Kingdom, the amount of salary or Benefit advised at each Date Refresh Date must be expressed in pounds sterling, using an appropriate Bank of England exchange rate. The exchange rate will be based on the Bank of England exchange rate and will be fixed at each Data Refresh Date. Therefore, in the event of a claim for a Member who isn't paid in pounds sterling, and where Benefit is based on a multiple of salary, the Benefit will be calculated based on the exchange rate agreed at the most recent Data Refresh Date before the date of diagnosis.

9.3 We won't provide cover for Insured Persons who are permanently working outside the United Kingdom.

10 Payment of Benefit to Members

10.1 In the event of the diagnosis of the occurrence of an Insured Illness, and as stated in the Policy, We'll pay Benefit in respect of that Member, where the individual survives for at least 14 days. The survival period begins from:

- the date of diagnosis of the Insured Illness
- the date of surgery where the Insured Illness requires surgery, or
- the date of inclusion on an official United Kingdom transplant waiting list (or date of surgery if earlier) where the Insured Illness is major organ transplant.

10.2 The amount of the Benefit will depend on the Category applicable to the Member.

10.3 The Benefit will be paid to the Member.

10.4 The Benefit is payable in pounds sterling.

11 Cover for Partners of Members

11.1 Where it is stated in the Policy Schedule that cover for Members' Partners is included, Members' Partners will be covered from the later of:

a) the date the Member's cover commences where the Member already has a Partner
b) the date they meet the definition of Partner, if they do so after the Member is covered under the Policy, or
c) the date their flexible benefit commences if the Member selects flexible benefit for the Partner.

11.2 The cover in respect of a Partner will last until the earlier of:

a) the date on which the Member's cover ceases
b) the Partner dies
c) the Partner reaches the Date Cover Ceases as stated in the Policy Schedule, unless We've agreed with You that their cover can be continued, or
d) on divorce, dissolution or ceasing to meet the definition of Partner.

11.3 The Partner's Benefit will become payable if there's an occurrence of an Insured Illness and where the Partner survives at least 14 days. The survival period begins from:

- the date of diagnosis of the Insured Illness
- the date of surgery where the Insured Illness requires surgery, or
- the date of inclusion on an official United Kingdom transplant waiting list (or date of surgery if earlier) where the Insured Illness is major organ transplant.

11.4 If a Partner is covered for total permanent disability, the cover will be based on an 'activities-based assessment' as set out in Clause 14.4.

11.5 Subject to Clause 6, cover for Partners will be subject to the pre-existing Insured Illness and Related Medical Conditions exclusions outlined in Clause 18.

11.6 An individual can't have cover as both a Member and a Member's Partner.

12 Cover for Children

12.1 Cover for Children is automatically provided under the Policy. Cover in respect of Children will commence on the later of:

a) commencement of the Member's cover
b) the Child's birth, and
c) the child meeting the definition of Child.

12.2 There's no limit on the number of Children that can be covered. The cover will last until the earlier of:

a) the Child reaches their 18th birthday (23rd birthday if in full-time education), and
b) the date on which the Member's cover ceases.

12.3 The Child's Benefit becomes payable if there is an occurrence of an Insured Illness and where the Child survives at least 14 days. The survival period begins from:

- the date of diagnosis of the Insured Illness
- the date of surgery where the Insured Illness requires surgery, or
- the date of inclusion on an official United Kingdom transplant waiting list (or date of surgery if earlier) where the Insured Illness is major organ transplant.

12.4 If total permanent disability is selected, the cover for Children will be based on an 'activities-based assessment' as set out in Clause 14.4.

12.5 Cover for Children will be subject to the pre-existing Insured Illness and Related Medical Conditions exclusions and the additional exclusion in relation to Children outlined in Clause 18.

12.6 If both parents work for the same organisation, the Children's cover will be 25% of the highest parent's Benefit up to a maximum of £25,000.

13 Extended cover

13.1 Cover can continue for Members who are working beyond the Date Cover Ceases, but will be subject to:

- new pre-existing Insured Illness and Related Medical Conditions exclusions detailed in Clause 18, applying on the Date Cover Ceases if the Policy has an Automatic Acceptance Limit of greater than £0 on the date the Member reaches the Date Cover Ceases, or
- Individual Assessment and acceptance by Us if the Policy has an Automatic Acceptance Limit of £0 on the date the Member reaches the Date Cover Ceases.

13.2 Cover can continue for Partners who are beyond the Date Cover Ceases, but will be subject to:

- new pre-existing Insured Illness and Related Medical Conditions exclusions detailed in Clause 18, applying on the Date Cover Ceases if the Policy has an Automatic Acceptance Limit of greater than £0 on the date the Partner reaches the Date Cover Ceases, or
- Individual Assessment and acceptance by Us if the Policy has an Automatic Acceptance Limit of £0 on the date the Partner reaches the Date Cover Ceases.

For the avoidance of doubt, if the Member has new pre-existing Insured Illness and Related Medical Condition exclusions applying to them because they're being covered beyond the Date Cover Ceases, these new exclusions won't apply to the Member's Partner (unless they too are being covered beyond the Date Cover Ceases).

