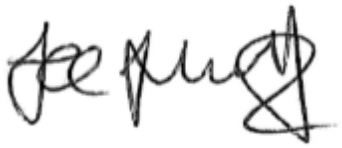
GROUP CRITICAL ILLNESS POLICY

TERMS AND CONDITIONS

In consideration of You paying the Premiums to Us and complying with these terms and conditions, We agree to pay the Benefit when they become payable under the terms of this Policy**.**

Signed for and on behalf of Ellipse
By:



Managing Director

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SECTION A - INTERPRETATION

1. INTERPRETATION

1.1 In this Policy:

a) save where the context otherwise requires, a reference to a statute or statutory provision shall include a reference:

i. to that statute or provision as from time to time consolidated, modified, re-enacted or replaced by any statute or statutory provision; and

ii. any subordinate legislation made under the relevant statute;

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

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

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

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

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

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

"Accounting Period"	the periods in respect of which data is provided by You on the Data Refresh Dates and in respect of which Premium is paid;
"Actively At Work"	in relation to an individual, an individual who: (a) is either actively performing their normal occupation or is taking leave (other than sick leave) that has been authorised by their Employer; (b) is working the normal number of hours required by their contract with their Employer, either at their normal place of work, a location as agreed with their Employer or at a location to which they are required to travel for business; (c) is mentally and physically capable of performing all the duties normally associated with their job; and

	(d) is not acting against medical advice in meeting any requirements of (a) to (c);
"Adviser"	a firm regulated by the Financial Conduct Authority (or other recognised professional body) who acts on behalf of You;
"Automatic Acceptance Limit"	the maximum level of Benefit specified in the Policy Schedule which will be provided in respect of a Member without the need to undergo an Individual Assessment;
"Benefit"	the benefit payable in the event that an Insured Person fulfils the claim conditions set out in Clause 14;
"Business Day"	a calendar day other than a Saturday, Sunday or other statutory holiday in London, England;
"Category"	a class of Member (or if We have agreed to cover them, a Member's Partner) as stated in the Policy Schedule;
"Child" and "Children"	a Member's child, step-child or legally adopted child from birth to their 18th birthday (23rd birthday if in full-time education);
"Commission Rate"	the amount of commission payable to Your Adviser as set out in the Policy Schedule;
"Data Refresh"	the provision of data in accordance with Clauses 2.5 and 2.6;
"Data Refresh Date"	the dates on which You will give Us the data We require to calculate the Premium;
"Data Refresh Frequency"	the agreed frequency at which You will give Us the data We require to calculate the Premium;

“Date Cover Ceases”	the date You have agreed with Us being the date at which a Member (and if We have agreed to cover them, a Member’s Partner) ceases to be eligible for cover under this Policy as stated in the Policy Schedule;
“Deposit Premium”	a sum calculated by Us which is an estimate of the Premium for the current Accounting Period based on information provided by You, the Premium Rates and any other relevant matters which is payable at the beginning of each Accounting Period in circumstances where the Premium is payable annually;
“Effective Date”	the date from which the Premium Rates and terms of the Policy apply;
“Eligibility Conditions”	the conditions that an Eligible Person must satisfy in order to be a Member of the Scheme, as described in each Category outlined in the Policy Schedule;
"Eligible Person"	an individual who meets the Eligibility Conditions;
“Employee”	an individual who is either (i) gainfully employed either permanently or for a fixed term by an Employer as evidenced by a contract of employment; or (ii) an Equity Partner; or (iii) where We have agreed to include such an individual, a worker engaged through a Zero Hour Contract;
“Employer”	an Employer listed in the Policy Schedule, whether it is the Principal Employer or a Participating Employer;

“Equity Partner”	a partner in a partnership who is a part owner of the business and is entitled to a proportion of the distributable profits of the partnership;
“Flexible Benefits Rules”	where applicable, outline the rules and requirements governing the particular flexible benefit Scheme;
“Flexible Benefits Scheme Type”	is the basis on which the Scheme is arranged, as stated in the Policy Schedule;
“HMRC”	HM Revenue & Customs;
“Individual Assessment”	an assessment carried out by Us consisting of medical and other lifestyle questions via a secure website, requests for further medical tests and where necessary information from the individual’s professional medical advisers;
“Insured Illness”	the illnesses and conditions details of which are set out in Section D. The Policy Schedule will state which apply to Your Policy;
“Insured Person”	any individual covered under this Policy whether they are a Member, a Member’s Child or Partner of a Member;
“Maximum Benefit”	the Maximum Benefit payable in respect of Insured Person is as follows: Member: the lower of 5 x salary and £500,000, Partner (where included in the Policy): the lesser of £250,000 or the Member’s Benefit, and Child: the lesser of £20,000 or 25% of the Member’s Benefit;
“Member”	an Employee who satisfies the Eligibility Conditions and is included in the Scheme;

