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of healthy living

Personal Protection Plan Provisions.

Health insurance · Life insurance · Car insurance

Personal Protection Plan Provisions.

This document is *your plan* provisions. It explains how *your plan* works. It includes details about the covers and options in *your plan*, how you pay *your plan* premiums, and how to make a claim if *you* need to. It explains how taking steps to improve *your* health can reduce *your plan* premium.

If there is anything that is not clear, please speak to *your* financial adviser, if *you* have one. *You* can also email *us* at lifeenquiries@vitality.co.uk or call *us* on 0345 601 0072. If *you* call *us*, please have *your plan* number to hand. To help *us* improve *our* service, *we* may record or monitor phone conversations with *you*.

In these provisions, *we*, *us* or *our*, means Vitality Life Limited. *You* or *your* means the plan owner or their legal successors unless the context otherwise requires. *We* have put some other words in italics. *We* explain what *we* mean by these words in the Definitions section.

Please contact us on 0345 601 0072 or speak to your adviser if you would like this document in large print or braille.

A. How your plan works.

Your plan includes at least one of the core covers. These are:

- Life Cover;
- Serious Illness Cover;
- Life with Serious Illness Cover;
- Income Protection Cover.

Your plan schedule shows which core covers will apply to the *person covered*. Under a joint life cover, core cover(s) will apply to both *persons covered*.

Payments *we* make to *you* in respect to any core cover(s) will be treated independently.

A1. Your cover structure

When *you* take out core cover(s), the following structure(s) is applied to *your* cover(s), as shown in *your plan schedule*:

Your cover structure	What this means
Level	The cover amount stays the same over *your* cover term. It will only change if something happens such as *you* make a claim or change a cover.
Indexed	The cover amount increases on each *cover anniversary*, in line with the *Retail Prices Index* (RPI) rounded to the next 0.25%. Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI figure that applies five months before each *cover anniversary*. If *your* cover lasts for the whole of *your* life then the increases will be applied automatically until the *cover anniversary* immediately before *your* 80th birthday. If *your plan* is a *joint life plan* this will be based on the *you*nger of the two *persons covered*. At this point *we* will write to *you* and ask *you* to confirm whether *you* want *your* cover amount to continue to be indexed. If *you* do not tell *us* that *you* want *your* cover amount to be indexed *we* will automatically change it to a level cover structure.
Decreasing	The cover amount decreases each month over *your* cover term. It decreases in the same way that the outstanding capital on a repayment mortgage would if the mortgage had: • An annual equivalent interest rate which *you* selected when *you* applied for *your* cover; • The same term as the cover. *You* can only have a *decreasing* cover if it is *fixed term*.

The amount *you* can claim on each cover may change if *we* pay a *benefit*, or because of a change to *your plan*. There is more about changes to *your plan* in provision D.

A2. How other covers work

The other covers *you* may have in *your plan* are set individually and will not impact the cover amount of *your* core cover(s).

A3. How long your plan lasts

Each cover in *your plan* lasts for a defined term. This term can be up to a fixed date – this is called a *fixed term*. Life Cover can instead be for the whole of *your* life – this is called *whole of life*. *Your plan schedule* shows the date on which each of *your* covers terminates.

Serious Illness Cover and Life with Serious Illness Cover will continue beyond

its *date of expiry* as Dementia and FrailCare Cover. There is more about this in provision B2.8.

Once *your plan* has started, *you* cannot change the term of any cover from *whole of life* to *fixed term*, or from *fixed term* to *whole of life*.

B. Core Covers.

This section provides details of each of the core covers. *Your plan schedule* shows which core covers *you* have.

B1. Life Cover

Life Cover pays a lump sum if the *person covered* dies, or is diagnosed with a *terminal illness*. This cover may be for a *fixed term* or for *whole of life*. Life Cover is not available for *children*.

B1.1 When we will pay the benefit

When *we* pay the *benefit* depends on whether *your plan* is a single life or joint life.

Single or joint life?	When we will pay the benefit
Single life plan	*We* will pay the *benefit* if the *person covered* dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit*, the *plan* ends.
Joint life first death	With a *joint life first death plan*, there are two people covered. If both people have Life Cover, *we* will pay the *benefit* if one of those people dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* for one *person covered*, *we* cancel all the covers that solely apply to that person. *We* also cancel the Life Cover for the remaining *person covered*. If the remaining person has other covers in the *plan*, the *plan* continues. This will include other *joint life covers* in the *plan*. The remaining person can apply to *us* for new Life Cover under a new *plan*. For more about this, see provision D6.
Joint life second death	This option is only available if *you* have chosen *Whole of Life* Cover, see provision A3. With a *joint life second death plan*, there are two people covered. *We* will pay the Life Cover *benefit* after both of the people covered have died, or have been diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* the *plan* will come to an end.

B1.2 How much we will pay

If both people covered in a *joint life plan* die, and it is not possible to determine who died first, *we* will pay *your* cover amount. This is specified in *your* plan schedule, and may change over time depending on *your* cover structure. For more about this, see provision A1.

The maximum amount of Life Cover *we* will pay for each *person covered* under all policies issued by *us* is £18,000,000. In all other circumstances *we* will pay the *benefit* amount.

B1.3 When we will not pay

We will not pay the *benefit* if the death or diagnosis of *terminal illness* happens after the Life Cover's *date of expiry*. *Your plan schedule* shows this date.

Under certain circumstances, *we* may also not pay the *benefit* if the claim is due to *suicide*. For more about this, see provision D5.6.

B1.4 What happens if you need to claim while we are still assessing your application for Life Cover

If *you* have applied for Life Cover on either a *single life plan* or *joint life first death plan* but *we* are still assessing *your* application, *we* automatically give *you* some limited Life Cover. This is called Immediate Cover. Immediate Cover is free of charge.

We will pay a *benefit* under Immediate Cover as long as all of the following apply:

- *We* have received a completed application from *you*
- *We* have received a completed direct debit instruction from *you*
- The claim is for death – *terminal illness* is not covered
- *You* are under 50 when *we* receive *your* application
- *You* are a *resident of the United Kingdom*
- *You* are not applying for Life Cover with any other company
- *You* have appropriately answered 'no' to all *our* medical and health questions, and would normally be accepted on standard rates
- *You* do not take part in any hazardous pursuits or sports or have an *occupation* that *we* would exclude or charge *you* extra for

Immediate Cover stops when one of these happens:

- *We* accept *your* application
- *We* decline *your* application
- *Your* application is cancelled
- 90 days pass since *we* received *your* application

The total amount *we* will pay for Immediate Cover for Life Cover and Life with Serious Illness Cover is the amount *you* applied for, up to a combined maximum of £500,000 across all *plans you* have applied with *us*.

Immediate Cover does not apply to *plans* which have been arranged on a *joint life second death plan* basis.

B1.5 LifestyleCare Cover

LifestyleCare Cover allows *you* to access some or all of *your* Life Cover if *you* are diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision and Appendix 3.

LifestyleCare Cover is only available if *you* have chosen *Whole of Life* Cover. It is available on *single life plans* only.

B1.5.1 When we will pay

Your claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that *we* cover. *Your* condition must meet one of the definitions set out in Appendix 3. *We* will use the criteria in Appendix 3 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have, *we* will not pay a claim for that condition.

We will ask *your* General Practitioner, and any *appropriate medical specialists* who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 3. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

Benefits under LifestyleCare Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

B1.5.2 How much we will pay

Your plan schedule shows *your* amount of LifestyleCare Cover. If *your* cover structure is indexed, *your* LifestyleCare Cover will increase in the same way at each cover *anniversary*. For more about indexation see provision A1.

The amount *we* will pay depends on:

- How severe *your* condition is, and
- The amount of LifestyleCare Cover *you* have

The lump sum *we* will pay *you* will be a percentage of *your* amount of LifestyleCare Cover. The percentage depends on how severe *your* condition is.

There are two severity levels:

Severity level	What percentage of your amount of LifestyleCare Cover we pay
Level 1	20%
Level 2	100%

Appendix 3 shows which conditions are covered under Severity Level 1 and Severity Level 2.

B1.5.3 When we will not pay

We will not pay the *benefit* for LifestyleCare Cover if:

- *You* suffer from a condition that *we* do not cover
- *You* suffer from a condition that *we* excluded from *your* cover after assessing *your* application
- *Your* condition does not meet *our* definition for that condition
- *You* are making a subsequent claim that does not meet the criteria for a further payment
- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*
- *We* believe the condition that led to *your* claim was one *you* were already experiencing before *your plan* started and which *you* should have disclosed to *us* when *you* first applied
- *You* have selected LifestyleCare Cover Protector, and *you* do not survive for at least 14 days after the date that *you* meet a severity level 2 definition.

B1.5.4 What happens if you need to make a subsequent claim

We will only make one Severity Level 1 payment.

If *we* have paid *you* a claim under Severity Level 1 *you* can make a subsequent claim for a Severity Level 2 condition. This can be for the same underlying condition, or a different one.

For the subsequent Severity Level 2 condition, *we* will pay the remaining amount of *your* LifestyleCare Cover.

B1.5.5 How your cover continues after a claim for LifestyleCare Cover

The way *your* cover continues after a claim will depend on whether *you* have chosen LifestyleCare Cover Protector.

There are two types of LifestyleCare Cover Protector - LifestyleCare Cover Protector (level 1) and LifestyleCare Cover Protector (level 1 & 2). *Your plan schedule* will indicate whether *you* have selected LifestyleCare Cover Protector and if so which type.

LifestyleCare Cover Protector not selected

If *we* make a payment to *you* for a Severity Level 1 condition, the amount of *your* Life Cover and LifestyleCare Cover will reduce by the amount *we* have paid *you*.

If *we* pay *you* a claim for a Severity Level 2 condition, LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1)

If *you* have chosen LifestyleCare Cover Protector (level 1) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future Life Cover or LifestyleCare Cover claims.

If *we* pay *you* a claim under Severity Level 2, LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1 & 2)

If *you* have chosen LifestyleCare Cover Protector (level 1 & 2) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future Life Cover or LifestyleCare Cover claims.

If *you* meet the definition for a Severity Level 2 condition and *you* survive for at least 14 days after *you* meet the definition *we* will pay *your* remaining LifestyleCare Cover amount. LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will not reduce. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

B2. Serious Illness Cover

Serious Illness Cover pays a lump sum if *you* are diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision.

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from levels A to G. For more about severity levels, see 'How much *we* will pay', at provision B2.3.

Serious Illness Cover must be for a *fixed term*. If *your plan* also has Life Cover for a *fixed term*, the Serious Illness Cover must have the same *date of expiry* as *your* Life Cover.

Your plan schedule shows if Serious Illness Cover will continue beyond the *date of expiry* as Dementia and FrailCare Cover. For more information, please see provisions B2.8.

You can cancel Dementia and FrailCare Cover at any time if *you* do not wish for *your* Serious Illness Cover to continue beyond its *date of* expiry.

B2.1 When we will pay during *your* Serious Illness Cover term

Your claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that *we* cover. The *serious illnesses we* cover are specified in Appendix 1. They are grouped into *body system categories* to help *us* assess claims
- *Your* condition must meet any of the definitions set out in Appendix 1 that apply to it. *We* will use the criteria in Appendix 1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have, *we* will not pay a claim for that condition.
- *You* must survive for at least 14 days after the date of the *life-changing event* which causes *you* to claim. If *you* make a *permanent* disability claim, *you* must survive until the date when *we* confirm that *you* are totally and *permanently* disabled. For more about *permanent* disability claims, see Appendix 1. *Your plan schedule* will show whether *you* are able to make a *permanent* disability claim.

Benefits under Serious Illness Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

How we will assess your claim if your occupation has changed

You do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed. If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *functional activity tests* to assess *your* claim. For more about *functional activity tests*, see provision D5.4.

Medical evidence

We will ask *your* General Practitioner, and any specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid and, if appropriate, which severity level applies to *your* condition.

B2.2 When we will not pay

We will not pay if:	Where to find more information:
You suffer from a condition that *we* do not cover	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application	*Your plan schedule*
Your condition does not meet *our* definition for that condition	Appendix 1
You do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim	Provision B2.1
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment	Provision B2. 4
We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim	
We do not receive the medical evidence *we* need from *your* General Practitioner and any specialists who are treating *you*	Provision B2.1
We are not satisfied that the *serious illness* that has lead to *your* claim occurred either while *we* were providing *you* with Serious Illness Cover or was disclosed to *us* when *you* applied	
Your Serious Illness Cover expires before the *life-changing event* which leads to *your* claim and the claim doesn't meet the requirements under Dementia and FrailCare Cover	*Your plan schedule* Provisions B2.8

B2.3 How much we will pay

The amount *we* will pay depends on:

- How severe *your* condition is;
- The type of cover *you* have;
- The amount of cover *you* have and *your* percentage of cover remaining;
- Whether *your* claim is for a condition listed in Appendix 2.

How severe your condition is

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to G.

Severity level	The percentage of your cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

The type of cover

You are covered for severity levels A to D if *you* have chosen Serious Illness Cover 1X, A to E if *you* have chosen Serious Illness Cover 2X and all the severity levels from A to G if *you* have chosen Serious Illness Cover 3X.

Your plan schedule shows whether *you* have:

- Serious Illness Cover 1X;
- Serious Illness Cover 2X; or
- Serious Illness Cover 3X.

The amount of cover *and your percentage of cover remaining*

Your plan schedule shows the amount of Serious Illness Cover *you* have. This is the amount *you* would get if *we* paid 100% of *your* Serious Illness Cover, which may change depending on *your* cover structure. For more about this, see provision A1.

Where the percentage of a severity illness claim exceeds the *percentage of cover remaining, we* will pay out the lower of the two. The percentage of cover *you* have remaining depends on prior claims made on *your* cover. For more detail on this see Provision B2.4.

Appendix 2 and 100% *payouts*

If *your plan schedule* indicates that *you* have selected Serious Illness Cover 2X or Serious Illness Cover 3X the lump sum that *we* pay *you* in the event of a claim for certain *serious illness* conditions will be increased to 100% of *your* cover amount. These conditions are listed in Appendix 2.

B2.4 How *your* cover continues under Serious Illness Cover after a claim.

The way *your* cover will continue after a claim depends on the severity level *we* have paid *you* under the previous serious illness claim and the type of cover *you* have selected.

- *You* can receive up to a total of 100%, 200% or 300% of *your* Serious Illness Cover amount across multiple claims depending on claims *you* make and the type of Serious Illness Cover *you* have chosen.
- Each claim *we* pay *you* will reduce *your percentage of cover remaining* by up to 100% depending on the percentage of the cover amount that is paid. For more information on amounts paid when *you* claim, see provision B2.3.
- Once the total percentage *we* have paid *you* across all Serious Illness Cover claims is equal to
  - 100% if *you* have Serious Illness Cover 1X;
  - 200% if *you* have Serious Illness Cover 2X;
  - 300% if *you* have Serious Illness Cover 3X

your cover will end.

- There is no limit to the number of Serious Illness Cover claims *you* can make during the cover term.

What happens if we've paid the maximum amount of Serious Illness Cover *benefit*

There is a maximum of £3,000,000 for the total amount of *benefit you* can receive under Serious Illness Cover or Life with Serious Illness Cover across all claims under these covers.

On *joint life cover* this maximum applies to the cover amount for both *persons covered,* which will be shown in *your* plan schedule. The maximum *benefit* includes any payments *we* make under for any conditions listed in Appendix 1 or Appendix 2.

If *you* reach this maximum *benefit* amount, *we* will not accept any further *serious illness* claims and Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly and *you* will no longer be covered after the *date of expiry* under Dementia and FrailCare Cover.

If *you* are also covered by other policies issued by us, the overall maximum amount that *we* will ever pay in respect of a *person covered* is £3,000,000. This includes any payments we make for any conditions listed in Appendix 1 and Appendix 2. If *we* have not yet paid the maximum *benefit*, but a future claim might breach it, *we* might restrict *your* cover.

Subsequent Claims

If *you* claim once and then claim again, *we* call the second claim a subsequent claim. This can be for the same condition, or a different one. For more about how *we* pay subsequent claims, see the flowcharts in Appendix 5.

Only one *benefit* will be paid under a condition where *you* have been included on an official *UK* waiting list for a procedure and have undergone surgery for the same procedure.

If *you* have already claimed *we* will classify any subsequent claims *you* make as either a *progressive claim* or an *unrelated claim*.

Progressive claims	
Definition	A *progressive claim* occurs when: 1. A *person covered* has a *life-changing event* that causes a *serious illness;* 2. They make a claim for that *serious illness;* 3. They later make a claim for the same illness, or another *serious illness* that was caused by the same *life-changing event.*
When *we* won't pay	No further payment will be made if: • the severity of the *progressive claim* is the same as or lower than the severity level of the previous claim; or • if the previous claim was for a condition listed in Appendix 2 and the *progressive claim* is also for a condition that is listed in Appendix 2 or is for a severity level A condition.
When *we* will pay	If the severity level of *your progressive claim* is higher than the severity level of *your* previous claim, *we* will make another payment.
How *we* calculate the amount *we* will Pay	*We* will base the amount *we* pay on the increase in severity from the previous claim to the new claim. *We* will use *your* cover amount and *percentage of cover remaining* at the time of subsequent claim.

Unrelated claims	
Definition	An *unrelated claim* occurs when: 1. A *person covered* has a *life-changing event* that causes a *serious illness* 2. They make a claim for that *serious illness* 3. They later make a claim for another *serious illness* that was caused by a different *life-changing event*
How *we* calculate the amount *we* will pay	*We* will use *your* cover amount, the *percentage of cover remaining* and the severity level of the claim at the time of the subsequent claim.

There are three types of claim that *we* treat differently compared to the table above.

1. Subsequent claims due to Heart Attack or Stroke

If *you* make a valid claim that is caused by a Heart Attack or Stroke, *we* will treat any subsequent claim of the same or lower severity as an *unrelated claim* if:

- the subsequent claim is caused by the same *life changing event* as the previous claim; and
- the Heart Attack or Stroke that causes the subsequent claim occurs at least 30 days after the *life changing event* that caused the previous valid claim.

Note: Heart Attack and Stroke are treated as two different *life changing events*.

2. Subsequent claims under the major organ transplant body system category that are caused by a condition or illness that is named under another body system category

The underlying cause of a claim under the major organ transplant *body system category* may be a condition or illness named under another category.

- If *we* have previously paid out for that condition – no matter what category it is listed under – *we* will treat *your* claim as a *progressive claim*. For more about *progressive claims*, see the start of this provision.
- If *we* have not previously paid out for that named condition, *we* will treat *your* claim in the same way that *we* treat 'subsequent claims' – see above.

3. Subsequent permanent disability claims

Your plan schedule will tell *you* whether *you* can claim for *permanent* disability claims under this category. If *you* make a claim that is valid under both the *permanent* disability category and another *body system category*, *we* will treat this as a *permanent* disability claim. *We* will manage any subsequent claims on the basis that *we* have already paid a claim under the *permanent* disability category.

- If *we* have made a previous payment for a *permanent* disability claim, and *your* condition then progresses to a higher severity level within that category, *we* will:
  - Pay an amount based on the increase in severity from the previous claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover 2X or 3X and *your* claim is for a condition listed in Appendix 2 the amount *we* will pay will include a lump sum increase to 100% as a result of *your* chosen cover; and
- If *we* have made a previous payment under any *body system category* other than *permanent* disability, and *your* condition then progresses so it becomes valid under the *permanent* disability category, *we* will:
  - Pay an amount based on any increase in severity from the previous claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover 2X or 3X and *your* new claim is for a condition listed in Appendix 2 the amount *we* will pay will include a lump sum increase to 100% as a result of *your* chosen cover; and
  - Manage any subsequent claims on the basis that this was a *permanent* disability claim

The underlying cause of *your permanent* disability claim may be a condition or illness that is named under another *body system category*. *We* will treat *your* subsequent claim as a separate claim if, after making a *permanent* disability claim, *you* go on to make a claim either:

- Under the same *body system category* that the underlying cause of *your permanent* disability claim is listed under; or
- Under a different *body system category*.

If *we* pay a severity A claim because *you* fail the relevant *functional activity tests*,

we will not assess any further claims using these tests – irrespective of which category of illness *your* claim is under.

Once *we* have paid a severity A claim under the *permanent* disability *body system category*:

- *We* will not pay any further claims under this *body system category*
- *We* will only pay a subsequent Serious Illness Cover claim if it is for a condition or illness that is not related to the underlying cause of *your permanent* disability claim

B2.5 What happens if a single life-changing event causes you to claim for more than one serious illness

If a single *life-changing event* causes *you* to have valid claims for more than one *serious illness*, *we* will only pay one claim. *We* will pay the claim for the illness with the highest severity level. Any *serious illness*, that resulted from a single *life-changing event,* that progresses will be treated as a *progressive claim*.

B2.6 What happens if a single life-changing event causes claims for more than one person covered

If a single *life-changing event* causes claims for more than one *person covered* – including any *children* covered – and those claims are each made within three calendar months of the *life-changing event*, then *we* will make more than one *benefit* payment.

We will calculate each payment using the *percentage of cover remaining* at the time of the *life-changing event*.

B2.7 Complications of Pregnancy Conditions

If *you* have Serious Illness Cover in *your plan*, *we* automatically include Complications of Pregnancy conditions.

B2.7.1 When we will pay the benefit

We will pay a lump sum of £5,000 if *you*, *your* spouse or *your* civil partner is diagnosed by a Consultant Obstetrician with one of the following conditions:

- Disseminated Intravascular Coagulation (DIC)
- Eclampsia (this excludes Preeclampsia)
- Ectopic Pregnancy
- Foetal death in utero after at least 20 weeks gestation and confirmed by a death certificate.
- Hydatidiform Mole
- Placental Abruption
- Still birth (excluding elective pregnancy termination) after at least 20 weeks gestation.

B2.7.2 When we will not pay under Complications of Pregnancy

We will not pay if:

- The claim is due to a *pre-existing medical condition*, or
- The *life-changing event* that causes *you* to claim happens after *your* Serious Illness Cover's *date of expiry*.

For the Complications of Pregnancy conditions *we* will only make one payment per pregnancy, rather than per *child*.

B2.7.3 How much we will pay

We will pay £5,000 for each claim for Complication of Pregnancy conditions. The total amount that *we* will pay for all claims under this *benefit,* Specified Congenital Conditions and Child Funeral Contribution across all VitalityLife plans which *you* hold is £20,000.

Claims *we* pay under Complication of Pregnancy will not reduce *your* Serious Illness Cover amount or *percentage of cover remaining*.

B2.7.4. When *your* cover for Complications of Pregnancy conditions will end

It will end on the earliest of:

- *your* Serious Illness Cover's *date of expiry*, or
- when *we* have paid a total of £20,000 under Complications of Pregnancy, Specified Congenital Conditions and Child Funeral Contribution, if you have Child Serious Illness Cover or
- the *cover* ceasing.

B2.8. Dementia and FrailCare Cover

Your plan schedule shows if *your* Serious Illness Cover will continue beyond the *date of expiry* as Dementia and FrailCare Cover. Dementia and FrailCare Cover will pay a lump sum if *you* are diagnosed with an illness or condition that *we* cover, subject to *you* continuing to pay premiums and meeting our definition of that condition under Dementia and FrailCare Cover. *We* set these conditions out in Appendix 4.

B2.8.1 How much we will pay

If *you* are diagnosed with an illness or condition that *we* cover, the amount *we* will pay depends on:

- How severe *your* condition is, and
- *Your* Dementia and FrailCare Cover amount.

How severe your condition is

The lump sum *we* will pay *you* will be a percentage of *your* Dementia and FrailCare Cover amount between 25% and 100%. The percentage depends on how severe *your* condition is, based on a scale from A to D. Appendix 4.1 shows which severity levels apply to which conditions.

Severity Level	The percentage of your cover we will pay
A	100%
B	75%
C	50%
D	25%

The amount of cover

Your Dementia and FrailCare Cover amount will be calculated when *your* Serious Illness Cover converts into Dementia and FrailCare Cover upon its *date of expiry*. When *you* have Dementia and FrailCare Cover attached to more than one policy issued by *us*, the maximum amount of Dementia and FrailCare Cover is considered across all policies with us.

The Dementia and FrailCare Cover amount is calculated as the lesser of:

- *Your percentage of cover remaining* at the *date of expiry* of *your* Serious Illness Cover, subject to a maximum of 100%, multiplied by:
  - 50% of *your* cover amount at *date of expiry*, if *you* have a level or indexed cover structure;
  - 25% of *your* cover amount at *your* start date if *you* have a decreasing cover structure
- £100,000 - the maximum amount. If your Serious Illness Cover is indexed, the maximum amount will also increase at each plan anniversary in line with the Retail Prices Index (RPI rounded to the next 0.25%). Each increase is limited to a minimum of 0% and to a maximum of 10%. This maximum amount will be considered across all policies with Dementia and FrailCare Cover with us.

Any claims made during *your* term of Serious Illness Cover will reduce *your percentage of cover remaining* at *date of expiry,* upon which *your* Dementia and FrailCare Cover amount will be calculated. This means that *your* cover amount under Dementia and FrailCare Cover may be affected by Serious Illness Cover claims.

Where the maximum amount of cover for Dementia and FrailCare Cover is exceeded at *date of expiry* and the *benefit* amount is reduced as a result, premiums payable will be reduced in proportion to the reduction in *benefits*.

B2.8.2 When will we pay

Cover under Dementia and FrailCare Cover will commence once *your* Serious Illness Cover reaches beyond its *date of expiry*.

Your claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that meets one of the definitions set out in Appendix 4.1. *We* will use the criteria in Appendix 4.1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If we have, *we* will not pay a claim for that condition.
- *We* will ask *your* General Practitioner, and any appropriate medical specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness or conditions. For more about this, see Appendix 4.1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

Benefits under Dementia and FrailCare Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

B2.8.3. When *we* will not pay

We will not pay under Dementia and FrailCare Cover if:

- Cover under Dementia and FrailCare Cover has not begun.
- *You* suffer from a condition *we* do not cover.
- *Your* condition does not meet *our* definition for that condition.
- The claim is due to a condition that *we* have excluded from *your* Serious Illness Cover.

- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim.
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*.
- *You* do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim.
- *You* have already claimed for a condition before *your* Serious Illness Cover *date of expiry* which is regarded as a related condition under Dementia and FrailCare Cover. All related conditions are listed in Appendix 4.2.

B2.8.4. What happens if *your* claim meets multiple definitions at one time

If *your* claim meets multiple definitions at one time, *we* will only pay out for one definition. *We* will pay out based on the definition with the highest severity at that time.

B2.8.5. What happens if *you* need to make a subsequent claim

If *you* have already claimed under Dementia and FrailCare Cover, any subsequent claims will be paid as below.

Subsequent claims under Dementia and FrailCare Cover	
When *we* won't pay	No further payment will be made if the severity level of *your* subsequent claim is the same as or lower than the severity level of *your* previous claim
When *we* will pay	If the severity level of *your* subsequent claim is higher than the severity level of *your* previous, most recent, claim.
How *we* calculate the amount *we* pay	*We* will base the amount *we* pay on the increase in severity from the previous claim to the new claim. The pay-out will be based on the Dementia and FrailCare Cover amount at the time of the subsequent claim.

B2.8.6 How do *your* premiums work

Your Serious Illness Cover premium will continue to be payable upon continuation into *your* Dementia and FrailCare Cover. *Your* premium will be subject to the following adjustments after the *date of expiry*:

- Removal of the premium attributable to Serious Illness Cover 2X when compared to Serious Illness Cover 1X, if applicable to *your* cover.
- Removal of the premium attributable to Serious Illness Cover 3X when compared to Serious Illness Cover 1X, if applicable to *your* cover.
- Reducing *your* premium in proportion to any limitation on *your* Dementia and FrailCare Cover amount resulting from the maximum cover amount.

If *your* cover includes indexation, *your* Dementia and FrailCare Cover will also be indexed. This means both *your* cover amount and premium will continue to increase with indexation. The amount by which *your* premium will increase will depend on *your* age and the percentage rise in the *Retail Prices Index* at the time *your* cover increases. For more about how indexation could affect *your* premiums, see provision D1.3. *You* can remove indexation from *your* cover at any time.

Your premiums may continue to change by *your Vitality Status*.

This works differently if *you* have made a successful claim under Dementia and FrailCare Cover. Please see provision B2.8.8. for more information on this.

B2.8.7 When *your* Dementia and FrailCare Cover will end

Your Dementia and FrailCare Cover will end when the first of the following occurs:

- *You* have claimed *your* full Dementia and FrailCare Cover amount
- It is removed from *your plan*
- *You* cancel *your cover*
- *Your* death

B2.8.8 What happens if *you* claim under *your* Dementia and FrailCare Cover

Premiums for Dementia and FrailCare Cover will be payable until *you* have claimed *your* full Dementia and FrailCare Cover amount. If *you* make a successful claim under Dementia and FrailCare Cover, we will not increase *your* cover *premium* by *your* Vitality Status.

Once *you* have claimed *your* full Dementia and FrailCare Cover amount, the cover will end.

If *your* cover includes indexation, this will be removed from *your* Dementia and FrailCare Cover following a claim.

B2.8.9 How *your* Dementia and FrailCare Cover works on joint life cover

For *joint life covers*, *your plan schedule* shows if Serious Illness Cover continues into Dementia and FrailCare Cover upon its *date of expiry*. This will apply to both *persons covered*.

For *joint life covers,* Dementia and FrailCare Cover will begin for each *person covered* once Serious Illness Cover reaches its *date of expiry*. Each *person covered* will have their own separate cover. Each *person covered* is able to cancel their respective covers at any time if they do not wish for their Serious Illness Cover to continue beyond its *date of expiry* as Dementia and FrailCare Cover.

Separate premiums will be payable for Dementia and FrailCare Cover for each *person covered* after the expiry of their Serious Illness Cover. Premiums for both *persons covered* will amount to be the same premium paid during the Serious Illness Cover term, subject to any premium reductions *we* may apply. For more about how *benefits* may be reduced, see provision B2.8.6.

B2.8.10 How changes made during *your* Life with Serious Illness term can impact *your* Dementia and FrailCare Cover

If *you* make any changes during the term of *your* cover to either increase or decrease *your* Serious Illness Cover, *your* Dementia and FrailCare Cover amount which applies when the cover starts will be different.

- For level and indexed cover structures, the Serious Illness Cover amount on *date of expiry* will be different and this new amount will be used.
- For decreasing cover structure, this differs for increases and decreases. For decreases, the Serious Illness Cover amount at the start date will be adjusted proportionately down by the decrease made to Serious Illness Cover. For increases, the Serious Illness Cover amount at the start date will increase by the increase in cover.

This adjusted amounts above are then used in determining the Dementia and FrailCare Cover amount. For more information, see provision B2.8.1.

You will not be able to increase *your* Dementia and FrailCare Cover amount if *your* remaining Serious Illness Cover term is below the minimum required *plan* term.

If *you* remove Serious Illness Cover during the term of *your* cover, *you* will not be eligible for Dementia and FrailCare Cover.

Once *you* remove the continuation of Serious Illness Cover into Dementia and FrailCare Cover, no cover will be available after the *date of expiry* of *your* Serious Illness Cover.

Any changes *you* make will be subject to *our* terms and conditions when *you* make the change.

You are not able to increase the amount of Dementia and FrailCare Cover once it commences, although *you* are able to reduce it, subject to minimum premium requirements on the plan.

B3. Life with Serious Illness Cover

Life with Serious Illness Cover pays a lump sum if:

- the *person(s) covered* is diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition; or
- the *person(s) covered* dies, or is diagnosed with a *terminal illness* that meets *our* definition

The amount *we* pay for each claim is also dependent on a number of factors. *We* set these out in this provision.

Life with Serious Illness Cover must be for a *fixed term*. If *your plan* also has Life Cover for a *fixed term*, the Life with Serious Illness Cover must have the same *date of expiry* as *your* Life Cover.

Your plan schedule shows if Life with Serious Illness Cover will continue beyond the *date of expiry* as Dementia and FrailCare Cover. For more information on how this works, please see provisions B3.8.

You can cancel Dementia and FrailCare Cover at any time if *you* do not wish for *your* Life with Serious Illness Cover to continue beyond its *date of* expiry.

B3.1 When we will pay during *your* Life with Serious Illness Cover term

We will pay a *serious illness* claim if:

- *You* are diagnosed with a condition that *we* cover. The *serious illnesses we* cover are specified in Appendix 1. They are grouped into *body system categories* to help *us* assess claims.
- *Your* condition meets any of the definitions set out in Appendix 1 that apply to it. *We* will use the criteria in Appendix 1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have*, we* will not pay a claim for that condition.
- *You* survive for at least 14 days after the date of the *life-changing event* which causes *you* to claim.
- If *you* make a *permanent* disability claim, *you* survive until the date when *we* confirm that *you* are totally and *permanently* disabled. For more about *permanent* disability definitions, see Appendix 1. *Your plan schedule* will show whether *you* are able to make a *permanent* disability claim.

We will pay a life claim if the *person(s) covered* dies or is diagnosed with a *terminal illness* that meets *our* definition.

