AIG

Group Protection

Group Critical Illness Insurance

Technical Guide

Contents

Welcome to AIG

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

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

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

Contact us

Group Client Service,
AIG Life Limited
The AIG Building
58 Fenchurch Street
London
EC3M 4AB

Call us on:

0330 303 9972

Calls are charged at standard rates from a BT landline but may cost more via mobiles and other networks.

Email: groupclientservice@aiglife.co.uk

We are open Monday to Friday 9am to 5.30pm, except bank holidays. Please note these opening hours are UK local time.

We may record or monitor calls to make sure we have an accurate record of the instructions we are given, for training purposes, to improve the quality of our service and to prevent and detect fraud.

This document is available in other formats. If you would like a Braille, large print or audio version, please contact us.

Group Critical Illness Insurance

This Group Critical Illness insurance is designed to pay a lump sum benefit if an insured person suffers from one of the illnesses specified in the Policy Terms and Conditions.

It's available to UK registered organisations (either with Companies House or similar) and isn't available to UK branches of overseas organisations.

This Technical Guide has been produced based on the standard format recommended by the Group Risk Development Group and the Association of British Insurers (ABI).

This document is aimed at the employers and describes the main features and benefits of the product. It should be read alongside the quote issued. It doesn't form part of the policy contract – the Policy Terms and Conditions can be found on our website.

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 covered, a spouse/partner of a member) suffers from one of the insured illnesses specified in the Policy Terms and Conditions.

Your commitment

- To pay the premiums when they're due
- To comply with the Policy Terms and Conditions
- To tell us of any claims as soon as possible
- To provide us, at the agreed intervals, with the information specified in the Policy Terms and Conditions as needed to ensure cover
- To ensure that any information you supply is complete and accurate when you provide it
- To provide information about the policy and how it works to members.

Our commitment

- We'll deal with claims promptly and fairly and will provide information on the progress of the claim. Once we've determined that the claim is valid, we'll pay the benefit to the member
- We'll pay promptly any premium refunds that may arise
- We'll request information about you or the insured members only to the extent it's necessary to ensure the efficient running of your policy
- We'll copy in your adviser to any correspondence we send to you
- We won't copy you or your adviser into any correspondence sent to members in connection with assessing their health (to protect their privacy), but we'll ensure you and your adviser are aware of the progress and results of such assessments.

Risk factors

- If you don't 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 ask for may result in individuals not being covered or having less than their full cover
- If you don't fairly present the risk (i.e. the information we've 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 Policy Terms and Conditions or cease the policy – see section 9.4 'What happens if you don't make a fair presentation of the risk'
- Certain types of claims will be excluded – see section 6 'What isn't covered'
- We won't pay claims for any pre-existing insured illness or related medical condition – see section 6 'What isn't 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?'
- There could be legislative, regulatory or other HM Revenue & Customs (HMRC) changes that could affect this policy.

Your questions answered

How does the policy work?

- You decide the eligibility conditions and the level of cover that you would like us to provide. You can choose different levels of cover for different categories of members, as well as whether or not to include total permanent disability. 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 to provide cover to members' spouses or partners
- In order to comply with relevant employment and taxation legislation, you should obtain appropriate legal and tax advice
- You pay premiums when they're due. Where you pay the premium, it's 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 Terms and Conditions and survives for more than 14 days
- The benefit to be paid in the event of claims will be as detailed in the Policy Schedule. If the scheme is part of a flexible benefits arrangement, you'll 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 a 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 – see section 2.2 'Does evidence of health have to be provided before members are covered?'
- Once we've determined that a claim is valid, we'll pay the lump sum to the member
- You must provide us with membership data within 14 days of us requesting it. We'll confirm at the start of the policy how often you'll provide updated membership data (known as the data refresh) which needs to be complete and accurate. This should include details of new entrants who've joined the scheme since the previous data refresh and who'll normally be covered as soon as they join the scheme. However, we should be told immediately rather than at the next data refresh if a new entrant's benefit exceeds the automatic acceptance limit because they'll need to complete an individual assessment to establish the terms, if any, on which cover can be offered
- The Policy Terms and Conditions and rate(s) are normally guaranteed for two years and won't 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 three
  - the new inclusion of a 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's no longer an adviser acting for you in connection with this policy
  - there's a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy, or
  - you don't give us complete and accurate information.

Section 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 hours contracts won't automatically be covered by the policy. If you want to cover workers engaged through zero hours contracts, they must be in a separate category with suitable eligibility and salary definitions. 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 to provide cover to members' spouses or partners.

Cover can be provided for equity partners and limited liability partners, providing all 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 (e.g. you might specify that individuals must have completed three months' service)
- the date on which new entrants will be included, (e.g. 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, and
- the date on which benefit increases are applied, which can be daily, monthly or annually.