"Minimum Membership Number"	two Members;
"Parent Company"	the legal entity that owns or controls AIG Life Limited as defined by the laws applicable to the jurisdiction within which the legal entity resides;
"Participating Employer"	an Employer stated as such in the Policy Schedule;
"Partner"	at the date cover starts: a) a person to whom the Member is married; b) a person with whom the Member has entered into a contractual partnership formally recognised by law under the Civil Partnership Act 2004; c) a person who is not a relative of the Member, or married to or a civil partner of the Member at the date cover starts and when cover starts is in a relationship resembling marriage with the Member and has the same main residence as the Member and has done so for at least six months and is either: (i) financially dependent on the Member; or (ii) in a relationship of mutual financial dependence with the Member;
"Policy"	this document and the Policy Schedule;
"Policy Anniversary` Date"	the date stated as such in the Policy Schedule;
"Policy Schedule"	at any given date, the latest Policy Schedule which We have posted in the Policyholder area on Our secure website or otherwise issued to You;

“Policy Start Date”	the Policy Start Date stated in the Policy Schedule;
“Policy Terms and Conditions Reference”	the reference to the version of the terms and conditions that should be read in conjunction with the Policy Schedule;
“Policyholder”	the legal owner of the Policy, as stated in the Policy Schedule;
“Premium”	the sums payable by You pursuant to Clause 2;
“Premium Payment Frequency”	the frequency stated in the Policy Schedule with which Premium will be paid by You;
“Premium Rates”	the annual rates used to calculate the Premium which are set out in the Policy Schedule;
“Principal Employer”	the Participating Employer who arranged this insurance contract;
“Quotation”	the Quotation provided to You by Us prior to the Policy Start Date on the basis of detailed information submitted by You and confirmed by Us in Our standard application form;
“Rate Review Date”	the date We review Our Premium Rates and terms as stated in the Policy Schedule;
“Related Medical Condition”	any medical condition, or symptom, which in the opinion of Our chief medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the Insured Illness;
“Scheme”	an arrangement under the terms of which the Employer has agreed to make a certain payment to Members in the event that they or another Insured Person suffers an Insured Illness;
“Temporary Cover”	shall have the meaning provided in Clause 6.5 of this Policy;

“Voluntary Benefits Rules”	where applicable, outline the rules and requirements governing the particular voluntary benefits Scheme;
“We”, “Us” and “Our”	AIG Life Limited;
“You” and “Your”	the Employer(s) for the time being of the Scheme as provide in the application form and identified in the Policy Schedule; and
“Zero Hour Contract”	a contract between You and a worker whereby You are not obliged to provide the individual with any minimum working hours and the individual is not obliged to accept any of the hours offered.

SECTION B - PREMIUM

2. CALCULATION AND PAYMENT OF PREMIUM

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

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

a) name;

b) National Insurance number or unique identifier (whichever We have agreed with You will be provided);

c) gender;

d) date of birth;

e) Scheme salary and, if requested by Us, Benefit;

f) Category;

g) normal working location (postcode if in the United Kingdom or country if outside the United Kingdom);

h) e-mail addresses for Members who require Individual Assessments;

i) Members for whom restricted benefits or special terms currently apply;

j) where it is stated in the Policy Schedule that cover will be provided for Members who work past the Date Cover Ceases under this Policy ceases, details of any such Members.

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

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

a) name;

b) National Insurance number;

c) gender;

d) date of birth;

e) the Member's Scheme salary and, if requested by Us, the Partner's Benefit;

f) Category;

g) the Member's normal working location (postcode if in the United Kingdom or country if outside the United Kingdom);

h) e-mail addresses for Partners who require Individual Assessments;

i) Partners for whom restricted benefits or special terms currently apply;

j) where it is stated in the Policy Schedule that cover will be provided for Partners who are to be covered past the Date Cover Ceases under this Policy, details of any such Partners.

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

2.4 If We do not receive complete data within fourteen days of Our request We will request payment based on the estimated annual premium in the Quotation. For annual paying policies which pay Premiums by bank transfer We will issue an invoice for the estimated annual premium and payment must be made within fourteen days. For quarterly paying policies which are temporarily paying Premiums by bank transfer We will issue an invoice for 25% of the estimated annual premium and payment must be made within fourteen days. For quarterly paying policies which pay Premiums by direct debit We will request a payment for 25% of the estimated annual premium. For monthly paying policies which are temporarily paying Premiums by bank transfer We will issue an invoice for 1/12th of the estimated annual premium and payment must be made within fourteen days. For monthly paying policies which pay Premiums by direct debit We will request a payment for 1/12th of the estimated annual premium.

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

a) a list of all Members as at the Data Refresh Date. The list should include in respect of each Member the following details:-

i. name;

ii. National Insurance number or unique identifier(whichever We have agreed with You will be provided);

iii. gender;

iv. date of birth;

v. Scheme salary and, if requested by Us, Benefit;

vi. Category;

vii. normal working location (postcode if in the United Kingdom or country if outside the United Kingdom);

viii. the dates on which individuals, who have become Members since the last Data Refresh Date, joined the Scheme.

b) the date on which any individual ceased to be a Member.

c) where it is stated in the Policy Schedule that cover will be provided for Members who work past the Date Cover Ceases under this Policy, details of any such Members.

