group critical illness technical guide

ellipse

Any reference in this technical guide to employer can include the principal employer and participating employers.

Policy aims

- To provide insurance to pay a lump sum benefit if a member or child of a member (or, if insured, a spouse/partner of a member) suffers from one of the insured illnesses specified in the policy.

Your commitment

- To pay the premiums when they are due.
- To comply with the policy terms and conditions.
- To tell us of any potential claims as soon as possible.
- To provide us, at the agreed intervals, with the information specified in the policy as needed to ensure effective and timely cover.
- To ensure that any information you supply is complete and accurate at the time when you provide it.
- To provide information about the policy and how it works to members.

Our commitment

- Once we accept a claim we will pay the benefit within five days providing we have valid payment details.
- We will pay promptly any premium refunds that may arise.
- We will request information about you or the insured persons only to the extent it is necessary to ensure the efficient running of your policy.
- We will copy in your adviser to any correspondence we send to you.
- We will not copy you or your adviser into any correspondence sent to individuals in connection with assessing their health (to protect their privacy), but we will ensure you and your adviser are aware of the progress and results of such assessments.

Document reference:

GCI-TechGuide-Jan19 -1

Risk factors

- If you do not pay premiums on time, provide data when requested or you fail to comply with any of the policy terms and conditions we reserve the right to cease the policy and not pay any new claims.
- Any delay in providing the information we require may result in individuals not being covered or having less than their full cover.
- If you do not fairly present the risk (e.g. the information we have requested is not provided, is incomplete or is inaccurate) then we have the right to adjust the premiums we charge for the cover and/or the terms and conditions or cease the policy – see section 9.4 'What happens if you do not make a fair presentation of the risk'.
- Certain types of claims will be excluded – see section 6 'What is not covered'.
- We will not pay claims for any pre-existing insured illness or related medical condition – see section 6 'What is not covered'. The pre-existing insured illness and related medical conditions exclusions will also apply in respect of children and spouses/partners (if covered under the policy).
- The premiums may be reviewed and varied, even within a rate guarantee period, in the circumstances described in the next section 'How does the policy work?'

Your questions answered

How does the policy work?

- You decide the eligibility conditions and the type and level of cover that you would like us to provide. You can choose different types and levels of cover for different categories of members. Members' children are automatically covered from birth to their 18th birthday (23rd birthday if in full time education) as long as the member remains covered. You can choose if cover is to be provided to members' spouses or partners.
- In order to ensure that you comply with relevant employment and taxation legislation you should obtain appropriate legal and tax advice.
- You pay premiums when they are due. Where you pay the premium it is normally treated as a business expense for tax purposes but is treated as a benefit in kind for employees. However, you should confirm this with your tax advisers.
- We provide the cover whilst premiums are being paid and the policy remains in force no matter how many claims you make.
- A lump sum benefit becomes payable if an individual covered by the policy suffers one of the insured illnesses as defined in the policy and survives for more than fourteen days.
- The benefits to be paid in the event of claims will be as shown in the policy schedule. If the scheme is part of a flexible benefits arrangement, you will select the levels of cover members can choose from and the amount paid in the event of a claim will be the level most recently selected by the member from the range available to them.
- All members will be covered for benefit up to an automatic acceptance limit specific to your policy. Any benefit that exceeds the automatic acceptance limit will be subject to individual assessment.
- Once we have admitted a claim we will pay the lump sum to the member.

- You will be required to provide us with membership data within fourteen days of us requesting it. We will confirm at the start of the policy how often you will provide updated membership data which needs to be complete and accurate. This should include details of new entrants who have joined the scheme since the previous data refresh and who will normally be covered as soon as they join the scheme. However, we should be informed immediately rather than at the next data refresh if a new entrant's benefit exceeds the automatic acceptance limit because they will need to complete an individual assessment to establish the terms, if any, on which cover can be offered.
- The policy terms and conditions and the underlying premium rate table are normally guaranteed for two years and will not be reviewed during that time unless one of the following occurs:
    - a greater than 30% variation in the number of members (and if covered, spouses/partners) or their total salaries
    - the number of members drops below two
    - the new inclusion of an participating employer or a TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006) transfer
    - the disposal of a participating employer or closure of a part of a participating employer's business
    - the inclusion of a new category
    - a change in policy design such as an amendment to the benefit level, the age cover ceases or eligibility conditions
    - a change in the nature of a participating employer's business
    - more than 30% of the total number of members or total salary change location
    - there is no longer an adviser acting for you in connection with this policy
    - there is a change in legislation, regulation, HM Revenue & Customs (HMRC) practice or taxation which affects the treatment of this policy
    - you do not give us complete and accurate information.

  These matters define the risk as a whole.

Table of Contents

Policy aims **1**

Your commitment **1**

Our commitment **1**

Risk factors **2**

Your questions answered **2**

1. What factors should be considered in deciding what benefits to provide? **6**

1.1 Who can be covered? 6

1.2 Eligibility conditions 6

1.3 When will cover cease? 6

1.4 What types of cover are available? 8

1.5 What level of cover can be provided? 9

1.6 When is the lump sum payment due? 10

1.7 Do members continue to be covered if they are absent from work? 10

1.8 Can members' families be covered? 11

1.9 Are any additional options available under the policy? 12

1.10 Additional benefit provided at no extra cost 13

1.11 Flexible Benefits 13

2. Setting up the policy **14**

2.1 What are the requirements for setting up the policy? 14

2.2 Does any evidence of health have to be provided before members are covered? 15

2.3 What happens if a claim arises before an underwriting decision has been made? 18

3. What premiums will be charged for the cover? **19**

3.1 How will premiums be calculated? 19

3.2 Will there be any extra premium? 19

3.3 Is there a discount for a good claims history? 20

3.4 What commission is included within the premium? 20

4. How does the policy accounting work? **21**

4.1 What information is required for accounting purposes? 21

4.2 How are accounts adjusted for members who join, leave or have benefit changes during the year? 22

4.3 If the policy is cancelled mid-year, will premiums paid in advance be lost? 22

5. Claiming benefit 23
5.1 How are claims made? 23
5.2 Can another claim be made for an individual? 24
6. What is not covered? 25
6.1 Pre-existing insured illness exclusion 25
6.2 Related medical conditions exclusion 26
6.3 Additional exclusions applied after individual assessment 28
6.4 Additional exclusions in relation to children 28
6.5 Excluded claims 28
7. Can cover be provided for an individual who is not based in the UK? 29
7.1 Individuals who travel outside the UK 29
7.2 Individuals seconded outside the UK 29
7.3 Individuals permanently based outside the UK 29
8. Taxation of policies 31
8.1 Payment of premiums 31
8.2 Payment of benefits 31
9. Your duty of fair presentation of the risk 32
9.1 What you know or ought to know 32
9.2 Material facts 32
9.3 Paying claims in full means that we are contracting out of this part of the Insurance Act 2015 32
9.4 What happens if you do not make a fair presentation of the risk 32
9.5 Fraudulent claims 33
10. Critical illness definitions 34
10.1 Core illnesses 34
10.2 Additional illnesses 37
10.3 Total permanent disability 42
11. Glossary of terms used 45
12. Further information 47
12.1 Questions and complaints 47
12.2 Compensation 48
12.3 Data Protection 48
12.4 Law 48

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

We can provide a wide range of options to match your budget and needs.

1.1 Who can be covered?

Full time, part time and fixed term contract workers can be included in the policy. Workers engaged through zero hour contracts will not ordinarily be covered by the policy. If you want to cover workers engaged through zero hour contracts they must be in a separate category with suitable eligibility and salary definitions. An individual will be covered once they fulfil the eligibility conditions. Members' children are automatically covered from birth to their 18th birthday (23rd birthday if in full time education) as long as the member remains covered. You can choose if cover is to be provided to members' spouses or partners.

Cover can be provided for equity partners, providing all equity partners are included.

1.2 Eligibility conditions

The eligibility conditions must be clearly defined and agreed with us before the policy starts. Different eligibility conditions can be applied to different categories of membership.

