AIG

Individual Protection

YourLife Plan Term Assurance with Critical Illness Choices

Cover Details

Contents

Welcome to AIG

Thanks for choosing YourLife Plan Term Assurance with Critical Illness Choices from AIG.

YourLife Plan Term Assurance with Critical Illness Choices is designed to pay you a sum of money if you die or are diagnosed with a terminal illness or critical illness.

Who are we?

We're AIG Life Limited (AIG for short). We specialise in insurance in the UK that helps people experiencing tough times in life – such as life insurance, critical illness and income protection cover.

How to use this document

The purpose of this document is to explain how YourLife Plan Term Assurance with Critical Illness Choices works. Please read this document carefully and keep it in a safe place in case you need to make a claim. There are three important documents to keep safe together, as they form your policy with us:

- the Cover Details (this document)
- the Cover Summary (a personalised summary of your cover), and
- the Application Details (the answers you gave when you applied for the cover)

You'll find these in your policy pack when you took out your cover.

If there's anything that isn't clear about the cover you've purchased from us or if you have any questions, please get in touch.

If you're taking out Term Assurance with Critical Illness Choices to cover another person

Section 1 explains how this changes the terms and conditions of the cover detailed in sections 2, 3 and 4.

The language we use in the Cover Details

'We', 'us' or 'our' means AIG Life Limited. 'You' or 'your' means the owner of the cover or, where appropriate, anyone legally entitled to the policy payout – unless a different meaning is given in a particular paragraph of this document.

Some words in this document are **bold**. These are words that we provide an extra definition of. They're all explained in section 5.

How to contact us

Call us on:

0345 600 6820

If calling from outside the UK, please call:

+44 1737 441 820

Email us at:

enquiries@aiglife.co.uk

Write to us at:

AIG Life Limited,
PO Box 12010,
Harlow CM20 9LG

We're open Monday to Thursday, 8.30am to 6.00pm and Friday, 8.30am to 5.30pm except bank holidays.

Please note these opening hours are UK local time. To make sure we have an accurate record of the instructions, we may record or monitor phone calls.

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

What am I covered for?

Term Assurance with Critical Illness Choices is a type of **cover** that's designed to support you and your family when you're seriously ill, or no longer there for them. It'll provide you with the **benefit** if you make a valid claim.

The table below outlines the main benefit that is included as standard with this **cover**, plus the optional benefits that may be included in your **cover** for an additional cost. Depending on the **cover** you have, there will be different conditions, illnesses and treatments covered. You should refer to page 39 in the appendix to see how these are defined.

If you're not sure what **cover** you have, please refer to your **Cover Summary** which is given to you when you buy this policy.

The main benefit

This **cover** gives you the main benefit as standard. These are:

Optional benefits

When you take out this **cover**, you can choose to add optional benefits for an additional cost. The optional benefits are:

Section 1

Setting up the cover

1.1 The owner of the cover

If you apply for Term Assurance with Critical Illness Choices on your own life, you'll be the **owner of the cover**. If two people apply for **joint life cover** on both of their own lives, they'll be joint **owners of the cover**.

If you apply for Term Assurance with Critical Illness Choices to cover the life of another person or persons, you'll be the **owner of the cover** and they will be the person or persons covered. This means you'll be the recipient of the **benefit** in the event of a claim, unless you chose to assign the **benefit** or place it in trust.

1.2 Who can take out Term Assurance with Critical Illness Choices

When the **cover** is applied for, the **owner of the cover** must either be a British citizen or resident in the **UK**, **Channel Islands**, Isle of Man or Gibraltar, and the person covered must either be a British citizen, resident in the **UK**, **Channel Islands**, Isle of Man or Gibraltar or otherwise fulfil our overseas residency criteria.

You're considered resident if:

- You have indefinite leave to remain in the **UK**, **Channel Islands**, Isle of Man or Gibraltar
- You're an EU or EEA national living permanently, and have settled status, in the **UK**, **Channel Islands**, Isle of Man or Gibraltar, or
- You've resided in the **UK**, **Channel Islands**, Isle of Man or Gibraltar for the last 12 months, have a **UK, Channel Islands**, Isle of Man or Gibraltar bank account, live there permanently and will continue to do so.

You must have an insurable interest in the person covered at the time you take out the **cover**. An insurable interest is when you have a reasonable expectation of experiencing a financial loss upon their death or illness. You'll always have an insurable interest in your own life and the life of your spouse or civil partner. You may also have an insurable interest in another person. If you're not sure if you have an insurable interest in a particular person, you should ask your adviser for guidance.

Where the **owner of the cover** is different from the person covered, we may also ask for evidence of the insurable interest.

1.3 Buying this cover

There are a number of options available in this **cover** and some of these options may not be available to you depending on where you buy your **cover**.

Your **Cover Summary**, which you'll receive when you purchase your **cover**, will show which options you've selected.

If you would like to find out more about these options and whether they might suit your needs, please speak to a financial adviser.

Section 2

The cover

2.1 The main benefit

This **cover** gives you the main benefit as standard. These are:

- Death benefit
- Terminal illness benefit, and
- Core critical illness cover

For a **single life cover**, the **cover** stops after we've paid the full **sum assured**.

For a **joint life cover**, the **cover** stops after we've paid the full **sum assured** for one of the persons covered.

Death benefit

When we'll pay the **benefit**

If the person covered dies during the **term of the cover**, at which point the **cover** will end.

What we'll pay
The full **sum assured** as shown in the **Cover Summary**.

When we won't pay

- If the person covered dies as a result of their own actions within one year of the **cover** start date or of them restarting the **cover**. Once the **cover** has been active for more than 12 months, if the person covered has asked us to increase the **sum assured** in the 12 months prior to them dying as a result of their own actions, no death benefit will be payable in respect of this increase.
- For any reason listed in section 2.4.

Terminal illness benefit

When we'll pay the **benefit**
If the person covered meets our definition of **terminal illness** during the **term of the cover**, at which point the **cover** will end.

What we'll pay
The full **sum assured** as shown in the **Cover Summary**.

When we won't pay

- If the diagnosis doesn't meet the criteria for our definition of **terminal illness**.
- For any reason listed in section 2.4.

Core critical illness cover

The **benefit** falls within two groups – Group 1 and Group 2. Each Group provides cover for different conditions and different payment amounts.

Core critical illness cover – Group 1

When we'll pay the **benefit**

If the person covered suffers a **critical illness** listed in appendix A1 during the **term of the cover** and survives for at least 10 days.

What we'll pay

The full **sum assured** as shown in the **Cover Summary**.

What is covered?

For the list of conditions covered and how we define them, please refer to appendix A1.

How often can a claim be made?

Once, at which point the **cover** will end.

When we won't pay

- If the person covered is diagnosed with a critical illness that isn't covered, or they suffer a **critical illness** listed in appendix A1 but the diagnosis doesn't meet the criteria for our definition.
- For any reason listed in section 2.4.

Core critical illness cover – Group 2

When we'll pay the **benefit**

If the person covered suffers a **critical illness** listed in appendix A2 during the **term of the cover** and survives for at least 10 days.

What we'll pay

25% of the **sum assured** or £25,000, whichever is lowest.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim. However, if you have more than one **cover**, this is the maximum **benefit** we'll pay per person covered for each core critical illness cover Group 2 condition.

What is covered?

For the list of conditions covered and how we define them, please refer to appendix A2.

How often can a claim be made?

A claim can be made once for each condition per person covered.

When we won't pay

- If the person covered is diagnosed with a critical illness that isn't covered or they suffer a **critical illness** listed in appendix A2 but the diagnosis doesn't meet the criteria for our definition.
- If the person covered meets any of the **critical illness** definitions listed in appendix A1, resulting in a claim being considered.
- For any reason listed in section 2.4.

2.2 Optional benefits

The Cover Summary will show any optional benefits included in the **cover**. These are:

- Enhanced critical illness cover
- Children's cover
- Waiver of Premium
- Total Permanent Disability

Enhanced critical illness cover

When you take out **cover**, you can choose to add enhanced critical illness cover for an additional cost.

Enhanced critical illness cover is in addition to core critical illness cover and provides:

- cover for more conditions in Group 1
- cover for more conditions in Group 2 (replacing those in core critical illness cover) and a higher **benefit**, and
- pregnancy cover.

The enhanced critical illness cover will apply to both people covered on a **joint life cover**.

For a **single life cover**, the **cover** stops after we've paid the full **sum assured**.

For a **joint life cover**, the **cover** stops after we've paid the full **sum assured** for one of the persons covered.

The **benefit** falls within two groups – Group 1 and Group 2. Each Group provides cover for different conditions and different payment amounts.

Enhanced critical illness cover – Group 1

When we'll pay the **benefit**

If the person covered suffers a **critical illness** listed in appendix A1 or B1 during the **term of the cover** and survives for at least 10 days.

What we'll pay

The full **sum assured** as shown in the **Cover Summary**.

What is covered?

The conditions in appendix B1, in addition to the conditions in appendix A1.

For the list of conditions covered and how we define them, please refer to appendices A1 and B1.

How often can a claim be made?

Once, at which point the **cover** will end.

When we won't pay

- If the person covered is diagnosed with a critical illness that isn't covered or they suffer a **critical illness** listed in appendix A1 or B1 but the diagnosis doesn't meet the criteria for our definition.
- For any reason listed in section 2.4.

Enhanced critical illness cover – Group 2

When we'll pay the **benefit**

If the person covered suffers a **critical illness** listed in appendix B2 during the **term of the cover** and survives for at least 10 days.

What we'll pay

£35,000 or the full **sum assured**, whichever is lowest.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim. However, if you have more than one **cover**, this is the maximum **benefit** we'll pay per person covered for each Group 2 condition.

What is covered?

For the list of conditions covered and how we define them, please refer to appendix B2.

How often can a claim be made?

A claim can be made once for each condition per person covered.

When we won't pay

- If the person covered is diagnosed with a critical illness that is not covered or they suffer a **critical illness** listed in appendix B2 but the diagnosis doesn't meet the criteria for our definition.
- If the person covered meets any of the **critical illness** definitions listed in appendices A1 and B1, resulting in a claim being considered.
- For any reason listed in section 2.4.

Pregnancy cover

When we'll pay the **benefit**

If any of the persons covered has a specified complication of pregnancy.

What we'll pay

£5,000 per pregnancy.

If the claim is because of foetal death in utero, we'll pay £5,000 per foetal death.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim. However, if you have more than one **cover**, this is the maximum we'll pay for each pregnancy.

What is covered?

A definite diagnosis by a **consultant** Obstetrician of one of the following conditions:

- Disseminated Intravascular Coagulation (DIC)
- Ectopic Pregnancy
- Hydatidiform Mole
- Placental Abruption
- Eclampsia (excluding Pre-eclampsia), or
- Foetal death in utero after at least 20 weeks gestation.

