

Group Critical Illness

CLASS Technical Guide

Introduced from 30 January 2024.



About us



We provide support when it's needed most

We are Canada Life Group Insurance, one of the UK's largest provider of group insurance. We have over 50 years' experience covering thousands of businesses throughout the UK.

Our mission is to help people when they need it most, so we specialise in three products that help employers do exactly that – **Life Insurance**, **Income Protection** and **Critical Illness** cover.

We've grown considerably since we first arrived in the UK in 1903. We now support over **27,500 employers**, covering **2.98 million employees** for over £353 billion of benefits. This makes us the largest provider of group insurance in the UK.

Support Services

At Canada Life, we believe insurance is about much more than just a financial benefit. When employers choose our Group Critical Illness policy, they also get access to four Support Services¹. Supporting employees back to work following absence and helping them stay healthy at every stage of their life.

Second Medical Opinion

The Second Medical Opinion service provides access to over 50,000 leading consultants worldwide. They offer second opinions on diagnoses and treatments for almost any condition.

Personal Nurse Service

The Personal Nurse Service provides long-term practical and emotional support over the phone with the same qualified nurse, for employees who make a Critical Illness claim.

Toothfairy

Toothfairy is the UK's first health regulated, smart dental app. Designed by dentists and partnering with real dentists in the UK, Toothfairy provides instant access to advice, guidance and prescriptions, all from the comfort of your employees' homes.

myStrength

myStrength is a mental wellbeing app. Employees can choose the support they need and get free personalised guidance to help them and their immediate family members², who are aged 16+, overcome life's challenges.

Find out more

We are dedicated to helping more employers support their employees when they need it most.

Call us
0345 223 8000



Lines are open Monday
to Friday from 9am to 5pm

Online
www.canadalife.co.uk/group



To find out more about our Support Services please visit

www.canadalife.co.uk/group

These are Support Services provided by Canada Life's service company CLFIS (U.K.) Ltd (CLFIS), through its service providers Best Doctors® Inc, RedArc Assured Ltd, Toothfairy and Teladoc. These services are non-contractual benefits and are only available if you have a Group Critical Illness policy with us. They cannot be provided independently by us. The provision of these services does not form part of your insurance contract with us and we provide access to these services as a value-added extra.

These services are non-contractual benefits provided through Canada Life and can be altered or withdrawn at any time.

- 1 All Support Service costs are absorbed within the Group Insurance premium.
- 2 Immediate family includes any spouse, partner, parent or sibling living in the same household; any legal dependant under the age of 21 and in full time education; or any other legal dependant who is dependent on the member because of disability.

An excellent choice

Canada Life Limited (Canada Life) aims to satisfy your specific requirements for Group Critical Illness cover.

You will directly benefit from the full support of a dedicated team of specialist underwriters, administrators and account managers who work together to establish and administer your scheme.

Your quotation gives you an illustration of the first year costs you may incur and the technical guide outlines the main features of this product. You should be comfortable that you understand its features before you ask us to provide you with cover. If there is anything you are not sure about, you can ask us or your intermediary.

This document should be read in conjunction with the quotation. This document does not override the Policy, which contains full details.

Visit our website to download all our forms and materials.

Follow us on Twitter and receive our news as it happens.

Subscribe to our YouTube Channel to be notified of our latest webcasts.

Current **Policy** Conditions, claims guides and forms can be found in our Document Library section [click here](#).

You can also request copies of any items or contact us at the following address:

CLASS User Support Team
Canada Life Group Insurance
Canada Life Limited
Canada Life Place
Potters Bar
Hertfordshire EN6 5BA

Or e-mail: class@canadalife.co.uk
or ring **0345 223 7137**.

Lines are open Monday to Friday, 9am to 5pm.

This technical guide has been produced based on the 'best practice' format recommended by the Group Risk Development group (GRiD) and the Association of British Insurers (ABI).

Terms and expressions we use

In this guide when we refer to ‘we’, ‘us’ or ‘our’ we mean Canada Life Limited. When we refer to ‘you’ or ‘your’, we mean the existing or prospective Policyholder. Some terms have specific meanings. These are listed below in alphabetical order together with their meanings. If a particular term cannot be identified you may need to combine more than one of the definitions listed below.

‘Actively at work’:

means that a person:

- is present at their place of work, and
- has not received medical advice to refrain from work, and
- is mentally and physically capable of performing fully the normal regular duties associated with the job they are engaged to do, and
- is working their normal contracted number of hours, either at their normal place of business or at a place that the business requires.

‘Alcohol abuse’:

where an **insured illness** arises from inappropriate use of alcohol but not limited to consuming too much alcohol.

‘Annual revision date’:

the date in each calendar year when the premiums are calculated.

‘Cease age’:

the age agreed between us as being the age at which cover for a **member** ceases. The maximum age must not exceed any insured person’s 70th birthday.

‘Child’:

any natural, legally adopted or step-child (by marriage or registered civil partnership) of the **member** who is

- under 18 years old, or
- under 22 years old, if they are in full time education

at the time they meet the definition of an **insured illness**.

This includes any child for whom the member has been granted a Special Guardianship Order.

Full time education means attending school, college or university full time and includes work placements that are part of the course. Any break from education such as a gap year is excluded.

‘Circulatory system illnesses’:

for the purposes of assessment of a claim, the following are all considered to be circulatory system illnesses:

- aorta graft surgery,
- balloon valvuloplasty,
- cardiac arrest,
- cardiomyopathy,
- coronary artery bypass grafts,
- heart attack,
- heart transplant,
- heart valve replacement or repair,
- open heart surgery,
- primary pulmonary hypertension,
- pulmonary artery surgery, and
- stroke.

‘Claim benefit’:

the amount of **insured benefit** or **child’s benefit** that we have agreed to pay following the diagnosis of an **insured illness**.

‘Cognitive dysfunction’:

refers to deficits in attention and to focus on the task at hand, verbal and non-verbal communication, short-term and working memory, visual and auditory processing of information, problem solving, processing speed of the brain response, and motor functioning.

‘Commencement date’:

the date that the **Policy** starts.

‘Decision Letter’:

written confirmation issued by us following our assessment of medical and other evidence obtained for an **insured person**.

For the purpose of this definition this will include:

- acceptance of benefits,
- declinature of benefits,
- postponement of a decision,
- restriction of benefits.

Terms and expressions we use

‘Discretionary benefit’:

a benefit you want us to provide for a **member** that is larger or smaller than the normal **scheme benefit** for which the **member** would be eligible.

‘Discretionary entrant’:

someone:

- who is not an **eligible employee** but who you wish to include in the **Policy**, or
- who is an **eligible employee** but who you want covered from a different date to their normal **inclusion date**, or
- who is a late entrant.

‘Drug abuse’:

where an **insured illness** arises from inappropriate use of drugs including but not limited to the following:

- taking an overdose of drugs, whether lawfully prescribed or otherwise,
- taking Controlled Drugs (as defined by the Misuse of Drugs Act 1971) unless in accordance with a lawful prescription.

‘Earlier claim’:

any claim paid for an **insured illness** in respect of the **insured person**, or **child**:

- under this Policy, or
- under any group critical illness policy arranged by you in connection with the **member’s** employment.

This will also include an **insured illness** in respect of the **insured person**, or **child** which would have qualified as a claim under any group critical illness policy arranged by you in connection with the **member’s** employment.

‘Eligible employee’:

someone who meets the eligibility requirements for inclusion in the **Policy**.

‘Employer’:

any company, partnership or organisation that we have agreed to include in the **Policy**.

‘Evidence of insurability’:

any documentary or medical evidence that we may reasonably require to include someone for benefits in the **Policy**.

‘Existed’:

an **insured illness** or **related condition** is said to have existed if it was:

- first diagnosed, or
- treated, or
- known to the **insured person** or **child**

prior to the date of inclusion (as detailed in Section 6 – What is not covered?) or the date of any increase in benefit.

As long as a later diagnosis confirms this, we will consider an **insured illness** or **related condition** to have existed if the **insured person** or **child**:

- has had symptoms of, or
- has sought or been given advice or counselling on, or received treatment for, or
- has undergone, is awaiting diagnostic tests, or is undergoing ongoing medical investigations or monitoring

for the **insured illness** or **related condition** even if the condition has not been formally diagnosed.

In addition, in respect of a claim for a **child**, we will consider an **insured illness** or **related condition** to have existed where

- the **insured person** or either parent knew or had received medical advice or counselling in respect of that **insured illness** or related condition in relation to the **child**.
- the **insured person** or either parent, prior to the birth of the child, had received medical advice or counselling in respect of that **insured illness** or **related condition** before the **insured person’s** inclusion in the **policy** or on the date of any increase in benefit.

‘Free cover limit’:

the total amount of a **normal entrant’s** benefit that we will cover on standard terms without the need for **evidence of insurability**. Your quotation will show the amount based on the information provided for the quotation. The **free cover limit** is calculated at the **commencement date** and at each subsequent **annual revision date**, based on the number of lives and the benefit basis.

Should either of these change, the **free cover limit** may also change.

Terms and expressions we use

‘HMRC’:

HM Revenue & Customs.

‘Insured benefit’:

the total amount of benefit for which an **insured person** has been accepted under the **Policy**.

‘Insured illness’:

one of the medical conditions or events described in the table in Section 9 of this guide.

‘Insured person’:

someone who is a **member**, covered by the **Policy**.

‘Irreversible’:

An **insured illness** that cannot be cured by medical treatment and/or surgical procedures used by the National Health Service in the UK at the time of the claim.