All eligibility conditions must take account of any relevant employment or discrimination legislation and will include:

- the minimum and maximum entry ages
- any service qualification (for example, you might specify that individuals must have completed three months' service)
- the date on which new entrants will be included, for example, on the day they satisfy the eligibility conditions or on the first of the following month
- full details of the pension scheme eligibility conditions where eligibility is linked to membership of a workplace pension scheme
- the date on which benefit increases are applied, which can be daily, monthly or annually.

1.2.1 Eligibility can be linked to membership of a workplace pension scheme. Where this is the case, membership of the pension scheme must be open to all employees who satisfy the eligibility conditions and must not be discretionary.

Individuals who join the scheme are covered for their benefits up to the policy's automatic acceptance limit, subject to the conditions set out in section 6 – 'What is not covered'.

If the policy's automatic acceptance limit is zero, individuals will have to be individually assessed before we will consider providing cover.

1.3 When will cover cease?

1.3.1 Under normal circumstances

A member will cease to be covered if they:

a) reach the age at which their cover ceases according to the terms of the policy, unless we have agreed with you that their cover can be continued

b) cease being employed by the employer or otherwise become ineligible for membership
c) retire
d) are a worker engaged through a zero hour contract who has not received earnings from the employer for a period of six consecutive months unless they are unavailable for work due to ill health
e) are absent from work due to ill health and reach the end of the period of cover we provide during temporary absence as detailed in section 1.7 'Does a member continue to be covered if they are absent from work'
f) die.

Cover for children will cease once the member's cover has ceased or if they reach the maximum age for children.

If cover is provided for spouses/partners it will cease

- once the member's cover has ceased
- if the spouse/partner dies
- if the spouse/partner reaches the age at which cover ceases, unless we have agreed with you that their cover can be continued
- on divorce, dissolution or ceasing meeting the definition of partner.

A member cannot be covered as both an employee and a spouse/partner.

Under no circumstances can cover continue beyond a member's or spouse/partner's 70th birthday.

1.3.2 Cancelling the cover

The policy does not have a termination date. You can cancel the policy at any time providing you notify us in writing. Cancellation cannot be backdated and we will charge for the time on risk.

We reserve the right to cancel the policy if:

a) you do not pay premiums when they are due
b) you do not comply with the policy terms and conditions
c) you do not provide information we have requested within 90 days
d) there is a change in legislation, regulation, HMRC practice or taxation which affects this policy
e) an employer covered under the policy ceases to carry on business, or if any order is made or resolution passed for the winding up of that employer
f) you fail to fairly present the risk prior to setting up the policy, or at a rate review, or when you request a change to the policy.

1.4 What types of cover are available?

The insured illnesses can consist of 'Core illnesses' only, or both these and 'Additional illnesses'. ('Total permanent disability' can be added in either case.) The conditions covered under each of these options are listed below, but these headings are a guide of what is covered and the full definitions are provided in section 10, 'Critical illness definitions'. In all cases our cover matches or exceeds the cover provided by the Association of British Insurers model definitions.

1.4.1 Core illnesses

The illnesses covered under this option are:

- Alzheimer's disease – *resulting in permanent symptoms*
- Cancer – *excluding less advanced cases*
- Coronary artery bypass grafts – *with surgery to divide the breastbone*
- Creutzfeldt-Jakob disease – *resulting in permanent symptoms*
- Dementia – *resulting in permanent symptoms*
- Heart attack – *of specified severity*
- Kidney failure – *requiring permanent dialysis*
- Major organ transplant
- Motor neurone disease – *resulting in permanent symptoms*
- Multiple sclerosis – *with persisting symptoms*
- Parkinson's disease – *resulting in permanent symptoms*
- Stroke – *resulting in permanent symptoms*

1.4.2 Additional illnesses

- Aorta graft surgery – *for disease of the aorta*
- Aplastic anaemia – *with permanent bone marrow failure*
- Bacterial meningitis – *resulting in permanent symptoms*
- Balloon valvuloplasty
- Benign brain tumour – *resulting in permanent symptoms*
- Benign spinal cord tumour – *with permanent symptoms or specified treatments*
- Blindness – *permanent and irreversible*
- Cardiac arrest – *with insertion of a defibrillator*
- Cardiomyopathy – *of specified severity*
- Coma – *with associated permanent symptoms*
- Deafness – *permanent and irreversible*
- Encephalitis – *resulting in permanent symptoms*
- Heart valve replacement or repair – *with surgery to divide the breastbone*
- HIV infection – *caught from a blood transfusion, a physical assault or at work in an eligible occupation*
- Liver failure – *irreversible*
- Loss of a hand or a foot – *permanent physical severance*

- Loss of independent existence – *permanent and irreversible*
- Loss of speech – *total permanent and irreversible*
- Open heart surgery – *with surgery to divide the breastbone*
- Paralysis of limbs – *total and irreversible*
- Primary pulmonary hypertension – *of specified severity*
- Progressive supranuclear palsy – *resulting in permanent symptoms*
- Pulmonary artery graft surgery – *with surgery to divide the breastbone*
- Respiratory failure – *of specified severity*
- (Chronic) rheumatoid arthritis – *resulting in the loss of ability to do specified physical activities*
- Systemic lupus erythematosus
- Terminal illness – *where death is expected within twelve months*
- Third degree burns – *covering 20% of the body's surface area*
- Traumatic brain injury – *resulting in permanent symptoms*

1.4.3 Total Permanent Disability

Whether you choose to cover just the Core illnesses or the Additional ones too, cover for total permanent disability can also be provided as an insured illness on one of the following bases:

- own occupation
- suited occupation
- an activities based assessment.

Full definitions are detailed in section 10 'Critical illness definitions'.

An own occupation definition is not available for members aged 65 or over. Any member covered for total permanent disability on an own occupation basis will automatically be switched to a suited occupation basis at age 65 (if cover is provided beyond age 65).

Irrespective of which basis is used for employees, the basis applicable to any children (or spouse/partner if covered) will always be an activities based assessment.

1.5 What level of cover can be provided?

The lump sum benefit payable can be a fixed amount or a multiple (up to five) of salary. The maximum benefit available for a member is the lower of five times that member's salary and £500,000. For workers engaged through zero hours contracts the maximum fixed amount we will normally offer is £50,000. You can vary the basis (including the multiple of salary) from one category to another, but not within a category.

In flexible benefit schemes, a range of fixed amounts or salary multiples is offered that members can choose from.

Where benefit is a multiple of salary, the definition of salary used to calculate the benefit will be agreed at outset. It can be the member's basic annual salary or additional variable pay (bonuses, commission etc.) can be taken into account. Where dividends form part of the salary definition they must be averaged over the preceding three years (or shorter period if applicable e.g. if dividends have only been payable for 18 months they must be averaged over the 18 month period).

The salary definition available for equity or limited liability partners is either:

- the taxable earnings after the deduction of business expenses, derived by the member from the partnership, averaged over the preceding three years (or shorter period if applicable), or
- the taxable earnings received by the member as detailed in the partnership accounts for the partnership year ending immediately prior to the date of diagnosis.

The salary definition available for workers engaged through zero hour contracts is either:

- P60 earnings in the tax year immediately preceding or coinciding with the date of diagnosis (if there are no P60 earnings for that tax year we will use the total earnings in the twelve months up to the date of diagnosis), or
- total earnings in the twelve months up to the date of diagnosis.

Please note we will not pro rata earnings for workers engaged through zero hour contracts who have worked for less than twelve months – their cover will be based on their earnings for the period of time worked.

1.6 When is the lump sum payment due?

A lump sum benefit becomes payable if an individual covered by the policy suffers one of the insured illnesses as defined in the policy and survives for more than fourteen days. The survival period begins from the date of diagnosis in respect of the insured illness, the date of surgery where the insured illness requires surgery, or the date of inclusion on an official UK waiting list (or the date of surgery if earlier) for a major organ transplant.

1.7 Do members continue to be covered if they are absent from work?

In many circumstances, cover continues while a member is absent from work.