13.3 Under no circumstances can cover continue beyond the age of 70.

13.4 Premiums in respect of Members (and, if We've agreed to cover them, Members' Partners) covered under this option must continue to be paid and those individuals must be identified on the data supplied to Us.

13.5 Where cover for total permanent disability, as set out in Clause 14.4, is being provided on an 'own occupation' basis, this will be amended to a 'suited occupation' basis for Members aged over their State Pension Age.

Section D

The Insured Illnesses

14 Critical illnesses covered under the Policy

14.1 For the purposes of the Insured Illness definitions, the following definitions apply:

- 'Irreversible' means it can't be reasonably improved upon by medical treatment and/or surgical procedures based on best clinical practice in the United Kingdom at the time of the claim
- 'Permanent' means it's expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the Insured Person expects to retire
- 'Permanent neurological deficit with persisting clinical symptoms' means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the Insured Person's life. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma
- The following aren't covered:
  - an abnormality seen on brain or other scans without defined related clinical symptoms
  - neurological signs occurring without symptomatic abnormality e.g. brisk reflexes without other symptoms, or
  - symptoms of psychological or psychiatric origin.

14.2 Illnesses covered

The Insured Illnesses are detailed below. You may also select to have cover for total permanent disability as defined in this section. The cover provided to You hereunder will be set out in the Policy Schedule.

Angioplasty – requiring treatment to multiple coronary vessels

Multi-vessel coronary artery disease treated by multi-vessel percutaneous coronary intervention (PCI) or a single coronary artery lesion of the left main stem treated by PCI. PCI is defined as any therapeutic intra-arterial catheter procedure including balloon angioplasty and/or stenting.

The PCI must have been carried out to treat a lesion in the left main stem or lesions in two or more of the main coronary arteries. Multiple vessels must be treated at the same time or as part of a planned stage procedure within 60 days of the first PCI.

For the purpose of this definition the main coronary arteries are:

1) right coronary artery or its branches
2) left anterior descending artery or its branches, or
3) circumflex artery or its branches.

For the above definition the following isn't covered:

- Diagnostic angiography

Bacterial meningitis – resulting in permanent symptoms

Bacterial meningitis causing inflammation of 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.

For the above definition the following isn't covered:

- all other forms of meningitis including viral meningitis.

Balloon valvuloplasty

The actual insertion, on the advice of a consultant cardiologist, of a balloon catheter through the orifice of one of the valves of the heart, and the inflation of the balloon to relieve valvular abnormalities.

Benign brain tumour – resulting in permanent symptoms or specified treatment

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms
- undergoing invasive surgery to remove part or all of the tumour, or
- undergoing either stereotactic radiotherapy or chemotherapy to destroy tumour cells.

For the above definition, the following aren't covered:

- tumours in the pituitary gland, or
- angioma.

Benign spinal cord tumour – resulting in permanent symptoms or specified treatment

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
- surgical removal of part or all of the tumour, or
- undergoing either stereotactic radiotherapy or chemotherapy treatment to destroy tumour cells.

For the above definition, the following isn't covered:

- angiomas.

Blindness or removal of an eyeball – permanent and irreversible

The undergoing of surgery to permanently remove an eyeball or, permanent and irreversible loss of sight to both eyes to the extent that, even when tested with the use of visual aids, sight is measured by an ophthalmologist as having a best corrected (with glasses or lenses) visual acuity in the better eye of:

- 6/60 or worse using a Snellen eye chart, or
- a loss of peripheral visual field where the residual visual field is reduced to an arc of 20 degrees or less.

For the above definition, surgical removal of an eyeball resulting from intentional self-inflicted injuries isn't covered.

Brain injury – resulting in permanent symptoms

Death of brain tissue due to a traumatic injury or reduced oxygen supply (anoxia or hypoxia) resulting in permanent neurologic deficit with persisting clinical symptoms.

Cancer – excluding less advanced cases and including aplastic anaemia

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:

- aplastic anaemia resulting in permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia
- essential thrombocythaemia
- leukaemia
- lymphoma (except cutaneous lymphoma – lymphoma arising from or confined to the skin)
- Merkel cell cancer
- polycythaemia vera
- primary myelofibrosis
- pseudomyxoma peritonei, and
- sarcoma (except cutaneous sarcoma - sarcoma arising from or confined to the skin).

For the above definition, the following aren't covered:

- all cancers which are histologically classified as any of the following:
  - pre-malignant
  - cancer in situ
  - having either borderline malignancy, or
  - having low malignant potential
- 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 skin cancer (including cutaneous lymphoma and sarcoma) that arises from, or is confined to, one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin unless it has spread to lymph nodes or metastasised to distant organs
- all thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0
- neuroendocrine tumours that have not spread to lymph nodes or metastasised to distant organs unless classified as WHO Grade 2 or above
- gastrointestinal stromal tumours that have not spread to lymph nodes or metastasised to distant organs unless classified by either AFIP/Lasota-Miettinen as having a moderate or high risk of progression, or as UICC TNM8 stage II or above, and
- 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).

Cancer – second and subsequent

This provides some cover for Insured Persons who've been previously diagnosed with cancer. A Benefit would be payable for a diagnosis of a new, unrelated cancer which meets the definition as defined in 'Cancer - excluding less advanced cases and including aplastic anaemia'.