When *you* have made a life claim under a *single life* plan, *your* cover ends.

Under *joint life* plans, when *we* have paid a life claim for one *person covered*, *we* cancel all the covers that applies solely to that person. *We* will also end *joint life* Life with Serious Illness Cover if the *percentage of cover remaining* has reduced to zero. For more information around *your percentage of cover remaining*, see provision B3.3.

If Life with Serious Illness Cover continues for the remaining person due to the *percentage of cover remaining* being higher than zero, no further life claims can be made under this cover. If the remaining person has other covers in the *plan*, those *covers also* continue.

We will pay under Life and Serious Illness Cover when *we* confirm that the claim is valid – irrespective of when the claim is made.

How *we* will assess *your* claim if *your* occupation has changed

You do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed. If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *functional activity tests* to assess *your* claim. For more about *functional activity tests*, see provision D5.4.

Medical evidence

We will ask *your* General Practitioner, and any specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid and, if appropriate, which severity level applies to *your* condition.

B3.2 When we will not pay

We will not pay a life claim if the death or diagnosis of *terminal illness* happens after *your* cover has ended. *Your plan schedule* will show this information.

Under certain circumstances, *we* may also not pay a life claim if it is due to suicide. For more about this, see provision D5.6.

We will not pay under a *serious illness* claim if:

We will not pay if:	Where to find more information:
You suffer from a condition that *we* do not cover	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application	*Your plan schedule*
Your condition does not meet *our* definition for that condition	Appendix 1
You do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim	Provision B3.1
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment	Provision B3.4
We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim	
We do not receive the medical evidence *we* need from *your* General Practitioner and any specialists who are treating *you*	Provision B3.1
We are not satisfied that the *serious illness* that has lead to *your* claim occurred either while *we* were providing *you* with Life with Serious Illness Cover or was disclosed to *us* when *you* applied	
Your Life with Serious Illness Cover expires before the *life-changing event* which leads to *your* claim and the claim doesn't meet the requirements under Dementia and FrailCare Cover	*Your plan schedule* Provisions B3.8

B3.3 How much we will pay

Serious Illness Claims

The amount we will pay under a *serious illness* claim depends on:

- How severe *your* condition is;
- The type of cover *you* have;
- The amount of cover *you* have and *your percentage of cover remaining*;
- Whether *your* claim is for a condition listed in Appendix 2.

How severe your condition is

The lump sum *we* pay *you* will be a percentage of *your* Life with Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to G. The severity levels covered for each person's Life with Serious Illness Cover will be the same on *your* joint life cover. *Your* plan schedule shows more details on *your joint life* Life with Serious Illness Cover.

Severity level	The percentage of your cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

The type of cover

You are covered for severity levels A to D if *you* have chosen Life with Serious Illness Cover 1X, A to E if *you* have chosen Life with Serious Illness Cover 2X and all the severity levels from A to G if *you* have chosen Life with Serious Illness Cover 3X.

Your plan schedule shows whether *you* have:

- Life with Serious Illness Cover 1X;
- Life with Serious Illness Cover 2X; or
- Life with Serious Illness Cover 3X.

The amount of cover and your percentage of cover remaining

Your plan schedule shows the amount of Life with Serious Illness Cover *you* have. This is the amount *you* would get if *we* paid 100% of *your* Life with Serious Illness Cover which may change depending on *your* cover structure. For more about this, see provision A1.

Where the percentage of a *serious illness* claim exceeds the *percentage of cover remaining, we* will pay out the lower of the two. The percentage of cover *you* have remaining depends on prior claims made on the cover. For more detail on this see provision B3.4.

Appendix 2 and 100% payouts

If you have chosen Life with Serious Illness Cover 2X or 3X, the lump sum that *we* pay *you* in the event of a claim for certain *serious illness* conditions will be increased to 100% of *your* cover amount. These conditions are listed in Appendix 2.

Life Claims

The amount *we* will pay under a life claim depends on if *you* have previously made serious illness claims. If *you* make a life claim before any serious illness claim, *we* will pay *your* cover amount at time of claim.

If *you* make serious illness claims prior to a life claim, *your* life claim will be reduced by the total percentage of cover paid across all previous serious illness claims. If this is equal to or greater than 100%, then no *benefit* will be paid. For more details on how cover continues after a claim, please see provision B3.4.

Only one life claim can be made under *joint life* Life and Serious Illness Cover, regardless of the *percentage of cover remaining*.

B3.4 How *your* cover continues under *your* Life with Serious Illness Cover after a claim.

The way *your* cover will continue after a claim depends on the type and amount of claim *we* have paid under the previous Life with Serious Illness Cover claim, and the type of cover *you* have selected.

- The type of Life with Serious Illness Cover *you* have selected determines the starting *percentage of cover* that *you* can benefit from across multiple claims. For *serious illness* claims, this percentage is:
  - 100% if *you* have Life with Serious Illness Cover 1X;
  - 200% if *you* have Life with Serious Illness Cover 2X;
  - 300% if *you* have Life with Serious Illness Cover 3X.

For life claims, this percentage is 100% for all types of Life with Serious Illness Cover.

- Depending on the percentage of the cover amount that is paid at claim, each life or *serious illness* claim *we* pay *you* will reduce *your percentage of cover remaining* by up to 100%. This new *percentage of cover remaining* is then available for future claims. The *percentage of cover remaining* is tracked separately for life claims and serious illness claims. For more information on amounts paid on claim, see provision B3.3.
- Once the total percentage we have paid you across multiple claims is equal to:
  - 100% if you have Life with Serious Illness Cover 1X;
  - 200% if you have Life with Serious Illness Cover 2X;
  - 300% if you have Life with Serious Illness Cover 3X

  your cover will end.
- Under a single life plan, if *we* paid the person covered for a life claim, the cover will end.
- Under a *joint life* plan, if *you* have chosen Life with Serious Illness Cover 1X and we paid either *person covered* for a life claim, the cover will end.
- Under a *joint life* plan, if *you* have chosen Life with Serious Illness Cover 2X or 3X and we paid either *person covered* for a life claim, the *percentage of cover remaining* will reduce by 100% with the person remaining still being able to claim for subsequent serious illness claims if the *percentage of cover remaining* is higher than zero. If the *percentage of cover remaining* is less than 100% before the claim, *we* will pay the *percentage of cover remaining* and the cover will end. Following a life claim under a *joint life* plan, no further life claim can be made by the person remaining.

Premium payments for cover will continue to be the same following a serious illness cover claim for person(s) covered, up until the cover ends.

Where a life claim is made under a *joint life* cover, the person died will be removed from the plan and *we* will recalculate *your* premiums to reflect the removal at the time of claim.

What happens if we've paid the maximum amount of Life with Serious Illness Cover benefit

There is a maximum of £3,000,000 for the total amount of benefit *you* can receive under Serious Illness Cover or Life with Serious Illness Cover across all claims under these covers.

On *joint life cover* this maximum applies to the cover amount for both *persons covered*. The maximum *benefit* includes any claims *we* pay *you* for any conditions listed in Appendix 1 or Appendix 2.

If *you* reach this maximum *benefit* amount, *we* will not accept any further life or *serious illness* claims and Life with Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly and *you* will no longer be covered after the *date of expiry* under Dementia and FrailCare Cover.

If *you* are also covered by other policies issued by us, the overall maximum amount that *we* will ever pay in respect of a *person covered* is £3,000,000. This includes any claims *we* pay *you* for any conditions listed in Appendix 1 or Appendix 2. If *we* have not yet paid the maximum *benefit*, but a future claim might breach it, *we* might restrict *your* cover.

Subsequent Claims

If *you* claim once and then claim again, *we* call the second claim a subsequent claim. This can be for the same condition, or a different one. For more about how *we* pay subsequent claims, see the flowcharts in Appendix 5.

Only one *benefit* will be paid under a condition where *you* have been included on an official *UK* waiting list for a procedure and have undergone surgery for the same procedure.

If *you* have already claimed, *we* will classify any subsequent claims *you* make as either a *progressive claim* or an *unrelated claim*.

Progressive claims	
Definition	A *progressive claim* occurs when: **1.** A *person covered* has a *life-changing event* that causes a *serious illness;* **2.** They make a claim for that *serious illness;* **3.** They later make a claim for the same illness, or another *serious illness* that was caused by the same *life-changing event*.
When *we* won't pay	No further payment will be made if: • the severity of the *progressive claim* is the same as or lower than the severity level of the previous claim; or • if the previous claim was for a condition listed in Appendix 2 and the *progressive claim* is also for a condition that is listed in Appendix 2 or is for a severity level A condition.
When *we* will pay	If the severity level of *your progressive claim* is higher than the severity level of *your* previous claim, *we* will make another payment.
How *we* calculate the amount *we* will pay	*We* will base the amount *we* pay on the increase in severity from the previous claim to the new claim. *We* will use the cover amount and *your percentage of cover remaining* at the time of subsequent claim

Unrelated claims	
Definition	An *unrelated claim* occurs when: **1.** A *person covered* has a *life-changing event* that causes a *serious illness* **2.** They make a claim for that *serious illness* **3.** They later make a claim for another *serious illness* that was caused by a different *life-changing event*
How *we* calculate the amount *we* will pay	*We* will base *your* cover amount, the *percentage of cover remaining* and the severity level of the claim at the time of subsequent claim.

There are three types of claim that *we* treat differently compared to the table above.

1. Subsequent claims due to Heart Attack or Stroke

If *you* make a valid claim that is caused by a Heart Attack or Stroke, *we* will treat any subsequent claim of the same or lower severity as an *unrelated claim* if:

- the subsequent claim is caused by the same *life changing event* as the previous claim; and
- the Heart Attack or Stroke that causes the subsequent claim occurs at least 30 days after the *life changing event* that caused the previous valid claim.

Note: Heart Attack and Stroke are treated as two different *life changing events*.

2. Subsequent claims under the major organ transplant body system category that are caused by a condition or illness that is named under another body system category

The underlying cause of a claim under the major organ transplant *body system category* may be a condition or illness named under another category.

- If *we* have previously paid out for that condition – no matter what category it is listed under – *we* will treat *your* claim as a *progressive claim*. For more about *progressive claims*, see the start of this provision.
- If *we* have not previously paid out for that named condition, *we* will treat *your* claim in the same way that *we* treat 'subsequent claims' – see above.

3. Subsequent permanent disability claims

Your plan schedule will tell *you* whether *you* can claim for *permanent* disability claims under this category. If *you* make a claim that is valid under both the *permanent* disability category and another *body system category*, *we* will treat this as a *permanent* disability claim. *We* will manage any subsequent claims on the basis that *we* have already paid a claim under the *permanent* disability category.

- If *we* have made a previous payment for a *permanent* disability claim, and *your* condition then progresses to a higher severity level within that category, *we* will:
  - Pay an amount based on the increase in severity from the previous claim to the new one. If *your plan schedule* indicates that *you* have selected Life with Serious Illness Cover 2X or 3X and *your* claim is for a condition listed in Appendix 2 the amount *we* will pay will include a lump sum increase to 100% as a result of *your* chosen cover; and

- If *we* have made a previous payment under any *body system category* other than *permanent* disability, and *your* condition then progresses so it becomes valid under the *permanent* disability category, *we* will:
  - Pay an amount based on any increase in severity from the previous claim to the new one. If *your plan schedule* indicates that *you* have selected Life with Serious Illness Cover 2X or 3X and *your* new claim is for a condition listed in Appendix 2 the amount *we* will pay will include a lump sum increase to 100% as a result of *your* chosen cover; and
  - Manage any subsequent claims on the basis that this was a *permanent* disability claim

The underlying cause of *your permanent* disability claim may be a condition or illness that is named under another *body system category*. *We* will treat *your* subsequent claim as a separate claim if, after making a *permanent* disability claim, *you* go on to make a claim either:

- Under the same body system category that the underlying cause of *your* permanent disability claim is listed under; or
- Under a different body system category.

If *we* pay a severity A claim because *you* fail the relevant *functional activity tests*, *we* will not assess any further claims using these tests – irrespective of which category of illness *your* claim is under.

Once *we* have paid a severity A claim under the *permanent* disability *body system category*:

We will not pay any further claims under this *body system category*

We will only pay a subsequent Life with Serious Illness Cover claim if it is for a condition or illness that is not related to the underlying cause of *your permanent* disability claim

B3.5. What happens if a single life-changing event causes you to claim for more than one serious illness

If a single *life-changing event* causes *you* to have valid claims for more than one *serious illness*, *we* will only pay one claim. *We* will pay the claim for the illness with the highest severity level. Any *serious illness*, that resulted from a single *life-changing event,* that progresses will be treated as a *progressive claim*.

B3.6. What happens if a single life-changing event causes claims for more than one person covered

If a single *life-changing event* causes claims for more than one *person covered* – including any *children* covered – and those claims are each made within three calendar months of the *life-changing event*, then *we* will make more than one *benefit* payment.

We will calculate each payment using the *percentage of cover remaining* at the time of the *life-changing event*.

B3.7 Complications of Pregnancy Conditions

If *you* have Life with Serious Illness Cover in *your plan*, *we* automatically include Complications of Pregnancy conditions.

B3.7.1 When we will pay the benefit

We will pay a lump sum of £5,000 if *you*, *your* spouse or *your* civil partner is diagnosed by a Consultant Obstetrician with one of the following conditions:

- Disseminated Intravascular Coagulation (DIC)
- Eclampsia (this excludes Preeclampsia)
- Ectopic Pregnancy
- Foetal death in utero after at least 20 weeks gestation and confirmed by a death certificate.
- Hydatidiform Mole
- Placental Abruption
- Still birth (excluding elective pregnancy termination) after at least 20 weeks gestation.

B3.7.2 When we will not pay under Complications of Pregnancy

We will not pay if:

- The claim is due to a *pre-existing medical condition*, or
- The *life-changing event* that causes *you* to claim happens after *your* Life with Serious Illness Cover's *date of expiry*.

For the Complications of Pregnancy conditions, *we* will only make one payment per pregnancy, rather than per *child*.

Claims *we* pay under Complication of Pregnancy will not reduce *your* Life with Serious Illness Cover amount or *percentage of cover remaining*.

B3.7.3 How much we will pay

We will pay £5,000 for each claim for Complication of Pregnancy Conditions. The total amount that *we* will pay for all claims under this *benefit*, Specified Congenital Conditions and Child Funeral Contribution on all *plans* which *you* hold with VitalityLife is £20,000.

B3.7.4. When *your* cover for Complications of Pregnancy conditions will end

It will end on the earliest of:

- *your* Life with Serious Illness Cover's *date of expiry,* or
- when *we* have paid a total of £20,000 under Complications of Pregnancy or under Specified Congenital Conditions and Child Funeral Contribution if *you* have Child Serious Illness Cover;
- or the *cover* ceasing.

B3.8. Dementia and FrailCare Cover

Your plan schedule shows if *your* Life with Serious Illness Cover will continue beyond the *date of expiry* as Dementia and FrailCare Cover. Dementia and FrailCare Cover will pay a lump sum if *you* are diagnosed with an illness or condition that *we* cover, subject to *you* continuing to pay premiums and meeting *our* definition of that condition under Dementia and FrailCare Cover. *We* set these conditions out in Appendix 4.

B3.8.1 How much we will pay

If *you* are diagnosed with an illness or condition that *we* cover, the amount *we* will pay depends on:

- How severe *your* condition is, and
- *Your* Dementia and FrailCare Cover amount.

How severe your condition is

The lump sum *we* will pay *you* will be a percentage of *your* Dementia and FrailCare Cover amount between 25% and 100%. The percentage depends on how severe *your* condition is, based on a scale from A to D. Appendix 4.1 shows which severity levels apply to which conditions.

Severity Level	The percentage of your cover we will pay
A	100%
B	75%
C	50%
D	25%

The amount of cover

Your Dementia and FrailCare Cover amount will be calculated when *your* Life with Serious Illness Cover converts into Dementia and FrailCare Cover upon its *date of expiry*. When *your* Dementia and FrailCare Cover attached to more than one policy issued by *us*, the maximum amount of Dementia and FrailCare Cover is considered across all policies with us.

The Dementia and FrailCare Cover amount is calculated as the lesser of:

- *Your percentage of cover remaining for serious illness claims* at the *date of expiry* of *your* Life with Serious Illness Cover, subject to a maximum of 100%, multiplied by:
  - 50% of *your* cover amount at *date of expiry*, if *you* have a level or indexed cover structure;
  - 25% of *your* cover amount at *your* start date if *you* have a decreasing cover structure
- £100,000 - the maximum amount. If *your* Life with Serious Illness Cover is indexed, the maximum amount will also increase at each *plan anniversary* in line with the *Retail Prices Index* (RPI rounded to the next 0.25%). Each increase is limited to a minimum of 0% and to a maximum of 10%. This maximum amount will be considered across all policies with Dementia and FrailCare Cover with us.

You are not able to increase the amount of Dementia and FrailCare Cover once it commences, although *you* are able to reduce it, subject to minimum premium requirements on the plan.

Any claims made during *your* term of Life with Serious Illness Cover will reduce *your percentage of cover remaining* at *date of expiry*, upon which *your* Dementia and FrailCare Cover amount will be calculated. This means that *your* cover amount under Dementia and FrailCare Cover may be affected by Life with Serious Illness Cover claims.

Where the maximum amount of cover for Dementia and FrailCare Cover is exceeded at *date of expiry* and the *benefit* amount is reduced as a result, premiums payable will be reduced in proportion to the reduction in *benefits*.

B3.8.2 When will *we* pay

Cover under Dementia and FrailCare Cover will commence once *your* Life with Serious Illness Cover reaches beyond its *date of expiry*.

Your claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that meets one of the definitions set out in Appendix 4.1. *We* will use the criteria in Appendix 4.1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If we have, *we* will not pay a claim for that condition.
- *We* will ask *your* General Practitioner, and any appropriate medical specialists who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness or conditions. For more about this, see Appendix 4.1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

Benefits under Dementia and FrailCare Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

As each Life with Serious Illness Cover reaches its *date of expiry*, premiums and cover will continue under Dementia and FrailCare Cover.

B3.8.3. When *we* will not pay

We will not pay under Dementia and FrailCare Cover if:

- Cover under Dementia and FrailCare Cover has not begun.
- *You* suffer from a condition *we* do not cover.
- *Your* condition does not meet *our* definition for that condition.
- The claim is due to a condition that *we* have excluded from *your* Life with Serious Illness Cover.

We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim.

- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*.
- *You* do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim.
- *You* have already claimed for a condition before *your* Life with Serious Illness Cover *date of expiry* which is regarded as a related condition under Dementia and FrailCare Cover. All related conditions are listed in Appendix 4.2.

B3.8.4. What happens if *your* claim meets multiple definitions at one time

If *your* claim meets multiple definitions at one time, *we* will only pay out for one definition. *We* will pay out based on the definition with the highest severity at that time.

B3.8.5. What happens if *you* need to make a subsequent claim

If *you* have already claimed under Dementia and FrailCare Cover, any subsequent claims will be paid as below.

Subsequent claims under Dementia and FrailCare Cover	
When *we* won't pay	No further payment will be made if the severity level of *your* subsequent claim is the same as or lower than the severity level of *your* previous claim
When *we* will pay	If the severity level of *your* subsequent claim is higher than the severity level of *your* previous, most recent, claim.
How *we* calculate the amount *we* pay	*We* will base the amount *we* pay on the increase in severity from the previous claim to the new claim. The pay-out will be based on the Dementia and FrailCare Cover amount at the time of subsequent claim.

B3.8.6 How do *your* premiums work

Your Life with Serious Illness Cover premium will continue to be payable upon continuation into *your* Dementia and FrailCare Cover. *Your* premium will be subject to the following adjustments after the *date of expiry*:

- Removal of the premium attributable to Life with Serious Illness Cover 2X when compared to Serious Illness Cover 1X, if applicable to *your* cover.
- Removal of the premium attributable to Life with Serious Illness Cover 3X when compared to Serious Illness Cover 1X, if applicable to *your* cover.
- Reducing *your* premium in proportion to any limitation on *your* Dementia and FrailCare Cover amount resulting from the maximum amount.

If *your* cover includes indexation, *your* Dementia and FrailCare Cover will also be indexed. This means both *your* cover amount and premium will continue to increase with indexation. The amount by which *your* premium will increase will depend on *your* age and the percentage rise in the *Retail Prices Index* at the time *your* cover increases. For more about how indexation could affect *your* premiums, see provision D1.3. *You* can remove indexation from *your* cover at any time.

Your premiums may continue to change by *your Vitality Status*.

This works differently if *you* have made a successful claim under Dementia and FrailCare Cover. Please see provision B3.8.8. for more information on this.

B3.8.7 When *your* Dementia and FrailCare Cover will end

Your Dementia and FrailCare Cover will end when the first of the following occurs:

- *You* have claimed *your* full Dementia and FrailCare Cover amount
- It is removed from *your plan*
- *You* cancel *your plan*
- *Your* death

B3.8.8 What happens if *you* claim under *your* Dementia and FrailCare Cover

Premiums for Dementia and FrailCare Cover will be payable until *you* have claimed *your* full Dementia and FrailCare Cover amount.

If *you* make a successful claim under Dementia and FrailCare Cover, *we* will not increase *your* cover *premium* by *your* Vitality Status.

Once *you* have claimed *your* full Dementia and FrailCare Cover amount, the cover will end.

If *your* cover includes indexation, this will be removed from *your* Dementia and FrailCare Cover following a claim.

B3.8.9 How *your* Dementia and FrailCare Cover works on joint life cover

For *joint life covers*, *your plan schedule* shows if Life with Serious Illness Cover continues into Dementia and FrailCare Cover upon its *date of expiry*. This will apply to both *persons covered*.

For *joint life covers,* Dementia and FrailCare Cover will begin for each *person covered* once Life with Serious Illness Cover reaches its *date of expiry*. Each *person covered* will have their own separate cover. Each *person covered* is able to cancel their respective covers at any time if they do not wish for their Life with Serious Illness Cover to continue beyond its *date of expiry* as Dementia and FrailCare Cover.

Separate premiums will be payable for Dementia and FrailCare Cover for each *person covered* after the expiry of their Life with Serious Illness Cover. Premiums for both *persons covered* will amount to be the same premium paid during the Life with Serious Illness Cover term, subject to any premium reductions *we* may apply. For more about how *benefits* may be reduced, see provision B3.8.6.

B3.8.10 How changes made during *your* Life with Serious Illness term can impact *your* Dementia and FrailCare Cover

If *you* make any changes during the term of *your* cover to either increase or decrease *your* Life with Serious Illness Cover, *your* Dementia and FrailCare Cover amount which applies when the cover starts will be different.

- For level and indexed cover structures, the Life with Serious Illness Cover amount on *date of expiry* will be different and this new amount will be used.
- For decreasing cover structure, this differs for increases and decreases. For decreases, the Life with Serious Illness Cover amount at the start date will be adjusted proportionately down by the decrease made to Life with Serious Illness Cover. For increases, the Life with Serious Illness Cover amount at the start date will increase by the increase in cover.

This adjusted amounts above are then used in determining the Dementia and FrailCare Cover amount. For more information, see provision B3.8.1.

You will not be able to increase *your* Dementia and FrailCare Cover amount if *your* remaining Life with Serious Illness Cover term is below the minimum required plan term.

If *you* remove Life with Serious Illness Cover during the term of *your* cover, *you* will not be eligible for Dementia and FrailCare Cover.

Once *you* remove the continuation of Life with Serious Illness Cover into Dementia and FrailCare Cover, no cover will be available after the *date of expiry* of *your* Life with Serious Illness Cover.

Any changes *you* make will be subject to *our* terms and conditions when *you* make the change.

B3.9 What happens if you need to claim while we are still assessing your application for Life with Serious Illness Cover

If *you* have applied for Life with Serious Illness Cover but *we* are still assessing *your* application, *we* automatically give *you* some limited Life with Serious Illness Cover. This is called Immediate Cover and is free of charge.

We will pay a *benefit* under Immediate Cover as long as all of the following apply:

- *We* have received a completed application from *you*
- *We* have received a completed direct debit instruction from *you*
- The claim is for death - *terminal illness* is not covered
- The *person covered* is under 50 when we receive *your* application
- The *person covered* is a *resident of the United Kingdom*
- The *person covered* is not applying for Serious Illness Cover or Critical Illness Cover with any other company
- The *person covered* has appropriately answered 'no' to all *our* medical and health questions, and would normally be accepted on standard rates
- The *person covered* does not take part in any hazardous pursuits or sports or have an *occupation* that we would exclude or charge *you* extra for

Immediate Cover stops when one of these happens:

- *We* accept *your* application
- *We* decline *your* application
- *Your* application is cancelled
- 90 days has passed since *we* received *your* application

The total amount *we* will pay for Immediate Cover for Life Cover or Life with Serious Illness Cover is the amount *you* applied for, up to a combined maximum of £500,000 across all plans *you* applied with *us*. On *joint life plans* this maximum applies to each *person covered* separately.

B4. Income Protection Cover

Income Protection Cover pays *you* a regular income if *you* become incapacitated and cannot work, and *your* incapacity meets *our* definitions. For more information about the different *ways we* define incapacity, see provision B4.1.

If *you* have a *joint life plan* and both people covered have Income Protection Cover, *we* will treat each person's Income Protection Cover separately.

B4.1 When we will pay

We will pay if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. These are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

An *activities of daily living* definition means that *we assess your* incapacity according to a specific set of everyday physical activities. These are designed to help show how able someone is to look after themselves. *We* list these activities in provision D5.4. *We* use this definition to *assess houseperson* claims. For more about this, see provision B4.6.

A special definition means that:

1. For the first 12 months, *we* will pay *you* the full monthly *benefit* if illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. As with the standard definition, these are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. *You* must also not be working in any other *occupation* for payment or profit.
2. After 12 months, *we* will assess *you* again. If, at this point, *you* are unable to perform at least three of the *activities of daily living* without another person's help, *we* will continue to pay *you* the full monthly *benefit*. If *you* do not fail at least three *activities of daily living*, but are still unable to perform *your own occupation* as described in the paragraph above, *we* will reduce the amount *we* pay *you* to 50% of the monthly *benefit* amount.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

How we will assess your claim

We will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed.

If *we* would not normally use the standard definition of incapacity for that *occupation*, then *we* may use the special definition or *activities of daily living* definition to assess *your* claim. For more about *activities of daily living* assessments, see provision D5.4.

When we will start paying your claim

Your benefit will be due at the end of the first month following *your deferred period*.

The *deferred period* starts on the date *you* become incapacitated according to the definition that applies to *your plan*. It ends when *you* have been continuously incapacitated for one of:

- Seven days
- One month
- Two months
- Three months
- Six months
- Twelve months
- Twenty-four months
- Sixty months

You can choose to set up two *deferred periods* under *your plan*. If *you* have two *deferred periods* then, when *you* claim, *we* start paying *you* part of *your* monthly *benefit* amount at the end of the first *deferred period*. *We* will start paying *your* full monthly *benefit* amount at the end of *your* second *deferred period*.

Your plan schedule shows which *deferred period* or periods apply to *your* Income Protection Cover.

If *you* have selected that *you* work in the Public Sector and have chosen a 12 months *deferred period*, *we* may start to pay *your* monthly *benefit* according to *your* employer's sick-pay structure. For more information see provision B4.10.

Telling us that you want to claim

If *you* become incapacitated and need to claim, *you* need to give *us* written notice within a specified period of time. This notification period depends on the *deferred period you* have chosen:

Deferred period	Notification period
7 days (this is only an option if you are self-employed)	Immediately
1 month	2 weeks
2 months	2 weeks
3 months	1 month
6 months	2 months
12 months	2 months
24 months	2 months
60 months	2 months

Your plan schedule shows the *deferred period* that applies to *your* cover. If *we* do not receive notice of *your* incapacity within the specified period, *we* may treat the *deferred period* as if it started on the date *we* actually receive notice. If *we* receive notice more than 90 days after the end of the *deferred period, we* may decline *your* claim.

If public sector *deferred period* applies to *you* then *you* need to give *us* written notice within 2 weeks.

Providing us with evidence for your claim

We will need to be satisfied that *your* claim is valid in order to pay *you* any *benefits* under Income Protection Cover.

When *you* first make *your* claim, *we* will ask for evidence to substantiate it. *We* may also ask for evidence at reasonable intervals to confirm that *you* are still entitled to Income Protection *benefits*.

This evidence may include, but is not limited to:

- A report from *your* General Practitioner
- Copies of *your* medical records;
- A report from any other *appropriate medical specialist;*
- *Your* hospital records, including copies of the results of any clinical tests or investigations;
- Information from *your* employer, including details of the duties of *your employment;*
- *Your* human resources records, including details of sickness absence;
- *Your pre-incapacity earnings* evidence.

We may also need *you* to have a medical examination with an examiner that *we* choose, at *our* expense. *We* may appoint a disability counsellor or someone who represents *us* to talk to *you* about any aspect of *your* claim.

If *you* do not give consent for *us* to *access your* medical information, or to get any other assistance or information that *we* need to assess *your* claim, then *we* may decline, suspend, or stop paying *you* any *benefits* under Income Protection Cover.

B4.2 How much we will pay

Your plan schedule shows the monthly *benefit you* have chosen for *your* Income Protection Cover. If *you* need to claim, *we* will pay *you* the lesser of:

- *Your* monthly *benefit* amount; and
- The *maximum monthly benefit amount* less any continuing income

The maximum monthly *benefit* amount will depend on whether *you* have verified *your* earnings or not as follows:

a) If *you* have verified *your* earnings

If *you* have verified *your* earnings, *your* maximum monthly *benefit* amount is calculated as the greater of:

- 60% of the first £5,000 per month of *your verified earnings*, plus 50% of *your verified earnings* between £5,000 and £15,000 per month, and;
- 60% of the first £5,000 per month of *your pre-incapacity earnings*, plus 50% of *your pre-incapacity earnings* in excess of £5,000 per month.

If *your* Income Protection Cover includes indexation, *your* monthly *benefit* amount will increase annually in line with the *Retail Prices Index* rounded to the next 0.25%. This means *you* do not need to verify any additional increases due to indexation if *you* have verified *your* earnings. Indexation increases will apply while we are paying a claim under this cover.

For more about this please see 'How do I verify my earnings'.

b) If *you* have not verified *your* earnings

If *you* have not verified *your* earnings, *your* maximum monthly *benefit* amount is calculated as below:

- 60% of the first £5,000 per month of *your pre-incapacity earnings*, plus 50% of *your pre-incapacity earnings* in excess of £5,000 per month.

However, *you* will be eligible for the Earnings Guarantee if *your* income has reduced since *your* policy was taken out and:

- Immediately before *you* claim *you* have been *employed* working at least 30 hours a week, or
- Immediately before *you* claim *you* have been *self-employed* working at least 20 hours a week

If *you* are eligible for the Earnings Guarantee, *your maximum monthly benefit amount* is calculated as, the greater of:

- 60% of the first £5,000 per month of *your pre-incapacity earnings*, plus 50% of *your pre-incapacity earnings* in excess of £5,000 per month, and
- Earnings Guarantee.

Your Earnings Guarantee is the lesser of £1,500 and *your* monthly *benefit* amount. If *your occupation is a medical doctor or medical surgeon then your* Earnings Guarantee is the lesser of £3,000 and *your* monthly *benefit* amount. If *your* Income Protection Cover includes indexation, *your* monthly *benefit* amount and Earnings Guarantee will both increase annually in line with the *Retail Prices Index*, rounded to the next 0.25%. If *you* have an Income Protection claim and then return to work, *we* will look at the policy anniversaries missed while *you* were in claim to index *your* monthly *benefit* amount and Earnings Guarantee to the level it would have been if *you* had not claimed.

The *maximum monthly benefit amount* will be reduced by continuing income which is the total gross monthly equivalent of:

- Any *benefits* that are due to *you* under any other insurance against incapacity or illness. These will involve a regular payment to *you* or to a financial institution on *your* behalf. This includes other income protection policies and mortgage payment protection policies;
- 60% of any salary, wages, income, fees, dividends or commission which *you* continue to receive directly from *employment* or *your* business; and
- Any early retirement pension *you* receive from any office, *employment*, trade, profession or vocation as a result of *your* incapacity. This will be net of any Income Tax or National Insurance contributions that apply.

State *benefits*, non-*employment* related dividends, income from renting property or goods, and any waiver of premium *benefit* will not reduce *your maximum monthly benefit amount*.

The maximum monthly benefit amount we will pay is £16,666 a month.

A different *maximum monthly benefit amount* will apply if *we* are assessing *your* claim under the *houseperson* category. For more about this, see provision B4.6.

How do I verify my earnings

You can ask *us* to verify *your* earnings prior to the start of *your plan* or at any time during the first 6 months *your plan* starts.

You can verify *your* earnings according to the following:

- *Employed: Your* base salary or wages, plus *your* bonus capped at 20% of *your* base salary or wages.
- *Self-Employed*: The lesser of the average of *your* annual income over the last three years and 120% of the lowest annual income over the three year period.

You are able to verify *your* earnings for up to £15,000 per month. This will equate to a monthly *benefit* amount of £8,000. *Your pre-incapacity earnings* will be used for the monthly *benefit* amount in excess of £8,000 when *you* claim.