1.7.1 In the event of a member being absent from work due to ill health they will continue to be covered until they reach the age at which cover ceases.

1.7.2 If a member is absent due to maternity, paternity or adoption leave cover will continue whilst they are still considered an employee.

1.7.3 If they are absent from work for any other reason cover will cease after three years.

1.7.4 If a member is on a fixed term contract, then regardless of the reason for absence, cover during periods of temporary absence will not continue beyond the end of the contract in force at the date the member was first absent.

1.7.5 For members who are workers engaged through zero hour contracts cover during periods of temporary absence due to ill health will cease on the earlier of

- **a)** the end of the zero hour contract in force when the member was first absent
- **b)** when the zero hour contract is terminated
- **c)** three years from the start of the ill health

1.7.6 If a member is beyond the age cover ceases and still being covered (see 'extended cover' section below) their cover during periods of temporary absence will be until age 70 if due to ill health and for up to twelve months if absence is due to any other reason.

In the event that a member is temporary absent, cover for children (and if covered, spouse/partner) will continue whilst the member continues to be covered.

Members who are being covered during periods of temporary absence must be included in the data. If cover is being provided for spouses/partners they must also be included in the data if the member is being covered during periods of temporary absence.

Whilst any member is absent and where the basis of cover is based on their 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 higher increase is enshrined in law).

1.8 Can members' families be covered?

1.8.1 Children's cover

Cover for children is automatically provided under the policy. A child is covered from their birth to their 18th birthday (23rd birthday if in full time education). A member's child, step child or legally adopted child will be covered and there is no limit on the number of children that can be covered. The benefit for each child will be 25% of the member's benefit up to a maximum of £20,000. If a child is covered for total permanent disability it will be on the 'activities based assessment' basis.

If both parents work for the same organisation the children's cover is 25% of the highest parent's benefit up to a maximum of £20,000.

Children's cover will always be subject to the pre-existing insured illness and related medical conditions exclusions and the exclusions specific to children which are all set out in section 6 – 'What is not covered'.

1.8.2 Spouse/partner's cover

Cover can be provided for spouses or partners at an additional cost.
A member's partner is defined as a person at the date cover starts

- **a)** to whom the member is married,
- **b)** with whom the member has entered into a contractual partnership formally recognised by law under the Civil Partnership Act 2004, or
- **c)** who is not a relative of a member, or married to or a civil partner of the member at the date cover starts and when the 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

- financial dependent on the member, or
- in a relationship of mutual financial dependence with the member.

The benefit can be an amount up to the member's benefit up to a maximum of £250,000. If a spouse/partner is covered for total permanent disability it will be on the 'activities based assessment' basis.

Spouse/partner's cover will always be subject to the pre-existing insured illness and related medical conditions exclusions set out in section 6 – 'What is not covered', unless we have individually assessed them and confirmed in writing that these exclusions have been removed.

An individual cannot be covered as an employee and spouse/partner.

1.9 Are any additional options available under the policy?

1.9.1 Extended cover

Cover for members beyond the age cover ceases will be subject to

- new pre-existing insured illness and related medical conditions exclusions applying to their total benefit on and from the date the member reaches the age cover ceases if the policy has an automatic acceptance limit of greater than £0, or
- individual assessment and acceptance by us if the policy has an automatic acceptance limit of £0.

Where cover for total permanent disability is being provided on an 'own occupation' basis (see definition in section 10 – 'Critical illness definitions'), this will be amended to a 'suited occupation' basis for members age 65 and over.

If cover is required for a spouse/partner beyond the age cover ceases this will be subject to

- new pre-existing insured illness and related medical conditions exclusions applying to their total benefit on and from the date they reach the age cover ceases if the policy has an automatic acceptance limit of greater than £0, or
- individual assessment and acceptance by us if the policy has an automatic acceptance limit of £0.

Please note that if the member has new pre-existing insured illness and related medical condition exclusions applying to them because they are being covered beyond the age cover ceases, these new exclusions will not apply to the member's partner (unless they too are being covered beyond the age cover ceases).

Under no circumstances can cover continue beyond an individual's 70th birthday.

Premiums in respect of individuals covered under this option must continue to be paid and these individuals must be identified on the data supplied to us.

1.10 Additional benefit provided at no extra cost

Claimants and their families are offered RED ARC's Critical Illness Service, including the allocation of a personal nurse adviser for as long as they are needed. The nurse adviser may commission a specialist nurse home visit or a programme of therapy or counselling – whichever is the most appropriate – free of charge at point of use. The acceptance or otherwise of a claim and the amount of any benefit that might be paid are entirely unaffected, irrespective of whether or not the claimant decides to take up the offer.

The RED ARC service is provided on a non-contractual basis and may be withdrawn without notice at any time.

1.11 Flexible Benefits

We can provide cover under a flexible benefits scheme, whereby members can decide the level of cover that is most appropriate for their lifestyle. Increases in cover can be selected at policy anniversary date and following a 'lifestyle event', such as marriage or the birth of a child. Additional terms and conditions, including actively at work conditions, will apply to flexible benefit schemes and these will be set out in our quotation.

2. Setting up the policy

2.1 What are the requirements for setting up the policy?

The information we require to prepare a quotation is detailed at the beginning of section 3 'What premiums will be charged for the cover?'. We will prepare a quotation based on the information you provide and it is normally valid for three months. If you want us to assume risk, you or your adviser will need to confirm this, and supply any outstanding information that is shown in the quotation as subject to our review and approval before cover can be provided.

We will create an application form which has been partially completed with the information you have provided, then post it on our secure website.

If your adviser has provided your email address, we will send you an email with details of how to register to access the site. Once you have registered and downloaded the form, you must:

a) review the application form to ensure that the information it contains is complete and accurate. Please pay particular attention to the section on the application form headed 'Information you provided on which we produced our quotation'. It is essential that you tell us if this information is incomplete or inaccurate.

b) answer all our questions clearly and completely and provide any further material information requested or tell us if you do not have the information we requested.

c) insert any information that is shown as required (for example, we need the scheme name and cover start date).

d) sign the form and the direct debit mandate (if you are paying by direct debit) and return it to us by email before the policy start date (cover cannot be backdated).

If your adviser has not provided your email address, the application form will be sent to the adviser, who will contact you about completion.

If any of the information used to pre-populate the application form is incorrect or information you subsequently add affects the risk presented, it may mean the terms of our quotation, including the premium, are invalidated and may have to be reviewed, or even that we have to withdraw our quotation entirely.

Once we have confirmed cover can start, we will need details of the terms of acceptance for members who have been individually assessed (underwritten) by the previous insurer to be sent to us within fourteen days of our request.

We will also request membership data (including National Insurance numbers or unique identifier) as at the policy start date, and require that to be supplied within fourteen days of our request.

Premiums payable on an annual basis will be paid by bank transfer. Premiums payable quarterly or monthly will be paid by direct debit.

If we do not receive complete data within fourteen days of our request we will request payment based on the estimated annual premium in the quotation.

For annual payment policies which pay premiums by bank transfer we will issue an invoice for the estimated annual premium and payment must be made within fourteen days.

For quarterly payment policies which pay premiums by direct debit we will request a payment for 25% of the estimated annual premium. For quarterly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 25% of the estimated annual premium and payment must be made within fourteen days.

For monthly payment policies which pay premiums by direct debit we will request a payment for 1/12th of the estimated annual premium. For monthly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 1/12th of the estimated annual premium and payment must be made within fourteen days.

If, once the data is received, there is a greater than 30% variation in the number of members (and, if insured, member's spouses/partners) or total salary for the insured members compared to the data used for the quotation we reserve the right to review our pricing and/or terms and conditions.

If, once the data is received, there is a material change in the risk, it may mean we have to review our pricing and/or terms and conditions or withdraw our offer. We would withdraw our offer if the change in the risk is such that if we had known about it when we were asked to quote we would have declined to quote, for example, all of the members being based outside the UK.