The pre-existing Insured Illness exclusion applies in the normal manner to subsequent cancer claims unless:

- treatment for the previous cancer has been completed and the Insured Person hasn't received medical advice for further treatment of the condition for at least five years; and there is no evidence, confirmed by appropriate up-to date investigations and tests, of any continuing presence, recurrence or spread of the previous cancer, and
- the new cancer:
  - affects an organ that is physically and anatomically separate to any previous cancer, and
  - is not a secondary cancer or histologically related to any previous cancer, or
  - for haematological cancers, the new cancer is categorised or divided according to defined cell characteristics in a distinctly different manner to any previous cancer.

Treatment includes chemotherapy, radiotherapy, monoclonal antibody therapy, and invasive or non-invasive surgery, but doesn't include long-term maintenance hormone treatment.

Coma – of specified severity

A state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems for a period of at least 96 hours.

For the above definition, the following isn't covered:

- coma secondary to alcohol or drug abuse.

Deafness – permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram.

Degenerative neurological disorder – of specified severity

A definite diagnosis by a relevant consultant of a neurodegenerative disorder with worsening symptoms over time, expected to progress throughout the lifetime of the Insured Person, resulting in either:

- permanent clinical impairment of motor function effecting body movement, or
- permanent loss of the ability to remember, reason, understand, express and give effect to ideas.

For this definition, the following aren't covered:

- essential tremor, migraine, epilepsy, myasthenia gravis, Charcot-Marie-Tooth disease, functional nervous disorder, conversion disorder, fibromyalgia and chronic fatigue syndrome, mild cognitive impairment, spastic paraplegia and peripheral neuropathy
- conditions or symptoms of psychological or psychiatric origin, or
- conditions related to or exacerbated by alcohol or drug usage.

Encephalitis – resulting in permanent symptoms

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

Heart attack – of specified severity

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

- typical clinical symptoms (for example, characteristic chest pain)
- new characteristic electrocardiographic changes or new diagnostic imaging changes
- the characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following aren't covered:

- myocardial injury without myocardial infarction, and
- angina without myocardial infarction.

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 – end stage

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

- permanent jaundice
- permanent ascites, and
- encephalopathy.

For the above definition the following isn't covered:

- liver failure secondary to alcohol or drug abuse.

Loss of independence – of specified severity (for adults only)

Confirmation by a consultant physician of the permanent loss of the ability to live independently which meets the following criteria:

Either

- Mental failure: The diagnosis by a consultant neurologist or psychiatrist, of an irreversible and permanent mental impairment due to an organic brain disease or brain injury supported by evidence of all of the following:
  - the loss of the ability to remember, reason and give effect to ideas which causes a significant reduction in mental and social functioning, and
  - the Insured Person covered requires continuous supervision.

Or

- The Insured Person covered is unable to perform two out of the following five activities without the help of another person, even with the use of appropriate assistive devices:
  - Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower)
  - Dressing: The ability to put on and take off, secure and unfasten all garments
  - Getting between rooms: The ability to get from room to room on a level floor
  - Feeding themselves: The ability to feed themselves when food and drink has been prepared, or
  - Maintaining personal hygiene: The ability to maintain a satisfactory level by using the toilet or otherwise managing bowel and bladder functions.

Note: This Insured Illness is only available for adults. Children will be covered under the Child specific Insured Illness 'Permanent dependence'.

Loss of use of a limb

Permanent loss of the use of a limb due to:

- physical severance of a hand or foot at or above the wrist or ankle joint, or
- total and irreversible loss of muscle function to the whole arm or leg.

Lung disease or removal – as specified

The undergoing of surgery to remove an entire lung (pneumonectomy), or confirmation by a consultant physician of chronic lung disease, which is evidenced by all of the following:

- the need for continuous daily oxygen therapy on a permanent basis
- evidence that oxygen therapy has been required for a minimum period of six months
- forced expiratory volume (FEV1) being less than 40% of normal, and
- vital capacity less than 50% of normal.

Major organ transplant – from another donor

The undergoing as a recipient of a transplant from either a human donor, animal or insertion of an artificial device, or inclusion on an official United Kingdom waiting list for any of the following:

- transplant of a bone marrow
- haematopoietic stem cell preceded by total bone marrow ablation
- transplant of a complete heart, kidney, liver, lung or pancreas
- transplant of a lobe of liver, or
- transplant of a lobe of lung.

For the above definition, the following isn't covered:

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

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

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

The following isn't covered:

- neuromyelitis optica spectrum disorder.

Reduced heart function – of specified severity

Permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classification of functional capacity due to reduced heart function resulting from a definite diagnosis by a consultant cardiologist of:

- cardiomyopathy
- pulmonary hypertension, or
- any other cardiac condition which has also resulted in a permanent and irreversible ejection fraction of 39% or less.

For this definition, the following isn't covered:

- any heart impairment related to alcohol or drug misuse.

