Keep me safe

Business Protection Combined Life & Critical Illness Guaranteed Premiums

Policy Conditions

LV= Business Protection Combined Life & Critical Illness Guaranteed Premiums is provided by Liverpool Victoria Financial Services Limited (LV=).

These Policy Conditions tell you how LV= Business Protection Combined Life & Critical Illness Guaranteed Premiums works in more detail. 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 form the terms and conditions of your insurance (the contract between you and LV=). Please take the time to read them carefully and keep them in a safe place.

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

Find out how we use your personal information, and what rights you have by visiting **LV.com/dataprotectionlife**
Please let us know if you'd like us to send you a copy, or have any questions. This includes who we are, how long we hold your information, what we do with it and who we share it with.

You'll see some of the words in this document are in bold text. This is because they may have different meanings in everyday use, we've explained them in more detail in the definitions section on page 31.

Contents

Why choose LV= Business Protection Combined Life & Critical Illness Guaranteed Premiums?

This **policy** is designed to pay out a cash sum if the person insured dies before the **end date** of your **policy**, or, if earlier, they are diagnosed with a **critical illness** which is covered under this **policy**.

This **policy** could be used by a business to protect itself against the financial implications of a key employee dying or being diagnosed with a **critical illness** (key person cover), the money could be used to help recruit new staff, or protect the money invested by a business partner or shareholder. It could also be used by business owners (partners and shareholders) to protect their business in the event that one of their shareholders dies or is diagnosed with a **critical illness** (shareholder / partnership protection), it could provide funds to buy the deceased shareholder / partner's share of the business.

For a critical illness claim the diagnosis or operation must occur between the **start date** and the **end date** of your **policy**. If the person insured is diagnosed with a **critical illness**, we will pay a claim, provided they live for at least 14 days or more, after the diagnosis, or undergoing the operation. For claims relating to children's cover, the **child** doesn't need to have survived for 14 days after their diagnosis or having their operation.

If we pay out the cash sum before the **end date**, the **policy** will end unless we pay a claim for an **additional payment condition** or children's cover.

We've included a list of all the illnesses, medical conditions and operations covered in section A1, and more detailed information including an explanation of when we will pay out for each one is detailed in the Appendix at the back of these Policy Conditions.

Choosing the critical illnesses to be covered for

When you apply you can choose to be covered for following options:

- All of the **critical illnesses** including total permanent disability

or

- All of the **critical illnesses** excluding total permanent disability

More details can be found in section A1 and your chosen option is shown on your Policy Schedule.

Choosing the type of cover

You can also choose whether you want the **amount of cover** to stay the same, increase, or decrease, during the term of your **policy**. This will be shown on your personal quote if you haven't yet taken out a **policy**, and once your **policy** has started you will find this on your Policy Schedule.

You can choose:

- **Level cover** – This means your **amount of cover** and the **premium** you pay is fixed when your **policy** starts, and doesn't change.
- **Inflation-linked cover** – This means that your **amount of cover** will go up each year in line with **inflation**. The **premium** will increase in line with **inflation** multiplied by 1.5. This may be shown on your personal quote as increasing amount of cover, or index-linked amount of cover.
- **Decreasing cover** – You would generally take out this type of cover to provide the money to pay off a capital and interest repayment mortgage in the event of the person insured's death. Your **amount of cover** goes down each month, but the **premium** remains the same.

Most commercial mortgages don't decrease in the same way as a personal mortgage which our **policy** has been designed to cover, so this option may not be suitable for you.

These choices are explained in more detail in section A3.

Section A – Your Business Protection Combined Life & Critical Illness Guaranteed Premiums policy

This section tells you about:

- What you're covered for
- The types of cover available
- When we will pay the **amount of cover**
- How to make a claim
- How much we will pay
- Who the money will go to

A1 – What you're covered for

There are two different options available. You will find which of the following you are covered for on your Policy Schedule. More detailed information can be found in the Appendix. In some cases we may not be able to provide cover for all of the illnesses or operations listed in each section. If this happens, this will be noted on your Policy Schedule under the heading of Special Provisions.

On the following pages we explain the different options available in more detail, and explain what you're covered for, and what you're not covered for.

Important

You only need to read the section that applies to the cover shown on your Policy Schedule.

So, if your Policy Schedule shows that you are covered for all **critical illnesses** including total permanent disability, you only need to read section A1(a). If it shows that you are covered for all **critical illnesses** excluding total permanent disability, read section A1(b).

A1(a) – All critical illnesses including total permanent disability

What's covered

✔ Death or diagnosis of a critical illness

We will normally pay out the **amount of cover** if the person insured dies or is diagnosed with one of the **critical illnesses** listed in section A1(a) between the **start date** and the **end date** of your **policy**.

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**.

For an **additional payment condition** we will only pay out an amount equal to part of your **amount of cover**. The amount we pay for each **additional payment condition** is shown in the list of **additional payment conditions**, and more detail can be found in the Appendix under the additional payment conditions section.

If we pay a claim for an **additional payment condition**, we don't reduce the **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** and not the **additional payment condition** as well.

For example if we paid a claim for the **full payment condition** for blindness (condition no. 6) we won't also pay a claim for the **additional payment condition** for partial loss of sight (condition no. 65). Similarly if the person insured had one of the lobes of their lung removed as a result of being diagnosed with lung cancer and we agreed to pay the a claim for the **full payment condition** for cancer (condition no. 9), then we won't also pay a claim for the **additional payment condition** for removal of a lobe or lobes of the lung (condition no. 68).

Once we have paid a claim on this **policy** (unless we've paid a claim for an **additional payment condition** or for children's cover which is explained in section A4), it will end.

✔ 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 abscess –** undergoing specified treatments
8 **Brain injury due to trauma, anoxia or hypoxia** – resulting in permanent symptoms
9 **Cancer** – excluding less advanced cases and including aplastic anaemia
10 **Cardiac arrest**
11 **Cardiomyopathy** – of specified severity
12 **Coma** – with associated permanent symptoms
13 **Coronary artery bypass grafts**
14 **Creutzfeldt-Jakob disease**
15 **Crohn's disease** – treated with two intestinal resections
16 **Deafness** – permanent and irreversible
17 **Encephalitis** – resulting in permanent symptoms
18 **Heart attack** – of specified severity
19 **Heart failure** – of specified severity
20 **Heart valve replacement or repair**
21 **HIV infection** – caught in a specified list of countries from a blood transfusion, a physical assault or at work
22 **Idiopathic pulmonary arterial hypertension** – of specified severity
23 **Kidney failure** – requiring permanent dialysis
24 **Liver failure**
25 **Loss of hand or foot** – permanent physical severance
26 **Loss of independent existence** – unable to look after yourself ever again
27 **Loss of speech** – permanent and irreversible
28 **Major organ transplant** – from another donor

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

30 **Multiple sclerosis** – with persisting symptoms

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

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

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

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

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

36 **Pneumonectomy** – Removal of an entire lung

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

38 **Severe lung disease**

39 **Severe mental illness** – of specified severity

40 **Severe sepsis –** resulting in admission to a critical care unit for 3 days or more

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

42 **Stroke** – of specified severity

43 **Syringomyelia or syringobulbia** – treated by surgery

44 **Surgical removal of an eyeball**

45 **Systemic lupus erythematosus**

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

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

48 **Ulcerative colitis** – with operation to remove the entire large bowel

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

Additional payment conditions

For the following **additional payment conditions** we will pay the lower of 50% of your **amount of cover** or £30,000

50 **Accident hospitalisation cover**

51 **Aortic aneurysm** – with endovascular repair

52 **Carotid artery stenosis** – treated by endarterectomy or angioplasty

53 **Cauda equina syndrome** – with permanent symptoms

54 **Cerebral or spinal arteriovenous malformation** – with surgery or radiotherapy

