Keep me safe

Life and Critical Illness

Policy Conditions

Life and Critical Illness is provided by Liverpool Victoria Financial Services Limited (LV=). These policy conditions tell you all about this policy and together with your application, any declarations you've made, your policy schedule and any documents we send you confirming changes to your policy and the amount of cover, they make up your insurance contract with us. You can find the details of your cover that are specific to you (for example, your cover amount, policy start and end dates) in your policy schedule.

Our illness and medical conditions definitions meet or exceed the ABI Guide to Minimum Standards for Critical Illness Cover (2022).

LV= Life & Critical Illness cover at a glance

You are covered for:

Death or one of the listed critical illnesses from the date your policy starts until the date it ends. This period is also known as the term of your policy.

If you have a question about your policy
Call 0800 678 1906

To make a claim
Call 0800 756 5869

or write to us at
LV= Emperor House, Grenadier Road, Exeter Business Park, Exeter, EX1 3LH.

Remember:

- Death is covered anywhere in the world, but we will only pay a critical illness claim if you are diagnosed in one of the countries listed in section A1.
- Children's cover is an option you can choose to include in your policy for an additional cost.
- If you have added Children's cover to your policy it's important to tell us (or your financial adviser) when your youngest child reaches their 23rd birthday. Otherwise you could be paying for something you can't claim on.

When you can change your cover (within certain limits) without providing medical information:

- Marriage or civil partnership
- Having a child (birth or legal adoption)
- Rent or mortgage increase
- Mortgage extension
- Basic salary increase
- Divorce or dissolution of civil partnership
- Separation

Where to find out more:

Your policy schedule includes all of the details about your policy that are specific to you, including your policy start and end date, cover amount, how much you pay, when your payments are due, and cover type.

What we don't cover:

- Death as a result of taking your own life within the first 12 months of your policy.
- Anyone who deliberately provides false or inaccurate information when they apply for the policy, make a claim, or ask to restart a cancelled policy.
- Children's critical illnesses or operations, unless you have chosen to add Children's cover to your policy.
- Any illness or operation that's not listed in these policy conditions, or is shown as an exclusion in the as a special provisions section in your policy schedule.
- If you die or are diagnosed with a critical illness that happens after the end date of your policy.

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Definitions

Additional payment condition refers to a critical illness where you're covered for part of the **amount of cover**. The amount we would pay in the event of a claim is shown next to the relevant **critical illnesses** in appendix B.

Amount of cover means the amount you are insured for (which is shown on your policy schedule). This will increase in line with **inflation** if you have chosen inflation linked cover. If you have chosen decreasing cover then your **amount of cover** goes down each month. We explain more about this in section A3.

Child or **children** means your children (including legally adopted, biological, or stepchildren). Your children are only covered if you have chosen to add Children's cover to your **policy**, and your policy schedule will show if you have chosen to add Children's critical illness cover to your **policy**. We explain Children's cover in section A10. We explain which illnesses, medical conditions or operations children are covered in appendix C, and the specified pregnancy complications in appendix D.

Critical illness or **critical illnesses** mean the illnesses, medical conditions or operations detailed in appendix A and B, for Children's cover these are detailed in appendix C. Your policy schedule explains if there are any of these illnesses, medical conditions or operations that you are not covered for.

End date is the date your **policy** ends. You can find this date in your policy schedule. We explain any other instances where your **policy** will end in more detail in section B7.

Full payment condition means a **critical illness** where you're covered for the full **amount of cover**.

Inflation means the rising cost of goods and services. We measure this using the Retail Prices Index (RPI), if the RPI is ever discontinued we'll use a similar measure and let you know before we make the change.

Plan means your LV= Flexible Protection Plan and includes other policies that you have with us, as well as this one.

Plan anniversary is the date every 12 months from the date your **plan** originally started. This may be different from the **start date** of your **policy**.

Policy refers specifically to your Life and Critical Illness cover. Your policy is made up of these conditions and other documents that you get with this cover, any **special provisions** included in your policy schedule, and any documents we send you confirming changes to your **policy**.

Premium and **premiums** refer to the amount you pay to us for your **policy** each month.

Special provisions are also known as exclusions; this means things we wouldn't pay a claim for, that are individual to you. We base these on your individual circumstances and will list them in your policy schedule if you have any.

Start date is the date your **policy** began (not the date you applied). You can find this in your policy schedule.

You or **your** refer to the person who applied for, is insured by and is legally entitled to the payment from this **policy** and when we say **we**, **us** or **our**, we mean Liverpool Victoria Financial Services Limited (these words are not in bold throughout the document).

Section A – Life and Critical Illness in detail

A1 – What you're covered for

There are different choices you have depending on whether or not you want to include certain options such as Children's cover or cover for total permanent disability (condition 39). You can find out whether your **policy** includes these options in your policy schedule. Your cover will either be for:

- **All critical illnesses including total permanent disability** (condition 39, total permanent disability – of specified severity)
- **All critical illnesses, but not total permanent disability**
- **All critical illnesses including Children's cover and total permanent disability** (condition 39, total permanent disability – of specified severity)
- **All critical illnesses including Children's cover but not total permanent disability**

✔ **You're covered for:**

✔ Death or diagnosis of a critical illness

We will normally pay out the **amount of cover** if you die or are diagnosed with one of the **critical illnesses** listed in this section between the **start date** and the **end date** of your **policy**.

✔ Travelling abroad

You're covered if you die anywhere in the world, but we'll only pay a **critical illness** claim if you get the diagnosis confirmed, or the operation is performed, by a doctor who practices in any of these places:

Australia, Austria, Belgium, Bulgaria, Canada, Channel Islands, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, Ireland, Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, UK or USA.

✔ Existing illnesses or previous medical conditions

We will ask you for all your medical information when you apply for this **policy**, so we might apply an exclusion based on your personal circumstances. If we do you won't be covered for this. This will be shown as a **special provision** on your policy schedule.

✔ Critical illnesses we cover

We have split the **critical illnesses** into **full payment conditions** and **additional payment conditions**. For a **full payment condition** we will normally pay out the full **amount of your cover**, and your **policy** will end. For an **additional payment condition** we will pay the lower of 25% of your **amount of cover** or £30,000.

If we pay a claim for an **additional payment condition**, we don't reduce your **amount of cover**, and your **policy** continues for your full **amount of cover**.If you make a claim that meets the definition for both an **additional payment condition** and a **full payment condition** at the same time, then we will only pay a claim for the **full payment condition**.

Once we have paid a claim for a **full payment condition** your **policy** will end.

For example

If we paid a claim for the full payment condition for cancer (condition no. 8) we won't also pay a claim for the additional payment condition for prostate cancer (condition no.41).

If we pay a claim for Children's cover (if you've chosen to include this with your **policy**), we don't reduce your amount of **cover**, and your **policy** continues for the full **amount of cover**. We explain more in section A10.

You're covered for the following **critical illnesses:**

Full payment conditions

1 **Alzheimer's disease or other forms of dementia** – resulting in permanent symptoms
2 **Aorta graft surgery** – for disease or traumatic injury
3 **Bacterial meningitis** – resulting in permanent symptoms
4 **Benign brain tumour** – resulting in permanent symptoms or specified treatment
5 **Benign spinal cord tumour** – resulting in permanent symptoms
6 **Blindness** – permanent and irreversible
7 **Brain injury due to trauma, anoxia or hypoxia** – resulting in permanent symptoms
8 **Cancer** – excluding less advanced cases and including aplastic anaemia
9 **Cardiac arrest**
10 **Cardiomyopathy** – of specified severity
11 **Coma** – with associated permanent symptoms
12 **Coronary artery bypass grafts**
13 **Creutzfeldt-Jakob disease**
14 **Deafness** – permanent and irreversible
15 **Encephalitis** – resulting in permanent symptoms
16 **Heart attack** – of specified severity
17 **Heart valve replacement or repair**
18 **Idiopathic pulmonary arterial hypertension** – of specified severity
19 **Kidney failure** – requiring permanent dialysis
20 **Liver failure**
21 **Loss of hand or foot** – permanent physical severance
22 **Loss of speech** – permanent and irreversible
23 **Major organ transplant** – from another donor
24 **Motor neurone disease and specified diseases of the motor neurones** – resulting in permanent symptoms
25 **Multiple sclerosis** – with persisting symptoms

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

27 **Paralysis of limb** – total and irreversible

28 **Parkinson's disease** – resulting in permanent symptoms

29 **Parkinson plus syndromes** – resulting in permanent symptoms

30 **Pneumonectomy** – removal of an entire lung

31 **Pulmonary artery surgery** – for disease only

32 **Severe lung disease**

33 **Spinal stroke** – resulting in permanent symptoms

34 **Stroke** – of specified severity

35 **Surgical removal of an eyeball**

36 **Systemic lupus erythematosus**

37 **Terminal illness** – where death is expected within 12 months

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

The following condition is optional, your policy schedule will say if this is included

39 **Total permanent disability** – of specified severity

We provide more details about each of these **full payment conditions** in appendix A.

Additional payment conditions

For the following **additional payment conditions** we will pay the lower of 25% of your **amount of cover** or £30,000.

40 **Ductal or lobular carcinoma in-situ of the breast** – with specified treatment

41 **Prostate cancer**

We provide more details about each of these **additional payment conditions** in appendix B.

A1(a) - Enhanced payments

For some of the **full payment conditions** we will pay an additional 50% on top of the **amount of cover** if the cause of the claim was as a direct result of an accident. The maximum payment you can receive on top of your **amount of cover** is limited to £200,000.

We give more details about which **full payment conditions** are included, and how we define what an accident is in appendix A.

A2 – What isn't covered

✘ **You're not covered for:**

✘ Any claims made past the policy's end date

Your **policy** will end on the **end date**. If you die or are diagnosed with one of the listed **critical illnesses** after the **end date** of your **policy**, we will not pay a claim as you cover has ended. When your **policy** ends you won't get back any of the money (the **premiums**) you have paid for it.

✘ If you take your own life within 12 months of starting your policy

We won't pay a claim if you intentionally take your own life within 12 months of the **start date** of your **policy**. If this happens we'll cancel your **policy** and refund all the money (the **premiums**) you've paid.

✘ If there was incorrect information on your application

It might affect your **policy**, and any claim you make, if you provided incorrect information, (for example an incorrect date of birth) when you completed your application. This may result in non-payment of a claim, an increase to the amount you pay (your **premium**), a reduction in your **amount of cover**, or we may add a special provision to your **policy**.

For fraud and deliberate misrepresentation

If someone deliberately withholds information, provides false information, or lies to us in their application, at any point during the lifetime of the **policy** or when making a claim, we'll cancel the **policy** and won't refund any of the money they've paid (the **premiums**). We will refuse to pay any claim made if we've had to cancel the **policy** for any of these reasons.

✘ For any special provisions listed on your policy schedule

Anything we've already said we can't insure you for before your **policy** started, we'll list these in the **special provisions** section of your policy schedule.

✘ All types of illness

You are only covered for the **critical illnesses** listed in section A1. If you are diagnosed with any other illness, medical condition, have an operation that is not listed, or if your illness, medical condition, or operation does not meet our definition of one of the **critical illnesses** we cover then we will not pay a claim.

✘ A second claim for an additional payment condition

We'll only pay one claim for each **additional payment condition** covered under this **policy**. If we pay a claim for an **additional payment condition**, we don't reduce your **amount of cover**, and your **policy** continues for your full **amount of cover**.