(Chronic) Rheumatoid arthritis – of specified severity

Severe chronic rheumatoid arthritis with widespread joint destruction and deformity of at least three major joint groups, which results in the inability to do at least three of the following:

- bend or kneel to pick up something from the floor and stand up again
- use hands and fingers to pick up and manipulate small objects such as cutlery, including being unable to write using a pen or pencil or keyboard
- lift, carry or otherwise move everyday objects by hand (everyday objects include a kettle of water, a bag of shopping and an overnight bag or briefcase), or
- walk a distance of 200 metres on flat ground, with or without the aid of a walking stick and without experiencing severe discomfort.

Stroke – of specified severity

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either:

- permanent neurological deficit with persisting clinical symptoms, or
- definite evidence of death of tissue or haemorrhage on a brain scan and neurological deficit with persisting clinical symptoms lasting at least 24 hours.

For the above definition, the following aren't covered:

- transient ischaemic attack, or
- death of tissue of the optic nerve or retina / eye stroke.

Surgery to the heart, aorta or pulmonary artery – as specified

The undergoing of, or inclusion on an official United Kingdom waiting list for, one of the following procedures on the advice of an attending consultant:

- surgery to the heart requiring thoracotomy
- surgery to the aorta or pulmonary artery requiring excision and surgical replacement of a portion of either with a graft, or
- implantation of a cardioverter-defibrillator (ICD) or cardiac resynchronisation therapy with defibrillator (CRT-D).

The following isn't covered:

- any other surgery including endovascular surgery.

Surgery via the skull – as specified

The undergoing of, or inclusion on an official United Kingdom waiting list for, surgery requiring craniotomy or craniectomy.

Systemic lupus erythematosus (SLE) – of specified severity

A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist where either of the following are also present:

- SLE affecting the kidneys which has resulted in permanent impaired kidney function with a Glomerular Filtration Rate (GFR) below 30 ml/min, or
- SLE affecting the central nervous system which has caused permanent neurological deficit with persisting clinical symptoms.

Terminal illness – where death is expected within twelve 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 can't be cured, and
- in the opinion of the attending consultant, the illness is expected to lead to death within 12 months.

Third degree burns – covering 20% of the body's surface area or 20% of the face's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue either:

- covering at least 20% of the surface area of the body, or
- covering at least 20% of the surface area of the face.

14.2.1 Child specific Insured Illnesses

Cerebral palsy

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

Cystic fibrosis

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

Down's syndrome

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

Edwards' syndrome

A definite diagnosis of Edwards' syndrome by an attending consultant.

Hydrocephalus – treated with insertion of a shunt

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

Muscular dystrophy

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

Osteogenesis imperfecta

A definite diagnosis of osteogenesis imperfecta by an attending consultant.

For the above definition the following isn't covered:

- Type 1 osteogenesis imperfecta.

Patau syndrome

A definite diagnosis of Patau syndrome by an attending consultant.

Permanent dependence – of specified severity

Confirmation by a consultant physician and Our consultant medical officer of permanent dependence and the inability to live independently through illness or injury, to the extent that a Child will require lifelong medical attention and constant supervision by another person.

Having met Our definition, a Child must survive for 90 days.

Spina bifida

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

For the above definition, the following aren't covered:

- spina bifida occulta, and
- spina bifida with meningocele.

Total permanent disability

14.3 Where total permanent disability cover has been selected, the cover selected will be specified in the Policy Schedule.

14.4 In order to claim for total permanent disability, the disability must have continued for six months. For the purpose of this benefit, the word permanent means that the disability is expected to last throughout the Insured Person's life, irrespective of when the cover ends or the Insured Person retires, and is irreversible (i.e. can't be reasonably improved upon by medical treatment and/or surgical procedures based on best clinical practice in the United Kingdom at the time of the claim). Evidence must be supplied that the condition has been investigated and managed by an appropriate consultant.

14.5 Total and permanent disability of the Insured Person, will be measured by their inability to perform the following (as selected), as a result of illness or injury:

Own occupation – unable to do their own occupation ever again before the Member's State Pension Age

Loss of physical or mental ability through an illness or injury before the Member's State Pension Age to the extent that the

Member is unable to do the material and substantial duties of their own occupation ever again.

- Material and substantial duties means those that are normally required for and/or form a significant and integral part of the performance of the Member's own occupation and which can't be reasonably omitted or modified by the Member or the Employer.
- Own occupation means the Member's profession or type of work they do for profit or pay. It isn't a specific job with any particular employer and is irrespective of location and availability.

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

For this definition, disabilities for which the relevant specialists can't give a clear prognosis aren't covered.

Suited occupation – unable to do a suited occupation ever again

Loss of physical or mental ability through an illness or injury to the extent that the Member is unable to do the material and substantial duties of their own occupation and any other reasonable alternative occupation to which they are suited.

- Material and substantial duties means those that are normally required for and/or form a significant and integral part of the performance of the Member's own occupation (or of a reasonable alternative occupation) and which can't be reasonably omitted or modified by the Member or the Employer.
- Reasonable alternative occupation means any work the Member could do for profit or pay taking into account their employment history, knowledge, transferable skills, training, education and experience and is irrespective of location and availability.
- Own occupation means Member's profession or type of work they do for profit or pay. It isn't a specific job with any particular employer and is irrespective of location and availability.