55 **Cerebral or spinal aneurysm** – with surgery or radiotherapy

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

57 **Coronary artery angioplasty**

58 **Diabetes mellitus type 1** – requiring permanent insulin injections

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

60 **Guillain-Barré syndrome** – with persisting clinical symptoms

61 **Less advanced cancer** – of named sites and specified severity

- **Carcinoma in-situ of the anus** – with surgery
- **Carcinoma in-situ of the bile ducts** – with surgery
- **Carcinoma in-situ of the cervix uteri** – requiring treatment with hysterectomy
- **Carcinoma in-situ of the colon or rectum** – resulting in intestinal resection
- **Carcinoma in-situ of the gallbladder** – with surgery
- **Carcinoma in-situ of the larynx** – with specified treatment
- **Carcinoma in-situ of the lung or bronchus** – with specified treatment
- **Carcinoma in-situ of the oesophagus** – with surgery
- **Carcinoma in-situ of the oral cavity or oropharynx** – with surgery
- **Carcinoma in-situ of the pancreas** – with surgery
- **Carcinoma in-situ of the renal pelvis or ureter**
- **Carcinoma in-situ of the stomach** – with surgery
- **Carcinoma in-situ of the urinary bladder**
- **Carcinoma in-situ of the uterus** – with hysterectomy
- **Carcinoma in-situ of the vagina** – with surgery
- **Carcinoma in-situ of the vulva** – with surgery
- **Ductal or lobular carcinoma in-situ of the breast** – with specified treatment
- **Ovarian tumour of borderline malignancy/low malignant potential** – with surgical removal of an ovary
- **Prostate cancer**
- **Testicular carcinoma in-situ** – requiring surgery to remove at least one testicle

62 **Non-severe cardiomyopathy** – definite diagnosis

63 **Other carcinomas in-situ** – with surgery

64 **Partial loss of hearing** – of specified severity

65 **Partial loss of sight** – permanent and irreversible

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

67 **Pituitary tumour** – resulting in permanent symptoms or surgery

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

To help you understand what these **critical illnesses** cover, please refer to the explanation in the Appendix at the back of this document.

Cost of diagnosis of cancer

If the person insured's condition and treatment meet the criteria for any of the cancers covered by this policy (and are not listed as an exclusion in the **policy** schedule) we'll pay the person insured £1,000 when we receive evidence of their cancer diagnosis. We'll just need a copy of the diagnosis letter from their consultant showing the histological classification of the cancer and details of the proposed treatment.

This payment is to help with any costs they may be facing following their diagnosis (such as hospital travel). Receiving this payment doesn't guarantee we'll go on to pay your claim under a **full payment condition** or an **additional payment condition** as their final diagnosis and actual treatment may not meet the definition of the condition you're claiming for. This payment doesn't reduce your **amount of cover**.

Enhanced payments

These are conditions where we will pay twice the **amount of cover**. The maximum payment you can receive on top of your **amount of cover** is limited to £200,000.

- For ten of our **full payment conditions**, if the cause of the claim was as a direct result of an accident.
- For four of our **full payment conditions** if the person insured is under 55 years of age at the time they are diagnosed with the illness or condition.
- If the person insured has a major organ transplant, liver failure or severe lung disease that meets our definition for one of these **full payment conditions**.

More details on which **full payment conditions** are included, and how we define what an accident is can be found in the Appendix at the back of these Policy Conditions.

✔ **Existing illness or medical condition that you had before you applied**

As we ask you for all the person insured's medical history before we offer you the **policy**, we'll cover them for all the **critical illnesses** listed in section A1(a) unless we have told you that we won't before your **policy** starts.

We will list any exclusions on your Policy Schedule under the heading of Special Provisions.

We will tell you about any exclusions before we ask you for the first **premium**.

✔ **Travelling abroad**

You're covered if the person insured dies anywhere in the world. However if they're diagnosed with one of the **critical illnesses** listed in section A1(a) we will only pay your claim if the diagnosis has been 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.

If the person insured is diagnosed in a country not listed above, they will need to go to one of the places listed, to have that diagnosis confirmed, or to have the operation.

What's not covered

✘ **Death as a result of the person insured taking their own life in the first 12 months of your policy**

We won't pay a claim if the person insured dies as a result of intentionally taking their own life in the first 12 months from the **start date** of your **policy**. If this happens we'll cancel your **policy** and refund all the **premiums** that you've paid.

✘ **All types of illness**

You are only covered for the **critical illnesses** listed in the 'What's covered' section. If the person insured is diagnosed with any other illness, medical condition or has an operation that is not listed, then we will not pay a claim under this **policy**.

Also, if the person insured's 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. For example some types of cancer are not covered.

You are not covered for any exclusions listed on your Policy Schedule under the heading of Special Provisions.

✘ **If we've paid a claim for an additional payment condition.**

We'll only pay one claim for each **additional payment condition** under the **policy**. However, you can make a claim under any of the other **critical illnesses** covered by this **policy**.

For less advanced cancer (condition no.61) this also means we'll only pay one claim for each of the cancers listed under that condition.

✘ **Death within 14 days of the critical illness being diagnosed, or having the operation.**

If the person insured dies within 14 days of being diagnosed with one of the **critical illnesses** or having the operation, then we will not pay a critical illness claim under this **policy**. However if this happens before the end date of your **policy**, we will pay a death claim.

If the person insured dies after the **end date** of your **policy** then we won't pay a claim.

✘ Unemployment

This **policy** will only pay out if the person insured dies or is diagnosed with one of the listed **critical illnesses** in these policy conditions. This means we will not pay a claim if the person insured is unable to work due to sickness or accident, made involuntarily redundant or if they become unemployed.

✘ Financial crime and deliberate non-disclosure

We do need to protect ourselves against the effects of financial crime.

For this reason we can cancel the **policy** and not pay a claim if we find you or anyone you're insuring has deliberately withheld information from us or has intentionally provided us with false information or lied to us, when they applied, when they claim, or when they apply to re-start their **premiums** (see section C3). More detailed information on when we can cancel the **policy** can be found in section C7.

A1(b) – All critical illnesses excluding total permanent disability

What's covered

✔ Death or diagnosis of a critical illness

We will normally pay out the **amount of cover** if the person insured dies or is diagnosed with one of the **critical illnesses** listed in section A1(b) between the **start date** and the **end date** of your **policy**.

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**.

For an **additional payment condition** we will only pay out an amount equal to part of your **amount of cover**. The amount we pay for each **additional payment condition** is shown in the list of **additional payment conditions**, and more detail can be found in the Appendix under the additional payment conditions section.

If we pay a claim for an **additional payment condition**, we don't reduce the **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** and not the **additional payment condition** as well.

For example if we paid a claim for the **full payment condition** for blindness (condition no. 6) we won't also pay a claim for the **additional payment condition** for partial loss of sight (condition no. 65). Similarly if the person insured had one of the lobes of their lung removed as a result of being diagnosed with lung cancer and we agreed to pay the a claim for the **full payment condition** for cancer (condition no. 9), then we won't also pay a claim for the **additional payment condition** for removal of a lobe or lobes of the lung (condition no. 68).

Once we have paid a claim on this **policy** (unless we've paid a claim for an **additional payment condition** or for children's cover which is explained in section A4), it will end.