How often can a claim be made?

A claim can be made once for each pregnancy.

When we won't pay

- If the person covered is diagnosed with a complication of pregnancy that is not covered.
- If the person covered was aware of an increased risk of having a complication of pregnancy before the **cover** started or restarted.
- If the pregnancy resulted in a child life cover benefit being paid (if children's cover is included).
- For any reason listed in section 2.4.

Children's cover

You can choose to add children's cover for an additional cost.

There's two levels of children's cover: core and enhanced. Which you can add will depend on the type of main cover you've chosen.

Core children's cover

Core children's cover is our standard cover for children. If you have core critical illness cover as part of your main **cover**, you can only add core children's cover. It includes:

- Children's critical illness cover, listed in appendix C1 and C2
- Child life cover
- Hospitalisation benefit

Children's critical illness cover

The **benefit** falls within two groups – Group 1 and Group 2. Each Group provides cover for different conditions and different payment amounts.

When we'll pay the **benefit**

If a **child** suffers a **critical illness** listed in appendix C1 or C2 during the **term of the cover** and survives for at least 10 days.

What we'll pay

- Group 1: £25,000 or 50% of the full **sum assured**, whichever is lower
- Group 2: £25,000 or 25% of the full **sum assured**, whichever is lower.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim on this **cover**.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each **child**. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

What's covered?

For the list of conditions covered in Group 1 and how we define them, please refer to appendix C1.

For the list of conditions covered in Group 2 and how we define them, please refer to appendix C2.

How often can a claim be made?

Once per **child** under each Group. This means that if a **child** suffers a **critical illness** covered in Group 1 (in appendix C1), and later suffers a **critical illness** covered in Group 2 (in appendix C2), or vice versa, due to separate events, we'll pay a claim under each Group.

At this point, the children's critical illness cover will end for that **child**. The **cover** continues for other children.

In the instance where one event causes a **child** to suffer a **critical illness** covered in Group 1 (in appendix C1) and Group 2 (in appendix C2), we'll only pay one claim.

We'll always pay the higher amount under Group 1, unless we've previously paid a claim under Group 1.

When we won't pay children's critical illness cover

There's some instances where we may not be able to pay a claim for children's critical illness cover and we'll always explain these in full. We won't pay:

- If either **parent** was aware of the increased risk of the **child** having the condition, or had received counselling or medical advice in relation to the condition before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- If the **child** was born before the children's cover started or was last restarted and had already had a **critical illness** unless:
  - treatment for the condition has been completed
  - the **child** has been discharged from follow-up for the condition, and
  - the **child** hasn't consulted any medical practitioner or received further treatment or advice for the condition within the last five years.
- For any reason listed in section 2.4.

Child life cover

When we'll pay the **benefit**

If a **child** dies, including stillbirth after at least 24 weeks gestation. This doesn't include elective pregnancy termination.

We'll pay the child life cover early if the **child** meets the definition of terminal illness under Group 2 as listed in appendix C2.

What we'll pay

£5,000.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim on this **cover**.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each child. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

How often can a claim be made?

Once per **child**.

When we won't pay

There's some instances where we may not be able to pay a claim for child life cover and we'll always explain these in full.

We won't pay:

- If the cause of death first arose before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- If either **parent** was aware of the increased risk of the **child** having the condition that caused death, or had received counselling or medical advice in relation to the condition that caused death before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- For any reason listed in section 2.4.

Hospitalisation benefit

When we'll pay the **benefit**

For every night a **child** is in hospital from the seventh consecutive night, up to a maximum of 30 nights. If, after a successful claim, the **child** returns to hospital for the same condition, the **benefit** can be paid from the first night up to a combined maximum of 30 nights.

What we'll pay

£100 per night per **child**.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim on this **cover**.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each **child**. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

How often can a claim be made?

More than once, up to a maximum of £3,000 per **child**.

When we won't pay

There's some instances where we may not be able to pay a claim for hospitalisation benefit and we'll always explain these in full. We won't pay:

- If the hospitalisation is as a result of a **child** being born prematurely (before 37 weeks gestation).
- For any reason listed in section 2.4.

Enhanced children's cover

Enhanced children's cover includes more conditions and higher payment amounts. If you have enhanced critical illness cover as part of your main **cover**, you can only add enhanced children's cover. It includes:

- Children's critical illness cover, listed in appendix C1, C2, C3 and C4
- Birth defect cover
- Child life cover
- Hospitalisation benefit

Children's critical illness cover

The **benefit** falls within two groups – Group 1 and Group 2. Each Group provides cover for different conditions and different payment amounts.

When we'll pay the **benefit**

If a **child** suffers a **critical illness** listed in appendix C1, C2, C3 or C4 during the **term of the cover** and survives at least 10 days.

What we'll pay

- Group 1: £50,000 or 50% of the full **sum assured**, whichever is lower
- Group 2: £25,000 or 25% of the full **sum assured**, whichever is lower

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim on this **cover**.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each **child**. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

What's covered?

For the list of conditions covered in Group 1 and how we define them, please refer to appendix C1 and C3.

For the list of conditions covered in Group 2 and how we define them, please refer to appendix C2 and C4.

How often can a claim be made?

Once per **child** under each Group. This means that if a **child** suffers a **critical illness** covered in Group 1 (in appendix C1 or C3) and later suffers a critical illness covered in Group 2 (in appendix C2 or C4), or vice versa, due to separate events, we'll pay a claim under each Group.

At this point, the children's critical illness cover will end for that **child**. The **cover** continues for other children.

In the instance where one event causes a **child** to suffer a **critical illness** covered in Group 1 (in appendix C1 or C3) and Group 2 (in appendix C2 or C4), we'll only pay one claim. We'll always pay the higher amount under Group 1, unless we've previously paid a claim under Group 1.

Overseas treatment for children's critical illness cover

We'll pay double the amount of **benefit** if in the opinion of the treating **consultant** and our Consultant Medical Officer:

- the **child** is unable to receive treatment for the **critical illness** listed in appendix C1, C2, C3 or C4 in the **UK** that is effective in curing or preventing further deterioration of the condition, and
- a prescribed specialist service or treatment directly commissioned by the NHS that is effective in curing or preventing further deterioration, is available overseas.

When we won't pay children's critical illness cover

There's some instances where we may not be able to pay a claim for children's critical illness cover and we'll always explain these in full. We won't pay:

- If either **parent** was aware of the increased risk of the **child** having the condition, or had received counselling or medical advice in relation to the condition before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- If the **child** was born before the children's cover started or was last restarted and had already had a **critical illness** unless:
  - treatment for the condition has been completed
  - the **child** has been discharged from follow-up for the condition, and
  - the **child** hasn't consulted any medical practitioner or received further treatment or advice for the condition within the last five years.
- For any reason listed in section 2.4.

Birth defect cover

When we'll pay the **benefit**
If a **child** has a specified birth defect condition listed in appendix C5.

What we'll pay
£5,000.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim on this **cover**.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each **child**. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

What's covered?
For the list of conditions covered and how we define them, please refer to appendix C5.

How often can a claim be made?
Once per **child**.

When we won't pay
There's some instances where we may not be able to pay a claim for birth defect cover and we'll always explain these in full. We won't pay:

- If either **parent** was aware of the increased risk of the **child** having the condition, or had received counselling or medical advice in relation to the condition before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- If the **child** was born with the condition before the children's cover started or was last restarted.
- For any reason listed in section 2.4.

Child life cover

When we'll pay the **benefit**
If a **child** dies, including stillbirth after at least 24 weeks gestation. This doesn't include elective pregnancy termination.

We'll pay the child life cover early if the **child** meets the definition of terminal illness under Group 2 as listed in appendix C2.

What we'll pay
£10,000.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim on this **cover**.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each **child**. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

How often can a claim be made?
Once per **child**.

When we won't pay
There are some instances where we may not be able to pay a claim for child life cover and we'll always explain these in full.

We won't pay:

- If the cause of death first arose before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- If either **parent** was aware of the increased risk of the **child** having the condition that caused death, or had received counselling or medical advice in relation to the condition that caused death before the children's cover started, was last restarted or before the **child** was covered by the **cover**.
- For any reason listed in section 2.4.

Hospitalisation benefit

When we'll pay the **benefit**
For every night a **child** is in hospital from the seventh consecutive night, up to a maximum of 30 nights.

If, after a successful claim, the **child** returns to hospital for the same condition, the **benefit** can be paid from the first night up to a combined maximum of 30 nights.

What we'll pay
£100 per night per **child**.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim.

However, if the person covered has more than one Term Assurance with Critical Illness Choices, this is the maximum we'll pay for each **child**. If each **parent** has their own **cover**, we'll pay a claim on each **parent's cover**.

How often can a claim be made?
More than once, up to a maximum of £3,000 per **child**.

When we won't pay
There's some instances where we may not be able to pay a claim for hospitalisation benefit and we'll always explain these in full. We won't pay:

- If the hospitalisation is as a result of a **child** being born prematurely (before 37 weeks gestation).
- For any reason listed in section 2.4.

Waiver of Premium

When you take out **cover**, you can choose to add Waiver of Premium for an additional cost.

The **Cover Summary** will show if Waiver of Premium is included in the **cover** and when it ends, and whether an **own occupation**, **suited occupation**, or **work tasks** (also known as **daily activities**) definition of incapacity applies to the person covered.

For **joint life cover**, you can choose Waiver of Premium for one or both of the people covered.

When we'll waive **premiums**

We'll waive the Term Assurance with Critical Illness Choices **premiums** if the person covered by Waiver of Premium is **incapacitated** for longer than 26 weeks.

Premiums due in the first 26 weeks of being **incapacitated** won't be waived.

How much we'll waive

We'll waive the cost of any **cover** that includes Waiver of Premium.

When we'll stop waiving **premiums**

We'll stop waiving **premiums** when the earliest of the following happens:

- the person covered no longer meets the criteria for our definition of **incapacitated** that applied when they first claimed
- a successful claim is made resulting in the full **sum assured** being paid, or
- either the **cover** ends or the Waiver of Premium end date is reached, as shown in the **Cover Summary**.

While we're waiving a **premium**, we can ask the person covered to see a doctor or health specialist of our choice, to help us confirm whether they still meet the definition of **incapacitated** that applies to them.

When we won't waive **premiums**

We won't waive **premiums** if any of the following apply:

- the diagnosis doesn't meet the criteria for our definition of **incapacitated**
- the person covered is **incapacitated** but Waiver of Premium isn't included in the **cover** for that person (this will be shown in the **Cover Summary**)
- the person doesn't satisfy the geographical restrictions set out in section 3.4.
- Waiver of Premium has ended as shown in the **Cover Summary**, or
- For any reason listed in section 2.4.

Total Permanent Disability

When you take out **cover**, you can choose to add Total Permanent Disability for an additional cost.