If any of these requirements are not provided when they are due, we reserve the right to withdraw cover. We will notify you that we have ceased the policy and charge you for the cover provided between the policy start date and the date we ceased the policy.

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

One of the advantages of a group policy is that it is normally possible to provide cover for all eligible employees up to a certain limit without the need to individually assess them. This limit is known as the automatic acceptance limit. Individuals are automatically covered for benefits up to the policy's automatic acceptance limit subject to the exclusions detailed in section 6 'What is not covered?'.

The automatic acceptance limit is reviewed at the end of every rate guarantee period (usually two years) and is dependent on the number of members and benefits insured.

Any individual whose benefits have been restricted, declined, postponed or accepted on non-standard terms will not benefit from any increase in the automatic acceptance limit.

Example:
The automatic acceptance limit is £75,000 and a new member joins the scheme with a benefit of £100,000. The pre-existing insured illness and related medical conditions exclusions (detailed in section 6 'What is not covered?') will apply from the date the member joined the policy for a benefit of £75,000. The benefit above £75,000 (£25,000) is subject to individual assessment. The member is asked to complete the individual assessment process, but does not do so. As a result their cover is restricted to £75,000. After this, the automatic acceptance limit is increased to £500,000. The member's benefit will remain at £75,000 because they did not complete the

individual assessment process and had their cover restricted.

Where there are fewer than three individuals in the policy, no automatic acceptance limit will be given.

2.2.1 What happens if you want to make a change to the scheme?

If you wish to make a change to the policy design (such as an amendment to the benefit level, the age cover ceases or the eligibility conditions), you must put the request in writing. We will consider the request and advise if the change can be made and details of any requirements we may have.

If you wish to include a group of employees as a result of a TUPE you must provide details of the individuals to be covered under the TUPE and details of the claims experience and scheme history. You must also tell us if any of them have had benefit declined or postponed or who have had a medical exclusion applied to any part of their benefit. In addition you must tell us of any employees who travel on business to, are seconded to, or are resident in countries that we consider high risk. An up to date list of these countries can be found on our website here. We will then assess the impact that including these individuals would have on the existing policy and advise if we are willing to provide cover for them or if we need further information before we can make a decision.

2.2.2 What happens if the automatic acceptance limit is exceeded or does not apply?

Any individual whose promised benefits exceed the automatic acceptance limit will need to be individually assessed for their excess benefit. We must be told about these individuals immediately as their level of cover cannot be confirmed until the individual assessment has been completed.

Individuals who need to be assessed will be sent an email containing a link to our secure online questionnaire. During this questionnaire they will be asked questions about their health and lifestyle and they will be expected to take reasonable care not to make a misrepresentation. In many cases a decision as to what cover can be provided and on what terms, is given at the end of the assessment. In some cases further medical information is needed, e.g. blood tests, independent medical examination, etc., before a final decision can be made. If further tests or examinations are required, the individual will be sent instructions as to how to make an appointment with one of our medical test providers in order for the tests to be carried out. On rare occasions we may need to get further information from the individual's GP and/or other medical professionals who have attended them. The individual continues to have a duty to take reasonable care not to make a misrepresentation during this process.

Using the results of the online questionnaire and any other medical information gathered, we advise if the individual can be accepted at standard rates or if we need to apply special terms, decline or postpone our decision. (We may postpone it, for example, if the individual is about to undergo an operation which could radically affect their state of health once completed.) Special terms will take the form of a premium loading or an exclusion for a specific condition. We will advise both the individual and you of our decision. If there is a

premium loading we will assume that it is acceptable and adjust future premium collections accordingly, unless you write to tell us otherwise. If this is the case, we will remove the loading and restrict the member's benefit accordingly.

Once an individual has been individually assessed, any increase in benefit will be subject to further individual assessments.

2.2.3 How does a member's cover transfer from the previous insurer?

Where a scheme transfers its insurance to us from another insurer the following will apply:

- Our pre-existing insured illnesses and related medical conditions exclusions and exclusions relating to children (as detailed in section 6 – 'What is not covered?') will apply from the date the member joined the scheme and to any increase in cover that has occurred since joining the scheme.
- Any insured illness that we cover that was not covered by the previous insurer will be subject to a pre-existing insured illness and related medical conditions exclusions from the date the policy started with us.
- If members have been individually assessed by a previous insurer we will need copies of the terms of acceptance in order to confirm the exact terms of transfer of their cover.

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

Whilst we are assessing an individual we will provide them with temporary cover for a maximum period of 30 days or until our assessment is completed, if earlier.

Temporary cover starts from the date we are advised of the level of benefit required. It is subject to the pre-existing insured illness and related medical conditions exclusions – see section 6 'What is not covered?'

Temporary cover will not be given to any individual who:

a) has previously been declined, offered cover on non-standard terms or where a decision on their benefits has been postponed (either by Ellipse of another insurer)
b) has failed to provide medical evidence that has been requested
c) is requesting cover beyond the age cover ceases and is subject to Individual Assessment because the policy has an automatic acceptance limit of £0 .

If we are unable to complete our assessment before the temporary cover expires, the individual's cover will be restricted to their previous accepted level of cover. If the previous accepted level of cover was based on an assessment carried out by an insurer other than Ellipse, we will require documentary proof of the previous acceptance terms.

3. What premiums will be charged for the cover?

The premium we charge depends on a number of factors including:

- the cover options you select
- the amount of cover provided
- the eligibility and entry conditions
- the age cover ceases
- if cover is provided for members' spouses/partners, their age and genders
- the nature of the industry you are in and your principal activity
- the salaries of the members
- the location of the workforce (postcode if in the UK or country if outside the UK)
- details of any members who travel on business to, are seconded to, or are resident in countries that we regard as high risk – an up to date list of these countries can be found on our website here.
- the claims experience.

3.1 How will premiums be calculated?

Premiums are calculated for the cover provided to each member (and spouse/partner if covered) based on age-related premium rate tables which we apply to the amount of their insured benefit.

3.2 Will there be any extra premium?

Premium loadings may be imposed on individuals' cover as a result of them being individually assessed. Any loading will reflect their medical condition or hazardous pursuit and will apply only to the benefit that has been individually assessed.

The actual premium payable will depend on the membership and benefits provided during each accounting period.

We normally guarantee the policy terms and underlying premium rate tables for two years until the second policy anniversary date. They will be reviewed at the end of the guarantee period and a new guarantee period will be set. However we may review them part way through a guarantee period if any of the following occurs:

a) a greater than 30% variation in the number of members (and if covered, spouses/partners) or their total salaries
b) the number of members drops below two
c) the inclusion of a new participating employer or a TUPE transfer
d) the disposal of a participating employer or closure of a part of an employer's business
e) the inclusion of a new category
f) a change in policy design such as an amendment to the benefit level, the age cover ceases or eligibility conditions
g) a change in the nature of a participating employer's business
h) more than 30% of the total number of members or total salary change location
i) there is no longer an adviser acting for you in connection with this policy

j) there is a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy

k) you have not given us complete and accurate information.

These matters define the risk as a whole.

3.3 Is there a discount for a good claims history?

Claims experience, both good and bad, can have an impact when calculating the premiums for policies. Generally, the larger the policy the greater the significance that will be attached to claims experience.

3.4 What commission is included within the premium?

You and your adviser are responsible for deciding the level of commission, if any, to be paid by us to your adviser. The premium charged will include the level of commission payable. We will confirm the rate of commission payable to your adviser in your quotation and at regular intervals during the life of the policy.

4. How does the policy accounting work?

During the year, you will send us updated data at a frequency agreed when the policy starts. The frequency can be quarterly or every twelve months. For policies that use our Livewire™ automated data link data can be updated monthly. After each data refresh, the cost of providing the cover will be recalculated to reflect the actual cover being provided.

The quotation will show the estimated first year cost assuming that all members (and if covered their spouse/partner) are accepted at standard terms for their full benefit entitlement, based on the data supplied. The actual premium payable will vary from this:

- if the membership data changes (which will happen as people join or leave the company, or the amount of their benefits change)
- if any of the circumstances set out in section 3.2 'Will there be any extra premium?' arise.