✔ 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 abscess – undergoing specified treatments**
8 **Brain injury due to trauma, anoxia or hypoxia – resulting in permanent symptoms**
9 **Cancer – excluding less advanced cases and including aplastic anaemia w**
10 **Cardiac arrest**
11 **Cardiomyopathy – of specified severity**
12 **Coma – with associated permanent symptoms**
13 **Coronary artery bypass grafts**
14 **Creutzfeldt-Jakob disease**
15 **Crohn's disease – treated with two intestinal resections**
16 **Deafness – permanent and irreversible**
17 **Encephalitis – resulting in permanent symptoms**
18 **Heart attack – of specified severity**
19 **Heart failure – of specified severity**
20 **Heart valve replacement or repair**
21 **HIV infection – caught in a specified list of countries from a blood transfusion, a physical assault or at work**
22 **Idiopathic pulmonary arterial hypertension – of specified severity**
23 **Kidney failure – requiring permanent dialysis**
24 **Liver failure**
25 **Loss of hand or foot – permanent physical severance**
26 **Loss of independent existence – unable to look after yourself ever again**
27 **Loss of speech – permanent and irreversible**
28 **Major organ transplant – from another donor**
29 **Motor neurone disease and specified diseases of the motor neurones – resulting in permanent symptoms**
30 **Multiple sclerosis – with persisting symptoms**
31 **Neuromyelitis optica (Devic's disease) – with persisting symptoms**
32 **Open heart surgery – with surgery to divide the breastbone**
33 **Paralysis of limb – total and irreversible**
34 **Parkinson's disease – resulting in permanent symptoms**
35 **Parkinson plus syndromes – resulting in permanent symptoms**
36 **Pneumonectomy – removal of an entire lung**

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

38 **Severe lung disease**

39 **Severe mental illness – of specified severity**

40 **Severe sepsis – resulting in admission to a critical care unit for 3 days or more**

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

42 **Stroke – of specified severity**

43 **Syringomyelia or syringobulbia – treated by surgery**

44 **Surgical removal of an eyeball**

45 **Systemic lupus erythematosus**

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

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

48 **Ulcerative colitis – with operation to remove the entire large bowel**

Additional payment conditions

For the following **additional payment conditions** we will pay the lower of 50% of your **amount of cover** or £30,000

50 **Accident hospitalisation cover**

51 **Aortic aneurysm – with endovascular repair**

52 **Carotid artery stenosis** – treated by endarterectomy or angioplasty

53 **Cauda equina syndrome** – with permanent symptoms

54 **Cerebral or spinal arteriovenous malformation** – with surgery or radiotherapy

55 **Cerebral or spinal aneurysm** – with surgery or radiotherapy

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

57 **Coronary artery angioplasty**

58 **Diabetes mellitus type 1** – requiring permanent insulin injections

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

60 **Guillain-Barré syndrome** – with persisting clinical symptoms

61 **Less advanced cancer** – of named sites and specified severity

- **Carcinoma in-situ of the anus** – with surgery
- **Carcinoma in-situ of the bile ducts** – with surgery
- **Carcinoma in-situ of the cervix uteri** – requiring treatment with hysterectomy
- **Carcinoma in-situ of the colon or rectum** – resulting in intestinal resection
- **Carcinoma in-situ of the gallbladder** – with surgery
- **Carcinoma in-situ of the larynx** – with specified treatment
- **Carcinoma in-situ of the lung or bronchus** – with specified treatment
- **Carcinoma in-situ of the oesophagus** – with surgery
- **Carcinoma in-situ of the oral cavity or oropharynx** – with surgery
- **Carcinoma in-situ of the pancreas** – with surgery
- **Carcinoma in-situ of the renal pelvis or ureter**
- **Carcinoma in-situ of the stomach** – with surgery
- **Carcinoma in-situ of the urinary bladder**
- **Carcinoma in-situ of the uterus** – with hysterectomy
- **Carcinoma in-situ of the vagina** – with surgery
- **Carcinoma in-situ of the vulva** – with surgery
- **Ductal or lobular carcinoma in-situ of the breast** – with specified treatment
- **Ovarian tumour of borderline malignancy/low malignant potential** – with surgical removal of an ovary
- **Prostate cancer**
- **Testicular carcinoma in-situ** – requiring surgery to remove at least one testicle

62 **Non-severe cardiomyopathy** – definite diagnosis

63 **Other carcinomas in-situ** – with surgery

64 **Partial loss of hearing** – of specified severity

65 **Partial loss of sight** – permanent and irreversible

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

67 **Pituitary tumour** – resulting in permanent symptoms or surgery

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

To help you understand what these **critical illnesses** cover, please refer to the explanation in the Appendix at the back of this document.

Cost of diagnosis of cancer

If the person insured's condition and treatment meet the criteria for any of the cancers covered by this **policy** (and are not listed as an exclusion in the policy schedule) we'll pay the person insured £1,000 when we receive evidence of their cancer diagnosis. We'll just need a copy of the diagnosis letter from their consultant showing the histological classification of the cancer and details of the proposed treatment.

This payment is to help with any costs they may be facing following their diagnosis (such as hospital travel). Receiving this payment doesn't guarantee we'll go on to pay your claim under a **full payment condition** or an **additional payment condition** as their final diagnosis and actual treatment may not meet the definition of the condition you're claiming for. This payment doesn't reduce your **amount of cover**.

Enhanced payments

These are conditions where we will pay twice the **amount of cover**. The maximum payment you can receive on top of your **amount of cover** is limited to £200,000.

- For ten of our **full payment conditions**, if the cause of the claim was as a direct result of an accident.
- For four of our **full payment conditions** if the person insured is under 55 years of age at the time you are diagnosed with the illness or condition.
- If the person insured has a major organ transplant, liver failure or severe lung disease that meets our definition for one of these full payment conditions.

More details on which **full payment conditions** are included, and how we define what an accident is can be found in the Appendix at the back of these Policy Conditions.

What's covered

✔ **Existing illness or medical condition that you had before you applied**

As we ask you for all the person insured's medical history before we offer you the **policy**, We'll cover them for all the **critical illnesses** listed in section A1(b) unless we have told you that we won't before your **policy** starts. We will list any exclusions on your Policy Schedule under the heading of Special Provisions.

We will tell you about any exclusions before we ask you for the first **premium**.

✔ **Travelling abroad**

You're covered if the person insured dies anywhere in the world. However if they're diagnosed with one of the **critical illnesses** listed in section A1(b) we will only pay your claim if the diagnosis has been 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.

If the person insured is diagnosed in a country not listed above, they will need to go to one of the places listed, to have that diagnosis confirmed, or to have the operation.

What's not covered

✘ **Death as a result of the person insured taking their own life in the first 12 months of your policy**

We won't pay a claim if the person insured dies as a result of intentionally taking their own life in the first 12 months from the **start date** of your **policy**. If this happens we'll cancel your **policy** and refund all the **premiums** that you've paid.

✘ **All types of illness**

You are only covered for the **critical illnesses** listed in the 'What's covered' section. If the person insured is diagnosed with any other illness, medical condition or has an operation that is not listed, then we will not pay a claim under this **policy**. Also, if the person insured's 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. For example some types of cancer are not covered.

You are not covered for any exclusions listed on your Policy Schedule under the heading of Special Provisions.

✘ **If we've paid a claim for an additional payment condition.**

We'll only pay one claim for each **additional payment condition** under the **policy**. However, you can make a claim under any of the other **critical illnesses** covered by this **policy**.

For less advanced cancer (condition no.61) this also means we'll only pay one claim for each of the cancers listed under that condition.

✘ **Death within 14 days of the critical illness being diagnosed, or having the operation.**

If the person insured dies within 14 days of being diagnosed with one of the **critical illnesses** or having the operation, then we will not pay a critical illness claim under this **policy**. However if this happens before the **end date** of your **policy**, we will pay a death claim.

If the person insured dies after the **end date** of your **policy** then we won't pay a claim.

✘ **Unemployment**

This **policy** will only pay out if the person insured dies or is diagnosed with one of the listed **critical illnesses** in these policy conditions. This means we will not pay a claim if the person insured is unable to work due to sickness or accident, made involuntarily redundant or if they become unemployed.

✘ **Financial crime and deliberate non-disclosure**

We do need to protect ourselves against the effects of financial crime.

For this reason we can cancel the **policy** and not pay a claim if we find you or anyone you're insuring has deliberately withheld information from us or has intentionally provided us with false information or lied to us, when they applied, when they claim, or when they apply to re-start their **premiums** (see section C3). More detailed information on when we can cancel the **policy** can be found in section C7.

A2 – What if you're insuring someone else?