- ✘ Death within 14 days of the critical illness being diagnosed, or an operation

  If you die within 14 days of being diagnosed with one of the **critical illnesses** or having the operation you are claiming for, then we will not pay a **critical illness** claim under this **policy** but we will pay a death claim if it's before the **end date** of the **policy**.

- ✘ Children's cover and pregnancy complications

  Unless your policy schedule shows that you have Children's cover your **children** aren't covered by this **policy** and you won't be covered for the pregnancy complication payments. We explain Children's cover in section A10, and the illnesses covered for Children's cover are explained in appendix C, and pregnancy complication payments in appendix D.

- ✘ Unemployment

  This **policy** will only pay out if you die or are diagnosed with one of the listed **critical illnesses** in these policy conditions. This means we will not pay a claim for any other reason, for example if you you're unable to work due to sickness or accident, made involuntarily redundant or if you become unemployed.

A3 – Types of cover

You only need to read about the type of cover you have – you can find this in your policy schedule.

A3(a) – Level cover

This means that your **amount of cover** and the amount you pay (your **premium**) each month will not change between the **start date** and the **end date** of your **policy**. For example, if you chose an **amount of cover** of £150,000 and we pay a claim in fifteen years' time, this amount will not have increased to keep up with **inflation**.

A3(b) – Inflation linked cover

This means that your **amount of cover** will go up each year (on your **plan anniversary**) in line with **inflation**, and the **premium** you pay to us will go up by inflation multiplied by 1.5. The rate of **inflation** we use will be based on the 12 month period that ends three months before your **plan anniversary**.

If the Retail Prices Index (which is how we measure **inflation**) doesn't change, or goes down then your **amount of cover** and the amount you pay (your **premium**) will stay the same.

If the Retail Prices Index goes up, the increases we make to your **amount of cover** and the amount you pay (your **premium**) , will happen on your **plan anniversary**. If you have added this **policy** to an existing **plan** and your **plan anniversary** is less than three months after the **start date** of this **policy** we won't increase your **amount of cover** until the next **plan anniversary**.

We'll let you know if there is going to be an increase and you can choose whether to accept it or not. If you don't want to accept the increase you must let us know before the next **plan anniversary** and we'll change your **policy** to level cover for the rest of the term of your **policy** (read section A3(a)) to find out more about level cover).

If you decide that you want inflation linked cover again later on you'll need to apply for a new **policy**. We can't guarantee that we'll be able to offer you inflation linked cover again because this will depend on your circumstances and whether we're still offering that type of insurance at the time.

If you've added Children's cover to your **policy**, the amount you pay and the amount of Children's cover we'll provide won't change from the amounts shown in your policy schedule. Only the **amount of cover** for the person we're insuring and amount you pay (your **premium**) will be affected by inflation linked changes.

A3(c) – Decreasing cover

This means that your **amount of cover** will go down each month, but the amount you pay (your **premium**) stays the same.

This type of insurance is intended to cover the amount owed on a mortgage where repayments are based on the amount you borrowed from your mortgage lender, plus interest (known as a capital and interest or repayment mortgage).

When a claim is made we'll pay an amount that is equal to what would have been outstanding on a capital and interest repayment mortgage if you had borrowed the same amount as your **amount of cover** on the **start date** of your **policy**, for the same amount of time that your **policy** was taken out for, and interest rates had been 6% compounded annually.

If this isn't enough to cover the outstanding amount on your mortgage we will pay the remaining amount left on your mortgage from the date the person we're insuring died or was diagnosed with a **critical illness** (we'll also pay any **interest** that has built up since that date) as long as:

- There's still a mortgage being repaid in equal monthly instalments.
- The mortgage was taken out no later than three months after the **start date** of your **policy**.
- The mortgage is a capital and interest repayment mortgage which is on track to be fully repaid at the end of the term of the mortgage.
- The length of the mortgage is the same as the length of time on your **policy**.
- The amount remaining to pay for your mortgage is not more than it would have been if you borrowed the same amount on the **start date** of your **policy** for the same amount of time that your **policy** was taken out for, and interest rates had been 12% compounded annually.

For us to pay this higher amount we must have written confirmation from your lender of the mortgage details and the amount owed.

If you have changed your **amount of cover** we treat the **start date** of your **policy** as being the date that you made the changes to your **amount of cover** (not the date you took the **policy** out).

Example

Here's an example where a claim is made and the remaining mortgage is £80,000.

- First we work out the minimum we would pay using 6% interest, which is £76,000.

As this isn't enough to clear the mortgage:

- We would work out the maximum we would pay using 12% interest, which is £87,000.

As the remaining mortgage amount is less than the maximum amount we would pay, and as long as all the other criteria we've listed have been met, we would pay an amount equal to the remaining mortgage (in this example it's £80,000).

If any changes have been made to the mortgage (for example it had been repaid, or increased or extended) without changes having been made to the policy, we would pay out at least the minimum amount, which would be £76,000.

This is only an example. We'll need to work out the minimum and maximum amounts we'd pay based on the exact amount outstanding on your mortgage at the time a claim is made.

If the amount owing on your mortgage when you took out your **policy** was more than your chosen **amount of cover** on the **start date** of your **policy**, we'll reduce the amount we will pay by the same percentage when a claim is made.

Example

A claim is made on a policy where the amount of cover was £90,000 at the start of the policy, but the mortgage outstanding at the start of the policy was £100,000. This means the amount of cover at the start of the policy was 10% less than the amount outstanding on the mortgage.

When a claim is made the remaining amount outstanding on the mortgage is £80,000,
so we deduct 10% and pay a claim for £72,000.

If you've added Children's cover to your **policy**, the amount you pay for it and the amount of Children's cover we'll provide won't change from the amounts shown in your policy schedule. Only the **amount of cover** for the person we're insuring will go down each month, as explained above.

A4 – If the person insured by the policy has died

It's a good idea to tell the person you want to receive the claim payment when you die that you have this **policy**, and consider including this information in your will (if you have one). This makes it quicker and easier for us to pay the claim to the right person or organisation if you die. The person making the claim should tell us about your death as soon as they can. They can do this by email, over the phone or in writing. Visit **LV.com** for our contact details.

Before we can pay a claim we'll need the original death certificate (not a photocopy) and may also need:

- Proof of age for the person insured by this **policy**, for example their birth certificate.
- Evidence that the person making the claim is the right person (for example, proof that you named them in your will as the executor of your estate).
- If you have put your **policy** into a trust or assigned it to someone else please tell us straight away as we'll need to see a copy of the trust or assignment documents.
- A report from the doctor who diagnosed or treated the person insured by this **policy**.

A5 – How to make a critical illness claim

Please tell us straight away if you are diagnosed with a **critical illness** so that we can begin your claim. It's important that you complete and return any forms we send you as soon as possible so that we can deal with your claim quickly.

We'll also need information from the doctor (or medical practitioner) who diagnosed or is treating your **critical illness**. We might need you to see a doctor of our choice to confirm how your treatment is progressing – if we ask you to do this we'll pay all the costs involved.

We won't know exactly what other information we'll need until you make a claim because it'll depend on your circumstances.

We understand you might not be well enough to do what we ask, so don't worry if there is a delay. Just tell us why you've been unable to provide what we asked for as soon as you can. You can always give a friend or relative permission to act on your behalf and help you with your claim. If you need any extra help or support with anything we ask you for please just let us know.

We'll work with you at the time you claim to obtain the evidence we need. However, without evidence that shows you have been diagnosed with one of the **critical illnesses** we cover we won't be able to pay your claim.

A6 – Claiming for an additional payment condition

If we pay a claim for an **additional payment condition**, your **policy** will continue in full. We don't deduct the amount of the additional payment we've paid from your **amount of cover**.

If you make a claim that meets the definition for an **additional payment condition** and a **full payment condition** we will only pay a claim for the **full payment condition**.

Example

If we paid a claim for the full payment condition for cancer (condition no. 8) we won't also pay a claim for the additional payment condition for Prostate cancer (condition no. 41).

We will only pay one claim for each **additional payment condition** for each person insured by this **policy**. However you can still make a claim for any other **critical illnesses** covered by the **policy**.

If you die before the **end date** of your **policy** we will pay the full **amount of cover** and your **policy** will end.

A7 – Who we'll pay the claim to

Once a claim is approved we pay the money to the legal owner of the **policy**.

- If that person has died we'll pay the person named as the executor in the policy owner's will. If there isn't a will, we'll pay whoever the court appoints as the administrator of the estate.
- If the **policy** has been put into a trust we'll pay the claim to the trustees.
- If the original owner of the **policy** has legally signed it over to someone else (for example, their bank) then we'll pay the claim to them as they are the current policy owner.

If we pay the **amount of cover** because the person insured by this **policy** has died the **policy** will end.

If we pay a **critical illness** claim for a **full payment condition** the **policy** will end.

If we pay a **critical illness** claim for an **additional payment condition**, or if you have added Children's cover, a child's claim or pregnancy complications the **policy** will continue.

We explain what happens for claims made for an **additional payment condition** in section A6, and what happens when a claim for Children's cover is made in section A10.

We always try and pay claims as quickly as possible. Sometimes it's not possible to pay straight away, so if it takes us longer than 60 days from the date of the event you're claiming for to pay your claim we'll add interest to the amount we pay from day 61 to the date of payment. If this changes we'll let you know when you claim.

If there are two people insured by this **policy**, or two policy owners

- If there are two people insured by this **policy** (who are also the policy owners) we'll pay a claim to the surviving person if either person dies. If one policy holder is diagnosed with a **critical illness** before the **end date** of your **policy**, we'll pay a claim to both policy owners jointly. If we have paid a claim because the person insured has died or a **full payment condition** for a **critical illness** the **policy** will end.
- If two policy owners die at the same time the law states the older person will be the one considered to have died first. So we would pay a claim to the estate of the younger policy owner because we pay to the surviving party.

A8 – If you're insuring someone else

You can insure someone else, but only if you would suffer financially if anything happened to them. You'll be the policy owner, and they will be the person insured by the **policy**.

We'll always pay the claim to you as the legal owner of the **policy** if the person insured dies or is diagnosed with a critical illness before the **end date** of your **policy**.

We will need the person you're insuring to provide details about the **critical illness** they have been diagnosed with if you are making a **critical illness** claim. We'll also need consent from the person insured by this **policy** to speak to their doctor if claiming for a **critical illness**.

You cannot change who is insured once your **policy** has started. If you want to do this, you'll need to apply for a new policy.

A9 – Claiming from this policy and state benefits

Claim payments from this **policy** may affect the amount of state benefits you receive.

If you apply for or receive state benefits we recommend you ask about this with the Department for Work and Pensions. Please remember you must tell them about the money you receive from this **policy**.

A10 – Children's cover

This section only applies if you have included Children's cover on your policy. Your children will be covered for the critical illnesses listed in appendix C, and the person insured by this policy will be covered for the pregnancy complication payments explained in appendix D.

Children's cover is an option you can choose to include in your **policy** for an additional cost. We explain when this can be added or removed from your **policy** in section B11.

It covers your **children** (from birth up to your **child's** 23rd birthday) for all of the **critical illnesses** listed in appendix C under the Children's critical illness conditions section. The limits we apply to Children's cover are explained in section A10(f).

For claims relating to Children's cover, your **child** doesn't need to have survived for 14 days after their diagnosis or having their operation. If you need to make a claim under Children's cover we will pay the lower of:

- 50% of your **amount of cover** (the amount that is shown on your policy schedule), or
- £35,000

We will only pay a claim for one **full payment condition** for each **child** on this **policy**. If we have paid a claim for a **full payment condition** for that **child** they are no longer covered under this **policy**. If your **child** is also covered under Children's cover for any other policy with us the most we would pay out across all of the policies you have with us is £70,000 in total.