The information *we* need in order to confirm *your pre-incapacity* or *verified earnings* may vary depending on whether *you* are *employed, self-employed* or the director of a limited company.

If you are	The information we require may include, but is not limited to, items such as:
Employed	• *Your* three most recent payslips and; • *Your* most recent P60.
Self-employed	• *Your* three most recent agreed HMRC tax computations and self assessments; • A copy of the accounts that relate to these.
The director of a limited company	• *Your* three most recent payslips; • Copies of *your* company accounts that have been submitted to HMRC, for the last three years; • Confirmation of the number of employees in the company.

If *you* provide the evidence above, and *we* accept it, then *we* will use these *verified earnings* to assess any claims *you* make under Income Protection Cover.

We may approach *your* employer, or HM Revenue and Customs, to confirm details of *your* earnings and allowances. However, *we* will ask *you* before *we* do this.

If *you* have been *unemployed* or on a *career break* for longer than one month when *you* claim, *we* will assess *you* as a *house person*. This means *we* will not use *your verified earnings* to assess *your* claims.

Indexation

Your plan schedule shows whether *you* have chosen for *your benefit* amount and Earnings Guarantee to:

- Remain level throughout the term of the cover; or
- Increase annually in line with the *Retail Prices Index* rounded to the next 0.25%

Indexation means that *your* cover amount and *your* claims in payment will increase annually in line with the Retail Prices Index rounded to the next 0.25%. This is subject to an annual minimum of 0% and maximum of 10%.

Any annual increase in *your* cover amount will result in an increase in *your* Income Protection Cover premium. The amount by which *your* premium will increase will depend on the percentage rise in the *Retail Prices Index* at the time *your* cover increases.

Your premiums will increase in one of three ways:

The percentage increase in the *Retail Prices Index*	Premium increase amount
Above 0% up to and including 1.75%	Total of the percentage increase in the *Retail Prices Index* plus 1.5%
2% up to and including 7.75%	Total of the percentage increase in the *Retail Prices Index* plus 2.5%
8% and above	Total of the percentage increase in the *Retail Prices Index*, to a maximum of 10%, plus 3.5%

If *you* are being paid an Income Protection claim then *your* Income Protection Cover *benefit* will increase annually while *we* are paying *your* Income Protection claim.

Increases due during a claim will be added to *your* claim amount annually, on the anniversary of the date *we* made the first Income Protection payment to *you*. *We* will calculate each increase using the *Retail Prices Index* that applies exactly five months before the date *we* add the increase.

When *you* return to work after an Income Protection claim then *we* will look at the policy anniversaries missed while *you* were in claim to index *your* benefit amount to the level it would have been if *you* had not been on claim. *Your* benefit amount and premium will be adjusted.

You can choose indexed Income Protection Cover when *you* take *your plan* out.

Income Boost

Your Income Protection benefits will be boosted for the first 6 months of *your* claim. The boosted amount will be determined by *your Vitality Status*. The *Vitality Status* used to determine *your* Income Boost will be *your* status at the time of *your* incapacity.

Vitality Status	Income Booster
Platinum	20%
Gold	15%
Silver	10%
Bronze	0%

The Income Boost will be calculated each month based on *your* monthly claim *benefit* paid that month. The Income Boost also applies to rehabilitation benefits and proportionate benefits.

If *you* return to work before receiving 6 months of *benefits*, then the Income Boost for the remainder of the 6 month period will be paid to *you* as a lump sum. This also applies if *you* are assessed as a *houseperson* and return to normal activities. After return to work or return to normal duties as a *houseperson*, the Income Boost will be calculated based on *your* average monthly *benefit* during *your* claim.

If *you* make any subsequent claims under Income Protection Cover and *your* subsequent claim is linked to a claim where the Income Boost has already been applied, then *we* will not apply the Income Boost again.

Your claim must last for 1 month or longer to be eligible for the Income Boost.

Hospitalisation benefit

Y*our cover* will include a Hospitalisation benefit.

During *your deferred period*, if *you* are hospitalised for medically necessary treatment for seven consecutive nights or more, *we* will provide a benefit of £100 a day from the seventh day onwards for the period that *you* remain in hospital.

We will pay the Hospitalisation benefit at the end of each month following hospitalisation. *You* will need to provide *us* with satisfactory proof of *your* entitlement to the *benefit* within 30 days of *us* asking for it.

We will limit the number of days *we* pay to an overall maximum of 90 nights. If *you* are also covered by other policies issued by *us*, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Hospitalisation benefit is £9,000. On *joint life plans*, this maximum applies to each *person covered* separately.

We will stop paying *you* the Hospitalisation benefit on the earliest of:

- *You* leaving hospital
- The end of *your deferred period*
- The end of *your* Income Protection Cover's *date of expiry*
- The *plan* ceasing
- *You* being removed from the *plan*
- *Your* death

Recovery Benefit

The Recovery Benefit is available to *you* once *you* have notified us of an Income Protection claim. The Recovery Benefit consists of three pathways that provides *you* access to a range of services that can help *you* recover from the conditions related to *your* claim.

There is no monetary cap applicable. The three pathways are:

- Musculoskeletal pathway
- Mental Health pathway
- Cancer pathway

The pathways are based on the support services that *we* offer at the time of *your* claim being notified. *We* will help to organise these services for *you*. These support services may change over time to allow *us* to better meet *your* needs.

An appropriate medical specialist must recommend the usage of the Recovery Benefit. *We* will offer the Recovery Benefit if there is a chance that it will help *you* recover faster and return to work. The Recovery Benefit may only be used for related conditions to *your* claim.

The decision to offer *you* the Recovery Benefit does not reflect the decision for *your* Income Protection claim, both are assessed independently. Offering the Recovery Benefit does not mean *we* have accepted *your* Income Protection claim.

We will not offer the Recovery Benefit for excluded conditions and any related conditions to those excluded conditions. *Your* plan schedule shows whether we have excluded any conditions from *your* cover.

If *your* plan is cancelled due to fraud then *we* may cancel usage of the Recovery Benefit.

You will need to cover the cost of any missed appointments when using the Recovery Benefit. *We* may cover the cost of the first missed appointment but will not cover the cost of subsequent missed appointments.

Payments for partial months

We will pay *your benefit* or *benefits* to *you* on a monthly basis. If *your benefits* do not stop for any other reason, *we* will pay *you* the final monthly *benefit* on the first day of the month that follows *your* Income Protection Cover's *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover.

Your first and last *benefit* payments may be for partial months. If they are, they will be fractions of the monthly amount.

We calculate *your* first monthly *benefit* payment by:

1. Determining the number of days between the end of the *deferred period* and the date of the first payment
2. Multiplying this number by 12
3. Dividing it by 365
4. Multiplying the result by the amount of monthly *benefit you* are due to get

We will calculate *your* final monthly *benefit* payment in the same way except that, for the first step, *we* will determine the number of days between *your* second last payment and *your* Income Protection Cover's *date of expiry*.

If the end of the *deferred period* and the *date of expiry* for *your* Income Protection Cover are within the same month, *we* will only make one payment. *We* will calculate it as above except that, for the first step, *we* will determine the number of days between the end of the *deferred period* and *your* cover's *date of expiry*.

What happens if we overpay your claim

If, for any reason, *we* pay *you* more under *your* Income Protection Cover than the *benefit* amount *you* are entitled to, *we* may recover the excess amount from *you*. *We* will do this either by offsetting the overpayment against *your* future *benefit*, or by asking *you* to return the excess amount to *us*.

B4.3 When we may not pay or reduce the amount we pay you

If *you* provided *us* with inaccurate information at application, this may impact the amount *we* pay *you*.

B4.4 How long we will pay for

When your benefit will start

The payment *we* make in respect of *your benefit* will be calculated on the day after *your deferred period* ends and *we* will start paying *your benefit* at the end of the first month following *your deferred period*. For more about the *deferred period,* see provision B4.1.

Retrospective payments if you are self-employed

If *you* are *self-employed* – and have a seven-day or one-month *deferred period* – payments will still start at the end of the first month following *your deferred period*. However, *we* may make retrospective Income Protection *benefit* payments, backdated to the date *you* became incapacitated.

You must be continuously incapacitated throughout the *deferred period* to get retrospective payments. *You* must also undergo or suffer from one of the following treatments or conditions during the *deferred period*, and it must be directly related to the cause of *your* claim:

- Any hospital outpatient treatment, excluding Accident and Emergency department consultations.
- Hospitalisation as an inpatient, for a continuous period of at least 24 hours
- Back problems where an MRI scan shows clear medical evidence of a condition such as a prolapsed intervertebral disc
- Diagnosable mental illness that meant *you* were referred to a hospital psychiatric unit
- Courses of chemotherapy or radiotherapy

When your benefit will end

If *you* have selected a full payment term, *we* will stop paying *you benefits* on the cover's *date of expiry*. *Your plan schedule* shows this date.

If *you* have selected Short Payment Term Income Protection Cover, *we* will stop paying *you benefits* under Income Protection Cover on the earlier of:

- The cover's *date of expiry*; and
- The *benefit* payment term

Benefit payment term under Short Payment Term Income Protection Cover

The short payment terms available are 12 months, 24 months and 60 months. Short Payment Term Income Protection Cover pays *you* monthly *benefit* payments up to the length of *your* chosen payment term. Once *you* have received *benefit* payments until the end of *your* payment term, *your* payments will stop, even if *you* are still unable to work.

If *you* have already claimed under Short Payment Term Income Protection, any subsequent claim will be assessed and paid out under the following circumstances:

1. **The reason you are unable to work is linked to the same condition as your previous claim and the subsequent claim is made within 6 months of the previous claim.**

   We will *pay out* for this subsequent claim and waive the *deferred period*. The total combined number monthly of *benefit* payments for the subsequent and original claim, are limited to the length of *your* payment term.

2. **The reason you are unable to work is linked to the same condition as your previous claim, the subsequent claim is made after 6 months of the previous claim and you have not returned to work for at least 6 months.**

   We will *pay out* this subsequent claim following the end of *your deferred period*. The total combined number of monthly *benefit* payments for the subsequent and original claim, are limited to the length of your payment term.

3. **The reason you are unable to work is linked to the same condition as your previous claim and the subsequent claim is made following 6 months of you going back at work since the previous claim.**

   We will *pay out* this subsequent claim subject to *you* having returned to work continuously for at least 6 months, working the same amount of hours as *you* did prior to the claim being made. This means when *your* claim is accepted, *we* will pay *your* monthly *benefit* payments limited to the length of your payment term.

4. **The reason you are unable to work is not linked to the same condition as your previous claim.**

   We will *pay out* this subsequent claim following the end of *your deferred period*. The total number of monthly *benefit* payments for *your* new claim are limited to the length of *your* payment term.

For all types of Income Protection Cover, *we* will stop paying *you benefits* earlier if any of the following occurs:

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work
- *You* are no longer suffering any loss of income from *your own occupation*, despite *your* illness or injury
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury
- *You* refuse reasonable modifications or adjustments – for example to *your* working environment or working practices – that would mean *you* were able to carry out the essential duties of *your occupation*
- *You* fail to provide *us* with satisfactory proof of *your* entitlement to *benefit* payments within 30 days of *us* asking for it
- *You* do not have a physical examination and medical tests – at *our* expense – when *we* ask
- *You* fail to provide *us* with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*.
- *You* are removed from the *plan*. For more about how this happens, see provision D
- *Your* death

You need to tell *us* if either of the following occurs while *we* are paying *benefits* to *you* under Income Protection Cover:

- *You* return to work and start earning again
- *You* start receiving an income or *benefits* under any other insurance because of *your* incapacity, including mortgage payment protection policies or any other type of policy that pays a *benefit* to *you* or to a financial institution on *your* behalf

If *you* do not tell *us* about any other income or *benefits*, *we* might cancel *your* Income Protection Cover claim and stop paying *your benefit*.

Reviewing your claim

We might review *your* claim at any time while *we* are paying *benefits* under Income Protection Cover, to make sure *you* continue to be eligible for the *benefit*. This means that *you* might periodically need to fill out claim forms.

B4.5 What happens if you live abroad

If *you* live or are travelling in the *United Kingdom* or *permitted countries*, *we* will pay *your* Income Protection *benefits* as normal. If *you* live or are travelling within other countries while *we* are paying *you benefits*, *we* will limit the amount *we* pay *you* to the equivalent of 183 days *benefit* in any 365 day period. *We* will also limit the amount *we* pay to an overall maximum of 365 day *benefit*.

B4.6 What happens if you are on parental leave when *you* make a claim, not in employment when you make a claim or you have chosen Houseperson Cover

If *you* are on *parental leave*

If *you* are on *parental, maternity or adoption leave* when *you* make a claim then *we* will assess *your* claim against *your* current occupation from which *you* are taking leave from. Earnings will be based on the 12 months earnings immediately before *your* leave started.

If you are unemployed or on a career break

If *you* become *unemployed* – or take a *career break* – and claim under Income Protection Cover within a month of leaving work, *we* will assess *your* claim against *your* previous *own occupation*.

If *you* claim more than one month after leaving work, *we* will assess *you* as a *houseperson*. *We* may also change the *deferred period* that applies to *your* Income Protection Cover. For more about the *deferred period*, see provision B4.1.

Houseperson claims

We will use the *houseperson* category to assess claims for anyone who is:

- A *houseperson*
- A student
- Retired
- Working less than 16 hours a week
- *Unemployed* – and has been for at least one month

When we will pay

If *you* become ill or injured to the extent that *you* cannot perform three out of the *six activities of daily living*, *we* will *pay you* a *benefit*. For more about *activities of daily living*, see provision D5.4. *You* will not need to give *us* details of *your* earnings when *you* claim.

How much we will pay

The *maximum monthly benefit amount* is £1,500 per month. This is the maximum even if *you* had a higher amount of Income Protection Cover in place, or had *verified earnings*, before *you* became eligible under the *houseperson* category. If *you* become *unemployed* or become a *houseperson*, *you* may want to reduce *your* cover so that it does not exceed this maximum.

If *your* Income Protection Cover is indexed, indexation increases can raise the *maximum monthly benefit amount* for *houseperson* claims over £1,500 per month. For more about indexation, see provision B4.2.

We will pay an extra £100 per month for any *children* that are dependent on *you*. This amount is per *child*, but is subject to a monthly maximum of £300 per month or 20% of *your* monthly *benefit* amount – whichever is lower.

How long we will pay for

We will stop paying *you benefits* under the *houseperson* category if:

- *You* start work in any *employment* or *occupation* for profit or *reward*
- *You* no longer fail three out of the six *activities of daily living*
- *You* have selected Short Payment Term Income Protection Cover and *your benefit* has ended according to provision B4.4
- *Your* cover reaches its *date of expiry*

If *you* start or return to work for profit or reward *you* need to tell *us* immediately. If *you* originally had full Income Protection Cover, *you* can ask *us* to reinstate this when *we* stop paying *you benefits* under the *houseperson* category.

If *you* were originally covered as a *houseperson*, *you* can ask to increase *your* cover to full Income Protection Cover. Any increase will be subject to all the provisions in these *plan* provisions that relate to Income Protection Cover. *We* will need details of *your employment* or *occupation* and evidence about *your* health before *we* can increase *your* cover. *We* will also need evidence of *your* earnings or what *you* expect to earn so *we* can make sure *your* cover would not exceed the *maximum monthly benefit amount*.

B4.7 What happens if you go back to work

In the same capacity as before you were ill or injured

If *you* recover sufficiently to go back to work in *your own occupation* or another *occupation*, in a capacity that means *you* are no longer suffering any loss of income *we* will stop paying all Income Protection *benefits* to *you*.

In a reduced capacity

If *you* go back to work in a reduced capacity – with lower earnings – *we* will continue to pay *you* some of *your benefit*.

Working in your own occupation for lower earnings: rehabilitation benefit

If *you* go back to *your own occupation*, but are unable to undertake it to the same extent that *you* were immediately before becoming incapacitated – and can prove this to *our* satisfaction – *we* will pay *you* a rehabilitation *benefit*. This is a fraction of *your* full *benefit* amount, based on how much *you* earn on *your* return to work.

We may ask *you* to have medical treatment or supervision to help *you* recover *your* former level of capacity.

Working in a different occupation for lower earnings: proportionate benefit

If *you* go back to work, but *your* new job is not in *your own occupation* and provides *you* with lower earnings, *we* will pay *you* a proportionate *benefit*. This is a fraction of *your* full *benefit* amount, based on how much *you* earn on *your* return to work. *We* must be satisfied that *your* incapacity makes *you* unable to continue in *your own occupation*.

We calculate the amount of rehabilitation or proportionate *benefit we* will pay in the following way:

1. *We* take *your* reduced earnings (how much *you* earn on *your* return to work) away from *your verified earnings* or *pre-incapacity earnings* (depending on which amount *we* have used to assess *your* claim)

2. *We* divide the result by *pre-incapacity earnings*
3. *We* then multiply that result by *your* monthly Income Protection *benefit*

How long we will pay for

We will stop paying *you benefits* under rehabilitation or proportionate *benefit* if:

- *You* have selected Short Payment Term Income Protection Cover and *your benefit* has ended according to provision B4.4
- *Your* cover reaches its *date of expiry*

If *you* do not tell *us* that *you* have returned to work, *we* might cancel *your* Income Protection Cover claim and stop paying *your benefit*.

B4.8 What happens if you need to claim again

If *you* recover and return to work but then need to make another Income Protection Cover claim, *we* will waive the *deferred period* for this subsequent claim. This waiver only applies if the two claims are linked to the same condition, and *you* make the second claim within six months of the original *benefit* payments ending.

If *we* determine that *your* claims are linked to the same condition, and *your* level of Income Protection Cover has increased due to indexation of cover since *you* returned to work, *we* will apply any increases to the amount *we* pay for *your* subsequent claim.

B4.9 Waiver of Income Protection Cover premiums

We will waive *your* Income Protection Cover premiums while *we* are paying *you* any *benefits* under that cover. This includes payments under the *houseperson* category, rehabilitation *benefit* and proportionate *benefit*.

For more about these, see, provisions B4.6 and B4.7.

We will continue to waive *your* premiums until the first of the following happens:

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work;
- *You* are no longer suffering any loss of income from *your own occupation*, despite *your* illness or injury;
- *You* perform any kind of work for profit or reward – except if *we* are paying *you* rehabilitation or proportionate *benefit;*
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury;
- *You* fail to provide *us* with satisfactory proof of *your* entitlement to the *benefit* within 30 days of *us* asking for it, or *you* do not have a physical examination and medical tests – at *our* expense – when *we* ask;
- *You* fail to provide *us* with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*;
- *You* Income Protection Cover reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover;
- *You* have selected Short Payment Term Income Protection Cover and *your benefit* has ended according to provision B4.4;
- *Your* death.

Waiver of Premium on Incapacity

The Waiver of Income Protection Cover premiums described above is separate from the Waiver of Premium on Incapacity explained in provision C3. Waiver of Premium on Incapacity means that *we* will waive the *plan premiums* for *your* whole *plan* – not just for Income Protection Cover – if *you* become incapacitated and *your* incapacity meets one of *our* definitions. Premium on Incapacity applies to all combinations of joint life and single life plans across Life Cover, Life with Serious Illness Cover, Serious Illness Cover and Income Protection Cover. Waiver of Premium on Incapacity is not applicable for a single life Income Protection Cover plan. For more about the definitions of incapacity that apply, see provision C3.1.

B4.10 Public Sector Deferred Period

If *you* have selected that *you* work in the Public Sector and *you* have selected a 12 months *deferred period*, *we* may start to pay *your* monthly *benefit* that links to *your* employer's sick-pay structure. If *you* have not chosen the 12 months *deferred period*, the public sector *deferred period* will not apply to *you*. The following *deferred periods* will apply to *your plan* depending on *your occupation*. The *deferred period* varies by the length of *your* service with *your* employer:

NHS and Council Employees		
Length of Service	**50% of monthly benefit amount**	**100% of monthly benefit amount**
	Deferred Period	
Up to 1 year	1 month	3 months
Between 1 and 2 years	2 months	4 months
Between 2 and 3 years	4 months	8 months
Between 3 and 5 years	5 months	10 months
Over 5 years	6 months	12 months
If *your plan* has been in force for more than 5 years	6 months	12 months

Teachers (England, Wales and Northern Ireland)		
Length of Service	**50% of monthly benefit amount**	**100% of monthly benefit amount**
	Deferred Period*	
Up to 4 months	-	25 days
Between 4 months and 1 year	50 days	75 days
Between 1 and 2 years	50 days	100 days
Between 2 and 3 years	75 days	150 days
Over 3 years	100 days	200 days
If *your plan* has been in force for more than 3 years	100 days	200 days

*Based on working days

Teachers (Scotland)		
Length of Service	**50% of monthly benefit amount**	**100% of monthly benefit amount**
	Deferred Period	
Up to 4 months	-	1 month
Between 4 months and 1 year	1 month	2 months
Between 1 and 2 years	2 months	4 months
Between 2 and 3 years	4 months	8 months

Between 3 and 5 years	5 months	10 months
Over 5 years	6 months	12 months
If *your plan* has been in force for more than 5 years	6 months	12 months

Who is eligible for the public sector deferred period

To be eligible for the public sector *deferred period you* must:

- Be *employed* in one of the *occupations* mentioned below throughout *your plan* and immediately before *you* claimed. *Your* sick-pay structure immediately before *you* claimed must be based on one of the specified structures above.
- Be employed in an occupation that is not mentioned in the list below but have a sick-pay structure that matches one of the specified structures above. You must also work in the public sector which means you are directly *employed* by local or national governments. You must be employed in that occupation throughout *your plan* and immediately before *you* claimed. Your sick-pay structure immediately before you claimed must be based on one of the specified structures above.

Teachers (England and Wales)

Teachers (Including head teachers) who work in schools or in centrally managed LEA services and who are remunerated either on full-time basis or a part-time basis and their sick-pay is set out in the 'Conditions of Service for School Teachers in England and Wales', also known as the Burgundy Book.

Teachers (Scotland)

Teachers who work in Scotland and are governed by the Scotland Negotiating Committee for Teachers (SNCT) bargaining arrangements and their sick-pay is set out in SNCT Handbook of Conditions of Service.

Teachers (Northern Ireland)

Teachers who work in Northern Ireland and their sick-pay is in accordance with the Department of Education, Teachers Terms and Conditions.

NHS employees

Employees who work for the NHS or one of the NHS employers and their sick-pay is based on part 3, section 14 of the NHS Terms and Conditions of Service Handbook, or the equivalent at the time of claim.

Council employees

Employees of local authorities or other authorities of equivalent status in the *UK* and their sick-pay is set out based on National Joint Council for Local Governments Services' "National Agreement on Pay And Conditions of Service" booklet, also known as Green Book.

Linked Deferred Period

To align *your deferred period* to *your* sick-pay structure, *you* do not need to be continuously off-work. *We* will take into account the total time *you* have been off work in any year for the same condition to work out when *we* will start paying *your* claim. A year refers to a calendar year except for teachers (England, Wales and Northern Ireland) where a year is regarded as beginning on 1st April and ending on 31st March the following year.

B4.11 When your cover will end

Your Income Protection Cover will end on the earliest of:

- *Your* cover's *date of expiry*, less the *deferred period*. For example, if *you* have a *deferred period* of three months, *your* cover will end three months before its *date of expiry*. The *deferred period* may not apply if *you* are making a subsequent claim. For more about this, see provision B4.7.
- *You* being removed from the *plan;*
- The *plan* ceasing;
- *Your* death.

C. Other covers and options.

C1. Child Serious Illness Cover

Child Serious Illness Cover pays a lump sum if *your child* suffers from a *serious illness* that *we* cover. *Your plan schedule* shows if *you* have Child Serious Illness Cover. Appendix 2 also applies to Child Serious Illness Cover, where applicable.

Any changes that may apply due to Premium Step will not affect premiums for Child Serious Illness Cover at each *cover anniversary*.

However, changes due to Optimiser and indexed cover will apply to premiums for Child Serious Illness Cover at each cover anniversary.

This cover does not need *underwriting*. It covers all eligible current and future *children* for all adult persons insured on the plan. Cover for *children* is from birth, unless *we* say otherwise for a specific condition. *We* pay any *benefits* under this cover to the *Planholder*.

You don't have to have Serious Illness Cover to have this cover.

C1.1 When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- *Your child* is diagnosed with a *serious illness* as defined in Appendix 1
- The *child you* are claiming for survives for at least 14 days after the *life-changing event* or the diagnosis of the *life-changing event*
- *We* receive *your* written claim within six months of the *life-changing event*
- *You* give *us* any evidence *we* ask for, as set out in provision B2
- *Your* claim meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated

If *your* claim is for a *serious illness we* will usually assess using *functional activity tests,* or that is defined as total *permanent* disability (unable to do *your own occupation* ever again) *we* will assess *your child's* condition based on total *permanent* disability for *children* in Appendix 1.

See Appendix 1 for a list of conditions which require the use of *functional activity tests* to assess claims.

C1.2 How much we will pay

How much *we* will pay depends on:

- How severe *your child's* condition is
- The type of cover *you* have; and
- The amount of cover for *your child*

How severe your child's condition is

We will pay a percentage of *your* Child Serious Illness Cover, depending on how severe the *serious illness* is, based on a scale from A to G:

Some *serious illnesses* are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

Severity level	The percentage of your Child Serious Illness Cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

The type of cover you have

With Child Serious Illness Cover 1X *your children* are covered for severity levels A to D. With Child Serious Illness Cover 2X *your children* are covered for severity levels A to E. With Child Serious Illness Cover 3X *your children* are covered for severity levels A to G.

Your plan schedule shows whether *you* have:

- Child Serious Illness Cover 1X;
- Child Serious Illness Cover 2X; or
- Child Serious Illness Cover 3X.

The type of Child Serious Illness Cover is determined by *your* Serious Illness Cover type and is shown in *your* plan schedule. Child Serious Illness Cover 2X will be included on *your plan* if *you* have Serious Illness Cover 2X or Life with Serious Illness Cover 2X. Child Serious Illness Cover 3X will be included on *your plan* if *you* have Serious Illness Cover 3X or Life with Serious Illness Cover 3X.

The type of cover cannot be changed while *we* are assessing a claim under this cover.

The amount of cover

Your plan schedule shows the Child Serious Illness Cover amount. This is the amount *you* would get if *we* paid 100% of *your* Child Serious Illness Cover. For more details around how *your* cover amount works following a claim, see provision C1.5.

If *you* have Child Serious Illness Cover 2X or Child Serious Illness Cover 3X, the lump sum that *we* pay *you* in the event of a claim for certain *serious illness* conditions will be increased to 100% of *your* Child Serious Illness Cover amount. These conditions are listed in Appendix 2.

The maximum percentage of cover *you* will benefit from across multiple claims for each *child* over the term of this cover is:

- 100% if *you* have Child Serious Illness Cover 1X
- 200% if *you* have Child Serious Illness Cover 2X
- 300% if *you* have Child Serious Illness Cover 3X

The maximum percentage of cover *you* will benefit from across multiple claims across all *children* over the term of this cover is:

- 300% if *you* have Child Serious Illness Cover 1X
- 600% if *you* have Child Serious Illness Cover 2X
- 900% if *you* have Child Serious Illness Cover 3X

If the *child* is covered by more than one of *our* policies, a maximum of £100,000 applies to the total Child Serious Illness Cover amount across all policies issued by *us* This includes where a *joint life plan* has been split and plans with previous versions of Child Serious Illness Cover issued by *us* that the *child* can claim on.

Where the *child* is covered under Child Serious Illness Cover and is also covered under an adult Serious Illness Cover or Life with Serious Illness Cover across any plans issued by *us*, the maximum under the core covers will apply instead of the maximums under Child Serious Illness Cover. For more information around this, see provision B2.4.

Where the *child* is only covered under Child Serious Illness Cover and they aren't covered under any other core cover(s) under any plans issued by *us,* the maximum of £100,000 will apply to the total Child Serious Illness Cover amount across all policies issued by *us.*

C1.3 When we will not pay

We will not pay the *benefit* if:

- The *life-changing event* that causes *you* to claim happens after *your* Child Serious Illness Cover's *date of expiry*, or
- The claim is due to a *pre-existing medical condition*

C1.4 What happens if a single life-changing event causes you to claim for more than one serious illness

If a single *life-changing event* results in a *child* being diagnosed with more than one *serious illness*, *we* will only pay a *benefit* for the illness with the highest severity level.

However, if one of the *serious illnesses* is a neurological condition that started after the *start date* of the Child Serious Illness Cover, *we* will assess it as a separate claim. *We* will base *our* assessment on reports from the consultant in charge of monitoring progress.

If a single life-changing event results in more than one *child* being diagnosed with *a serious illness*, *we* will assess both claims separately, subject to the per *child* and per *benefit* maximum. For more information about this, see provision C1.2.

C1.5 How your cover continues after a claim

When *we* make payments under this cover, the *percentage of cover remaining* for future claims for that *child* and for the cover overall will reduce by the percentage of cover amount *we* have paid *you*. Payments under the Specified Congenital conditions and Child Funeral Contribution will not reduce the *percentage of cover remaining*.

- *You* can receive up to 100%, 200% or 300% of *your* Child Serious Illness Cover amount for each *child* across multiple claims depending on the type of cover applied to *your plan,* subject to any changes from *your* initial cover amount due to *your* cover structure and changes *you* make to the cover during the term. For more information around cover structure, see provision C1.6. For more information around changing your cover, see provision D5.
- Each claim *we* pay *you* in respect to any *child* will reduce *your percentage of cover remaining* depending on the severity of the claim, subject to the per child maximum and per cover maximum. For more information, see provision C1.2.
- Where the percentage of claim exceeds the *percentage of cover remaining*, *we* will pay the lower of the two.

If *you* claim once and then again *we* may make a further payment. The circumstances in which *we* may make a further payment are outlined in provision B2.7. How *we* calculate the amount *we* will pay is also outlined in provision B2.4, however the calculation will be based on *your* amount of Child Serious Illness Cover rather than the adult Serious Illness Cover amount.

C1.6 Cover Structure

Your plan schedule will show whether *your* Child Serious Illness Cover is on a level or an indexed basis.

Level

The amount of Child Serious Illness Cover will stay the same over the life of the cover term. It will only change if something happens such as *you* change the cover.

Indexed

The amount of Child Serious Illness Cover *benefit* increases on each *cover anniversary,* in line with the *Retail Prices Index* (RPI rounded to the next 0.25%). Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI figure that applies five months before each *cover anniversary*.

If *your* Child Serious Illness Cover is indexed, *we* will increase *your* premiums annually. For more information around how indexed premiums work, see provision D1.3.

C1.7 Hospitalisation benefit

Your Child Serious Illness Cover also includes a Hospitalisation benefit.

If any of *your children* are hospitalised for medically necessary treatment for 14 consecutive nights or more following 30 days after their birth, *we* will provide a *benefit* of £100 a day from the fourteenth day onwards for the period that *your child* remains in hospital.

We will pay the Hospitalisation benefit at the end of each month following hospitalisation. *You* will need to provide *us* with satisfactory proof of *your* entitlement to the *benefit* within 30 days of *us* asking for it.

We will limit the number of days *we* pay to an overall maximum of 30 nights. The overall maximum amount that *we* will pay for any one *child* is £3,000. If *your child* is covered by more than one of *our plans* with Child Serious Illness Cover, this maximum applies to the total of all payments under these *plans* and not to each *plan* separately. This includes where a *joint life plan* has been split.

We will not pay out the Hospitalisation benefit if it is a result of *you* making a successful claim under Child Serious Illness Cover.

We will stop paying *you* the Hospitalisation benefit on the earliest of:

- *Your child* leaving hospital;
- *Your child* has reached the first *cover anniversary* after their 23rd birthday
- The *plan* ceasing;
- *Your child's* death;
- *You* making a successful claim under Child Serious Illness Cover that results in *your child's* hospitalisation.

C1.8 Specified Congenital conditions and Child Funeral Contribution

We automatically include Specified Congenital conditions and Child Funeral Contribution on *your* Child Serious Illness Cover.

It pays a lump sum of £5,000 in the circumstances described in this provision.

C1.8.1 When we will pay the benefit

We will pay if *your* claim meets one or more of the following criteria:

a. Specified Congenital Conditions

We will pay a lump sum of £5,000 if any *child* who was born living, and during the period of cover is diagnosed with any of the following conditions after the *start date* of the cover:

- Cerebral Palsy - a definite diagnosis of Cerebral Palsy by an *appropriate medical specialist*
- Cystic Fibrosis – a definite diagnosis of Cystic Fibrosis by an *appropriate medical specialist*
- Downs Syndrome – a definite diagnosis of Downs Syndrome by an *appropriate medical specialist*
- Edwards Syndrome – a definite diagnosis of Edwards Syndrome by an *appropriate medical specialist*
- Osteogenesis Imperfecta – a definite diagnosis of Osteogenesis Imperfecta by an *appropriate medical specialist*
- Patau Syndrome – a definite diagnosis of Patau Syndrome by an *appropriate medical specialist*
- Spina Bifida – a definite diagnosis of Spina Bifida by an *appropriate medical specialist*
- Surgical treatment of Craniosynostosis - surgical treatment of Craniosynostosis by a Consultant Neurosurgeon.

b. Children's Funeral Contribution

We will pay *Children's* Funeral Contribution of £5,000 towards the cost of the funeral if any *child* dies before the *date of expiry* of *your* Child Serious Illness Cover.