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 benefit up to the policy's automatic acceptance limit, subject to the conditions set out in section 6 'What isn't covered'.

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

1.3 When will cover end?

1.3.1 Under normal circumstances

Cover for a member will end if they:

a) reach the age at which their cover ceases according to the terms of the policy, unless we've agreed with you that their cover can be continued
b) are no longer being employed by a participating employer or otherwise become ineligible for membership
c) are a worker engaged through a zero hours contract who hasn't received earnings from their employer for a period of six consecutive months unless they're unavailable for work due to ill health
d) are absent from work 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're absent from work?', or
e) die.

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

If cover is provided for spouses/partners, it will end:

- once the member's cover has ended
- if the spouse/partner dies
- if the spouse/partner reaches the age at which cover ceases, unless we've agreed with you that their cover can be continued, or
- on divorce, dissolution or no longer meeting the definition of partner.

A member can't be covered as both an employee and a spouse/partner.

Cover can't continue beyond a member's or spouse/partner's 70th birthday.

1.3.2 Cancelling the cover

The policy doesn't have a termination date. You can cancel the policy at any time providing you notify us in writing. Cancellation can't be backdated and we'll charge for the time on risk.

We reserve the right to cancel the policy if:

a) you don't pay premiums when they are due
b) you don't comply with the Policy Terms and Conditions
c) you don't provide information we have requested within 90 days
d) there's a change in legislation, regulation, HMRC practice or taxation which affects the 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, or
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's covered?

The insured illnesses are listed below. The member, child and, if covered, a spouse/partner of a member are covered for these illnesses. However children are covered under the child specific illness of permanent dependence rather than the illness loss of independence.

You can add total permanent disability at an additional cost.

These headings are a guide of what is covered and the full definitions are provided in section 11 'Critical illness definitions'.

Our cover matches or exceeds the cover provided by the ABI's model definitions.

1.4.1 Illnesses covered

The following illnesses are grouped, focusing on their impact rather than a named condition:

- Blindness or removal of an eyeball – permanent and irreversible
- Brain injury – resulting in permanent symptoms
- Degenerative neurological disorder – of specified severity
- Loss of use of a limb
- Lung disease or removal – as specified
- Reduced heart function – of specified severity
- Surgery to the heart, aorta or pulmonary artery – as specified
- Surgery via the skull – as specified.

These conditions are also covered:

- Angioplasty – requiring treatment to multiple coronary vessels
- Bacterial meningitis – resulting in permanent symptoms
- Balloon valvuloplasty
- Benign brain tumour – resulting in permanent symptoms or specified treatment
- Benign spinal cord tumour – resulting in permanent symptoms or specified treatment
- Cancer – excluding less advanced cases and including aplastic anaemia
- Cancer – second & subsequent
- Coma – of specified severity
- Deafness – permanent and irreversible
- Encephalitis – resulting in permanent symptoms
- Heart attack – of specified severity
- Kidney failure – requiring permanent dialysis
- Liver failure – end stage
- Loss of independence – of specified severity (for adults only)
- Major organ transplant – from another donor
- Multiple sclerosis or Neuromyelitis optica (Devic's disease) – where there have been symptoms
- (Chronic) Rheumatoid arthritis – of specified severity
- Stroke – of specified severity
- Systemic Lupus Erythematosus (SLE) – of specified severity
- Terminal illness – where death is expected within twelve months
- Third degree burns – covering 20% of the body's surface area or 20% of the face's surface area.

1.4.2 Child specific illnesses

The following conditions are specific to any children covered:

- Cerebral palsy
- Cystic fibrosis
- Down's syndrome
- Edwards' syndrome
- Hydrocephalus – treated with the insertion of a shunt
- Muscular dystrophy
- Osteogenesis imperfecta
- Patau syndrome
- Permanent dependence – of specified severity
- Spina bifida.

1.4.3 Total permanent disability

You can add cover for total permanent disability on one of the following bases:

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

Full definitions are detailed in section 11 'Critical illness definitions'. An own occupation definition isn't available for members aged over their State Pension age. Any member covered for total permanent disability on an own occupation basis will automatically be switched to a suited occupation basis at their State Pension age (if cover is provided beyond the State Pension age).

Irrespective of which basis is used for employees, the basis applicable to children and 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 of salary. The maximum benefit available for a member is £500,000. For workers engaged through zero hours contracts, the maximum fixed amount we'll normally offer is £50,000. You can vary the basis (including the multiple of salary or value of the fixed amounts) 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 the 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 (such as bonuses and commission) 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 hours contracts is either:

- total earnings in the 12 months up to the date of diagnosis, or
- 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'll use the total earnings in the 12 months up to the date of diagnosis).