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

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

a) a list of all Partners as at the Data Refresh Date. The list should include in respect of each Partner the following details:-

i. name;

ii. National Insurance number;

iii. gender;

iv. date of birth;

v. the Member's Scheme salary and, if requested by Us, the Partner's Benefit;

vi. Category;

vii. the Member's normal working location (postcode if in the United Kingdom or country if outside the United Kingdom);

viii. the dates on which individuals, who have become Partners since the last Data Refresh Date, joined the Scheme.

b) the date on which any individual ceased to be a Partner.

c) where it is stated in the Policy Schedule that cover will be provided for Partners who are to be covered past the Date Cover Ceases under this Policy, details of any such Partners.

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

2.7 For Policies where the Premium is paid on an annual basis, the terms and conditions of payment are set out in Clauses 2.8 – 2.17. For Policies where the Premium is paid on a monthly or quarterly basis, the terms and conditions of payment are set out in Clauses 2.18 – 2.26.

Policies where Premium is paid on an annual basis

2.8 The Deposit Premium payable in respect of the first Accounting Period will be the amount set out in the Quotation. We will issues an invoice to You and it will be payable by bank transfer within fourteen of the date on which the invoice was issued.

2.9 We will then use the information given to Us pursuant to Clauses 2.2 and 2.3 to check the calculation of the Deposit Premium for the first Accounting Period. If it is different to the amount stated in the Quotation and paid by You then We will make an adjustment.

2.10 We will notify You within thirty days of receiving the information of any adjustment made.

2.11 Any additional Premium required must be paid by You within fourteen days of the date of Our notification pursuant to Clause 2.10.

2.12 Any refund due to You will be refunded to You within fourteen days of the date of Our notification pursuant to Clause 2.10.

2.13 Subsequent Deposit Premiums will be based on the final premium agreed for the previous Accounting Period. We will issue an invoice for subsequent Deposit Premiums thirty days before the Policy Anniversary Date and this will be payable within fourteen days of Our request.

2.14 We will use the information given to Us pursuant to Clauses 2.5 and 2.6 to:-

a) confirm that You have paid the correct Premium for the Accounting Period which is about to expire; and

b) re-calculate the Deposit Premium payable for the next Accounting Period.

2.15 We will notify You within thirty days of receiving the data required under Clauses 2.5 and 2.6 of:

a) any additional Premium payable by You in respect of the Accounting Period which expired on the Data Refresh Date in question or any refund of Premium due to You in respect of that Accounting Period; and

b) the actual Deposit Premium payable in respect of the Accounting Period commencing on the Data Refresh Date. This will be based on the revised Premium Rates notified to You pursuant to Clause 3.9 where the Deposit Premium is payable in respect of

an Accounting Period commencing on a Rate Review Date.

2.16 We will add any additional Premium payable by You to the Deposit Premium payable in respect of the next Accounting Period.

2.17 We will deduct any refund of Premium due to You from the Deposit Premium payable in respect of the next Accounting Period.

Policies where Premium is paid on a monthly or quarterly basis

2.18 We will use the information given to Us pursuant to Clauses 2.2 and 2.3 to calculate the Premium for the first Accounting Period.

2.19 We will notify You within thirty days of receiving the information of the amount of Premium payable in respect of the first Accounting Period. This amount will be collected by Us by direct debit at regular intervals in accordance with the terms of the Policy Schedule.

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

2.21 We will use the information given to Us pursuant to Clauses 2.5 and 2.6 to:-

a) confirm that You have paid the correct Premium for each Accounting Period to date; and

b) calculate the Premium payable for subsequent Accounting Periods.

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

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

2.24 Where the information You provide to Us shows that You have paid too much Premium, We will normally reduce the Premium We will collect at the next payment date.

2.25 We will notify You within fourteen days or receiving the data pursuant to Clauses 2.5 and 2.6 of the amount of Premium payable in respect of subsequent Accounting Periods. This will be based on the revised Premium Rates notified to You pursuant to Clause 3.9 where the Premium is payable in respect of an Accounting Period commencing on a Rate Review Date. This amount will be collected by Us by direct debit.

2.26 The same amount of Premium will be payable in the same manner for each subsequent Accounting Period until notice is given by Us pursuant to Clause 2.25.

3. VARIATIONS TO THE TERMS AND CONDITIONS OF THIS POLICY

3.1 We reserve the right to revise at Our discretion (prospectively or retrospectively) the terms and conditions of this Policy and the Premium Rates at any time if:

a) the number of Members (and if We have agreed to cover them, Member's Partners) or the total of all Members' salaries is changed by more than 30% from that notified to Us prior to the Policy Start Date or prior to the last Rate Review Date whichever is the later; or

b) there are fewer Members than the Minimum Membership Number; or

c) We agree to include a new Employer or a TUPE (Transfer of Undertaking (Protection of Employment) Regulations 2006) transfer; or

d) an Employer is disposed of or the closure of part of an Employer's business; or

e) We agree to the inclusion of a new Category; or

f) We agree to change the terms of this Policy following a request from You; or

g) there is a change in the nature of the business carried on by any Employer; or

h) more than 30% of the total number of Members or total salary change location; or

i) there is no longer an Adviser acting for You in connection with this Policy; or

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

k) You did not make a fair presentation of the risk when setting up the Policy or at any subsequent review of the terms.