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

For this definition, disabilities for which the relevant specialists can't give a clear prognosis aren't covered.

Activities-based assessment

Unable to perform three or more of the following activities without the assistance of another person, even with the use of appropriate assistive devices:

- climbing – the ability to climb a set of normal household stairs
- hearing – the ability to hear, with a hearing aid if required, well enough to understand someone speaking a common language in a normal voice in a quiet room
- speech – the ability to be understood in a common language in a quiet room
- vision – the ability to see well enough to read 16 point print using glasses or other aids if required
- washing - the ability to wash themselves all over
- bending – the ability to bend or kneel to pick up something from the floor and stand up again and the ability to get into and out of a standard saloon car
- dexterity – the ability to use hands and fingers to pick up and manipulate small objects such as cutlery, including being unable to write using a pen or pencil or keyboard
- lifting – the ability to lift, carry or otherwise move everyday objects by hand (everyday objects include a kettle of water, a bag of shopping and an overnight bag or briefcase), or
- mobility – the ability to walk a distance of 200 metres on flat ground, even with the aid of a walking stick if prescribed by a treating practitioner, and without having to rest.

Or in the event of mental incapacity, they have a mental incapacity which:

- has failed to respond to optimal treatment based on best clinical practice in the United Kingdom and requires the need for continuous psychotropic medication, or
- is due to an organic brain disease or brain injury supported by evidence of progressive loss of ability to:
  - remember
  - reason, and
  - perceive, understand, express and give effect to ideas

and in either case causes a significant reduction in mental and social functioning, requiring the continuous supervision of the person covered.

For this definition, disabilities for which the relevant specialists can't give a clear prognosis aren't covered.

14.6 Irrespective of which basis is used for Members, the basis applicable to a Partner (if this cover is selected) or Child will always be an activities-based assessment.

Section E

Making a Claim

15 Making a claim

15.1 You must notify Us as soon as possible following the occurrence of an Insured Illness for any Insured Person by telephoning Our claims team on 0330 303 9973 or by emailing groupclaims@aiglife.co.uk. We'll then issue a claim form for You to complete, sign and return to Us and a claim form for the Insured Person to complete, sign and return to Us.

15.2 We'll only consider claims if We've been notified of them within two years of the date of the diagnosis.

15.3 You must provide Us with all information requested by Us to investigate the claim properly. This information may include any of the following:

a) a completed claim form signed by the policyholder
b) proof of the Member's age (for example the Member's passport or birth certificate, or confirmation that You have seen one of these documents)
c) a member claim form completed by the Insured Person (or their representative), including their consent for Us to seek further medical information as required by the Access to Medical Reports Act 1988
d) where a claim is being made in respect of a Member's spouse or civil partner, an original copy of their marriage or civil partnership certificate (We are unable to accept a photocopy)
e) where a claim is being made in respect of a Member's Partner who isn't a spouse or civil partner, an original copy of their birth certificate (We are unable to accept a photocopy) and evidence that they meet the definition of Partner
f) where a claim is being made in respect of a Member's Child, an original copy of their birth or adoption certificate (We are unable to accept a photocopy)
g) where a claim is being made for total permanent disability on either an own occupation or suited occupation basis, a copy of the Member's job description detailing their regular duties at the date of the claim, or
h) any other information, evidence, test, evaluation or report that may be requested at any time by Us.

15.4 We won't pay claims where the Premium is outstanding.

15.5 We aren't responsible for any errors or omissions from any information or evidence provided to Us from any source.

15.6 Any diagnosis or medical opinion must be given by a medical professional who is a specialist in an area of medicine appropriate to the cause of the claim and is acceptable to Our consultant medical officer.

15.7 Once We determine that a claim is valid, We'll pay the Benefit in pounds sterling by direct credit (via the BACs system) to the Member's United Kingdom bank account.

Section F

Termination

16 Termination of the Policy as a whole

16.1 This Policy doesn't have a termination date.

16.2 You shall be entitled to terminate this Policy at any time by giving Us notice in writing stating the date on which You want cover to cease.

16.3 We shall be entitled to terminate the Policy immediately if:

a) You don't pay the Premium when it's due
b) You don't comply with any of the Policy Terms and Conditions
c) You don't provide data requested by Us in accordance with the Policy Terms and Conditions within 90 days of receipt of a request
d) You don't provide any information requested by Us in accordance with the Policy Terms and Conditions within 90 days of receipt of a request
e) an Employer stated in the Policy Schedule ceases to carry on business, or if an order is made or a resolution passed for the winding up of that Employer, or
f) there's a change in legislation, regulation, HMRC practise or taxation which affects this Policy.

16.4 If the Policy is terminated, You shall be required to provide information as at the date of termination in order for Us to determine the Premium payable up to the date of termination. If this information isn't provided within one month of its being requested, We shall determine what Premium is payable having regard to the information then available, and any sum or sums which had been payable to Us shall remain payable.

16.5 If the Policy is terminated no Benefit shall be payable in respect of any Insured Illness claim arising for any Insured Person after the effective date of termination of this Policy.

Setting up the Policy

16.6 If You deliberately or recklessly don't make a fair presentation of the risk when setting up the Policy and We wouldn't have agreed to enter into the Policy at all if We'd known the material facts, We may avoid the Policy, refuse all claims and recover claims paid.