This definition is associated with the following **insured illnesses**:

- blindness,
- deafness,
- liver failure,
- loss of independent existence,
- loss of speech

permanent physical severance of a hand or foot, or total and irreversible paralysis of an arm or a leg.

‘Late Entrant’:

a person who joins an **employer’s** pension arrangement after the date on which they first became eligible to join that arrangement where entry and/or the benefit entitlement under this **Policy** is dependent on membership of that arrangement.

‘Member’:

an **eligible employee** included in the **Policy**.

‘Neurological deficit creating clinical symptoms’:

dysfunction in the nervous system that is present on clinical examination.

Dysfunction of the nervous system includes:

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

The following are not covered:

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

This definition is associated with the following insured illnesses: Stroke

Terms and expressions we use

‘Neurological illnesses’:

for the purposes of assessment of a second claim, the following are all considered to be neurological illnesses:

- Creutzfeldt-Jakob disease,
- Dementia including Alzheimer’s disease,
- Parkinson’s disease.

‘Normal entrant’:

an **eligible employee** who you include in the **Policy**:

- on the first day that they meet the normal entry conditions, and
- for the normal **scheme benefit**.

‘Normal inclusion date’:

the first day that an **eligible employee** qualifies for inclusion in the **Policy**.

‘Periodic review date’:

the date when your premium rates, **Policy Conditions** and **Policy fee** are reviewed.

‘Permanent’:

an **insured illness** that is expected to last throughout life, irrespective of when the cover ends or the **insured person** or **child** expects to retire.

This definition is associated with the following **insured illnesses**:

- aplastic anaemia,
- blindness,
- cardiomyopathy,
- Creutzfeldt-Jakob disease,
- deafness,
- dementia including Alzheimer’s disease,
- kidney failure,
- liver failure,
- loss of independent existence,
- loss of speech,
- motor neurone disease,
- Parkinson’s disease,
- permanent physical severance of a hand or foot, or total and irreversible paralysis of an arm or a leg,
- primary pulmonary hypertension, and
- progressive supranuclear palsy.

‘Permanent neurological deficit with persistent clinical symptoms’:

dysfunction in the nervous system that is present on clinical examination and expected to last throughout the **insured person’s** or **child’s** life.

Dysfunction of the nervous system includes:

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

The following are not covered:

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

This definition is associated with the following **insured illnesses**:

- bacterial meningitis,
- benign brain or spinal cord tumour,
- coma,
- encephalitis,
- stroke,
- Systemic lupus erythematosus, and
- traumatic brain injury.

‘Policy’:

this is comprised of:

- the **Policy Conditions** and any subsequent updates, and/or replacements,
- the information provided in the Proposal Form,
- your **Policy Particulars** and any subsequent updates, and/or replacements,
- the information provided prior to the **commencement date**, or in relation to any alteration to the cover provided under the **Policy**,
- any questionnaire or written statement relating to an **insured person**, including but not limited to, a Health Declaration Form,
- any **decision letter** issued in writing by us in respect of any **insured person**, and
- any special terms, exclusions or limitations issued by us in writing.

‘Policy fee’:

an annual charge for each **Policy** towards our costs.

‘Policy year’:

any 12 month period from an **annual revision date** during which the **Policy** is in full force.

‘Pre-existing conditions exclusion’:

Please see Section 6.1.1 of this guide for full details.

‘Related condition’:

a medical condition described in the table in Section 9 of this guide which is either directly or indirectly associated with, or is likely to have led to, the occurrence of an **insured illness**.

‘Relevant date’:

the **commencement date** or such other date specified by us.

‘Scheduled territories’:

the United Kingdom, all European Union (EU) countries, Andorra, Australia, Canada, the Channel Islands, Gibraltar, Hong Kong, Iceland, the Isle of Man, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA and the Vatican City.

‘Scheme benefit’:

the benefit or benefits set out in your quotation.

‘Scheme salary’:

the basis of **salary** you have agreed with us.

‘Secondment’:

A period of time when an employee works somewhere other than their normal place of work on a temporary basis with an expectation of return to their original job, or to their original **employer** in their original location.

‘Self-inflicted injury’:

where an **insured illness** arises from intentional self-inflicted injury.

‘State pension age’:

the age at which the **insured person** is first entitled to receive the basic state pension or any benefit that may replace it.

‘Statutory leave’:

any leave taken from employment due to an entitlement to:

- adoption leave,
- carer’s leave,
- maternity leave,
- parental bereavement leave.
- paternity leave, or
- shared parental leave.

‘Survival period’:

the period that starts after the following insured events that the **insured person** or **child** has to survive before a claim becomes valid:

The 14 day period starts:

- on the day of surgery for:
 - aorta graft surgery,
 - balloon valvuloplasty,
 - a coronary artery bypass graft,
 - a heart valve replacement or repair,
 - open heart surgery, or
 - pulmonary artery surgery.
- for a major organ transplant, on the earlier of:
 - the date the **insured person** or **child** is included on an official UK transplant waiting list for a heart, liver, lung, kidney, pancreas or bone marrow, or
 - the actual date of surgery.
- for any other **insured illness**, on the date the **insured illness** was diagnosed.

‘Underwriting’:

the process whereby evidence of insurability is obtained and assessed.

Contents

	The aim of the Policy	12
	Your commitment	12
	Risk factors	13
	How does the Policy work?	13
	Your questions answered	14
Section 1	What factors should be considered in deciding what benefits to provide?	14
	1.1 Who can be covered?	14
	1.1.1 Eligibility requirements	14
	1.1.2 Actively at work requirements	15
	1.1.3 Cover for children	16
	1.2 When will cover cease?	16
	1.2.1 Under normal circumstances	16
	1.2.2 Cancelling the cover	17
	1.2.2.1 When you can cancel the cover	17
	1.2.2.2 When we can cancel the cover	17
	1.3 What types of cover are available?	17
	1.3.1 How salary is defined	17
	1.3.2 Core illnesses	18
	1.3.3 Optional additional illnesses	18
	1.4 When is the benefit due?	19
	1.5 Is any special cover possible under the scheme?	19
Section 2	Setting up the policy	20
	2.1 Requirements to set up the policy	20
	2.2 Evidence of insurability to be provided before members are covered	21
	2.3 What happens if a claim arises before an underwriting decision has been made?	21
Section 3	What premiums will be charged for the cover?	22
	3.1 How will premiums be calculated?	22
	3.2 Will there be any unexpected extra premiums?	22
	3.3 What commission is included within the premium?	22
	3.4 Is there a discount for good claims experience?	22

Section 4	How does the Policy accounting work?	23
4.1	What information is required for accounting purposes?	23
4.2	How are the accounts adjusted for members who join, leave or have benefit changes during the year?	23
4.2.1	Single premium schemes	23
4.2.2	Unit rated schemes	23
4.3	If the policy is discontinued mid-year will premiums paid in advance be lost?	23
<hr/>		
Section 5	Claiming benefit	24
5.1	When can claims be made?	24
5.1.1	What will happen next?	24
5.1.2	How will we assess your claim?	25
5.1.3	How will the benefit be paid?	25
5.2	After an insured person or child meets the definition of an insured illness, can another claim be made for that individual?	25
<hr/>		
Section 6	What is not covered?	26
6.1	Pre-existing conditions exclusion and other exclusions	26
6.1.1	Pre-existing conditions exclusion	26
6.1.2	Related conditions	26
6.1.2.1	Insured illnesses where a related conditions exclusion applies indefinitely	26
6.1.2.2	Insured illnesses where a related conditions exclusion is applied for a period of 2 years	26
6.1.2.3	Application of the related conditions exclusion to increases in benefit	27
6.1.3	Other exclusions applicable to all claims	27
6.1.4	Exclusions as a result of underwriting	27
6.2	Second claims	27
<hr/>		
Section 7	Can cover be provided for someone who is outside the UK, Channel Islands or the Isle of Man?	28
<hr/>		
Section 8	Taxation of schemes	28
<hr/>		
Section 9	Critical illness definitions	29
9.1	Core Insured Illnesses	29
9.2	Additional insured illnesses	40
<hr/>		
Section 10	Further information	60
10.1.1	The Company	60
10.1.2	What we do	60
10.1.3	Remuneration	60
10.1.4	Financial strength	60
10.2	Queries and complaints	60
10.3	Compensation	60
10.4	Law	60
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The aim of the policy

The aim of the Policy is to provide a benefit if a member or child meets the definition of an insured illness.

Your commitment

If you choose to insure benefits with us you must:

- ensure that any intermediary you appoint to act for you is authorised and registered to use the CLASS web portal,
- give us your current Companies House registration number,
- ensure that your intermediary deals immediately with any data or information provided to them in connection with your Policy using the CLASS web portal,
- give us accurate and complete information and data at all times and tell us immediately, whenever this changes.
- pay us all of the premiums we ask for, when they are due, in UK currency,
- submit any claims in line with the process described in Section 5 of this guide and within the timescales permitted. We will not pay any benefit or any additional amounts of benefit if we receive the completed claim form or the completed personal statement after this period,
- abide by the terms and conditions of the Policy.

You must also tell us immediately, whenever:

an insured person or child meets the definition of an insured illness.

- there is any change to the companies or groups of people included in the Policy, or
- there is any change to the structure or legal status of any of the employers, or
- you wish to change the cover or the way in which benefits are calculated, or
- there are changes to the work locations or business travel destinations of any members, or
- there are any changes in the nature of an employer's business which makes the occupations of the members more hazardous, or
- changes are made to an employee's pension scheme, to which the membership or levels of benefit insured under the Policy are linked, or
- a member's scheme benefit exceeds the free cover limit, or
- you want to include someone who is a discretionary entrant, or
- an organisation, who is not an employer becomes involved in the administration of the policy, or
- you change or dismiss your intermediary, or
- you want to cancel cover completely.