These matters define the risk as a whole.

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

3.3 Where there has been a delay in You providing the information We need to review the terms and conditions or Premium Rates of this Policy We will backdate any change to the appropriate date.

3.4 In addition, the terms and conditions of this Policy and the Premium Rates may be varied by Us for any reason at any Rate Review Date.

Rate Review

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

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

3.7 Where We have not received the requested information, We will base any changes We intend to make to the terms and conditions of the Policy or the Premium Rates on the Rate Review Date on the information available to Us.

3.8 Where there has been a delay in You providing the information We require to review the terms and conditions or Premium Rates of this Policy We will backdate any change to the appropriate date.

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

SECTION C – THE CRITICAL ILLNESS COVER

4. COVER FROM THE POLICY START DATE

4.1 In respect of the scheme (the "Scheme") under which You promise and are obliged to pay the Benefit, and in consideration of the Premium, We agree to insure, upon the terms of this Policy, such proportion (as recorded in the Policy Schedule) of Your obligation to Members to pay the Benefit.

4.2 Subject to Clause 4.5 each Member is covered under this Policy up to the Automatic Acceptance Limit on and from the Policy Start Date.

4.3 Subject to Clause 4.4, in respect of any Member in respect of whom cover in excess of the Automatic Acceptance Limit is sought We shall be entitled in Our sole discretion to require an Individual Assessment of the Member to enable Us to consider whether to grant the requested excess cover (for the avoidance of doubt, such Member will be covered up to the Automatic Acceptance Limit regardless of the decision made by Us following the Individual Assessment). While the Individual Assessment is being conducted the cover provided will be as set out in Clause 6.

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

4.5 If, immediately prior to the Policy Start Date, the Members were insured under a group critical illness policy with an identical benefit structure to this Policy and there has been no material change in the number of Members or the Eligibility Conditions, then We will accept the previously insured level of Benefit in respect of each Member, up to the Automatic Acceptance Limit subject to Clauses 4.4 and 4.6. Any previously insured level of Benefit in excess of the Automatic Acceptance Limit will be accepted subject to:

a) You providing satisfactory evidence of the level of cover and the details of any special terms and conditions to Us; and

b) Our right to conduct an Individual Assessment pursuant to Clause 6 and to impose special terms where We consider it appropriate to do so.

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

a) Our pre-existing insured illnesses, related medical conditions exclusions and additional exclusions in relation to Children as defined in Clause 18 will apply from the date the Member joined the Scheme and to any increase in Benefit that has occurred since joining the scheme; and

b) Any Insured Illness that We cover that was not covered by the previous insurer will be subject to our re-existing insured illnesses, related medical conditions exclusions and additional exclusions in relation to Children as defined in Clause 18 from the Policy Start Date.

5. INDIVIDUALS BECOMING MEMBERS OF THE SCHEME AFTER THE POLICY START DATE

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

6. INDIVIDUAL ASSESSMENTS AND TEMPORARY COVER

6.1 In circumstances where,

a) You seek cover in excess of the Automatic Acceptance Limit (or no Automatic Acceptance Limit applies) in respect of any Insured Person; or

b) You ask Us to change the terms of the Policy and We have identified Insured Persons whose increase is subject to Individual Assessment

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

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

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

6.4 Where Insured Persons are outside the United Kingdom, and provision of their Benefit is subject to Individual Assessment, if after this further medical information is required to enable Us to complete Our assessment, the Insured Person will be responsible for arranging and paying for the tests to be conducted. Examinations, tests or reports may only be arranged or conducted at a centre or provider with prior approval from Us

otherwise We will not be liable for any costs and the Insured Person may be required to undertake another set of tests with an approved centre or provider.

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

Benefits in excess of the Automatic Acceptance Limit in respect of any Insured Person

6.5 Where You seek cover in excess of the Automatic Acceptance Limit in respect of any Insured Person then subject to Clauses 6.6 to 6.9, You will have cover in respect of the Insured Person in question until the completion of the Individual Assessment. Subject to Clause 4.4, Your cover will be the **higher** of the Automatic Acceptance Limit and their previously accepted level of Benefit. In addition, You will receive Temporary Cover equivalent to the additional cover being sought subject to the following:

a) the pre-existing Insured Illness and Related Medical Conditions exclusions as set out in Clause 18;

b) You will not be given Temporary Cover if You have previously had a request for the Benefit You now seek in respect of the Insured Person declined, restricted due to failure to provide medical evidence, postponed or accepted on non-standard terms;

c) No Temporary Cover will be available to Insured Persons beyond the Date Cover Ceases who require Individual Assessment because the Policy has an Automatic Acceptance Limit of £0, or any Insured Person We have identified as needing to be Individual Assessed before benefiting from any change to the cover under the Policy.