The **Cover Summary** will show if Total Permanent Disability is included in the **cover** and when it ends, and whether an **own occupation**, **suited occupation**, or **work tasks** (also known as **daily activities**) definition of incapacity applies to the person covered.

For **joint life cover**, you can choose Total Permanent Disability for one or both of the people covered.

For a **single life cover**, the **cover** stops after we've paid the full **sum assured**.

For a **joint life cover**, the **cover** stops after we've paid the full **sum assured** for one of the persons covered

When we'll pay the **benefit**

If the person covered is **incapacitated** and meets the definition of Total Permanent Disability that applies to them, but their condition doesn't meet our definition of **critical illness**. They'll usually have to be **incapacitated** for at least 26 weeks before we can establish whether the incapacity is **permanent**.

Total Permanent Disability definitions

Own occupation: the person covered is unable to do their **own occupation** ever again – the kind of job they did before they had to stop work.

Suited occupation: the person covered is unable to do a **suited occupation** ever again – the kind of job they could do.

Work tasks: the person covered is unable to do three specified **work tasks** ever again – the things people need to do in everyday life.

What we'll pay

The full **sum assured**.

How often can a claim be made?

Once, at which point the **cover** will end.

When we won't pay

- If the diagnosis doesn't meet the criteria for our Total Permanent Disability definition.
- If Total Permanent Disability has ended as shown in the **Cover Summary**.
- For any reason listed in section 2.4.

2.3 What we'll base benefit payments on

The amount of the **sum assured** can change during the **term of the cover**. How the **sum assured** changes is shown in the **Cover Summary**.

If you've chosen a level lump sum, we'll base **benefit** payments on the **sum assured** that's shown in the **Cover Summary**.

If you've chosen an increasing lump sum, we'll base **benefit** payments on the current **sum assured**. For the first year of the **cover**, this will be the initial **sum assured**. This amount is shown in the **Cover Summary**. After a year, the **sum assured** will increase by 5%. Every year after that, the **sum assured** will increase by 5% of the current **sum assured**.

We'll write to you each year to tell you the new **sum assured** and the new premium that you'll be paying.

If you've chosen a decreasing lump sum, we'll base **benefit** payments on the current **sum assured**. The **sum assured** will reduce each month after the first month of **cover** in line with the capital outstanding on a repayment mortgage with:

- an annual interest rate you chose. The **Cover Summary** will show which interest rate has been chosen. The interest rate is fixed and won't vary during the **term of the cover**, and
- a term equal to the remaining **term of the cover**.

2.4 When we won't pay a benefit

Sections 2.1 and 2.2 list specific circumstances when we won't pay a **benefit**.

We also won't pay any of the **benefits** described in 2.1 and 2.2 if any of the following apply:

- you, the person covered or their personal representatives don't give us medical or other evidence that we ask for
- we find you, the person covered or their personal representatives has given us inaccurate, incomplete or false information on the application which would have affected our decision to offer this **cover**, or would have led us to offer it with different conditions
- the **cover** is no longer active
- the claim is caused by something that we've specifically excluded from this **cover** – this will be shown in the **Cover Summary**, or
- the **terminal illness** claim wasn't submitted while the **cover** was **active**, before the **cover** ended.

It's really important that you take sufficient care to provide us with information that's true, accurate and complete. If any of the information given to us is fraudulent, deliberately misleading or untrue, incomplete or inaccurate:

- the **cover** will be cancelled
- we won't pay any **benefit**
- any **benefit** that has already been paid under the **cover** must immediately be repaid to us, and
- any **premium** payments made for the **cover** will not be returned.

If you didn't purposely give us incomplete or inaccurate information, we may amend your **cover** to reflect the true, complete and accurate information had it been provided by you when you applied for the **cover**. We're entitled to do the following:

1. If we wouldn't have offered you the **cover**, we'll cancel the **cover** and refund any **premiums** you've already made.
2. If we would have offered different terms and conditions for the **cover** (other than your **premiums**), we'll change the terms and conditions and treat the **cover** as having had the different terms and conditions from the start of **cover**.
3. If we would have offered the **cover** with higher payments from you, we may reduce the **sum assured** to reflect the higher **premiums** that would have applied. In these circumstances, we'll use this formula:

New **sum assured** = existing **premiums** x original **sum assured**, divided by higher **premiums**.

Section 3

Managing the cover

3.1 Paying for the cover

When the **cover** is on a life of another basis, you may choose whether you or the person covered pays the **premiums**.

When the **premium** is paid

First **premium**

We'll collect this by Direct Debit (via the **BACS** system) on, or shortly after, the date the **cover** starts. The Direct Debit must be from a **UK**, **Channel Islands**, Isle of Man or Gibraltar bank account. **Premiums** must be paid in pounds sterling.

Regular **premium**

If a monthly **premium** has been selected, we'll collect the **premium** on the same date each month. The person paying can choose a date between the 1st and the 28th of the month that suits them. They'll pay the **premium** every month for the **term of the cover**, unless we accept a Waiver of Premium claim for the **cover**.

If an annual **premium** has been selected, we'll collect the **premium** on the same date each year.

When the **premium** collection falls on a weekend or bank holiday, we'll collect it on the next working day.

What happens if the **premium** isn't paid?

If any **premium** remains unpaid for more than 30 days from the date it was due to be collected, we'll cancel the **cover**. We'll write to you and (if different) the person covered to tell them that the **cover** has been cancelled.

Restarting a **cover**

If we cancel a **cover** because a **premium** isn't paid, you can ask us to restart it. You can do this at any time up to six months after the date of the first missed **premium**. We'll tell you what we need in order to restart the **cover** and you must clear any premium arrears. There may be circumstances when we reserve the right not to restart a **cover**. If this happens, we'll explain our decision.

When the **premium** could change

The **premium** could change if:

- you make a change to the **cover**
- it becomes subject to tax
- we accept a Waiver of Premium claim or a Waiver of Premium claim ends
- Waiver of Premium or Total Permanent Disability ends as shown in the **Cover Summary**, if these were selected when the **cover** started, or
- any of the information provided as part of the application process is incorrect – more details can be found in sections 4.8 and 4.13.

If the **cover** has an increasing **sum assured**, the **premium** will increase annually and will increase by a higher percentage than that of the **sum assured**, given the increased likelihood of a claim as you get older.

We'll write to you each year to tell you the new **sum assured** and the new **premium** that you'll be paying. You don't need to accept the increase, but must advise us if you don't. If you don't accept the increase, we won't increase the **sum assured**. However, if you decide to decline the increase for three consecutive years, you'll no longer have the option of an increasing **sum assured** under the **cover** in future years.

3.2 Telling us about changes to personal details

You or the person covered need to tell us if they change:

- their name
- their contact details (postal address, telephone number, email address), or
- their bank account.

We don't need to be told if the person covered changes their occupation.

You or the person covered can contact us using the details on page 5.

We'll ask for the **cover** number. We'll also ask some security questions to confirm their identity.

3.3 Changing the cover

Life event changes

You can increase the **sum assured** or the **term of the cover** without the need to answer any more health or lifestyle questions if the person covered's circumstances change as described below:

Life event	Evidence needed	Increase allowed to the:
Getting married or entering into a civil partnership	Marriage or civil partnership certificate	Sum assured
Divorce, dissolution of civil partnership or separation	Decree absolute or dissolution order, or Evidence of new mortgage, mortgage transfer or new separate addresses	Sum assured
Having or legally adopting a child	Birth or adoption certificate	Sum assured
Mortgage increase due to home improvements	Builder's estimate or planning consent	Sum assured and term of the cover
Mortgage increase due to house move or purchase	Mortgage offer letter from lender	Sum assured and term of the cover
Salary increase by at least 10% after a promotion or change of employment	Proof of income or confirmation of promotion and new salary	Sum assured

Changes in relation to a life event must be made within 26 weeks of the event taking place. We'll ask to see evidence of the event, and where you are different to the person covered, we may also ask for evidence of the insurable interest (which is when you have a reasonable expectation of experiencing a financial loss upon their death or illness). Without this, there may be circumstances where we refuse to allow the increase.

These options aren't available to everyone. This could be because, for example, the person covered has a particular medical condition when **cover** is first taken out. The **Cover Summary** will show whether these options are available. Before taking up any of these options, you should consider speaking to your financial adviser.

Whenever a change is requested, we'll send written confirmation once this has been processed.

Increase the **sum assured**

More than one increase can be requested but the total increase in **cover** can't be more than the lower of:

- 100% of the original **sum assured**, or
- £200,000.

If it's in relation to a mortgage increase, then the increase in **sum assured** can't exceed the increase to the mortgage.

Increase the **term of the cover**

You can increase the **term of the cover** in relation to an increase in your mortgage term.

More than one increase can be requested but the total of all increases can't result in the new term being:

- more than 150% of the original term
- extending beyond the end of the term of the new mortgage, or
- extending past the 65th birthday of the oldest person covered.

If your **cover** includes Total Permanent Disability or Waiver of Premium, we may have to restrict the increased term for these options.

How these changes affect the cost of the **cover**

If you change your **cover** in these ways, the **premium** will increase.

The **premium** for the additional **cover** will be based on the person covered's age when the change is made.

Please contact us for details about how your **premium** will change.

Asking us to change the **cover**

To ask us to change your **cover**, you can contact us using the details on page 5.

When these options can't be taken up:

- after the 55th birthday of the oldest person covered
- while we're waiving the **premiums**
- in the last five years of the **term of the cover** except where the **term of the cover** at the start date is five years or less, in which case we'll allow increases in the first two years of **cover**
- while we're paying a **benefit** under any **cover**
- while you're in a position to make a claim under the **cover**, or
- if you or the person covered have received **benefit** payments under the **cover** in the last two years.

Cover changes

The following section explain how you can change the cover.

Those options that aren't automatically available to everyone have 'limited' after the heading. The **Cover Summary** will show whether these options are available. Before taking up any of these options, you should consider speaking to your financial adviser.

Whenever a change is requested, we'll send written confirmation once this has been processed.

Reducing the **sum assured**

You can reduce the **sum assured** at any time, as long as the reduction doesn't mean that the **sum assured** falls below the minimum allowed. If you later want to increase the **sum assured** through the life event change option, the amount by which you'll be able to do so will be based on the new, lower **sum assured**, not the initial one.

Reducing the **term of the cover**

You can reduce the **term of the cover** at any time. You can reduce it by as much as you want, as long as the reduction doesn't mean:

- the new term is lower than our minimum term, or
- the **premium** would fall below our minimum level.

If you later want to increase the term through the life event change option, the amount by which you'll be able to do it will be based on the new, lower term, not the original one.