Risk factors

- It is important that you fulfil your commitments under the Policy. A breach of certain commitments within the Policy will result in us rejecting your claim, or withdrawing cover.
- We will only continue your cover if you keep your premium payments up to date and give us the information and data we need.
- Any delay in paying your premiums or giving us the information or data we need, may result in unexpected premium arrears or someone not being fully covered.
- In order for us to pay any insured benefit or any additional amounts of insured benefit, we must be provided with a completed claim form and a completed personal statement, in respect of the benefit being claimed, within 2 years of the date an insured person or child meets the definition of an insured illness.
- All claims are subject to a pre-existing conditions exclusion. Please see Section 6.1 of this guide for full details.
- Certain causes of claim are excluded. Please see Section 6.1 of this guide for full details, and also the table in Section 9 of this guide for details of related conditions.
- We may alter the premium rates, Policy Conditions and policy fee at the periodic review date or at any other time if a change that affects any of these occurs.
- There may be changes to the legislation, regulation, state pension age, HMRC practice or tax rules affecting this Policy, the Policy benefits or premiums.
- You may request or advise us of a change to your cover that is not available through the CLASS web portal. In which case, we will tell you, and you can either:
 - modify or cancel your change to enable the online services of the CLASS web portal to continue to be used, or
 - request our standard product. If accepted this will result in an increase in premium.

How does the policy work?

You contact your intermediary before you want cover to start, or change. Together with your intermediary you decide the basis of the eligibility conditions and the benefits you would like us to cover.

Your intermediary obtains a quotation for this cover using the CLASS web portal.

If you agree the quotation provided, your intermediary will arrange cover with us online.

If you want to make any changes to the eligibility conditions or benefit after the Policy has started, you can, but you must agree any changes with us before they can take effect.

If you provide us with all the information we require and pay the premiums we ask for, we will provide cover on the basis we have agreed with you.

If we can settle your claim, we will pay the benefit to the member concerned.

This product does not acquire a surrender value.

Your questions answered

Section 1.0

1.0 What factors should be considered in deciding what benefits to provide?

You will need to consider:

- what benefit promises you have made.
- the importance of group critical illness benefits as part of your overall benefits package.
- what salary basis you wish to use for benefit purposes, for example basic salary only, fixed at a specified date.
- whether you wish to insure the additional insured illnesses.
- whether you want to give the same level of benefit to all members.
- any legislation relating to sex discrimination, age regulations or discrimination against part time, fixed term and disabled employees.

The maximum scheme benefit for members is £500,000.

Our Group Critical Illness eProduct offers you simplified options to enable the business to be processed online.

1.1 Who can be covered?

We can cover all employees or defined groups of employees.

The eligibility criteria / categories must be clear and agreed with us before cover can commence.

We can cover up to 8 categories of membership. If there is more than one category, there must be at least 2 members in each category.

Only employees who are employed and resident in the United Kingdom can be covered, other than as shown in Section 7 of this guide.

These requirements will also apply to increases in the basis of cover for existing members. We can cover different categories of membership for different levels of benefit.

1.1.1 Eligibility requirements

The eligibility conditions will normally include:

- the minimum and maximum entry ages and any service qualifications,
- the age at which cover ceases. This can be a fixed age up to a maximum of age 70 for an insured person, or linked to state pension age,
- the eligible categories, normally by occupation or job title that you want us to cover,
- when new entrants will be included in the Policy, and
- when members may have increases in their benefits.

There must be at least 2 members when your Policy starts.

Inclusion in the Policy must be available to all individuals who meet the eligibility conditions and not solely at your invitation.

If either the eligibility conditions or the benefit categories depend on inclusion in a scheme for pension benefits, you must tell us what the eligibility conditions are for those benefits. A minimum take up rate of 80% is required.

If someone is not included in the Policy when they are first eligible, we will have further requirements.

1.1.2 Actively at work requirements

There are no actively at work requirements for eligible employees who, after the commencement date, join the scheme for the normal agreed benefits basis when they first satisfy the agreed eligibility conditions.

However, there are other circumstances where we will apply our actively at work requirements.

Benefits are to be insured for the first time, including when benefits have been previously self-insured

Our actively at work requirement will be applied to all employees who are to be insured on the commencement date.

Benefits are already insured but you wish to switch the cover to Canada Life

- where there are less than 50 members involved in the switch our actively at work requirement will be applied to all members at the commencement date.
- where there are more than 50 lives involved in the switch we may agree to waive our actively at work requirement, provided you have given sufficient information about anyone who does not satisfy those requirements on the commencement date.

Changes to the eligibility conditions or increases in benefits on the date the cover switches to Canada Life

In addition to any requirement detailed above, our actively at work requirement will also be applied to all members who are affected by, or whose benefits increase as a result of, the switch on the commencement date who are affected by the change.

Changes to the eligibility conditions or increases in benefits after the commencement date

Our actively at work requirement will be applied to all members who are affected by the change or whose benefits increase on the date we agree to make the changes to the policy.

Inclusion of a new group of people including a company or organisation (including new categories, new companies or transfers to new contracts of employment)

Our actively at work requirement will be applied to all members who are included as a result of the new group being added on the date we agree to make the changes to the policy.

What we need if our actively at work requirement is not met

Any person who is not actively at work due to ill health or disablement on their last contractual working day before the relevant date, will not be covered for any benefit or increase in benefit, until they either:

- complete 7 consecutive days actively at work with the employer, or
- provide evidence of insurability to us and we issue our decision letter.

If a person's benefit is insured under another group critical illness policy immediately prior to the relevant date, and the actively at work condition has not been applied, any member not actively at work on the relevant date will continue to be covered until the earlier of:

- the end of a period of temporary leave of absence, as shown in Section 1.2.1 of this guide, or
- the date on which cover under that other policy ceases.

Please note that there will be circumstances where we will require other forms of evidence of insurability in order to provide cover. These are as follows:

- benefits that have not been accepted by a previous insurer, or
- benefits that are above the free cover limit, or
- benefits that were subject to special terms or were declined by a previous insurer, or
- changes to the eligibility conditions or increases in benefits which affect less than 5 members

1.1.3 Cover for children

Cover is automatically provided for any child of a member.

We will pay the benefit to a member if their child meets the definition of one of the insured illnesses and survives for at least the length of the survival period.

The maximum benefit will be the lower of:

- 25% of the member's scheme benefit, or
- 25% of the member's insured benefit, or
- £25,000.

Notes:

- The pre-existing and related conditions exclusions (see Section 6.1.1 and 6.1.2 of this guide) will apply in respect of a child at the date the member joins the scheme (or at the date the child qualifies for cover, if later).
- The other exclusions (see Section 6.1.3 of this guide) will apply in respect of a child.
- A member's child will cease to be included in the Policy:
 - when a claim for one of the insured illnesses has been paid for that child, or
 - the date the member ceases to be included in the Policy (if earlier), other than if the member's cover ceases due to the member having received the maximum number of claim payments for which they are eligible.

This cover is not available if a child met the definition of an insured illness under a previously insured group critical illness policy arranged in connection with the member's employment with you or any other employer.

We will not pay a claim where:

- the child's condition was present at birth, or
- the symptoms first arose before the child was covered.

1.2 When will cover cease?

1.2.1 Under normal circumstances

Cover will cease for a member on whichever of the following events is first to occur:

- on reaching their cease age, or
- on ceasing to satisfy the agreed eligibility conditions, or
- on ceasing to be actively employed by the employer (other than during a period of temporary leave of absence), or
- on reaching the end of a period allowed under the Policy for a temporary leave of absence and having not returned to active employment, or
- on ceasing to work in the UK, other than shown in Section 7 of this guide, or
- on reaching the end of their contract of employment, or
- having received the maximum number of claim payments for which they are eligible.

Cover for child may be maintained if the member's cover ceases due to the member having received the maximum number of claim payments for which they are eligible.

In all other circumstances where the member's cover ceases, child cover will also cease.

Where the cease age is linked to state pension age, and the state pension age changes, the cease age will be based on the member's new state pension age.

Cover may continue for a member during a period of temporary leave of absence from work. If you continue to pay premiums, we will continue to cover a member:

- during any period of illness, disablement or statutory leave, or
- for up to 3 years for any other reason.

Any benefit increases during a period of temporary leave of absence will be restricted as shown in Section 1 of our Policy Conditions – Who is covered.

1.2.2 Cancelling the cover

1.2.2.1 When you can cancel the cover

If you want to cancel the Policy you must ask your intermediary to tell us using the termination facility within eAdmin in CLASS. The Policy will continue until we receive your instructions.

We will not backdate cancellation of cover and will charge for the time we have been providing cover.

1.2.2.2 When we can cancel the cover

We reserve the right to cancel cover if:

- you do not pay the premiums requested within 30 days of the date they were due, or
- an organisation, who is not an employer becomes involved in the administration of the policy, or
- new legislation or regulations are introduced, or changes are made to existing legislation which affect group critical illness policies or the Policy.

1.3 What types of cover are available?

You may choose from the following benefit levels:

- 1, 2, 3, or 4 times salary, subject to a maximum scheme benefit of £500,000, or
- a flat benefit of up to £100,000.

You can choose to insure:

- just the core insured illnesses described in Section 1.3.2 of this guide, or
- the core insured illnesses described in Section 1.3.2 of this guide, and the additional insured illnesses described in Section 1.3.3 of this guide.