6.6 The Temporary Cover will commence from the date of receipt by Us of the notice given pursuant to Clause 6.2 and will be in place until the earlier of completion of the Individual Assessment and the expiry of 30 days. If We are unable to complete Our assessment before the Temporary Cover period expires, the individual's cover will be restricted to their previous accepted level of cover.

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

6.8 If the Insured Person's previous accepted level of cover was provided by another insurer,

You must provide satisfactory evidence of the level of cover and any special terms and conditions to Us.

Insured Persons requiring Subsequent Individual Assessments

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

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

7. THE AUTOMATIC ACCEPTANCE LIMIT

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

a) there are fewer than three Members; or

b) the number of Members reduces by 30% or more from the number of Members at the Policy Start Date or the last Rate Review Date (if later).

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

7.3 If We determine that the Automatic Acceptance Limit shall be reduced the level of Benefit which applied to an Insured Person before the reduction becomes effective shall continue to apply on no worse terms.

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

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

8. TEMPORARY ABSENCE FROM WORK

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

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

17.

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

a) the end of the contract in force when the Member was first absent, or

b) when that contract is terminated, or

c) three years form the start of the ill health

unless cover ceases pursuant to Clause 17.

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

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

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

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

9. INSURED PERSONS WORKING OUTSIDE THE UNITED KINGDOM

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

a) the Member satisfies the Eligibility Conditions of the Scheme; and

b) the Member has a contract of employment or for services with a Participating Employer; and

c) the country of secondment is declared for each Insured Person at the Policy Start Date and at each Data Refresh.

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

USA provided:

a) the Member remains a Member of the Scheme; and

b) the Member has a contract of employment or for services with a Participating Employer; and

c) the country of residence is declared for each Insured Person at the Policy Start Date and at each Data Refresh Date.

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

10. PAYMENT OF BENEFIT TO MEMBERS

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

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

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

10.3 The Benefit will be paid to the Member.

10.4 The Benefit is payable in pounds sterling.

11. COVER FOR PARTNERS OF MEMBERS

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

(a) the date the Member's cover commences where the Member already has a Partner; or

(b) the date they meet the definition of Partner, if they do so after the Member is covered under the Policy; or

(c) the date their flexible benefit commences if the Member selects flexible benefit for

the Partner.

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

(a) the date on which the Member's cover ceases; and

(b) the Partner dies; and

(c) the Partner reaches the Date Cover Ceases as stated in the Policy Schedule, unless We have agreed with You that their cover can be continued; and

(d) on divorce, dissolution or ceasing to meet the definition of Partner.

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

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

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

11.2 An individual cannot have cover as both a Member and a Member's Partner.

12. COVER FOR CHILDREN

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

(a) commencement of the Member's cover; and

(b) the Child's birth

(c) the child meeting the definition of Child.

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

(a) the Child reaches their 18th birthday (23rd birthday if in full-time education); and

(b) the date on which the Member's cover ceases.

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

- the date of diagnosis of the Insured Illness; or
- the date of surgery where the Insured Illness requires surgery; or
- the date of inclusion on an official United Kingdom transplant waiting list (or date

of surgery if earlier) where the Insured Illness is major organ transplant.

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

12.4 If both parents work for the same organisation the Children's cover will be 25% of the highest Member's Benefit up to a maximum of £20,000.

13. EXTENDED COVER

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

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

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

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

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

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

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

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

SECTION D – THE INSURED ILLNESSES

14. CRITICAL ILLNESSES COVERED UNDER THE POLICY

14.1 Types of cover

There are two types of cover available – core and additional. In addition You may select to have cover for total permanent disability as defined in this section. The cover provided to You hereunder will be set out in the Policy Schedule.

14.1.1 Core illnesses

Alzheimer's disease – *resulting in permanent symptoms*

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

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

For the above definition, the following are not covered:

- other types of dementia.

Cancer – *excluding less advanced cases*

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

- all cancers which are histologically classified as any of the following:
  - pre-malignant;
  - non-invasive;
  - cancer in situ;
  - having borderline malignancy; or
  - having low malignant potential
- all tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0

- chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A
- malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin)
- any skin cancer (including cutaneous lymphoma) that has not spread to lymph nodes or metastasised to distant organs.

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

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

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

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

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

Dementia – *resulting in permanent symptoms*

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

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

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

For the above definition, the following is not covered:

- dementia directly resulting from alcohol or drug abuse.

Heart attack – *of specified severity*

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

- typical clinical symptoms (for example, characteristic chest pain)

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

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- other acute coronary syndromes or angina without myocardial infarction.

Kidney failure – *requiring permanent dialysis*

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

Major organ transplant

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

For the above definition, the following is not covered:

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

Motor neurone disease – *resulting in permanent symptoms*

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

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

There must also be permanent clinical impairment of motor function.

Multiple sclerosis – *with persisting symptoms*

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

Parkinson's disease – *resulting in permanent symptoms*

A definite diagnosis of Parkinson's disease by a consultant neurologist or consultant

geriatrician. There must be permanent clinical impairment of motor function with associated tremor and muscle rigidity.