Please note that we won't annualise earnings for workers engaged through zero hours contracts who've worked for less than 12 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 Terms and Conditions and survives for more than 14 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 Does a member continue to be covered if they're 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'll 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're still considered an employee.

1.7.3 If they're absent from work for any other reason, cover will end 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 won't 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 hours contracts, cover during periods of temporary absence due to ill health will end on the earlier of:

a) the end of the zero hours contract in force when the member was first absent

b) when the zero hours contract is terminated, or

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 section 1.9.1 'Extended cover'), their cover during periods of temporary absence can be until age 70 if due to ill health and for up to 12 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.

Whilst any member is absent their benefit during this period will be the benefit they had on their last working day before they became absent. However, 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, e.g. an increase in the National Minimum Wage).

Members who are being covered during periods of temporary absence must be included in the data (on the correct amount of salary and/or benefit). 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.

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, stepchild or legally adopted child will be covered and there's 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 £25,000. If a child's 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 £25,000.

Children's cover will always be subject to the pre-existing insured illness and related medical conditions exclusions and the exclusion specific to children which are all set out in section 6 'What isn't 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 or is in a civil partnership with, or

b) someone they've been living with for a minimum of six months as if they were married or in a civil partnership and when the cover starts is either:

- financially 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 isn't covered', unless we've individually assessed them and confirmed in writing that these exclusions have been removed.

An individual can't be covered as an employee and spouse/partner.

1.9 Are there 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 11 'Critical illness definitions'), this will be amended to a 'suited occupation' basis for members over their State Pension age.

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're being covered beyond the age cover ceases, these new exclusions won't apply to the member's partner (unless they too are being covered beyond the age cover ceases).

Cover can't continue beyond an individual's 70th birthday.

The 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 Flexible benefits

We can provide cover under a flexible benefits scheme, where members can decide the level of cover that's 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 will apply to flexible benefit schemes and these will be set out in our quote.

Section 2

Setting up the policy

2.1 What are the requirements for setting up the policy?

The information we need to prepare a quote is detailed at the beginning of section 3 'What premiums will be charged for the cover?'. We'll prepare a quote based on the information you provide and it's normally valid for three months. If you want us to start cover, your adviser will need ask us do so, and supply any outstanding information that is requested in the quote.

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

If your adviser has provided your email address, we'll send you an email with details of how to register to access the site. Once you've 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's 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 don't have the information we requested

c) insert any information that is shown as required (e.g. we'll need the scheme name and cover start date), and

d) sign the form and the direct debit mandate and return it to us by email before the policy start date (cover can't be backdated).

If your adviser hasn't provided your email address, the application form will be sent to the adviser, who'll 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 quote, including the premium, are no longer valid and may have to be reviewed, or even that we have to withdraw our quote entirely.

Prior to the policy start date, we need details in writing of the terms of acceptance for any members who've been individually assessed (underwritten) by the previous insurer. Please send this to us alongside the completed application form. We'll need copies of the original decision letters for these members within 14 days of us confirming cover.

Once we've confirmed cover can start, we'll request membership data (including National Insurance numbers or unique identifiers) as at the policy start date, and this must be supplied within 14 days of our request.

The premium payment options available are as follows:

Payment frequency	Payment method	
	Schemes with up to 199 members	Schemes with 200 or more members
Monthly	Direct debit	Direct debit
Quarterly	Direct debit	Direct debit
Annual	Direct debit	Bank transfer

If we don't receive complete data within 14 days of our request, we'll request payment based on the estimated annual premium in the quote.

For annual payment policies that pay premiums by bank transfer, we'll issue an invoice for the estimated annual premium and payment must be made within 14 days. For annual payment policies that pay premiums by Direct Debit, we'll request a payment for the estimated annual premium.

For quarterly payment policies, we'll request a payment for 25% of the estimated annual premium.

For monthly payment policies, we'll request a payment for 1/12th of the estimated annual premium.

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

If, once the data is received, there's a material change in the risk, it may mean we have to review our pricing and/or Policy Terms and Conditions or withdraw our offer. We would withdraw our offer if the change in the risk means that if we'd 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 aren't provided when they're due, we reserve the right to withdraw cover. We'll notify you that we've 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's 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 benefit up to the policy's automatic acceptance limit, subject to the exclusions detailed in section 6 'What isn't 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 insured.

Any individual whose benefit has been restricted, declined, postponed or accepted on non-standard terms won't benefit from any increase in the automatic acceptance limit.

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'll 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 or are seconded to countries that we consider high risk. An up to date list of these countries can be found on our website here. We'll then assess the impact that including these individuals would have on the existing policy and advise if we're 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 doesn't apply?