If we pay any **child** claims for any of the **additional payment conditions**, we'll pay the lower of:

- 25% of your **amount of cover** (the amount that is shown on your policy schedule), or
- £15,000

If you have chosen either inflation linked or decreasing cover, the amount you pay for Children's cover and the amount of Children's cover we'll provide won't change from the amounts shown in your policy schedule.

A10(a) – Enhanced claim payments

We also include an enhanced claim payment for **children's** claims for ten specified conditions where the claim is made as a result of an accident. We will also pay an enhanced payment for **children's** claims for: liver failure (condition no.31), major organ transplant (condition no. 35) or severe lung disease (condition no.47). The payment will be the lower of:

- 100% of your **amount of cover** (the amount that is shown on your policy schedule), or
- £70,000

If your **child** is also covered under Children's cover for any other policy with us, the most we would pay out for a claim made for one of the enhanced payment conditions is £140,000 in total, across all of the policies they are covered under with us.

You will find further information on the illnesses that qualify for enhanced payments, and we how define what an accident is, in appendix C.

Remember to tell us when your youngest child reaches their 23rd birthday

This **policy** will not cover your **children** once they reach their 23rd birthday, so it's very important that you tell us when you no longer have any **children** under the age of 23.

We won't remove Children's cover from your **policy** automatically as we don't know the ages of your **children**. This means that if you don't cancel it at the right time, you could end up paying for something you can't use.

You can either tell us directly or ask your financial adviser to do it.

A10(b) – Child funeral payment

If your **child** dies between their birth and their 23rd birthday, including stillbirth occurring at least 24 weeks in to the pregnancy (but excluding elective pregnancy termination) as long as it's before the **end date** of this **policy** we will pay £5,000 towards the cost of their funeral. This is in addition to any payment made for a claim on one of the listed **critical illness** conditions for **children**.

The funeral payment is only paid once per **child**, and we won't pay more than this if your **child** is also covered under any other policy with us. This feature is part of the **policy** and cannot be assigned or placed in trust unless the whole **policy** is assigned or placed into a trust.

A10(c) – Cost of diagnosis of cancer

If your **child's** condition and treatment meet the criteria for any of the cancers covered by this **policy** we'll pay you £1,000 when we receive evidence of your **child's** cancer diagnosis. We'll just need a copy of the diagnosis letter from your **child's** consultant showing the histological classification of the cancer and details of the proposed treatment.

This payment is to help with any costs you may be facing following your **child's** diagnosis (such as hospital travel). Receiving this payment won't reduce your **amount of cover** and it doesn't guarantee we'll pay a claim, as your **child's** final diagnosis and treatment may not meet the definition of the condition you're claiming for.

A10(d) – Junior option

Any **child** covered under the **policy** can choose to start a new life and critical illness policy with us without having to go through medical underwriting by activating the junior option. Your **child** can only use this option within six months of their 23rd birthday, and we can't offer this option if we have already paid a critical illness claim for them under any policy you have with us.

The terms and conditions for the new policy will be explained in the life and critical illness policy conditions at the time of using the option (these may differ from the terms and conditions in this **policy**, and will be based on the type of life and critical illness cover you have with us).

The amount your **child** pays for their policy will be based on their age and smoker status at the time of using this option.

The duration of the policy that they can take out can match up to the same duration as your **policy**. For example, if your **policy** was originally for 20 years, then when using the junior option your **child** can take out a policy for up to, but no more than 20 years.

Your **children** can always apply for their own policy without using the junior option – and they may pay a different amount for the same amount of cover than they would have by using the junior option. This is because if they don't use the junior option we'll take their medical history into account, so we may be able to offer a lower price for the same cover. However, it is possible that the amount they'll pay may be higher depending on their medical history.

Please speak to us, or a financial adviser for more information.

Each **child** can choose to be covered for up to the lower of:

- 50% of their parent's cover, or
- £35,000.

Where this option is used for more than one policy, the total combined cover for all new policies using this option is limited to £70,000.

We may not be able to include cover for total permanent disability (TPD) if your **child** is a student or unemployed, also their **occupation** at the time may impact whether we can offer own occupation or work tasks cover under TPD. Speak to us or your financial adviser if you'd like more information about what occupations we cover for TPD.

Once your **child** uses this option to create a life and critical illness **policy** of their own, unless their own children are added to the policy they will not be covered.

A10(e) – Pregnancy complication payments

We'll also pay £5,000 per pregnancy if the person insured by the main Life and Critical Illness **policy** is diagnosed with one of the listed specified pregnancy complications listed in appendix D. If we make a payment for one of the listed pregnancy complications the main **policy** and Children's cover will continue and your **amount of cover** won't be affected.

A10(f) – What is and isn't covered

✔ **Children's cover includes:**

✔ Travelling abroad

If your **child** is diagnosed with one of the **critical illnesses** listed in appendix C under the children's critical illness section, excluding child intensive care we'll pay a claim as long as they have their operation, or get the diagnosis confirmed by a doctor who practices in one of the following places:

Australia, Austria, Belgium, Bulgaria, Canada, Channel Islands, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, Ireland, Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, UK or USA.

✘ **Children's cover will not include:**

✘ All types of illness

Your **child** is only covered for the **critical illnesses** listed in appendix C. If they are diagnosed with any other illness, medical condition, have an operation that is not listed, or their illness, medical condition, or operation does not meet our definition of one of the critical illnesses we cover then we will not pay a claim.

✘ All causes of illness

We won't pay a claim for Children's cover if:

- you were aware of an increased risk of your **child** suffering the **critical illness** before the **start date** of your **policy** or before the date you added Children's cover, if this has been added after you have taken out your **policy** (for example you had received medical advice or counselling in relation to the **critical illness** before your **policy** started).
- symptoms relating to the **critical illness** had arisen before the **start date** of your **policy**, or before the date you added Children's cover, if this has been added after you have taken out your **policy**. However if your **child** had already suffered the **critical illness**, and had been discharged from follow-up, and hasn't consulted any medical practitioner or received treatment or advice for the condition for at least five years before the diagnosis of the **critical illness**, then they would still be covered.

We will not pay a claim if the **critical illness** your **child** has been diagnosed with, or the reason they need to have an operation is caused by any of the following:

- intentional self-inflicted injury
- alcohol or solvent abuse
- taking drugs (unless prescribed by a doctor)
- not having a reasonable explanation for choosing not to follow medical advice.

✘ Pregnancy complications before the policy started

- We will not pay a claim for any of the specified pregnancy complications if the person insured by the main Life and Critical Illness **policy** had suffered from, or were aware of an increased risk of suffering from that specific pregnancy complication before either their **policy** started or before adding Children's cover to their **policy**.

Section B – Managing your policy

B1 – Paying for your policy

It's your responsibility to make sure you pay for your **policy** on the date shown in your policy schedule (this is known as your **premium** due date) otherwise you won't be covered.

You must make your payments (your **premiums**) monthly, from a UK bank account by Direct Debit.

If we're assessing a claim under your **policy**, you'll still need to pay your **premiums**. If you don't then your **policy** will be cancelled – read section B2 for more information about this.

B2 – What happens if you stop paying for your policy

You'll have 60 days from the due date to make up any missed payments (your **premiums**). If we don't receive a payment we'll let you know, just in case something has gone wrong that you didn't know about.

If we don't receive your payment within the 60 day period we'll cancel your **policy**, you'll no longer be covered and we won't refund the money you've already paid. If this happens we'll let you know your **policy** has ended – this means we won't pay a claim if you die or are diagnosed with a **critical illness**, or for Children's cover (if your **policy** includes it).

B3 – Restarting your policy

If your **policy** stopped because we didn't receive your **premium** payments you can ask us to start it again within six months of the first missed payment. You'll just have to answer some health questions first then make up all the missed payments. If your health has changed since originally taking out the **policy** we might need you to take out a new policy, or accept different terms from those of your existing **policy**.

We might not be able to restart your **policy** at all if we're no longer providing this kind of cover, or your circumstances have changed since the **policy** started. If your **policy** ends because you didn't make your payments we are not required to agree to restart it.

We won't pay claims on policies with **premium** payments that haven't been kept up to date. You must make up any missed payments before we can consider a claim.

Please remember that even if your **policy** payments are brought up to date we maybe unable to pay the claim, check sections A1 and A2 for more information about what's covered and what isn't covered. For Children's cover please read section A10.

B4 – When the amount you pay can change

This will only usually happen due to changes for inflation linked cover (as explained in section A3(b)) or if you change your **policy** yourself. We could change the **amount** you pay us after the start date of your **policy** for the following reasons:

- Changes to legislation that changes the way your **policy** or the amount you pay (your **premium**) for it is taxed
- Changes to legislation that changes the factors we can legally use to work out the amount you pay
- A decision by a court that changes the law in the UK and that changes the factors that we can take account of.

Other than stated elsewhere in these policy conditions these are the only times when we can change the amount you pay (your **premium**) for your **policy**.

We can't change your **premium** for any of the following reasons:

- To increase our profits
- To make up for any losses we've made in the past
- If you've made a claim
- If there have been any changes in the person insured's health since the **start date** of your **policy** (unless your policy has ended and you are restarting it as explained in section B3).

If the amount you pay (your **premium**) is going to change, we will let you know at least 60 days before we change it.

If we advise you of an increase to the amount you pay (your **premiums**), you can choose to continue paying the previous amount instead. Your **amount of cover** will then be reduced to the amount that your existing **premium** will pay for.

You need to let us know if you decide to do this, at least 30 days before the change is due to be made.

You can also choose to cancel your **policy**, although you should think about it carefully before doing so. If you decide to do this, your **policy** will end, the person insured won't be covered, and you won't get anything back.

B5 – Proof of your age and name when claiming

We use the age of the person being insured to work out how much you need to pay us for your **policy** (these are your **premiums**). So it's really important that you check that the date of birth shown in your policy schedule is correct, as it affects the amount we can pay for a claim if we don't have the right information.

For a death claim we'll usually get confirmation of age from the death certificate. If you've been diagnosed with a **critical illness**, we'll usually get these details from your medical information. In some cases we might need your original birth certificate or passport (not photocopies).

If we didn't have the correct date of birth for the person being insured, we'll change your **amount of cover** to the amount that would have been available based on their actual age when your **policy** started, we'll also take into account how much you've already paid for it.

If your (or the person being insured's) name is different from the name on your policy schedule and medical records, birth or death certificate we'll need evidence of this change before we can pay a claim (for example, a change of name certificate).

B6 – Cancelling your policy

You can cancel your **policy** at any time, just get in touch and tell us you no longer want it.

When you cancel your **policy** you (and your **children** if you've chosen to include Children's cover within your **policy**) will no longer be covered and we won't refund any of the money (your **premiums**) you've already paid – unless you are cancelling your **policy** within 30 days of the **start date**, in which case we will refund everything you've paid.

If your decision to cancel your **policy** is due to a change in circumstances (not because you no longer want cover) please speak to us or your financial adviser first, as there may be an alternative solution for you.

Please remember that once you cancel your **policy** you'll no longer be covered, so we won't pay a claim if you die or are diagnosed with a **critical illness** (or for Children's cover if you have included it in your **policy**).

We explain how you can add or remove Children's cover in section B11.