The maximum amount of *Children's* Funeral Contribution that *we* will pay following the death of a *child* across all *plans* which *you* hold with VitalityLife is £5,000.

We will only pay *Children's* Funeral Contribution in respect of a *child* who:

- Has not reached the first *plan anniversary* after their 23rd birthday; and
- Is *your* natural *child*, *adopted child* or step-child; and
- Is looked after by or is financially dependent on *you*; and
- Is a *Resident of the United Kingdom*.

Children's Funeral Contribution includes all *your children* for the term of the cover.

We will only pay the *benefit* if:

- *We* receive *your* written claim form within six months of the *life-changing event*
- *You* provide *us* with any evidence *we* ask for
- *Your child* was born living.

C1.8.2 When we will not pay under Special Congenital conditions and Child Funeral Contribution

We will not pay if:

- The claim is due to a *pre-existing medical condition*
- The *life-changing event* that causes *you* to claim happens after *your* Child Serious Illness Cover's *date of expiry*.

A maximum of one payment will be made under each of the two categories for each *child* across all VitalityLife *plans*. If *you* have Serious Illness Cover or Life with Serious Illness Cover, this maximum will also apply to payments made under Complications of Pregnancy Conditions.

C1.8.3 How much we will pay

We will pay £5,000 for each claim under Specified Congenital conditions and Child Funeral Contribution. The total amount that *we* will pay for all claims under both benefits and under Complications of Pregnancy conditions on all plans which *you* hold with VitalityLife is £20,000.

Claims *we* pay under Specified Congenital conditions and Child Funeral Contribution will not reduce *your* Child Serious Illness Cover amount.

C1.8.4. When cover under Specified Congenital conditions and Child Funeral Contribution will end

It will end on the earliest of:

- *your* Child Serious Illness Cover's date of expiry; or
- when *we* have paid a total of £20,000 under both benefits and Complications of Pregnancy conditions if you have Serious Illness Cover or Life with Serious Illness Cover; or
- the cover ceasing.

C2. Mortgage Free Cover

Mortgage Free Cover is temporary Life Cover, Serious Illness Cover or Life with Serious Illness Cover, or both, that covers *you* before *your plan* starts. It may be relevant to *you* if:

- *Your plan* is to cover a loan to buy or improve *your* home
- *You* do not want *your plan* to start until *you* start paying back *your* loan

We offer *you* Mortgage Free Cover in this situation because *you* might be legally committed to the loan before *you* start paying it back – for example, if *you* have exchanged contracts to buy a new home.

Mortgage Free Cover only provides cover for conditions of severity level A or B. For more about how severity levels apply for Serious Illness Cover and Life with Serious Illness Cover, see provision B2.3 or provision B3.3.

We do not charge *you* any premium for Mortgage Free Cover.

C2.1 When you are eligible for Mortgage Free Cover

To be eligible for Mortgage Free Cover, *your plan* application must meet all of the following criteria:

- *You* are using *your plan* to cover a loan arranged through a recognised financial institution
- *You* are using *your* loan to buy or improve *your* home
- *You* are not using *your* loan to pay for a remortgage

- *Your* loan is not covered by another life assurance policy or free cover arrangement like this one
- *You* have applied for Life Cover or Serious Illness Cover or Life with Serious Illness Cover, and *we* have accepted *your* application and told *you* which of *your* covers the Mortgage Free Cover applies to
- The period from when *you* applied for *your plan* to when *you* are legally committed to a loan for buying or improving *your* home – for example when *you* exchange contracts – is less than four months
- *You* and any other *person covered* must be younger than 50 on the date *we* issue *your acceptance letter*
- *You* have a *single life plan* or a *joint life first death plan*

C2.2 When Mortgage Free Cover starts

Mortgage Free Cover starts when either of the following events happen:

- *We* issue *your acceptance letter*
- *You* become legally committed to a loan for buying or improving *your* home – for example this might be when *you* exchange contracts

You can only have Mortgage Free Cover in the period immediately before *your plan* starts. *You* cannot have it when *you* are changing *your plan* at a later stage.

C2.3 When we will pay

If *you* need to make a life claim under Life Cover or Life with Serious Illness Cover while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision B and provision B3.

If *you* need to make a severity A or B claim under Serious Illness Cover or Life with Serious Illness Cover while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision B2. *We* will not pay out under Mortgage Free Cover for conditions of lower severity levels.

You must claim within six months of the *life-changing event*.

C2.4 How much we will pay

The amount of Life Cover or Serious Illness Cover *benefit we* pay will be the lowest of:

- The amount of cover that *we* state on *your acceptance letter*
- The amount of *your* mortgage or loan; and
- £300,000

C2.5 When the cover ends

The *date of expiry* of Mortgage Free Cover is when the first of any of these events happen:

- Three months pass since *we* issued *your acceptance letter*
- *Your* mortgage starts
- *Your cover* starts; or
- *You* are no longer legally committed to the loan, for any reason

C3. Waiver of Premium on Incapacity

Waiver of Premium on Incapacity means that if *you* become incapacitated, *we* stop charging the *plan premium* for *your plan*.

- If *you* have a *single life plan*, *you* can choose to add this cover
- If *you* have a *joint life plan*, *you* can choose to add this cover for just one *person covered*, or both people can have it separately

Your plan schedule shows if *your plan* includes this cover. *You* can add or remove this cover at any time. If *you* apply to add it, *we* will *underwrite your* request.

C3.1 When we will waive your premiums

We will waive *your plan premium* if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. These are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

A special definition means the loss of the physical ability through an illness or injury to do at least three of the six *tasks designed to assess whether you can look after yourself. We* list these tasks in provision D5.4. *We* use this definition to assess *houseperson* claims, see provision C3.6.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

When we will start waiving your plan premium

We will start waiving *your plan premium* on the day after *your deferred period* ends.

The *deferred period* starts on the date *you* become incapacitated according to the definition that applies to *your plan*. It ends when *you* have been continuously incapacitated for one of:

- Seven days (this is only an option if *you* are self-employed)
- One month
- Two months
- Three months
- Six months
- Twelve months

You choose *your deferred period* when *you* set up this cover. If *you* have a *joint life plan*, each *person covered* can choose their own *deferred period*. For some *own occupations you* cannot choose a *deferred period* of one month. *We* will tell *you* if this applies to *you*.

Your plan schedule shows which *deferred period* applies to *your* Waiver of Premium on Incapacity.

Telling us that you want to claim

If *you* become incapacitated and need to claim, *you* need to give *us* written notice within a specified period of time. This notification period depends on the *deferred period you* have chosen. If *you* have a *deferred period* of:

- Seven days, *you* should notify *us* immediately
- One or two months, *your* notification period is two weeks
- Three, six or twelve months, *your* notification period is two months

If *we* don't receive notice of *your* incapacity within the specified period, *we* may treat the *deferred period* as if it started on the date *we* actually receive notice.

If *we* receive notice more than 90 days after the end of the *deferred period*, *we* may decline *your* claim.

Providing us with evidence for your claim

We will need to be satisfied that *your* claim is valid in order to waive *your plan premium*.

When *you* first make *your* claim, *we* will ask for evidence to substantiate it. This evidence may include, but is not limited to:

- A report from *your* General Practitioner
- Copies of *your* medical records
- A report from any other *appropriate medical specialist*
- *Your* hospital records, including copies of the results of any clinical tests or investigations
- Information from *your* employer, including details of the duties of *your employment*
- *Your* human resources records, including details of sickness absence

We may also need *you* to have a medical examination with an examiner that *we* choose, at *our* expense. *We* may appoint a disability counsellor or someone who represents *us* to talk to *you* about any aspect of *your* claim.

At reasonable intervals *we* may also ask *you* to fill in a claim form, to confirm that *you* are still entitled to Waiver of Premium on Incapacity.

If *you* do not give consent for *us* to access *your* medical information, or to get any other assistance or information that *we* need to assess *your* claim, then *we* may decline, suspend, or stop paying *you* any *benefits* under Waiver of Premium on Incapacity Cover.

C3.2 How long we will waive your plan premium for

When we will start waiving your plan premium

We will start waiving *your plan premium* on the day after *your deferred period* ends. For more about the *deferred periods*, see provision C3.1.

When we stop waiving your plan premium

We will continue to waive *your plan premium* until the first of the following occurs:

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work;
- *You* perform any kind of work for profit or reward;

- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury;
- *You* fail to provide *us* with satisfactory proof that *you* are entitled to the *benefit* within 30 days of *us* asking for it, or *you* do not have a physical examination and medical tests – at *our* expense – when *we* ask;
- *You* fail to provide *us* with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*;
- *Your* Waiver of Premium on Incapacity reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover;
- *You* are removed from the *plan;*
- The *plan* is cancelled;
- *Your* death.

C3.3 Which plan premium increases we will waive

While *we* are waiving *your plan premium*, *we* will waive any increases that happen because:

- We review *your* premiums
- *You* have an indexed cover;
- *Your plan premium* increases as a result of Optimiser or Premium Step;
- *We* review *your plan premium*.

While *we* are waiving *your plan premium*, *you* will have to pay any increases that happen because *you* have increased the amount of one of the covers on *your plan*.

C3.4 When we will not waive your plan premium

We will not waive *your plan premium* if the *life-changing event* which causes *your* claim occurs after the *date of expiry* for this cover.

C3.5 What happens if you need to claim again

If *you* recover and return to work but then need to make another claim under this cover, *we* will waive the *deferred period* for this subsequent claim. This waiver only applies if the subsequent claim is:

- Caused by the same *life-changing event* as the previous claim
- Within three months of the original waiver of premium ending

C3.6 What happens if you are not in employment when you make a claim

If you are unemployed or on a career break

If *you* become *unemployed* – or take a *career break* – and claim under Waiver of Premium on Incapacity Cover within a month of leaving work, *we* will assess *your* claim against *your* previous *own occupation*.

If *you* claim more than one month after leaving work, *we* will assess *you* as a *houseperson*. *We* may also change the *deferred period* that applies to *your* Waiver of Premium on Incapacity Cover. For more about the *deferred period* for Waiver of Premium on Incapacity Cover, see provision C3.1.

Houseperson claims

We will use the *houseperson* category to assess claims for anyone who is:

- A *houseperson;*
- A student;
- Retired;
- Working less than 16 hours a week;
- *Unemployed* – and has been for at least one month.

When we will accept your claim

If *you* become ill or injured to the extent that *you* cannot perform three out of the six *activities of daily living*, *we* will accept *your* claim. For more about *activities of daily living*, see provision D5.4. *You* will not need to give *us* details of *your* earnings when *you* claim.

How long we will pay for

We will stop waiving *your* premiums under the *houseperson* category if:

- *You* start work in any *employment* or *occupation* for profit or reward
- *You* no longer fail three out of the six *activities of daily living*

C3.7 What happens if you start to earn an income

If *you* start or return to work for profit or reward *you* need to tell *us* immediately. If *you* don't do this, *we* may:

- Stop waiving *your plan premium;*
- Cancel *your plan*.

C3.8 What happens if you change your occupation

You do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed.

If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *activities of daily living* to assess *your* claim. For more about *activities of daily living* assessments, see provision D5.4.

C4. Guaranteed Insurability Options

Guaranteed Insurability options allow *you* to increase certain cover amounts when particular events happen in *your* life, without giving *us* any more information about *your* health. The cover amounts *you* can increase are for:

- Life Cover;
- Serious Illness Cover;
- Life with Serious Illness Cover;
- Income Protection Cover;

Guaranteed Insurability options are automatically included in *your plan* as long as:

- *We* accepted *you* and any other *person covered* at standard rates;
- *We* have not added any special exclusions to *your plan;*

Your plan schedule shows if *your plan* includes Guaranteed Insurability options.

C4.1 When can you use Guaranteed Insurability options

Event	The cover you can increase the amount on			
	Life Cover	Serious Illness Cover	Income Protection Cover	Life with Serious Illness Cover
Childbirth or adoption	✓	✓	✓	✓
Marriage or Civil Partnership	✓	✓	✓**	✓
New or increased mortgage	✓	✓	✓	✓
Rental Increase	✓	✓	✓	✓
Promotion or change in job leading to a salary increase	✓	✓	✓	✓
Every third *plan anniversary*	-	-	✓	-
Increase in value of estate leading to an increase in inheritance tax liability*	✓	-	-	-
Legislative change leading to an increase in inheritance tax liability*	✓	-	-	-

*Only available where Life Cover is arranged on a *whole of life* basis.

You can apply to increase *your* cover amount using Guaranteed Insurability options at any time, as long as *your* application meets all of the following criteria:

- *You* already have the relevant cover;
- One of the events shown in the table above has happened in the last three months;
- *You* give *us* the evidence *we* ask for to show that the event has happened within the last three months;
- *You* have not made a successful claim under *your plan*, apart from under Child Serious Illness Cover;
- *You* have not reached the *plan anniversary* immediately before *your* 55th birthday for:
  - *Childbirth* or *adoption;*
  - *Marriage* or *Civil Partnership;*
  - New or increased mortgage;
  - Rental Increase;
  - *Promotion or change in job leading to a salary increase;*
  - Every third *plan anniversary.*

- *You* have not reached *your* 70th birthday for:
  - Legislative change leading to increase in inheritance tax liability;
  - Increase in value of estate leading to an increase in inheritance tax liability options.
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1;
- If *you* apply to increase Income Protection Cover, *you* must give *us* proof of *your* earnings.

If *you* have a *joint life plan*, and either *person covered* wants to increase their Income Protection Cover, the increase must take place on a *plan anniversary* that occurs at least a year before the Guaranteed Insurability options expire. This means that the increase cannot take place on the *plan anniversary* immediately before that person's 55th birthday.

If *you* want to use a Guaranteed Insurability option to increase *your* cover amount in line with an increase in *your* mortgage, *your* application must meet all of the following criteria:

- *You* are using *your plan* to cover a mortgage or mortgages on *your* main residence;
- *Your* mortgage has increased, or *you* have taken out a new mortgage;
- Any increase in *your* total mortgage payments is solely to pay for a new main residence or to improve *your* existing main residence.

If *you* want to use a Guaranteed Insurability option to increase *your* cover amount in line with a rental increase, *your* application must meet one of the following criteria:

- *Your* rental amount has increased as a result of *you* moving into a new property as *your* main residence; or
- *Your landlord* has increased the rental amount *you* are liable for.

We will increase *your* cover amount as soon as *we* have accepted *your* application.

Legislative change leading to an increase in inheritance tax liability

If *your plan* has been arranged on a *whole of life* basis, *you* can also increase *your* Life Cover amount if a change in legislation increases the inheritance tax (IHT) liability on *your* estate. A legislative change is limited to a change in inheritance tax rate, inheritance tax rate bands, inheritance tax reliefs and exemptions.

In order to exercise this option there must be evidence that the death *benefit* under the *plan* is in force to cover the potential IHT liability on *your* estate.

VitalityLife will reserve the right to request evidence of the increased potential IHT liability.

Increase in value of estate option

If *your plan* has been arranged on a *whole of life* basis, *you* can also increase *your* Life Cover amount if the potential IHT liability on *your* estate increases as a result of an increase in the value of the estate due to receipt of a gift or inheritance.

VitalityLife will reserve the right to request evidence of the event and the increase in IHT liability before allowing the Guaranteed Insurability *benefit* to be exercised.

Splitting a joint life plan into two single life plans upon divorce or dissolution of a civil partnership

You can split a *joint life first death plan* into two separate *single life plans* upon getting divorced or dissolving *your civil partnership*.

You can apply to split *your joint life plan* using the Guaranteed Insurability option at any time, as long as *your* application meets all of the following criteria:

- *You, your* spouse or *your* civil partner must be both *persons covered* under the original *plan*
- The original *plan* was used for the purpose of protecting a mortgage where:
  - The mortgage has been rearranged to be in the name of just *you, your* spouse or *your* civil partner, *or*
  - *You, your* spouse or *your* civil partner have taken out a new mortgage
- The divorce or dissolution of *civil partnership* has happened in the last three months, and *you* can provide necessary evidence *we* request
- *You* have not made a successful claim under *your plan*, apart from under Child Serious Illness Cover.
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1
- The two new plans must each meet *our* minimum premium requirements.

The two new *plans* will be subject to premium rates and provisions applicable at the time of the request. Any *underwriting* terms that applied to the original *plan* for either *person covered* will also apply to their new, respective *plans*.

Each *plan* term must be at least as long as *our* minimum term requirements and the amount of cover and term must not be greater than the amount of cover and term *you* had on the original *plan*.

If either *person covered* wants to increase their cover or increase the *date of expiry* they had under the original *plan*, *we* will need to *underwrite* their request and will be calculated using premium rates applicable at the time of the request.

We will include any remaining Child Serious Illness Cover in the *plan* of whoever was the *first person covered* in the original *plan*. If *you* would like *us* to include it in the other person's *plan*, or would like *us* to split it evenly between the two *plans, you* will need to write to *us*. The maximum cover under Child Serious Illness Cover across all plans held with *us* is £100,000.

C4.2 Limits to using Guaranteed Insurability options

- The maximum *you* can increase *your* Life Cover, Serious Illness Cover and Life with Serious Illness Cover by, using Guaranteed Insurability options, is £150,000. This maximum applies across the whole life of *your plan*;
- The maximum *you* can increase Income Protection Cover by, using Guaranteed Insurability Options, is £24,000. This maximum applies across the whole life of *your plan*;

There are also limits to the amount *you* can increase certain cover amounts by, and the number of times *you* can increase them:

Event	Life Cover Serious Illness Cover	Income Protection Cover	Life with Serious Illness Cover
Childbirth or adoption	The limit is 50% of the initial cover amount. *You* cannot increase it more than twice.	The limit is 50% of the initial cover amount, and no more than £8000 a year. *You* cannot increase it more than twice.	The limit is 50% of the initial cover amount. *You* cannot increase it more than twice.
Marriage or Civil Partnership	The limit is 50% of the initial cover amount. *You* cannot increase it more than once.	The limit is 50% of the initial cover amount, and no more than £8000 a year. *You* cannot increase it more than once.	The limit is 50% of the initial cover amount. *You* cannot increase it more than once.
New or increased mortgage	The limit is the amount of the new mortgage or the increase in the mortgage.	The limit is the amount of *your* increased regular mortgage payment, and no more than £8000 a year, and no more than 50% of the initial cover amount.	The limit is the amount of the new mortgage or the increase in the mortgage.
Rental Increase	The limit is the lower of 50% of the initial cover amount and the increase in the annual rental amount that *you* are liable for multiplied by the remaining cover term in years.	The limit is the lower of 50% of the initial cover amount, the increase in the annual rental amount that *you* are liable for or £8000 a year.	The limit is the lower of 50% of the initial cover amount and the increase in the annual rental amount that *you* are liable for multiplied by the remaining cover term in years.
Promotion or change in job leading to a salary increase	The limit is the lower of 50% of the initial cover amount, the increase in *your* salary or £50,000.	The limit is the lower of 50% of the initial cover amount, the increase in *your* salary or £8000 a year.	The limit is the lower of 50% of the initial cover amount, the increase in *your* salary or £50,000.

Event	Whole of Life Cover
Legislative change leading to an increase in IHT liability	The limit is 50% of the initial cover amount or the increase in the IHT liability on the portion of *your* estate covered by the *plan* which is a direct result of the legislative change.
Increase in value of estate option	The limit is the lower of: • 50% of the initial cover amount or • The increase in the IHT liability on the portion of *your* estate covered by the *plan*. This increase must be as a direct result of the receipt of the gift or inheritance, or • £50,000 This option can only be exercised once.

If *you* use a Guaranteed Insurability option to split a *joint life first death plan* into two *single life plans* upon divorce or dissolution of a *civil partnership*, the maximum cover for the *second person covered* is £500,000.

The maximum number of times that *you* can increase any of *your* cover amounts using these options over the period of cover is three. In addition to these limits, *you* can increase Income Protection Cover by up to 10% of the current cover amount, on every third *plan anniversary*.

C4.3 How using Guaranteed Insurability options affects your plan

If *you* use Guaranteed Insurability options to increase a cover amount, *we* will increase *your* premium for that cover. *We* will work out the amount of the premium increase using *your* age and the premium rates applicable at the time of the request.

We will apply the same provisions to an increase in the cover amount as those *we* applied when *your* cover started.

C4.4 When your Guaranteed Insurability options end

If you make a claim

If *you* make a successful claim under any cover except Child Serious Illness Cover, *we* will cancel *your* Guaranteed Insurability options.

The other person covered, on *your* joint life plan, can still use their Guaranteed Insurability Options except for on the following covers:

- Life Cover
- Serious Illness Cover
- Life with Serious Illness Cover

Ability to utilise Guaranteed Insurability Options for Income Protection cover is not impacted by a claim from the other life on a joint life plan.

Date of expiry

Your Guaranteed Insurability options end on the *plan anniversary* immediately before *your*:

- 55th birthday for *childbirth* or *adoption*, *marriage or Civil Partnership, divorce or dissolution of Civil Partnership*, new or increased mortgage options, rental increase, *promotion* or *change of job leading to a salary increase* and every third *plan anniversary*;
- 70th birthday for legislative change leading to increase in inheritance tax liability or, increase in value of estate leading to an increase in inheritance tax liability options.

C4.5 Additional Guaranteed Insurability Options for Income Protection Cover

You have additional Guaranteed Insurability Options with *your* Income Protection Cover that allow *you* to decrease *your* deferred period or increase *your* term.

You can use these additional Guaranteed Insurability Options when particular events happen in *your* life, without giving us more information about *your* health:

	Decrease your deferred period to match this event	Increase your term to match this event
Change in retirement age		✓
Change in *your* mortgage term		✓
Change in *your* job leading to differing sick pay	✓	
Change in *your* Group Income Protection payment period	✓	

You can apply to use the Additional Guaranteed Insurability options for Income Protection if *your* application meets all of the following criteria:

- *You* already have the relevant cover;
- One of the events listed above has happened in the last three months;
- *You* give us the evidence we ask for to show that the event has happened within the last three months and that the event has created a genuine need to change the deferred period or term;
- *You* have not made a successful claim under *your* plan, apart from under Child Serious Illness Cover;
- *Your* plan is not suspended. For more about how this can happen, see provision D1.1;

You also need to meet the following criteria for certain Additional Guaranteed Insurability options for Income Protection:

- *You* have not reached the plan anniversary immediately before *your* 55th birthday for:
  - Change in *your* mortgage term;
  - Change in *your* job *leading to differing sick pay*;
  - Change in *your* Group Income Protection payment period.
- *You* have not reached *your* 70th birthday for:
  - Legislative change leading to change in *your* retirement age;

The number of times *you* can use the Guaranteed Insurability Options and the Additional Guaranteed Insurability Options over the period of cover is three.

Deferred period cannot be reduced to less than 3 months.

D. Managing your plan.

D1. Paying your premiums

Your plan premium is made up of the individual premiums for each of the covers in *your plan*. *Your plan schedule* shows the details of *your plan premium*.

You pay *your plan premiums* either monthly or annually, in advance. *Your* selected payment frequency is shown in *your plan schedule*. If *you* have selected monthly, *your plan premiums* will be paid by direct debit. If *you* have selected annually, the *plan premium* will be paid for by either direct debit, Electronic Fund Transfer (EFT) or Telegraphic Transfer (TT).

The premiums for any waiver of premium covers depend on the premiums *you* pay for the other covers *you* have in *your plan*.

When *you* apply for multiple plans at the same time, *we* apply a discount to *your* plan premiums. This discount is subject to change or removal if any of the multiple plans *you* applied for at the same time are altered or cancelled.

We will send *you* a new *plan schedule* on each anniversary which will show any changes to *your* premiums as a result of:

- Indexation – for more information, see provision D1.3;
- Review of premiums – for more information, see provision D3;
- *Optimiser* - for more information , see provision E;
- *Premium Step* - for more information, see provision D3

D1.1 What happens if you do not pay your plan premium

If *you* do not pay *your plan premium* by the due date, *we* will suspend all the covers in *your plan*. However, *you* can ask *us* to reinstate *your plan* within seven months of the date of the first unpaid *plan premium* as long as:

- *You* pay all of the outstanding *plan premium*. If *your* premium would have increased in the time that *you* have not been paying it, *you* will need to pay the increased amounts.
- *You* provide *us* with a new direct debit instruction so *we* can collect future *plan premium*.
- *You* and any other *person covered* by the *plan* completes a reinstatement application form. This is so that *we* can *underwrite your* request. *We* may offer *you* revised terms, or decline *your* request. If *your plan* is reinstated, *we* will not pay any *child's* claim for a condition that was pre-existing at the time of reinstatement.

D1.2 When your premiums end

Your plan schedule shows the *date of expiry* of each of *your* covers. It also shows whether *your* premium will increase automatically. The *date of expiry* may be different for each *person covered* by the *plan*.

We will collect *your* final premium for each cover on the last due date before the *date of expiry*.

Once *your* Serious Illness Cover or Life with Serious Illness Cover continues into Dementia and FrailCare Cover upon *date of expiry* of that cover, premiums will continue to be payable. *You* have the choice to reject this continuation at any time during *your* cover *term*.

D1.3 Indexed premium increases

If *your* cover is indexed, *we* will increase *your* premiums annually. The amount by which *we* will increase *your* premiums will depend on *your* age at the time *your* cover increases. For *joint life plans* this will be based on the age of the *younger* of the two people covered.

If *you* have not reached the *plan anniversary* immediately before *your* 80th birthday the amount by which *we* increase *your* premiums will also depend on the percentage rise in the *Retail Prices Index*, rounded to the next 0.25% at the time *your* cover increases.

Your premiums will increase in one of three ways:

The percentage increase in the Retail Prices Index	Premium increase amount
Above 0% up to and including 1.75%	Total of the percentage increase in the *Retail Prices Index* plus 1.5%
2% up to and including 7.75%	Total of the percentage increase in the *Retail Prices Index* plus 2.5%
8% and above	Total of the percentage increase in the *Retail Prices Index*, to a maximum of 10%, plus 3.5%

If the percentage change in the *Retail Prices Index* is 0% or less, then there will be no change in *your* cover amount or premium.

Once *you* have reached the *plan anniversary* immediately before *your* 80th birthday the premiums will increase by the total of:

- The percentage rise in the *Retail Prices Index* rounded to the next 0.25%, from a minimum of 0% to a maximum of 10%; and
- 5%

If the *Retail Prices Index* is not suitable, *we* will use another index that measures retail price inflation.

We will increase indexed premiums on each anniversary of *your plan*. *We* will send *you* a new *plan schedule* one month before the increase is due to take effect. The *plan schedule* will show *you* how much the premiums are going to increase by.

You do not have to accept the increase to *your* premiums. However, if *you* do not want to accept them, *you* need to notify *us* before the date that the increases are due to take effect. *You* can ask *us* not to apply indexation in any year. If *you* decline indexation, then *your* premium and cover amount will not increase due to indexation for that year. If *you* do this for three consecutive years for any individual cover, *we* will cancel the indexation for that cover.

If *your* cover continues beyond *your* 80th birthday, then at the *plan anniversary* immediately before *your* 80th birthday (for *joint life plans* this will be based on the age of the younger of the two people covered) *we* will write to *you* and ask *you* to confirm whether *you* want *your* covers to continue to be indexed. If *you* do not tell *us* that *you* want *your* covers to be indexed *we* will cancel indexation on *your plan* and *your* premiums and cover amounts will no longer increase due to indexation.

There will be no change to *your* premiums or *your* cover amounts if *we* cancel indexation at any time.

If *we* have removed indexation, *you* can apply for *us* to reintroduce it. However, *we* will need to repeat the *underwriting* process for all the *persons covered*.

D1.4 How making a claim affects your premiums

Your premiums may be affected if *you* make a claim.

Your premiums will stay the same after *you* or either *person covered* under a *joint life* cover have made a claim, except when the cover ends after a claim. In this case, *you* will no longer have to pay the premium for that cover.

D1.5 How your Vitality Status affects your premiums

Your premium may change as a result of *your Vitality Status*. *We* will apply these changes on *your plan anniversary* in addition to any other changes that are due. *We* apply any changes as a result of *your Vitality Status,* after any changes that result from indexation, a review of *your* premiums, or if *you* have chosen Premium Step.

Your Vitality Status may affect premiums for Child Serious Illness Cover.

We will tell *you* if *your* premium is going to change at least one month before *your plan anniversary*.

For more about how *your Vitality Status* may affect *your* premium, see provision E2.

D1.6 Premium Step

Premium Step is only available if *you* have selected *Whole of Life* Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Premium Step *your* initial *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium starts lower than an equivalent *Whole of Life* premium that does not include Premium Step.

At each *plan anniversary your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium will increase by 2.5%.

We will apply any change in *your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium as a result of Premium Step before any change as a result of indexation or *your Vitality status*. *Your Plan Schedule* indicates whether *you* have chosen Premium Step.

D2. Guaranteed premiums

Your plan schedule shows whether any of *your* covers have guaranteed premiums.

D2.1 A guaranteed premium is one that will only change:

- If *you* change *your plan*
- If *you* make a claim
- Depending on *your Vitality Status* (see provision E)
- If *your* premiums are indexed
- At each *plan anniversary* if *you* have chosen Premium Step

D3. Reviewable premiums

We will review *your* premiums periodically if *your plan schedule* shows that any of *your* covers have reviewable premiums.

D3.1 How we review your premiums

When *we* review *your* premiums, *we* do not look at *your* individual circumstances such as *your* health. *We* look at the premiums *we* are charging to everyone *we* insure.

We will look at:

- *Our* claims experience, and the experience of the whole insurance industry
- Medical trends and advances, including treatments and diagnostic techniques that could affect *our* claims experience for any of the covers that *we* provide

- The potential future costs to *us* of settling claims
- Changes in applicable law or taxation

A review will affect each type of cover in *your plan* separately. It will apply to the full amount for each cover in *your plan*, including any changes *you* have made to *your* cover since *you* set *your plan* up. The date for each review will be based on the *start date* of the cover for each *person covered*, even if *you* have made later additions to the cover.

For some premiums, any change following a review could affect other covers in *your plan*. For more about this, see provision D1.

If *your* premium changes because of the *Vitality Programme,* choosing Optimiser, choosing Premium Step, or indexation, this does not count as a review.

D3.2 Reviewing premiums for Life, Serious Illness and Life with Serious Illness Covers

Unless *your plan schedule* shows that *you* have guaranteed premium rates *we* will review *your* premiums for each *of your* Life, Serious Illness or Life with Serious Illness covers on the tenth anniversary of that cover. *We* may then review them every year. However, if *we* change one of *your* premiums as a result of a review, *we* will not review that premium again for another ten years. The exceptions to this are:

- For Serious Illness Cover, *we* will also review the premium on the 70th birthday of each *person covered*. Even if *we* change the premium, *we* will then review it each subsequent year.
- For Life Cover, *we* will also review the premium on the 75th birthday of each *person covered*. Even if *we* change the premium, *we* will review it each subsequent year.

If *you* have a *joint life plan*, *we* will review the premiums for both *persons covered* together.

This section applies to Life Cover, Life with Serious Illness Cover, Serious Illness Cover and Child Serious Illness Cover.

There is no limit on the amount *we* might increase or reduce *your* premium by after a review.

D3.3 Reviewing premiums for Income Protection Cover

For Income Protection Cover where *you* have chosen reviewable premiums, *we* will review *your* premiums on the fifth anniversary of *your plan*. *We* may then review them every year.

However, if *we* change one of *your* premiums as a result of a review, *we* will not review that premium again for another five years. If *you* have a *joint life plan*, *we* will review the premiums for both persons covered together person *covered separately*.

There is no limit on the amount *your* premium could increase or reduce by after a review.

D3.4 Telling you if your premium needs to change

If *your* premium needs to change as a result of a review, *we* will tell *you* at least one month before the date the change is due to take effect. *We* will also explain *your* options.

D3.5 Your options if your premium needs to change as a result of a review

This table shows *your* options if *your* premium needs to change as the result of a review.

If your premium needs to:	You can choose to:	What you need to do:
Increase	Accept the increased premium	*You* do not need to do anything
	Keep *your* current premium and have less cover	Tell *us* in writing within 30 days of receiving *our* notification. If *your* current premium is below *our* allowable minimum, *we* will ask *you* to increase *your* premium to the minimum level.
	Cancel *your* cover	For how to cancel a cover, see provision F
Decrease	Accept the decreased premium	*You* do not need to do anything
	Ask to keep *your* current premium and have more cover	Apply to *us* in writing within 30 days of receiving *our* notification. *We* may need to *underwrite your* request.
	Cancel *your* cover	For how to cancel a cover, see provision F

D4. Changing your covers

There are several ways *you* can change *your* covers. *You* can apply to:

- Add Child Serious Illness Cover;
- Increase covers;
- Remove or reduce covers;
- Remove the *second person covered* from a *joint life plan;*
- Change the *fixed term* of *your* covers;
- Lower *your* premiums because of a change in *your* circumstances;
- Remove Optimiser; and/or
- Remove Premium Step.