Any individual whose promised benefit exceeds 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 can't 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'll be asked questions about their health and lifestyle and they'll 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 or an independent medical examination) 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'll advise both the individual and you of our decision. If there's a premium loading, we'll assume that it's acceptable and adjust future premium collections accordingly, unless you write to tell us otherwise. If this is the case, we'll 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 on the same basis to us from another insurer, the following will apply:

- our pre-existing insured illnesses and related medical conditions exclusions and exclusion relating to children (as detailed in section 6 'What isn't 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 wasn't covered by the previous insurer will be subject to a pre-existing insured illness and related medical conditions exclusions and exclusion relating to children (as detailed in section 6 'What isn't covered?') from the date the policy started with us, and
- if members have been individually assessed by a previous insurer, we'll need copies of the terms of acceptance in order to confirm the exact terms of transfer of their cover.

An example of how the exclusions work for insured illnesses which weren't covered by the previous insurer is as follows:

A new scheme is set up on 1 August 2019 and is insured with insurer A which provides cover for 15 illnesses of which one is cancer but liver failure isn't covered. A member joins the scheme on 1 August 2019. The scheme switches its insurance to AIG on 1 August 2021 and we cover both cancer and liver failure. If a member first started experiencing symptoms of cancer in June 2021 and was diagnosed with cancer in August 2021, they could make a claim against our insurance. If the member first started experiencing symptoms of liver failure in June 2021 and was diagnosed with liver failure in August 2021, they couldn't make a claim against our insurance because liver failure is a new illness covered and therefore the exclusions apply from 1 August 2021.

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

Whilst we're assessing an individual we'll provide them with temporary cover for a maximum period of 90 days or until our assessment is completed, if earlier.

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

Temporary cover won't be given to any individual who:

a) has previously been declined, offered cover on non-standard terms or where a decision on their benefit has been postponed (either by AIG or another insurer)

b) has failed to provide medical evidence that has been requested, or

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're 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 AIG, we'll require documentary proof of the previous acceptance terms.

Section 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
- the age and sex of the members to be covered
- if cover is provided for members' spouses/partners, their age and sex
- the nature of the industry you're 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 or are seconded to 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, and
- the level of commission (if any) you've agreed with your adviser.

3.1 How will premiums be calculated?

The costing basis will depend on how many members there are in the scheme when the policy is set up and when the policy is reviewed.

3.1.1 Age specific rate table

This basis normally applies to schemes of up to 999 members. Premiums are calculated for the cover provided to each member (and spouse/partner if they're being covered) based on age-related premium rates which we apply to the amount of their benefit.

3.1.2 Unit rate

This basis normally applies to schemes of 1,000 or more members. A weighted average rate is calculated based on the factors detailed in the beginning of this section and this is applied to the amount of members' (and spouse/partner's if they're being covered) 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 Conditions and rate(s) for two years until the second policy anniversary date. They'll 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 three
c) the inclusion of a participating employer or a TUPE transfer
d) the disposal of a participating employer or closure of a part of a participating 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's no longer an adviser acting for you in connection with this policy
j) there's a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy, or
k) you haven't given us complete and accurate information.

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'll confirm the rate of commission payable to your adviser in your quote and at regular intervals during the life of the policy.

Section 4

How does the policy accounting work?

During the year you'll send us updated membership data at a frequency agreed when the policy starts. For schemes with up to 199 members, data can be provided quarterly or annually. For schemes with 200 or more members, data can only be provided annually. The data will be used to calculate the premium.

The quote 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 benefit change), or
- 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've chosen to use)
- name
- sex
- 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), and
- amount of benefit.

If cover is provided for spouses/partners, we'll need data including:

- their National Insurance number
- their name
- their sex
- 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), and
- the employee's location (postcode if in the UK or country if outside the UK).

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 and we'll agree with you before the policy starts which of the following bases will be used.

4.2.1 Exact cover cost

This basis applies as standard for all schemes with up to 999 members. Premiums will be calculated based on the amount of cover and time on cover for each member, i.e. member's join and leave dates will be taken into account.

4.2.2 Simplified administration

This basis is only available to schemes over 200 lives with annual data refreshes. It's standard for all schemes with over 1,000 members where premiums are calculated on a unit rate basis. The premium for the first accounting period will be based on the membership data as at the inception date. For subsequent accounts, a premium adjustment is calculated to allow for changes during the policy year such as joiners, leavers and any changes in benefit. It is payable at the end of the policy year. As a result join/leave dates don't need to be provided and data should only include members covered as at the data refresh date.

Where premiums are collected by direct debit, the amount collected will be adjusted from the next due date. Where premiums are paid by bank transfer, we'll request any additional premium due or refund premium if there has been an overpayment.

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.