B7 – When we can cancel your policy

If we cancel your **policy** you won't be entitled to a refund of any of the money (the **premiums**) you've paid (unless we've canceled it as a result of you taking your own life as explained below).

We'll only cancel your **policy** if:

- you've died as a result of taking your own life within 12 months of the **start date**
- we haven't received any **premium** payments for more than 60 days (see section B2)
- you or anyone you're insuring acts fraudulently, provides untrue, inaccurate or misleading information when applying for your **policy**, making a claim, or when applying to change or restart your **policy** (see section B3)
- we identify involvement or association with financial crime. We'll also pass the details to crime prevention and law enforcement agencies.

For fraud and deliberate misrepresentation

If someone deliberately withholds information, provides false information, or lies to us in their application, at any point during the lifetime of the **policy** or when making a claim, we'll cancel the **policy** and won't refund any of the money they've paid (the **premiums**). We will refuse to pay any claim made if we've had to cancel the **policy** for any of these reasons.

However, we understand that you might have provided the wrong information by mistake and if this happens we won't automatically cancel your **policy**. But we might reduce your **amount of cover**, make changes to your **policy**, be unable to pay your claim, or cancel your **policy** if having the incorrect information caused us to make a different decision about your **policy** than we would have made if we'd had the correct information. For example, if:

- we would have charged you more for your **amount of cover**
- we would have provided a lower **amount of cover**
- the **end date** of your **policy** would have changed
- it would have caused us to not go ahead with your application, or to apply a **special provision** (an exclusion) to your **policy**

B8 – When your policy ends

Your **policy** will stop on the **end date** shown in your policy schedule or once we've paid a claim (unless the claim is for an **additional payment condition**, or for Children's cover, if included within your **policy**). After this you're no longer covered so the payments (your **premiums**) you pay to us will also stop, please remember that you won't get a refund of the money you've already paid.

Once we pay a claim if the person insured by this **policy** has died, or we pay a **critical illness** claim for a **full payment condition** on your **policy** we won't pay any further claims (for example, if we pay a claim for **critical illness** we won't pay another claim if you die).

If you die or are diagnosed with a **critical illness** after the **end date** of your **policy** you cannot make a claim as the **policy** will no longer be active.

B9 – You choose who we pay the claim to

If you want us to pay a death or **critical illness** claim made on your **policy** to another person or company (such as a family member or mortgage lender) you can transfer your **policy** to them – this is called 'assigning' it, or you can place it into a trust.

You can only do this before a claim is made and you can't change who the **policy** is insuring, just the owner.

If you choose to do this you'll need to send us the relevant documents confirming the change of ownership otherwise we won't pay the right person when a claim is made. It'll be your responsibility to make sure the **policy** has been assigned or placed in trust correctly – otherwise it won't be valid, so you may want to talk to a solicitor or a financial adviser first.

Please be aware that you cannot assign, or separately place into trust the Children's cover (if you've chosen to include this) under this **policy**.

B10 – Increasing your cover using a guaranteed increase option (GIO)

This means we guarantee you'll be able to get more cover (without having to answer any further health questions) within three months of any of the GIO events happening to the person insured by this **policy**. You can do this as long as the payments are all up to date and the person insured by the **policy** is aged 54 or under (for joint life policies the age limit applies to the older person), and hasn't been diagnosed with a **critical illness** or been advised by a medical practitioner to have an operation or undergo a medical procedure covered by this **policy**. You don't need to have told us that you intend to make a claim.

If we're unable to offer you the option due to your medical history or personal circumstances, we'll tell you before your **policy** starts and this will be shown in your policy schedule.

If you're taking this **policy** out to insure someone else then it's their circumstances we need to know about, not yours.

You can increase your **amount of cover** by up to £150,000. However, you can't increase it by more than 50% of the **amount of cover** shown in your policy schedule when you want to use this option.

You can use these options more than once but can only use one option at a time. Over the lifetime of your **policy** you can use GIOs as many times as you want to increase your **amount of cover**, but the total of all these increases in your **amount of cover** cannot be more than £200,000.

If you want to increase your **amount of cover** by more than these limits you'll have to answer some health questions first, and we won't guarantee you'll be able to increase your cover. In all cases when you use a GIO the amount you pay to us (your **premium**) will go up because your **amount of cover** will have increased. The new amount you pay will take into account your age and whether or not you smoke.

The events covered by guaranteed increase options are:

- **Mortgage increase**, due to moving to a new home or doing home improvements on your main residence. You can't increase your **amount of cover** by more than the amount that your mortgage has increased by.
- **Mortgage extension**, if you extend the repayment term of your current mortgage, or have taken out a new mortgage, and the new repayment date is more than one year after the **end date** of your **policy**. You can extend your **policy** by replacing it with a new one as long as:
  - it ends before both of the insured people reach the age of 80 (for level and decreasing cover) or 70 (for inflation linked cover)
  - the end date of the new policy isn't after the end date of the new mortgage
  - the **amount of cover** for the new policy is the same or lower than:
  - the **amount of cover** for your current **policy**, and
  - the amount owing on your mortgage.
- **Rent increase** due to moving to a new rented home or having your rent increased at your current home by your landlord. You can increase the **amount of cover** by the lower of:
  - the increase in the rental amount (monthly increase multiplied by the months remaining on policy term), or
  - 50% of the **amount of cover** shown on your policy schedule at the time you wish to use this option.
- **Marriage or civil partnership** – that's legally recognised in the UK.
- **Divorce or dissolution of a civil partnership** – that's legally recognised in the UK.
- **Having a child** – if you've adopted a child this must be legally recognised within the UK.
- **Basic salary increase of at least 10%** – this must be due to getting a new job, a promotion, or obtaining a recognised award or qualification. This option isn't available for self-employed people or if you are (or related to) the owner, director or partner in the company you are employed by. You can't increase your **amount of cover** by more than five times the actual amount of your salary increase.

Converting a joint life policy into two separate policies

You can only use this option where two people are insured under the same **policy**. We will need agreement from both parties in order to do this and this option can only be used within six months of a divorce, dissolution of civil partnership, or legal separation.

If you choose to use this option your current joint **policy** will be cancelled and replaced with a new policy for each of you. The **amount of cover** each of you can have for your new individual policies cannot be more than the **amount of cover** on your joint **policy**.

Alternatively you can choose to share your current **amount of cover** between you when you take out new policies within 12 months of a divorce, dissolution of civil partnership, or legal separation.

Your options depend on how long it takes to complete the separation:

- If you complete your separation within six months you can each have your own policy for the full **amount of cover**.
- If you have joint cover but take longer than six months to complete the separation you can divide the **amount of cover** equally between you both.
- Or you can share the **amount of cover** unequally as long as the total of both policies is no more than the original **amount of cover** on your current **policy**.

To do this we'll need both policy owners to agree, please be aware that these options are only available up to 12 months after the separation event.

If Children's cover is included in the original **policy** then you'll have the option to include it in the new policies, but you'll need to ask for it to be included, it will not be added automatically. If Children's cover wasn't on the original **policy** then you can only add it if the new policy has at least five years remaining until the **end date**. Remember that Children's cover comes at an additional cost. Please see sections A10 and B11 for more information about Children's cover.

If you want to use a GIO we'll ask you to provide some evidence of the change your option relates to, for example:

- Your marriage certificate, or civil partnership registration certificate.
- Your divorce papers, or civil partnership dissolution papers.
- Your mortgage offer and proof of your previous mortgage amount.
- Your new rental agreement and proof of your previous rent amount.
- Your **child's** birth or adoption certificate.
- A letter from your employer regarding your salary increase.
- Your payslips.

Event	Increase limit	Maximum increase allowed to the annual amount of cover	Maximum age of insured person
Mortgage increase	50% of the **amount of cover** shown on the policy schedule when you want to use this option, limited to the increase in the total amount owed on the mortgage	£150,000	54
Mortgage extension	The new amount of cover can't be more than the lower of your current **amount of cover** on the original **policy** when you want to use this option, or the amount owing on your mortgage at the time you use this option	Not applicable	54
Rent increase	50% of the **amount of cover** shown on the policy schedule when you want to use this option, limited to the total increase in rent payments (monthly increase multiplied by the number of months remaining on policy term)	£150,000	54
Marriage and civil partnership	50% of the **amount of cover** shown on the policy schedule when you want to use this option	£150,000	54
Converting a joint life policy into two individual policies	The **amount of cover** can't be more than the **amount of cover** on the original policy at the time you use this option	Not applicable	No age limit
Divorce and dissolution of civil partnership	50% of the **amount of cover** shown on the policy schedule when you want to use this option	£150,000	54
Having a child – by birth or legal adoption	50% of the **amount of cover** shown on the policy schedule when you want to use this option.	£150,000	54
Basic salary increase of at least 10%	50% of the **amount of cover** shown on the policy schedule when you want to use this option, limited to a maximum of five times the increase in basic salary	£150,000	54

B11 – Adding or Removing Children's cover

You have the option to add Children's cover to your **policy** at an additional cost. You may decide to do this when you first applied for your **policy**, or at a later date after your **policy** started. You can only add it to your **policy** where the term of your **policy** has at least five years remaining. If Children's cover is added to your **policy**, your **children** will be covered by the **critical illness** conditions listed within appendix C.

If you add Children's cover the amount you pay will be based on your personal circumstances for example your age (or the age of the person insured by this **policy**) at the time of adding Children's cover, and not your **child's** age. This is because the cover provided by Children's cover is linked to the **amount of cover** provided by your main **policy**.

We won't pay a claim if you were aware of an increased risk or there were symptoms of a **critical illness** before adding Children's cover on to your **policy**. We explain what is and isn't covered in section A10(f).

If you decide you no longer want Children's cover you can ask us to remove this from your **policy** at any time. This means your **children** will no longer be covered by the **policy**, and you will not be covered for the pregnancy complication conditions as listed in appendix D. Once you have removed Children's cover, you can't add it back onto the same **policy**. If you wanted to add it again, you can only do this if you apply for a new policy. We can't guarantee that we'll be able to offer you a new policy in the future, as it will depend on your age, health and medical history, leisure activities and whether we are offering Life and Critical Illness policies at that time.

Remember to tell us when your children reach 23 years of age

This **policy** will not cover your **children** once they reach the age of 23, so it's very important that you tell us when you no longer have any **children** under the age of 23.

We won't remove Children's cover from your **policy** automatically as we don't know the ages of your children. This means that if you don't cancel it at the right time, you could end up paying for something you can't use.

You can either tell us directly or ask your financial adviser to do it.

B12 – Other ways to make changes to your policy

You can ask us to make changes to your **amount of cover** or the **end date** of your **policy** at any time (other than using a guaranteed increase option explained in section B10 or inflation linked cover explained in section A3(b)). However, we can't guarantee you'll be able to make these changes as it depends on whether we're still offering Life and Critical Illness policies, as well as your age and current circumstances, so we'll also need you to provide some up to date health and lifestyle information first.

If you do wish to make any changes you need to let us know at least six months before the **end date** of your **policy**. If we are able to make the changes we'll let you know your new **amount of cover** and the new amount you'll need to pay us for your **policy**. Then all you have to do is confirm that you're happy to go ahead.

B13 – Increasing your amount of cover if you have Children's cover

If you make any changes to your **policy** such as using a GIO (explained in section B10), or other changes (explained in section B12) that increase your **amount of cover**, you may be able to increase the amount of Children's cover that you have. You can't change the amount of Children's cover unless you change your **amount of cover** for the whole **policy**.