We explain below when and how *you* can make these changes.

If *your plan* is suspended, *you* cannot make any changes to it. Any changes will be subject to the premium rates applicable and covers available at the time of the request. Premiums for other covers may also change as a result of *your* requested update to any of *your* covers.

D4.1 Adding Child Serious Illness Cover

You can apply to add Child Serious Illness cover at any time during *your* cover term. *We* will increase *your* premium based on the Child Serious Illness cover amount *you* have chosen and the type of Child Serious Illness Cover being applied for. Any other types of cover cannot be added.

D4.2 Increasing covers

You can apply to or increase *your* existing levels of cover, at any time – subject to the restrictions explained below. Applications for any increase *you* make will be subject to *our* terms and conditions when *you* make the change.

Restrictions on increasing covers

- *You* cannot make an increase if it would be beyond the limits that apply to *your plan*
- *We* may subject *your* request for increase to *underwriting*
- *You* cannot increase covers if *you* are *resident* outside the *United Kingdom*
- *You* cannot increase *your* Income Protection Cover if *we* have already paid *you* a *benefit*
- *You* cannot increase *your* Life with Serious Illness Cover if *we* have already paid *you* a *benefit*
- *You* cannot increase *your* Serious Illness Cover if *we* have already paid *you* a *benefit*
- *You* cannot increase *your* Child Serious Illness Cover if *we* have already paid *you* a *benefit* for any *child* covered.
- If *your plan premiums* are being waived at the time *you* ask to add or increase covers, *you* will need to pay the premium for the increased amount
- *You* cannot increase *your* Dementia and FrailCare Cover amount after the *date of expiry* of *your* Serious Illness Cover or Life with Serious Illness Cover
- *You* cannot reinstate Dementia and FrailCare Cover once *you* ask for *your* plan to not continue following *your* Serious Illness Cover's or Life with Serious Illness Cover's *date of expiry*

D4.3 Removing or reducing covers

You can apply to remove covers from *your plan*, or reduce *your* existing levels of cover, at any time. *You* can do this as long as *you* leave at least one of the following covers in *your plan*:

- Life Cover
- Life with Serious Illness Cover
- Serious Illness Cover
- Income Protection Cover

If *your plan premium* drops below the minimum *plan premium we* allow, *we* may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher premium.

D4.4 Removing the second person covered from a joint life plan

If *you* have a *joint life first death plan*, *you* can remove the *second person covered* from it. If *you* do, the *plan* will continue as a *single life plan* as long as *you* have at least one of the following covers:

- Life Cover;
- Life with Serious Illness Cover;
- Serious Illness Cover;
- Income Protection Cover.

When *we* remove the *second person covered* from *your plan*, *we* will remove all the covers from the *plan* that apply solely to that person and *we* will recalculate *your* premiums to replace any joint life covers with equivalent single life covers.

If *your* new *plan premium* drops below the minimum *plan premium we* allow, *we* may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher *plan premium*.

This option is not available on *joint life second death plan*.

D4.5 Changing the fixed term of your covers

You can change the *fixed term* of *your* covers at any time, as long as *your* new *plan premium* does not drop below *our* minimum allowable *plan* premium. If *you* have cover with a decreasing cover structure, *you* cannot change the term of *your* cover; Life Cover, Serious Illness Cover and Life with Serious Illness Cover must have the same term.

If *you* want to increase a *fixed term*, *we* will need to *underwrite your* request. Life Cover must have the same term as Serious Illness Cover and Life with Serious Illness Cover.

If *you* make a change to certain covers, other covers in *your plan* could be affected. For more about this, see provision D1.

D4.6 Lowering your premiums because of a change in your circumstances

If a change in *your* circumstances could lead to a lower premium, it is in *your* interest to tell *us*. *We* may then offer *you* a new premium, as long as:

- *You* complete a declaration of health form, if *we* ask *you* to, that confirms *you* are in good health;
- The new *plan premium* is lower than *your* current one.

An example of a change in circumstance that *we* will consider is giving up smoking.

D4.7 Removing Optimiser

If *your plan schedule* shows that *you* have chosen Optimiser, *you* can apply to remove this option at any time.

Optimiser is available with *Vitality Benefits* (*Vitality Plus* or *Vitality Select*). For more information on *Vitality Plus* or *Vitality Select* please see *your* separate terms and conditions. If *you* cancel *your Vitality Plus*, Optimiser will be removed from *your plan*.

If Optimiser is removed, *Vitality Plus* will also be removed from *your plan* and *your* premiums will change as follows:

- If *you* want to keep *your* premium at the same level until the *date of expiry*, the level of cover will be reduced. *We* will calculate the new level of cover for each of the covers in *your plan*.
- If *you* want to keep *your benefit* at the same level until the *date of expiry*, the premium will increase.

Vitality Select will remain on *your plan*, but *you* may not be able to add Optimiser to *your plan* again after it has been removed.

D4.8 Removing Premium Step

If *your plan schedule* shows that *you* have chosen Premium Step, *you* can apply to remove this option at any time.

If Premium Step is removed *your* premiums will change as follows:

- If *you* want to keep *your* premium for *Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover at the same level, the level of cover will be reduced.
- If *you* want to keep *your Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover *benefit* at the same level, the premium will increase.

D5. Claiming a benefit

This provision explains:

- How and when *you* can claim a *benefit* under *your plan*
- Who *we* will pay the *benefit* to
- The exclusions to claiming a *benefit*

D5.1 Who we will pay the benefit to

We will pay the *benefit* to the person legally entitled to receive it.

D5.2 Telling us about a claim

If a claim needs to be made under *your* cover, *we* need *you* to tell *us* as soon as possible. *We* describe the exact notification requirements for each type of cover in the individual cover sections of these *plan* provisions.

D5.3 What we need before we can settle a claim

For a life claim under Life Cover or Life with Serious Illness Cover or *Childrens* Funeral Contribution claim, *we* will need proof that the *person covered* has died. If *your plan* is arranged on a *joint life second death* basis *we* will need proof that both people covered have died. *We* may also need proof of the age(s) of the person(s) covered, if *we* have not already received it.

If *your plan* has been placed in trust, *we* will require a copy of the original trust deed. Please ensure that the trustees keep this in a safe place.

For any claim under Child Serious Illness Cover, *we* will need to see a birth certificate. *We* may also need proof of *your* relationship to the *child* if their birth certificate does not provide this.

For each type of cover, *we* describe what *we* need before *we* can settle a claim in the individual cover sections of these *plan* provisions.

For the purposes of complying with *our* Anti-Money Laundering obligations, *we* may require a claim recipient to give *us* satisfactory proof of their identity.

D5.4 Confirming that you are incapacitated

For some types of cover, *we* may need to assess whether *you* are incapacitated. To make this assessment, *we* will need an *appropriate medical specialist* to confirm that *you* have an ongoing inability to perform a series of *functional activity tests*. *You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. *We* explain these tests below. The individual cover sections in these provisions will explain which tests are relevant to a claim under that cover.

There are two types of *functional activity tests:*

- *Tasks designed to assess whether you can look after yourself* (*we* also refer to these as *activities of daily living* in these *plan* provisions)
- *Work tasks*

Types of functional activity tests

Tasks designed to assess whether you can look after yourself ever again (also called activities of daily living)	How we define this activity
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
Getting dressed and undressed	The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
Feeding yourself	The ability to feed *your*self when food has been prepared and made available
Maintaining personal hygiene	The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function
Getting between rooms	The ability to get from room to room on a level floor
Getting in and out of bed	The ability to get out of bed into an upright chair or wheelchair and back again.

Work tasks	How we define this activity
Walking	The ability to walk more than 200 metres on a level surface
Climbing	The ability to climb up a flight of 12 stairs and down again, using the handrail if needed
Lifting	The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table
Bending	The ability to bend or kneel to touch the floor and straighten up again
Getting in and out of a car	The ability to get into a standard saloon car, and out again
Writing	The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard

For the above definitions, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

Knowing which tests are relevant to your claim

The specific tests *you* need to take will depend on the cover *you* are claiming under.

Serious Illness Cover or Life with Serious Illness Cover

If *you* are aged between 16 and 70 when *you* make *your* claim *we* will assess *your* claim based on whether *you* can perform *activities of daily living* or *work tasks*. When *we* assess whether *you* are incapacitated there will be no accumulation of the number of failures for *tasks designed to assess whether you can look after yourself* and *work tasks*. *We* will assess each set of tasks separately and after *you* have taken the tests *we* will use the results that are most favourable to *you* to assess whether *you* are incapacitated.

If *your* claim is for *your child* under Child Serious Illness Cover, *we* will assess *your child's* disability level based on the reports from the *appropriate medical specialist* in charge of monitoring *your child's* progress.

Income Protection or Waiver of Premium on Incapacity

If *you* have the special definition of incapacity or *you* are a *houseperson* then *we* will assess *your* claim based on whether *you* can perform *activities of daily living*.

The tests *you* will need to take are also explained in the individual cover sections of these provisions.

For any claim, *your* inability to perform a particular activity needs to have been caused by a condition that arose after the *start date* of *your plan*.

D5.5 Making a claim when you are abroad

If *you* are outside the *United Kingdom*, the Channel Islands or the Isle of Man when *you* make a claim for anything other than Life Cover, *we* will need an *appropriate medical specialist* to confirm all *your* information and *your* diagnosis. *We* will consider information from *appropriate medical specialists* in *permitted countries*.

D5.6 Exclusions

General exclusions

If the illness, condition or procedure *you* are claiming for is a consequence of an excluded condition, *we* will not pay any *benefit* under any of these covers:

- Serious Illness Cover;
- Life with Serious Illness Cover;
- Child Serious Illness Cover;
- Income Protection Cover;
- Mortgage Free Cover;
- Waiver of Premium on Incapacity;
- LifestyleCare Cover;
- Dementia and FrailCare Cover.

This applies to the excluded conditions in the definitions of named conditions or any exclusions that were included in *your* acceptance terms at the start of the *plan*.

Exclusions for Life Cover and Life with Serious Illness Cover

Exclusions for suicide

We will not pay a claim for Life Cover or Life with Serious Illness Cover if one of the people covered dies as a result of *suicide* within 12 months of:

- The *start date* of the Life Cover or Life with Serious Illness Cover;
- The date the *plan* was re-instated if it was suspended because *your plan premiums* were not paid.

If *you* have increased the Life Cover or Life with Serious Illness Cover under *your plan*, and one of the people covered dies as a result of *suicide* within 12 months of the increase, *we* will not normally pay the additional amount as part of the claim.

Exclusions for Serious Illness Cover and Life with Serious Illness Cover.

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Serious Illness Cover or Life with Serious Illness Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your* cover.

We may have excluded specific conditions from *your* Serious Illness Cover or Life with Serious Illness Cover. If *we* have, and *you* make a claim for another *body system category*, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that the illness is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your* cover, or *you* disclosed it to *us* when *you* applied for cover.

Exclusions for Income Protection Cover

We will not pay the *benefit* if the *life-changing event* that causes *you* to claim happens before the *start date* of *your* Income Protection Cover.

Exclusions for Recovery Benefit

We will not pay the Recovery Benefit if the *life-changing event* that causes *you* to claim happens before the start date of *your* Income Protection Cover.

Exclusions for LifestyleCare Cover

Appendix 3 explains the exclusions that apply to claims for specific illnesses under LifestyleCare Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 3. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* LifestyleCare Cover. If *we* have, and *you* make a claim, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that *your* illness is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to *us* when *you* applied for cover.

Exclusions for Mortgage Free Cover and Immediate Cover

Mortgage Free Cover and Immediate Cover may provide limited Life Cover or Serious Illness Cover or Life with Serious Illness Cover, depending on *your plan*. For more about these, see provision C3, B1.4 and C4.6. The exclusions that apply to Life Cover, Serious Illness Cover and Life with Serious Illness Cover apply in the same way to Mortgage Free Cover and Immediate Cover, as appropriate.

Exclusions for Child Serious Illness Cover

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Child Serious Illness Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1 or Appendix 2 if applicable to *your* cover type. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

Exclusions under Waiver of Premium on Incapacity

If the person making the claim is temporarily based outside the *permitted countries*, *we* will only waive a maximum of 12 months' *plan premiums* for Waiver of Premium on Incapacity.

Exclusions for Guaranteed Insurability options

If *you* used *your* Guaranteed Insurability options to increase or add to *your* cover, *we* will not pay a claim if the illness or disability causing the claim:

- Was known when *you* used *your* Guaranteed Insurability options, or
- Would have resulted in *us* paying a *benefit* before *you* used *your* Guaranteed Insurability options, or
- Would have been in the *deferred period* of an Income Protection Cover claim before *you* used *your* Guaranteed Insurability options.

Exclusions for Complications of Pregnancy Conditions

We will not pay the *benefit* if:

- The claim is due to a *pre-existing medical condition*, or
- The *life-changing event* that causes *you* to claim happens after *your* Serious Illness Cover's or Life with Serious Illness Cover's *date of expiry*.

Exclusions for Specified Congenital conditions and Child Funeral Contribution

- *We* will not pay the *benefit* if:
- The claim is due to a *pre-existing medical condition*; or

The *life-changing event* that causes *you* to claim happens after *your* Child Serious Illness Cover's *date of expiry*.

Exclusions for Dementia and FrailCare Cover

Appendix 4 explains the exclusions that apply to claims for specific illnesses under Dementia and FrailCare Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 4.1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

If *you* claim for a condition under Serious Illness Cover or Life with Serious Illness Cover, *you* will not be able to claim for that condition, or any related conditions, once it continues into Dementia and FrailCare Cover upon *date of expiry*. Related conditions are listed in Appendix 4.2.

We may have excluded specific conditions from *your* Dementia and FrailCare Cover. If *we* have, and *you* make a claim, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that *your* illness or condition is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your* Serious Illness Cover or Life with Serious Illness Cover. Additionally, *we* will base any *benefit* on the cover amount that was in force at the time the condition, which *you* are claiming for, occurred.

D6. How a joint life first death plan continues if one person dies

If one of the people covered on a *joint life first death plan* dies, *we* will remove all the covers that solely applies to the person who has died from the *plan*.

Any other *joint life* covers attached to the *plan* may continue for the surviving person, as described further in provisions D6.1 and D6.2.

D6.1 How the premiums change

For the *surviving person covered*, *we* will recalculate the *plan premium* to reflect the removal of the other person covered from the *plan*.

If the new *plan premium* drops below the minimum *plan premium we* allow, *we* may ask the surviving person to maintain it at a higher level. If that happens, the surviving person will receive a level of cover that reflects that higher *plan premium*.

D6.2 How the covers change

For the surviving *person covered*, Income Protection Cover will continue without any changes to the *benefit*.

However, *we* will:

- Remove Life Cover for the surviving person if *we* have made a Life Cover payment, including for a *terminal illness;*
- Remove Child Serious Illness Cover if there are no core covers left on the *plan;*
- Remove Waiver of Premium if there are no core covers left on the *plan*
- Replace *joint life* Serious Illness Cover with the equivalent single life cover

Life with Serious Illness Cover will continue for the surviving *person covered* if the *percentage of cover remaining* has not reduced to zero after the life claim.

Where a life claim is made under a *joint life* cover, the person died will be removed from the plan and *we* will recalculate *your* premiums to reflect the removal at the time of claim.

Once either *person covered* makes a life claim, *we* will not pay any further life claims under Life with Serious Illness Cover.

If the surviving person wants to increase their cover, *we* will need to *underwrite* their request. The *plan* will be subject to the provisions applicable at the time of the request.

If the surviving *person* wants further Life Cover they will need to set up a new *plan*. *We* will base any new Life Cover on the age of the person, provisions and premium rates that apply when they set up the new *plan*. This request is subject to *underwriting*.

D7. How a joint life second death plan continues if one person dies

If one of the people covered on a *joint life second death plan* dies, the policy will continue and the *plan premium* will continue at the same level.

E. How Vitality rewards you for being healthy.

The *Vitality Programme* helps *you* improve *your* health – and saves *you* money at the same time. It encourages *you* to be healthy by offering all adults on the *plan* discounts with a range of health partners. By taking steps to look after *your* health, *you* can increase *your Vitality Status*. To begin with, this is Bronze. Then as *you* make an effort to be healthy, *you* can increase *your* Status to Silver, Gold or even Platinum. The higher *your* status, the greater the discounts and rewards. Some Vitality rewards and *benefits* are only available to those who are over the age of 18.

The *Vitality Programme* is provided to *you* by Vitality Corporate Services Limited.

Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

E1. Your Vitality Status

When *you* take steps to look after *your* health, *you* could improve *your Vitality Status*. There are four *Vitality Statuses*:

Vitality status	Effort threshold
Bronze	*You* start at this level on *your plan's start date*. *You* may return to this level on each anniversary of *your plan*, depending on the *Vitality Status* rules at that time
Silver	*You* will be able to achieve Silver *Vitality Status* between *plan* anniversaries if *you* make a moderate but regular effort to look after *your* health
Gold	*You* will be able to achieve Gold *Vitality Status* between *plan* anniversaries if *you* make a strong and regular effort to look after *your* health
Platinum	*You* will be able to achieve Platinum *Vitality Status* between *plan* anniversaries if *you* make a very strong and regular effort to look after *your* health

E2. Optimiser

With Optimiser *your* initial premium starts lower than an equivalent *plan* that does not include Optimiser and *your* premium may change on each *plan anniversary*. Optimiser will affect premiums for Child Serious Illness Cover. *Your plan schedule* indicates whether *you* have chosen Optimiser.

Optimiser can be added at any time during the term of *your plan* and once added, will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select* on *your plan*. Please see provision E3 for more information on *Vitality Benefits*.

We will recalculate *your* premium on each *plan anniversary* until the *date of expiry* of each cover.

E2.1 How we calculate the change in your plan premium

Where *you* have chosen Optimiser, *we* will recalculate *your plan premium* based on *your Vitality Status* at each *plan anniversary*. The following table shows *you* how *your plan premium* can change:

Vitality status	Premium change
Bronze	+2.5%
Silver	+1.5%
Gold	+0.5%
Platinum	No change

If the premiums for *your* covers change, the premiums for any waiver of premium cover could also change (see provision D1). *We* will apply any change in premium as a result of Optimiser after any changes as a result of indexation, Premium Step or a review of *your* premiums. For more about how indexation could affect *your* premiums, see provisions D1.3. For more about how a review of *your* premiums could affect *your* premiums, see provision D3. For more information about how Premium Step could affect *your* premiums, see provision D1.6.

E3. Vitality Benefits on your plan

E3.1 Vitality Benefits for plans without Optimiser

Vitality Select is automatically included on *your plan* at no additional cost.

Vitality Select gives *you* access to the wide range of discounts and rewards. Please refer to the separate terms and conditions for more information on *Vitality Select* and the *Vitality Programme*.

E3.2 Vitality Benefits for plans with Optimiser

When *you* have Optimiser *your plan* will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select*. *Your plan schedule* indicates whether *your plan* includes *Vitality Plus* or *Vitality Select*.

Your initial *premium* will define which *Vitality Benefits your plan* includes, either *Vitality Plus* or *Vitality Select*. If *your* initial *premium* is:-

- Below £45* for a *single life plan* or £60* for a *joint life plan* then *Vitality Select* will automatically be included on *your plan*,
- £45* or above for a *single life plan* or £60* or above for a *joint life plan* then *Vitality Plus* will automatically be included on *your plan*.

E3.3 How my Vitality Benefits may change during the duration of my plan

There will be no change to *your Vitality Benefits* as a result of a change to *your* premiums for any of the following:-

- *Vitality status* premium adjustments;
- Indexation;
- Premium Step adjustments;
- Review of *your* premiums;
- Premium adjustments under Dementia and FrailCare Cover
- Existing covers expire; or
- A valid claim on existing cover.

However, the *Vitality Benefits you* have access to may change if *you* make one or more of the following changes to *your plan*:-

- Add or remove Child Serious Illness cover;
- Increase covers;
- Remove or reduce covers;
- Remove Optimiser;
- Remove the second life covered from a *joint life plan;*
- Split a *joint life plan* into two *single life plans*;
- Change the *fixed term* of *your* covers; or
- Change *your deferred period*;
- Reduce *your* premiums because of a change in *your* circumstances.

The *Vitality Benefits you* have access to will only change if, as a result of one of the above, *your* premium changes. This will only happen in one of following ways:-

1. *Your plan* has Optimiser including *Vitality Select* and *you* make a change to *your plan* such that *your* premium increases to £45* (single life) or £60* (joint life) or more. In this case *Vitality Select* would be removed from *your plan* and replaced with *Vitality Plus*.
2. *Your plan* has Optimiser including *Vitality Plus* and *you* make a change to *your plan* such that *your* premium reduces below £45* (single life) or £60* (joint life). In this case *Vitality Plus* would be removed from *your plan* and replaced with *Vitality Select*.

** This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Select) you will receive on your plan. This applies to all plans that have selected Optimiser now. The premium requirements which determine your Vitality Benefits may change.*

E3.4 Cancelling your Vitality Benefits

If *Vitality Plus* is cancelled, Optimiser will be removed from *your plan* and *your* premiums will change as described in provision D4.6.

If *you* have *Vitality Select*, this will remain on *your plan*, but *you* may not be able to add Optimiser to *your plan* again after it has been removed.

E4. The Vitality commitment

The *Vitality Programme* will give *you* access to discounts and rewards for the duration of *your plan*. Because *your plan* could last many years,the discounts and rewards offered to *you* may need to be revised from time to time.

There may be instances where other aspects of the *Vitality Programme* may be significantly enhanced, changed or withdrawn and *we* may make these changes at any time.

As new opportunities and technologies emerge, the way *you* are rewarded for being healthy will change over time. The discounts and rewards depend on relationships with third party providers and the range of services these providers offer.

Please refer to the separate terms and conditions for more information on the *Vitality Programme*. This includes changes to the way *you* are awarded *Vitality Programme* points, the eligible activities, incentives and partners offered, and how *your Vitality Status* could change as a result.

If *you*'re not satisfied with the changes, *you* may cancel *your plan* in accordance with the information in provision F3.

If *you* would like details of the incentives and rewards that are in effect at any time, *you* can call *us* on 0345 601 0072.

F. General terms and conditions.

F1. When your plan ends

Your plan will end when the first of the following occurs:

- The death of the *person covered* in a *single life plan*, or both *persons covered* in a *joint life second death plan* (see provision D7)
- *Your percentage of cover remaining* reduces to zero after a claim, and *you* haven't chosen Income Protection Cover part of *your plan* at that time
- All covers under *your plan* have reached their *date of expiry*
- *You* cancel *your plan*

F2. When we can make changes to your plan

We may change the terms of *your plan* for any of the following reasons:

a. To respond, in a proportionate manner, to changes in the way *we* administer plans of this type.

b. To respond, in a proportionate manner, to changes in technology or general practice in the life and pensions industry.

c. To respond, in a proportionate manner, to changes in taxation, the law or interpretation of the laws of England and Wales, decisions or recommendations of an Ombudsman, regulator, *UK* Court, the European Court of Justice, or similar person, or any code of practice with which *we* intend to comply (with the exception of Guaranteed Premiums, unless such change in required by the Financial Services Regulator from time to time).

If *we* consider any variation to these conditions is to *your* advantage or is necessary to meet regulatory requirements, *we* may make the change immediately and will tell *you* at a later date.

We will tell *you* in writing of any change *we* consider is to *your* disadvantage (other than any change necessary to meet regulatory requirements) at least 60 days before the change becomes effective, unless it is not possible for *us* to do this, in which case *we* will give *you* as much notice as *we* can.

F3. Cancelling your plan

When you may cancel your plan

You can cancel *your plan* at any time.

If *you* cancel within 30 days of receiving *your plan* details, *we* will refund *your plan premium*, as long as *you* have not made a claim.

If *you* pay *your* premiums monthly and *you* cancel *your plan* after 30 days, *we* will not refund *your plan premium*.

If *you* pay *your* premiums annually and *you* cancel *your plan* after 30 days, *we* will calculate *your* premium as though it were monthly and will refund *you* for the remainder of the *plan year* from the cancellation date.

To cancel *your plan, you* will need to contact *us* via one of the following methods:

Phone:	0800 030 4903
Email:	VitalityLife_CreditControl@vitality.co.uk
Post:	VitalityLife, PO BOX 619, Darlington, DL1 9FH

When we may cancel your plan

FRAUD

We may cancel *your plan* if *you*:

- Make any untrue statements to *us*
- Fail to disclose any material facts relevant to *your plan* or a claim
- Act fraudulently in any other way

If *we* cancel *your plan* because of fraud, *your plan* will become void.

OTHER REASONS

The Financial Conduct Authority (FCA) publishes an Insurance Conduct of Business Sourcebook that sets out the rules to do with when it is reasonable for a company to cancel a *plan* like this one. *We* will apply these rules to *your plan*. *We* will apply these rules to the *plan* as a whole, rather than to each type of cover separately.

The FCA may update their rules during the life of *your plan*. For the latest rules, please contact the FCA at consumer.queries@fca.org.*uk* or by phoning 0800 111 6768. *You* can also download the Conduct of Business Sourcebook at www.fca.org.uk.

F4. Cash value

Your plan does not have any cash value.

F5. Mis-statement of age

If any *person covered* under the *plan* did not state their age accurately when they applied, *we* will change the terms of the *plan* in a way that *we* consider to be just and reasonable.

F6. Assignment

If *you* assign any of *your* legal rights under the *plan* to someone else, including changing who is entitled to the *plan*, *you* need to give *us* written notice. Please do this by writing to: Vitality Life Limited, PO BOX 619, Darlington, DL1 9FH.

We will not change who is entitled to *benefits* under *your plan* until *we* receive this notice.

F7. Payments and currency

All payments *we* make to *you* will be to a bank account registered in the *United Kingdom*. In addition, all payments made to *us* must be from a bank account registered in the *United Kingdom*. *You* must also be the registered account holder of the bank account; alternatively there must be an *insurable interest* between *you* and the registered account holder of this bank account.

We cannot make any payments to *you*, nor accept any payments from *you* if the bank account is registered outside the *United Kingdom*.

All payments must be in pound sterling (GBP).

F8. Impact on means tested benefits

Payments of *benefits* from this *plan*, including LifestyleCare Cover may affect *your* entitlement to receive means tested *benefits* from the government or *your* local authority. *We* recommend that *you* seek professional advice if *you* are concerned about this.

F9. Complaints

Our commitment to you

We understand that sometimes things can go wrong. *You* are important to *us*, so if *you* have reason to complain *we* want to know. *We* will try to resolve *your* complaint quickly in a professional and helpful way.

How to contact us

You can contact *us* by letter, phone or email. It will help if *you* give *your* name, address and *plan* number. Either send *us* a secure message via *our* Member Zone, or call *us* on the number shown on *your* certificate of insurance. Or *you* can write to *us* at:

VitalityLife Customer Services, PO Box 619, Darlington, DL1 9FH

How we will deal with your complaint

The time it takes to resolve *your* complaint will depend on how complex it is and how much investigation *we* have to do. *We* will always try to resolve *your* complaint as quickly as possible, keeping *you* informed of *our* progress.

We will:

- Acknowledge *your* complaint promptly
- Tell *you* who is dealing with *your* complaint so contacting *us* is easier. This person will be a trained complaint handler not directly involved with *your* case before the complaint
- Fully investigate *your* complaint and send *you* a detailed report about *our* findings. *We* will clearly explain the reasons behind *our* decision and what action *we* will take to put things right, if appropriate
- Update *you* every four weeks if the investigation is not complete and explain the reason for the delay

What to do if you are still not happy with the outcome

We want to resolve complaints to *your* satisfaction whenever possible. If *we* cannot reach agreement with *you*, *you* can refer *your* complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms. If *you* are going to ask the Financial Ombudsman to review *your* case, *you* should do so within six months of *our* giving *you our* final decision on *your* complaint.

You can contact the Financial Ombudsman in the following ways:

The Financial Ombudsman Service,
Exchange Tower,
London, E14 9SR
Enquiry line: 0800 023 4567
Fax number: 020 7964 1001
Website: www.financial-ombudsman.org.UK
Email: complaint.info@financial-ombudsman.org.UK

If *you* contact the Financial Ombudsman Service, this does not affect *your* right to take legal action if *you* are dissatisfied with and do not accept the outcome of the review.

F10. If we cannot meet our obligations

We are covered by the Financial Services Compensation Scheme (FSCS). *You* may be entitled to compensation from the scheme if *we* cannot meet *our* obligations. Whether or not *you* are able to claim and how much *you* may be entitled to will depend on the specific circumstances at the time.

For further information about the scheme please contact the FSCS at: www.fscs.org.uk.

F11. Insurable interest

You must have an *insurable interest* in the *person covered* when *you* take out the *plan*. If *insurable interest* does not exist, *your plan* will become void.

F12. Law

We will govern and interpret *your plan* according to the applicable laws and regulations of England and Wales. Where *we* are required to change *your plan* under these laws and regulations *we* will do so. *Your plan* will be subject to the exclusive jurisdiction of the English courts.

Anyone who is not party to this contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this *plan*. *We* include the *planholder* and any other *person covered* as party to the *plan*.

Sanctions

We will not be responsible or liable to make any payment to *you* or any third party covered under *your plan* howsoever arising (including, but not excluding, payment of any *benefit*) when doing so would put *us* in breach of any applicable economic sanctions, laws and regulations of the European Union, the *United Kingdom*, the United Nations or any other legal regime or code of practise *we* may consider applicable.

Economic sanctions are subject to changes and include prohibiting the transfer of funds to a sanctioned country, freezing the assets of a government, the corporate entities and residents of a sanctioned country, or freezing the assets of specific individuals or corporate entities.

If *you*, or any third party who is covered under *your plan*, are the subject of sanctions, *we* may not be able to provide cover under *your plan* and *we* may terminate *your plan* with *us*.

F13. Data Protection Notice

Why should you read this notice?

We think it is important for all of *our* members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that *we* comply with the data protection legislations. The following is a summary of *our* Privacy Policy. For details of the full Privacy Policy (effective from 25 May 2018) please visit vitality.co.uk/privacy.

Who Vitality are

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of Vitality

Health Limited ("VitalityHealth") and Vitality Life Limited ("VitalityLife") Together "Vitality" arranges and administers products provided by VitalityHealth and VitalityLife. Vitality Corporate Services Limited is the data controller for the management of interactions between *us* and *you*; VitalityHealth and VitalityLife respectively are the data controllers for the personal data and special category data that *you* or *your* representative provide to *us*.

Sharing your personal data

We may need to share *your* personal data for legal or regulatory purposes, with *your* authorised representative where *you* have appointed an insurance or financial adviser or with other companies in order provide *our* products and services.

Processing claims

In the event of a claim *we* may require a medical report from *your* GP. Such a report will only be requested with *your* consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from *your* GP will be limited to only the information relevant to *your* claim. *You* have the right to request to see the GP's report and to request any amendments be made by the GP where *you* consider the data to be inaccurate. The GP may agree to this at his/her discretion. *You* will be informed about the AMRA process at the time *we* request *your* consent to enable *us* to ask *your* GP for a report.

We may have to give some information about *your plan* and about *your* health or medical status to those involved in *your* treatment or care, (and/or *your* representative if *you* have consented to *us* doing this). Any such disclosure will be done confidentially unless *you* specifically instruct *us* otherwise.

If the claimant is aged 13 or over *we* will address any correspondence to the claimant in order to protect their right to confidentiality. The *planholder* will be informed only that a claim has been made and the value of the payment *we* have made; no details about the medical condition or treatment provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform *us* at the time the claim is made.

If *you* have another insurance *plan* that covers the same costs that *you* are claiming from *us* then *we* may also disclose *your* relevant personal data to that other insurer so that *we* can ensure *we* only pay *our* proportion of the claim.

Your information, and that of others also covered by the *plan*, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Marketing

Vitality Corporate Services Limited would like to send *you* information about *our* products and future products, which currently include health and life insurance, investments and general insurance. *We* are focused on bringing exciting new products to *you* and to enhance those already available by offering improved services and *benefits* as a Vitality member.

When *you* purchase a product from Vitality *you* will be provided with access to the Member Zone where *you* can manage *your* marketing preferences and choose *your* preferred method of receiving information about *our* products, services and the *benefits* at any time.

You can manage *your* marketing preferences and choose *your* preferred method of receiving information about *our* products, services and the *benefits* at any time by calling *our* customer services team.

Data protection complaints

We want all of *our* members to be happy with the way their personal data, health data and medical information has been processed by *us*. If *you* are unhappy about the way *we* have managed *your* personal data *we* would like to know about it as *we* are constantly striving to ensure *we* do the right thing and *we* would like to be able to put things right.

You'll find the contact details for *our* complaints teams at:

vitality.co.uk/legal/complaints

However, if *you* are still dissatisfied *you* have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at:

ico.org.uk

You can also call the ICO on 0303 123 1113 or 01625 545 745, or write to them at:

Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

If *you* have any queries in respect of *your* data protection rights or the way *your* personal data is processed by Vitality, please call *us* on 0207 133 8600, or write to *us* at:

Data Protection Officer
Vitality
3 More London Riverside
London
SE1 2AQ

All information about data protection and privacy can be found at vitality.co.uk/privacy.