For the above definition, the following are not covered:

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

Stroke – *resulting in permanent symptoms*

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

For the above definition, the following are not covered:

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

14.1.2 Additional illnesses

Aorta graft surgery – *for disease*

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

For the above definition, the following are not covered:

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

Aplastic anaemia – *with permanent bone marrow failure*

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

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

For the above definition, the following are not covered:

- all other forms of anaemia.

Bacterial meningitis – *resulting in permanent symptoms*

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

For the above definition, the following are not covered:

- all other forms of meningitis including viral meningitis.

Balloon valvuloplasty

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

Benign brain tumour – *resulting in permanent symptoms*

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

For the above definition, the following are not covered:

- tumours in the pituitary gland
- tumours originating from bone tissue
- angioma and cholesteatoma.

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

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

- permanent neurological deficit with persisting clinical symptoms, or
- undergoing invasive surgery to remove the tumour, or
- undergoing stereotactic radiotherapy to the tumour.

For the above definition, the following is not covered:

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

Blindness – *permanent and irreversible*

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

Cardiac arrest – *with insertion of a defibrillator*

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

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

For the above definition, the following is not covered:

- insertion of a pacemaker.

Cardiomyopathy – *of specified severity*

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

The diagnosis must also be evidenced by:

- electrocardiographic changes, and
- echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy.

For the above definition, the following are not covered:

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

Coma – *resulting in permanent symptoms*

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

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

For the above definition, the following is not covered:

- coma secondary to alcohol or drug abuse.

Deafness - *permanent and irreversible*

Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

Encephalitis – *resulting in permanent symptoms*

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

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

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

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

Infection by human immunodeficiency virus resulting from:

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

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

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

For the above definition, the following is not covered:

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

Eligible occupations are:

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

Liver failure – *irreversible*

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

- permanent jaundice
- ascites
- encephalopathy.

For the above definition the following is not covered:

- liver failure secondary to alcohol or drug abuse.

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

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

Loss of independent existence – *permanent and irreversible*

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

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

Loss of speech – *total permanent and irreversible*

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

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

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

Open heart surgery to correct structural defects includes the following:

- repair of atrial or septal defects or patent foramen ovale
- cardiac tumours (atrial myxoma)
- cardiomyopathy surgery to reduce the size of the left ventricular walls
- heart transplant
- repair of anuerysms
- transposition of the great vessels
- Eisenmengers syndrome
- Tetralogy of Fallot.

Paralysis of limb – *total and irreversible*

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

Primary pulmonary hypertension – *of specified severity*

Primary pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in permanent irreversible physical impairment to the degree of at least class 3 of the New York Heart Association's classification of heart failure.

The New York Heart Association's classification of heart failure states this is 'heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain'.

Progressive supranuclear palsy – *resulting in permanent symptoms*

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

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

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

Respiratory failure – a *of specified severity*

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

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

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

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

- there must be morning stiffness in the affected joints of at least one hour duration
- there must be arthritis of at least three joint groups with soft tissue swelling or fluid observed by a physician
- the arthritis must involve at least one of the following sites:
  (i) wrists or ankles
  (ii) hands and fingers
  (iii) feet and toes
- the arthritis must affect both sides of the body
- presence of rheumatoid factor or anti CCP (anticyclic citrulinated protein) antibodies, unless all other criteria are met
- there must be subcutaneous nodules (nodular swelling under the skin)
- there must be radiographic changes typical of active rheumatoid arthritis plus evidence of clinical deformity.

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

Systemic lupus erythematosus

A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

- permanent neurological deficit with persisting clinical symptoms, or
- permanent impairment of kidney function with a Glomerular Filtration Rate (GFR)

below 30 ml/min.

Terminal illness – *where death is expected within twelve months*

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

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

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

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

Traumatic brain injury – *resulting in permanent symptoms*

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

Total permanent disability

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

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

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

Own occupation – unable before the Member's state pension age to do their own occupation ever again

Loss of physical or mental ability through an illness or injury before the Member's state pension age to the extent that the Member is unable to do the material and substantial

duties of their own occupation ever again.

- material and substantial duties means those that are normally required for and/or form a significant and integral part of the performance of the Member's own occupation and which cannot be reasonably omitted or modified by the Member or the Employer.
- own occupation means the Member's profession or type of work they do for profit or pay. It 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 the Member expects to retire.

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

Suited occupation – unable to do a suited occupation ever again

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

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

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

Activities-based assessment

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

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

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

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

and in either case causes a significant reduction in mental and social functioning,

requiring the continuous supervision of the person covered.

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

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

SECTION E - CLAIMS

15. MAKING A CLAIM

15.1 You must notify Us as soon as possible following the occurrence of an Insured Illness for any Insured Person by telephoning Our claims team on 020 3003 6161 or such other number as notified to You from time to time. We will then issue a claim form for You to complete, sign and return to Us.