16.7 If You don't make a fair presentation of the risk when setting up the Policy but You haven't been deliberate or reckless, and We wouldn't have agreed to enter into the Policy if We'd known the material facts, We may avoid the Policy, refuse all claims and recover claims paid.

Rate Reviews

16.8 The duty of fair presentation of risk applies at each Rate Review. If You deliberately or recklessly don't make a fair presentation of the risk at Rate Review and We wouldn't have agreed to the contract at all or on the terms offered if We'd known the material facts, We may terminate the contract with effect from the Rate Review Date, refuse claims and recover claims paid.

16.9 If You don't make a fair presentation of the risk at a Rate Review, but You haven't been deliberate or reckless, and We wouldn't have entered into the contract at all if We'd known the material facts, We may terminate the contract with effect from the Rate Review Date, refuse claims and recover claims paid.

Variations

16.10 If You deliberately or recklessly don't make a fair presentation of the risk when applying to vary the Policy and We wouldn't have agreed to enter into the variation of the Policy if We'd known the material facts, We may by notice to You treat the contract as terminated with effect from the time the variation was made, refuse claims and recover claims paid.

16.11 If You don't make a fair presentation of the risk when applying to vary the Policy, but You haven't been deliberate or reckless, and We wouldn't have agreed to enter into the variation of the Policy if We'd known the material facts, We may treat the contract as if the variation had not been made.

Fraudulent claims

16.12 If You make a fraudulent claim, We may:

a) terminate the Policy by notice and treat the contract as being terminated from the time of the fraudulent act
b) recover any claims paid since the fraudulent act, and
c) refuse to pay any claims submitted since the fraudulent act.

17 Termination of cover in respect of individuals

17.1 Cover under this Policy in respect of individual Members ceases on the earliest of the following occurrences:

a) the Member ceases to be an Employee
b) the Member ceases to be a Member of the Scheme
c) the Member dies
d) the Member's a worker engaged through a Zero Hours Contract who hasn't received earnings from the Employer for a period of six consecutive months unless they're unavailable for work due to ill health
e) the Member reaches the Date Cover Ceases, as stated in the Policy Schedule, unless We've agreed with You that their cover can be continued
f) in respect of a Member before the Date Cover Ceases, the Member has been absent from work (with the approval of their Employer) for three years for a reason other than ill health or statutory leave (or the end of the contract in force on the date first absent if the Member's on a fixed term contract)
g) in respect of a Member after the Date Cover Ceases, the Member has been absent from work (with the approval of their Employer) for 12 months for a reason other than ill health or statutory leave (or the end of the contract in force on the date first absent if the Member's on a fixed term contract)
h) the Member reaches the Date Cover Ceases, as stated in the Policy Schedule, unless We've agreed with You that their cover can be continued, or
i) the Member reaches the end of a fixed term contract.

17.2 Cover for a Child will cease once the Member's cover has ceased or if they reach the maximum age for Child's cover.

17.3 If cover is provided for a Member's Partner, it will cease:

a) once the Member's cover has ceased
b) if the Partner dies
c) if the Partner reaches the Date Cover Ceases as stated in the Policy Schedule, unless We've agreed with You that their cover can be continued, or
d) on divorce or dissolution or ceasing to meet the definition of Partner.

17.4 In any event, no cover is provided under this Policy for Members or Partners who are aged 70 or over.

Section G

Miscellaneous

18 Exclusions and limits

18.1 No Benefit will be payable in respect of an Insured Person where the illness is one of the excluded conditions listed below.

18.2 An individual can't have cover as both a Member and a Member's Partner.

Pre-existing Insured Illness exclusion

18.3 No Benefit will be payable for any Insured Illness or repeat of the same Insured Illness which the Insured Person:

- has received treatment for
- has sought advice on
- has experienced symptoms of, or
- was diagnosed with

before entry to the Scheme.

18.4 For the purposes of this Policy, the illnesses in each group listed below will be deemed to be the same Insured Illness:

Group 1	• Angioplasty • Balloon valvuloplasty • Heart attack • Heart transplant (under the major organ transplant) • Heart valve replacement or repair • Reduced heart function • Stroke • Surgery to the heart, aorta, or pulmonary artery. For example, where an Insured Person suffers a heart attack, no Benefit shall be payable in respect of any subsequent stroke claim.
Group 2	• Kidney failure • Kidney transplant (under the major organ transplant). For example, where an Insured Person suffers from kidney failure, no Benefit shall be payable in respect of any subsequent claim for kidney transplant under the major organ transplant definition.
Group 3	• Liver failure • Liver transplant (under the major organ transplant). For example, where an Insured Person suffers from liver failure, no Benefit shall be payable in respect of any subsequent claim for liver transplant under the major organ transplant definition.
Group 4	Where the Insured Person has suffered from any malignant tumours, defined as 'cancer – excluding less advanced cases and including aplastic anaemia', no Benefit shall be payable in respect of any subsequent 'cancer – excluding less advanced cases and including aplastic anaemia' where it is connected to, or associated with the prior diagnosis of cancer. This exclusion doesn't apply if the criteria defined under 'Cancer – second and subsequent' is met.