4.1 What information is required for accounting purposes?

When each data refresh is due, you must provide complete and accurate details of all current members including their:

- National Insurance number or unique identifier(whichever you have chosen to use)
- name
- gender
- date of birth
- salary (based on the policy salary definition)
- benefit category
- location (postcode if in UK or country if outside the UK)
- date of joining/leaving (if applicable)
- amount of benefit.

If cover is provided for spouses/partners we will need data including:

- their National Insurance number (whichever you have chosen to use)
- their name
- their gender
- their date of birth
- their benefit category
- their date of joining/leaving (if applicable)
- the amount of their benefit
- the employee's salary (based on the policy salary definition)
- the employee's location (postcode if in the UK or country if outside the UK).

For the avoidance of doubt, fair presentation of the risk at a data refresh is providing the information we ask for completely and accurately.

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

Premiums will be adjusted according to the latest data received, allowing for joiners, leavers and benefit changes. Where premiums are collected monthly or quarterly, the amount collected will be adjusted from the next due date. Where premiums are paid annually, at each policy anniversary date we will calculate if any premium is due or is to be refunded, based on the actual cover provided since the previous anniversary date.

4.3 If the policy is cancelled mid-year, will premiums paid in advance be lost?

No, a final account will be produced based on the cover we provided up until the date you cancelled the policy.

5. Claiming benefit

We know the importance of handling claims quickly and efficiently. In this section we have set out how we handle claims made in respect of an insured person.

5.1 How are claims made?

To ensure a claim is processed quickly, you must advise us as soon as possible of the potential claim by calling our claims team on 020 3003 6161. We will send you a claim form to complete and return to us. To ensure no breach of the insured person's right to medical confidentiality, the form will not contain any information about the insured person's condition.

A separate form – called a personal statement – will be provided for the individual to complete.

We will only consider claims if we have been notified within two years of the date of diagnosis of the insured illness.

In additional to the completed forms we will need

- 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)
- proof of membership and earnings
- if a claim is being made for a spouse or civil partner, we will need original copies of their marriage or civil partnership certificate
- if a claim is being made for a partner who is not a spouse or civil partner, we will need original copy of their birth certificate and evidence that they meet the definition of partner
- if a claim is being made for a child, we will need original copies of their birth or adoption certificate
- if the claim is being made for total permanent disability on either an own occupation or suited occupation basis, we will need a copy of the member's job description detailing their regular duties.

This list is not exhaustive and there may be times where more information is required.

Claims will not be paid while premiums are overdue.

Upon receipt of a claim, we will deal with it promptly and fairly and will provide appropriate information on the progress of the claim. Once we accept a claim we will pay the benefit to the member by direct credit within five days providing we have valid payment details. We will only make payments to UK bank accounts.

What happens to potential claims if the scheme transfers to another insurer?
In the circumstances where cover provided by our policy ceases, if the date of diagnosis of an insured illness is prior to the date on which cover ceases it will still be possible for a valid claim to be made against our cover. The following sequence gives an example:

1. A member discovers a lump and has a biopsy on 1st March.
2. The histology results are analysed on 22nd March (i.e. 3 weeks later) and cancer is confirmed to be present. This is the date of diagnosis for the purposes of our cover.

3. The scheme is transferred from Ellipse to another insurer a few days later on 1st April.
4. The member is told of the diagnosis on 5th April.
5. A claim is submitted to us on 7th April.

We would consider this to be our claim, even though the cover has moved to another insurer at the time the claim was made.

Conversely, where the date of diagnosis of an insured illness precedes the start of our cover, we will not accept a claim. The following sequence gives an example:

1. A member discovers a lump and has a biopsy on 1st March.
2. The histology results are analysed on 22nd March (i.e. 3 weeks later) and cancer is confirmed to be present. This is the date of diagnosis for the purposes of our cover.
3. The scheme is transferred from another insurer to Ellipse a few days later on 1st April.
4. The member is told of the diagnosis on 5th April.
5. A claim is submitted to us on 7th April.

We would consider this to be the previous insurer's claim because the date of diagnosis (22nd March) was prior to cover starting with us.

5.5.1 Can a claim decision be appealed?

If a claim is declined and you disagree with our decision you or the insured person can appeal our decision.

An email should be sent to claims@ellipse.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 was not involved in the original claim decision.

If the appeal process upholds the original decision contact details of the Financial Ombudsman Service will be provided.

5.2 Can another claim be made for an individual?

Yes, provided it is not for the same insured illness, a related medical condition or the earlier claim is not directly or indirectly associated with the new insured illness – see section 6 'What is not covered'. If a claim was paid for an individual by a previous insurer of your scheme a claim cannot be made in respect of that individual for the same or related medical condition under this policy.

6. What is not covered?

6.1 Pre-existing insured illness exclusion

Insured illnesses are any of the illnesses defined within the policy contract that are within the options – Core illnesses, Core plus Additional illnesses, with or without cover for Total Permanent Disability - selected by the policyholder. A list of insured illness and their definitions can be found in section 10 – 'Critical illness definitions'

A pre-existing insured illness exclusion will always apply to an individual's benefit unless we have individually assessed the individual and advised of the removal of the exclusion in writing. In any event a pre-existing insured illness exclusion will always apply to children.

The pre-existing insured illness exclusion means no benefit will be payable for any insured illness or repeat of the same insured illness which the insured person:

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

before entry to the scheme.

For the purpose of the policy the illnesses in each group below will be considered to be the same insured illness:

Group 1	Aorta graft surgery Balloon valvuloplasty Cardiac arrest Cardiomyopathy Coronary artery by-pass grafts Heart attack Heart transplant (under the major organ transplant) Heart valve replacement or repair Open heart surgery Primary pulmonary hypertension Pulmonary artery graft surgery Stroke For example, where an insured person suffers a heart attack then 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 than 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 then 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*' then no benefit shall be payable in respect of any subsequent 'cancer – *excluding less advanced cases*' whether or not this is connected to, or associated with the prior diagnosis of cancer.

In addition, no benefit will be payable for any insured illness which the insured person:

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

before entry to the scheme and which leads to a claim for coma, loss of independent existence, loss of speech, paralysis of limbs, 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.

The criteria under this pre-existing insured illness exclusion shall also apply to any increase in benefit. In this case, no increase in benefit will be payable for any insured illness or repeat of the same insured illness suffered before the benefit increase.

6.2 Related medical conditions exclusion

A related medical condition is defined as any medical condition, or symptoms, which in the opinion of our chief medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the insured illness.

We will not pay any claim for an insured illness where a related medical condition existed prior to entry to the scheme unless the insured person had neither received any treatment, nor experienced symptoms, nor sought advice for that related medical condition for at least two consecutive years since entry to the scheme.

We will not pay any claim for coma, loss of independent existence, loss of speech, paralysis of limbs, terminal illness or total permanent disability benefit where a related medical condition existed before entry to the scheme.

We will not pay any claim in respect of an increase in benefit for an insured illness where a related medical condition exists, unless the insured person had neither received any treatment nor experienced symptoms, nor sought advice for that related medical condition for at least two consecutive years since the increase.

In addition, we will not pay any claim in respect of an increase in benefit for a claim for coma, loss of independent existence, loss of speech, paralysis of limbs, terminal illness or total permanent disability benefit where a related medical condition existed before the increase in benefit.

Examples of how the exclusions described in sections 6.1 and 6.2 work

Example 1: How the pre-existing insured illness exclusion works for a new joiner:
A new member joins the scheme. Before they joined the scheme they had been treated for a heart attack. After they join the scheme they have another heart attack. We would not pay a claim for that heart attack because of the heart attack they had before they joined the scheme. If, after they join the scheme, they get a cancer which meets the policy definition of cancer we would pay a claim.