If you are insuring someone else, you will be the policy owner, and they will be the person insured. We will pay a claim to you (or the legal owner explained in section A8) if the person insured dies or if earlier, is diagnosed with a **critical illness**, before the **end date** of your **policy**.

If we need any doctor's reports, these will need to be provided by the doctor of the person you are insuring and they will need to give us their consent for us to ask for these.

A3 – What are the types of cover available?

There are three different types of cover available. You will find which type of cover you have on your Policy Schedule.

Important

You only need to read the section that applies to the type of cover you have.

A3(a) – Level amount of cover

This means that your **amount of cover** does not change between the **start date** and the **end date** of your **policy**. It won't keep up with **inflation** and you will be able to buy less with it in the future. The **premium** you pay each month will not change.

A3(b) – Inflation-linked amount of cover

This means that your **amount of cover** increases each year in line with **inflation**. We may also refer to this as index-linked or increasing cover on your personal quote. If you're unsure whether this applies to you, you will find whether or not this is included, on your Policy Schedule.

What inflation-linked means

We will increase your **amount of cover** on each **plan anniversary**.

Where we apply this increase, your **amount of cover** will go up in line with the increase in **inflation**. The **premium** will increase in line with **inflation** multiplied by 1.5. The **inflation** increase will be based on the 12 month period ending three months before your **plan anniversary**.

If you have added this **policy** to an existing **plan** and your **plan anniversary** is less than 3 months after the **start date** of this **policy**, the first increase to your **amount of cover** will be made on the next **plan anniversary**.

We'll tell you what we'll increase your **amount of cover** to and what your new **premium** will be before we increase them.

Any Special Provisions that apply to your **policy** are shown in your Policy Schedule and will also apply to any inflation-linked increases.

You can ask us not to increase your **amount of cover**. If you don't want us to increase your **amount of cover**, you must let us know before the **plan anniversary** when the increase is due. We then won't make any further increases to your **amount of cover** for the rest of the term of your **policy**. This means your cover will change to a level amount of cover (as explained in A3(a)) for the rest of the term of your **policy**.

Please note if you ask us not to increase your **amount of cover**, but later on decide that you want us to start increasing it again, you will need to re-apply for inflation-linked cover. We can't guarantee that we will be able to offer you inflation-linked cover again, as it will depend on the person insured's health, occupation and leisure activities and whether we are offering the same type of insurance at that time.

A3(c) – Decreasing amount of cover

You would generally take out this type of cover to provide the money to pay off a capital and interest repayment mortgage in the event of the person insured's death or them being diagnosed with a **critical illness**. Your **amount of cover** goes down each month, but the **premium** remains the same.

Most commercial mortgages don't decrease in the same way as a personal mortgage which our **policy** has been designed to cover, so this option may not be suitable for you.

We will normally pay out the amount of the outstanding mortgage (this includes commercial mortgages if they meet the conditions below) on the date of the person insured's death, or the date they're diagnosed with a **critical illness** (including any interest that has built up since that date) as along as:

- there is still a mortgage in place that is repayable by equal monthly instalments

and

- the mortgage was taken out no later than three months after the **start date** of your **policy** (you will find this on your Policy Schedule),

and

- 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

and

- the term of the mortgage is the same as the term of your **policy**,

and

- the outstanding mortgage is not more than it would have been had you borrowed the same amount on the **start date** of your **policy** with the same term, and interest rates had been 12% compounded annually.

For the purposes of this section, if you have changed the **amount of cover**, since the **start date** we treat the **start date** of your **policy** as being the date that you made the changes to the **amount of cover**. If you have changed the term of your **policy**, this means the **end date** of your **policy** will have changed, so for the purposes of this section, we will use this new **end date**. More details about how you can change your **amount of cover**, or the term of your **policy** can be found in section B.

However if we only pay a claim for one of the **additional payment conditions** then we'll only pay out the amount shown for that condition, and not the full **amount of cover**. Please see the additional payment conditions section of the Appendix for more details on the amounts we'll pay out for each **additional payment condition**.

Important

We must have written confirmation from the mortgage lender of the mortgage details and the amount outstanding, before we pay a claim for decreasing cover.

There are some exceptions.

We won't pay any mortgage repayment arrears.

If, during the term of the mortgage, the repayments have reduced or stopped for any period (other than as a result of an interest rate reduction), we may reduce the amount we pay out. We will pay the amount that you would have owed if the repayments had not been changed, or had been paid in full and on time.

If the amount of your mortgage was more than the **amount of your cover** at the **start date** of your **policy** we will reduce the amount we will pay out proportionately.

Example

If you had a £100,000 commercial mortgage and you insured it for £90,000 at the start of the policy. The cover is 10% less than the mortgage. On the person insured's death or on the date they were diagnosed with a critical illness the outstanding mortgage was £80,000.

We would pay out £72,000 which is 10% less than the outstanding mortgage.

We realise that it is quite possible that you will have changed your mortgage or even paid all of it off, without you changing or stopping your **policy**. So, as a minimum we will pay out the amount that would have been outstanding if a capital and interest mortgage, which is repaid by equal monthly payments had been taken out:

- for the same amount as the **amount of cover**,

and

- that started on the same date as the **start date**,

and

- that ends on the same date as the **end date**,

and

- the interest rate on that mortgage had been 6% each year compounded annually.

For the purposes of this section, if you have changed the **amount of cover** since the **start date**, we treat the **start date** of your **policy** as being the date that you made the changes to your **amount of cover**.

If you have changed the term of your **policy**, this means the **end date** of your **policy** will have changed, so for the purposes of this section, we will use this new **end date**. More details about how you can change your **amount of cover**, or the term of your **policy** can be found in section B.

A4 – Children's cover

Children's cover is automatically included in your **policy** at no extra cost. It covers the insured person's **children** (from birth up to the child's 23rd birthday) for all of our **critical illnesses** listed in section A1, except for total permanent disability (condition no. 49) and diabetes mellitus type 1 (condition no. 58). We do apply some limits to children's cover which are explained in the 'What's not covered' section.

For claims relating to children's cover, the **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 the **amount of cover**

or

- £25,000

We will only pay a claim for one **full payment condition** for each **child** on this **policy**. If the **child** has children's cover under more than one policy with us the most we would pay out across all of the policies is £50,000 in total.

If we pay any child claims against our **additional payment conditions**, they'll be limited to 50% of the amount we would pay if you made an **additional payment condition** claim for the person insured (see section A1 for details).

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: major organ transplant (condition no. 28), liver failure (condition no.24) or severe lung disease (condition no.38). The payment will be the lower of:

- 100% of your **amount of cover**

or

- £50,000

If the **child** has children's cover under more than one policy with us, the most we would pay out for a claim made for one of the enhanced payment conditions is £100,000 in total, across all of the policies they are covered under. You will find further information on the illnesses that qualify for enhanced payments in the Appendix at the back of these Policy Conditions.

Child funeral payment

If the person insured's **child** dies during the term of the **policy** we will pay £5,000 towards the cost of their funeral in addition to any payment made for a claim on one of the listed children's **critical illness** conditions. The funeral payment is only paid once per **child**, it is not based on how many **policies** the **child** is covered under 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.

Cost of diagnosis of cancer

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

This payment is to help with any costs they may be facing following their **child's** diagnosis (such as hospital travel). Receiving this payment doesn't guarantee we'll go on to pay a children's cover claim under a **full payment condition** or an **additional payment condition** as their **child's** final diagnosis and actual treatment may not meet the definition of the condition that is being claiming for. This payment doesn't reduce your **amount of cover.**

What's covered

✔ **Travelling abroad**

If the person insured's **child** is diagnosed with one of the **critical illnesses** listed in section A1, excluding total permanent disability (condition no. 49) and diabetes mellitus (condition no. 58), we will pay a claim provided the diagnosis has been 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.

If the person insured's **child** is diagnosed in a country not listed above, they will need to go to one of the places listed, to have the diagnosis confirmed, or have the operation.