G. Definitions

Acceptance letter

The letter *we* send *you* when *we* accept the application for a *plan* that names *you* as a *person covered*. This letter includes the terms of the *plan*, and any special conditions.

Activities of daily living (also referred to as tasks designed to assess whether you can look after yourself)

A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4.

Adoption

For a *single life plan*, the legal *adoption* of a *child* or *children* by the *Person Covered*.

For a *joint life plan*, the legal *adoption* of a *child* or *children* by both people covered.

Alcohol or drug abuse

Inappropriate use of alcohol or drugs, including but not limited to:

- Drinking too much alcohol
- Taking controlled drugs as defined by the Misuse of Drugs Act 1971, unless they are legally prescribed
- Taking an overdose of drugs, whether legally prescribed or not

Appropriate medical specialist

Someone who is:

- A medical consultant or equivalent at a hospital in the *United Kingdom* or any of the *permitted countries*
- A specialist appropriate to the cause of the claim
- Registered in the *United Kingdom* or any of the *Permitted countries*
- Not related by blood or *marriage* to the person or people covered
- Accepted by *our* Chief Medical Officer

Benefit

Money *we* pay to *you* if *you* make a successful claim under the *plan*.

Body system category

The category of *serious illnesses* that affect a particular body system, as outlined in the appendices.

Career break

A specific period that *you* take away from *your own occupation*, after which *you* intend to return to the same position.

Child/children

A person who:

- Has not reached the first *plan anniversary* after their 23rd birthday and
- Is *your* natural *child*, adopted *child* or *step-child* or a *child you* are the legal guardian of, and
- Is looked after by, or financially dependent on, *you*.

Childbirth

For a *single life plan*, the birth of a *child* or *children* to the *person covered*.

For a *joint life plan*, the birth of a *child* or *children* to both people covered.

Civil partnership

This applies to same sex *marriages* only, registered in terms of the Civil *Marriages* Act 2004. For a *single life plan*, a partnership between the *person covered* and another person, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

For a *joint life plan*, a partnership between the two people covered, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

Date of expiry

The date a cover ends. The *date of expiry* of each of *your* covers is shown on the *plan schedule*.

Decreasing cover

A cover amount that decreases in value over the life of the *plan*. It decreases in the same way as a repayment mortgage that has a specified equivalent interest rate. If the *plan* is *fixed term*, *you* can choose to have a *decreasing* cover.

Deferred period

The period during which an insured person must be ill or disabled before *we* will pay any *benefit* under Income Protection Cover.

Employed/employment

Paid work under a contract of *employment* and paying Class 1 National Insurance contributions.

First person covered

For a *single life plan*, this is the insured person. For a *joint life plan*, this is the *first person covered* is the first person named on the application form.

Fixed term

The term of a cover is how long the cover lasts. A *fixed term* has a defined *date of expiry*.

Functional activity tests

Specific sets of everyday physical or functional activities that help to show how able someone might be to work or look after themselves. The two kinds of tests are called *work tasks* and *activities of daily living* (sometimes *we* refer to these as *tasks designed to assess whether you can look after yourself ever again). We* may refer to these activities if *you* make a claim to do with incapacity.

Full-time occupation

An *occupation* that normally takes up at least 16 hours a week on a regular basis.

Houseperson

A person who has a *full-time occupation* maintaining the home or caring for one or more dependants.

Indexed cover

A cover amount that is designed to increase in value on each *plan anniversary*. This percentage will be equal to the *Retail Prices Index* that applies exactly five months before the *plan anniversary*, subject to a maximum of 10% and a minimum of 0%.

Insurable interest

The following conditions must be satisfied for an *insurable interest* to exist:

- The person taking out the *plan* must stand to be financially worse off if the life assured dies or becomes seriously ill (to a degree capable of valuation); and
- There must be a *legally recognised relationship* between the person taking out the *plan* and the life assured.

Irreversible

Cannot be reasonably improved by medical treatment and/or surgical procedures used by the National Health Service in the *United Kingdom* at the time of the claim.

Joint life plan

A *plan* that provides cover for two people. *We* call these two people the *first person covered* and the *second person covered*.

Joint life first death

A cover where the payment is made when the first of the *persons covered* dies or is diagnosed with a *terminal illness*.

Joint life second death

A cover where the payment is made

when the last of the *persons covered* dies or is diagnosed with a *terminal illness*.

Legally recognised relationship

A *legally recognised relationship* includes:

- An individual has an unlimited *insurable interest* in their own life;
- Legally married couples, or registered civil partners, have unlimited *insurable interest* in each other's lives;
- Employee/employer relationship provided there would be detrimental financial impact to an employer in the event that the employee dies or becomes seriously ill;
- A partner, of a partnership, has *insurable interest* in the life of a co-partner;
- Trustees accountable to pay the inheritance tax on the death of a beneficiary have an *insurable interest* in that beneficiary; and
- Creditor on the life of a debtor, however, only up to the amount of the debt.

Life-changing event

A single identifiable event or condition that causes *you* to make a claim.

Level cover

A cover that stays the same unless *you* make a successful claim or change a cover.

Marriage

For a *single life plan*, the *marriage* of the *person covered*, excluding re-*marriage* to a former spouse.

For a *joint life plan*, the *marriage* of the two people covered to each other, excluding their re-*marriage*.

Maximum monthly benefit amount

The maximum monthly benefit amount for Income Protection is £16,666 a month. There is more about this in provision B4.2.

Non-invasive

A description of malignant or cancerous cells that have not spread into surrounding healthy cells or tissue.

Optimal therapy

Therapy that is currently recommended by:

- The National Institute for Clinical Excellence
- NHS Prodigy Guidelines
- British (or European) Cardiac or Hypertension Societies

Occupation

A trade, profession or type of work undertaken for profit or pay. It is not a specific job with any particular employer and is independent of location and availability.

Own occupation

The *full-time occupation you* had immediately before the start of the illness or injury (or incapacity for the purposes of Income Protection Cover).

Percentage of cover remaining

The percentage of cover amount left after a claim is made, which will be available for future claims payments. This is applicable to Serious Illness Cover, Life with Serious Illness Cover and Child Serious Illness Cover. For more information, see provision B3.4.

Permanent/permanently

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

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout *your* 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;
- Coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

Permitted countries

Andorra, Australia, Austria, Belgium, Canada, Channel Islands, Denmark, Finland, France, Germany, Gibraltar, Greece, Isle of Man, Italy, Liechtenstein, Luxembourg, Malta, Monaco, The Netherlands, New Zealand, Norway, Portugal, Republic of Ireland, San Marino, Spain, Sweden, Switzerland, *United Kingdom* and United States of America.

Person Covered

The *first person covered* or the *second person covered* as appropriate.

Plan

The Personal Protection *plan*.

Planholder

The owner of the *plan*.

Plan anniversary

The anniversary of the *start date* of the *plan*.

Plan premium

This is the total premium payable in respect of the covers in *your plan*. This does not include any fee which *you* may be charged for Optimiser in accordance with the separate Vitality terms and conditions for the healthy living part of *your plan*.

Plan schedule

A document that shows:

- The cover or covers in the *plan*
- The amount of each cover
- The premium for each cover
- The *date of expiry* of each cover, unless the cover is *whole of life*
- Any special conditions

Pre-existing medical condition

A medical condition: where symptoms first arose, that was first suspected or diagnosed, or where any life covered received counselling or medical advice in relation to the condition before any of these dates, as appropriate:

- The *start date* of the *plan;*
- The *start date* of the relevant cover or any increases to the relevant cover;
- The relevant *child's* date of birth - only for Child Serious Illness Cover;
- The legal *adoption* of the relevant *child* - only for Child Serious Illness Cover;
- The date the *planholder* became the legal guardian of the relevant *child* - only for Child Serious Illness Cover;
- The date that the *plan* is reinstated following non-payment of *plan premiums*.

Pre-incapacity earnings

This depends on whether *you* are *employed* or *self-employed*, as explained below:

If you are employed

Your average gross monthly earnings for PAYE purposes from *your own occupation* in the 12 months before the incapacity. This includes:

- The last 12 months' payslips or the last P60 certificate.
- Salary before any tax or national insurance contributions have been taken off.
- Regular commission or bonus payments.
- Regular overtime payments.
- P11D *benefits* in kind as long as these will be lost in the event of incapacity.
- Dividend income from this *employment* as long as:
  - It is paid directly to *you* in lieu of salary
  - It ceases in the event of incapacity
  - It is consistent with the salary, and
  - The company's trading position reasonably allows *you* to receive it on a continuing basis.

If you are self-employed

Your average gross monthly taxable earnings from *your* business in the 12 months before the incapacity. *You* can take off from this figure any amounts allowable as expenses against income tax. *You* must not take off from this figure any income tax or national insurance contributions.

*(Please note that if *you* make a claim for Income Protection Cover and *you* have not verified *your* earnings *we* will require *your* last 12 months' payslips or *your* most recent P60 certificate as evidenceof *your* income.)

When *you* work out *your pre-incapacity earnings*, do not include any of these:

- Income from savings
- Income from rental of property or goods
- Dividends which are not included in the box above

Income from furlough schemes or Self Employment Income Support Schemes (SEISS) or any other payment in lieu of income.

Pre-malignant

A description of abnormal or cancerous cells that might develop into a malignant tumour but have not yet done so.

Progressive claim

A second claim that happens in the following way:

1. A *person covered* has a *life-changing event* that causes a *serious illness*;
2. They make a first successful claim for that *serious illness;*
3. They later make a second claim which is for the same *serious illness* or another *serious illness* that was caused by the same *life-changing event*.

Promotion or change in job leading to a salary increase

An increase in basic salary as a direct result of one of these single events:

- A promotion with the same employer leading to a salary increase of at least 10%;
- The award of a recognised professional qualification;
- A change of both *employment* and employer.

Resident of the United Kingdom

A person who legally lives in the *United Kingdom* for at least 183 days in any 365 day period.

Residual deficit

Persisting loss or incapacity that is expected to last throughout *your* life.

Retail Prices Index

The measure of *UK* inflation known as the *Retail Prices Index* (all items), as published by the Office for National Statistics. If the *UK* Government

replaces that index with another index of *UK* retail price increases, *we* shall use that replacement index or an appropriate index.

Second person covered

If two people are insured on a *plan*, this is the insured person who is not the *first person covered*. This person cannot be a *child*.

Self-employed

- Actively working alone, with others in a partnership, or as a member of a limited liability partnership
- Paying Class 2 National Insurance contributions
- Assessable for income tax under Schedule D Case I or II

Serious illness

An illness or condition that:

- Is defined in Appendix 1
- Meets *our* criteria for that illness or condition

The *serious illnesses* are divided into *body system categories*. These categories are set out in Appendix 1.

Simultaneous claims

Two or more *serious illness* claims that meet all of the following criteria:

- They are being made by more than one *person covered* or *child* under a *plan*
- They are a result of the same *life-changing event*
- They are within three calendar months of that *life-changing event*

Single life plan

A *plan* that provides cover for one person only, referred to in this *plan* as the *person covered*. This does not include any cover provided for *children*.

Start date

The date when cover under the whole *plan* begins or, where relevant, when a particular cover begins.

Suicide

An event where, in *our* reasonable opinion, the life insured took their own life voluntarily and intentionally or through intentional self-inflicted injury.

Tasks designed to assess whether you can look after yourself ever again

A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4. *We* also call these *activities of daily living*.

Terminal illness - where death is expected within 12 months

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

- The illness either has no known cure or has progressed to the point

where it cannot be cured;

- In the opinion of the attending Consultant, the illness is expected to lead to death within 12 months.

Underwrite/underwriting/underwritten

The process *we* use to assess *your* application to include or change a cover. *Underwriting* may lead *us* to:

- Accept *your* application
- Reject *your* application
- Amend one or more terms

Unemployed/unemployment

Ceasing to follow *your own occupation* for more than one month, and not following any other *occupation*.

United Kingdom/UK

The *United Kingdom* of Great Britain and Northern Ireland. This excludes the Channel Islands and the Isle of Man.

Unrelated claim

A second claim that happens in the following way:

1. A *person covered* has a *life-changing event* that causes a *serious illness*
2. They make a first claim for that *serious illness*
3. They later make a second claim for another *serious illness* that was caused by a different lifechanging event

Verified Earnings

A figure for *your* earnings that *we* verify when *you* make *your* application for Income Protection Cover or, where appropriate, for an increase to this cover. *You* may need to provide *us* with evidence of these earnings. There is more information about this in provision B3.2.

Vitality Benefits

Vitality Benefits are the additional *benefits* provided to *you* under the *Vitality Programme*. They are either *Vitality Plus* or *Vitality Select*.

Vitality Select

Vitality Select is automatically included on *your plan* and provides the opportunity to earn additional points and a number of rewards when *you* look after *your* health. *Vitality Select* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

Vitality Plus

Vitality Plus provides the opportunity to earn additional points and rewards when *you* look after *your* health. *Vitality Plus* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

Vitality programme

The discounts and rewards available to all adults on the *plan*. These are provided by Vitality Corporate Services Limited. Please refer to the separate terms and conditions for more information.

Vitality Status

Your Vitality Status is a measure of how much *you*'ve done to look after *your* health. There are four statuses: Bronze, Silver, Gold and Platinum. *We* work out *your Vitality Status* using the activities *you*'ve recorded between each *plan anniversary* - the harder *you* work, the higher *your* status.

We/us/our

Vitality Life Limited.

Whole of life

The term of a cover that lasts from the cover's *start date* to the death of the insured person for *joint life first death* or the death of both *persons covered* for *joint life second death*.

Work tasks

A specific set of everyday physical or functional activities that help to show how able someone is to work. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4.

You/your

The person named on the *plan schedule* as the *person covered*. For a *joint life plan*, either or both people covered, as appropriate.

Appendix 1

Illnesses and Conditions – Definitions for Serious Illness Cover and Life with Serious Illness Cover (see provision B2 and provision B3).

This *plan* follows the ABI Guide to Minimum Standards for Critical Illness Cover (2018). All model illness definitions are included and the amount *we* pay *you* ranges from 25% to 100% depending upon their severity. However, some conditions at a lower level of severity may qualify for an increased payment if, or when, their severity increases.

For example cancer is included at a minimum severity of 25%, although higher staged tumours may qualify for an increased payment. The ABI model wording has been used however for the purpose of this *plan we* also provide cover for low grade prostate cancers that have a Gleason score of between 2 and 6 inclusive or a TNM classification of T1N0M0.

The full definitions of the illnesses covered and the circumstances in which *you* can claim are given in this Appendix. These definitions typically use medical terms to describe the illnesses and severities and how they are measured. In some cases the cover may be limited, for example some types of cancer are not covered and to make a claim for some illnesses, *you* need to have *permanent* symptoms.

1.A Cancer category – specified conditions of defined severity

1. Definitions

Advanced Cancer

An advanced malignant tumour that has progressed to at least Group Stage II of the TNM Classification of Malignant Tumours as described in the 7th edition of the International Union against Cancer (pub.Wiley-Liss). For the above definition the following are not covered:

- Stage II non-melanoma skin cancer

Advanced Chronic Lymphocytic Leukaemia

For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood. Chronic Lymphocytic Leukaemia is covered when it has progressed to Binet Stage C.

Advanced Hodgkin's Disease

This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver characterised by Reed-Sternberg cells in the abnormal lymph tissue. The staging must have progressed to at least Stage II of the Ann-Arbor system.

Advanced Non-Hodgkin's Lymphoma

This is an advanced malignant condition of the reticuloendothelial system, which includes the lymph nodes, spleen and liver. The staging must have progressed to at least Stage II of the Ann-Arbor system.

Borderline Ovarian Cancer

A diagnosis of an ovarian tumour of borderline malignancy or low malignant potential which has been positively diagnosed with histological confirmation, resulting in surgical removal of an ovary.

For the above definition, the loss of an ovary due to a cyst is excluded.

Cancer – excluding less advanced cases

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

The term malignant tumour includes leukaemia, sarcoma, Merkel Cell Carcinoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
  - *Pre-malignant*
  - *Non-invasive*
  - Cancer in situ
  - Having borderline malignancy
  - Having low malignant potential
- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification T2N0M0
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin)

Carcinoma in-situ

Any *pre-malignant, non-invasive* cell growth positively diagnosed and histologically confirmed as carcinoma in situ.

For the above definition, the following are not covered:

- Any dysplasia, hyperplasia, metaplasia, intraepithelial neoplasia or low grade squamous intraepithelial lesions not histologically classified as carcinoma in situ
- Polycystic dysplasia or disease
- Polyps at any site not histologically classified as carcinoma in situ
- *Non-invasive* papillary bladder carcinoma, TA bladder carcinoma
- Basal cell and squamous cell carcinoma of the skin

Carcinoma in-situ – treated with surgery to remove the tumour

Diagnosis of Carcinoma in-situ, Gastrointestinal Stromal Tumour or Neuroendocrine Tumour with histological confirmation and characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of organs and that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

- Any dysplasia, hyperplasia, metaplasia, intraepithelial neoplasia or low grade squamous intraepithelial lesions not histologically classified as carcinoma in-situ
- Polycystic dysplasia or disease
- Polyps at any site not histologically classified as carcinoma in-situ
- For cervical carcinoma in-situ - loop excision, laser surgery, conisation and cryosurgery are not covered
- For carcinoma in-situ of the colon or rectum – local excision and polypectomy are not covered
- *Non-invasive* papillary bladder carcinoma, TA bladder carcinoma
- Basal cell and squamous cell carcinoma of the skin
- Tumours treated with only radiotherapy, laser therapy, cryotherapy or diathermy treatment
- Procedures that are solely for diagnostic purposes.

Carcinoma in-situ of the Oesophagus requiring surgery

A definite diagnosis, which has been supported by histological evidence, of carcinoma in-situ of the oesophagus which has been treated with surgery to remove the tumour.

For the above definition the following are excluded:

- Barrett's Oesophagus

Desmoid-type fibromatosis – with specified treatment

A positive diagnosis with histological confirmation of non-malignant aggressive fibromatosis by a hospital consultant resulting in either:

- Surgical removal;
- Radiotherapy; or
- Chemotherapy.

Low Grade Prostate Cancer

Low-Grade Prostate Cancer means any malignant tumour of the prostate characterised by uncontrolled growth and spread of malignant cells and invasion of tissue which is histologically classified as having a Gleason score of between 2 and 6 inclusive or having progressed to a TNM classification of T1N0M0.

Lumpectomy for Carcinoma in-situ of the Breast

The undergoing of a lumpectomy, cystectomy or partial mastectomy for the removal of a tumour in one breast which has been histologically classified as Carcinoma in-situ.

Moderately Severe Aplastic Anaemia

There must be bone marrow cellularity less than 30% plus 2 of the following present for a minimum of six months:

- Neutrophils less than 1 x 10^9/L
- Platelets less than 50 x 10^9/L
- Reticulocytes less than 20 x 10^9/L

Mastectomy for Carcinoma in-situ of the Breast

Total removal of all the tissue of one breast for the treatment of carcinoma in-situ in the removed breast. Prophylactic mastectomy without histological evidence of cancer in-situ is not covered. *We* only cover mastectomy, any other surgical procedures such as lumpectomy and partial mastectomy are also excluded.

Multiple Myeloma

A malignant proliferation of plasma cells in the bone marrow with destruction of surrounding tissue on bone marrow examination. It must also cause a high level of abnormal proteins in the blood called paraproteinaemia demonstrated on protein electrophoresis. Monoclonal gammopathy of unknown significance will be excluded.

Myelodysplasia

Myelodysplasia is a clonal disorder of at least one cell line of the bone marrow causing insufficient number of normal blood cells.

Non-Melanoma Skin Cancer – of specified severity

The presence of one or more of any of the following malignant skin lesions;

- Basal cell carcinoma as determined by histological examination that is greater than 5cm in diameter requiring either Mohs' micrographic surgery or standard excision
- Squamous cell carcinoma as determined by histological examination that is greater than 2cm in diameter
- Non-melanoma skin cancer that is larger than 2 centimetres (cm) across and has at least one of the following features:
  - tumour thickness of at least 4 millimetres (mm);
  - invasion into subcutaneous tissue (Clark level V);
  - invasion into nerves in the skin (perineural invasion);
  - poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope); or
  - has recurred at the site of previous treatment.

For the above definition, the following are not covered:

- Gorlin's Syndrome
- Skin Cancers secondary to Xeroderma Pigmentosa
- Skin Cancers secondary to Albinism
- Bowen's Disease

Severe Aplastic Anaemia

There must be bone marrow cellularity less than 25% plus two of the following present for a minimum of three months:

- Neutrophils less than 0.5 x 10^9/L
- Platelets less than 20 x 10^9/L
- Reticulocytes less than 20 x 10^9/L

2. Severity levels

How is severity measured?

The severity level determines the payment(s) *we* make. The severity of cancer is measured by staging at diagnosis, so the higher the stage at diagnosis the higher the initial *benefit*. If a cancer progresses, *we* will assess the progression of the cancer using the same staging criteria as will be used at diagnosis.

For example, if *you* are diagnosed with stage 1 breast cancer, this is stage 1 disease at diagnosis. If this metastasises (spreads, or invades different organs or parts of the body) *we* will reclassify the staging, even if *your* medical records still state 'stage 1 but with metastases to the bones'. In this example *we* will reclassify the claim as stage 4. Please tell *us* if *you* believe that the cancer has spread to other organs or parts of the body, *we* will then liaise with *your* Oncologist and/or other specialist.

For the purpose of this *plan we* will assess the staging of cancer using The International Union against Cancer TNM Classification of Malignant Tumours 7th edition (Pub.Wiley-Liss). *We* will use the group stages 1–4 as defined within this reference book to allocate the severities.

Leukaemia:

The severity of Chronic Lymphocytic is measured by the Binet classification which covers stages A to C.

Hodgkin's Disease and Non-Hodgkin's Lymphomas:

The severity is measured by staging and uses the Ann-Arbor system which covers stages I to IV.

Myelodysplasia:

The severity is assessed using the International Scoring System for Prognosis in Evaluating Myelodysplasia syndromes as published by Greenberg et al, in the Journal 'Blood' 1997: 6; p 2079-2088. The prognostic score and details must be provided by the Consultant Haematologist supervising the monitoring or treatment of the patient. If no prognostic score is available *our* Chief Medical Officer will assess the most likely severity in conjunction with the Haematologist monitoring the patient.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Acute Lymphoblastic Leukaemia
- Acute Myeloid Leukaemia
- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified Ann-Arbor Stage III or above
- Chronic Myeloid Leukaemia
- Multiple Myeloma
- Severe Aplastic Anaemia

Severity Level C:

- Advanced cancer classified as a TNM Group Stage II tumour
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage II
- Advanced Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage II
- Myelodysplasia classified as Intermediate 1 under the International Prognostic Scoring System

Severity Level D:

- Cancer - excluding less advanced cases
- Carcinoma in-situ of the Oesophagus requiring surgery
- Low-Grade Prostate Cancer
- Lumpectomy for Carcinoma in-situ of the Breast
- Moderately Severe Aplastic Anaemia
- Mastectomy for Carcinoma in-situ of the Breast

Severity Level E:

- Borderline Ovarian Cancer
- Carcinoma in-situ – treated with surgery to remove the tumour
- Desmoid-type fibromatosis – with specified treatment
- Myelodysplasia classified as Low risk on the International Prognostic Scoring System

Severity Level G:

- Carcinoma in Situ
- Non-Melanoma Skin Cancer – of specified severity

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Confirmation of the diagnosis by an *appropriate medical specialist* and copies of the specialist and hospital reports
- Relevant CT/MRI scans, histological evidence and Full Blood Count results where appropriate

4. Specific exclusions

- All tumours which are histologically described as *pre-malignant*, as *non-invasive* or cancer in situ (other than those stated as covered in this document and *your plan schedule*)
- Cervical, vaginal, vulval or prostatic intraepithelial neoplasia (dysplasia) with histology showing CIN-1, CIN-2, VAIN-1, VAIN-2, VIN-1, VIN-2, PIN-1 or PIN-2
- Lesions where there has been no invasion of tissue including, but not limited to, papillary micro-carcinoma of the thyroid or papillary cancer of the bladder histologically described as TisN0M0,TaN0M0 or of lesser classification (other than those stated as covered in this document and *your plan schedule)*
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this illness category, or not meeting the stated minimum required severity

- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.B Heart and Artery category – specified conditions of defined severity

1. Definitions

Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty)

PTCA or other percutaneous coronary artery procedures performed by a Consultant Cardiologist to dilate and treat a coronary artery stenosis. The procedure may or may not involve the use of a stent.

Angioplasty to correct Carotid Artery Stenosis

Therapeutic angioplasty with or without stent to correct symptomatic stenosis of the carotid artery.

Any Cardiac Condition resulting in a Reduced Ejection Fraction

Any cardiac condition causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

Aorta Graft Surgery

The undergoing of, or inclusion on the NHS waiting list for, surgery for disease or traumatic injury to the aorta with excision and surgical replacement of a portion of the diseased or injured aorta with a graft.

The term aorta includes the thoracic and abdominal aorta but not its branches. For the above definition, the following are not covered:

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

Balloon Valvuloplasty

The dilation of a stenotic valve of the heart by percutaneous balloon procedure performed by a Consultant Cardiologist.

By-pass Graft Surgery to 3 or more Coronary Arteries

The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage to three or more coronary arteries with by-pass grafts.

Cardiomyopathy resulting in a Reduced Ejection Fraction

A disease of the heart muscle causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

Cardioversion for Cardiac Arrhythmia

The intentional therapeutic medically supervised application of an electrical shock, using at least 40 joules, to correct a documented and recorded arrhythmia of the heart.

Congestive Heart Failure

The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and *optimal therapy* must have been established for at least 6 months. There must be at least 4 signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound
- Jugular venous pressure above 6 cms
- Rales present in both bases on auscultation
- Cardiomegaly on chest x-ray
- Grade 3, or gross ascites, associated with marked abdominal distension
- Severe oedema to a level above the knee

Coronary Angioplasty – with specified treatment

Percutaneous coronary intervention (PCI) to correct narrowing or blockages of the left main stem artery, or two or more main coronary arteries. Multiple vessels must be treated at the same time or as part of a planned stage procedure within 60 days of the first PCI.

The main coronary arteries for this purpose are defined as right coronary artery, left anterior descending artery, circumflex artery, or their branches.

PCI is defined as any therapeutic intra-arterial catheter procedure including balloon angioplasty and/or stenting.

The following are not covered:

- Diagnostic angioplasty
- Two angioplasty procedures to a single main artery or branches of the same artery.

Coronary Artery By-pass Grafts

The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation

Documented Ventricular Tachycardia or Ventricular Fibrillation requiring admission to hospital for the treatment of intra-venous antiarrhythmic therapy.

Endovascular Repair of Aortic Aneurysm

The repair through endovascular methods of an aortic aneurysm with the replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

Femoral Artery Aneurysm Repair

The undergoing of, or inclusion on the NHS waiting list for, surgical repair of an aneurysm of the femoral artery by surgery or by endovascular techniques.

Heart Attack

Death of heart muscle, due to inadequate blood supply that has resulted in the following:

- Definite Diagnosis of an acute Myocardial Infarction by a Consultant Cardiologist, which is supported by current medical reports, tests and investigations, as defined by the recognised international standard* prevailing at the time of claim.

For the above definition, the following are not covered:

- Other acute coronary syndromes
- Angina without myocardial infarction
- Myocardial Infarctions that meet the international standard that occurred before cover commenced

*(International standard defined by the European Society of Cardiology or the universal standard definition of Myocardial Infarction.)

Heart Valve Replacement or Repair

The undergoing of, or inclusion on the NHS waiting list for, surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

Heart Attack resulting in a Reduced Ejection Fraction

A heart attack causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 45% or less. The measurement must be performed at least one month after an acute heart attack. The heart attack must have been diagnosed according to the criteria stated under the Heart Attack definition in provision 1 b) 1 above for a claim to be considered.

Hypertrophic Cardiomyopathy - of specified severity

A disease of the heart muscle which results in thickening and enlargement of the interventricular septum or any myocardial segment. There must be a maximal LV wall thickness of at least 15mm in any myocardial segment confirmed via cardiac imaging and the diagnosis of hypertrophic cardiomyopathy must be confirmed by a consultant cardiologist.

For the above definition the following are not covered:

- Cardiomyopathy secondary to *alcohol or drug abuse*

Iliac Artery Aneurysm Repair

The undergoing of, or inclusion on the NHS waiting list for, surgical repair of an aneurysm of the iliac artery by surgery or by endovascular techniques.

Infective Endocarditis

Endocarditis is the infection on the valves of the heart with vegetations (clumps of small clot and bacteria) visible on the echocardiogram.

There must be echocardiographic evidence of vegetation on the valves of the heart, and blood cultures must show bacterial growth in at least two samples taken at the same time. Endocarditis as a result of drug misuse is not covered.

Keyhole Coronary Artery Bypass Surgery

The undergoing of, or inclusion on the NHS waiting list for, surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts via a thorascope or mini thoracotomy.

Pericardectomy

The undergoing of, or inclusion on the NHS waiting list for, the surgical excision of part of the pericardium surrounding the heart via thoracotomy or sternotomy to relieve a constriction of the heart. Biopsy and aspiration of pericardial effusion is excluded.

Permanent Defibrillator Insertion

The undergoing of, or inclusion on the NHS waiting list for, the *permanent* insertion of an automatic implantable defibrillator after the occurrence of ventricular tachycardia or ventricular fibrillation.

Permanent Defibrillator Insertion due to Cardiac Arrest

The *permanent* insertion of an automatic implantable defibrillator as a result of a cardiac arrest.

Permanent Pacemaker Insertion

The undergoing of, or inclusion on the NHS waiting list for, the *permanent* insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to *us*.

Severe Peripheral Vascular Disease

A definite diagnosis of peripheral vascular disease by a consultant cardiologist or vascular surgeon with objective evidence from imaging of obstruction in the arteries requiring, or being included on the NHS waiting list for, bypass graft surgery to an artery of the legs.

The following is not covered:

- Angioplasty

Severe Vascular Disease affecting Multiple Systems

Severe vascular disease affecting the heart, kidney and/or brain. There must be at least 2 of the following:

- Stroke*
- Left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3
- Renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/lGrade 4 retinopathy

combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase greater than 110mmHg on *optimal therapy*.

*For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be *residual deficit* with a Modified Rankin Scale of 2 or above.

Surgery for Cardiac Arrhythmia

The surgical or endovascular division or ablation of abnormal conduction pathways to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to *us*.

Surgery to correct Carotid Artery Stenosis

Therapeutic correction by open surgical techniques with endarterectomy or bypass of symptomatic stenosis of the carotid artery.

For the above definition the following are excluded:

- Surgery using intravascular techniques

Surgical repair of an Atrial or Ventricular Septal Defect

The undergoing of, or inclusion on the NHS waiting list for, the surgical closure of a defect in the interatrial or interventricular septum. This can be performed through a thoracotomy or by using endovascular techniques.

Surgical repair of a Structural Abnormality of the Heart

The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to repair a structural abnormality of the heart.

2. Severity levels

How is severity measured?

Reduction in ejection fraction:

The ejection fraction is a measure of the efficiency of the pumping action of the heart; in a healthy heart this is typically greater than 50%. Damage to the muscle of the heart (myocardium) such as that sustained during myocardial infarction or cardiomyopathy, impairs the heart's ability to eject blood and therefore reduces ejection fraction. Where a severity is measured by the *permanent* reduction in ejection fraction it is measured by the percentage of the contents of the left ventricle that is expelled in each contraction of the ventricle. This can be measured by echocardiography or through radioisotope measurements. It must be measured in a cardiac laboratory, which has regular quality control audits available to *us*, and be supervised by a Consultant Cardiologist.

The disease or disorder causing the reduction in ejection fraction must be established as being *permanent* and *irreversible* and the measurement must be taken whilst the patient is on optimal treatment.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Cardiomyopathy resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25 mm
- Heart attack resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- Any other cardiac condition resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- At least 4 signs of congestive heart failure on *optimal therapy* for at least 6 months
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 110mmHg on *optimal therapy*
- Severe peripheral vascular disease

Severity Level B:

- Cardiomyopathy resulting in a *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of between 15mm and 25mm
- Heart attack resulting in a *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy**
- Any other cardiac condition resulting in a *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy**
- Aorta Graft Surgery
- By-pass Graft Surgery to three or more Coronary Arteries

*See 'How is severity measured?' (above) for details as to how a reduction in ejection fraction is measured.