If the amount of Children's cover hasn't reached the maximum limit (which is £35,000), you'll have the option to increase it by up to 50% of the amount that you are covered for at the same time.

Section C – Other information

C1 – Legal information

We'll always communicate in English and your Life and Critical Illness **policy** and its terms and conditions are governed by the laws of England and Wales. This means that any legal disagreements will be settled exclusively by the courts of England and Wales.

C2 – How claim payments are taxed

Income tax and capital gains tax don't currently apply to claims paid from this **policy**, but inheritance tax might.

Inheritance tax only applies to death claims. If you are the policy owner and the person insured at the time a death claim is paid, the **amount of cover** will be included in your estate for the purpose of working out whether inheritance tax applies. This will depend on what your total estate is worth.

Your estate is the total value of everything you own (for example your home, savings, and personal belongings) after any debts you owe have been paid (for example a mortgage or credit card bill).

If you've put your **policy** into a trust it will not normally be included in your estate.

Please speak to your financial adviser or solicitor if you have any questions about trusts or inheritance tax.

If you're insuring someone else, the amount we pay will go straight to you, because you're the policy owner. This means that it won't be included in the estate of the person being insured, so won't be subject to inheritance tax for their estate.

If you own the **policy** with somebody else please speak to your financial adviser or solicitor about the tax implications of this.

This information is based on our understanding of the current laws and HM Revenue and Customs practice, which can change at any time.

C3 – How to make a complaint

If you have a complaint about any part of the service you receive from us, it's important that we know about it, so we can help to put things right. You can let us know by emailing **lifecomplaints@LV.com** or calling **0800 678 1906**, or you can write to us at: Box 2, Liverpool Victoria Financial Services Limited, County Gates, Bournemouth, BH1 2NF. Your complaint will be dealt with promptly and fairly and in line with the Financial Conduct Authority's requirements. Please visit **LV.com/complaints** if you'd like more information on how we handle complaints.

We hope that we will be able to resolve any complaint that you have, but if you're unhappy with the outcome of your complaint the Financial Ombudsman Service may be able to help you free of charge. You'll need to contact them within six months of receiving our final response letter. Visit their website **financial-ombudsman.org.uk** for information about the service and their contact details. If you make a complaint it won't affect your right to take legal action.

C4 – How we use your information

We'll always protect your personal data, visit **LV.com/data-protection** to find out exactly how we use, share, store and dispose of the information we have about you.

If you have any other questions or would like our data protection details in print or an accessible format please email our data protection officer **DPO@LV.com** or write to: Data protection officer, Liverpool Victoria Financial Services Limited, Frizzell House, County Gates, Bournemouth, BH1 2NF.

C5 – Financial crime and terrorist financing

The personal information we have collected from you will be shared with crime prevention agencies who will use it to prevent financial crime and money-laundering and to verify your identity. If financial crime is detected, you could be refused certain services, finance or employment. For details of how your information will be used by us and these fraud prevention agencies, and your data protection rights just write to us at: Financial Crime, Liverpool Victoria Financial Services Limited, County Gates, Bournemouth, BH1 2NF.

We use your information to make sure we comply with any financial sanctions that apply in the UK and overseas. This includes:

- checking your information against sanctions lists
- sharing your information with HM Treasury and international regulators if required.

We will contact you if we need more information to comply with financial sanctions.

Appendix – all critical illnesses and definitions

In this section you'll find detailed definitions of the **critical illnesses** that are covered by this **policy**.

We have split this into **full payment conditions** – where we would pay the full **amount of cover**, and **additional payment conditions**, where we would pay a proportion of your **amount of cover**. For **additional payment conditions** we will only make one payment for each condition. You can't make multiple claims for one single **additional payment condition**.

Your policy schedule explains which of these **critical illnesses** you're covered for. This depends on whether you've chosen to be covered for all of the **critical illnesses**, or all of the **critical illnesses** except total permanent disability (condition no. 39), and whether you have added Children's cover or not. If you have added Children's cover to your policy, your **children** will be covered by the conditions detailed in appendix C, and the person insured by this **policy** will be covered by the pregnancy complications detailed in appendix D.

Also in some cases due to your health, occupation or leisure activities we may not be able to cover all of these **critical illnesses**. If that is the case, it will be noted on your policy schedule under the heading of **special provisions**.

Appendix A – Full payment conditions

A **full payment condition** is a condition where we pay your full **amount of cover**. If we pay a claim under one of these conditions then your **policy** will normally end. The only exception to this is if we pay a claim under Children's cover (if you have added Children's cover to your **policy**).

For some of the **full payment conditions** we will pay an additional 50% on top of your **amount of cover** if the cause of the claim was as a direct result of an accident. This is subject to a maximum £200,000 more than your **amount of cover**. We have explained this under the relevant conditions below.

For the purposes of this an 'accident' means: any violent, external and visible event that happens by chance, solely and independently of any other cause, which results in a bodily injury being sustained.

It doesn't include any event where the injury is caused by, or a contributing factor is:

- an intentional self-inflicted act
- an act deliberately inflicted by another person
- taking drugs
- drinking alcohol
- consuming poisonous substances (including inhaling gases or fumes)
- actively taking part in any criminal or fraudulent act
- actively taking part in any riot, civil commotion, uprising or war (whether declared or not), or any related act or incident
- taking part in any form of motor racing (including time trials) taking part in any form of aviation, including travelling in an aircraft (except as a fare paying passenger)
- natural causes, or an illness or disease of any kind

To help you understand when this applies we have highlighted the word 'accident' in bold text like this: **accident**.

1 Alzheimer's disease or other forms of dementia – resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease, or other forms 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; and
- perceive, understand, express and give effect to ideas

2 Aorta graft surgery – for disease or traumatic injury

The undergoing of surgery for disease or trauma to the aorta with excision and surgical replacement of a portion of the diseased or damaged 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

3 Bacterial meningitis – resulting in permanent symptoms

A definite diagnosis of bacterial meningitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

For this definition, the following are not covered:

- All other forms of meningitis other than those caused by bacterial infection.

4 Benign brain tumour – resulting in permanent symptoms or specified treatment

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

- Permanent neurological deficit with persisting clinical symptoms; or
- surgical removal of part or all of the tumour; or
- undergoing radiotherapy, including stereotactic radiosurgery, [or chemotherapy treatment] to destroy tumour cells.

The following are not covered:

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

5 Benign spinal cord tumour – resulting in permanent symptoms

A non-malignant tumour within the spinal canal and originating in, or arising from the meninges or spinal cord.

The tumour must be interfering with the function of the spinal cord which results in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must be made by a medical specialist and must be supported by appropriate evidence.

The following conditions are not covered:

- Cysts
- Granulomas
- Malformations in the arteries or veins of the spinal cord
- Haematomas
- Abscesses
- Disc protrusion
- Osteophytes

6 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 6/60 or worse in the better eye using a Snellen eye chart; or a loss of peripheral visual field and a central visual field of no more than 20 degrees in total.

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

7 Brain injury due to trauma, anoxia or hypoxia – resulting in permanent symptoms

Death of brain tissue due to trauma or reduced oxygen supply (anoxia or hypoxia) resulting in permanent neurological deficit with persisting clinical symptoms.

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

8 Cancer – excluding less advanced cases and including aplastic anaemia

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

The term malignant tumour includes

- Leukaemia;
- Sarcoma;
- Lymphoma except cutaneous lymphoma (lymphoma confined to the skin);
- Pseudomyxoma peritonei;
- Merkel cell cancer; and
- A definite diagnosis of aplastic anaemia by a consultant haematologist resulting in permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.

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 either 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 TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate).
- Malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin).
- Any non-melanoma skin cancer (including cutaneous lymphoma) that has not spread to lymph nodes or metastasised to distant organs.

If the claim doesn't meet the definition above then they may be able to claim on one of our additional payment conditions if the person insured has suffered from one of the following:

- Ductal or lobular carcinoma in-situ of the breast (condition no.40)
- Prostate cancer (condition no.41)

9 Cardiac arrest

Confirmation by an appropriate medical specialist of a definite diagnosis of sudden cardiac arrest that results in unconsciousness, loss of effective circulation and the undergoing of cardio-pulmonary resuscitation to sustain life.

There must be permanent insertion of an implantable cardiac defibrillator (ICD) or Cardiac Resynchronization Therapy with Defibrillator (CRT-D).

For this definition, the following are not covered:

- Cessation of cardiac function induced to perform a surgical or medical procedure

10 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 35% or less for at least 6 months when stabilised on therapy advised by the Consultant.

The diagnosis must be evidenced by:

- Electrocardiographic changes; and
- Echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of Cardiomyopathy.

For this definition, the following are not covered:

- All other forms of heart disease, heart enlargement and myocarditis; and
- Cardiomyopathy related to alcohol or drug abuse.

11 Coma – with associated permanent symptoms

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

- requires the use of life support systems; and
- with associated permanent neurological deficit with persisting clinical symptoms.

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

12 Coronary artery bypass grafts

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

13 Creutzfeldt-Jakob disease

Confirmation by a Consultant Physician of a definite diagnosis of Creutzfeldt-Jakob disease.

14 Deafness – permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies in the better ear using a pure tone audiogram.

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

15 Encephalitis – resulting in permanent symptoms

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

For this definition the following are not covered:

- chronic fatigue syndrome and myalgic encephalitis.

16 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:

- New characteristic electrocardiographic changes (or findings on a heart scan); and
- The characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction.

For this definition, the following are not covered:

- Other acute coronary syndromes or angina without myocardial infarction

17 Heart valve replacement or repair

The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.

18 Idiopathic pulmonary arterial hypertension – of specified severity

A definite diagnosis of Idiopathic pulmonary arterial hypertension that has caused permanent and irreversible impairment of heart function which is classified by a Consultant Cardiologist as at least Class III on the New York Heart Association (NYHA) scale of functional capacity.

19 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.

20 Liver failure

A definite diagnosis by a Consultant Physician or other appropriately qualified medical professional, of irreversible end stage liver failure due to cirrhosis resulting in all of the following:

- Permanent jaundice,
- Ascites, and
- Encephalopathy.

For this definition, the following is not covered:

- Liver failure secondary to alcohol or drug abuse

21 Loss of hand or foot – permanent physical severance

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

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

22 Loss of speech – permanent and irreversible

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

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

23 Major organ transplant – from another donor

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

For this definition, the following is not covered:

- Transplant of any other organs, parts of organs (other than those specified above), tissues or cells.

24 Motor neurone disease and specified diseases of the motor neurones – resulting in permanent symptoms

A definite diagnosis by a UK Consultant Neurologist of one of the following motor neurone diseases:

- Amyotrophic lateral sclerosis (ALS)
- Kennedy's disease (SBMA)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Spinal muscular atrophy (SMA)

There must also be permanent clinical impairment of motor function.

25 Multiple sclerosis – with persisting symptoms

A definite diagnosis of Multiple Sclerosis by a Consultant Neurologist that has resulted in either of the following:

- clinical impairment of motor or sensory function, which must have persisted from the time of diagnosis; or
- 2 or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on Magnetic Resonance Imaging (MRI scan)

All of the evidence must be consistent with multiple sclerosis.

26 Open heart surgery – with surgery to divide the breastbone

The undergoing of open heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct a disease or defect of the heart,

For this definition, the following are not covered:

- any percutaneous, transluminal or other procedure that does not involve median sternotomy
- investigative procedures

27 Paralysis of limb – total and irreversible

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

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

28 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 either associated tremor or muscle rigidity.