What's not covered

✘ **All types of illness**

The person insured's **child** is only covered for the **critical illnesses** listed in section A1, apart from total permanent disability (conditon no.49) and diabetes mellitus type 1 (condition no. 58) which are not covered. If they are diagnosed with any illness, medical condition, or have an operation that is not listed, then we will not pay a claim for children's cover. If the 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. For example some types of cancer are not covered.

Unlike the main policy, **children** are not covered for an enhanced payment of twice the **amount of cover** for four of our neurological conditions.

✘ **All causes of critical illness**

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

— you were aware of an increased risk of the **child** suffering the **critical illness** before the **start date** of your **policy** (for example medical advice or counselling in relation to the **critical illness** had been received before your **policy** started),

or

— symptoms relating to the **critical illness** had arisen before the **start date** of your **policy**. However if the **child** had already suffered the **critical illness**, and had been discharged from follow-up, and had not 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.

Also we will not pay a claim if the **critical illness** the **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,

or

— alcohol or solvent abuse,

or

— the taking of drugs (unless prescribed by a doctor),

or

— failing to follow medical advice. We would only not pay a claim for this, if the reason that you chose not to follow medical advice is unreasonable.

✘ **Child funeral payment**

We will not pay a child funeral payment if the cause of death is stillbirth.

A5 – How to make a claim if the person insured has died

The person making the claim should tell us about the death of the person insured as soon as they can.

The claim can be made to us in writing, by phone, by email, or by fax. For details of how best to contact us, visit our website **LV.com**.

When we're informed of the death, we will ask the person making the claim to send us the original death certificate (not a photocopy). If we need any further information, we'll write to them to explain what we need and why we need it. Examples of further information we may need are:

- Proof of the person insured's age, for example their birth certificate if this was not provided when you applied for the **policy**

and

- evidence of the right of the person to make the claim (for example, evidence that you have named them in your will as the executor of your estate).

and

- if you have put your **policy** in trust, we'll need to see a copy of the trust deed.

We appreciate that this will be a difficult time, and we'll only ask for the information we need to pay the claim as quickly as possible.

A6 – When you need to tell us about the person insured's critical illness

To help us process your claim quickly, if the person insured is diagnosed with a **critical illness**, please tell us as soon as you can after their diagnosis, or the date they had the operation. You can tell us in writing, by phone, by email or by fax. For details of how best to contact us, please visit **LV.com**

A7 – What you need to do to make a critical illness claim

Once you've told us about the person insured's **critical illness**, we'll ask you to complete a claim form (which we'll send you at the time). This allows us to collect the core information we need about the **critical illness**.

We want to make sure that your claim is dealt with quickly, and to help us with this, it is important that you complete and return the form to us as soon as you can. If you need help completing the form, please let us know.

We'll need evidence from the doctor (or the medical practitioner} who is treating the person insured confirming that they have been diagnosed with a **critical illness**. We may also need to get medical reports from the doctor. If we do, we'll send you a consent form to complete.

We don't know exactly what evidence we'll need until you make a claim, as all claims are looked at individually.

We appreciate this is a difficult time, so we won't ask for anything unreasonable or unnecessary, and we will explain why we need anything we ask for.

We may need the person insured to be examined by a doctor of our choice. We may also ask for other evidence to consider your claim, such as:

- a report from their doctor, or any other doctor who has treated or examined them, or any alternative medical practitioner
- a report on tests or investigations carried out to make the diagnosis
- a report from a consultant that we appoint, confirming the diagnosis.

We'll pay for the cost of all medical reports and other evidence we ask for.

Because we rely on the information we're given to assess your claim, if any of the information is untrue or incomplete you may not be covered and we may not be able to pay your claim.

We do need to protect ourselves against the effects of financial crime. Therefore if we ask for additional information, please do not take this as a reflection of our opinion of you or the person insured.

A8 – Who we'll pay the claim to

Once your claim has been approved we'll pay the claim to the legal owner of your **policy**. This will usually be one of the following:

- you, or if you are not the policy owner, the person named as the policy owner in your Policy Schedule.

or

- if you have arranged for your **policy** to be put in trust, we will pay the claim to the trustees.

or

- if you have assigned your **policy** to someone else (this is where you have legally signed over the ownership of your **policy** to someone else), then we will pay the claim to them.

or

- if the person insured has died, and they are also the policy owner, we will pay the claim to the person named in their Will to look after their affairs if they die. This person is called an executor.

or

- if the person insured has died, and they are also the policy owner but they haven't made a Will we will pay the claim to the person appointed by the courts to look after their affairs. This person is called an administrator.

If we pay out the amount of life cover on the death of the person insured the **policy** will end. If we pay a critical illness claim for a **full payment condition** the **policy** will end unless we pay a critical illness claim for an **additional payment condition** or for children's cover. We explain what we do in relation to claims for children's cover in section A4, and what we do for claims for an **additional payment condition** in section A9.

When we pay a claim, we'll try to do this as quickly as possible. Sometimes it's not possible to pay straight away, so if it takes longer than 60 days from the date of diagnosis of the insured event for a critical illness claim and from the date of death for a life claim, we'll add interest to the amount we pay, from day 61, to the date of payment.
If this changes we will let you know at the time of claim.

A9 – What happens when a claim has been paid for an additional payment condition?

If we pay a claim for an **additional payment condition**, your **policy** will continue in full, for your full **amount of cover**. We don't reduce the **amount of cover** by the amount of the additional payment we've paid. This is as long as you continue to pay the **premiums** for your **policy** as and when they are due.

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** and not the **additional payment condition** as well.

For example if we paid a claim for the **full payment condition** for blindness (condition no. 6) we won't also pay a claim for the **additional payment condition** for partial loss of sight (condition no. 65). Similarly if the person insured had one of the lobes of their lung removed as a result of being diagnosed with lung cancer and we agreed to pay a claim for the **full payment condition** for cancer (condition no. 9), then we won't also pay a claim for the **additional payment condition** for removal of a lobe or lobes of the lung (condition no. 68).

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

If the person insured dies before the **end date** of your **policy** we will pay the full **amount of cover**, and your **policy** will then end.

A10 – What if there are two people insured on the policy?

If there are two people insured on the **policy**, we will pay a claim if either of them dies or are diagnosed with a **critical illness** before the **end date** of your **policy**. If we have paid a claim for life cover or a **full payment condition** for a critical illness claim, the **policy** will end. If you are also both policy owners, and one of you dies, we will normally pay the claim to the surviving policy owner.

However your **policy** won't end if the claim we've paid relates to children's cover (which we've explained in section A4) or if we pay a claim for an **additional payment condition** (see section A9).

Section B – Options to change your policy

This section tells you about how you can change the amount of your cover or the term of your policy.

If you have chosen for the **amount of your cover** to increase in line with inflation this is explained in section A3(b).

However you can also choose to change the **amount of your cover** between the **start date** and the **end date**.

If you want to do this, please let us know, and we'll send you an application form to complete. We'll let you know what information we need at the time, and we'll be able to help you complete the application.

It is very important that you don't cancel your existing **policy**. We will confirm the changes you've requested to you, and if you wish to proceed with them, we'll tell you if your existing **policy** needs to be cancelled. If it does need to be cancelled, we'll automatically do this for you.

B1 – Guaranteed Increase Options for business cover

You can increase your **amount of cover**, without completing a full application, if certain events happen. We call these Guaranteed Increase Options, because we guarantee that you can change your **policy**, within certain limits, as long as you and the person insured are eligible.

Occasionally, due to the person insured's medical history, or personal circumstances you may not be able to take advantage of these options. If this applies we'll tell you before your **policy** starts and this will be detailed on your Policy Schedule under the heading of Special Provisions.

The event must happen to the person insured. This means that if you're insuring someone else then it's their circumstances we'll consider, not yours.

Unfortunately you won't be able to use these options if:

- The person insured has been diagnosed with a **critical illness** or had an operation covered by this **policy**.
- The person insured has been advised by a medical practitioner to have an operation covered by this **policy**.