18.5 In addition, no Benefit will be payable for any Insured Illness which the Insured Person:

- has received treatment for
- has sought advice on
- has experienced symptoms of, or
- was diagnosed with

before entry to the Scheme, and which leads to a claim for coma, loss of independence, loss of use of a limb, terminal illness or total permanent disability. For example, where a Member claims under the terminal illness benefit as a result of cancer, but had suffered from cancer before entering the Scheme, this claim will be declined.

18.6 The criteria under this pre-existing Insured Illness exclusion shall also apply to any increase in Benefit.

In this case, rather than no Benefit being payable, the exclusion means that no increase in Benefit will be payable, and rather than only applying to Insured Illness or a repeat of the same Insured Illness suffered before entry to the Scheme, it applies to ones suffered before the Benefit increase.

18.7 A pre-existing Insured Illness exclusion will apply to a Member's (and, if they're covered under the Policy, a Member's Partner) Benefit unless We've Individually Assessed them and confirmed the removal of the exclusion in writing. In any event, the pre-existing Insured Illness exclusion will always apply to a Member's Child.

Related Medical Conditions exclusion

18.8 No Benefit will be paid in respect of any Insured Illness where a Related Medical Condition existed prior to entry to the Scheme unless the Insured Person has been in the Scheme for two consecutive years or more and the Insured Illness hasn't occurred in that two year period.

18.9 We won't pay any claim in respect of an increase in Benefit for an Insured Illness where a Related Medical Condition existed prior to the increase unless at least two consecutive years has passed since the increase and the Insured Illness hasn't occurred in that two year period. However, this Related Medical Conditions exclusion won't apply to Benefit increases where Benefit is based on salary and the increase is as a result of a salary increase which is in line with average company pay awards (up to a maximum of 5% per annum).

18.10 No Benefit will be paid for any coma, loss of independence, loss of use of a limb, terminal illness or total permanent disability benefit where a Related Medical Condition existed before entry to the Scheme.

18.11 No increase in Benefit will be paid for any coma, loss of independence, loss of use of a limb, terminal illness or total permanent disability benefit where a Related Medical Condition existed before the last increase in Benefit.

Additional exclusions applied after Individual Assessment

18.12 After the Individual Assessment of Insured Persons, exclusions may apply for claims arising from certain specified medical conditions or in specified circumstances.

Additional exclusion in relation to Children

18.13 No Benefit will be paid in respect of a Child if, before the Child was covered under the Scheme either parent received counselling or medical advice in relation to the Insured Illness or Related Medical Condition, or were aware of the increased risk of the Insured Illness or Related Medical Condition.

Excluded Claims

18.14 No Benefit will be paid where a claim is made which is, in the opinion of Our consultant medical officer, either directly or indirectly associated with an earlier claim which has been paid, or the basis of the earlier paid claim is likely to have led to the occurrence of the new Insured Illness.

18.15 An individual can't be covered as an Employee and a Partner. Where a Member is both an Employee and a Partner of another Member, a claim can't be submitted twice for the same condition.

18.16 If a claim was paid for an Insured Person by a previous insurer of Your scheme, a claim can't be made in respect of that individual for the same or Related Medical Condition under this Policy.

18.17 Benefit won't be paid if a Member failed to disclose any material information during the course of the Individual Assessment.

19 Contracting out of the Insurance Act 2015

19.1 You must provide a fair presentation of the risk when setting up the Policy, on an application to vary the Policy and at a Rate Review.

19.2 If We would've applied different terms and/or a higher Premium if You'd fairly presented the risk set out in Clause 19.1, then You agree that We can retrospectively charge the correct higher Premium (and apply any different terms to the Policy). You agree to promptly pay the corrected additional Premium.

19.3 Upon receipt of the corrected additional Premium set out in Clause 19.2, We'll pay the claim in full, rather than on the proportionate reduction basis described in Schedule 1 paragraphs 6 and 11 of the Insurance Act 2015. To that extent, Clause 19 contracts out of Schedule 1 paragraphs 6 and 11 of the Insurance Act 2015.

19.4 Other remedies in respect of the duty of fair presentation of the risk are set out at Clauses 16.6 – 16.12 inclusive of this Policy.

20 Remedies for fraudulent claims

20.1. To the extent that this Policy provides cover in respect of a person who isn't a party to the Policy and a fraudulent claim is made under the Policy by or in respect of that Insured Person, We may exercise the rights set out in Clause 20.2 as if there were an individual insurance contract between Us and the Insured Person concerned. However, the exercise of any of those rights won't affect the cover provided under the Policy in respect of any other Insured Person.

20.2. If there's a fraudulent claim by or in respect of an Insured Person under this Policy, We'll inform the Policyholder and the Insured Person that We cancelled the cover in respect of the Insured Person with effect from the time of the fraudulent act and that We'll seek to recover any sums paid by Us in respect of the claim.

20.3. If We exercise Our right to terminate under Clause 20.2, We won't be liable in respect of the claim for the Insured Person if it occurred after the time of the fraudulent act.