Stopping and restarting the annual increase – limited

If you have an **increasing sum assured**, we'll write to you each year to tell you the new **sum assured** and the new **premium** that you'll pay. You can ask for the increases to stop at any time. If you do, the **sum assured** will be frozen at the level it has reached when you ask us to stop the increase. You can ask us to start increasing it again, but we can't do this if:

- we're waiving the **premiums**
- the **sum assured** has been frozen for three consecutive years
- we're paying a **benefit** under any cover
- you're in a position to make a claim under the **cover**, or
- you or the person covered have received **benefit** payments under the **cover** in the last two years.

Changing from a decreasing to a level lump sum – limited

If you have a decreasing **sum assured**, you can change it to a level amount within the first five years of the **term of the cover**. If you do, the **sum assured** will then be frozen at the level it has reached when you ask us to make the change and your **premium** will increase.

Adding another person to the **cover**

You can ask us to change a **single life cover** to **joint life cover** if you are also the person covered. We'll need information about the new person so we can decide whether to add them to the **cover**, and on what terms. The **premium** may increase if this change is made, and the new person will become a joint **owner of the cover**.

Changing a **joint life cover** to two **single life covers** – limited

Where the people covered are also the **owners of the cover**, either person can ask us to change the **cover** from **joint life cover** to two **single life covers**. They can do this providing it's within six months of separating and taking out new mortgages, however not in the last three years of the **cover**. Both people must agree to this change. We'll ask to see evidence of the separation and the new mortgages. The total of the two new **sums assured** cannot be more than 100% of the **sum assured** under the **joint life cover**.

Changing how often a **premium** is paid

You can change from monthly **premiums** to annual **premiums** and vice versa. If you make this change, it will start from the date that your next **premium** is due to be collected.

Add or remove children's cover

You can choose to add children's cover at any time for an additional cost.

If children's cover is added, the **premium** will be based on the person covered's (not the **child's**) age at the time of the change, their **sum assured** and the number of years left on the **term of the cover**.

You can also choose to remove children's cover at any time and the **premium** will be reduced appropriately.

Children's cover will continue unless you tell us you no longer need it.

Remove enhanced critical illness cover, Waiver of Premium or Total Permanent Disability

If enhanced critical illness cover, Waiver of Premium or Total Permanent Disability are included in the **cover**, you can choose to remove them at any time and the **premium** will be reduced appropriately.

Your **Cover Summary** will show which **benefits** you can remove.

If they're removed, they can't be subsequently added back to the **cover**.

How these changes affect the cost of the **cover**

If you change your **cover**, the premium may change.

Please contact us for details about how your **premium** may change.

Asking us to change the **cover**

To ask us to change your **cover**, you can contact us using the details on page 5.

3.4 Claiming a benefit

When to claim

The person claiming should contact us as soon as possible.

For Waiver of Premium claims, we ask that we're notified within eight weeks of the person covered becoming **incapacitated**.

How to make a claim

The person claiming can:

- phone us on 0345 600 6815. If calling from outside the **UK**, please call +44 1737 441 815.
- email us at claimsteam@aiglife.co.uk
- write to us at Claims Team, AIG Life Limited, PO Box 12010, Harlow CM20 9LG

We're open Monday to Thursday, from 8.30am to 6pm and Friday, 8.30am to 5.30pm, except for bank holidays. Please note these opening hours are UK local time.

If we're considering a death claim, we'll stop collecting **premiums**. If we're considering any other type of claim, **premiums** must be paid whilst it's being assessed. If the claim is paid, we'll advise you if we can refund any of the **premiums** paid whilst we assessed the claim.

If you, the person claiming or the person covered doesn't give us the evidence we ask for, or the information they do give us is inaccurate or incomplete, we may not pay a claim or stop paying one. We'll pay the reasonable cost of all medical reports or evidence we ask for.

Geographical restrictions

Some types of **cover** require the person covered, or the doctor that diagnoses them, to be in a particular part of the world when a claim is made or when we're paying the **benefit**.

For a death claim, the person covered or the **child** of the person covered can be anywhere in the world.

For **terminal illness**, **critical illness** and children's cover claims, the person covered or the **child** of the person covered can be residing anywhere in the world, however the **consultant** must be in an **eligible country**.

For Waiver of Premium and Total Permanent Disability claims, the person covered must be living in an **eligible country** when they become **incapacitated**. They must return to and remain

in the **UK**, **Channel Islands**, Isle of Man or Gibraltar within 26 weeks of becoming **incapacitated** in order to receive the **benefit**.

We may consider claims that fall outside our geographical restrictions if we're satisfied that we're able to obtain sufficient and reliable information to allow us to fully assess the claim.

Support during a claim – Claims Support Fund

If we've agreed that the person claiming may have a valid claim, we may pay up to £500 from our Claims Support Fund for services that support the person covered or their family. The services that are covered by this support payment will depend on the circumstances, but could range from physiotherapy or counselling to the cost of taking taxis to hospital appointments.

Whether we can pay the Support Fund depends on the situation of the person covered and the advice of their doctor. Our claims adviser will explain the types of services that we can pay for and once agreed, we'll pay this as soon as we can.

Please remember that if we pay for support services, it doesn't necessarily mean we'll approve a claim on your **cover**.

We won't pay for support services in relation to a Waiver of Premium claim.

This is an additional payment. This means that any payments made won't affect other **benefits** we pay for any subsequent claim.

Who we'll pay the **benefit** to

We'll pay the **benefit** to the person legally entitled to receive it. Who this will be depends on the nature of the claim, the circumstances at the time and whether the **cover** has been assigned or put under trust.

During the course of the claim assessment, we'll establish and confirm who we identify as legally entitled to receive the **benefit**.

We'll normally pay the **benefit** to you or your personal representatives if you've died. Personal representatives need to send us the original Grant of Representation, Letters of Administration or Confirmation before we can pay any **benefit** to them.

If you've instructed us to pay the **benefit** to someone else by a deed of assignment, we'll pay this **assignee**. **Assignee(s)** need to send us the original deed of assignment before we can pay any **benefit** to them.

If the **cover** is under trust, we'll pay the **benefit** to the **trustee(s)**. The **trustee(s)** must then follow the terms of the trust to distribute the money to the chosen beneficiaries. **Trustee(s)** need to send us the original Trust Deed and any deeds altering the trust before we can pay any **benefit** to them. We'll return these when we pay the claim.

How we'll pay the **benefit**

We'll pay any **benefit(s)** due under the **cover** in pounds sterling by direct credit (via the **BACS** system) into a **UK**, **Channel Islands**, Isle of Man or Gibraltar bank account nominated by you, the **trustee(s)**, the **assignee(s)** or their personal representative.

If the **claimant** wishes to receive the **benefit(s)** outside of the **UK**, **Channel Islands**, the Isle of Man or Gibraltar, then arrangements for such transfer from the **claimant's UK**, **Channel Islands**, Isle of Man or Gibraltar bank account must be made at the **claimant's** own expense. The **claimant** will bear the risk of any difference due to the currency exchange rates.

Section 4

General terms and conditions

4.1 Cancelling the cover

When your **cover** starts, we'll send you information about your right to change your mind and cancel your **cover**. You have 30 days from the date you receive this information to cancel your cover. If you cancel your **cover** in this time we'll refund any **premiums** you've paid to us, unless we've paid you a **benefit** before you cancel.

If you don't cancel your **cover** within this time period, your **cover** will remain **active** as set out in the **Cover Summary**.

You can stop your **cover** at any other time. Once you tell us, your **cover** will end on the day before your next monthly **premium** is due to be collected. Any **premiums** paid to date won't be refunded. If you're paying annual **premiums**, your **cover** will end on the day before the next monthly anniversary of the **cover**. We'll retain the cost of any full (or partial) months of **cover** up to the date of cancellation and will refund any balance of the annual **premium**.

4.2 Cash value

The **cover** doesn't have any cash value at any time unless a valid claim is made.

4.3 Inflation

The purchasing power of the **benefit(s)** paid out may be reduced in real terms, due to the effects of **inflation**.

If the **cover** has an increasing **sum assured**, this may provide some protection against the effects of **inflation**, however this isn't guaranteed. For more information on the effects of **inflation**, please speak to your financial adviser.

4.4 Interest

If we start paying the **benefit** any later than eight weeks after we receive all of the information we need, we'll pay interest on the overdue amount from the date payment should have started. This will be at the Bank of England base rate at the time.

4.5 Data protection

We're committed to protecting the privacy of customers, claimants and other business contacts.

In order to provide our products and services and to run our business, we'll collect, use and disclose your personal information, including sensitive personal data (health information). Where we do this, we'll rely either on your consent, or on a combination of the following justifications: performing a contract with you or preparing to enter into a contract with you; complying with regulatory requirements; or having a legitimate interest to request your personal information.

'Personal information' identifies and relates to you or other individuals (e.g. your partner or other members of your family). If you provide personal information about another individual, you must (unless we agree otherwise) inform the individual about the content of this notice and our Privacy Policy and obtain their permission (where possible) for sharing of their personal information with us.

Personal information we collect

Personal information we may collect about you or the person covered and their dependants includes:

- General identification and contact information
- Family details
- Sensitive information such as health and lifestyle details
- Other sensitive information such as racial/ethnic origin, religious or other beliefs, sexual life, criminal proceedings – outcomes and sentences, offences/alleged offences, and
- Financial details: bank account details and other financial information.

How we use your personal information

We may use the personal information provided to us to:

- Make decisions about whether to provide insurance and assistance services (such as deciding the right **premium**, claim assessment, claim processing and claim settlement)
- Administer the policy, assess and pay claims, and general customer service activities (including complaint resolution and claims disputes)
- Detect, investigate and prevent crime, including fraud and money laundering
- Carry out market research and analysis
- Comply with applicable laws and regulatory obligations (including those outside your country of residence), and
- Market products and services of the **AIG Group**, only in instances where you've opted in to receiving such communications.

Sometimes, as part of our business operations, decisions are taken about you using automated computer software and systems. These decisions don't involve human input. For example, we use automated decision making to assess your eligibility for insurance and to determine the **premium** amount.

To opt-out of any marketing communications that we may send you, contact us by:

email DataProtectionOfficer@aiglife.co.uk

or write to The Data Protection Officer, AIG Life, 58 Fenchurch Street, London, EC3M 4AB.

If you opt-out, we may still send you other important service and administration communications relating to the services which we provide to you from which you can't opt-out.

Where we may get personal information from

We may get personal information about you or the person covered from them, their financial adviser, or from other sources – for instance their doctor.

We may ask their doctor for information before we offer **cover**. We may also get a report from their doctor or telephone them for more information after the **cover** has started. If we find that we've been given incomplete, inaccurate or false information, we don't receive the report from their doctor or they are unavailable for interview, we reserve the right to cancel the **cover** within 13 weeks.