You don't need to have told us that you intend to make claim.

Your **policy** must be current with all **premiums** paid to date.

If you want to change your **policy** using one of the Guaranteed Increase Options, you won't have to provide any additional medical information at that time.

This means we do have to apply some limits to the amount you can change your cover by. Please see the table on page 15 for more details.

These options only allow you to increase the **amount of cover**. They don't allow you to extend the term of your **policy**.

The events which are covered by our Guaranteed Increase Options are:

- **Increase in shareholding value or partnership share** – You can use this option if the person insured is a shareholder or partner in a business and there has been an increase in the value of their ownership or interest in that business. You can increase the **amount of cover** by up to 50% of the **amount of cover** shown in your Policy Schedule at the time you wish to use the option.
- **Increase in key person's value** – If the person insured is a key person to the business and there has been an increase to their basic salary or an increase in the profits attributable to that person, you can increase the **amount of cover** by the lower of:

  — Five times the increase in the person insured's basic salary

  or

  — two times the increase in gross profits attributable to the person insured

  or

  — 50% of the **amount of cover** shown in your Policy Schedule at the time you wish to use the option.

- **Increase in net taxable earnings** – You can use this option if there has been an increase in the person insured's net taxable earnings.

  You can increase the **amount of cover** by the lower of:

  — Five times the increase in net taxable earnings

  or

  — 50% of the **amount of cover** shown in your Policy Schedule at the time you wish to use the option.

- **Increase in a business loan** – You can use this option if there has been an increase in the amount borrowed under a business loan that you are covering with your **policy**. You can increase the **amount of cover** by the lower of:

  — The amount the business loan has increased by

  or

  — 50% of the **amount of cover** shown in your Policy Schedule at the time you wish to use the option.

General limits for Guaranteed Increase Options for business cover

There are some limits to how much you can change the **amount of cover** by. These limits depend on which option you use. The total of all the Guaranteed Increase Options you use can't be more than 50% of the **amount of cover** shown on your Policy Schedule at the time you wish to use the option. Also the total amount that you can increase your **amount of cover** by over the lifetime of your **policy** using these Guaranteed Increase Options can't be more than £250,000.

The table below explains these limits in more detail. It also shows the maximum age at which you can make use of these options. The maximum age applies to the person insured. If you're insuring two people, it's the older of them that the maximum age limit applies to. You can use these options as many times as you need to, however the increases can't be more than the limits shown below.

In all cases you can only use these options within six months of the event occurring.

Event	Increase limit	Maximum increase	Maximum age of person insured	Tell us within
Increase in shareholding value or partnership share	50% of the **amount of cover** at the time you wish to use the option.	£150,000	54	6 months
Increase in key person's value	The lower of: Five times the increase in employee's basic salary or two times the increase in gross profits attributable to the person insured or 50% of the **amount of cover** at the time you wish to use the option.	£150,000	54	6 months
Increase in net taxable earnings	The lower of: Five times the increase in net taxable earnings or 50% of the **amount of cover** at the time you wish to use the option.	£150,000	54	6 months
Increase in a business loan	The lower of: The amount of the business loan has been increased by or 50% of the **amount of cover** at the time you wish to use the option.	£150,000	54	6 months

If you change the **amount of cover** using one of these options, the **premium** you need to pay will also change to reflect this. The **premium** will be based on the age and smoker status of the person insured at the time of the change. If you had to pay any extra **premiums** on your original **policy**, because of their health or leisure activities, then this extra **premium** may also be applied to the increased **amount of cover**.

If you want to use one of the Guaranteed Increase Options, we'll ask for evidence of the change of the person insured's circumstances, such as:

- Confirmation from the finance director or company secretary that the value of the person insured's ownership or interest in the business has increased, or a copy of the shareholder / partnership agreement confirming the increase.
- A statement from the finance director or company secretary confirming that gross profits attributable to the key person have increased, or that the key person's (who is also the person insured) salary has increased, or three months' payslips confirming the increase.
- A statement from the finance director or company secretary confirming an increase in net taxable earnings.
- Three months' payslips confirming the salary increase, or a copy of the financial report and accounts confirming the increase in net taxable earnings.
- A copy of the loan offer for an increase in a business loan, or confirmation from the lender that the loan has been increased.

We'll let you know exactly what evidence we need at the time you wish to use one of these options.

B2 – Other ways to change the amount of cover

You can change your **amount of cover**, or the term of your **policy** at any time. If you want to do this (other than using the Guaranteed Increase Options in section B1, or inflation-linking, which is explained in section A3(b)) we'll work out the new **premium** depending on the person insured's age, health and medical history, leisure activities, whether they smoke and the premium rates available at the time.

We'll confirm the new **amount of cover** and **premium** before we make the changes. Unfortunately, we can't guarantee that we'll be able to offer you an increase in the future, as it will depend on the person insured's age, health and medical history, leisure activities and whether we are offering the same type of insurance at that time.

Section C – Other conditions

This section tells you about other things you need to know, such as how to pay your premiums, and how to cancel your policy.

C1 – Paying your premiums

You are responsible for paying **premiums** on the date shown in your Policy Schedule (these are known as **premium** due dates). You must pay your **premiums** by Direct Debit through a bank or building society. Your **premiums** are guaranteed not to increase unless you have chosen inflation-linked cover (which we explain in section A3(b)).

C2 – Stopping your premiums

We give you 60 days from the due date for you to pay a **premium**. If we haven't received a **premium** from you, we will send you a reminder to let you know.

If you fail to pay any **premium** within this 60 day period, then your **policy** stops immediately, and we will cancel it. We will not pay anything to you if this happens. If we cancel your **policy**, we'll let you know.

C3 – Re-starting your premiums

If your **policy** has stopped because you didn't pay a **premium**, you can ask us to start it again. You can do this within six months of the first unpaid **premium**. So that we can restart your **policy**, we will need you to pay all of the **premiums** that you haven't paid. The person insured will also need to complete some health questions.

Unfortunately, it is possible that we may not be able to restart your **policy**, or if we can it may be on different terms to those originally offered, for example if the person insured's health has got worse since your **policy** started. If this happens, we will explain our decision to you and the reasons for it. Please note as the **policy** has actually ended we are not obliged to restart it for you.

C4 – Can you change the amount of my premium?

We have designed your **policy** with the aim that the amount of your **premium** won't change (other than changes for inflation-linked cover, or if you change your **policy** yourself).

We work out the **premium** for your **policy** based on our current understanding of:

- the way your **policy** is taxed

and

- the factors that we're legally able to take into account.

We could only change the **premium** after the **start date** of your **policy** for the following reasons:

- Changes to legislation that changes the way its taxed,
- Changes to legislation that changes the factors we can legally use,
- A decision by a UK court or the European Court of Justice that changes the factors that we can take account of.

These are the only times when we can change the **premiums** 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 your health since the **start date** of your **policy**.

If 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 your **premium**, you can choose to continue paying the previous amount instead. Your **amount of cover** will then be reduced to the amount that we work out your existing **premium** will pay for.

You must tell us, 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, you will lose all of the cover under the **policy** and you won't get anything back.

C5 – Proof of age and name

The **premium** you pay for your **amount of cover** is based on the person insured's date of birth as shown in your Policy Schedule.

Before we can pay a claim on your **policy** we'll need to confirm the person insured's date of birth. For a death claim we'll take this information from their death certificate. If they've been diagnosed with a **critical illness** we'll get this information from their medical records. In some cases we may also ask to see the person insured's original birth certificate or passport (not photocopies) to help confirm their age.

We recognise that these are valuable documents that other people may need at the same time. We will look after the documents carefully, and return them to you quickly.

It is really important that you check your Policy Schedule has the person insured's correct date of birth on it, as it affects the amount we can pay out for a claim. If their actual date of birth differs from that shown on your Policy Schedule, we will change your **amount of cover** to the amount that would have been available, based on the person insured's actual age and the **premiums** you have paid.