1.3.1 How salary is defined

So that we both know what is covered, we need to agree how to define salary. You must also agree with us when salary changes become effective, and therefore alter a member's benefit. Some examples of acceptable salary bases are:

- basic salary only,
- basic salary plus agreed other variable earnings from the employer (for example overtime, bonus, commission or directors' fees) averaged over a given 3 year period,
- P60 earnings in the preceding tax year, or
- pre salary sacrifice.

If a salary sacrifice arrangement is being operated which will reduce a member's contractual basic salary and you want to base the benefits on the pre-sacrificed salary level, you must agree the basis with us.

These must be fixed on either the date an insured person meets the definition of an insured illness or the annual revision date.

Salary cannot include dividends from the employer.

You must give us data that is consistent with the salary basis you have agreed with us. We will use the agreed salary basis to determine the amount payable for any claims you make, not the data provided.

1.3.2 Core illnesses

The following are included as insured illnesses in all cases. Please see the table in Section 9.1 of this guide, for the full definitions of these illnesses.

You cannot select individual illnesses to be included.

- Cancer – excluding less advanced cases
- Cardiac Arrest – followed by surgical implantation of a defibrillator
- Coronary artery bypass grafts
- Creutzfeldt-Jakob disease – resulting in permanent symptoms
- Dementia including Alzheimer’s disease – of specified severity
- Heart attack – of specified severity
- Kidney failure – requiring permanent dialysis
- Major organ transplant – from another person
- Motor neurone disease – resulting in permanent symptoms
- Multiple sclerosis – with persisting symptoms
- Parkinson’s disease – resulting in permanent symptoms
- Stroke – resulting in clinical symptoms

1.3.3 Optional additional illnesses

All of the following may be included as insured illnesses for additional cost. Please see the table in Section 9.2 of this guide, for the full definitions of these illnesses.

You cannot select individual illnesses to be included.

- Aorta graft surgery – for disease
- Aplastic anaemia – with permanent bone marrow failure
- Bacterial meningitis – resulting in permanent symptoms
- Balloon valvuloplasty
- Benign brain or spinal cord tumour – resulting in permanent symptoms or with specified treatment
- Blindness – permanent and irreversible
- Cardiomyopathy – of specified severity
- Coma – with associated permanent symptoms
- Deafness – permanent and irreversible
- Encephalitis – resulting in permanent symptoms
- Heart valve replacement or repair
- HIV infection – caught in the UK, the Channel Islands, the Isle of Man or the EU, from a blood transfusion, physical assault or at work in an eligible occupation
- Liver failure – irreversible
- Loss of independent existence – a disability which results in an insured person being unable before the cease age to look after themselves ever again

- Loss of speech – total, permanent and irreversible
- Open heart surgery – with surgery to divide the breastbone
- Permanent physical severance of a hand or foot, or total and irreversible paralysis of an arm or a leg
- Primary pulmonary hypertension – of specified severity
- Progressive supranuclear palsy – resulting in permanent symptoms
- Pulmonary artery surgery – with surgery to divide the breastbone
- Respiratory failure – resulting in breathlessness when resting
- Rheumatoid arthritis – of specified severity
- Systemic lupus erythematosus – with severe complication
- Terminal illness – where death is expected within 12 months
- Third degree burns – covering 20% of the body's surface area
- Traumatic brain injury – resulting in permanent symptoms

1.4 When is the benefit due?

Subject to the exclusions contained in Section 6.1 of this guide, we will pay the claim benefit if an insured person or child:

- meets the definition of one of the core insured illnesses (see Section 1.3.2 of this guide), or
- if also insured, meets the definition of one of the additional insured illnesses (see Section 1.3.3 of this guide) and
- survives for at least the length of the survival period.

1.5 Is any special cover possible under the scheme?

There is no cover available for a member's spouse or civil partner.

Section 2.0

2.0 Setting up the Policy

2.1 Requirements to set up the Policy

Before the quotation expires (usually 3 months) your intermediary must instruct us to assume risk by completing the CLASS online process.

If the basis of risk differs from the quotation, your intermediary will need to obtain a new quotation.

You can accept the quotation up to 30 days before the commencement date. Cover cannot start on the same day that you accept the quotation. Cover will start at 00.01 on the selected commencement date. Cover cannot be backdated.

In order to complete the CLASS process, whereby we assume risk, your intermediary will need:

- the employer's company name, address and Companies House registration number,
- full details of the scheme basis, including eligibility conditions and benefit structure.

Once the Policy starts and in order for cover to continue, you must also provide the following within 30 days of the date your cover starts:

- a fully completed proposal form,
- a deposit premium or a completed Direct Debit mandate,
- completed 'actively at work' and/or 'continuation of cover' declarations as appropriate, and
- any specific requirements set out in the letter confirming risk.

Failure to provide these items within 30 days means your cover will cease. We will treat the Policy as never having been on risk and any premiums paid will be refunded.

2.2 Evidence of insurability to be provided before members are covered

If you include members in the Policy as soon as they satisfy the agreed eligibility conditions and on the agreed benefit basis for that category of member, we can usually allow a free cover limit. The amount is shown on your quotation and may change at any annual revision date.

If a member is included in more than one Group Critical Illness Policy insured by our Group Insurance department, all of the member's benefits across all policies will be used to assess whether the free cover limit is exceeded.

Benefits in excess of the free cover limit and benefits for discretionary entrants and late entrants will also normally require evidence of insurability.

We may impose additional premiums, special terms, postpone or decline cover as a result of evidence of insurability to reflect a member's medical condition, hazardous occupation, or any hazardous pursuits undertaken (see Section 3.2 of this guide).

You must tell us immediately if you require cover for anyone in the above situations so that we can tell you what evidence of insurability we will need before we can provide you with cover.

If a member's benefits above the free cover limit have been declined, the member will not be entitled to any future increase in the free cover limit.

2.3 What happens if a claim arises before an underwriting decision has been made?

If evidence of insurability is needed by us before we can accept a member's benefit, we will provide temporary cover.

This will apply for up to 120 days, from the date:

- the person is first included in the Policy, or
- when an increase in a member's scheme benefit applies, or
- when we are notified of any discretionary entrant or late entrant, or

and will cease when we tell you what our decision is, if earlier.

However, temporary cover will not apply:

- if that person has previously had some or all of their scheme benefit declined or postponed, or
- if any additional premiums chargeable following the issue of our decision letter have not been accepted, or
- if a decision letter has not been issued where evidence of insurability has previously been requested, or
- to any part of the person's benefit that exceeds £500,000, or
- if the person meets the definition of an insured illness and that illness has occurred as a result of a related condition.

Section 3.0

3.0 What premiums will be charged for the cover

The premiums we calculate depend on various factors including the:

- amount of benefits,
- eligibility and entry conditions,
- cease age,
- critical illness conditions insured,
- company profile such as age, sex, occupation, and locations of the workforce,
- claims history, and
- amount of the policy fee.

There is a minimum total annual premium of £480.

3.1 How will premiums be calculated?

For policies with up to and including 9 members, we will use our single premium basis. Where there are 10 or more members, we will use our unit rate basis.

Full details of our standard terms that apply to each premium basis are set out in our Policy Conditions, See Section 7 – Premiums, and the circumstances when we may alter the rates to apply are set out in Section 8 – Alterations to the Policy cover.

3.2 Will there be any unexpected extra premiums?

If the information we need to calculate the premium is delayed or inaccurate, your premiums could change.

The premium rates and Policy Conditions and policy fee may change at the periodic review date. They may also change at any time that you make any changes that affect the factors we have used to calculate your premiums, as set out in Section 8 – Alterations to the Policy cover of our Policy Conditions.

We may charge additional premiums for member's benefits that have special terms applied following the issue of our decision letter. Any additional premiums will only be charged for the amount of insured benefit to which those special terms apply and will reflect a member's medical condition, hazardous occupation or participation in any hazardous pursuits.

3.3 What commission is included within the premium?

The rate of commission payable to financial advisers is shown in the quotation. The premium shown includes the level of commission payable.

3.4 Is there a discount for good claims experience?

A poor claims experience may affect the availability of this eProduct.

Section 4.0

4.0 How does the Policy accounting work?

The Policy operates on one year accounting periods. You will normally pay your premiums annually in advance. If you choose to pay monthly by Direct Debit premiums increase by 2%.

While we are awaiting complete accurate information we will charge a deposit premium.

A statement of account showing the accurate premiums due will be provided once the information has been received. The account will show any arrears which are due from you, or we will make a refund to you, if you have paid too much.

4.1 What information is required for accounting purposes?

We will normally advise you before each annual revision date what information we require.

Full details of the information we need to calculate your premiums are set out in the Policy Conditions, see Section 7 – Premiums.

4.2 How are the accounts adjusted for members who join, leave or have benefit changes during the year?

4.2.1 Single premium schemes

At each annual revision date, we will calculate a premium adjustment for the amount and duration of the cover actually provided since the commencement date (or the last annual revision date, if later).

4.2.2 Unit rated schemes

At each annual revision date, we will calculate a premium adjustment to allow for any increases or decreases in salaries or membership since the commencement date, or the last annual revision date, if later. We will assume that all changes occur half way through the policy year.

If there has been any change during the policy year to the following:

- basis of cover,
- eligibility,
- membership
- employers or groups of people included,
- legislation, or
- unit rate

we will calculate adjustments for the periods before and after that change took effect.

4.3 If the Policy is discontinued mid-year will premiums paid in advance be lost?

A final statement of account will be produced based on the cover actually provided and premiums paid up to the date when cover ceased. We will either send you a refund or request the balance of premiums you owe us.

Section 5.0

5.0 Claiming benefit

Our claims guide helps you through the process and answers some of the questions we are frequently asked.