Who we'll share personal information with

We may share personal information about you or the person covered solely for the purposes listed above in 'How we use your personal information' with certain named third parties. These third parties are:

- **AIG Group** companies: AIG Life Limited is a member company of American International Group, Inc. As such, we have group companies throughout the world (for example, in the USA)
- Our reinsurers (a list of these reinsurers can be provided on request)
- Our external third party service providers (including medical screening service providers)
- Your financial adviser
- Your own doctor and other medical consultants
- Legal and regulatory bodies
- Law enforcement and fraud prevention agencies, and
- Other insurance companies or organisations.

International transfer of personal information

Due to the global nature of our business, personal information may be transferred to parties located in other countries (including the USA, China, Mexico, Malaysia, Philippines and Bermuda) that have data protection regimes that are different to those in the country where you're based, including countries which haven't been found to provide adequate protection for personal information by the **UK Government**.

When making these transfers, we'll take steps to ensure that your personal information is adequately protected and transferred in accordance with the requirements of data protection law.

Security of personal information

Appropriate technical and physical security measures are used to keep your personal information safe and secure. When we provide personal information to a third party (including our service providers) or engage a third party to collect personal information on our behalf, the third party will be selected carefully and required to use appropriate security measures to protect the confidentiality and security of personal information.

Your rights

You have a number of rights under data protection law in connection with our use of your personal information. These rights may only apply in certain circumstances and are subject to certain exemptions. These rights may include a right to access personal information, a right to correct inaccurate data, a right to erase data or suspend our use of data. These rights may also include a right to transfer your data to another organisation, a right to object to our use of your personal information, a right to request that certain automated decisions we make have human involvement, a right to withdraw consent and a right to complain to the data protection regulator.

More information about your rights and how you may exercise them is set out in full in our Privacy Policy (see below).

Privacy notice

For full details on how we use personal information, how we maintain the security of personal information, who we share personal information with, the data protection rights available to individuals in the **UK**, and who to contact in the event of any queries, please refer to our full privacy notice which can be found on our website (aiglife.co.uk/privacy-policy).

Alternatively, you may request a copy by writing to The Data Protection Officer, AIG Life, 58 Fenchurch Street, London, EC3M 4AB or by email at DataProtectionOfficer@aiglife.co.uk

4.6 Taxation, laws and regulations

This contract between you and AIG Life Limited, and any dispute or claim arising out of or in accordance with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by and interpreted in accordance with the **laws**. By taking out this contract, the **owner of the cover** agrees to submit to the exclusive jurisdiction of the courts of England and Wales if there is ever a dispute between them and AIG Life Limited. **Laws** may change in future and AIG Life Limited can't be held responsible for any information given or any changes in tax provisions or legislation.

Benefit(s) payable under this **cover** are normally free from Income Tax and Capital Gains Tax for **UK** residents. This may change if the **law** changes.

Professional guidance should be sought before any type of assignment or changed ownership is undertaken.

We can't advise whether a trust is suitable in any particular circumstances or give tax advice in relation to the use of trusts and would recommend that you take professional advice before setting up a trust.

Cover held by the **trustee(s)** of a trust shouldn't normally form part of the estate of the person covered for Inheritance Tax purposes. There's a potential Inheritance Tax charge when **benefit(s)** are paid out of a trust (known as 'exit charges') or on every tenth anniversary of the creation of the trust (known as 'periodic charges'). This applies to **UK** residents only.

Claimant(s) who are outside of the **UK** when **benefit(s)** are received may also be subject to additional taxation in the local jurisdiction. Please consult your tax adviser or local tax inspector for clarification. If there's any change to tax and other **laws**, or **State Benefits**, AIG Life Limited may change the terms and conditions set out in the cover documents in order to comply with such **laws**.

4.7 Contract

The contract between the **owner of the cover** and AIG Life Limited consists of:

- any information provided by the person covered or the **owner of the cover** in their application and any subsequent information they've provided
- these terms and conditions, which we may amend from time to time
- any additional terms and conditions detailed in the **Cover Summary** that we send when the **cover** starts, and
- any additional terms and conditions detailed in any subsequent **Cover Summary**.

The contract between the **owner of the cover** and AIG Life Limited as described above constitutes the entire agreement and understanding between the parties and supersedes and extinguishes all previous drafts, agreements, arrangements and understandings between them, whether written or oral, relating to its subject matter. If there's a conflict between these terms and any of the terms set out in the **Cover Summary**, the terms set out in the **Cover Summary** will take precedence.

If any court finds that any provision of the **Cover Summary** or any other document embodying the contract between the **owner of the cover** and AIG Life Limited (or part thereof) is invalid, illegal or unenforceable that provision or part-provision shall, to the extent required, be deemed to be deleted, and the validity and enforceability of the other provisions of the **Cover Summary** or any other document embodying the contract between the **owner of the cover** and AIG Life Limited won't be affected.

4.8 Misstatement of age

If, after the **cover** is taken out, we learn that the person covered has a different date of birth than the one originally stated by you, this will impact on the **premium** and/or **sum assured** of their **cover**.

In some cases, this may affect their right to the **cover** or your **cover** may be cancelled. It may also affect how we've interpreted medical evidence, which may result in a claim not being paid or the **sum assured** being reduced.

4.9 Complaints

If you, the person covered or any person to whom the **benefit** of the **cover** has been assigned has a complaint, they can contact our customer care team as detailed on page 5 of this document.

We'll try to resolve complaints as quickly as possible. If we can't deal with their complaint promptly, we'll send a letter to acknowledge it and then give regular updates until it is resolved.

We're committed to resolving complaints through our own complaints procedures. However, if a matter can't be resolved satisfactorily, they may be able to refer their complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service helps settle disputes between consumers and financial firms. Their service is independent and doesn't cost anything. They can decide if we have acted wrongly and if the person with the complaint has lost out as a result. If this is the case they'll tell us how to put things right and whether we have to pay compensation.

If a complaint is made, we'll send them a leaflet explaining more about the Financial Ombudsman Service. The leaflet is also available at any time on request.

Alternatively, the Financial Ombudsman Service can be contacted at the following address:

Financial Ombudsman Service, Exchange Tower, Harbour Exchange Square, London E14 9SR.

Telephone 0800 023 4567 (calls to this number are free on mobile phones and landlines) or 0300 123 9123 (calls to this number cost no more than calls to 01 and 02 numbers). If calling from outside the UK, please call +44 20 7964 0500.

Email: complaint.info@financial-ombudsman.org.uk

Website: www.financial-ombudsman.org.uk

If a complaint is made, it won't affect their right to take legal proceedings

4.10 If we cannot meet our liabilities

Most of AIG's customers, including most individuals and small businesses, are covered by the Financial Services Compensation Scheme (FSCS), which is designed to pay compensation if a firm is unable to pay claims because it has gone out of business.

Before looking to pay compensation, the FSCS will first see if they can arrange for your current insurance to be replaced by a new policy with a different insurer. If this isn't possible, the FSCS aims to provide compensation. For policyholders who have a valid claim under an insurance policy with a failed insurer, the FSCS will look to pay 100% of the claim value.

You can find out more about the FSCS, including eligibility to claim, by visiting its website fscs.org.uk. Alternatively, you can contact the Financial Services Compensation Scheme at the following address:

Financial Services Compensation Scheme, PO Box 300, Mitcheldean, GL17 1DY.

Telephone: 0800 678 1100 or 020 7741 4100. If calling from outside the **UK**, please call +44 20 7741 4100. Email: enquiries@fscs.org.uk

Please be aware that the rules of the FSCS may change in the future, or FSCS may take a different approach on their application of the above, depending on the circumstances.

4.11 Assignment

If you assign any of your legal rights under the **cover** to someone else (including any assignment to the **trustee(s)** of a trust), we must see notice of the assignment when a claim is made. This notice must be sent to: AIG Life Limited, PO Box 12010, Harlow CM20 9LG.

An assignment could take place when you're using the **cover** as security for a loan.

4.12 Right of third parties

No term of this contract is enforceable under the Contracts (Right of Third Parties) Act 1999 by a person who isn't party to this contract. This doesn't affect any right or remedy of a third party which may exist or be available otherwise than under that Act.

The **owner of the cover** and AIG Life Limited are the parties to the contract.

4.13 Disclosure confirmation and verification

The person covered will be asked to provide details of their health and personal circumstances. You and the person covered must provide full, honest and accurate answers to all questions asked. Furthermore, subject to what we say in section 'Telling us about changes to personal details', we must be told immediately if the information in the **Application Details** isn't correct as this may affect the **cover**.

The information provided to us by the person covered is confidential and we won't disclose it to the **owner of the cover** without their permission. We'll send to the person covered details of their answers and a copy of their **Application Details**, and ask them to advise us of any corrections or additions they wish to make. If they don't answer our questions fully and honestly, this may result in us refusing any future claim.

We'll provide you and the person covered with a **Cover Summary** which will include information on any exclusions made as a result of the health information provided by the person covered.

We may select the application for a disclosure check. To complete the check, we'll either obtain a report from the doctor of the person covered, or call them for more information or perform data checks. If we've selected it for a check, the person covered must give permission for us to contact their doctor if required, and use all reasonable endeavors to ensure we're able to complete the check. If we've requested any additional information from you or the person covered they must provide it within 30 days.

If they don't respond to a request from us within 13 weeks for medical evidence or 30 days for other information, we'll cancel the **cover**.

4.14 Economic sanctions

We won't be responsible or liable to provide **cover** (including payment of a claim or provision of any other **benefit**) under this policy if we're prevented from doing so by any economic sanction which prohibits us or our **Parent Company** (or our **Parent Company's** ultimate controlling entity) from providing **cover** or dealing with you under this policy.

Economic sanctions change from time to time and can include prohibiting the transfer of funds to a sanctioned country, freezing the assets of a government, the corporate entities and residents of a sanctioned country, or freezing the assets of specific individuals or corporate entities. This means that if you, or any third party who has suffered a loss which would otherwise be covered under the **cover**, are the subject of an economic sanction, we may not be able to provide **cover** under the policy.

4.15 Restricted persons

This **cover** won't cover any injury, loss or expense sustained directly or indirectly by any person covered who is a member of a terrorist organisation, narcotics trafficker, or seller of nuclear, chemical or biological weapons.

4.16 When we can make changes to your cover

We can make changes to the terms and conditions of your **cover** that we reasonably consider are appropriate if there's a request from any regulatory authority to do so, or there's a change in the law, applicable legislation, regulation, taxation, or recommendations or decisions of a regulator or similar body affecting us or your **cover**.

These changes could affect the amount and type of cover provided under the **cover**. If we do decide to make any changes to your **cover**, we'll write to tell you at least 28 days before the change takes effect. If you're not happy with the changes, you have the right to cancel the **cover** (see the section 4.1 Cancelling the cover).

4.17 About our business

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

AIG Life Limited is the life insurance arm of AIG in the **UK, Channel Islands**, Isle of Man and Gibraltar.