21 Governing law and jurisdiction

21.1 This Policy is to be construed and governed in accordance with English and Welsh law and any dispute shall be subject to the exclusive jurisdiction of the English and Welsh courts.

21.2 This Policy has no surrender value and can't be assigned without Our prior written permission.

21.3 We won't be responsible or liable to provide cover (including the payment of a claim) under this Policy if We're prevented from doing so by any economic sanction which prohibits Us or Our Parent Company (or Our Parent Company's ultimate controlling entity) from providing cover or dealing with You under the Policy.

22 Contracts (Rights of Third Parties) Act 1999

22.1 No term or provision of this Policy may be enforced in any circumstances by any third party, whether under the Contracts (Rights of Third Parties) Act 1999, which is hereby excluded, or otherwise. The Policy may be amended or terminated without the consent of, or reference to, any third party.

23 Data protection

23.1 Unless the context otherwise requires, for the purpose of this Clause: (i) data protection law means all applicable laws and regulations, in each case pertaining to the security, confidentiality, protection or privacy of personal data, as amended or re-enacted from time to time, including (without limitation and to the extent applicable) the European General Data Protection Regulation (Regulation (EU) 2016/679) (the GDPR); and (ii) the terms controller, processor, processing/process, personal data and data subject shall be interpreted and construed by reference to data protection law. For the purposes of this Clause, Parties mean You and Us.

23.2 Without prejudice to Clause 23.3, each Party (the Disclosing Party) agrees that if it provides personal data to the other Party (the Receiving Party), it shall ensure that it has provided all necessary information to the data subjects of the personal data, in each case to enable the personal data to be disclosed to the receiving Party for the purposes of this agreement and in accordance with data protection law.

23.3 Each Party shall comply with its obligations under data protection law.

23.4 The Parties agree that, for the purposes of data protection law, each Party (to the extent it processes personal data pursuant to or in connection with this agreement) processes personal data as an independent data controller in its own right. Nothing in this agreement (or the arrangements contemplated by it) is intended to construe either Party as the data processor of the other Parties or as joint data controllers with one another.

23.5 We process personal data for the purposes of providing insured Benefit for the benefit of Your Members and their families in accordance with the Data Protection Act 2018. The information supplied by you may be transferred outside the United Kingdom including to countries outside the European Economic Area (including the USA, China, Mexico, Malaysia, Philippines and Bermuda). Full details can be found in Our privacy policy www.aiglife.co.uk/privacy-policy.

23.6 Where We undertake an Individual Assessment, We'll be responsible for obtaining appropriate consents from the individual in respect of data collected during the course of the Individual Assessment.

24 Notices

24.1 Any notice or other communication given under this Policy shall be in writing and may be served by delivering it personally, or sending it by pre-paid first class post, registered or recorded delivery to the relevant address or sent as a PDF attachment to an email to the relevant email address set out below or such other address or email address as either party may from time to time notify the other in writing.

24.2 Documents relating to the administration and operation of this Policy will be lodged in Our secure online document store and will be deemed to have been received as if by email.

24.3 Any notice or other communication given pursuant to this Policy shall be deemed to have been given or received:

a) in the case of dispatch by first class, registered post or recorded delivery, on the third day after its dispatch
b) in the case of delivery by hand, at the time of its delivery, or
c) in the case of email, within three hours of transmission,

provided that if deemed receipt occurs after 5pm on a Business Day or on a day which is not a Business Day, the notice shall be deemed to have been received at 9am on the next Business Day.

25 Appeals and complaints

25.1 If a claim is declined and You disagree with Our decision, You or the claimant can appeal Our decision. An email should be sent to groupclaims@aiglife.co.uk outlining the reason for the appeal and attaching any additional information. The claim will be reviewed by an appropriately qualified and experienced assessor who wasn't involved in the original claim decision.

25.2 Any complaints You may have should be referred to Us at the following address:

AIG Life Limited
The AIG Building
58 Fenchurch Street
London
EC3M 4AB

Tel **0330 303 9974** (Calls may be recorded for training and monitoring purposes.) or

by email to groupcomplaints@aiglife.co.uk.

25.3 If You remain dissatisfied with the outcome of Your complaint and You're an 'eligible complainant' for the purposes of the Financial Conduct Authority dispute resolution rules ('DISP'), the matter may be escalated to the Financial Ombudsman Service at the address below. Your legal rights won't be affected by contacting this organisation.

Financial Ombudsman Service Ltd,
Exchange Tower,
London, E14 9SR

Tel **0800 023 4567**

25.4 Any complaint from Insured Persons in connection with this Policy should be referred to You. You shall either deal with such complaint or, if appropriate, refer such complaint to Us at the address above. If the Insured Person remains dissatisfied the matter may be escalated to the Financial Ombudsman Service (if eligible). The Member's legal rights aren't affected by contacting this organisation.

26 Compensation

26.1 We're covered by the Financial Services Compensation Scheme ('FSCS'). You may be entitled to compensation from the scheme if We can't meet Our obligations. This depends on the type of business and the circumstances of the claim.

Further information about compensation scheme arrangements is available from the FSCS:

Financial Services Compensation Scheme
PO Box 300
Mitcheldean
GL17 1AY

Tel **0800 678 1100**

www.aiglife.co.uk