15.2 We will only consider claims if We have been notified of them within two years of the date of the diagnosis.

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

a) a completed claim form signed by the policyholder;

b) proof of the Member's age (for example the Member's passport or birth certificate, or confirmation that You have seen one of these documents);

c) a member claim form completed by the Insured Person (or their representative), including their consent for Us to seek further medical information as required by the Access to Medical Reports Act 1988;

d) where a claim is being made in respect of a Member's spouse or civil partner, an original copy of their marriage or civil partnership certificate (a photocopy is not acceptable);

e) where a claim is being made in respect of a Member's Partner who is not a spouse or civil partner, an original copy of their birth certificate (a photocopy is not acceptable) and evidence that they meet the definition of Partner;

f) where a claim is being made in respect of a Member's Child, an original copy of their birth or adoption certificate (a photocopy is not acceptable);

g) where a claim is being made for total permanent disability on either an own occupation or suited occupation basis, a copy of the Member's job description detailing their regular duties at the date of the claim;

h) any other information, evidence, test, evaluation or report that may be requested at any time by Us.

15.4 We will not pay claims where Premium is outstanding.

15.5 We are not responsible for any errors or omissions from any information or evidence provided to Us from any source.

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

15.7 Once We determine that a claim is valid, We will pay the Benefit to the Member within five days providing We have valid payment details. Payments will only be made to United Kingdom bank accounts.

SECTION F - TERMINATION

16. TERMINATION OF THE POLICY AS A WHOLE

16.1 This Policy does not have a termination date.

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

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

a) You do not pay Premium when due; or

b) You do not comply with any term of this Policy; or

c) You do not provide data requested by Us in accordance with the Policy terms within 90 days of receipt of a request; or

d) You do not provide any information requested by Us in accordance with the Policy terms within 90 days of receipt of a request; or

e) an Employer stated in the Policy Schedule ceases to carry on business, or if an order is made or a resolution passed for the winding up of that Employer; or

f) there is a change in legislation, regulation, HMRC practise or taxation which affects this Policy.

16.4 If We terminate the Policy under Clauses 16.1 or 16.2 You shall be required to provide information as at the date of termination in order to determine the Premium payable up to the date of termination. If this information is not provided within one month of its being requested, We shall determine what Premium is payable having regard to the information then available, and any sum or sums which had been payable to Us shall remain payable.

16.5 If the Policy is terminated under Clauses 16.1 or 16.2, no Benefit shall be payable in respect of any Insured Illness claim arising for any Insured Person after the effective date of termination of this Policy.

Setting up the Policy

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

16.7 If You do not make a fair presentation of the risk when setting up the Policy but You have not been deliberate or reckless, and We would not have agreed to enter into the Policy if We had known the material facts, We may avoid the Policy, refuse all claims and recover

claims paid.

Rate Review

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

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

Variations

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

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

Fraudulent claims

16.12 If You make a fraudulent claim, We

a) may terminate the Policy by notice and treat the contract as being terminated from the time of the fraudulent act; and

b) recover any claims paid since the fraudulent act; and

c) refuse to pay any claims submitted since the fraudulent act.

17. TERMINATION OF COVER IN RESPECT OF INDIVIDUALS

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

a) the Member ceases to be an Employee;

b) the Member ceases to be a Member of the Scheme;

c) the Member dies;

d) the Member is a worker engaged through a Zero Hour Contract who has not received earnings from the Employer for a period of six consecutive months unless they are unavailable for work due to ill health;

e) the Member retires;

f) the Member reaches the Date Cover Ceases, as stated in the Policy Schedule, unless We have agreed with You that their cover can be continued.

g) in respect of a Member after the Date Cover Ceases, the Member has been absent from work (with the approval of their Employer) for twelve months for a reason other than ill health or statutory leave (or the end of the contract in force on the date first absent if the Member is on a fixed term contract);

h) the Member reaches the Date Cover Ceases, as stated in the Policy Schedule, unless We have agreed with You that their cover can be continued.

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

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

a) once the Member's cover has ceased;

b) if the Partner dies;

c) if the Partner reaches the Date Cover Ceases as stated in the Policy Schedule, unless We have agreed with You that their cover can be continued;

d) on divorce or dissolution or ceasing to meet the definition of Partner.

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

SECTION G - MISCELLANEOUS

18. EXCLUSIONS AND LIMITS

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

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

Pre-existing Insured Illness exclusion

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

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

before entry to the Scheme.

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

Group 1	Aorta graft surgery Balloon valvuloplasty Cardiac arrest Cardiomyopathy Coronary artery by-pass grafts Heart attack Heart transplant (under the major organ transplant) Heart valve replacement or repair Open heart surgery Primary pulmonary hypertension Pulmonary artery graft surgery Stroke For example, where an Insured Person suffers a heart attack then no Benefit shall be payable in respect of any subsequent stroke claim.
Group 2	Kidney failure Kidney transplant (under the major organ transplant) For example, where an Insured Person suffers from kidney failure than no Benefit shall be payable in respect of any subsequent claim for kidney transplant under the major organ transplant definition.