The following are not covered:

- Parkinsonian syndromes/Parkinsonism

29 Parkinson Plus Syndromes – resulting in permanent symptoms

A definite diagnosis of one of the following Parkinson Plus Syndromes by a Consultant Neurologist:

- Multiple system atrophy
- Progressive supranuclear palsy
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Corticobasal ganglionic degeneration
- Diffuse Lewy Body disease

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

The following are not covered:

- Other Parkinsonian syndromes
- Parkinsonism

30 Pneumonectomy – removal of an entire lung

The undergoing of surgery to remove an entire lung for disease or trauma.

The following are not covered:

- Partial removal of a lung (lobectomy) or lung resection or incision

31 Pulmonary artery surgery – for disease only

The undergoing of surgery on the advice of a Consultant Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

32 Severe lung disease

Confirmation by a Consultant Physician of severe lung disease where there is permanent impairment of lung function evidenced by all of the following:

- The need for daily oxygen therapy for at least 15 hours per day for a minimum of six months, and
- Forced Vital Capacity (FVC) being less than 50% of normal, and
- Forced Expiratory Volume at 1 second (FEV1) being less than 40% of normal

33 Spinal Stroke – resulting in permanent symptoms

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.

34 Stroke – of specified severity

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that has resulted in all of the following evidence of stroke:

- Neurological deficit with persistent clinical symptoms lasting at least 24 hours; and
- Definite evidence of death of tissue or haemorrhage on a brain scan.

For this definition, the following are not covered:

- Transient ischaemic attack.
- Death of tissue of the optic nerve or retina/eye stroke

35 Surgical removal of an eyeball

Surgical removal of a complete eyeball as a result of injury or disease.

For this definition the following is not covered:

- Self-inflicted injuries

If the cause of the claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

36 Systemic lupus erythematosus

A definite diagnosis of systemic lupus erythematosus (SLE) by a Consultant Rheumatologist resulting in:

- permanent impaired renal function evidenced by a glomerular filtration rate below 30ml/min/1.73m2 and
- urinalysis showing proteinuria or haematuria;

or

- permanent neurological deficit evidenced by one of the following persisting clinical symptoms - paralysis, localised weakness, dysarthria (difficulty with speech), dysphagia (difficulty in swallowing), difficulty in walking or lack of co-ordination.

For the purposes of this definition:

seizures, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin will not be accepted as evidence of permanent neurological deficit.

37 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 a 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

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

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 or affecting 20% of the area of the face or head.

If the cause of your claim was as a direct result of an **accident** then we will pay an additional 50% on top of the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

39 Total permanent disability – of specified severity

This is an optional condition, and won't be included in all policies. Your policy schedule states whether this is included and, if so, which of the following types of cover applies.

Although you don't need to tell us if you change your occupation after your **policy** starts, we will assess any claim based on the occupation that you are in when you have to stop working due to illness or accident. We will use the type of cover shown on your policy schedule.

If you are not in paid or unpaid work at the time of the claim, then the work tasks definition will apply to your claim in all cases. This is irrespective of the cover shown on your policy schedule.

- **(a) Own occupation – unable to do your own occupation ever again.**

  Loss of the physical or mental ability through an illness or injury to the extent that you are unable to do the essential duties of your own occupation ever again. The essential 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 the 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 **policy** ends or you expect to retire.

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

- **b) Work Tasks – unable to do three specified work tasks ever again**

  Loss of the physical or mental ability through an illness or injury to do at least three of the six work tasks list below ever again.

  The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the **policy** 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 specialist equipment routinely available to help and having taken any appropriate prescribed medication.

The work tasks are:

- **Walking** – the ability to walk more than 200 metres on a level surface
- **Climbing** – the ability to climb up a flight of 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 definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

It is important to understand that for us to pay a claim under either Own Occupation cover or Work Tasks cover, we need to be satisfied that your disability is expected to last for the remainder of your life, irrespective of when your **policy** ends, or when you retire.

This means we won't pay a claim if we determine you are only partially or temporarily disabled, or the medical evidence we have received in connection with your claim indicates that your disability is not expected to last for the remainder of your life.

We will pay a claim if the medical evidence we have received in connection with your claim shows that you have received all reasonable treatment options, these have been given a reasonable time to work, and have still failed to show any improvement in your symptoms.

More information on how to make a claim, and the types of evidence we need are explained in section A5.

Appendix B – Additional payment conditions

An **additional payment condition** is a condition where we pay an amount equal to part of your **amount of cover**. If we pay a claim under one of these conditions, then your **policy** will still continue for your full **amount of cover**. We don't reduce your **amount of cover**.

For the following **additional payment conditions** we will pay the lower of 25% of your **amount of cover** or £30,000. However we will only pay a claim once for each of these conditions. If the claim you make meets the definition of one of the **full payment conditions** as well as one of the **additional payment conditions** we will only pay a claim for the **full payment condition**, and your **policy** will then end.

40 Ductal or lobular carcinoma in-situ of the breast – with specified treatment

Ductal or lobular carcinoma in-situ of the breast that is histologically confirmed, and results in you undergoing surgical removal on the advice of your hospital consultant.

41 Prostate cancer

Tumour of the prostate gland histologically classified as having a Gleason score between 2 and 6 inclusive provided:

- the tumour has progressed to at least clinical TNM classification T1N0M0; and
- treatment included the complete removal of the prostate gland or external beam or interstitial implant radiotherapy, or High Intensity Focused Ultrasound, or Hormone therapy or Cryotherapy

For this definition, the following are not covered:

- Experimental treatments, or
- Observation

Appendix C – Children's critical illness cover conditions

This section only applies if you have Children's cover on your policy schedule

Full payment conditions

If you need to make a claim under your Children's cover we will pay the lower of 50% of your **amount of cover** (the amount that is shown on your policy schedule) or £35,000. We will only pay a claim for one of the following **conditions** for each **child** on this **policy**.

We will pay an enhanced claim payment for certain conditions where we'll pay the lower of 100% of your **amount of cover** (the amount that is shown on your policy schedule) or £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

We have explained this under the relevant conditions below.

For the purposes of this, an accident means:
any violent, external and visible event that happens by chance, solely and independently of any other cause, which results in bodily injury being sustained.

It does not include any event where the injury is caused by or a contributing factor is:

- an intentional self-inflicted act
- an act deliberately inflicted by another person
- taking drugs;
- drinking alcohol;
- consuming poisonous substances (including inhaling gases or fumes).
- actively taking part in any criminal or fraudulent act
- actively taking part in any riot, civil commotion, uprising or war (whether declared or not) or any related act or incident
- taking part in any form of motor racing (including time trials)
- taking part in any form of aviation, including travelling in an aircraft (except as a fare-paying passenger)
- natural causes, an illness or disease of any kind

To help you understand when this applies we have highlighted the word 'accident' in bold text like this: **accident**.

1 Alzheimer's disease or other forms of Dementia – resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease, or other forms 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; and
- perceive, understand, express and give effect to ideas

2 Aorta graft surgery – for disease or traumatic injury

The undergoing of surgery for disease or trauma to the aorta with excision and surgical replacement of a portion of the diseased or damaged 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

3 Bacterial meningitis – resulting in permanent symptoms

A definite diagnosis of bacterial meningitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

For this definition, the following are not covered:

- All other forms of meningitis other than those caused by bacterial infection.

4 Benign brain tumour – resulting in permanent symptoms or specified treatment

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

- Permanent neurological deficit with persisting clinical symptoms; or
- surgical removal of part or all of the tumour; or
- undergoing radiotherapy, including stereotactic radiosurgery, [or chemotherapy treatment] to destroy tumour cells.

The following are not covered:

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

5 Benign spinal cord tumour – resulting in permanent symptoms

A non-malignant tumour within the spinal canal and originating in, or arising from the meninges or spinal cord.

The tumour must be interfering with the function of the spinal cord which results in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must be made by a medical specialist and must be supported by appropriate evidence.

The following conditions are not covered:

- Cysts
- Granulomas
- Malformations in the arteries or veins of the spinal cord
- Haematomas
- Abscesses
- Disc protrusion
- Osteophytes

6 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 6/60 or worse in the better eye using a Snellen eye chart; or a loss of peripheral visual field and a central visual field of no more than 20 degrees in total.

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

If the claim doesn't meet the definition above then you may be able to claim on our a children's **additional payment condition** Partial loss of sight. Please see condition 73 in the Childrens Additional Payment Conditions section.

7 Brain abscess – undergoing specified treatments

A definite diagnosis of an intracerebral abscess within brain tissues by a Consultant Neurologist, resulting in either of the following:

- Surgical removal; or
- Surgical drainage of the abscess

8 Brain injury due to trauma, anoxia or hypoxia – resulting in permanent symptoms

Death of brain tissue due to trauma or reduced oxygen supply (anoxia or hypoxia) resulting in permanent neurological deficit with persisting clinical symptoms.

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

9 Cancer – excluding less advanced cases and including aplastic anaemia

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

The term malignant tumour includes

- Leukaemia;
- Sarcoma;
- Lymphoma except cutaneous lymphoma (lymphoma confined to the skin);
- Pseudomyxoma peritonei;
- Merkel cell cancer; and
- A definite diagnosis of aplastic anaemia by a consultant haematologist resulting in permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.

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 either 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 TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate).
- Malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin).
- Any non-melanoma skin cancer (including cutaneous lymphoma) that has not spread to lymph nodes or metastasised to distant organs.

If the claim doesn't meet the definition above then you may be able to claim on one of our children's **additional payment conditions** if a **child** has suffered from one of the following:

- Gastrointestinal stromal tumour (GIST) or Neuroendocrine tumour (NET) of low malignant potential (condition no. 67)
- Less advanced cancers - of named sites and specified severity (condition no. 69)
- Other carcinoma in-situ- with surgery (condition no.71)

Please see the relevant numbered condition in the Children's **additional payment conditions** section.

If the condition and treatment meets the criteria for the above condition we'll pay £1,000 if a **child** is diagnosed with one of the listed cancers when we receive a copy of the diagnosis letter from their consultant showing the histological classification of the cancer and details of the proposed treatment. Receiving this payment doesn't guarantee we'll go on to pay the children's critical illness claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce the **amount of cover**.

10 Cardiac arrest

Confirmation by an appropriate medical specialist of a definite diagnosis of sudden cardiac arrest that results in unconsciousness, loss of effective circulation and the undergoing of cardio-pulmonary resuscitation to sustain life.

There must be permanent insertion of an implantable cardiac defibrillator (ICD) or Cardiac Resynchronization Therapy with Defibrillator (CRT-D).

For the above definition, the following are not covered:

- Cessation of cardiac function induced to perform a surgical or medical procedure

11 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 35% or less for at least 6 months when stabilised on therapy advised by the Consultant.

The diagnosis must 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, heart enlargement and myocarditis; and
- Cardiomyopathy related to alcohol or drug abuse.

If the claim doesn't meet the definition above then you may be able to claim on our **additional payment condition** Non-severe cardiomyopathy. Please see condition 70 in the children's **additional payment condition** section.

12 Cerebral palsy

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

13 Child diabetes type 1 – requiring permanent insulin injections

A definite diagnosis of type 1 insulin depending diabetes mellitus requiring the permanent use of insulin injections that have continued for a period of at least 12 months.

For this definition the following are not covered:

- Gestational diabetes
- Type 2 diabetes (including type 2 diabetes treated with insulin)

14 Child intensive care – requiring mechanical ventilation for 7 consecutive days

Any sickness or injury resulting in requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more in an intensive care unit in a UK hospital.