Severity Level C:

- Coronary Artery By-pass Grafts
- Heart Attack

Severity Level D:

- Surgical Repair of a Structural Abnormality of the Heart
- Heart Valve Replacement or Repair
- Endovascular Repair of an Aortic Aneurysm
- *Permanent* Defibrillator Insertion due to Cardiac Arrest

Severity Level E:

- Coronary Angioplasty – with specified treatment
- Iliac Artery Aneurysm Repair
- Femoral Artery Aneurysm Repair
- Keyhole Coronary Artery Bypass Surgery
- Balloon Valvuloplasty
- Pericardectomy
- Surgery to correct Carotid Artery Stenosis

Severity Level F:

- Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty) with or without stent
- Angioplasty to correct Carotid Artery Stenosis
- *Permanent* Pacemaker Insertion
- *Permanent* Defibrillator Insertion
- Surgery for Cardiac Arrhythmia
- Infective Endocarditis
- Surgical Repair of an Atrial or Ventricular Septal Defect
- Cardioversion for Cardiac Arrhythmia
- Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- History of signs and symptoms compatible with the condition claimed
- Full cardiologist's, cardiothoracic, neurosurgeon or vascular surgeon's assessment and operation notes
- Relevant electrocardiographs, angiograms, aortograms, thallium scans, echocardiograms, X-rays, CT scans or any other relevant test results and reports
- Cardiac enzyme results for heart attacks. Raised serum CKMB fraction or positive Troponin-T or I, if performed. Raised creatine kinase and LDH alone are not considered.

4. Specific exclusions

- Any acute coronary syndromes which do not completely satisfy any of the definitions listed in the Definitions section of this illness category including, but not limited to, angina
- Alcoholic Cardiomyopathy
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Any second claim at any time under any of the Severity Level F procedures listed in provision 1 b) 2 above
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.C Stroke and Nervous System category- specified conditions of defined severity

1. Definitions

Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of previous or current symptoms (these symptoms do not need to be *permanent*).

For the above definition, the following are not covered:

- Other types of dementia.

Alzheimer's Disease - resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

For the above definition, the following are not covered:

- Other types of dementia

Bacterial Meningitis

Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis. All other forms of meningitis, including viral, are not covered.

Bacterial Meningitis – resulting in permanent symptoms

Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis resulting in *permanent neurological deficit with persisting clinical symptoms*. All other forms of meningitis, including viral, are not covered.

Bilateral Hemianopia

Permanent and *irreversible* loss of vision in one half of the visual field of both eyes.

Brain and Spinal tumours

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull or spinal cord.

For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angioma and cholesteatoma

Brain and Spinal tumours – of specified severity

A non-malignant tumour or cyst originating from the brain, cranial nerves, meninges within the skull or spinal cord resulting in *permanent neurological deficit with persisting clinical symptoms*, or the undergoing of, or inclusion on the NHS waiting list for, surgical removal.

For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angioma and cholesteatoma

Brain Injury due to anoxia or hypoxia

Death of brain tissue due to reduced oxygen supply (anoxia or hypoxia) resulting in *permanent neurological deficit with persisting clinical symptoms.*

Coma

A state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems.

The following is not covered:

- Coma secondary to *alcohol or drug abuse*

Craniotomy

Any surgical treatment of brain tissue via craniotomy by a Consultant Neurosurgeon for any of the following:

- Intracranial infections
- Subdural, Intracerebral and Epidural Haematomas or Subarachnoid bleeds
- Traumatic Brain Injury

For the above definition, the following are not covered:

- Burr Holes procedures
- Insertion of deep brain stimulators

Craniotomy to treat a Cerebral Arteriovenous Malformation

The undergoing of, or inclusion on the NHS waiting list for, surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or aneurysm.

Creutzfeldt-Jakob Disease

A definite diagnosis of Creutzfeldt-Jakob Disease by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

This must have been reported the National CJD Monitoring Unit as a confirmed case.

Creutzfeldt-Jakob Disease - resulting in permanent symptoms

A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist, Psychiatrist or Geriatrician. This must have been reported to the National CJD Monitoring Unit as a confirmed case. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Dementia

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Dementia - resulting in permanent symptoms

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Devic's Disease (Neuromyolitis Optica)

A definite diagnosis of Devic's disease by a Consultant Neurologist resulting in current symptoms.

Drainage of Brain Abscess by Craniotomy

The surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

Encephalitis

A definite diagnosis of Encephalitis by a Consultant Neurologist with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Encephalitis – resulting in permanent symptoms

A definite diagnosis of Encephalitis by a Consultant Neurologist, resulting in *permanent neurological deficit with persisting clinical symptoms.*

Endovascular Treatment of a Cerebral Arteriovenous Malformation

The undergoing of, or inclusion on the NHS waiting list for, endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or aneurysm.

Functional Surgery for Movement Disorders

Undergoing of surgery, in the form of deep brain stimulation, to treat tremor, parkinsonism, dyskinesia, or dystonia.

Guillain-Barré Syndrome - of specified severity

A definite diagnosis of Guillain-Barré Syndrome by a Neurologist, confirmed by electromyography and lumbar puncture. There must be evidence of continual and *permanent* weakness or numbness being present for a minimum period at least 2 years, which is supported by appropriate neurological evidence. The *residual deficit* must measure at least 3 on the Modified Rankin Scale.

Guillain-Barré Syndrome

A definite diagnosis of Guillain-Barré Syndrome by a Neurologist, confirmed by electromyography and lumbar puncture. There must be evidence of continual and *permanent* weakness or numbness being present for a minimum period of at least 6 months, which is supported by appropriate neurological evidence.

Loss of Manual Dexterity to age 75

Total and *irreversible* loss of the ability to use the hands and fingers with precision to perform daily activities of work such as picking up or manipulating small objects, operating a range of equipment manually or communicating through writing or typing. The disability must be *permanent* and supported by appropriate neurological evidence.

Loss of Muscle Power resulting in the inability to grip to age 75

Total and *irreversible* loss of all muscle power in both hands resulting in the inability to grip any tool, utensil or assistive device. The disability must be *permanent* and supported by appropriate neurological evidence.

Loss of Speech

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

Motor Neurone Disease

A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Kennedy's disease, also known as spinal and bulbar muscular atrophy (SBMA)
- Spinal muscular atrophy (SMA)

There must also be evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Multiple Sclerosis

A definite diagnosis of multiple sclerosis by a Consultant Neurologist with evidence of previous or current symptoms (even if these are not *permanent*).

Muscular Dystrophy

The definite diagnosis of Muscular Dystrophy by a Consultant Neurologist which must be supported by typical changes on muscle biopsy.

Myasthenia Gravis

A definite diagnosis of myasthenia gravis by a consultant neurologist. There must have been clinical impairment of motor function in parts of the body other than the eye muscles caused by myasthenia gravis.

For the above definition, the following is not covered:

- myasthenia gravis limited to eye muscles only.

Neurological Diseases

For the purpose of this *plan* this includes any *permanent irreversible* disease affecting the basal ganglia, cerebellum, neurones, horn cells or myelin sheaths that produce identifiable *permanent* neurological deficit. If the disease, disability or symptom is not defined as a named condition in this provision 1 c) 1, *benefits* will be paid only when there is an inability to perform the *functional activity tests* see provision D5.4. *Alcohol or drug abuse* is excluded.

Paralysis of a limb

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

Paralysis of limbs

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

Parkinson's Disease

A definite diagnosis of Parkinson's disease by a Consultant Neurologist with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist.

There must be *permanent* clinical impairment of motor function with associated tremor and muscle rigidity.

For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Parkinson's plus syndromes

A definite diagnosis of one of the following Parkinson-plus syndromes by a consultant neurologist:

- Multiple system atrophy
- Parkinsonism-Dementia-ALS complex
- Lewy body disease
- Corticobasal degeneration

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

- Motor function; or
- Eye movement disorder; or
- Postural instability; or
- Dementia.

For the above definition, the following are not covered:

- Other Parkinsonian syndromes
- Parkinsonism.

Persistent Vegetative State to age 75

A severe neurological condition of decreased consciousness where there must be all of the following:

- The loss of an awareness of surroundings
- The lack of speech
- The lack of response to commands
- The lack of any purposeful movements

This condition must be *permanent* and supported by appropriate neurological evidence.

Progressive Supra-nuclear Palsy

Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supra-nuclear Palsy with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Progressive Supra-nuclear Palsy – resulting in permanent symptoms

Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supranuclear Palsy. There must be *permanent* clinical impairment of motor function.

Shunt Insertion for Hydrocephalus

Surgical insertion of a *permanent* drainage shunt for the treatment of hydrocephalus. There must be enlargement of the ventricles which has been confirmed by a radiologist.

Spinal aneurysm or arteriovenous malformation

The undergoing of surgical resection, wrapping, clipping or embolisation of a spinal aneurysm or arteriovenous malformation.

Spinal Stroke

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in *permanent neurological deficit with persisting clinical symptoms*.

Stereotactic Brain Surgery

The undergoing of, or inclusion on the NHS waiting list for, the stereotactic surgery to the brain performed by a Consultant Neurosurgeon for neurological disease. Biopsy of brain tissue is specifically excluded.

Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting clinical symptoms lasting for at least 24 hours. For the above definition, the following are not covered:

- Transient ischaemic attack

- Death of tissue of the optic nerve or retina / eye stroke

Surgery for Drug Resistant Epilepsy

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

Surgical Repair of Depressed Skull Fracture

Undergoing surgery to correct a depression in the skull as a result of an accidental traumatic fracture or break in the cranial bone.

Syringomyelia or syringobulbia

The undergoing of, or inclusion on the NHS waiting list for, surgery to treat a syrinx in the spinal cord or brain stem.

Traumatic Brain Injury - with clinical symptoms

Death of brain tissue due to traumatic injury resulting in clinical symptoms that have persisted for a continuous period of at least 2 weeks (these symptoms do not need to be *permanent*).

For the above definition the following is not covered:

- Traumatic Brain injury secondary to *alcohol or drug abuse*

Traumatic Brain Injury – resulting in permanent symptoms

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

2. Severity levels

How is severity measured?

Modified Rankin Scale:

Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

Functional Activity Tests (FATs):

For neurological diseases (including those not specifically stated under this *benefit*) *we* will pay a *benefit* if *you* become *permanent* unable to perform certain *functional activity tests* due to the disease.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- A Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform four out of six *functional activity tests*. See provision D5.4.
- Loss of Speech
- Paralysis of limbs
- Loss of Manual Dexterity
- Loss of muscle power resulting in the inability to grip

- Persistent Vegetative State

Severity Level B:

- A Stroke with a *residual deficit* measuring at least 3 on the Modified Rankin Scale
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform three out of six *functional activity tests*. See provision D5.4.
- Bilateral Hemianopia
- Guillain-Barré Syndrome - of specified severity
- Paralysis of a limb

Severity Level C:

- A Stroke with a *residual deficit* measuring at least 2 on the Modified Rankin Scale
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform two out of six *functional activity tests*. See provision D5.4
- Surgery for Drug Resistant Epilepsy

Severity Level D:

- Alzheimer's disease – resulting in *permanent* symptoms*
- Bacterial Meningitis – resulting in *permanent* symptoms
- Brain and Spinal tumours - of specified severity
- Brain Injury due to anoxia or hypoxia
- Coma*
- Craniotomy
- Craniotomy to treat a Cerebral Arteriovenous Malformation
- Creutzfeldt-Jakob Disease – resulting in *permanent* symptoms*
- Devic's Disease (Neuromyolitis Optica)
- Dementia – resulting in *permanent* symptoms*
- Drainage of Brain Abscess by Craniotomy
- Encephalitis - resulting in *permanent* symptoms*
- Functional Surgery for Movement Disorders
- Motor Neurone Disease*
- Multiple Sclerosis*
- Muscular Dystrophy*
- Parkinson's Disease – resulting in *permanent* symptoms*
- Parkinson's plus syndromes*
- Progressive Supra-nuclear Palsy – resulting in *permanent* symptoms*
- Shunt Insertion for Hydrocephalus (restricted to one payment only)
- Spinal Stroke
- Stroke*
- Syringomyelia or syringobulbia
- Traumatic Brain injury* - resulting in *permanent* symptoms

*these conditions can be continually re-assessed as they progress in severity by use of the Modified Rankin Scale or *functional activity tests* (FATs) as described in 'How is severity measured' above. Please also refer to provision B2.7.

Severity Level E:

- Endovascular treatment of a Cerebral Arteriovenous Malformation
- Guillain-Barré Syndrome
- Myasthenia Gravis
- Spinal aneurysm or arteriovenous malformation
- Surgical Repair of Depressed Skull Fracture

Severity Level F:

- Alzheimer's Disease
- Bacterial Meningitis
- Brain and Spinal tumours
- Creutzfeldt-Jakob Disease
- Dementia
- Encephalitis
- Parkinson's Disease
- Progressive Supra-nuclear Palsy
- Stereotactic Brain Surgery
- Traumatic Brain Injury - with clinical symptoms

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results
- Diagnosis made by an *appropriate medical specialist*
- Loss of neurological function compatible with area of damage of the brain involved

4. Specific exclusions

- Any condition stated in 1c) above where the required permanence has not been established before the cover terminates or at age 75 where stated, if sooner
- Chronic Fatigue Syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free Disease.
- Pituitary tumours – specified treatments are covered within the Endocrine *benefit*
- Transient Ischaemic Attacks
- Benign intracranial hypertension
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.D Gastrointestinal category – specified conditions of defined severity

1. Definitions

Bowel Ischaemia requiring surgery

Death of intestinal tissue as a result of impaired blood supply caused by one of the following conditions;

- Acute mesenteric ischaemia
- Chronic mesenteric ischaemia
- Ischaemic colitis

Chronic Inflammatory Hepatitis

An inflammation of the liver which has been present for at least one year. The liver function tests including liver enzymes called transaminases must be elevated to at least three times normal laboratory range throughout this period. Causes of this condition can include chronic Hepatitis B or C or Autoimmune Disease.

There must be all of the following on a liver biopsy:

- Moderate plate necrosis or severe focal cell necrosis on liver biopsy
- Periportal or septal fibrosis on liver biopsy.

Or extensive liver fibrosis as measured by a non-invasive liver scan, namely a transient elastography or FibroScan, with a measurement of 20 kPa or higher that is expected to persist for longer than six months.

Chronic Pancreatitis

Chronic Inflammation of the pancreas with calcification throughout the body and tail of the gland. There must also be all of the following:

- Proof of calcification on CT scan
- Evidence of failure of secretion of pancreatic enzymes
- Evidence of chronic inflammation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP)

Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy or advanced liver fibrosis as measured by a non-invasive liver scan, namely a transient elastography or FibroScan, with a measurement of 27 kPa or higher that is expected to persist for longer than six months.

Fulminant Hepatic Necrosis

Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

Loss of the use of more than one third of the tongue

Loss of the use of more than one third of the tongue through loss of motor function, traumatic amputation or through surgery.

Moderately Severe Inflammatory Crohn's Disease or Ulcerative Colitis

A definite diagnosis of Crohn's Disease or Ulcerative Colitis by a Consultant Gastroenterologist. To meet the definition of moderate, at least one of deep tissue intestinal tract must be affected by continued or relapsing inflammation, with one or more flare-ups each year.

Partial Hepatectomy

The surgical excision of at least 25% of the liver mass by laparotomy. Liver biopsy and donation are specifically excluded.

Permanent Faecal Incontinence to age 75

There must be *permanent* incontinence of faeces with constant soiling, despite *optimal therapy* for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

Permanent Rectal Fistula

A *permanent* abnormal tract or connection between the rectum and the skin, bladder or vagina due to a disease of the rectum. There must be radiological evidence of the abnormal tract or connection. Fistula in ano is specifically excluded.

Portal Vein Thrombosis

The thrombosis of the portal vein causing ascites and enlargement of the spleen. There must be radiological evidence of the blockage to the portal vein as well as proof of oesophageal varices as a complication.

Sclerosing Cholangitis

An inflammation of the bile ducts proven on cholangiography, with abnormal liver function tests. There must be diagnostic appearances with irregular stricturing and dilatation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP).

Severe Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy. To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/litres;
- Abnormal protein production marked by decreased albumin levels below 27 G/L;
- Abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR) test above 2.0

Severe Gastrointestinal Disease - requiring hospitalisation

Objective evidence of severe gastrointestinal disease with all of the following:

- Disturbance of bowel function at rest with severe persistent pain for a minimum of 3 consecutive months
- Limitation of activity with continued restriction of diet and no response to

medical therapy for a minimum of 3 months

- There have been 2 hospital admissions to treat this condition in the 12 months prior to claim

For the above definition, the following are not covered:

- Any hospitalisation for diagnostic purposes
- Any hospitalisation for other conditions
- Any hospitalisation relating to *alcohol or drug abuse*
- Irritable Bowel Syndrome

Severe Inflammatory Crohn's Disease

A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To be considered as severe, symptoms must not have responded to *optimal therapy* while under the continued supervision of a Gastroenterologist.

There must also be evidence of continued inflammation with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital
- Fistula formation between loops of bowel or bowel to another organ
- At least one resection of a segment of small bowel

Surgical Repair of a Tracheo-Oesophogeal Fistula

The undergoing of, or inclusion on the NHS waiting list for, the surgical repair of an abnormal tract between the trachea and oesophagus as demonstrated by radiological methods.

Total Colectomy

Removal of the whole of the colon creating an opening on the abdomen joining the small intestine to the abdomen wall called an Ileostomy. This procedure is covered if it is established that the ileostomy is *permanent* in the opinion of both a Consultant Gastroenterologist and *our* Chief Medical Officer.

2. Severity levels

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level A:

- Fulminant Hepatic Necrosis
- *Permanent* Faecal Incontinence
- Severe Cirrhosis of the Liver

Severity Level C:

- Sclerosing Cholangitis
- Severe Gastrointestinal Disease - requiring hospitalisation
- Severe Inflammatory Crohn's Disease

Severity Level D:

- Bowel Ischaemia requiring surgery
- Chronic Pancreatitis
- Total Colectomy

Severity Level E:

- Partial Hepatectomy
- Portal Vein Thrombosis
- Loss of use of more than one third of the Tongue

Severity Level F:

- Cirrhosis of the Liver
- Chronic Inflammatory Hepatitis
- Surgical Repair of a Tracheo-Oesophageal Fistula
- *Permanent* Rectal Fistula
- Moderately Severe Inflammatory Crohn's Disease or Ulcerative Colitis

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Diagnosis and treatment by an *appropriate medical specialist*
- Relevant investigations, results, copies of hospital and histology reports signed by suitably qualified Consultant Histopathologist

4. Specific exclusions

- Any condition stated in 1d) above where the required permanence has not been established before the cover terminates or at age 75 where stated, if sooner
- *Alcohol or drug abuse*
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.E Connective Tissue Diseases category – specified conditions of defined severity

1. Definitions

For the purposes of this *plan* other diseases which are not specifically named such as sero-negative arthritis, sero-negative rheumatoid arthritis, psoriatic arthritis or osteoarthritis are not covered by this *plan*, but complications of these diseases may be paid out should criteria be met under any of the other categories of illnesses.

Giant Cell Arteritis

The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Pemphigus Vulgaris

A chronic, relapsing autoimmune skin disease that causes blisters and

erosions of the skin and mucous membranes. For the purpose of this *plan* only Pemphigus Vulgaris is covered, with the diagnosis supported by a biopsy and presence of PV auto-antibodies in the blood.

Polyarteritis Nodosa

The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Polymyositis

Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this illness category there must be all of the following:

- Elevated serum muscle enzymes (CK, aldolase)
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM)
- Muscle biopsy findings typical of PM or DM (as defined immediately above)
- Compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation

Rheumatoid Arthritis

The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Lupus Erythematosis (SLE)

The definite diagnosis of Systemic Lupus Erythematosis (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Sclerosis (Scleroderma)

The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Wegener's Granulomatosis

The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rhematic Diseases.

2. Severity levels

How is severity measured?

Connective Tissue Diseases:

Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. For the purposes of this *plan* the severity of Connective Tissue Diseases will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least four out of six *functional activity tests*. See provision D5.4.

Severity Level B:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least three out of six *functional activity tests*. See provision D5.4.

Severity Level C:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least two out of six *functional activity tests*. See provision D5.4.

Severity Level D:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least one out of six *functional activity tests*. See provision D5.4.

Severity Level F:

- A definite diagnosis of giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis
- Pemphigus Vulgaris

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant blood tests and tissue biopsies which satisfy the relevant defined diagnostic criteria
- Histological proof of the presence of the disease

4. Specific exclusions

- Fibromyalgia, or any synonym including, but not limited to, fibromyositis, fibrositis, muscular rheumatism, myofascial pain syndrome
- Osteoarthritis, wear and tear or any other subjective, non-diagnosed condition
- Chronic fatigue syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free disease
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition.

- Any exclusion applied specifically to *your plan*

1.F Urogenital Tract and Kidney category – specified conditions of defined severity

1. Definitions

Acute Renal Dialysis

Undergoing more than two treatments of haemodialysis over a three week period or a cumulative total of more than 24 hours haemofiltration due to a rapid decline of renal function leading to renal failure.

Bilateral Orchidectomy

The undergoing of, or inclusion on the NHS waiting list for, the therapeutic surgical removal of all of both testicles due to trauma or for the treatment of a disease of the testicles or of the blood vessels supplying the testicles.

Bladder Fistula

The abnormal connection or tract between the bladder and the skin, vagina or rectum due to disease of the bladder. This must be proven by radiological evidence.

Chronic Renal Impairment

The impairment in kidney function such that the estimated glomerular filtration rate is below 25 mls/litre/min/1.73 m2 surface area persistently for a period of six months or more.

Cystectomy

The surgical removal of the complete organ of the bladder with the construction of a urostomy or nephrostomies to allow urine to be collected external to the body. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

Kidney Failure

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

Nephrectomy

Undergoing the surgical removal of a complete kidney as a result of documented renal disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

Partial Cystectomy

Undergoing the surgical removal of at least 50% of the bladder, measured by surface area, as a result of documented disease or trauma. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

Partial Nephrectomy

Undergoing the surgical removal of at least 30% of the mass of one kidney as a result of documented disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below. Biopsy is excluded.

Severe Chronic Renal Impairment

The impairment in renal function such that the estimated glomerular filtration rate is below 15 mls/ litre/min/1.73 m2 surface area persistently for a period of six months or more.

Surgical Repair of a Kidney

Surgical repair of acute damage to the kidney as a result of trauma. Keyhole surgery, including laparoscopic surgery, is specifically excluded.

2. Severity levels

How is severity measured?

Renal function:

Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Kidney Failure

Severity Level B:

- Severe Chronic Renal Impairment

Severity Level C:

- Chronic Renal Impairment
- Cystectomy

Severity Level D:

- Acute Renal Dialysis
- Nephrectomy
- Partial Cystectomy

Severity Level E:

- Partial Nephrectomy
- Bilateral Orchidectomy
- Surgical repair of a Kidney

Severity Level F:

- Bladder Fistula

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5

Any or all of the following may apply to any claim under this category

- Diagnosis and treatment by an *appropriate medical specialist*
- Copies of all available specialist reports
- Details of current and historic renal function tests
- Histology of biopsies and any other relevant investigations must be available

4. Specific exclusions

- Kidney transplant. This is covered in the Major Organ Transplant category
- Kidney donation
- Elective gender reassignment
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.G Respiratory Disease to Age 75 category – specified conditions of defined severity

1. Definitions

Chronic Obstructive Pulmonary Disease

A disease of the airways of the lung causing obstruction to the exhalation of air. There must be *permanent* and *irreversible* reduction of the maximum volume of air expelled in one second (FEV1) of less than 50% of predicted.

There must be *permanent* and *irreversible* obstruction to airflow demonstrated by a FEV1/ FVC ratio of less than 50% and there must be less than 5% variation in three repeated measurements, (which must be performed under the direction of a specialist respiratory physician) whilst on *optimal therapy*. They must be measured in a respiratory laboratory, which has regular quality control audits available to *us*.

These measurements must be repeated after an interval of at least three months and must also satisfy the criteria mentioned above for a claim to be considered.

Only the following severities are covered:

- Stage III – where FEV1 is between 31% and 49% of predicted
- Stage IV – where FEV1 is 30% or less of predicted

When both Chronic Obstructive Pulmonary Disease and Fibrotic Lung Disease co-exist, only one payment will be made for the condition which is at the highest severity level.

Cor Pulmonale

Irreversible right ventricular failure due to a lung disease producing raised pulmonary artery pressure (Pulmonary Arterial Hypertension). There must be evidence of raised pulmonary artery pressure of at least 30mmHG (mm of mercury) and there must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

Fibrotic Lung Disease

For the purpose of this *plan* fibrotic lung disease is defined as one of the following only:

- Sarcoidosis
- Fibrosing Alveolitis
- Aspergilosis

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

There must be radiological evidence of fibrosis and there must be a *permanent* and *irreversible* restriction of Vital Capacity (VC), the maximum total volume of air that can be expelled from the lung after maximum inhalation, to below 75% of predicted. There must also be a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 55% of predicted or less.

These tests must be performed under the direction of a specialist respiratory physician whilst on *optimal therapy*. They must be measured in a respiratory laboratory, which has regular quality control audits available to *us*, and be supervised by the treating specialist. When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made (for the condition which is at the highest severity level).

Home Oxygen Therapy

Chronic hypoxaemia on a *permanent* basis with a concentration of oxygen in the arteries of less than 8 kPa. Supplemental oxygen therapy must be used at home for at least 13 hours each day.

Mechanical Ventilatory Support for Near Drowning

Mechanical ventilatory support for at least 24 hours following full resuscitation as a consequence of near drowning.

Pleurectomy

The therapeutic surgical excision of the pleura (the membrane covering the lungs) for documented disease.

Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

A definite diagnosis of one of the following by a consultant cardiologist or consultant respiratory physician:

- idiopathic pulmonary arterial hypertension
- chronic thrombo-embolic pulmonary hypertension

With either:

- The measurement reported at the average level measured by cardiac catheterisation at 30mmHG (mm of mercury) or higher at rest. There must also be right ventricular dilation and hypertrophy on echocardiogram with characteristic ECG changes; or
- The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist for the disease of the pulmonary artery to excise and replace the disease pulmonary artery with a graft.

Pulmonary Embolus

The blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs) or an angiography.

Removal of One Lobe of the Lungs

The undergoing of, or inclusion on the NHS waiting list for, the therapeutic surgical removal of one lobe of the lungs for documented disease or trauma.

Removal of Two or more Lobes of the Lungs

The undergoing of, or inclusion on the NHS waiting list for, the therapeutic surgical removal of two or more lobes of the lungs for documented disease or trauma.

Surgical Drainage of a Lung Abscess

The surgical drainage of an abscess in the parenchyma of the lung using a thoracotomy.

Surgical Drainage of Empyema

The collection of pus in the pleural space. This is the space between the lung and the ribcage. The empyema must have been drained using a thoracotomy operation to qualify for this *benefit*.

2. Severity levels

How is severity measured?

Chronic Obstructive Pulmonary Disease:

Severity is assessed by the measurement of:

1. Vital Capacity (VC). This is the maximum total volume of air that can be expelled from the lung after maximum inhalation.
2. The Forced Expiratory Volume 1 (FEV1). The maximum volume of air expelled in one second.
3. The ratio of the two measurements.

Fibrotic Lung Disease:

The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor. The amount of the claim depends on the severity of the illness *you* suffer.

The following levels apply:

Severity Level A:

- Fibrotic Lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less
- Home Oxygen Therapy
- Cor Pulmonale
- Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

Severity Level C:

- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 35% and 39% of predicted
- Stage IV Chronic Obstructive Pulmonary Disease
- Removal of two or more lobes of the lungs

Severity Level D:

- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 40% and 49% of predicted
- Stage III Chronic Obstructive Pulmonary Disease
- Removal of one lobe of the lungs

Severity Level E:

- Surgical Drainage of a Lung Abscess
- Surgical Drainage of Empyema
- Pleurectomy
- Pulmonary Embolus

Severity Level F:

- Mechanical Ventilatory Support for Near Drowning
- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 50% and 55% of predicted

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant pulmonary and cardiac investigations must be done and be available
- Histology report must be available if needed

4. Specific exclusions

- Any condition stated in 1g) above where the required permanence has not been established before the cover terminates or at age 75 where stated, if sooner
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.H Accidental Human Immunodeficiency Virus (HIV) category – meeting specified criteria

1. Definitions

HIV infection

Infection by HIV resulting from:

- A blood transfusion given as part of medical treatment
- A physical or sexual assault
- An incident occurring during the course of performing normal duties of *employment*
- An organ transplant

After the start of the *plan* and satisfying all of the following:

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures
- Where HIV infection is caught through a physical or sexual assault or as a result of an incident occurring during the course of performing normal duties of *employment*, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus
- The incident causing infection must have occurred in one of the countries in the list of *permitted countries*

For the above definition, the following is not covered:

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

2. Severity levels

Severity Level A:

HIV infection resulting from:

- A blood transfusion given as part of medical treatment
- A physical or sexual assault
- An incident occurring during the course of performing normal duties of *employment*
- An organ transplant

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

We will require evidence of a negative HIV test within 5 days of the incident and the subsequent positive HIV antibody test with a confirmatory Western Blot test within 12 months of the incident.

4. Specific exclusions

- Any method of infection of HIV or AIDS that is not stated above
- No cover under this *benefit* is effective unless there is shown to be a negative HIV test within five days of the incident causing the claim
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.I Musculoskeletal Trauma category – specified conditions of defined severity

1. Definitions

Amputation of Two or More Fingers or Thumbs

Permanent physical severance of two or more fingers or thumbs at the metacarpal bone.

Intensive care for 10 days continuous duration

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

For the above definition the following are not covered:

- *Children* under the age of 30 days
- Sickness or injury as a result of drug or alcohol intake or other self-inflicted means

Le Fort III Reconstruction

This is a form of surgical repair of the maxillofacial bones for severe facial trauma.

Less Extensive Skin Burns – covering 15% of the body's surface area

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue covering at least 15% of the body's surface area.

Less Extensive Skin Burns – covering 10% of the body's surface area

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue covering at least 10% of the body's surface area.

Less Extensive Skin Burns – covering 5% of the body's surface area or 10% of the surface area of the face

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue covering at least 5% of the body's surface area or 10% of the surface area of the face.

Face is the surface area of the front of the head from the top of the hairline to the base of the chin and from ear to ear.

Loss of a single hand or foot

The *permanent* physical severance of either hand or either foot at or above the wrist or ankle joints.

Loss of a single limb

The *permanent* physical severance of a single limb from above the knee or elbow joint or the total loss of motor power to the entire limb.

Loss of hands or feet

Permanent physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

Loss of the use of a Whole Hand

Total and *irreversible* loss of muscle function or sensation to the whole of a hand due to trauma. The disability must be *permanent* and supported by appropriate neurological evidence.

Necrotising fasciitis

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

Severe Sepsis

A definite diagnosis of severe sepsis by a consultant physician with at least one additional organ dysfunction, requiring admission to either an intensive care (ICU) or a high dependency unit (HDU) for at least 72 continuous hours.

Surgical Re-attachment of an Amputated Limb

Surgery to re-attach a limb following amputation at or above the wrist or ankle joint.

Extensive Skin Burns

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue, covering at least 20% of the body's surface area or 25% of the surface area of the face.

Face is the surface area of the front of the head from the top of the hairline to the base of the chin and from ear to ear.

2. Severity levels

How is severity measured?

Extensive Skin Burns:

Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area. Adding up the injured areas provides an assessment of burn percentage.

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level A:

- Extensive Skin Burns
- Loss of hands or feet

Severity Level B:

- Loss of a single limb
- Less Extensive Skin Burns covering 15% of the body's surface area

Severity Level C:

- Intensive Care of 10 days continuous duration
- Less Extensive Skin Burns covering 10% of the body's surface area
- Loss of use of a whole hand
- Loss of a single hand or foot
- Necrotising fasciitis

Severity Level D:

- Surgical Re-attachment of an Amputated Limb

Severity Level E:

- Le Fort III Reconstruction
- Less Extensive Skin Burns covering 5% of the body's surface area or 10% of the surface area of the face
- Severe Sepsis

Severity Level F:

- Amputation of two or more fingers or thumbs at the metacarpal bone

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Either or both of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Appropriate investigations and reports must be available

4. Specific exclusions

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.J Eye to Age 75 category – specified conditions of defined severity

1. Definitions

Blindness

Permanent and *irreversible* loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

Blindness in one eye

Total *permanent* and *irreversible* loss of all sight in one eye.

Central Blindness

Permanent and *irreversible* loss of central vision of 20 degrees from the centre of the horizontal plane of the visual field. The measurement of this must be supervised by a Consultant Ophthalmologist.

Central Retinal Occlusion

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

For the above definition, the following are not covered:

- Branch retinal artery or vein occlusion or haemorrhage

Corneal Transplant

Replacement of a portion or entire cornea with a healthy cornea as a result of disease, accident or trauma. The surgery must be performed by a consultant ophthalmic surgeon or ophthalmologist.

For the above definition, the following are not covered:

- Any corneal transplant surgery for vision correction in the absence of damage, disease or injury to the cornea.

Severe Visual Impairment

Permanent and *irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/36 after correction.

Significant Visual Impairment

Permanent and *irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/18 after correction.

Surgical Removal of one eye

Surgical removal of a complete eyeball for disease or trauma.

Surgical Repair of a Detached Retina

The surgical repair of a detached retina by a Consultant Ophthalmologist. Laser surgery is specifically excluded.