Section 5

Claiming a benefit

We know the importance of handling claims quickly and efficiently. In this section, we've 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 0330 303 9973. We'll 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 won't 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'll only consider claims if we've been notified within two years of the date of diagnosis of the insured illness.

In addition to the completed forms, we'll need the following from you:

- proof of the member's age (for example the member's passport or birth certificate, or confirmation that you've seen one of these documents)
- proof of membership and earnings
- if the claim is being made for total permanent disability on either an own occupation or suited occupation basis, we'll need a copy of the member's job description detailing their regular duties.

We'll also need the following from the member:

- if a claim is being made for a spouse or civil partner, we'll need original copies of their marriage or civil partnership certificate
- if a claim is being made for a partner who isn't a spouse or civil partner, we'll need an 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'll need original copies of their birth or adoption certificate
- where appropriate, or in the event that sufficient medical evidence is not available, we may need the person, in respect of who the claim is being made, to undergo an independent medical examination, paid for by us.

This list isn't exhaustive and there may be times where more information is required.

Once we receive the completed claim form and personal statement we'll write to the member's treating doctor to request the medical information we require to assess the claim.

Claims won't be paid while premiums are overdue.

Upon receipt of a claim, we'll deal with it promptly and fairly and will provide appropriate information on the progress of the claim. Once we agree that a claim is valid, we'll pay the benefit to the member's UK bank account by direct credit.

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'll 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. three 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 AIG 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'd 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 won't 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. three 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 AIG 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'd 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 groupclaims@aiglife.co.uk outlining the reason for the appeal and attaching any additional information. The claim will be reviewed by an appropriately qualified and experienced assessor who wasn't involved in the original claim decision.

5.5.2 Can another claim be made for an individual?

Yes, provided it isn't for the same insured illness, a related medical condition or the earlier claim isn't directly or indirectly associated with the new insured illness – see section 6 'What isn't covered'. However, if a claim was paid for an individual for cancer, a second claim for cancer will be considered providing it meets the definition of 'Cancer – second and subsequent'.

A claim can't be made under this policy for an individual if a claim was paid for the same or related medical condition under a previous policy.

Section 6

What isn't covered?

There are some important exclusions in this policy that may mean some claims won't be paid. In this section, we set out what the exclusions are and when they may affect a claim.

6.1 Pre-existing insured illness exclusion

Insured illnesses are any of the illnesses defined within the Policy Terms and Conditions. A list of insured illness and their definitions can be found in section 11 'Critical illness definitions'.

A pre-existing insured illness exclusion will always apply to an individual's benefit unless we've 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
- has sought advice on
- has experienced symptoms of, or
- was diagnosed with

before entry to the scheme.

For the purpose of the Policy Terms and Conditions, the illnesses in each group below will be considered to be the same insured illness:

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

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

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

before entry to the scheme and which leads to a claim for coma, loss of independence, loss of use of a limb, terminal illness or total permanent disability.

For example, where a member claims under the terminal illness benefit as a result of cancer, but had suffered from the cancer before entering the scheme, this claim will be declined.

The criteria under this pre-existing insured illness exclusion will 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 consultant medical officer is likely to have led to the occurrence of the insured illness.

We won't pay any claim for an insured illness where a related medical condition existed prior to entry to the scheme unless the insured person has been in the scheme for two consecutive years or more and the insured illness has not occurred in that two year period.

We won't pay any claim for coma, loss of independence, loss of use of a limb, terminal illness or total permanent disability benefit where a related medical condition existed before entry to the scheme.

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

In addition, we won't pay any claim in respect of an increase in benefit for a claim for coma, loss of independence, loss of use of a limb, terminal illness or total permanent disability benefit where a related medical condition existed before the increase in benefit.

Examples of how the exclusions described in the sections 6.1 and 6.2 above 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'd been treated for a heart attack. After they join the scheme, they have another heart attack. We wouldn't 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 that meets the Policy Terms and Conditions definition of cancer, we'd 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 2018 with a benefit of £50,000. Before they joined the scheme, they hadn't been tested, treated or had symptoms of kidney failure. In October 2018, they have tests for kidney failure. On 1 January 2019, they have an increase in benefit to £75,000. In March 2019, they're diagnosed with kidney failure (which meets the Policy Terms and Conditions definition of kidney failure) and they make a claim for kidney failure. Because they'd been tested for kidney failure before they had the increase in benefit from £50,000 to £75,000, we'd pay £50,000.

Example 3: How the related medical conditions exclusion works for a new joiner:

A new member joins the scheme on 1 January 2018. Just before they joined the scheme, they'd been diagnosed with uncontrolled high blood pressure. On 20 February 2019, they have a stroke. We wouldn't pay a claim for the stroke because the uncontrolled high blood pressure is considered a related medical condition to the stroke and the stroke occurred within two years of joining the scheme. If the stroke occurred after 1 January 2020, the claim would've been paid because the stroke occurred more than two years after joining the scheme.