For the above definition, the following is not covered:

- Any claim for children's critical illness benefit as a result of a child being born prematurely (before 37 weeks)

15 Coma – with associated permanent symptoms

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

- requires the use of life support systems; and
- with associated permanent neurological deficit with persisting clinical symptoms.

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

16 Coronary artery bypass grafts

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

17 Creutzfeldt-Jakob disease

Confirmation by a Consultant Physician of a definite diagnosis of Creutzfeldt-Jakob disease.

18 Crohns disease – treated with two intestinal resections

A definite diagnosis by a Consultant Gastroenterologist of Crohn's disease which has been treated with at least two surgical intestinal resections.

19 Cystic fibrosis

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

20 Deafness – permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies in the better ear using a pure tone audiogram.

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

If the claim doesn't meet the definition above then you may be able to claim on our children's **additional payment condition** Partial loss of hearing. Please see condition 72 in the children's **additional payment condition** section.

21 Down's syndrome

A definite diagnosis of Down's syndrome by an appropriate medical specialist.

22 Edward's syndrome

A definite diagnosis of Edward's Syndrome by an appropriate medical specialist.

23 Encephalitis – resulting in permanent symptoms

A definite diagnosis of encephalitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms. For the above definition the following are not covered:

- chronic fatigue syndrome and myalgic encephalitis.

24 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:

- New characteristic electrocardiographic changes (or findings on a heart scan); and
- The characteristic rise of cardiac enzymes or Troponins.

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

25 Heart failure – of specified severity

A definite diagnosis by a UK Consultant Cardiologist of the failure of the heart to function as a pump which is evidenced by all of the following:

- Permanent and irreversible limitation to function to at least Class III of the New York Heart Association (NYHA) classification of functionality capacity (i.e heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain)
- Permanent and irreversible ejection fraction of 39% or less

For the above definition, the following are not covered:

- Heart failure caused by alcohol and / or drug use

26 Heart valve replacement or repair

The undergoing of surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

27 HIV infection – caught in a specified list of countries from a blood transfusion, a physical assault or at work

Infection with Human Immunodeficiency Virus resulting from:

- A blood transfusion given as part of medical treatment;
- A physical assault; or
- An incident occurring during the course of performing normal duties of employment;

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.
- The incident causing infection must have occurred in one of the following countries:

  Australia, Austria, Belgium, Bulgaria, Canada, the Channel Islands, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, the Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the United States of America.

For this definition, the following is not covered:

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

28 Hydrocephalus – treated with the insertion of a shunt

A definite diagnosis of hydrocephalus which is treated with an insertion of shunt.

29 Idiopathic pulmonary arterial hypertension – of specified severity

A definite diagnosis of Idiopathic pulmonary arterial hypertension that has caused permanent and irreversible impairment of heart function which is classified by a Consultant Cardiologist as at least Class III on the New York Heart Association (NYHA) scale of functional capacity.

30 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.

31 Liver failure

A definite diagnosis, by a Consultant Physician or other appropriately qualified medical professional, of irreversible end stage liver failure due to cirrhosis resulting in all of the following:

- Permanent jaundice,
- Ascites, and
- Encephalopathy.

For this definition, the following is not covered:

- Liver failure secondary to alcohol or drug abuse

If your **child** is diagnosed with this illness or condition, we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) or £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

32 Loss of hand or foot – permanent physical severance

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

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of the your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

33 Loss of independent existence – resulting in permanent symptoms

Confirmation by a Consultant Physician and our Chief Medical Officer of loss of independent existence through illness or injury that results in either :

1. irreversible mental incapacity 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;

which causes a significant reduction in mental and social functioning, requiring the continuous supervision of the child

Or

2. A permanent inability to perform at least three of the six tasks listed below ever again:

- **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 yourself when food has been prepared and made available.
- **Maintaining personal hygien**e – 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.

The **child** must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate medication.

For the above definition, The Consultant Physician and our Chief Medical Officer must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends. Disabilities for which the relevant specialists cannot give a clear prognosis are not covered

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

34 Loss of speech – permanent and irreversible

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

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

35 Major organ transplant – from another donor

The undergoing as a recipient of a transplant from another person, of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or a whole lobe of the lung or liver, 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 (other than those specified above), tissues or cells.

If your **child** is diagnosed with this illness or condition, and the claim meets this definition we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) or £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

36 Motor neurone disease and specified diseases of the motor neurones – resulting in permanent symptoms

A definite diagnosis by a UK Consultant Neurologist of one of the following motor neurone diseases:

- Amyotrophic lateral sclerosis (ALS)
- Kennedy's disease (SBMA)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Spinal muscular atrophy (SMA)

There must also be permanent clinical impairment of motor function.

37 Multiple sclerosis – with persisting symptoms

A definite diagnosis of Multiple Sclerosis by a Consultant Neurologist, that has resulted in either of the following:

- clinical impairment of motor or sensory function, which must have persisted from the time of diagnosis; OR
- 2 or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on Magnetic Resonance Imaging (MRI scan)

All of the evidence must be consistent with multiple sclerosis.

38 Muscular dystrophy

A definite diagnosis of muscular dystrophy made by a Consultant Neurologist.

39 Neuromyelitis optica (Devic's disease) – with persisting symptoms

A definite diagnosis of Neuromyelitis optica 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 3 months.

40 Open heart surgery– with surgery to divide the breastbone

The undergoing of open heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct a disease or defect of the heart,

For the above definition, the following are not covered:

- any percutaneous, transluminal or other procedure that does not involve median sternomy
- investigative procedures

41 Paralysis of limb – total and irreversible

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

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

42 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 either associated tremor or muscle rigidity.

The following are not covered:

- Parkinsonian syndromes/Parkinsonism

43 Parkinson Plus Syndromes – resulting in permanent symptoms

A definite diagnosis of one of the following Parkinson Plus Syndromes by a Consultant Neurologist:

- Multiple system atrophy
- Progressive supranuclear palsy
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Corticobasal ganglionic degeneration
- Diffuse Lewy Body disease

There must be also permanent clinical impairment of at least one of the following:

- Motor function; or
- Eye movement disorder; or
- Postural instability; or
- Dementia

The following are not covered:

- Other Parkinsonian syndromes
- Parkinsonism

44 Patau's syndrome

A definite diagnosis of Patau's syndrome by an appropriate medical specialist.

45 Pneumonectomy – Removal of an entire lung

The undergoing of surgery to remove an entire lung for disease or trauma.

The following are not covered:

- Partial removal of a lung (lobectomy) or lung resection or incision

If the claim doesn't meet the definition above then you may be able to claim on our **additional payment condition** Removal of one or more lobe(s) of the lung. Please see condition 76 in the children's **additional payment** conditions section.

46 Pulmonary artery surgery – for disease only

The undergoing of surgery on the advice of a Consultant Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

47 Severe lung disease

Confirmation by a Consultant Physician of severe lung disease where there is permanent impairment of lung function evidenced by all of the following:

- The need for daily oxygen therapy for at least 15 hours per day for a minimum of six months, and
- Forced Vital Capacity (FVC) being less than 50% of normal, and

  Forced Expiratory Volume at 1 second (FEV1) being less than 40% of normal

If your **child** is diagnosed with this illness or condition, and the claim meets this definition we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) or £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

48 Severe mental illness – of specified severity

Any mental illness that that resulted in all of the following:

- an admission to a psychiatric ward where treatment was provided for at least 14 consecutive nights; and
- has chronic unremitting symptoms; and
- has not responded to comprehensive management and treatment for which the child has completed based on best clinical practice for more than 1 year

For this definition, the following is not covered:

- Conditions related to or exacerbated by alcohol or drug abuse

49 Severe sepsis- resulting in admission to a critical care unit for 3 days or more

Severe sepsis resulting in admission of at least 3 continuous days in either an intensive care unit (ITU) or a high dependency unit (HDU).

50 Spina bifida

A definite diagnosis of spina bifida myelomeningocele or rachischsis by an attending Paediatrician.

51 Spinal stroke- resulting in permanent symptoms

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.

52 Stroke – of specified severity

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that has resulted in all of the following evidence of stroke:

- Neurological deficit with persistent clinical symptoms lasting at least 24 hours; and
- Definite evidence of death of tissue or haemorrhage on a brain scan.

For the above definition, the following are not covered:

- Transient ischaemic attack.
- Death of tissue of the optic nerve or retina/eye stroke

53 Syringomyelia or syringobulbia – treated by surgery

A definitive diagnosis of Syringomyelia or syringobulbia by a Consultant Neurologist which has resulted in being put on the NHS waiting list for surgery. This includes being put on the NHS waiting list for surgical insertion of a permanent drainage shunt.

54 Surgical removal of an eyeball

Surgical removal of a complete eyeball as a result of injury or disease.

For the above definition the following is not covered:

- Self-inflicted injuries

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

55 Systemic lupus erythematosus

A definite diagnosis of systemic lupus erythematosus (SLE) by a Consultant Rheumatologist resulting in:

- permanent impaired renal function evidenced by a glomerular filtration rate below 30ml/min/1.73m2 and
- urinalysis showing proteinuria or haematuria;

  or
- permanent neurological deficit evidenced by one of the following persisting clinical symptoms - paralysis, localised weakness, dysarthria (difficulty with speech), dysphagia (difficulty in swallowing), difficulty in walking or lack of co-ordination.

For the purposes of this definition seizures, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin will not be accepted as evidence of permanent neurological deficit.

56 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 a 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

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

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 or affecting 20% of the area of the face or head.

If the cause of the claim was as a direct result of an **accident** then we'll pay 100% of your **amount of cover** (the amount that is shown on your policy schedule) up to £70,000. If your **child** is covered by more than one **policy** the maximum we'll pay across all policies is £140,000.

If the claim doesn't meet the definition above then you may be able to claim on our **additional payment condition** Partial third degree burns. Please see condition 74 in the children's **additional payment conditions** section.

58 Ulcerative colitis – with operation to remove the entire large bowel

A definite diagnosis of ulcerative colitis by a Consultant Gastroenterologist, which is treated with total colectomy (removal of the entire large bowel).

Children's additional payment conditions

An additional payment condition is a condition where we pay part of the amount of cover. If a claim is made for one of the **child additional payment conditions** the maximum we will pay is the lower of:

- 25% of your **amount of cover** (the amount that is shown on your policy schedule), or
- £15,000

We will accept one claim for a **full payment condition** and multiple claims for **additional payment conditions** (limited to one claim per condition). If a claim is paid for an **additional payment condition** this will not affect the amount paid thereafter for **additional payment conditions**.

For less advanced cancer (condition no.69) this also means we'll only pay one claim for each of the cancers listed under that condition.

If your **child's** claim meets the definition of one of the **full payment conditions** and one of the **additional payment conditions**, we will only pay the **full payment condition** and then that **child** will no longer be covered by the **policy**, but the **policy** will continue to cover your other **children**.

59 Accident Hospitalisation cover

Suffering a physical injury due to an accident, which under the advice of a specialist requires a stay in hospital in one of a number of listed countries for at least 28 consecutive days.

The following are not covered:

- Any accident caused by a self-inflicted act
- Any accident caused by taking alcohol or drugs or where it was a contributing factor
- Any accident caused by natural causes, an illness or disease of any kind

The listed counties are:

Australia, Austria, Belgium, Bulgaria, Canada, the Channel Islands, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, the Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the United States of America.