Example 2: How the pre-existing insured illness exclusion works for an increase in benefit:
A new member joins the scheme on 1 January 2016 with a benefit of £50,000. Before they joined the scheme they had not been tested, treated or had symptoms of kidney failure. In October 2016 they have tests for kidney failure. On 1 January 2017 they have an increase in benefit to £75,000. In March 2017 they are diagnosed with kidney failure (which meets the policy definition of kidney failure) and they make a claim for kidney failure. Because they had been tested for kidney failure before they had the increase in benefit from £50,000 to £75,000 we would pay £50,000.

Example 3: How the related medical conditions exclusion works for a new joiner where we would not pay a claim:
A new member joins the scheme on 1 January 2016. Just before they joined the scheme they had been diagnosed with uncontrolled high blood pressure. On 20 February 2017 they have a stroke. We would not pay a claim for the stroke because the uncontrolled high blood pressure is considered a related medical condition to the stroke and they had not been symptom free of uncontrolled high blood for more than 2 years before since joining the scheme.

Example 4: How the related medical conditions exclusion works for a new joiner where we would pay a claim:
A new member joins the scheme on 1 January 2014 with a benefit of £50,000 which does not change throughout the lifetime of the policy. Just before they joined the scheme they had suffered from chest pain. Since they joined the scheme they had not had any more chest pains or any other symptoms of heart problems. On 20 November 2017 they have a heart attack (which meets the policy definition of heart attack) and make a claim. We would pay the claim because although they had chest pain before they joined the scheme they had been symptom free for more than 2 years since joining the scheme.

Example 5: How the related medical conditions exclusion works for an increase in benefit:
A new member joins the scheme on 1 January 2012 with a benefit of £50,000. Just before they joined the scheme they had suffered from chest pain. Between 1 January 2012 and 30 June 2016

they had not had any more chest pain or any other symptoms of heart problems. In July 2016 they suffered chest pain and underwent tests for a heart condition. On 1 January 2017 their benefit increased by £25,000 to £75,000. On 5 August 2017 they have a heart attack (which meets the policy definition of heart attack) and they make a claim. We would pay £50,000 because they had been symptom free for more than 2 years from joining the scheme. We would not pay the additional £25,000 because they had not been 2 years symptom free since having the increase in benefit.

6.3 Additional exclusions applied after individual assessment

After the individual assessment of members who are subject to individual assessment (see section 2.2 'Does any evidence of health have to be provided before members are covered?' exclusions may apply for claims arising from certain specified medical conditions or in specified circumstances.

6.4 Additional exclusions in relation to children

A claim will not be considered for children's critical illness cover if, before the child is covered by the policy:

- 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 illness or condition
- the insured illness or related medical condition was as a result of intentional injury caused by either of the child's parents.

6.5 Excluded claims

Where a claim has already been paid and a new claim is made where in the opinion of our chief medical officer, the earlier claim is either directly or indirectly associated with, or is likely to have led to the occurrence of the new insured illness, then this new claim will not be met.

For example if a claim has previously been admitted for a stroke, we will not consider a claim for total and permanent disability benefit where the stroke has led to the disablement. A further example is where an insured person had a claim admitted for cancer, then submits a claim for terminal illness as a result of cancer. In this case we will consider the terminal illness claim to be related to the cancer claim and this new claim will be declined.

An individual cannot be covered as an employee and spouse/partner. Where a member is both an employee and a spouse/partner of another member, a claim cannot be submitted twice for the same condition.

7. Can cover be provided for an individual who is not based in the UK?

7.1 Individuals who travel outside the UK

We will provide cover for individuals based in the UK who travel on business or leisure outside the UK.

7.2 Individuals seconded outside the UK

We will provide cover for individuals who are temporarily seconded outside the UK providing:

a) the member satisfy the eligibility conditions of the scheme
b) the member has a contract of employment or for services with a participating employer
c) the country of secondment is declared for each individual at the start of the policy and at each data refresh.

7.3 Individuals permanently based outside the UK

We will provide cover for individuals who are permanently working outside the UK in any of the following locations; European Union, Andorra, Australia, Canada, Channel Islands, Hong Kong, Iceland, Isle of Man, Gibraltar, Liechtenstein, Monaco, New Zealand, Norway, San Marino, South Africa, Singapore, Switzerland or the USA, providing:

a) the member satisfy the eligibility conditions of the scheme
b) the member has a contract of employment or for services with a participating employer
c) the country of residence is declared for each individual at the start of the policy and at each data refresh.

Where individuals are working outside the UK the amount of salary and (if provided) benefit advised at each data refresh must be expressed in pounds sterling. The exchange rate will be based on the Bank of England exchange rate and will be fixed at each data refresh. Therefore in the event of a claim for a member who is not paid in pounds sterling benefit will be calculated based on the exchange rate agreed at the most recent data refresh before the date of diagnosis.

Where a scheme includes individuals who are resident outside the UK, the company must satisfy itself regarding any taxation consequences.

Where individuals are outside the UK, and provision of their benefits is subject to individual assessment, they will be invited to complete our online questionnaire as described in section 2.2 'Does any evidence of health have to be provided before members are covered?'. If after this further medical information is required to enable us to complete our assessment, the individual will be responsible for arranging and paying for the tests to be conducted. Examinations, tests or reports may only be arranged/conducted at a centre or provider with prior approval from Ellipse otherwise we will not be liable for any costs and the individual may also be required to undertake another set of tests with an approved centre/provider.

We will reimburse the member for the tests we have requested, up to a maximum of the amount we would pay for the same test in the UK. Reimbursement will be in pounds sterling to a UK bank account and the exchange rate used for reimbursement will be our bankers' rate of exchange on the date of reimbursement.

All results and/or reports must be provided in English.

8. Taxation of policies

The following outlines our understanding of current legislation and HMRC practice. You should get professional advice from your own advisers.

8.1 Payment of premiums

The whole cost of the policy will be met by you.

For tax purposes, premiums paid by you in respect of employees are treated as a business expense. They are treated as a P11D benefit for employees.

Tax relief on premiums paid in respect of any employees who have a proprietorial interest in the company will not normally be available. HMRC may agree to allow such relief if similar benefits are provided for a substantial number of other employees. Clarification of the tax position in such cases should be sought from your tax advisers.

Equity partners pay for their own premiums and there is no tax relief on these premiums.

8.2 Payment of benefits

Policy benefits to the members (including equity partners) are not normally subject to income tax. We will always pay them gross of any tax that may be due.

9. Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact which you know or ought to know of. If you do not have complete information, you must tell us.

9.1 What you know or ought to know

You must conduct a reasonable search for, and tell us of, all material facts available to you, senior management of any employers covered under this policy, or anybody responsible for your insurance. This may include your adviser or your contractors.

You do not need to tell us about a material fact if:

- it diminishes the risk
- we know it
- we ought to know it
- we are presumed to know it (because it is common knowledge) or
- we specifically say we do not require the information.

9.2 Material facts

A material fact is something that would influence our decision whether or not to offer cover and, if so, on what terms.

9.3 Paying claims in full means that we are contracting out of this part of the Insurance Act 2015

Under the Insurance Act 2015 if you make a misrepresentation of the risk (but you have not been deliberate or reckless in doing so) we can proportionately reduce the claim. We believe it is fairer to members to pay claims in full and charge you the correct higher premium. In order to do this we have to contract out of this part of the Act (i.e. Schedule 1 paragraphs 6 and 11 of the Insurance Act 2015). The remedies available for misrepresentation may be applied as outlined below.

9.4 What happens if you do not make a fair presentation of the risk

9.4.1 Deliberate or reckless misrepresentation of the risk

If you deliberately or recklessly do not make a fair presentation when setting up the policy we may avoid the policy from the beginning and recover claims paid. In the case of a deliberate or reckless failure to make a fair presentation of the risk at rate review or when you ask us to make a change to the policy, cancellation shall take effect from the rate review date or the date the change to the policy was made (as applicable).