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

Section 5

Definitions

An explanation of the terms we use across Term Assurance with Critical Illness Choices (please note these definitions aren't case sensitive).

Active
The **cover** has started, is within its term, **premiums** are up-to-date and we haven't written to you or the person covered to tell them that they're no longer covered.

AIG Group
Any wholly or partly owned, direct or indirect subsidiary of American International Group, Inc.

Application Details
A copy of all the information provided by the person covered and (if applicable) the **owner of the cover** in the application.

We must be told immediately if the information in the Application Details isn't correct as this may affect your **cover**.

Assignee
A person to whom this **benefit(s)** is legally transferred.

BACS
A scheme for the electronic processing of direct debits and direct credits.

Benefit
Any payments the **claimant** receives from AIG Life Limited.

Channel Islands
The Island of Jersey and the Island of Guernsey.

Child/Children
Anybody from birth up to age 22 who is:

- a natural **child** of the person covered or their **partner**
- legally adopted by the person covered or their **partner**, or
- a legal stepchild of the person covered following their marriage or civil partnership.

A child can be of either person covered on a **joint life cover**.

Claimant
The person(s) legally entitled to claim the **benefit(s)** under the **cover(s)**. This may be the **owners(s) of the cover**, **trustee(s)** on behalf of the trust and for the benefit of the beneficiaries, **assignee(s)** or personal representatives of the **owner(s) of the cover's** estate.

Consultant
A consultant doctor who:

- specialises in an area of medicine appropriate to the cause of the claim
- is employed at a hospital in an **eligible country**, and
- is treating the person covered for their condition.

All diagnoses made by a consultant must be confirmed by our Consultant Medical Officer.

Cover/covers
Term Assurance with Critical Illness Choices policy provided by AIG Life Limited.

Cover Summary
This is a document we send to the person covered or to the **owner of the cover** once you've purchased your **cover**. It explains any special conditions which apply to the **cover**, for example if there are any illnesses which are usually part of the **cover** but which we can't cover them for, and whether or not they have the automatic right to ask for an increase in the **sum assured** should their circumstances change.

Critical illness
An illness that:

- meets our definition of a condition found in appendices A1, A2, B1, B2, C1 or C2
- is diagnosed by a **consultant**
- is the first and unequivocal diagnosis of the illness, and
- is confirmed by our Consultant Medical Officer.

Daily activities
These are the things people need to do in everyday life. We refer to these as **work tasks**. See **work tasks** for more information.

Eligible country
An eligible country is one of the following: Australia, Austria, Belgium, Canada, **Channel Islands**, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, Ireland, Isle of Man, Italy, Japan, Luxembourg, Malta, The Netherlands, New Zealand, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, **UK**, USA.

Employed
Paid work under a contract of employment. Paying Class 1 National Insurance contributions.

Incapacitated

There are three different ways we define incapacitated in relation to the person covered.

These are based on their ability to do:

- their **own occupation** – the kind of job they did before they had to stop **work**
- their **suited occupation** – the kind of job they could do, or
- their **work tasks** (also known as **daily activities**) – the things people need to do in everyday life.

Which of these three definitions applies to the person covered depends on:

- whether they are in paid **work**, and
- what kind of **work** they do.

The **Cover Summary** shows which definition applied to the person covered when the **cover** was taken out. If you were **employed** when you took out the **cover** and at the point you became **incapacitated** you were unemployed, a **work tasks** definition will apply.

In all cases, their incapacity must be confirmed by appropriate medical evidence and agreed by our Consultant Medical Officer.

Inflation

Inflation is the rise in the general level of prices in goods and services over a period of time. As inflation rises, the real value of your money, and the **benefit(s)** provided by your **cover**, may fall because you may be able to afford less with the
same amount.

Irreversible

Cannot be reasonably improved upon by medical treatment and/or surgical procedures used by the National Health Service in the **UK** at the time of the claim.

Joint life

Cover for two people with the **sum assured** payable once.

Laws

The law of England and Wales.

Neurological deficit with persisting clinical symptoms lasting at least 24 hours

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last at least 24 hours.

Symptoms that are covered include:

- numbness
- hyperaesthesia (increased sensitivity)
- paralysis
- localised weakness
- dysarthria (difficulty with speech)
- aphasia (inability to speak)
- dysphagia (difficulty in swallowing)
- visual impairment
- difficulty in walking
- lack of co-ordination
- tremor
- seizures
- dementia
- delirium, and
- coma.

The following aren't covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms, and
- Symptoms of psychological or psychiatric origin.

Occupation

A trade, profession or the type of **work** undertaken for profit or pay. It isn't a specific job with any particular employer and is independent of location and availability.

Own occupation

The person covered isn't doing any paid **work** and has been diagnosed with an illness, injury or disability which prevents them from doing the essential duties of their own occupation. 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 your trade, profession or type of **work** you do for profit or pay. It isn't a specific job with any particular employer and is irrespective of location
and availability.

Owner(s) of the cover
A person or two persons that enter into a contract for **cover** to insure their lives or the life of another person on the basis of an insurable financial interest in that person.

Parent
Anybody who:

- is a biological mother or father of a **child**
- has legally adopted a **child**, or
- is a legal step-parent of a **child** following marriage or civil partnership to the **child's** biological parent, or
- is a **partner** to the parent of the **child**.

Parent Company
The legal entity that owns or controls AIG Life Limited as defined by the laws applicable to the jurisdiction within which the legal entity resides.

Partner
Someone the person covered is married to or in a civil partnership with, or someone they have been living with for a minimum of two years as if they were married or in a civil partnership.

Permanent/permanently
Expected to last throughout life with no prospect of improvement, irrespective of when the **cover** ends or the person covered expects to retire.

Permanent neurological deficit with persisting clinical symptoms
Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the life of the person covered.

Symptoms that are covered include:

- numbness
- hyperaesthesia (increased sensitivity)
- paralysis
- localised weakness
- dysarthria (difficulty with speech)
- aphasia (inability to speak)
- dysphagia (difficulty in swallowing)
- visual impairment
- difficulty in walking
- lack of co-ordination
- tremor
- seizures
- dementia
- delirium, and
- coma.

The following aren't covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms, and
- Symptoms of psychological or psychiatric origin.

Premium/premiums
The monthly or annual payment to AIG Life Limited for Term Assurance with Critical Illness Choices.

Single life
Cover for one person.

State Benefits
A payment made by the government of the state where the **claimant** resides.

Suited occupation
In relation to Waiver of Premium
The person covered isn't doing any paid **work** and has been diagnosed with an illness, injury or disability that:

- in the first 12 months following the date they stopped **work**, totally prevents them from doing the essential duties of their **own occupation**. 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 can't reasonably be omitted or modified, and
- after they've been off **work** for more than 12 months, totally prevents them from doing the essential duties of a suited occupation.

A suited occupation means one they could do for profit or pay taking into account their employment history, knowledge, transferable skills, training, education and experience, and is irrespective of location and availability.

In relation to Total Permanent Disability
The person covered isn't doing any paid **work** and has been diagnosed with an illness, injury or disability that totally prevents them from doing the essential duties of a suited occupation.

A suited occupation means one they could do for profit or pay taking into account their employment history, knowledge, transferable skills, training, education and experience, and is irrespective of location and availability.

Sum assured
The amount we'd pay for a successful claim on Term Assurance with Critical Illness Choices. We'd either pay this amount or a percentage of this amount, depending on the kind of **cover** and the options that are included in the **cover**.

Term of the cover
How long the **cover** lasts. In other words, the period between the date the **cover** starts and the date it ends as shown in the **Cover Summary**.

Terminal illness – where death is expected within 12 months
A definite diagnosis by the attending **consultant** of an illness which satisfies both of the following:

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

A claim will be considered where terminal illness is diagnosed and this definition is met at any time up to the day **cover** ends, provided a claim has been submitted while the **cover** is still **active**, before the **cover** ends.

Trustee
A person, often one of a group, who becomes the legal owner of the trust assets (in this case, the policy and its proceeds) and who has powers to deal with the trust assets in accordance with the terms of the trust and the duties imposed by **law**.

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

UK Government
The government of the **UK** or, upon the secession of Wales, Scotland and/or Northern Ireland from the **UK**, the government of the nation in which England remains.

Waiting list
A listing for surgery at a hospital in the **UK**, **Channel Islands**, Isle of Man or Gibraltar.

Work
Paid employment or self-employment.

Work tasks
The person covered has been diagnosed with an illness, injury or disability which prevents them from doing at least three out of the six work tasks, also known as **daily activities**.

The person covered must need the help or supervision of another person and be unable to perform the work tasks on their own, even with the use of special equipment routinely available to help and taking 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 12 stairs and down again, using the handrail if needed.

Lifting
The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.

Bending
The ability to bend or kneel to touch the floor and straighten up again.

Getting in and out of a car
The ability to get into a standard saloon car, and out again.

Writing
The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

In addition to the above, we'll pay the benefit where the person covered meets the following definition:

Mental failure
The diagnosis by a **consultant** neurologist or psychiatrist, of an **irreversible** and **permanent** mental impairment due to an organic brain disease or brain injury supported by evidence of all of the following:

- the loss of the ability to remember, reason and give effect to ideas which causes a significant reduction in mental and social functioning, and
- the person covered requires continuous supervision.

Or

Where the person covered is unable to meet both of the following definitions, or one of the following definitions and one work task:

Seeing
The ability to see well enough to read 16-point print using glasses or other reasonable aids.

Communicating
The ability to:

- Clearly hear conversational speech in a quiet room in their first language
- Understand simple messages in your first language, or
- Speak with sufficient clarity to be clearly understood in your first language.

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

Section 6

Appendices

Appendices

Depending on the **cover** you have, there will be different conditions, illnesses and treatments covered. The table below sets out which appendices you should refer to for each benefit.

The cover	Appendix	Page
The main benefit		
Core critical illness cover – Group 1	**A1**	Page 40
Core critical illness cover – Group 2	**A2**	Page 43
Optional benefits		
Enhanced critical illness cover – Group 1	**A1 & B1**	Page 40 & 44
Enhanced critical illness cover – Group 2	**B2**	Page 45
Core children's critical illness cover – Group 1	**C1**	Page 48
Core children's critical illness cover – Group 2	**C2**	Page 50
Enhanced children's critical illness cover – Group 1	**C3**	Page 52
Enhanced children's critical illness cover – Group 2	**C4**	Page 52
Birth defect cover	**C5**	Page 54
Supplementary condition information	**D1**	Page 55

Association of British Insurers - guide to minimum standards for critical illness cover

The Association of British Insurers (ABI) is a trade body for the UK's insurance and long term savings industry. Part of its remit is to set standards that insurers must follow.