Example 4: How the related medical conditions exclusion works for an increase in benefit:

A new member joins the scheme on 1 January 2014 with a benefit of £50,000. Just before they joined the scheme, they'd suffered from chest pain. Between 1 January 2014 and 30 June 2018, they hadn't had any more chest pain or any other symptoms of heart problems.

In July 2018, they suffered chest pain and underwent tests for a heart condition. On 1 January 2019, their benefit increased by £25,000 to £75,000. On 5 August 2019, they have a heart attack (which meets the Policy Terms and Conditions definition of heart attack) and they make a claim. We'd pay £50,000 because the heart attack occurred more than two years after they joined the scheme. We wouldn't pay the additional £25,000 because the heart attack occurred within two years of having the increase in benefit.

Example 5: How the additional exclusion in relation to children works for an increase in benefit:

A new member joins the scheme on 1 January 2016 with a benefit of £50,000. The member's partner becomes pregnant and during a scan in November 2019 they are told the baby will need heart surgery once it's born. On 1 January 2020 during a flexible benefits window, the member chose to increase their critical illness benefit by £50,000 to £100,000. On 5 February 2020, the baby is born and undergoes heart surgery to repair a hole in the heart a week later. We'd pay £12,500 (25% of £50,000) because the parent was aware of the requirement for surgery before they increased their 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?'), the pre-existing insured illness and related medical conditions exclusions are removed in respect of their accepted benefit. However, exclusions may apply for claims arising from certain specified medical conditions or in specified circumstances.

6.4 Additional exclusion in relation to children

A claim won't 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. For example, the insured illness or related medical condition was identified during pregnancy or a child underwent investigations related to the insured illness before being covered under the scheme.

6.5 Excluded claims

Where a claim has already been paid (either by us or a previous insurer) and a new claim is made where in the opinion of our consultant 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 won't be met.

For example, if a claim has previously been paid for a stroke, we won't 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 and then submits a claim for terminal illness as a result of that cancer. In this case, we'll consider the terminal illness claim to be related to the cancer claim and this new claim will be declined.

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

Section 7

Can cover be provided for an individual who isn't based in the UK?

7.1 Individuals who travel outside the UK

We'll 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'll usually 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 UK contract of employment or for services with a participating employer

c) there's the intent to return to the UK, and

d) the country of secondment 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 isn't paid in pounds sterling, the benefit will be calculated based on the exchange rate agreed at the most recent data refresh before the date of diagnosis.

Where individuals are outside the UK, and provision of their benefit is subject to individual assessment, they'll 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 us, otherwise we won't be liable for any costs and the individual may be required to undertake another set of tests with an approved centre/provider (this may include returning to the UK to undergo the necessary tests).

We'll reimburse the member for the tests we've requested, up to a maximum of the amount we'd 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.

7.3 Individuals permanently based outside the UK

We're unable to provide cover for individuals who are permanently based outside the UK.

Section 8

Taxation of policies

The following is 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're 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 won't 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's no tax relief on these premiums.

8.2 Payment of the benefit

The benefit to the member (including equity partners) isn't normally subject to income tax. We'll always pay it gross of any tax that may be due.

Section 9

Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact that you know or ought to know of. If you don't 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 don't 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's common knowledge), or
- we specifically say we don't 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're 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 haven't been deliberate or reckless in doing so) we can proportionately reduce the claim. We believe it's 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 don't make a fair presentation of the risk

9.4.1 Deliberate or reckless misrepresentation of the risk

If you deliberately or recklessly don't make a fair presentation when setting up the policy, we may void 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 don't make a fair presentation but you haven't been deliberate or reckless, the outcome depends upon what we would have done if we'd known the material facts:

- if we wouldn't have entered into the policy, we may void 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), or
- if we would have applied different terms and/or an additional premium, we'll 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's a fraudulent claim. If there's a fraudulent misrepresentation by a member that affects our acceptance of a claim made in respect of that member, we won't pay the claim in respect of that member. If there's fraudulent claim made by you, we won't pay the claim and we reserve the right to terminate the policy.

Section 10

Further information

Cover is provided by AIG. AIG provides information about the insurance contracts we offer but doesn't provide a personal recommendation about the insurance products we offer. Employees of AIG 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's 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.

10.1 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 Group complaints team at:

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

by email to groupcomplaints@aiglife.co.uk

or by calling **0330 303 9974** (calls may be recorded for training and monitoring purposes.)

If you're 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 4567**

10.2 Compensation

If we're 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
Mitcheldean
GL17 1DY

Tel **0800 678 1100**

10.3 Data Protection

We're 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 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 policy www.aiglife.co.uk/privacy-policy.