9.4.2 Not deliberate or reckless misrepresentation of the risk

If you do not make a fair presentation but you have not been deliberate or reckless the outcome depends upon what we would have done if we had known the material facts:

- if we would not have entered into the policy we may avoid the policy from the beginning and recover any claims paid. If the misrepresentation happened at the rate review or when you asked us to make a change to the policy, cancellation shall take effect from the rate review date or the date the change to the policy was made (as applicable).
- if we would have applied different terms and/or an additional premium we will apply those different terms and/or premium from the beginning. If the misrepresentation happened at the rate review or when you asked us to make a change to the policy, the additional premium and/or different terms will apply from the rate review date or the date the change to the policy was made (as applicable).

9.5 Fraudulent claims

The Insurance Act 2015 also sets out remedies if there is a fraudulent claim. If there is a fraudulent misrepresentation by a member which affects our acceptance of a claim made in respect of that member we will not pay the claim in respect of that member. If there is fraudulent claim made by you we will not pay the claim and we reserve the right to terminate the policy.

10. Critical illness definitions

For the purposes of the definitions of core illness and additional illness the following definitions apply:

- 'Irreversible' means it cannot be reasonably improved upon by medical treatment and/or surgical procedures used by the National Health Service in the UK at the time of the claim.
- 'Permanent' means it is 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 are not 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
    - symptoms of psychological or psychiatric origin.

10.1 Core illnesses

Alzheimer's disease – *resulting in permanent symptoms*

A definite diagnosis of Alzheimer's disease by a consultant neurologist, psychiatrist or geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- other types of dementia.

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 cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

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

    - having low malignant potential
- all tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0
- chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A
- any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

Coronary artery by-pass grafts – *with surgery to divide the breastbone*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

Creutzfeldt-Jakob disease (CJD) – *resulting in permanent symptoms*

A definite diagnosis of Creutzfeldt-Jakob disease by a consultant neurologist. There must be permanent clinical loss of the ability to do all of the following:

- remember
- reason and
- perceive, understand, express and give effect to ideas.

Dementia – *resulting in permanent symptoms*

A definite diagnosis of dementia by a consultant neurologist, psychiatrist or geriatrician. There must be progressive clinical loss of ability to do all of the following:

- remember
- reason and
- perceive, understand, express and give effect to ideas.

The condition must have progressed to the extent that continual supervision and the assistance of another person is required and must be irreversible with no reasonable prospect of there ever being any improvement.

For the above definition, the following is not covered:

- dementia directly resulting from alcohol or drug abuse.

Heart attack – *of specified severity*

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- typical clinical symptoms (for example, characteristic chest pain)
- new characteristic electrocardiographic changes
- the characteristic rise of cardiac enzymes or troponins recorded at the following levels or higher:
    - Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L)
    - Troponin I > 500ng/L (0.5 ng/ml or 0.5 ug/L).

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- other acute coronary syndromes or 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.

Major organ transplant

The undergoing as a recipient of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or inclusion on an official UK waiting list for such a procedure.

For the above definition, the following is not covered:

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

Motor neurone disease – *resulting in permanent symptoms*

A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist:

- amyotrophic lateral sclerosis (ALS)
- primary lateral sclerosis (PLS)
- progressive bulbar palsy (PBP)
- progressive muscular atrophy (PMA).

There must also be permanent clinical impairment of motor function.

Multiple sclerosis – *with persisting symptoms*

A definite diagnosis of multiple sclerosis by a consultant neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months.

Parkinson's disease – *resulting in permanent symptoms*

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

For the above definition, the following are not covered:

- Parkinsonian syndromes/Parkinsonism
- Parkinson's disease secondary to drug abuse.

Stroke – *resulting in permanent symptoms*

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- transient ischaemic attack

- traumatic injury to brain tissue or blood vessels
- death of tissue of the optic nerve or retina / eye stroke.

10.2 Additional illnesses

Aorta graft surgery – *for disease to the aorta*

The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:

- any other surgical procedure, for example the insertion of stents or endovascular repair
- surgery following traumatic injury to the aorta.

Aplastic anaemia – *with permanent bone marrow failure*

Confirmation by a consultant haematologist of a definite diagnosis of permanent bone marrow failure which results in all of anaemia, neutropaenia and thrombocytopaenia requiring treatment with at least one of the following:

- blood transfusion
- marrow stimulating agents
- immunosuppressive agents
- bone marrow transplants.

For the above definition, the following are not covered:

- all other forms of anaemia.

Bacterial meningitis – *resulting in permanent symptoms*

A definite diagnosis of bacterial meningitis by an appropriate consultant resulting in significant permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not 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*

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- tumours in the pituitary gland
- tumours originating from bone tissue

- angioma and cholesteatoma.

Benign spinal tumour – *with permanent symptoms or specified treatments*

A non-malignant tumour originating from 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 the tumour, or
- undergoing stereotactic radiotherapy to the tumour.

For the above definition, the following is not covered:

- granulomas, haematomas, abscesses, disc protrusions or osteophytes.

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 3/60 or worse in the better eye using a Snellen eye chart.

Cardiac arrest – *with insertion of a defibrillator*

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

- implantable cardioverter-defibrillator (ICD), or
- cardiac resynchronization therapy with defibrillator (CRT-D).

For the above definition, the following is not covered:

- insertion of a pacemaker.

Cardiomyopathy – *of specified severity*

A definite diagnosis by a consultant cardiologist of cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 40% or less for at least six months when stabilised on therapy advised by the consultant.

The diagnosis must also be evidenced by:

- electrocardiographic changes, and
- echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy.

For the above definition, the following are not covered:

- all other forms of heart disease and/or heart enlargement
- myocarditis
- cardiomyopathy related to alcohol or drug abuse.

Coma – *with associated permanent symptoms*

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- requires the use of life support systems for a continuous period of at least 96 hours, and
- with associated permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following is not covered:

- 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 95 decibels across all frequencies in the better ear using a pure tone audiogram.

Encephalitis – *resulting in permanent symptoms*

A definite diagnosis of encephalitis by a consultant neurologist. There must be permanent neurological deficit with persisting clinical symptoms.

Heart valve replacement or repair – *with surgery to divide the breastbone*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiologist to replace or repair one or more heart valves.

HIV infection – *caught from a blood transfusion, a physical assault or at work in an eligible occupation*

Infection by human immunodeficiency virus resulting from:

- a blood transfusion given as part of medical treatment, or
- a physical assault, or
- an incident occurring during the course of performing normal duties of employment from the eligible occupations listed below,

after the start of the policy and satisfying all of the following:

- the incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures
- where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within five days of the incident
- there must be a further HIV test within twelve months confirming the presence of HIV or antibodies to the virus.

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse.

Eligible occupations are:

- healthcare workers e.g. doctors, nurses, dentists including porters, administrators and cleaners
- armed forces
- emergency services e.g. police, fire, paramedics and ambulance services.

Liver failure – *irreversible*

A definite diagnosis of irreversible end stage liver failure due to cirrhosis by a consultant physician resulting in all of the following:

- permanent jaundice
- ascites
- encephalopathy.

For the above definition the following are not covered:

- liver failure secondary to alcohol or drug abuse.

Loss of a hand or a foot – *permanent physical severance*

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

Loss of independent existence – *permanent and irreversible*

Total, permanent and irreversible disablement of the insured person resulting in an inability to perform, even with the use of appropriate assistive devices, at least three of the following six 'activities of daily living' without the direct assistance of another person.

The following are the activities of daily living:

- feeding/eating – cutting meat, buttering bread, getting food and drink to the mouth using fingers or utensils
- dressing – dressing oneself including fastening zips and buttons, getting clothes from wardrobes and drawers
- bathing/grooming – turning on taps, getting in and out of the bath or shower, washing face and hands etc., drying oneself, combing hair
- continence – moving into and out of the bathroom, getting on and off the toilet unaided, recognising the need or urge to void bladder or bowel in time to get to the toilet
- mobility/transfer – getting into and out of bed, transferring from one place to another e.g. chair to bed, chair to standing, chair to chair
- walking – moving from one location to another by walking, wheelchair or using a frame.

Loss of speech – *total permanent and irreversible*

Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.

Open heart surgery – *with surgery to divide the breastbone*

The undergoing of open heart surgery on the advice of a consultant cardiologist to correct structural abnormality of the heart.