You can download our claims guides and claims forms from our website:

www.canadalife.co.uk/group or request them from the CLASS User Support Team using the contact details given at the beginning of this guide, on page 3.

5.1 When can claims be made?

As soon as possible after an insured person or child meets the definition of an insured illness.

If you want to make a claim we require

- a current claim form, fully completed by an official of the Policyholder, and
- a current personal statement fully completed by the person who meets the definition of an insured illness

You must provide us with any documents and information we may need to process your claim. Claims will only be paid if a completed claim form and a completed personal statement, in respect of the benefit being claimed, have been received by us within two years of the date an insured person meets the definition of an insured illness.

Where the claim is for a child, we will also need sight of an original copy (not a photocopy) of their birth certificate or adoption certificate. In the case of a step child we also need sight of the parent's marriage or civil partnership certificate. In the case of a child who has been granted special guardianship we will also require sight of the special guardianship order. If the child is over 18 years old we will also need sight of evidence they are in full time education.

You should send completed forms and documentation to:

E-mail: ciclaims@canadalife.co.uk

**Claims Management Services
Canada Life Group Insurance
Canada Life Limited
Canada Life Place
Potters Bar
Hertfordshire EN6 5BA**

5.1.1 What will happen next?

When we have received all of the initial forms and information from you, we aim to tell you within five working days what further information we need to determine whether your claim is eligible to be assessed.

If we cannot consider your claim we will tell you why not.

5.1.2 How will we assess your claim?

We will assess your claim based on the evidence of the insured person's or child's medical condition compared with the definition of the relevant insured illness.

The personal statement includes a consent that provides us with the authority to obtain further information from any relevant medical professional that has attended the insured person or child, as required under the Access to Medical Reports Act.

We will obtain details of the insured person or child's medical condition, including treatment and medical history from the relevant medical professional. We will also consider any medical reports or additional information that you or the member may wish to provide.

We will pay for any medical evidence obtained in the UK that we request.

Notes:

All diagnoses and medical opinions relating to any insured illness must be given by a medical specialist who:

- holds an appointment as a Consultant at a hospital in the United Kingdom, and
- whose specialism is appropriate to the cause of the claim.

The evidence provided must also be acceptable to our Medical Officer(s).

5.1.3 How will the benefit be paid?

If your claim is accepted in respect of the insured person or child, the benefit will be payable to the member in UK currency.

5.2 After an insured person or child meets the definition of an insured illness, can another claim be made for that individual?

Under the policy and in certain circumstances, you may claim for up to two different insured illnesses for an insured person. However, only one claim may be made for a member's child. Certain exclusions apply – these are set out in Section 6 – What is not covered, of our Policy Conditions.

Section 6.0

6.0 What is not covered?

6.1 Pre-existing conditions exclusion and other exclusions

Throughout this section where reference to a claim having been paid is made, this refers to any earlier claim.

6.1.1 Pre-existing conditions exclusion

No benefit will be payable under the Policy in respect of an insured illness (or a repeat of the same insured illness) which existed prior to the date of inclusion:

- of the insured person or child in the Policy, or
- the insured person or child's inclusion in a previous group critical illness policy arranged by you or any other employer in connection with the member's employment, if earlier, or
- of the illness in the Policy, if later.

No increase in benefit will be payable if selected by the member or you and the insured illness existed prior to the date of any increase in benefit.

For the purposes of Section 6.1.1 the following will be treated as the same insured illness.

- aorta graft surgery,
- balloon valvuloplasty,
- cardiac arrest,
- cardiomyopathy,
- coronary artery bypass grafts,
- heart attack,
- heart transplant,
- heart valve replacement or repair,
- open heart surgery,
- primary pulmonary hypertension,
- pulmonary artery surgery, and
- stroke.

If an insured person or child has been diagnosed with any form of cancer, as defined in the table in Section 9.1 of this guide, then no benefit will be payable in respect of any subsequent cancer whether or not this is connected to or associated with the earlier cancer.

6.1.2 Related conditions

6.1.2.1 Insured illnesses where a related conditions exclusion applies indefinitely

No benefit will be payable for:

- loss of independent existence,
- permanent physical severance of a hand or foot, or total and irreversible paralysis of an arm or a leg,
- terminal illness.

where any related condition, as detailed in the table in Section 9 of this guide, existed at any time prior to:

- the insured person or child's inclusion in this Policy, or
- the insured person or child's inclusion in a previous group critical illness policy arranged by you or any other employer in connection with the member's employment, if earlier, or
- the date of inclusion of the insured illness in the Policy, if later, or
- the date of any increase in benefit which has been selected by the member or you.

6.1.2.2 Insured illnesses where a related conditions exclusion is applied for a period of 2 years

No benefit will be payable for any insured illness not detailed in section 6.1.2.1 where any related condition, as detailed in the table in Section 9 of this guide, existed at any time prior to:

- the insured person or child's inclusion in this Policy, or
- the insured person or child's inclusion in a previous group critical illness policy arranged by you or any other employer in connection with the member's employment, if earlier, or
- the date of inclusion of the insured illness in the Policy, if later.

The related conditions exclusion will not be applied if the insured illness occurs 2 or more years following any of the dates listed above.

6.1.2.3 Application of the related conditions exclusion to increases in benefit

No increase in benefit selected by the member or you will be payable for any insured illnesses not detailed in Section 6.1.2.1 where any related condition, as detailed in the table in Section 9 of this guide, existed at any time prior to that increase in benefit.

The related conditions exclusion will not be applied if the insured illness occurs 2 or more years following the date of the increase in benefit.

This 2 year period will also be applied to any new increase in benefit each time that any further increases in benefit take place.

6.1.3 Other exclusions applicable to all claims

If an earlier claim has previously been paid to an insured person in respect of an insured illness, under a previous group critical illness policy arranged by you or any other employer in connection with the member's employment, that claim will be treated by us as a first claim under this Policy.

No claim will be payable under this Policy for the same insured illness.

If an insured person has already received an earlier claim, a further claim under this Policy will be treated as a second claim and the exclusions shown in Section 6.2 and Section 9 of this guide will apply.

If an insured person or child has been diagnosed with any form of cancer, as defined in the table in Section 9.1 of this guide, then no benefit will be payable in respect of any subsequent cancer whether or not the earlier cancer is connected to or associated with the subsequent cancer.

No benefit will be payable under the policy in respect of certain insured illnesses arising as a direct or indirect result of:

- Alcohol
- Drug abuse
- Self-inflicted injury

The definition of each illness will show whether these apply.

For a child, no benefit will be payable under the policy if the insured illness was the result of the child being intentionally harmed by a parent or guardian.

6.1.4 Exclusions as a result of underwriting

Exclusions may be imposed for claims arising from certain specified medical conditions or in specified circumstances on individual insured persons' benefits as a result of underwriting.

6.2 Second claims

If a member meets the definition of a second different insured illness then a second claim may be payable, subject to the pre-existing conditions exclusion and the other exclusions shown above and in the table in Section 9 of this guide.

Once a second claim has been paid for a member then a subsequent claim will not be payable in respect of that member.

Once a first claim has been paid for a child, then a subsequent claim will not be paid in respect of that child.

Section 7.0

7.0 Can cover be provided for someone who is outside the UK, Channel Islands or the Isle of Man?

Cover will be maintained for an insured person or child whilst they are outside the UK on holiday or for an insured person travelling in connection with their business.

We will agree to cover members who are working outside the UK on secondment to another country within the scheduled territories, provided that:

- they would otherwise meet the eligibility conditions for inclusion in the Policy, and
- they have a contract of employment with the employer or, if they are not employed by the employer, they have a contract with the employer to provide the benefits described in this Policy.

For members working outside the UK, all premiums must be paid in UK currency, and all claim benefits will be payable by us in UK currency.

The scheme salary for a member not paid in UK currency will be converted to UK currency based on the exchange rate at the previous annual revision date.

If we require medical evidence for evidence of insurability or in support of a claim and it is obtained outside the UK, then any medical evidence must be provided in English.

All diagnoses and medical opinions relating to any insured illness must be given by a medical specialist who is acceptable to our Medical Officer(s), and whose specialism is appropriate to the cause of the claim.

If we agree to contribute an amount towards the cost of obtaining evidence this will be equivalent to the cost of obtaining similar evidence in the UK.

Section 8.0

8.0 Taxation of schemes

According to our understanding of legislation and HMRC practice on 1 September 2023, premiums paid by you will normally be treated as a business expense. However, tax relief on premiums paid by you in respect of any members who have a proprietorial interest in the company will not normally be available. HMRC may, nevertheless, agree to allow such relief if similar benefits are provided for a substantial number of other employees. Clarification of the tax position in such cases should be sought from your local Inspector of Taxes.

For members who are working in the UK and are subject to UK tax:

- Premiums paid by you are normally treated as a P11D benefit for employees.
- Policy benefits paid to the member are not normally subject to tax.

If we have agreed to include members who are working outside the UK, the tax treatment of the premiums and benefits will depend on the individual member's circumstances.

Clarification of the tax treatment should be sought as the benefits paid to the member may be subject to tax.

Section 9.0

9.0 Critical illness definitions

All diagnoses and medical opinions relating to any insured illness must be given by a medical specialist who:

- holds an appointment as a Consultant at a hospital in the United Kingdom, and
- whose specialism is appropriate to the cause of the claim.

The evidence provided must also be acceptable to our Medical Officer(s).

9.1 Core Insured Illnesses

These are listed below and are subject to the exclusions described in Section 6.1 of this guide.

If a member meets the definition of a different insured illness a second claim may be payable subject to the terms described in this section, and Section 6.2 of this guide.