Tunnel Vision

Permanent and *irreversible* loss of peripheral vision such that the total field of vision is 90 degrees or less in the horizontal plane with both eyes open. The measurement of this must be supervised by a Consultant Ophthalmologist.

2. Severity levels

How is severity measured?

Visual acuity:

The Snellen rating is the measurement of visual acuity using a standard Snellen chart at 6 metres. This must be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at 6 metres letters that people with normal vision can read at 18 or 36 metres.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Blindness
- Severe Visual Impairment

Severity Level C:

- Significant Visual Impairment

Severity Level D:

- Central Blindness

Severity Level E:

- Blindness in one Eye
- Central Retinal Occlusion
- Tunnel Vision
- Surgical Removal of one Eye

Severity Level F:

- Corneal Transplant
- Surgical repair of a detached retina

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Signs and symptoms must be compatible with the condition claimed
- The Consultant Ophthalmologist's report must be available with details of corrected visual acuity
- Relevant investigations must be performed

4. Specific exclusions

- Any condition stated in 1j) above where the required permanence has not been established before the cover terminates or at age 75 where stated, if sooner
- Any temporary reduction in sight
- If a Consultant considers that a device or implant could result in the improvement of sight
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.k Ear to Age 75 category – specified conditions of defined severity

1. Definitions

Deafness

Permanent and *irreversible* loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

Radical Mastoid Surgery

The surgical drainage and excision of chronically infected bony tissue from the mastoid area of the skull. There must have been radiological proof of bony destruction of the mastoid bones by infection.

Significant Hearing Loss in Both Ears

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. There should be at least two measurements over a period of six months in order for a claim to be considered.

2. Severity levels

How is severity measured?

Hearing loss:

Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Deafness

Severity Level C:

- Significant hearing loss in both ears

Severity Level F:

- Radical Mastoid Surgery

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant investigations and reports must be available
- Must be diagnosed and treated by an *appropriate medical specialist*
- Must have relevant signs and symptoms

4. Specific exclusions

- Any condition stated in 1k) above where the required permanence has not been established before the cover terminates or at age 75 where stated, if sooner
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.L Endocrine and Metabolic Diseases category – specified conditions of defined severity

1. Definitions

The following conditions are covered (only one payment will be made for each):

Acromegaly

A disease of the pituitary gland with production of excess growth hormone which cannot be suppressed below 2 ng/ml after a 75 Gram oral glucose load.

Addison's Disease

Primary Adrenal insufficiency is a disease in an individual who has never taken steroids without pituitary disease. There must be low levels of circulating steroids and high levels of Adrenocorticotrophic hormone. This must be present for at least six months.

Adrenalectomy

The therapeutic surgical removal of the complete adrenal gland for documented disease.

Conn's Syndrome

A disease of the adrenal glands with persistently raised aldosterone levels and reduced rennin levels. There must be evidence of low serum levels of potassium of less than 3 Mmol/L, rennin levels of less than 1ng/ml/Hr and a plasma aldosterone level of greater than 15 nG/dl.

Cushing's Syndrome

A disease in an individual who has never taken steroids with raised cortisol on 24 hour urine collection and confirmatory testing such as dexamethasone test or imaging of the adrenal and/or pituitary glands. This must be present for at least six months.

Diabetes Insipidus

The *permanent* inability of the body to concentrate urine. This must be *permanent* and be caused by either the lack of the hormone vasopressin to be secreted or the failure of the kidney to respond to vasopressin. This is not Diabetes Mellitus (Sugar Diabetes).

Insulin dependent Diabetes Mellitus (Type I)

Diagnosis of Diabetes Mellitus (Type 1), characterised by absolute insulin deficiency requiring on going treatment with exogenous insulin for survival.

For the above definition, the following are not covered:

- Gestational Diabetes
- Type 2 Diabetes (including Type 2 Diabetes treated with insulin)
- Latent Autoimmune Diabetes of Adulthood

Insulinoma

A tumour of the pancreas producing high levels of insulin causing recurrent attacks of hypoglycaemia. The insulinoma must be diagnosed by MRI or CT scan.

Pheochromocytoma

A tumour of the adrenal gland producing high levels of adrenal hormones. The secretion can be demonstrated by high levels of urinary vanillyl mandelic acid and is associated with a compatible complication such as raised blood pressure.

Radiotherapy to the Pituitary Gland

Radiotherapy to the pituitary gland for the treatment of a documented pituitary adenoma.

Sheehan's Syndrome

Evidenced by radiological evidence of infarction of the pituitary gland, a serum prolactin of less than 5 ng per ml and evidence of failure of the pituitary to secrete other hormones.

Simmond's Disease

An *irreversible* failure of the pituitary to secrete normal levels of hormones. There must be all of the following: low T4 hormone levels, low T3 resin uptake, low testosterone levels and low prolactin levels. These must be present for at least six months and require replacement therapy.

Surgical Removal of the Pituitary Gland

The surgical removal of the pituitary gland for the treatment of a documented pituitary adenoma.

Thyrotoxic Crisis

A clinical condition in someone who has never taken thyroid hormones, with fever, rapid heart rate of over 130, delirium and coma. These symptoms must result in admission to hospital for at least seven days. There must be recorded levels of circulating thyroid hormones at least three times the normal level.

2. Severity levels

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level E:

- Diabetes Insipidus
- Insulin dependent Diabetes Mellitus (Type 1)
- Sheehan's Syndrome
- Thyrotoxic Crisis

Severity Level F:

- Conn's Syndrome
- Cushing's Syndrome
- Addison's Disease
- Pheochromocytoma
- Surgical Removal of the Pituitary Gland
- Radiotherapy to the Pituitary Gland
- Insulinoma
- Simmond's Disease
- Adrenalectomy
- Acromegaly

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant signs and symptoms must be present compatible with the condition claimed
- Investigations must be available
- Diagnosis and treatment must be by an *appropriate medical specialist*

4. Specific exclusions

- Any claim for Non-Insulin dependent Diabetes Mellitus (Sugar Diabetes)
- Any second claim at any time under any of the illnesses listed above in provision 1 l) 1.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.M Major Organ Transplant category

1. Definitions

Major Organ Transplant

The undergoing as a recipient of a transplant of bone marrow; or of a complete heart, kidney, liver, lung, pancreas; or of a lobe of lung or liver from another donor; or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells

Only one procedure is covered for transplants of the heart and/or both lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

2. Severity levels

Severity Level A:

- Major Organ Transplant

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigation results and any other supporting specialist reports required
- Histology report must be available if needed

4. Specific exclusions

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.N Permanent Disability

1. Definitions

Cauda equina

The compression of the nerve roots in the lumbar spine causing the loss of sensation and movement to the bladder, bowel and both legs. The disability must be *permanent* and supported by appropriate neurological evidence.

Mental and Behavioural Disorder: Persistent Confusional State to age 70

An individual shall be considered to be in a persistent confusional state where the individual cannot:

i) Follow simple instructions

ii) Perform simple daily tasks including eating, drinking and washing

iii) Have any insight into his or her disability

AND

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force.

Mental and behavioural disorder: total lack of social interaction to age 70

An individual shall be considered to have a total lack of social interaction where the individual has:

- Ongoing medical treatment from a psychiatrist for more than two years
- And more than two in-patient admissions, each greater than one week
- And total lack of social interaction of any kind
- And the *permanent* inability to carry out all of the following:
  - Answering the telephone
  - Holding a face to face conversation for at least five minutes
  - Travelling fifty metres outside using all available aids

Total permanent disability

Your plan schedule indicates which of the following definitions apply. Sections a and b do not apply to *children*, instead section c) total *permanent* disability for *children* will apply. Please see below

a) Total permanent disability – own occupation

i. Total permanent disability – unable before age 70 to do your own occupation ever again

Loss of the physical or mental ability through an illness or injury before age 70 to the extent that *you* are unable to do the material and substantial duties of *your own occupation* ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of *your own occupation* that cannot reasonably be omitted or modified.

Own occupation means *your* trade, profession or type of work *you* do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability.

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 *you* expect to retire.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

A maximum of £2,000,000 of Serious Illness Cover or Life with Serious Illness Cover will be assessed on a total permanent disability own occupation definition. Any Serious Illness Cover or Life with Serious Illness Cover in excess of this will have total permanent disability claims assessed based on activities of daily living definitions, (listed in provision D5.4)

b) Total permanent disability – permanent failure of functional activity

i. Total permanent disability Unable, before age 70 to do a specified number of work tasks ever again (listed in provision D5.4).

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 *you* expect to retire.

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

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii. Total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again

Loss of the physical ability through an illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself ever again* (listed in provision D5.4).

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 *you* expect to retire.

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

c) Total permanent disability for children – this section only applies to children

The *child you* are claiming for becomes *permanently* disabled through illness or injury to the extent that the *child* will require constant medical attention, and constant supervision by another person.

The disability and requirement for constant supervision must be expected to last throughout the *child*'s life.

All diagnoses must:

- be made by a consultant *employed* at a hospital within the *United Kingdom*, who is a specialist in an area of medicine appropriate to the cause of the claim,
- be definite and final, and
- be confirmed by *our* chief medical officer.

2. Severity levels

How is severity measured for total permanent disability – unable before age 70, to do a specified number of work tasks ever again or total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again?

The severity of a condition claimed under either of these *benefits* will be determined by the *permanent* inability to perform a number of tasks ever again. These tasks are listed in provision D5.4.

The inability to perform a particular task or number of tasks has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

Severity Level A:

- Cauda equina
- Mental and behavioural disorder – persistent confusional state to age 70

- Mental and behavioural disorder – total lack of social interaction to age 70
- Total *permanent* disability – unable before age 70 to do *your own occupation* ever again
- Total *permanent* disability – unable, before age 70, to do at least four *work tasks* ever again
- Total *permanent* disability – unable to do at least four *tasks designed to assess whether you can look after yourself ever again*
- Total *permanent* disability for *children*

Severity Level C:

- Total *permanent* disability – unable, before age 70, to do at least two *work tasks* ever again
- Total *permanent* disability – unable to do at least two *tasks designed to assess whether you can look after yourself ever again*

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision B2.1 and D5.

Any of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigations and reports must be available
- Signs and symptoms must be compatible with the condition claimed

In order for a total *permanent* disability claim to be paid, *we* will require that the extent of permanency has been established to *our* satisfaction.

4. Specific exclusions

- Any condition stated in 1n) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Any diagnosis. disease. disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion within the definition of any named condition
- Any exclusion applied specifically to *your plan*

Appendix 2

Illnesses and Conditions paid out at 100% for Serious Illness Cover 2X, Serious Illness Cover 3X, Life with Serious Illness Cover 2X, Life with Serious Illness Cover 3X, Child Serious Illness Cover 2X and Child Serious Illness Cover 3X definitions.

If *your* plan schedule indicates that *you* have selected Serious Illness Cover 2X, Serious Illness Cover 3X, Life with Serious Illness Cover 2X and Life with Serious Illness Cover 3X then in the event of a serious illness claim for a Serious Illness Cover condition listed below, we will increase the lump sum we pay *you* to 100% of *your* cover amount. For details of the definitions for these conditions please refer to Appendix 1.

Cancer

- Advanced Hodgkin's disease, classified as Ann-Arbor Stage II
- Advanced Non-Hodgkin's Lymphoma, classified as Ann-Arbor Stage II
- Cancer - excluding less advanced cases

Heart and artery

- Aorta graft surgery
- By-pass graft surgery to three or more coronary arteries
- Coronary artery by-pass grafts
- Heart Attack
- Heart Attack resulting in *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy*
- Heart valve replacement or repair
- Permanent Defibrillator Insertion due to Cardiac Arrest
- Surgical repair of a structural abnormality of the heart

Musculoskeletal trauma

- Loss of a single hand or foot
- Loss of a single limb

Respiratory

- Stage III Chronic obstructive pulmonary disease

Stroke and nervous systems

- Alzheimer's disease - resulting in *permanent* symptoms
- Bacterial Meningitis – resulting in *permanent* symptoms
- Brain and Spinal tumours – of specified severity
- Coma - with associated *permanent* symptoms
- Creutzfeldt-Jakob disease - resulting in *permanent* symptoms
- Dementia - resulting in *permanent* symptoms
- Encephalitis - resulting in *permanent* symptoms
- Motor neurone disease
- Multiple Sclerosis
- Paralysis of a limb

- Parkinsons Disease - resulting in *permanent* symptoms
- Spinal Stroke
- Stroke
- Stroke with a *residual deficit* measuring at least 3 on the Modified Rankin Scale
- Stroke with a *residual deficit* measuring at least 2 on the Modified Rankin Scale
- Traumatic Brain injury - resulting in *permanent* symptoms

Ear

- Significant hearing loss in both ears

Appendix 3

LifestyleCare Cover definitions

1. Definitions

Severity Level 1

The amount of the claim depends on the severity of the illness *you* suffer. In order to meet the criteria for Severity Level 1, *you* must meet one of the following definitions:

Alzheimer's Disease - resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas
- For the above definition, the following are not covered:
- Other types of dementia

Dementia - resulting in permanent symptoms

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be *permanent* clinical impairment of motor function with associated tremor and muscle rigidity. For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism

Severity Level 2

In order to meet the criteria for Level 2, *you* must meet one of the following three definitions:

i) **Permanent Inability to perform 3 out of 6 tasks designed to assess whether you can look after yourself ever again.**

There must be *permanent* clinical loss of the ability to perform three or more of the following tasks. To make this assessment *we* will need an *appropriate medical specialist* to confirm that *you* are *permanently* unable to perform these tasks. *You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication:

- Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means

- Getting dressed and undressed – The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
- Getting between rooms - The ability to get from room to room on a level floor
- Feeding *your*self – The ability to feed *your*self when food has been prepared and made available
- Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again.
- Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function

For the above definitions, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii) Persistent Confusional State

An individual shall be considered to be in a persistent confusional state where the individual cannot:

i. Follow simple instructions

ii. perform simple daily tasks including eating, drinking and washing; and

iii. have any insight into his or her disability

AND

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property

iii) Severe stroke - resulting in *permanent* symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in a *permanent* residual neurological deficit measuring 4 or above on the Modified Rankin Scale

For the above definition, the following are not covered:

- Transient Ischaemic Attack
- Death of tissue of the optic nerve or retina / eye stroke

2. Evidence required in the event of a claim

This should be read in addition to and in connection with provision D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results
- Diagnosis made by an *appropriate medical specialist*
- For conditions affecting the nervous system any loss of neurological function should be compatible with the area of damage of the brain involved.

We will use the Modified Rankin Scale (van Swieten et al. 1988) to measure the severity of a Stroke. This is an internationally accepted measure of disability for Stroke, It is scored from 0 to 5 with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

3. Specific exclusions

- Any condition stated in section 1 above where the required permanence has not been established before the cover terminates
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

Appendix 4

Illnesses and conditions impacted by Dementia and FrailCare Cover.

Appendix 4.1

1. Definitions

Advanced Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a consultant neurologist, psychiatrist or geriatrician resulting in *permanent* inability to perform 2 or more Cognitive Tasks. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

For the above definition, the following are not covered:

- Other types of dementia

Advanced Dementia

A definite diagnosis of dementia by a consultant neurologist, psychiatrist or geriatrician resulting in *permanent* inability to perform 2 or more Cognitive Tasks. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Nursing Home Care (for at least 3 months) – of specified cause

Permanently (full time) residing in a nursing home for at least 3 months or been receiving support from a nurse or carer at home for at least 5 hours a day on for at least 3 months, due to one of the following conditions:

- *Permanent* inability to perform 4 out of 6 *activities of daily living*
- Advanced Alzheimer's Disease with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Advanced Dementia with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Parkinson's disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale

For the purposes of this definition:

- A nursing home is defined as a residential care facility with registered nursing staff *permanently* on duty
- A carer is defined as a trained care worker, or group of care workers, in order to assist with nursing or care needs
- All nursing staff must be CQC trained (or equivalent)

Parkinson's disease resulting in the permanent inability to perform 2 or more out of 6 ADLs

A definite diagnosis of Parkinson's disease by a Consultant Neurologist resulting in the *permanent* inability to perform 2 or more out 6 ADLs. For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Permanent inability to perform activities of daily living (ADL)

The *permanent* loss of physical ability through illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself ever again*

The relevant specialist must reasonably expect that the disability will last throughout life with no prospect of improvement.

You must need the help of supervision of another person and be unable to perform the task on *your* own, even with the use of specialist equipment routinely available to help and having taken any appropriate prescribed medication.

These specified tasks (*we* also refer to these tasks as *activities of daily living*) are:

- Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – The ability to put on, take-off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Getting between rooms - The ability to get from room to room on a level floor.
- Feeding *yourself* – The ability to feed *yourself* when food has been prepared and made available.
- Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.
- Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

The above tasks will be assessed through standardised testing in place at the time of the claim.

Residential Home Care (for at least 3 months) – of specified cause

Permanently (full time) residing in a residential care home on a *permanent* basis for at least 3 months due to one of the following conditions:

- *Permanent* inability to perform 4 out of 6 *activities of daily living*
- Advanced Alzheimer's Disease with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Advanced Dementia with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Parkinson's disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale

For the purposes of this definition:-

- A residential care home is defined as a residential care facility with trained care assistants *permanently* on duty
- All residential staff must be CQC trained (or equivalent)

Stroke with a residual deficit measuring 3 or more on the Modified Rankin Scale

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting clinical symptoms lasting for at least 24 hours and measuring 3 or more or above on the Modified Rankin Scale.

For the above definition, the following are not covered:

- Transient ischaemic attack
- Death of tissue of the optic nerve or retina / eye stroke

2. Severity levels

How is severity measured?

To assess the severity of Advanced Alzheimer's disease and Advanced Dementia, the following cognitive tasks will be used.

Cognitive Tasks

The *permanent* loss of cognitive ability through illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself ever again*

The relevant specialist must reasonable expect that he disability will last throughout life with no prospect of improvement.

You must need the help of supervision of another person and be unable to perform the task on *your* own and having taken any appropriate prescribed medication.

The specific tasks are:

- Feeding – Demonstrate the cognitive ability to eat regular meals without being prompted
- Washing – Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence washing by any means, with the use of assistive devices where applicable
- Dressing – Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence, putting on and taking off of all necessary garments, with the use of assistive devices where applicable
- Communication – Demonstrate the ability to present rational ideas and to reason clearly
- Orientation - Demonstrate the cognitive ability to recognise people commonly known to *you* or to recognise when and where *you* are in time and location
- Continence - Demonstrate the cognitive ability to recognise, initiate and sequence the task of bowel and bladder functions such that an adequate level of personal hygiene can be maintained

The above cognitive tasks will be assessed through standardised testing in place at the time of the claim.

Severity Level A:

- Nursing Home Care (for at least 3 months) – of specified cause
- Residential Home Care (for at least 3 months) – of specified cause

Severity Level B:

- *Permanent* inability to perform 4 or more *activities of daily living*
- Stroke with a *residual deficit* measuring 4 on the Modified Rankin Scale
- Parkinson's Disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 4 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the *permanent* inability to perform 4 out of 6 Cognitive Tasks

Severity Level C:

- *Permanent* inability to perform 3 or more *activities of daily living*
- Parkinson's Disease resulting in the *permanent* inability to perform 3 out of 6 ADLs
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 3 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the *permanent* inability to perform 3 out of 6 Cognitive Tasks

Severity Level D:

- *Permanent* inability to perform 2 or more *activities of daily living*
- Stroke with a *residual deficit* measuring 3 on the Modified Rankin Scale
- Parkinson's Disease resulting in the *permanent* inability to perform 2 out of 6 ADLs
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 2 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the *permanent* inability to perform 2 out of 6 Cognitive Tasks

3. Evidence required in the event of a claim

This should be read in addition to and in connection with provision C1.2 and D5.

Any of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigations and reports must be available
- Signs and symptoms must be compatible with the condition claimed

In order for a claim to be paid, *we* will require that the extent of permanency has been established to *our* satisfaction.

4. Specific exclusions

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this Appendix, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.6 (Exclusions)
- Any exclusion within the definition of any named condition
- Any exclusion applied specifically to *your plan* during *your* Serious Illness Cover or Life with Serious Illness Cover term

Appendix 4.2

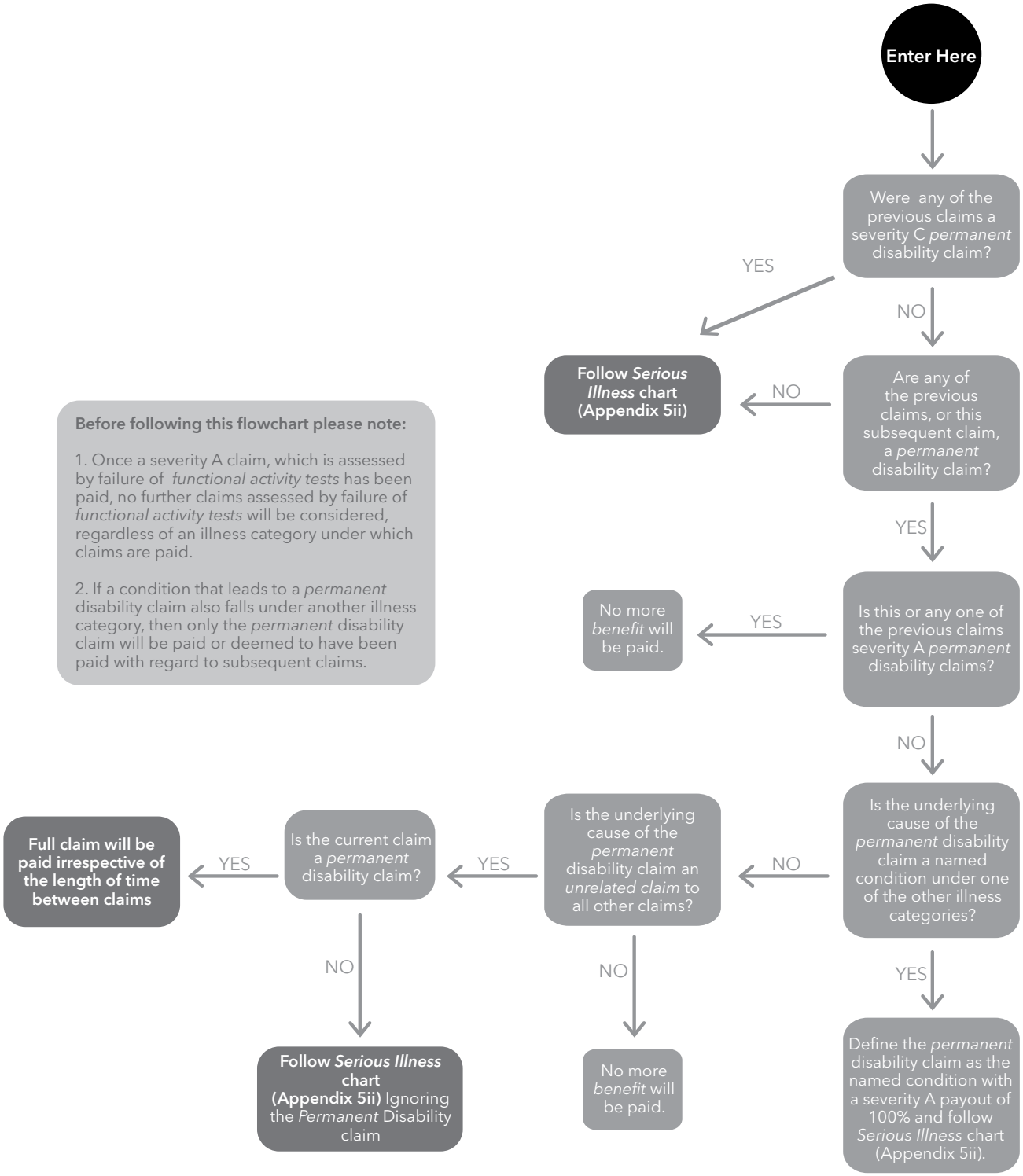
If *you* claim for the below conditions under Serious Illness Cover or Life with Serious Illness Cover, *you* will not be able to claim for that condition, or any related conditions, under Dementia and FrailCare Cover.

Serious Illness related conditions	Related conditions under Dementia and FrailCare Cover
• Total *permanent* disability • Any Neurological Disease causing the *permanent* and *irreversible* inability to perform two or more *functional activity tests* • Any connective tissue disease causing the *permanent* inability to perform one or more *functional activity tests* • A Stroke with a *residual deficit* measuring at least 2 on the Modified Rankin Scale	• Failure of 2 or more *activities of daily living* • Nursing Home Care • Residential Home Care • A Stroke with a *residual deficit* measuring at least 3 on the Modified Rankin Scale • Parkinson's disease resulting in the *permanent* inability to perform 2 or more out of 6 ADLs
• Alzheimer's disease – resulting in *permanent* symptoms • Alzheimer's disease • Dementia – resulting in *permanent* symptoms • Dementia • Persistent Confusional State • Parkinson's Plus syndromes	• Advanced Alzheimer's Disease • Advanced Dementia • Nursing Home Care • Residential Home Care

Appendix 5

(i) - Subsequent claims for Serious Illness Cover and Life with Serious Illness Cover

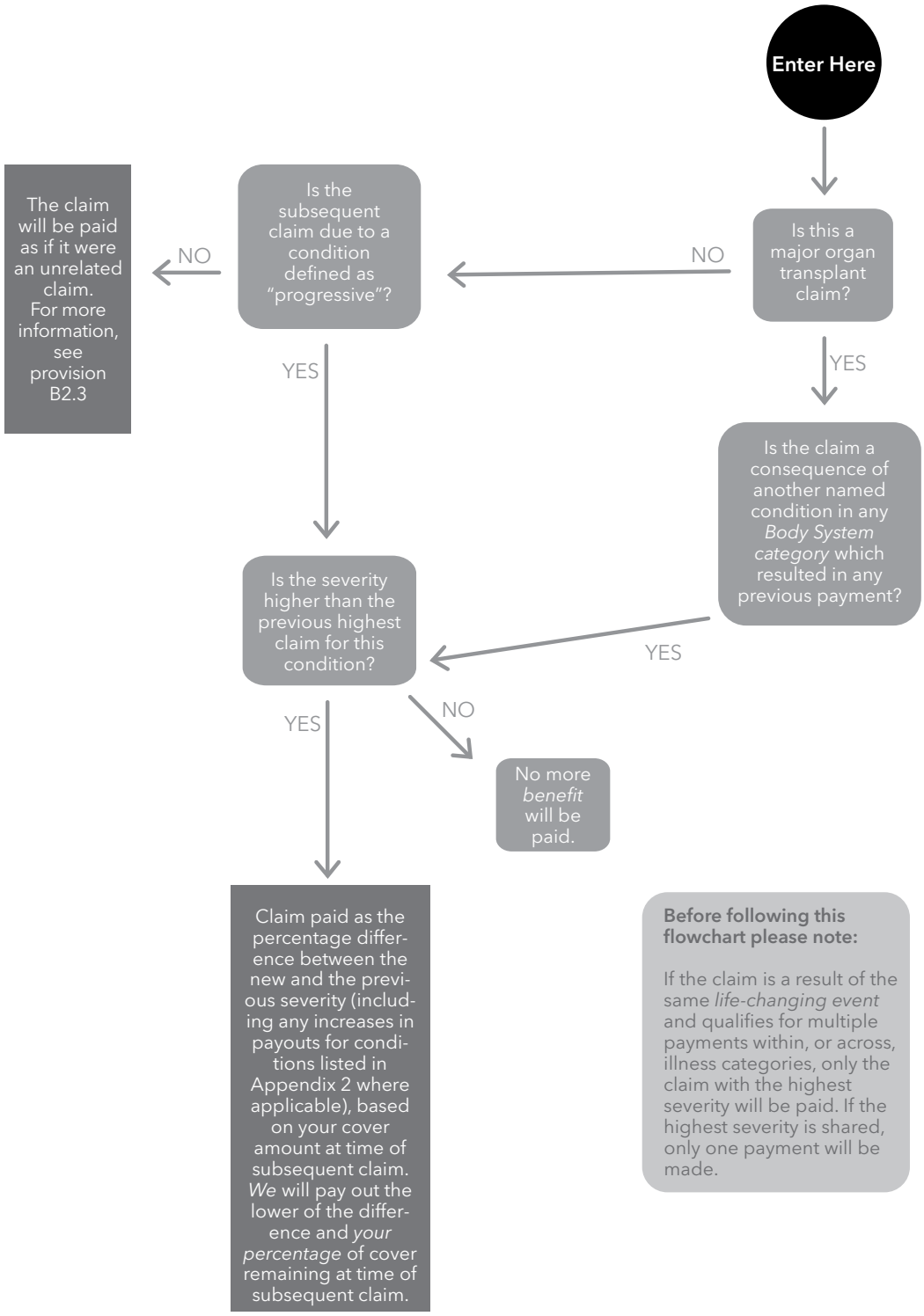
Assessment of subsequent claims for permanent disability



Appendix 5

(ii) - Subsequent Claims for Serious Illness Cover and Life with Serious Illness Cover

Assessment of subsequent progressive or subsequent unrelated serious illness cover claims

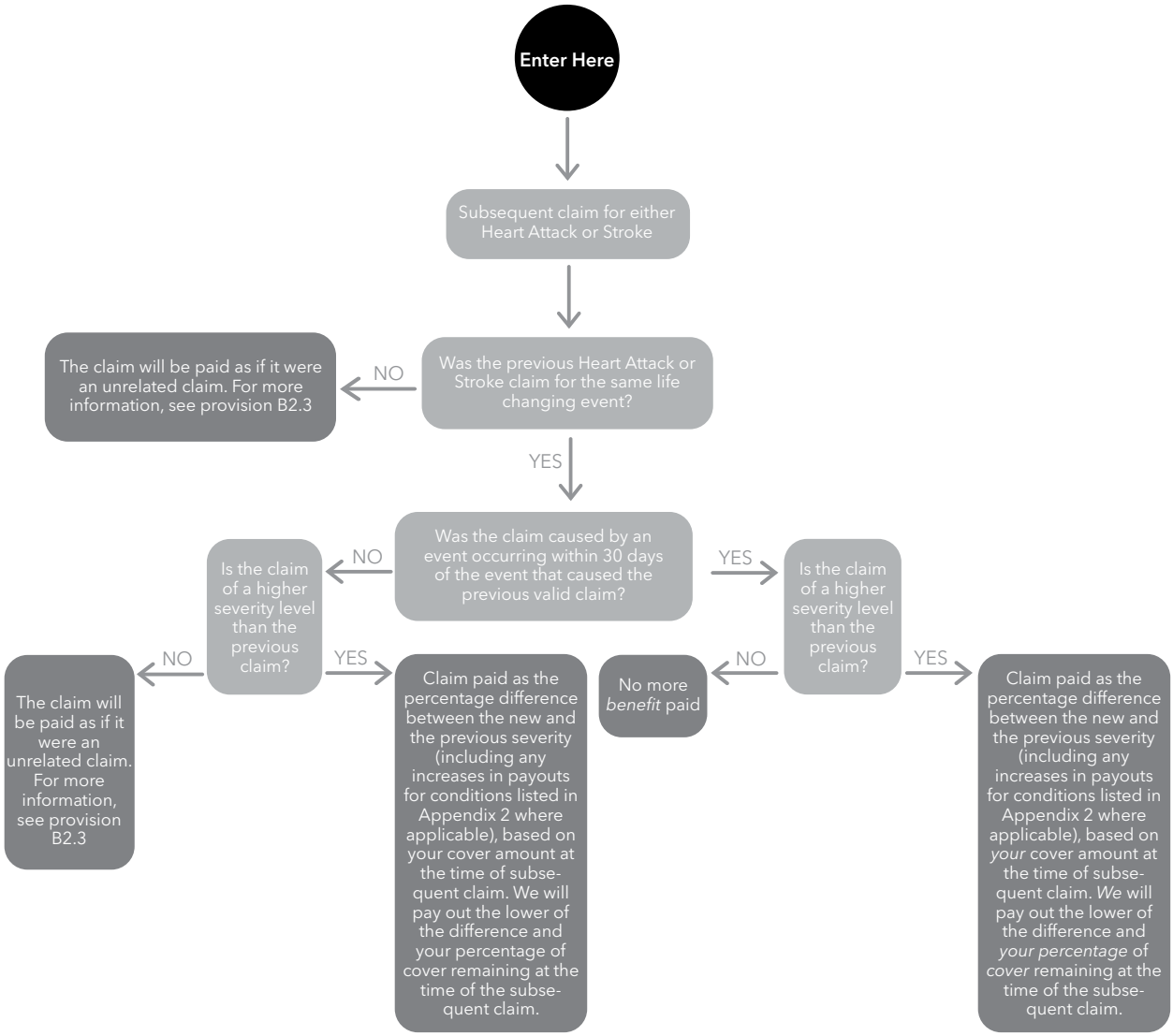


Note: this does not apply to Heart Attack and Stroke. Please refer to Appendix 5 (iii)

Appendix 5

(iii) - Subsequent Claims for Serious Illness Cover and Life with Serious Illness Cover

Assessment of subsequent claims for heart attack or stroke



Note: Heart Attack and Stroke are treated as two different life changing events.

Find out more.

For more information please speak to your adviser or visit our website vitality.co.uk/life

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