If when a claim is made the person insured's name is different from the name on your Policy Schedule and birth certificate we will also need evidence of this change (for example a marriage certificate). We may need to ask for additional evidence, but we won't ask for anything unreasonable. We will tell you what evidence we need, and why we need it.

C6 – When you can cancel your policy

You can cancel your **policy** at any time. If you cancel your **policy** within 30 days of it starting we will refund any **premiums** you've paid. If you cancel at any other time we won't refund anything.

If you decide to do this, please let us know, so that we don't ask you to pay any more **premiums**.

C7 – When we can cancel your policy

We'll cancel your **policy** if the person insured dies as a result of taking their own life within 12 months of the **start date** of your **policy**. Also we'll cancel your **policy** if you don't pay all of the **premiums** that are due. We've explained what happens if you stop paying **premiums** in section C2.

We do need to protect ourselves against the effects of financial crime so we can also cancel your **policy** in the following situations:

- We can cancel your **policy** or not pay the full **amount of cover**, if either you or anyone you are insuring acts fraudulently, or provides untrue, inaccurate or misleading information when applying for the **policy**, when making a claim, when applying to change your **policy**, or if applying to re-start your **premiums** (this is explained in section C3).
- We might reduce the amount we pay out, or cancel your **policy** if we determine that you or anyone you're insuring would have known, or ought to have reasonably known, the true answer to a question we asked, but have provided a false answer.
- We can cancel your **policy** and pass details to crime prevention and law enforcement agencies if we identify your involvement or association with financial crime.
- We may also cancel your **policy**, or not pay the **amount of cover** in full, if, had all of the questions we asked been answered honestly and in full, it would have led us to a different decision about the **amount of cover**.

For example:

— A higher **premium** would have applied for the **amount of cover**,

or

— the **amount of cover** would have been lower for the same **premium**,

or

— we would have restricted the **critical illnesses** covered under your **policy**,

or

— the term of your **policy** would have been restricted,

or

— the application would have been deferred, for example, pending the outcome of a medical investigation,

or

— the application would have been declined.

If you apply for the **policy** online, we'll send you and the person insured a summary of the questions we ask and the answers given.

We'll only send the summary to the person who was asked the question and provided the answer. For example, if the person insured was asked the question we'll send them the summary. We'll also do this, if, when you apply, we telephone you or the person insured to ask some further questions about the application. When either you or the person insured receive this summary it's very important that the person who receives the summary checks the answers they gave, as we rely on this information to set up your **policy**.

If we cancel your **policy** you won't be entitled to any refund of **premiums** or payment from it.

C8 – 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. Further details of how your information will be used by us and these fraud prevention agencies, and your data protection rights, can be found by contacting 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 more information is needed to comply with any financial sanctions.

C9 – When your policy ends

On the **end date** shown in your Policy Schedule, your **policy** will stop and no further **premiums** will be due. You won't receive anything back when it ends.

Also once we have paid a claim on your **policy** (unless the claim is for children's cover – see section A4 or for an **additional payment condition** – see section A10), it automatically ends, and we are not liable for any further claims.

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

C10 – Arranging for the amount of cover to be paid to a specific person

You might want to arrange for the **amount of cover** to be paid to another person, or company when you claim, such as the lender who provided your business loan.

You can do this by transferring ('assigning') your **policy** to another person (or people) or a company, or by placing it in trust. But remember, the person insured won't change.

If you do this, you need to send us the relevant documents so that we can update our records. If you don't, we may not pay the right person, people or company when a claim is made.

You are responsible for making sure that the **policy** has been assigned, or placed in trust in a way which is valid and effective. You may want to talk to a Solicitor before doing this.

C11 – The law that applies to your policy

Business Protection Combined Life & Critical Illness Guaranteed Premiums and its terms and conditions are governed by the laws of England and Wales. In the unlikely event of any legal disagreement, it would be settled exclusively by the courts of England and Wales. We'll always communicate in English.

C12 – 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 calling us on **0800 678 1906** (for textphone, dial 18001 first). 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. If you'd like more information on how we handle complaints, please contact us or visit **LV.com/complaints**.

We hope that we will be able to resolve any complaint that you have. 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. Their website is **financial-ombudsman.org.uk** which includes more information about the service, including details of the various ways they can be contacted. If you make a complaint it won't affect your right to take legal action.

Appendix – The list of critical illnesses

In this Appendix we have provided 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**.

For less advanced cancer (condition no.61) this also means we'll only pay one claim for each of the cancers listed under that condition.

Your Policy Schedule explains which of these **critical illnesses** you're covered for. This depends on whether you chose to be covered for all of the **critical illnesses**, or all of the **critical illnesses** except total permanent disability. The choices you have are explained in section A1.

Also in some cases due to the person insured's health, occupation or leisure activities we may not be able to cover all of these **critical illnesses**. If this is the case, it will be noted on your Policy Schedule under the heading of Special Provisions.

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.

We will pay twice the **amount of cover** if the person insured has a major organ transplant, liver failure or severe lung disease (the maximum amount we'll pay is capped at £200,000 more than the **amount of cover**). This is explained under the relevant conditions, so you'll be able to see where it applies. These payments are also available for children's cover (see section A4).

For some full **payment conditions** if the person insured is diagnosed as having the condition and they are under 55 years of age we will pay twice your **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**. We have explained this under the relevant conditions, so you'll know when this is available. This enhanced payment is not available for children's cover.

For some **full payment conditions** we will pay twice your **amount of cover** if the cause of your claim was as a direct result of an accident. We have explained this under the relevant conditions, so you'll know when this is available. These payments are also available for children's cover (see section A4).

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

If the person insured is under 55 years of age, and your claim meets this definition we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

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 twice the **amount of cover**. This is subject to a maximum of £200,000 more than the **amount of cover**.

If the person insured claim doesn't meet this definition you may still be able to claim on one of our **additional payment condition** – partial loss of sight. Please see condition no. 65 in the additional payment conditions section of this Appendix.

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 will pay twice the **amount of cover.** This is subject to a maximum of £200,000 more than the **amount of cover**.

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 person insured claim doesn't meet this definition you may still be able to claim on one of our **additional payment conditions** if the person insured suffered from one of the following:

- Gastrointestinal stromal tumour (GIST) or Neuroendocrine tumour (NET) of low malignant potential (Condition no.59)
- Less advanced cancers - of named sites and specified severity (Condition no. 61)
- Other carcinoma in-situ (Condition no. 63)

Please see the relevant numbered condition in the additional payment conditions section of this appendix.

If the person insured's condition and treatment meet the criteria for the above condition (and it's not listed as an exclusion in your policy schedule) we'll pay the person insured £1,000 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 your claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce your **amount of cover**. This payment is also included under Children's cover (see section A4).

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 this 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 this definition you may still be able to claim on our **additional payment condition** – Non-severe cardiomyopathy. Please see condition no. 62 in the additional payment conditions section of this appendix.

12 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 twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

13 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.

14 Creutzfeldt-Jakob disease

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

15 Crohn's 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.

16 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 twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

If the claim doesn't meet this definition you may still be able to claim on our **additional payment condition** – partial loss of hearing. Please see condition no.64 in the additional payment conditions section of this Appendix.

17 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.

18 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.

19 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 this definition, the following are not covered:

- Heart failure caused by alcohol and / or drug use

20 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.

21 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.

22 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.

23 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.

24 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 the above definition, the following is not covered:

- Liver failure secondary to alcohol or drug abuse

We will pay twice the amount of cover if the claim meets the above definition. This is subject to a maximum of £200,000 more than your **amount of cover**.

25 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 twice the **amount of cover.** This is subject to a maximum of £200,000 more than your amount of cover.

26 Loss of independent existence - unable to look after yourself ever again

Confirmation by a Consultant Physician and our Chief Medical Officer of loss of independent existence through illness or injury resulting in a permanent inability to perform at least three of the six tasks listed below ever again.

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.