Core Insured Illnesses

Cancer

– excluding less advanced cases

Definition

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

The term ‘malignant tumour’ includes leukaemia, sarcoma, and lymphoma except those that arise from or are confined to the skin (including cutaneous lymphomas and sarcomas).

Note: 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 either borderline malignancy, or
 - having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate).
- All urothelial tumours unless histologically classified as having progressed to at least TNM classification T1N0M0.
- Malignant melanoma skin cancers that are confined to the epidermis (outer layer of skin).
- All cancers (other than malignant melanoma) that arise from or are confined to one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin (including cutaneous lymphomas and sarcomas).
- All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0.
- Neuroendocrine tumours without lymph node involvement or distant metastases unless classified as WHO Grade 2 or above.
- Gastrointestinal stromal tumours without lymph node involvement or distant metastases unless classified by either AFIP/Miettinen and Lasota as having a moderate or high risk of progression, or as UICC/TNM8 stage II or above.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Malignant, borderline malignant or pre-malignant tumour or condition, leukaemia or lymphomas, plus polyposis coli, carcinoma-in-situ, papilloma of the bladder or gallbladder, chronic inflammatory bowel disease, Barrett’s oesophagus.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for cancer where there has been an earlier claim for any of the following insured illnesses:

- cancer, whether or not the earlier cancer is connected to or associated with the subsequent cancer,
- loss of independent existence,
- major organ transplant if this is connected to, or associated with, any cancer,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Cardiac arrest

– followed by surgical implantation of a defibrillator

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:</p> <ul style="list-style-type: none"> • implantable Cardioverter-Defibrillator (ICD), or • cardiac resynchronization device with Defibrillator (CRT-D). 	<p>Coronary artery disease, heart failure and cardiomyopathy, left ventricular hypertrophy, myocarditis, hypertrophic cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy, Brugada syndrome, idiopathic VF (also called primary electrical disease), congenital or acquired long QT syndrome, family history of Sudden Cardiac Death of uncertain cause, Wolff-Parkinson-White syndrome. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.</p>

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions,
- drug abuse.

In addition we will not pay a subsequent claim for cardiac arrest where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Core Insured Illnesses

Coronary artery bypass grafts

Definition

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

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Coronary artery anomalies, coronary vasospasms and myocardial bridging. All obstructive or occlusive arterial disease such as arteriosclerosis, coronary artery dissection or haematoma, coronary ectasia, diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions.

In addition we will not pay a subsequent claim for coronary artery bypass grafts where there has been an earlier claim for any of the other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Creutzfeldt-Jakob disease (CJD)

– resulting in permanent symptoms

Definition

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

- Remember,
- Reason, and
- Perceive, understand, express and give effect to ideas.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson's disease, epilepsy, depression, dementia, aphasia, amnesic memory disorder, psychosis, major head trauma.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for Creutzfeldt-Jakob disease where there has been an earlier claim in respect of any other neurological illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Dementia including Alzheimer's disease

– of specified severity

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A definite diagnosis of Dementia, including Alzheimer's disease, by a Consultant Geriatrician, Neurologist, Neuropsychologist or Psychiatrist supported by evidence including neuropsychometric testing.</p> <p>There must be permanent cognitive dysfunction with progressive deterioration in the ability to do all of the following:</p> <ul style="list-style-type: none"> • remember, • reason, and • perceive, understand, express, and give effect to ideas. <p>Note: For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> • Mild cognitive Impairment (MCI). 	<p>Circulatory brain disorder, disease of the central nervous system, mild cognitive impairment, Parkinson's disease, epilepsy, depression, aphasia, amnesic memory disorder, psychosis, stroke, brain tumour, hydrocephalus, Creutzfeld-Jacob disease and major head trauma.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. <p>In addition we will not pay a subsequent claim for Dementia including Alzheimer's disease where there has been an earlier claim in respect of any other neurological illnesses or any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Core Insured Illnesses

Heart attack

– of specified severity

Definition

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,
- the characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction.

Note: For the above definition, the following are not covered:

- myocardial injury without myocardial infarction,
- angina without myocardial infarction.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Familial Hyperlipidaemia, coronary artery anomalies, coronary vasospasms and myocardial bridging, all obstructive or occlusive arterial disease such as arteriosclerosis, coronary artery dissection or haematoma, coronary ectasia, diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions,
- drug abuse.

In addition we will not pay a subsequent claim for a heart attack where there has been an earlier claim in respect of any other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Kidney failure

– requiring permanent dialysis

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
Chronic and end-stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.	Polycystic kidney disease, pyelonephritis or glomerulonephritis, diabetes mellitus or any chronic renal disorder. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. <p>In addition we will not pay a subsequent claim for a Kidney failure where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • major organ transplant of the kidney, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Core Insured Illnesses

Major organ transplant

– from another person

Definition

The undergoing as a recipient of a transplant from another person of bone marrow or of a:

- transplant of a complete heart, kidney, liver, lung, or pancreas, or
- transplant of a lobe of liver, or
- transplant of a lobe of lung, or
- inclusion on an official UK waiting list for such a procedure.

Note: For the above definition, the following is not covered:

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

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Cystic fibrosis, leukaemia, diabetes mellitus, aplastic or hypoplastic anaemia, immunological defects or disease, cardiomyopathy, coronary artery disease, cardiac failure, chronic lung disease, chronic kidney disease, chronic liver disease, chronic pancreatitis or pulmonary hypertension.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions,
- alcohol abuse,
- drug abuse.

In addition we will not pay a subsequent claim for:

- any major organ transplant where there has been an earlier claim for any of the following insured illnesses:
 - aplastic anaemia,
 - cancer, if this is connected to or associated with the subsequent major organ transplant,
 - kidney failure,
 - liver failure,
 - any major organ transplant,
 - loss of independent existence,
 - respiratory failure,
 - total permanent disability, or
 - terminal illness.
- major organ transplant of the heart where there has been an earlier claim in respect of any circulatory system illnesses.

For further information see Section 6 – What is not covered.

Motor neurone disease

– resulting in permanent symptoms

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist.</p> <ul style="list-style-type: none"> • Amyotrophic lateral sclerosis (ALS), • Kennedy’s disease, • Primary lateral sclerosis (PLS), • Progressive bulbar palsy (PBP), • Progressive muscular atrophy (PMA). <p>There must also be permanent clinical impairment of motor function.</p>	<p>Any chronic neurological symptoms that would be attributable to or known to motor neurone disease.</p>

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for a motor neurone disease where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Multiple sclerosis

– with persisting symptoms

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function caused by multiple sclerosis.</p>	<p>Any form of neuropathy, encephalopathy or myelopathy (disorders of function of the nerves), abnormal sensation (numbness) of extremities, trunk or face, weakness or clumsiness of a limb, double vision, partial blindness, ocular palsy, vertigo (dizziness), difficulty of bladder control, optic neuritis, spinal cord lesion and abnormal MRI scan.</p>

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for multiple sclerosis where there has been an earlier claim in respect of any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Core Insured Illnesses

Parkinson's disease

– resulting in permanent symptoms

Definition

A definite diagnosis of Parkinson's disease by a Consultant Neurologist or Consultant Geriatrician. There must be permanent clinical impairment of motor function with associated tremor and muscle rigidity.

Note: For the above definition, the following are not covered:

- Parkinsonian syndromes/Parkinsonism.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Tremor, rigidity of limbs, slurred speech, dementia, extra pyramidal disease. Secondary parkinsonism.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions,
- alcohol abuse.

In addition we will not pay a subsequent claim for a Parkinson's disease where there has been an earlier claim for any other neurological illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Stroke – resulting in clinical symptoms	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either:</p> <ul style="list-style-type: none"> • permanent neurological deficit with persisting clinical symptoms, or • definite evidence of death of tissue or haemorrhage on a brain scan with neurological deficit creating clinical symptoms lasting at least 24 hours. <p>Note: For the above definition, the following are not covered:</p> <ul style="list-style-type: none"> • transient ischaemic attack (TIA), • traumatic injury to brain tissues or blood vessels, • death of tissue of the optic nerve or retina/eye stroke. 	<p>Any disease or disorders of the heart, including arrhythmia, valve disorder, cardiac tumour and obstructive or occlusive arterial disease such as arteriosclerosis. Transient ischaemic attack (TIA), intracranial aneurysm or vascular disorder, such as dissection. Anticoagulation treatment, thrombophilia and diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness, • related condition exclusions. <p>In addition we will not pay a subsequent claim for a stroke where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Cardiovascular Risk Table

If the insured person or child has had:

- 2 or more recorded blood pressure readings, either the diastolic or systolic, taken at least 7 days apart, or
- 2 or more recorded cholesterol readings taken at least 7 days apart

that exceeded the levels shown in the table below, in the two years prior to:

- inclusion in this Policy, or
- inclusion in a previous group critical illness policy arranged in connection with the member's employment with you or any other employer, if earlier, or
- the date of increase in insured benefit or child's benefit,

these will be treated as related conditions in respect of the insured illnesses cardiac arrest, coronary artery bypass grafts, heart attack, kidney failure and stroke.

Age bands (at date of reading)	Up to 50	51-60	61 and over
Blood Pressure	160/90	170/95	175/95
Total Cholesterol	5.5 mmol/l	6.5 mmol/l	7.5 mmol/l

Additional Insured Illnesses

9.2 Additional insured illnesses

If you have chosen to insure these, the additional insured illnesses covered are listed below. Exclusions may apply and these are shown below and in Section 6 of this guide.