The ABI Guide to Minimum Standards provides that, to be called 'critical illness' insurance, policies must include cover for cancer, heart attack and stroke according to specified minimum definitions of those conditions. It also sets out minimum definitions for other conditions which insurers may or may not offer so that there is a degree of comparability and consistency, and to ensure that the cover for all these conditions meets certain minimum standards.

Our Term Assurance with Critical Illness Choices meets, and in some instances improves on, the standards provided for in the ABI Guide to Minimum Standards for Critical Illness Cover.

Appendix A1

Refer to appendix A1 for conditions, illnesses and treatments covered in core critical illness cover – Group 1.

Bacterial meningitis – resulting in permanent symptoms

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in **permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be confirmed by a **consultant** neurologist.

For the above definition, the following are not covered:

- All other forms of meningitis including viral meningitis.

Benign brain tumour – resulting in permanent symptoms or specified treatment

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

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

For the above definition, the following are not covered:

- Tumours in the pituitary gland, and
- Angioma.

Blindness or removal of an eyeball – permanent and irreversible

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

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

For the above definition, surgical removal of an eyeball resulting from intentional self-inflicted injuries is not covered.

Brain injury – resulting in permanent symptoms

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

Cancer – excluding less advanced cases and including aplastic anaemia

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

- Aplastic anaemia resulting in permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia
- Essential thrombocythaemia
- Leukaemia
- Lymphoma (except cutaneous lymphoma – lymphoma arising from or confined to the skin)
- Merkel cell cancer
- Polycythaemia vera
- Primary myelofibrosis
- Pseudomyxoma peritonei, and
- Sarcoma (except cutaneous sarcoma – sarcoma arising from or confined to the skin).

For the above definition, the following are not covered:

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

Coma – of specified severity

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

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug abuse.

Deafness – permanent and irreversible

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

Degenerative neurological disorder – of specified severity

A definite diagnosis by a relevant **Consultant** of a neurodegenerative disorder with worsening symptoms over time, expected to progress throughout the lifetime of the person, that has resulted in either:

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

For this definition, the following are not covered:

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

For more information about when a claim will be paid, see appendix D1.

Encephalitis – resulting in permanent symptoms

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

Heart attack – of specified severity

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

- typical clinical symptoms (for example, characteristic chest pain)
- new characteristic electrocardiographic changes or new diagnostic imaging changes, 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:

- Myocardial injury without myocardial infarction, and
- Angina without myocardial infarction.

Kidney failure – requiring permanent dialysis

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

Liver failure – end stage

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

- **permanent** jaundice
- **permanent** ascites, and
- encephalopathy.

For the above definition, the following is not covered:

- Liver failure secondary to alcohol or drug misuse.

Loss of use of a limb

Permanent loss of the use of a limb due to:

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

Lung disease or removal – as specified

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

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

Major organ transplant – from another donor

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

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

For the above definition, the following is not covered:

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

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

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

The following is not covered:

- neuromyelitis optica spectrum disorder.

Reduced heart function – of specified severity

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

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

For this definition, the following are not covered:

- any heart impairment related to alcohol or drug misuse.

For more information about when a claim will be paid, see appendix D1.

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**.

Stroke – of specified severity

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

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

For the above definition, the following are not covered:

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

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

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

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

The following are not covered:

- any other surgery including endovascular surgery.

For more information about when a claim will be paid, see appendix D1.

Surgery via the skull – as specified

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

For more information about when a claim will be paid, see appendix D1.

Systemic lupus erythematosus (SLE) – of specified severity

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

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

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

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

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

Appendix A2

Refer to appendix A2 for conditions, illnesses and treatments covered in core critical illness cover – Group 2.

Cancer in situ of the breast – treated with surgery

Breast cancer in situ, including ductal and lobular cancer in situ, positively diagnosed with histological confirmation by biopsy together with the undergoing of surgery to remove the tumour.

For the above definition, the following are not covered:

- other forms of treatment.

Early stage prostate cancer – requiring treatment

Diagnosis and specified treatment of a tumour of the prostate histologically classified as having a Gleason score of 6 provided:

- the tumour has progressed to at least clinical TNM classification T1N0M0, and
- treatment included the complete removal of the prostate or external beam or interstitial implant radiotherapy or cryotherapy or hormone therapy or high intensity focused ultrasound.

For the above definition, the following are not covered:

- other less radical treatment (e.g. transurethral resection of the prostate), and
- tumours treated with experimental treatments.

Appendix B1

Refer to appendix B1 for conditions, illnesses and treatments covered in enhanced critical illness cover – Group 1.

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

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

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

The following are not covered:

- Angiomas.

Cauda equina – with permanent symptoms

A definite diagnosis of cauda equina syndrome (compression of the lumbosacral nerve roots) by a **consultant** neurologist resulting in all of the following:

- **permanent** bladder dysfunction, and
- **permanent** weakness and loss of sensation in the legs.

Intensive care – requiring mechanical ventilation for 7 consecutive days

Any sickness or injury resulting in the person covered requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more in an intensive care unit at a hospital in the **UK**, **Channel Islands**, Isle of Man or Gibraltar.

Loss of independence – of specified severity

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

Either

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

Or

- The person covered is unable to perform two out of the following five activities without the help of another person, even with the use of appropriate assistive aids:

Washing

The ability to wash in the bath or shower (including getting into and out of the bath or shower).

Dressing

The ability to put on and take off, secure and unfasten all garments.

Getting between rooms

The ability to get from room to room on a level floor.

Feeding yourself

The ability to feed yourself when food and drink has been prepared.

Maintaining personal hygiene

The ability to maintain a satisfactory level by using the toilet or otherwise managing bowel and bladder functions.

Peripheral vascular disease – requiring bypass surgery

A definite diagnosis of peripheral vascular disease with objective evidence from imaging of obstruction in the arteries, which results in the undergoing of, or inclusion on an official **waiting list** for, by-pass graft surgery to the arteries of the legs.

The following are not covered:

- angioplasty.

Severe bowel disease

A definite diagnosis by a **consultant** gastroenterologist of a bowel disease, resulting in either:

- surgical intestinal resection to remove part of the small intestine or bowel on at least two separate occasions, or
- total colectomy (removal of entire large bowel).

Severe mental illness – as specified

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

- an admission to a psychiatric ward where treatment was provided for at least 14 consecutive nights
- has chronic unremitting symptoms
- has not responded to comprehensive management and treatment 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.

For this definition, the following is not covered:

- Conditions related to or exacerbated by alcohol or drug abuse.

Appendix B2

Refer to appendix B2 for conditions, illnesses and treatments covered in enhanced critical illness cover – Group 2.

Accidental hospitalisation

An accident that results in physical injury which requires the person covered to stay in hospital for 28 consecutive days or more on the advice of an appropriate **consultant**.

For the above definition the following is not covered:

- an accident as a result of drug or alcohol intake or other self-inflicted means.

Angioplasty – requiring treatment to multiple coronary vessels

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

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

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

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

For the above definition, the following is not covered:

- Diagnostic angiography.

Bladder removal

Complete surgical removal of the urinary bladder (total cystectomy).

The following are not covered:

- urinary bladder biopsy, and
- removal of a portion of the urinary bladder.

Bowel disease – treated with intestinal resection

A definite diagnosis by a **consultant** gastroenterologist of a bowel disease treated with surgical intestinal resection.

Carotid artery stenosis – treated by endarterectomy or angioplasty

The undergoing of endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 50% narrowing or blockage of a carotid artery.

Angiographic evidence will be required.

Central retinal artery or vein occlusion (eye stroke) – resulting in permanent visual loss

Death of optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in **permanent** visual impairment of the affected eye.

For the above definition the following are not covered:

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

Cerebral or spinal arteriovenous malformation or aneurysm - with surgery or radiotherapy

The undergoing of endovascular repair or stereotactic radiotherapy to treat:

- a cerebral or spinal arteriovenous fistula or malformation, or
- a cerebral or spinal aneurysm.

More than one claim can be made under this definition, but only one claim can be made for a cerebral or spinal arteriovenous fistula or malformation and one claim for a cerebral or spinal aneurysm.

Diabetes mellitus Type 1 – requiring permanent insulin injections

A definite diagnosis of Type 1 diabetes mellitus, requiring the **permanent** use of insulin injections.

The following are not covered:

- gestational diabetes, and
- Type 2 diabetes (including Type 2 diabetes treated with insulin).

Endovascular surgery – as specified

The undergoing of endovascular surgery on the advice of an attending **consultant** to:

- repair or replace one or more heart valves, or
- repair an aneurysm of the thoracic or abdominal aorta with a graft.

The following are not covered:

- any procedures to any branches of the thoracic or abdominal aorta.

Less advanced cancers – of named sites and specified severity

Positive diagnosis confirmed with histological confirmation relating to any of the following:

Breast

Breast cancer in situ, including ductal and lobular cancer in situ, positively diagnosed with histological confirmation by biopsy together with the undergoing of surgery to remove the tumour.

For the above definition the following are not covered:

- Other forms of treatment.

Cervix

Cancer in situ of the cervix uteri resulting in trachelectomy (removal of the cervix) or hysterectomy.

For the above definition, the following are not covered:

- Loop excision, laser surgery, conisation and cryosurgery, and
- Cervical Intraepithelial neoplasia (CIN) grade 1 or 2.

Colon and rectum

Cancer in situ of the colon or rectum resulting in intestinal resection.

The following are not covered:

- Local excision and polypectomy.

Larynx

Cancer in situ of the larynx treated with either surgery, laser or radiotherapy.

Ovary

Ovarian tumour of borderline malignancy/low malignant potential and resulting in surgical removal of an ovary.

The following is not covered:

- Removal of an ovary due to a cyst.

Prostate

Diagnosis and specified treatment of a tumour of the prostate histologically classified as having a Gleason score of 6 provided:

- the tumour has progressed to at least clinical TNM classification T1N0M0, and
- treatment included the complete removal of the prostate or external beam or interstitial implant radiotherapy or cryotherapy or hormone therapy or high intensity focused ultrasound.

For the above definition, the following are not covered:

- Other less radical treatment (e.g. transurethral resection of the prostate), and
- Tumours treated with experimental treatments.

Renal pelvis (of the kidney) and ureter

Cancer in situ of the renal pelvis or ureter.

The following are not covered:

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

Thyroid

Diagnosis of a tumour of the thyroid following surgery to remove the tumour, which is histologically classified as having progressed to at least TNM classification T1N0M0.

Urinary bladder

Cancer in situ of the urinary bladder.

The following are not covered:

- Non-invasive papillary carcinoma and TNM classification stage Ta bladder cancer.

Uterus

Cancer in situ of the lining of the uterus (endothelium) resulting in hysterectomy.

A claim can be made for more than one less advanced cancer of different sites. Once a claim has been accepted, the person covered will no longer be covered for that same illness under any of the definitions listed in appendices A2 or B2.