10.4 Law

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

Our Group Policy Terms and Conditions 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 under section 9.3.

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

AIG won't be responsible or liable to provide cover (including the payment of a claim) under the policy if we're prevented from doing so by any economic sanction which prohibits us or our parent company (or our parent company's ultimate controlling entity) from providing cover or dealing with you under the policy.

The policy has no surrender value and can't be assigned without our prior written permission.

This document should be read in conjunction with the quotation. This document doesn't override the Policy Terms and Conditions. If there's a difference between the Policy Terms and Conditions and the Technical Guide, the Policy Terms and Conditions takes precedence.

Section 11

Critical illness Definitions

For the purposes of the critical illness definitions, the following definitions apply:

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

11.1 Critical illness definitions

Angioplasty – requiring treatment to multiple coronary vessels

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

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

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

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

For the above definition the following isn't covered:

- diagnostic angiography.

Bacterial meningitis – resulting in permanent symptoms

Bacterial meningitis causing inflammation of membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must be confirmed by a consultant neurologist.

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

- all other forms of meningitis including viral meningitis.

Balloon valvuloplasty

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

Benign brain tumour – resulting in permanent symptoms or specified treatment

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

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

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

- tumours in the pituitary gland, or
- angioma.

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

A non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges, resulting in any of the following:

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

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

- angiomas.

Blindness or removal of an eyeball – permanent and irreversible

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

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

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

Brain injury – resulting in permanent symptoms

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

Cancer – excluding less advanced cases and including aplastic anaemia

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes:

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

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

- all cancers which are histologically classified as any of the following:
  - pre-malignant
  - cancer in situ
  - having borderline malignancy, or
  - having low malignant potential.
- all urothelial tumours unless histologically classified as having progressed to at least TNM classification T1N0M0.
- malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin);
- any non-melanoma skin cancer (including cutaneous lymphoma and sarcoma) that arises from, or is confined to, one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin unless it has spread to lymph nodes or metastasised to distant organs;
- all thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0;
- neuroendocrine tumours that have not spread to lymph nodes or metastasised to distant organs unless classified as WHO Grade 2 or above;
- gastrointestinal stromal tumours that have not spread to lymph nodes or metastasised to distant organs unless classified by either AFIP/Lasota-Miettinen as having a moderate or high risk of progression, or as UICC TNM8 stage II or above; and
- all tumours of the prostate unless histologically classified as having a Gleason score of 7 or above, or having progressed to at least clinical TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate).

Cancer – second and subsequent

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

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

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

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

Coma – of specified severity

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

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

- coma secondary to alcohol or drug abuse.

Deafness – permanent and irreversible

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

Degenerative neurological disorder – of specified severity

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

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

For this definition, the following aren't covered:

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

Supplementary information

Neurodegenerative disorder is an umbrella term for a range of conditions which primarily affect the neurons in the brain. Neurons are the building blocks of the nervous system and normally don't reproduce or replace themselves. So when they become damaged or die they can't be replaced by the body.

Neurodegenerative disorders are incurable conditions that result in progressive degeneration of nerve cells. The rate of the degeneration will vary in each case and will cause problems with movement (called ataxias) or mental functioning (called dementias).

Well known examples of neurodegenerative diseases include Alzheimer's disease, motor neurone disease and Parkinson's disease – but there are many more.

A diagnosis will usually be made by a Consultant Geriatrician, Neurologist, Neuropsychologist or Psychiatrist and supported by evidence including neuropsychometric testing.

Conditions that have similar symptoms but aren't classified as neurodegenerative disorders, such as fibromyalgia, chronic fatigue syndrome and essential tremor, aren't covered. Also, claims won't be considered for any conditions that are related to alcohol or drug abuse.

Encephalitis – resulting in permanent symptoms

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

Heart attack – of specified severity

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

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

The evidence must show a definite acute myocardial infarction.

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

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

Kidney failure – requiring permanent dialysis

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.

Liver failure – end stage

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

- permanent jaundice
- permanent ascites, and
- encephalopathy.

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

- liver failure secondary to alcohol or drug abuse.

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

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

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

- the person covered requires continuous supervision.

Or

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

Note: This critical illness is only available for adults. Children will be covered under the child specific illness 'Permanent dependence'.

Loss of use of a limb

Permanent loss of the use of a limb due to:

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

Lung disease or removal – as specified

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

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

Major organ transplant – from another donor

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

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

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

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

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

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

The following isn't covered:

- neuromyelitis optica spectrum disorder.

Reduced heart function – of specified severity

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

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

For this definition, the following isn't covered:

- any heart impairment related to alcohol or drug misuse.