Aorta graft surgery – for disease	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Undergoing surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.</p> <p>Note: For the above definition, the following are not covered:</p> <ul style="list-style-type: none"> Any other surgical procedure, for example the insertion of stents or endovascular repair. Surgery following traumatic injury to the aorta. 	<p>Marfan’s syndrome, Ehlers-Danlos syndrome, bicuspid aortic valve, congenital malformation of the heart or aorta, coarctation of aorta, known previous aneurysms/dissection/ectasia of aorta, arteriosclerosis of aorta.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness, related condition exclusions. <p>In addition we will not pay a subsequent claim for aorta graft surgery where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:</p> <ul style="list-style-type: none"> loss of independent existence, total permanent disability, terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Aplastic anaemia

– with permanent bone marrow failure

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Permanent bone marrow failure which results in all of anaemia, neutropenia and thrombocytopenia, requiring treatment with at least one of the following:</p> <ul style="list-style-type: none"> • Blood transfusion, • Marrow stimulating agents, • Immunosuppressive agents, • Bone marrow transplant. 	<p>Any history of symptoms or abnormal blood tests that would be attributable to or known to aplastic anaemia.</p>

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for aplastic anaemia where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- major organ transplant of bone marrow,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Additional Insured Illnesses

Bacterial meningitis

– resulting in permanent symptoms

Definition

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

Note: For the above definition, the following is not covered:

- All other forms of meningitis including viral meningitis.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Chronic ear disease, cerebral shunt related to hydrocephalus, immunodeficiency syndromes.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for bacterial meningitis where there has been an earlier claim for any of the following insured illnesses:

- encephalitis,
- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Balloon valvuloplasty

Definition

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

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Rheumatic fever, carcinoid syndrome, bicuspid valve, mitral valve prolapse, myxomatous or calcified heart valve, cardiomyopathy, Ehlers-Danlos syndrome, Marfan's syndrome.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions.

In addition we will not pay a subsequent claim for balloon valvuloplasty where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Benign brain or spinal cord tumour – resulting in permanent symptoms or with specified treatment	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A non-malignant tumour:</p> <ul style="list-style-type: none"> • or cyst originating from the brain, cranial nerves, or meninges within the skull, or • in the spinal canal or spinal cord. <p>resulting in any of the following:</p> <ul style="list-style-type: none"> • permanent neurological deficit with persisting clinical symptoms, • undergoing invasive surgery to remove all or part the tumour, or • undergoing stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells. <p>Note: For the above definition, the following are not covered:</p> <ul style="list-style-type: none"> • tumours in the pituitary gland, • tumours originating from bone tissue, • angioma and cholesteatoma. 	<p>For both benign brain and spinal cord tumours: Neurofibromatosis (Von Recklinghausen’s disease).</p> <p>For a benign brain tumour: Pre-existing benign brain tumour, haemangioma (Von Hippel- Lindau disease), pituitary gland tumours, angioma/haemangioma/meningioma, any malformation of the arteries or veins of the brain.</p> <p>For a benign spinal cord tumour: Meningomyelocele and syringomyelia.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. <p>In addition we will not pay a subsequent claim for benign brain or spinal cord tumour where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>We will also not pay a subsequent claim for benign spinal cord tumour where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • Permanent physical severance of a hand or foot, or total and irreversible paralysis of an arm or a leg, <p>For further information see Section 6 – What is not covered.</p>	

Additional Insured Illnesses

Blindness

– permanent and irreversible

Definition

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 20 degrees or less of an arc, as certified by an ophthalmologist.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Stroke, transient ischaemic attack (TIA), head trauma, brain tumour, glaucoma, pituitary gland tumour, optic neuropathy, papilloedema, retrobulbar neuritis, sarcoidosis, malignant exophthalmus, diabetes mellitus, uveitis, retinal detachment, macular degeneration or registered blind.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for blindness where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Cardiomyopathy – of specified severity	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A definite diagnosis by a Consultant Cardiologist of cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 40% or less for at least six months when stabilised on therapy advised by the Consultant.</p> <p>The diagnosis must also be evidenced by:</p> <ul style="list-style-type: none"> • electrocardiographic changes, and • echocardiographic abnormalities. <p>The evidence must be consistent with the diagnosis of cardiomyopathy.</p> <p>Note: For the above definition, the following are not covered:</p> <ul style="list-style-type: none"> • All other forms of heart disease and/or heart enlargement. • Myocarditis, and • Cardiomyopathy related to alcohol or drug abuse. 	<p>Any disease or disorders of the heart. This will include congenital malformations, heart valve defects, any obstructive or occlusive arterial disease such as arteriosclerosis or Takotsubo Syndrome. Muscular dystrophy, acromegaly, amyloidosis, haemochromatosis, any previous chemotherapy or diabetes mellitus. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness, • related condition exclusions. <p>In addition we will not pay a subsequent claim for cardiomyopathy where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Additional Insured Illnesses

Coma

– with associated permanent symptoms

Definition

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

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

Note: For the above definition, the following are not covered:

- medically induced coma.
- coma secondary to alcohol or drug abuse.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Self inflicted injury or misuse of drugs or alcohol, diabetes mellitus, medically induced coma.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for coma where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Deafness – permanent and irreversible	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.	Stroke, transient ischaemic attack (TIA), head trauma, brain tumour, chronic ear infection, acoustic nerve tumour, presbycusis, otosclerosis, congenital deafness.
Exclusions applicable to a claim	
The following exclusions apply to any claim: <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. In addition we will not pay a subsequent claim for deafness where there has been an earlier claim for any of the following insured illnesses: <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. For further information see Section 6 – What is not covered.	
Encephalitis – resulting in permanent symptoms	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
A definite diagnosis of Encephalitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms. Note: For the above definition, the following is not covered: <ul style="list-style-type: none"> • Encephalitis in the presence of HIV. 	Bacterial meningitis, HIV Immuno deficiency syndromes, Lyme disease.
Exclusions applicable to a claim	
The following exclusions apply to any claim: <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. In addition we will not pay a subsequent claim for encephalitis where there has been an earlier claim for any of the following insured illnesses: <ul style="list-style-type: none"> • bacterial meningitis, • loss of independent existence, • total permanent disability, • terminal illness. For further information see Section 6 – What is not covered.	

Additional Insured Illnesses

Heart valve replacement or repair

Definition

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

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Endocarditis, congenital malformation of the heart, cardiomyopathy, any obstructive or occlusive arterial disease, rheumatic fever, Marfan's syndrome, Ehlers-Danlos syndrome, carcinoid syndrome, bicuspid aortic valve, mitral valve prolapse, myxomatous or calcified heart valve.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions.

In addition we will not pay a subsequent claim for heart valve replacement or repair where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

HIV infection

– caught in the UK, the Channel Islands, the Isle of Man or the EU from a blood transfusion, physical assault or at work in an eligible occupation

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Infection by Human Immunodeficiency Virus (HIV) resulting from:</p> <ul style="list-style-type: none"> • a blood transfusion given as part of medical treatment, • a physical assault, or an incident occurring in the course of performing normal duties of employment from the eligible occupations listed below: <ul style="list-style-type: none"> – medical practitioner, – a person employed in a medical facility, – a prison officer, – a dentist, or – a member of the fire, police or ambulance emergency services, <p>after the start of the insured person’s cover under the Policy and satisfying all of the following:</p> <ul style="list-style-type: none"> • The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures, • Where HIV infection is caught through a physical assault or as a result of an incident during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident, • There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus, • The incident causing infection must have occurred in the UK, the Channel Islands, the Isle of Man or the EU. <p>Note: For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> • HIV infection resulting from any other means, including sexual activity or drug abuse. 	<p>No benefit will be payable in respect of an insured person who, at any time prior to the date of entry into the scheme, has been infected with any Human Immunodeficiency Virus (HIV) or has demonstrated any antibodies to such virus.</p>

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for HIV where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Additional Insured Illnesses

Liver failure – irreversible	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A definite diagnosis of irreversible end stage liver failure due to cirrhosis by a Consultant Physician resulting in all of the following:</p> <ul style="list-style-type: none"> • Permanent jaundice, • Ascites, and • Encephalopathy. <p>Note: For the above definition, the following is not covered:</p> <ul style="list-style-type: none"> • Liver failure secondary to alcohol or drug abuse. 	<p>Chronic liver disease and hepatitis, primary sclerosing cholangitis, cirrhosis of the liver, portal hypertension, hepatic steatosis, autoimmune hepatitis.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. <p>In addition we will not pay a subsequent claim for liver failure where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • major organ transplant of the liver, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Loss of independent existence – a disability which results in an insured person being unable before the cease age to look after themselves ever again	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Loss of the physical ability through an illness or injury before the cease age to do at least 3 of the 6 tasks listed below ever again.</p> <p>The relevant medical specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.</p> <p>The insured person must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.</p> <ul style="list-style-type: none"> • Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. • Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances. • Feeding themselves – the ability to feed themselves when food has been prepared and made available. • Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function. • Getting between rooms – the ability to get from room to room on a level floor. • Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again. <p>For the above definition, disabilities for which the relevant medical specialists cannot give a clear prognosis are not covered.</p>	<p>Multiple sclerosis, muscular dystrophy, motor neurone disease, Parkinson’s disease, progressive supranuclear palsy or any disease or disorder of the central nervous system including the spinal cord or column. Back, neck or joint pain, arthritis, diabetes mellitus.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions, • alcohol abuse, • drug abuse, • self-inflicted injury. <p>In addition we will not pay a subsequent claim for loss of independent existence where there has been an earlier claim for any for any other insured illness.</p> <p>For further information see Section 6 – What is not covered.</p>	

Additional Insured Illnesses

Loss of speech

– total, permanent and irreversible

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.	Stroke, transient ischaemic attack (TIA), brain injury, brain tumour, motor neurone disease, muscular dystrophy, throat tumour, laryngeal polyps, Alzheimer's disease, Parkinson's disease.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for loss of speech where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Open heart surgery

– with surgery to divide the breastbone

Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct a structural abnormality of the heart.	Endocarditis, congenital malformation of the heart, cardiomyopathy, any obstructive or occlusive arterial disease, rheumatic fever, Marfan's syndrome, Ehlers–Danlos syndrome, carcinoid syndrome, bicuspid aortic valve, mitral valve prolapse, myxomatous or calcified heart valve, tumours of the heart such as myxomas. Any blood pressure or cholesterol readings above those set out in the cardiovascular risk table at the end of the section.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions.