Other early stage cancers – with surgery

Histological diagnosis of any of the following that has been treated by surgery to remove the tumour:

- cancer in situ characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of organs
- a neuroendocrine tumour (NET) classified as WHO grade 1, or
- a gastrointestinal stromal tumour (GIST) classified by either AFIP/Lasota-Miettinen as having no or a low risk of progression, or as UICC TNM8 stage 1.

The following are not covered:

- any skin cancer (including melanoma)
- tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment, or
- intra-epithelial neoplasia.

A claim can be made more than once under this definition for early stage cancers of different sites. Once a claim has been accepted, the person covered will no longer be covered for that same illness under any of the definitions listed in appendices A2 or B2.

Permanent pacemaker insertion – for heartbeat abnormalities

The **permanent** insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. There must be evidence of an abnormal rhythm of the heart on an ECG.

Pituitary gland tumours – with specified treatment

Pituitary gland tumours treated with either surgical removal or by radiotherapy.

The following are not covered:

- pituitary gland tumours treated by other methods.

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

A definite diagnosis of sepsis by a **consultant** physician resulting in admission to either an intensive care unit (ICU) or a high dependency unit (HDU) for at least 3 continuous days.

Significant visual impairment – permanent and irreversible

Permanent and **irreversible** loss of sight in the better eye to the extent that even when tested with the use of visual aids is measured by a certified ophthalmologist as follows:

- acuity of up to 6/24 (Snellen) with moderate contraction of the field, or aphakia (lens removal) or opacities blocking vision in the eye itself, or
- acuity of 6/18 or better, if in addition suffering from a gross defect of visual fields (of both eyes, such as hemianopia); or marked contraction of the visual field (i.e. in retinitis pigmentosa or glaucoma).

Single lobectomy – the removal of a complete lobe of a lung

The undergoing of surgery for the removal 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.

Skin cancer (not including melanoma) – advanced stage as specified

Non-melanoma skin cancer diagnosed with histological confirmation that the tumour is larger than 2 centimetres across and has at least one of the following features:

- tumour thickness of at least 4 millimeters (mm)
- invasion into subcutaneous tissue (Clark level V)
- invasion into nerves in the skin (perineural invasion)
- poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope), or
- has recurred despite previous treatments.

Syringomyelia or syringobulbia – treated by surgery

The undergoing of surgery to treat a syrinx in the spinal cord or brain stem.

Appendix C1

Refer to appendix C1 for conditions, illnesses and treatments covered in core children's critical illness cover – Group 1.

Blindness or removal of an eyeball – permanent and irreversible

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

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

For the above definition, surgical removal of an eyeball resulting from intentional self-inflicted injuries is not covered.

Cancer – excluding less advanced cases and including aplastic anaemia

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

- Aplastic anaemia resulting in permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia
- Essential thrombocythaemia
- Leukaemia
- Lymphoma (except cutaneous lymphoma - lymphoma arising from or confined to the skin)
- Merkel cell cancer
- Polycythaemia vera
- Primary myelofibrosis
- Pseudomyxoma peritonei, and
- Sarcoma (except cutaneous sarcoma - sarcoma arising from or confined to the skin).

For the above definition, the following are not covered:

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

Degenerative neurological disorder – of specified severity

A definite diagnosis by a relevant **Consultant** of a neurodegenerative disorder with worsening symptoms over time, expected to progress throughout the lifetime of the person, that has resulted in either:

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

For this definition, the following are not covered:

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

For more information about when a claim will be paid, see appendix D1.

Kidney failure – requiring permanent dialysis

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

Liver failure – end stage

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

- **permanent** jaundice
- **permanent** ascites, and
- encephalopathy.

For the above definition, the following is not covered:

- Liver failure secondary to alcohol or drug misuse.

Major organ transplant – from another donor

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

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

For the above definition, the following is not covered:

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

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

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

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

Appendix C2

Refer to appendix C2 for conditions, illnesses and treatments covered in core children's critical illness cover – Group 2.

Bacterial meningitis – resulting in permanent symptoms

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in **permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be confirmed by a **consultant** neurologist.

For the above definition, the following are not covered:

- All other forms of meningitis including viral meningitis.

Benign brain tumour – resulting in permanent symptoms or specified treatment

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

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

For the above definition, the following are not covered:

- Tumours in the pituitary gland, and
- Angioma.

Brain injury – resulting in permanent symptoms

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

Coma – of specified severity

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

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug abuse.

Deafness – permanent and irreversible

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

Encephalitis – resulting in permanent symptoms

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

Heart attack – of specified severity

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

- typical clinical symptoms (for example, characteristic chest pain)
- new characteristic electrocardiographic changes or new diagnostic imaging changes, 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:

- Myocardial injury without myocardial infarction, and
- Angina without myocardial infarction.

Loss of use of a limb

Permanent loss of the use of a limb due to:

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

Lung disease or removal – as specified

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

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

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

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

The following is not covered:

- neuromyelitis optica spectrum disorder.

Reduced heart function – of specified severity

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

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

For this definition, the following are not covered:

- any heart impairment related to alcohol or drug misuse.

For more information about when a claim will be paid, see appendix D1.

Stroke – of specified severity

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

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

For the above definition, the following are not covered:

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

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

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

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

The following are not covered:

- any other surgery including endovascular surgery.

For more information about when a claim will be paid, see appendix D1.

Surgery via the skull – as specified

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

For more information about when a claim will be paid, see appendix D1.

Systemic lupus erythematosus (SLE) – of specified severity

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

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

Terminal illness – where death is expected within 12 months

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

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

A claim will be considered where terminal illness is diagnosed and this definition is met at any time up to the day **cover** ends, provided a claim has been submitted while the **cover** is still active, before the **cover** ends.

Appendix C3

Refer to appendix C3 for conditions, illnesses and treatments covered in enhanced children's critical illness cover – Group 1. This is in addition to appendix C1.

Loss of use of two limbs

Permanent loss of the use of any combination of two or more limbs due to:

- physical severance of hands or feet at or above the wrist or ankle joint, or
- total and **irreversible** loss of muscle function to the whole arm or leg.

Muscular dystrophy

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

Permanent dependence – of specified severity

Confirmation by a **consultant** physician and our Consultant Medical Officer of **permanent** dependence and inability to live independently through illness or injury, to the extent that a **child** will require lifelong medical attention and constant supervision by another person. Having met our definition, a **child** must survive for 90 days.

Spina bifida

A definite diagnosis of spina bifida myelomeningocele or rachischisis by a paediatrician. For the above definition, the following are not covered:

- Spina bifida occulta, and
- Spina bifida with meningocele.

Appendix C4

Refer to appendix C4 for conditions, illnesses and treatments covered in enhanced children's critical illness cover – Group 2. This is in addition to appendix C2.

Accidental hospitalisation

An accident that results in physical injury which requires the **child** to stay in hospital for 28 consecutive days or more on the advice of an appropriate **consultant**.

For the above definition the following is not covered:

- an accident as a result of drug or alcohol intake or other self-inflicted means.

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

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

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

The following are not covered:

- Angiomas.

Bowel disease

A definite diagnosis by a **consultant** gastroenterologist of a bowel disease treated with either:

- surgical intestinal resection, or
- total colectomy (removal of entire large bowel).

Cerebral palsy

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

Cerebral or spinal arteriovenous malformation or aneurysm – with surgery or radiotherapy

The undergoing of endovascular repair or stereotactic radiotherapy to treat:

- a cerebral or spinal arteriovenous fistula or malformation, or
- a cerebral or spinal aneurysm.

Cystic fibrosis

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

Diabetes mellitus Type 1 – requiring permanent insulin injections

A definite diagnosis of Type 1 diabetes mellitus, requiring the **permanent** use of insulin injections.

The following are not covered:

- gestational diabetes, and
- Type 2 diabetes (including Type 2 diabetes treated with insulin).

Down's syndrome

A definite diagnosis of Down's syndrome by a paediatrician.

Edwards' Syndrome

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

Hydrocephalus – treated with the insertion of a shunt

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

Intensive care – requiring mechanical ventilation for 7 consecutive days

Any sickness or injury resulting in the person covered requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more in an intensive care unit at a hospital in the **UK, Channel Islands**, Isle of Man or Gibraltar.

For the above definition, the following is not covered:

- Any claim as a result of a **child** being born prematurely (before 37 weeks).

Osteogenesis imperfecta

A definite diagnosis of osteogenesis imperfecta by an attending **consultant**.

For the above definition the following is not covered:

- Type 1 osteogenesis imperfecta.

Patau syndrome

A definite diagnosis of Patau syndrome by an attending **consultant**.

Permanent pacemaker insertion – for heartbeat abnormalities

The **permanent** insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. There must be evidence of an abnormal rhythm of the heart on an ECG.

Severe mental illness – as specified

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

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

For this definition, the following is not covered:

- Conditions related to or exacerbated by alcohol or drug abuse.

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

A definite diagnosis of sepsis by a **consultant** physician resulting in admission to either an intensive care unit (ICU) or a high dependency unit (HDU) for at least 3 continuous days.

Third degree burns – covering at least 5% of the body's surface area or 10% of the face's surface area

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

- covering at least 5% of the surface area of the body, or
- covering at least 10% of the surface area of the face.

Appendix C5

Refer to appendix C5 for conditions, illnesses and treatments covered in birth defect cover.

Cleft lip

A definite diagnosis of a Cleft Lip by a Paediatrician or Cleft Nurse requiring the undergoing of surgery to repair the defect.

Cleft palate

A definite diagnosis of a Cleft Palate by a Paediatrician or Cleft Nurse requiring the undergoing of surgery to repair the defect.

Congenital Talipes Equinovarus (Club foot)

A definite diagnosis of Congenital Talipes Equinovarus following the routine post-birth examination and requiring treatment using the Ponseti method.

Developmental Dysplasia of the hip

A definite diagnosis of Developmental Dysplasia of the hip by a paediatric **consultant**, requiring surgery followed by a minimum of 6 weeks in plaster cast or abduction brace.

Appendix D1

Refer to appendix D1 for supplementary information for certain conditions as listed in appendix A1, C1 and C2.

Degenerative neurological disorder – of specified severity

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

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

Well known examples of neurodegenerative diseases include Alzheimer's disease, motor neurone disease and Parkinson's disease – but there are many more. A diagnosis will usually be made by a Consultant Geriatrician, Neurologist, Neuropsychologist or Psychiatrist and supported by evidence including neuropsychometric testing.

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

Reduced heart function – of specified severity

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

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

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

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

Claims will not be considered for any conditions that are related to alcohol or drug abuse.

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

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

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

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

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

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

Claims will not be considered for any surgeries other than those specified.

Surgery via the skull – as specified

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

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

Claims will not be considered for any other type of surgery.

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