Supplementary information

The human heart works like a pump sending blood around a person's body to keep them alive. It's a muscle that continuously pumps about eight pints of blood around the body through a network of blood vessels called the circulatory system. The heart and circulatory system work together to deliver blood to organs so they can function.

Conditions such as coronary heart disease, high blood pressure, heart attack and cardiomyopathy can lead to the heart stopping pumping blood around the body properly. When this happens, doctors typically use two methods to assess the severity of the condition:

i. New York Heart Association (NYHA) classification – has four categories and is based on how much a person is limited during physical activity. Class 3 of the NYHA classification means there is marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain.

ii. Ejection fraction – is a measurement that provides an indication of how well the heart is pumping out blood. A normal ejection fraction is between 50% and 70%.

Claims won't be considered for any conditions that are related to alcohol or drug abuse.

(Chronic) Rheumatoid arthritis – of specified severity

Severe chronic rheumatoid arthritis with widespread joint destruction and deformity of at least three major joint groups,

which results in the inability to do at least three of the following:

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

Stroke – of specified severity

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

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

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

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

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

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

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

The following isn't covered:

- any other surgery including endovascular surgery.

Supplementary information

The heart is a vital human organ, the aorta is the largest artery in the body and the pulmonary artery carries blood from the heart to the lungs. Therefore, surgical procedures to any of these represent major operations.

The most common type of heart surgery in adults is coronary artery bypass grafting, but doctors also use heart surgery to:

- repair or replace heart valves
- repair abnormal or damaged heart structure
- implant medical devices that help support heart function and blood flow, or
- replace a damaged heart with a healthy heart from a donor.

Thoracotomy is a medical term for the group of surgical procedures to gain access to the chest. It can range from open surgery to less invasive keyhole surgeries. Most heart surgeries require a thoracotomy.

The aorta includes both the thoracic and abdominal aorta but not its branches.

Claims won't be considered for any surgeries other than those specified.

Surgery via the skull – as specified

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

Supplementary information

Surgery involving the skull is a critical and complicated process. This type of surgery may be needed to treat a brain aneurysm, epilepsy, abscesses or a tumour. There are many more reasons too. The type of surgery done depends highly on the condition being treated.

A craniotomy involves making an incision in the scalp and creating a hole known as a bone flap in the skull. When the procedure is complete, the bone flap is usually secured in place with plates, sutures, or wires. A craniectomy is a similar procedure where the bone flap is permanently removed or replaced at a later date.

Claims won't be considered for any other type of surgery.

Systemic lupus erythematosus (SLE) – of specified severity

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

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

Terminal illness – where death is expected within twelve months

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

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

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

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

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

11.2 Child specific illnesses

Cerebral palsy

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

Cystic fibrosis

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

Down's syndrome

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

Edwards' syndrome

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

Hydrocephalus – treated with insertion of a shunt

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

Muscular dystrophy

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

Osteogenesis imperfecta

A definite diagnosis of osteogenesis imperfecta by an attending consultant.

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

- Type 1 osteogenesis imperfecta.

Patau syndrome

A definite diagnosis of Patau syndrome by an attending consultant.

Permanent dependence – of specified severity

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

Having met our definition, a child must survive for 90 days.

Spina bifida

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

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

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

11.3 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. can't be reasonably improved upon by medical treatment and/or surgical procedures based on best clinical practice 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:

Total permanent disability – unable before the member's State Pension age to do their own occupation ever again

Loss of physical or mental ability through an illness or injury before the member's State Pension age to the extent that the member is unable to do the material and substantial duties of their own occupation ever again.

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

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

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

Total permanent disability – unable to do a suited occupation ever again

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

- Material and substantial duties means those that are normally required for and/or form a significant and integral

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

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

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

Activities based assessment

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

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

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

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

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

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

Section 12

Glossary

Automatic acceptance limit

The maximum amount of benefit that can be provided for any individual without the need for them to be individually assessed.

Child

A member's child, stepchild 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 doesn't 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's the date of surgery. For major organ transplant, it's 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're included in the scheme.

Insured illness

The illnesses and conditions covered, details of which are set out in this document.

Insured person

A member or child and, if we've agreed to cover them, a member's spouse/partner.

Member

An employee, equity partner, limited liability partner and, if we've agreed to cover them, workers engaged through zero hours contracts.

Member's partner

A person at the date cover starts:

a) to whom the member is married or is in a civil partnership with, or

b) someone they've been living with for a minimum of six months as if they were married or in a civil partnership and when the cover starts 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 consultant medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the insured illness.

Spouse

A person to whom the member is married or is in a civil partnership with at the date cover starts.

UK

The United Kingdom consisting of England, Wales, Scotland and Northern Ireland.

www.aiglife.co.uk

EDCO 2821 - 0124

GCI-TechGuide-Jan24