The insured person 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.

The tasks are:

- **Washing** – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- **Getting dressed and undressed** – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- **Feeding yourself** – the ability to feed yourself when food has been prepared and made available.
- **Maintaining personal hygiene** – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- **Getting between rooms** – the ability to get from room to room on a level floor.
- **Getting in and out of bed** – the ability to get out of bed into an upright chair or wheelchair and back again.

For this definition, 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 will pay twice the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover.**

27 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 twice the a**mount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

28 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.

We will pay twice the **amount of cover** if the claim meets the above definition. This is subject to a maximum of £200,000 more than your **amount of cover**.

29 Motor neurone disease and specified diseases of the motor neurons – 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.

If the person insured is under 55 years of age, and your claim meets this definition we will pay twice the **amount of cove**r. This is subject to a maximum amount of £200,000 more than your **amount of cover.**

30 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.

31 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.

32 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

33 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 twice the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover.**

34 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

If the person insured is under 55 years of age, and your claim meets this definition we will pay twice the **amount of cover**. This is subject to a maximum amount of £200,000 more than your **amount of cover**.

35 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

If the person insured is under 55 years of age, and your claim meets this definition we will pay twice the **amount of cover**. This is subject to a maximum amount of £200,000 more than your **amount of cover**.

36 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 this definition you may still be able to claim on our **additional payment condition** – removal of one or more lobe(s) of the lung. Please see condition no.68 in the additional payment conditions section of this Appendix.

37 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.

38 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

We will pay twice the **amount of cover** if the claim meets the above definition. This is subject to a maximum amount of £200,000 more than your **amount of cover.**

39 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 person has completed based on best clinical practice for more than 1 year; and
- has resulted in the inability to perform any type of work for payment or reward for a period of at least 1 year **(this is not applicable for claims under children's cover)**.

For this definition, the following is not covered:

- Conditions related to or exacerbated by alcohol or drug abuse

40 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)

41 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.

42 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

43 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.

44 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 will pay twice the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

45 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.

46 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

47 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 will pay twice the **amount of cover.** This is subject to a maximum of £200,000 more than your **amount of cover**.

If the claim doesn't meet this definition you may still be able to claim on our **additional payment condition** – partial third degree burns. Please see condition no.66 in the additional payment conditions section of this Appendix.

48 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).

49 Total permanent disability – of specified severity

Your Policy Schedule states whether this is included and, if so, which of the following types of cover applies.

This condition is not covered under children's cover.

Although you don't need to tell us if the person insured changes their occupation after your **policy** starts, we will assess any claim based on the occupation that they were in when they became ill or had the accident which prevented them from working. We will use the type of cover shown on your Policy Schedule.

If the person insured is 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 the insured person is unable to do the essential duties of their 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 the person's own occupation that cannot reasonably be omitted or modified.

  Own occupation means the trade, profession or type of work the person insured does 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 the insured person expects to retire. For this definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

- **b) Work Tasks – unable to do 3 specified work tasks ever again**

  Loss of the physical or mental ability through an illness or injury to do at least 3 of the 6 work tasks listed ever again.

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

  The insured person 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 this 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 the person insured's disability is expected to last for the remainder of their life, irrespective of when your **policy** ends, or when they retire.

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

We will pay a claim if the medical evidence we have received in connection with your claim shows that the person insured has received all reasonable treatment options, these have been given a reasonable time to work, and have still failed to show any improvement in their symptoms. More information on how to make a claim, and the types of evidence we need are explained in Section A6.

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 50% of your **amount of cover** or £30,000. However we will only pay a claim once for each of these conditions.

For less advanced cancer (condition no.61) this also means we'll only pay one claim for each of the cancers listed under that condition.

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. The only exception to this is if we pay a claim under children's cover.

50 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 places 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.

51 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

52 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.

53 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

54 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.

55 Cerebral or spinal aneurysm – with surgery or radiotherapy

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

56 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 this definition, the following are not covered:

- Branch retinal artery or vein occlusion or haemorrhage
- Traumatic injury to tissue of the optic nerve or retina

57 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

This 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
- Circumflex

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

58 Diabetes mellitus type 1 – requiring permanent insulin injections

A definite diagnosis of type 1 insulin dependent 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)
- Latent autoimmune diabetes of adulthood

This condition is not included under Children's Critical illness cover

59 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.

For this definition the following is not covered:

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

If the person insured's condition and treatment meet the criteria for the above conditions (and it's not listed as an exclusion in your policy schedule) we'll pay the person insured £1,000 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 your claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce your **amount of cover**. This payment is also included under Children's cover (see section A4).

60 Guillian-Barré syndrome – with persisting clinical symptoms

Definite diagnosis of Guillian-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.

61 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 this 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.

  For this definition the following is not covered:

  — 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 this 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 undergoing surgery to remove the tumour.

  For this definition the following are not covered:

  — 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 this 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 undergoing 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 this 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 this 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 this 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 this 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 person insured's condition and treatment meet the criteria for any of the above conditions (and it's not listed as an exclusion in your policy schedule) we'll pay the person insured £1,000 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 your claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce your **amount of cover**. This payment is also included under Children's cover (see section A4).

62 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 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.

63 Other carcinomas in-situ – with surgery

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

For this definition the following are not covered:

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

If the person insured's condition and treatment meet the criteria for the above conditions (and it's not listed as an exclusion in your policy schedule) we'll pay the person insured £1,000 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 your claim under this condition as their final diagnosis and actual treatment may not meet the definition above. This payment doesn't reduce your **amount of cover**. This payment is also included under Children's cover (see section A4).

64 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.

65 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.

66 Partial third degree burns – covering 10% of the body's surface 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.

67 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

68 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.

Definitions

We explain these terms because this is a legal document. In some cases the words may have other meanings in everyday use. We have highlighted these words in bold (other than personal terms such as 'you' and 'we') so you know when they apply.

'**You**' or '**your**' means the policy owner(s) shown on the Policy Schedule or anyone else who becomes the legal owner of the **policy** (for example if you assign your **policy** to someone else, or another company after the **start date**).

'**We**', '**us**', or '**our**' means Liverpool Victoria Financial Services Limited.

'**Child**' or '**children**' means all of the person insured's natural children, stepchildren and legally adopted children.

'**Critical illness**' and '**critical illnesses**' mean the illnesses, medical conditions or operations detailed in the Appendix. Your Policy Schedule explains which of these you are covered for.

'**Additional payment condition**' means 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 detailed under the relevant **critical illnesses** in the Appendix.

'**Amount of your cover**' and '**amount of cover**' mean the amount you are insured for (shown on your Policy Schedule). This includes any inflation-linked increases. If you have applied for a decreasing **amount of cover**, then the **amount of cover** goes down each month. This is explained in more detail in section A3. You can choose different amounts of critical illness cover and life cover.

'**End date**' means the date when your **policy** ends. This date is shown in your Policy Schedule.

'**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 such as your weekly shopping, gas and electricity. We will measure this using the Retail Prices Index, unless this stops being published, in which case we would use another similar published index.

'**Plan**' means your LV= Flexible Protection Plan, your Plan Schedule, and any policies (including this **policy**) which are included in it.

'**Plan anniversary**' means each 12 month anniversary from the date your **plan** originally started. This will be the same as the 12 month anniversary of your **policy** unless you have added a new policy to an existing **plan**. You can check this on your Plan Schedule.

'**Policy**' means these conditions, your Policy Schedule, any Special Provisions listed in your Policy Schedule and any documents we send you to confirm changes to your policy or to the **amount of your cover**. We will apply a Special Provision when we are not able to offer you a **policy** based on the terms detailed in these conditions. This may be because of the person insured's occupation, health and medical history, or their leisure activities. We will let you know if this applies to you before we start asking you for any money.

'**Premium**' and '**premiums**' mean the monthly amount you pay for the **amount of your cover**.

'**Start date**' means the date when your **policy** started. This date is shown in your Policy Schedule.

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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