Group 3	Liver failure Liver transplant (under the major organ transplant) For example, where an Insured Person suffers from liver failure then no Benefit shall be payable in respect of any subsequent claim for liver transplant under the major organ transplant definition.
Group 4	Where the Insured Person has suffered from any malignant tumours, defined as 'cancer – *excluding less advanced cases*' then no Benefit shall be payable in respect of any subsequent 'cancer – *excluding less advanced cases*' whether or not this is connected to, or associated with the prior diagnosis of cancer.

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

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

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

18.6 The criteria under this pre-existing Insured Illness exclusion shall also apply to any increase in Benefit. In this case, rather than no Benefit being payable, the exclusion means that no increase in Benefit will be payable, and rather than only applying to Insured Illness or a repeat of the same Insured Illness suffered before entry to the Scheme, it applies to ones suffered before the Benefit increase.

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

Related Medical Conditions exclusion

18.8 No Benefit will be paid in respect of any Insured Illness where a Related Medical Condition existed prior to entry to the Scheme unless the Insured Person had neither received any treatment, nor experienced symptoms, nor sought advice for that Related Medical Condition for at least two consecutive years since entry to the Scheme.

18.9 We will not pay any claim in respect of an increase in Benefit for an Insured Illness where a Related Medical Condition existed unless the Insured Person had neither received any treatment, nor experienced symptoms, nor sought advice for that Related Medical Condition for at least two consecutive years since the increase.

18.10 No Benefit will be paid for any coma, loss of independent existence, loss of speech, paralysis of limbs, terminal illness or total permanent disability benefit where a Related Medical Condition existed before entry to the Scheme.

18.11 No increase in Benefit will be paid for any coma, loss of independent existence, loss of speech, paralysis of limbs, terminal illness or total permanent disability benefit where a Related Medical Condition existed before the last increase in Benefit.

Additional exclusions applied after Individual Assessment

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

Additional exclusion in relation to Children

18.13 No Benefit will be paid in respect of a Child if, before the Child was covered under the Scheme:

- either parent received counselling or medical advice in relation to the Insured Illness or Related Medical Condition, or were aware of the increased risk of the Insured Illness or Related Medical Condition;
- the Insured Illness or Related Medical Condition is a result of intentional injury caused by the either of Child's parent.

Excluded Claims

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

18.15 Benefit will not be paid if a Member failed to disclose any material information during the course of the Individual Assessment.

19. CONTRACTING OUT OF THE INSURANCE ACT 2015

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

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

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

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

20. REMEDIES FOR FRAUDULENT CLAIMS

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

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

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

21. GOVERNING LAW AND JURISDICTION

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

21.2 This Policy has no surrender value and cannot be assigned without Our prior written

permission.

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

22. CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

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

23. DATA PROTECTION

23.1 For the purposes of this Clause the terms "data controller", "personal data" and "process" shall have the meanings given to them in the Data Protection Act 2018.

23.2 We process personal data for the purposes of providing insured Benefits for the benefit of Your Employees and their families in accordance with the Data Protection Act 2018. The information supplied by you may be transferred outside the UK including to countries outside the European Economic Area (including the USA, China, Mexico, Malaysia, Philippines and Bermuda). Full details can be found in Our privacy notices https://ellipse.co.uk/data-protection/

23.3 You agree that We are the data controller in respect of personal data which We receive from You pursuant to this Policy.

23.4 We will process all personal data received pursuant to this Policy in accordance with Our obligations under the Data Protection Act 2018.

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

24. NOTICES

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

may from time to time notify the other in writing.

24.2 Documents relating to the administration and operation of this Policy will be lodged in Our secure on-line document store and will be deemed to have been received as if by e-mail.

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

a) in the case of dispatch by first class, registered post or recorded delivery, on the third day after its dispatch;

b) in the case of delivery by hand, at the time of its delivery;

c) in the case of email, within three hours of transmission,

provided that if deemed receipt occurs after 17.00 on a Business Day or on a day which is not a Business Day, the notice shall be deemed to have been received at 09.00 on the next Business Day.

25. APPEALS AND COMPLAINTS

25.1 If a claim is declined and You disagree with Our decision You or the claimant can appeal Our decision. An email should be sent to claims@ellipse.co.uk outlining the reason for the appeal and attaching any additional information. The claim will be reviewed by an appropriately qualified and experienced assessor who was not involved in the original claim decision. If the appeal process upholds the original decision contact details of the Financial Ombudsman Service will be provided.

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

5th floor

15 Bermondsey Square

London

SE1 3UN

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

25.3 Complaints from Insured Persons or their representative in connection with this Policy should be referred initially to You who shall either deal with such complaint or, if appropriate, refer such complaint to Us at the address above.

25.4 If the Insured Person or their representative remains dissatisfied, the matter may be escalated to the Financial Ombudsman Service (if eligible) at the address below. The Insured Person's legal rights are not affected by contacting this organisation.

Financial Ombudsman Service Ltd,

Exchange Tower

London, E14 9SR

Telephone 0800 023 4567

26. COMPENSATION

26.1 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. This depends on the type of business and the circumstances of the claim.

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

Financial Services Compensation Scheme
PO Box 300
Mitcheldean
GL17 1YA
Tel 0800 678 1100