Open heart surgery to correct structural defects includes the following:

- repair of atrial or septal defects or patent foramen ovale
- cardiac tumours (atrial myxoma)
- cardiomyopathy surgery to reduce the size of the left ventricular walls

- heart transplant
- repair of aneurysms
- transposition of the great vessels
- Eisenmenger's syndrome
- Tetralogy of Fallot.

Paralysis of limbs – *total and irreversible*

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

Primary pulmonary hypertension – *of specified severity*

Primary pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in permanent irreversible physical impairment to the degree of at least class 3 of the New York Heart Associations classification of heart failure. (The New York Heart Association's classification of heart failure states this is 'heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain'.)

Progressive supranuclear palsy – *resulting in permanent symptoms*

A definite diagnosis, by a consultant neurologist, of progressive supranuclear palsy. There must be permanent clinical impairment of eye movement and motor function with associated tremor, rigidity of movement and postural instability.

Pulmonary artery graft surgery – *with surgery to divide the breastbone*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiothoracic surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

Respiratory failure - *of specified severity*

Confirmation by a consultant physician of chronic lung disease resulting in all of the following:

- the need for continuous daily oxygen therapy on a permanent basis,
- FEV1 being less than 40% of normal, and
- vital capacity less than 50% of normal.

(Chronic) Rheumatoid arthritis – *resulting in the loss of ability to do specified physical activities*

A definite diagnosis by a consultant rheumatologist of chronic rheumatoid arthritis resulting in all of the following:

- there must be morning stiffness in the affected joints of at least one hour duration
- there must be arthritis of at least three joint groups with soft tissue swelling or fluid observed by a physician
- the arthritis must involve at least one of the following sites:
  - **a)** wrists or ankles
  - **b)** hands and fingers
  - **c)** feet and toes
- the arthritis must affect both sides of the body

- presence of rheumatoid factor or anti CCP (anticyclic citrulinated protein) antibodies, unless all other criteria are met
- there must be subcutaneous nodules (nodular swelling under the skin) there must be radiographic changes typical of active rheumatoid arthritis plus evidence of clinical deformity.

The symptoms must have been present for at least six months before a claim can be submitted and in the opinion of our chief medical officer all appropriate treatments such as disease modifying agents have been initiated for a reasonable therapeutic period.

Systemic lupus erythematosus

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 a Glomerular Filtration Rate (GFR) below 30 ml/min.

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 cannot be cured, and
- in the opinion of the attending consultant, the illness is expected to lead to death within twelve months.

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

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.

Traumatic brain injury – *resulting in permanent symptoms*

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

10.3 Total permanent disability

Disability must have continued for six months. For the purposes of this benefit the word permanent means that disablement 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. cannot be reasonably improved upon by medical treatment and/or surgical procedures used by the National Health Service in the UK at the time of the claim). Evidence must be supplied that the condition has been investigated and managed by an appropriate consultant.

Total and permanent disability of the insured person, measured by their inability to perform certain of the following, as a result of illness or injury:

Own occupation

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 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 cannot be reasonably omitted or modified by the member or the employer.
- own occupation means the occupation they performed at the time of claiming.

Suited occupation

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 cannot be reasonably omitted or modified by the member or the employer.
- reasonable alternative occupation means an occupation for which they are suited by virtue of their transferable skills (education, training or experience) and one that provides a reasonable, but not necessarily comparable, salary and status in relation to the insured occupation.
- own occupation means the occupation they performed at the time of claiming.

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 spectacles 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)
- 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 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.

11. Glossary of terms used

Actively at work: Describes an individual who is:

- **a)** either actively performing their normal occupation or is taking leave (other than sick leave) that has been authorised by their employer
- **b)** working the normal number of hours required by their contract with their employer, either at their normal place of employment, at a location as agreed with their employer, or at a location to which they are required to travel for business
- **c)** mentally and physically capable of performing all the duties normally associated with their job

and is not acting against medical advice in meeting any requirement of a) to c).

Automatic acceptance limit: The maximum amount of benefit that can be provided for any member without the need for them to be individually assessed.

Child: A member's child, step-child or legally adopted child from birth to their 18th birthday (23rd birthday if in full-time education).

Date of diagnosis: This is the date the survival period begins from. Where the insured illness does not require surgery, the date of diagnosis is the date a medical professional diagnosed the individual has having the insured illness – this will normally be a date before the individual is told of the diagnosis. Where the insured illness requires surgery it is the date of surgery. For major organ transplant it is the date of inclusion on an official UK transplant waiting list (or the date of surgery if earlier).

Eligibility conditions: The conditions which must be met by the employee before they are included in the scheme.

Insured illness: The illnesses and conditions, details of which are set out in this document.

Insured person: A member or child and, if we have agreed to cover them, a member's spouse/partner.

Member: An employee, equity partner and, if we have agreed to cover them, workers engaged through zero hour contracts.

Member's 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
- **c)** a person who is not a relative of a member, or married to or a civil partner of the member at the date cover starts and when the 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
    - financial dependent on the member, or
    - in a relationship of mutual financial dependence with the member.

Related medical condition: Any medical condition or symptom, which, in the opinion of our chief medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the insured illness.

Spouse: 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.

12. Further information

Ellipse is the trading style of AIG Life Limited. Cover is provided by AIG Life Limited.

Ellipse is a trading style of AIG Life Limited. Registered in England and Wales. Number 6367921. Registered address: The AIG Building, 58 Fenchurch Street, London EC3M 4AB. AIG Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. The registration number is 473752. AIG Life Limited's SFCR (Solvency and Financial Condition Report) is available on request.

AIG Life Limited provides information about the insurance contracts we offer but does not provide a personal recommendation about the insurance products we offer. Employees of AIG Life Limited are paid a basic salary and are also eligible for an annual performance bonus. On target bonus levels are dependent on grade. Each bonus is split so that there is a portion that relates to individual performance and a portion relating to company performance. Both elements are based on balanced objectives agreed at the start of each year which will include an element related to the overall volume of new premiums written and business retained during the year.

12.1 Questions and complaints

If you have any queries, please contact your adviser in the first instance. If you wish to raise any queries with us, or make a complaint, please contact our Chief Executive Officer at:

5th Floor
15 Bermondsey Square
London
SE1 3UN

or by email to puttingitright@ellipse.co.uk
or by calling 020 3003 6160 (Calls may be recorded for training and monitoring purposes.)

If you are still dissatisfied following a formal response to your complaint, you can approach the Financial Ombudsman Service at:

Financial Ombudsman Service Ltd
Exchange Tower
London
E14 9SR

Tel 0800 023 4 567

12.2 Compensation

If we are unable to meet our liabilities, you may be able to claim compensation from the Financial Services Compensation Scheme. Further information is available from the Financial Conduct Authority or the Financial Services Compensation Scheme.

Further information about compensation scheme arrangements is available from:

Financial Services Compensation Scheme
PO Box 300
Mitchledean
GL17 1DY

Tel: 0800 678 1100

12.3 Data Protection

We are the data controller in respect of personal data we receive from you in respect of the policy. We process personal data for the purposes of providing insured benefits on behalf of you for the benefit of your employees and their families. The information supplied by you may be transferred outside the UK 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 Notice https://ellipse.co.uk/data-protection/

12.4 Law

The policy is issued subject to the laws in England and Wales. The contract is with the named policyholder and members do not have any contractual rights under the policy under the Contracts (Rights of Third Parties) Act 1999.

Our Group policy should be read and interpreted in the context of the Insurance Act 2015, and (where applicable) the Consumer Insurance (Disclosure and Representations) Act 2012, except where we have contracted out as described in section 9.4.

Any dispute in relation to the policy will be subject to the jurisdiction of the English and Welsh courts only.

Ellipse shall not be responsible or liable to provide cover (including the payment of a claim) under the policy if we are 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.

The policy has no surrender value and cannot be assigned without our prior written permission.

This document should be read in conjunction with the quotation. This document does not override the policy. If there is a difference between the policy and the technical guide, the policy takes precedence.