60 Aortic aneurysm – with endovascular repair

Undergoing endovascular repair on an aneurysm of the thoracic or abdominal aorta with a graft,

The following is not covered:

- Procedures to any branches of the thoracic and abdominal aorta

61 Carotid artery stenosis – treated by endarterectomy or angioplasty

Undergoing endarterectomy or therapeutic angioplasty to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

62 Cauda equina syndrome – with permanent symptoms

Definite diagnosis of compression of the lumbosacral nerve roots (cauda equina) causing permanent neurological dysfunction as evidenced by;

- bladder dysfunction; and
- permanent weakness and loss of sensation in the legs

63 Central retinal artery or vein occlusion – resulting in permanent visual loss

Suffering 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
- Traumatic injury to tissue of the optic nerve or retina

64 Cerebral or spinal aneurysm – with surgery or radiotherapy

Undergoing craniotomy, endovascular repair or stereotactic radiotherapy to treat a cerebral or spinal aneurysm.

65 Cerebral or spinal arteriovenous malformation – with surgery or radiotherapy

Undergoing craniotomy, endovascular repair or stereotactic radiotherapy to treat a cerebral or spinal arteriovenous fistula or malformation.

66 Coronary artery angioplasty

Undergoing any of the following procedures to treat a narrowing or blockage in two or more of the main coronary arteries:

- Balloon angioplasty
- Atherectomy
- Rotablation
- Laser treatment
- Insertion of stents

The above procedure must have been carried out on the advice on a Consultant Cardiologist to treat severe coronary artery disease in two or more main coronary arteries at the same time. The procedure must be to treat at least 70% diameter narrowing. If the procedure is only performed on one main coronary artery there must be at least 70% diameter narrowing in another main coronary artery.

For the purpose of this definition main coronary arteries are described as one or more of the following:

- Right coronary artery
- Left main stem
- Left anterior descending

For this definition the following are not covered:

- Procedures to any branches of any of the main coronary arteries
- Any other procedures to treat narrowing or blockage of coronary arteries

67 Gastrointestinal stromal tumour (GIST) or Neuroendocrine tumour (NET) of low malignant potential – with surgery

Diagnosed with gastrointestinal stromal tumour (GIST) or neuroendocrine tumour (NET) of low malignant potential by histological confirmation and that has been treated by surgery to remove the tumour.

The following is not covered:

- Tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment

If the condition and treatment meets the criteria for the above condition we'll pay £1,000 if a **child** is diagnosed with one of the listed cancers when we receive a copy of the diagnosis letter from their consultant showing the histological classification of the cancer and details of the proposed treatment. Receiving this payment doesn't guarantee we'll go on to pay the children's critical illness claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce the **amount of cover.**

68 Guillain- Barré syndrome – with persisting clinical symptoms

Definite diagnosis of Guillain-Barré syndrome by a Consultant Neurologist. There must be clinical impairment of motor or sensory function which must have persisted for a continuous period of at least six months.

69 Less advanced cancer – of named sites and specified severity

Diagnosed with a less advanced cancer of a named site and of specified severity requiring treatment as detailed below.

There must be a positive diagnosis confirmed with histological confirmation relating to any of the following:

- **Carcinoma in-situ of the anus – with surgery**

  Carcinoma in-situ of the anus with surgery to remove the tumour.

  For the above definition, the following is not covered:

  — Anal intraepithelial neoplasia (AIN) grade 1 or 2.

- **Carcinoma in-situ of the bile ducts – with surgery**

  A positive diagnosis with histological confirmation of carcinoma in-situ of the extra-hepatic bile ducts with surgery to remove the tumour.

- **Carcinoma in-situ of the cervix uteri – requiring treatment with hysterectomy**

  Carcinoma in-situ of the cervix uteri (cervix) that requires treatment with hysterectomy.

  The hysterectomy must have been performed on the advice of a specialist to treat carcinoma in-situ of the cervix.

  The following are excluded:

  — All grades of dysplasia;Cervical squamous epithelial lesion (SIL) and Cervical intra-epithelial neoplasia (CIN), unless carcinoma in-situ is present.

  — Carcinoma in-situ of any other gynaecological organ (for example the ovaries, or the fallopian tubes)

  — Any other disease or disorder of the cervix or other gynaecological organs that is treated with hysterectomy

- **Carcinoma in-situ of the colon or rectum – resulting in intestinal resection**

  Carcinoma in-situ of the colon or rectum diagnosed with histological confirmation by biopsy together with the undergoing of surgery to remove part of the colon or rectum.

  For the above definition, the following are not covered:

  — Treatments including local excision or simple polypectomy.

- **Carcinoma in-situ of the gallbladder – with surgery**

  Carcinoma in-situ of the gallbladder with surgery to remove the tumour.

- **Carcinoma in-situ of the larynx – with specified treatment**

  Carcinoma in-situ of the larynx treated with either surgery, laser or radiotherapy

- **Carcinoma in-situ of the lung or bronchus – with specified treatment**

  Carcinoma in-situ of the lung or bronchus resulting in wedge resection or lobectomy

- **Carcinoma in-situ of the oesophagus – with surgery**

  A diagnosis of carcinoma in-situ of the oesophagus positively diagnosed with histological confirmation by biopsy together with the undergoing of surgery to remove the tumour.

  The following are excluded:

  — Treatment other than surgery.

  — Treatment for Barrett's Oesophagus.

- **Carcinoma in-situ of the oral cavity or oropharynx – with surgery**

  Carcinoma in-situ of the oral cavity or oropharynx with surgery to remove the tumour. Oropharynx includes lip, inside of cheek, floor of the mouth, tongue, gums, hard palate, soft palate and tonsils.

- **Carcinoma in-situ of the pancreas – with surgery**

  Carcinoma in-situ of the pancreas with surgery to remove the tumour.

- **Carcinoma in-situ of the renal pelvis or ureter**

  Carcinoma in-situ of the renal pelvis or ureter.

  For the above definition, the following are not covered:

  — Non-invasive papillary carcinoma and tumours of TNM classification stage Ta.

- **Carcinoma in-situ of the stomach – with surgery**

  A diagnosis of carcinoma in-situ of the stomach positively diagnosed with histological confirmation by biopsy together with undergoing of surgery to remove the tumour.

- **Carcinoma in-situ of the urinary bladder**

  Carcinoma in-situ of the urinary bladder that has been histologically confirmed on a pathology report.

  The following conditions are not covered:

  — Non-invasive papillary carcinoma;

  — Stage Ta bladder carcinoma,

  — All other forms of non-invasive carcinoma

- **Carcinoma in-situ of the uterus – with hysterectomy**

  Carcinoma in-situ of the lining of the uterus (endothelium) diagnosed with histological confirmation by biopsy together with the undergoing of a hysterectomy to remove the tumour.

- **Carcinoma in-situ of the vagina – with surgery**

  Carcinoma in-situ of the vagina resulting in surgery to remove the tumour.

  For the above definition, the following are not covered:

  — Laser surgery and diathermy; and

  — Vaginal intraepithelial neoplasia (VAIN) grade 1 or 2.

- **Carcinoma in-situ of the vulva - with surgery**

  Carcinoma in-situ of the vulva resulting in surgery to remove the tumour.

  For the above definition, the following are not covered:

  — Laser surgery and diathermy; and

  — Vulval intraepithelial neoplasia (VIN) grade 1 or 2.

- **Ductal or lobular carcinoma in-situ of the breast – with specified treatment**

  Ductal or lobular carcinoma in-situ of the breast that is histologically confirmed, and results in you undergoing surgical removal on the advice of your hospital consultant.

- **Ovarian tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary**

  Ovarian tumour of borderline malignancy/low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.

  For the above definition, the following is not covered:

  — Removal of an ovary due to cyst

- **Prostate Cancer**

  Tumour of the prostate gland histologically classified as having a Gleason score between 2 and 6 inclusive provided:

  — the tumour has progressed to at least clinical TNM classification T1N0M0; and

  — treatment included the complete removal of the prostate gland or external beam or interstitial implant radiotherapy, or High Intensity Focused Ultrasound, or Hormone therapy or Cryotherapy

  For the above definition, the following are not covered:

  — Experimental treatments, or

  — Observation

- **Testicular carcinoma in-situ – requiring surgery to remove at least one testicle.**

  Carcinoma in-situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU), histologically confirmed by biopsy, and as a result treated with an orchidectomy (complete surgical removal of the testicle).

If the condition and treatment meets the criteria for the above condition we'll pay £1,000 if a **child** is diagnosed with one of the listed cancers when we receive a copy of the diagnosis letter from their consultant showing the histological classification of the cancer and details of the proposed treatment. Receiving this payment doesn't guarantee we'll go on to pay the children's critical illness claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce the **amount of cover**.

70 Non-severe cardiomyopathy – definite diagnosis

Diagnosed with Cardiomyopathy by a Consultant Cardiologist resulting in permanently impaired ventricular function such that the ejection fraction is more than 35%.

The diagnosis must 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, heart enlargement and myocarditis; and
- Cardiomyopathy related to alcohol or drug abuse.

71 Other carcinomas in-situ – with surgery

Diagnosed with a with histological confirmation of carcinoma in-situ treated by surgery to remove the tumour.

The following are not covered:

- any skin cancer (including melanoma); and
- tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment

If the condition and treatment meets the criteria for the above condition we'll pay £1,000 if a **child** is diagnosed with one of the listed cancers when we receive a copy of the diagnosis letter from their consultant showing the histological classification of the cancer and details of the proposed treatment. Receiving this payment doesn't guarantee we'll go on to pay the children's critical illness claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce the **amount of cover**.

72 Partial loss of hearing – of specified severity

Suffering permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels but less than 90 decibels across all frequencies in the better ear using a pure tone audiogram.

73 Partial loss of sight – permanent and irreversible

Suffering permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/24 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 45 degrees or less of arc as certified by an Ophthalmologist.

74 Partial third degree burns – covering 10% of the body's surface area or affecting 10% of the area of the face or head

Suffering burns that involve damage or destruction of the skin to its full depth though to the underlying tissue and covering at least 10% of the body's surface area or affecting 10% of the area of the face or head.

75 Pituitary tumour – resulting in permanent symptoms or surgery

Diagnosed with a non-malignant tumour in the pituitary gland resulting in either of the following;

- permanent neurological deficit with persisting clinical symptoms; or
- surgical removal of the tumour

The following is not covered:

- tumours treated with radiotherapy
- where symptoms are absent with on-going medical treatment

76 Removal of one or more lobe(s) of the lung – for disease or trauma

Undergoing the removal of the whole of one or more lobes of the lung due to underlying disease or trauma. The surgery must be carried out on the advice of a Consultant Physician.

Appendix D – Pregnancy complication payments

This section only applies if you have Children's cover on your policy schedule

If the person insured is diagnosed with one of the specified complications of pregnancy we will pay £5,000 per pregnancy if there is a definite diagnosis by Consultant Obstetrician of one of the following conditions:

- Disseminated Intravascular Coagulation (DIC)
- Eclampsia (excluding pre-eclampsia)
- Ectopic pregnancy with surgery to remove a fallopian tube
- Foetal death in utero between 20-24 weeks gestation (excluding elective pregnancy termination). If a claim is for stillbirth this would be covered under the child funeral payment, and not under the pregnancy complication payment
- Hydatidiform mole
- Placental abruption (excluding placenta praevia)

If we pay claim for a pregnancy complication then your **children** would still be covered for the children's **critical illness** conditions, and your **policy** will still remain in place.

If you'd like us to send you this document or any future correspondence in another format, such as Braille or large print, please just let us know.

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