In addition we will not pay a subsequent claim for open heart surgery where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Permanent physical severance of a hand or foot, or total and irreversible paralysis of an arm or a leg	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<ul style="list-style-type: none"> Permanent physical severance of either a hand or foot at or above the wrist or ankle joint, or Total and irreversible loss of muscle function to the whole of an arm or a leg. 	<p>For severance of a hand or foot Peripheral vascular disease, bone cancer, soft tissue cancer, diabetes mellitus.</p> <p>For paralysis of an arm or leg Diseases of the central nervous system including multiple sclerosis, motor neurone disease, Parkinson’s disease, stroke, transient ischaemic attack (TIA), brain tumour and Alzheimer’s disease, tumours, infections, lesions and malformations of the spinal cord, muscular dystrophy.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> pre-existing conditions exclusion, related condition exclusions. <p>Self-inflicted injury will also be excluded if the claim for the permanent physical severance of a hand or foot.</p> <p>In addition we will not pay a subsequent claim for the permanent physical severance of a hand or foot where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> loss of independent existence, total permanent disability, terminal illness, <p>A subsequent claim for paralysis of an arm or a leg will not be paid where there has been an earlier claim for any other insured illness.</p> <p>For further information see Section 6 – What is not covered.</p>	

Additional Insured Illnesses

Primary pulmonary hypertension

– of specified severity

Definition

A definite diagnosis of primary pulmonary hypertension. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity*.

*NYHA Class 3: Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

There are no related conditions applicable.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness,
- related condition exclusions.

In addition we will not pay a subsequent claim for primary pulmonary hypertension where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Progressive supranuclear palsy

– resulting in permanent symptoms

Definition

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

Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide

Motor neurone disease.

Exclusions applicable to a claim

The following exclusions apply to any claim:

- pre-existing conditions exclusion,
- related condition exclusions.

In addition we will not pay a subsequent claim for progressive supranuclear palsy where there has been an earlier claim for any of the following insured illnesses:

- loss of independent existence,
- total permanent disability,
- terminal illness.

For further information see Section 6 – What is not covered.

Pulmonary artery surgery – with surgery to divide the breastbone	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.	Pulmonary valve disorder, Fallot's tetralogy, patent ductus arteriosus, congenital malformation of the heart and its vessels.
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, for the purposes of this exclusion circulatory system illnesses are considered to be the same illness, • related condition exclusions. <p>In addition we will not pay a subsequent claim for pulmonary artery surgery where there has been an earlier claim for any other circulatory system illnesses or any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	
Respiratory failure – resulting in breathlessness even when resting	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>Advanced stage chronic lung disease resulting in:</p> <ul style="list-style-type: none"> • Breathlessness at rest, and • The need for continuous daily oxygen treatment (PaO₂ < 7.3kPa when clinically stable as prescribed under British Thoracic Society and NICE guidelines) for at least 12 months. 	Chronic obstructive or restrictive pulmonary disease, emphysema. Any disease or disorder of the respiratory system including lung, bronchi and trachea. Tuberculosis or chronic inflammatory diseases. Autoimmune disorders affecting the lung, such as sarcoidosis.
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusion. <p>In addition we will not pay a subsequent claim for respiratory failure where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • major organ transplant of a lung, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Additional Insured Illnesses

Rheumatoid arthritis – of specified severity	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
<p>A definite diagnosis of chronic rheumatoid arthritis by a Consultant Rheumatologist resulting in all of the following:</p> <ul style="list-style-type: none"> • there must be morning stiffness in the affected joints of at least one-hour duration, • there must be arthritis of at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a physician, • the arthritis must involve two or more of the following sites: <ul style="list-style-type: none"> – wrists or ankles, – hands and fingers, – feet and toes, • the arthritis must affect both sides of the body, • presence of rheumatoid factor or anti CCP (anticyclic citrullinated protein) antibodies, unless all other criteria are met, • there must be subcutaneous nodules (nodular swelling beneath the skin), • there must be radiographic changes typical of active rheumatoid arthritis plus evidence of clinical deformity. <p>The symptoms must have been present for at least six months before a claim can be submitted and in the opinion of our Medical Officer(s) all appropriate treatments such as disease modifying agents have been prescribed for at least six months.</p>	<p>Inflammatory polyarthropathy, psoriatic arthropathy.</p>
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. <p>In addition we will not pay a subsequent claim for rheumatoid arthritis where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Systemic lupus erythematosus – with severe complication	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following: <ul style="list-style-type: none"> • permanent neurological deficit with persisting clinical symptoms, or • the permanent impairment of kidney function tests as follows: <ul style="list-style-type: none"> – Glomerular Filtration Rate (GFR) below 30 ml/min. 	Hughes syndrome, rheumatoid arthritis, and Sjogren’s syndrome.
Exclusions applicable to a claim	
The following exclusions apply to any claim: <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. In addition we will not pay a subsequent claim for systemic lupus erythematosus where there has been an earlier claim for any other insured illness. For further information see Section 6 – What is not covered.	

Additional Insured Illnesses

Terminal illness – where death is expected within 12 months	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
A definite diagnosis by the attending Consultant of an illness that satisfies both of the following: <ul style="list-style-type: none"> • 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. 	All covered Critical Illnesses.
Exclusions applicable to a claim	
The following exclusions apply to any claim: <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions. In addition we will not pay a subsequent claim for terminal illness where there has been an earlier claim for any other insured illness. For further information see Section 6 – What is not covered.	
Third degree burns – covering 20% of the body surface area	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.	There are no related conditions applicable.
Exclusions applicable to a claim	
The following exclusions apply to any claim: <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions, • alcohol abuse, • drug abuse, • self-inflicted injury. In addition we will not pay a subsequent claim for third degree burns where there has been an earlier claim for any of the following insured illnesses: <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. For further information see Section 6 – What is not covered.	

Traumatic brain injury – resulting in permanent symptoms	
Definition	Related Conditions relevant in the use of the exclusion shown in Section 6.1 of this guide
Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.	There are no related conditions applicable.
Exclusions applicable to a claim	
<p>The following exclusions apply to any claim:</p> <ul style="list-style-type: none"> • pre-existing conditions exclusion, • related condition exclusions, • alcohol abuse, • drug abuse, • self-inflicted injury. <p>In addition we will not pay a subsequent claim for traumatic head injury where there has been an earlier claim for any of the following insured illnesses:</p> <ul style="list-style-type: none"> • loss of independent existence, • total permanent disability, • terminal illness. <p>For further information see Section 6 – What is not covered.</p>	

Cardiovascular Risk Table

If the insured person or child has had:

- 2 or more recorded blood pressure readings, either the diastolic or systolic, taken at least 7 days apart, or
- 2 or more recorded cholesterol readings taken at least 7 days apart

that exceeded the levels shown in the table below, in the two years prior to:

- inclusion in this Policy, or
- inclusion in a previous group critical illness policy arranged in connection with the member’s employment with you or any other employer, if earlier, or
- the date of increase in insured benefit or child’s benefit,

these will be treated as related conditions in respect of the insured illnesses cardiomyopathy and open heart surgery.

Age bands (at date of reading)	Up to 50	51-60	61 and over
Blood Pressure	160/90	170/95	175/95
Total Cholesterol	5.5 mmol/l	6.5 mmol/l	7.5 mmol/l

Section 10.0

10.0 Further information

10.1.1 The Company

This Group Insurance is issued by Canada Life Limited, an incorporated company limited by shares, whose head office is in the United Kingdom. Its address is:

Canada Life Limited
Canada Life Place
Potters Bar
Hertfordshire EN6 5BA

10.1.2 What we do

Canada Life Limited is a company carrying out insurance business (also referred to as an insurance undertaking). We do not provide advice on whether the product meets your particular requirements.

10.1.3 Remuneration

Canada Life may pay some of our staff bonus payments which are linked to the number and/or value of the policies which we sell.

10.1.4 Financial strength

If you want to find out about our financial strength, including our solvency margin, you can view our Solvency and Financial Condition Report (SFCR) at www.canadalife.co.uk/adviser/about-us/solvency-2

10.2 Queries and complaints

For further information, or if you wish to complain about any aspect of the service you have received, please contact us directly:

Customer Services – Workplace Protection

Canada Life Group Insurance
Canada Life Limited
Canada Life Place
Potters Bar
Hertfordshire EN6 5BA

You can also e-mail:

groupcsc@canadalife.co.uk

or ring **0345 223 8000**.

Lines are open Monday to Friday, 9am to 5pm.

Complaints which we cannot settle can be referred to the Financial Ombudsman Service:

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

Telephone: **0800 0234 567** or, for mobile phone users:
0300 123 9123

E-mail:

complaint.info@financial-ombudsman.org.uk

Website: **www.financial-ombudsman.org.uk**

Making a complaint will not prejudice your right to take legal proceedings.

10.3 Compensation

If we are unable to meet our liabilities, you may be able to claim compensation from the Financial Services Compensation Scheme. Further information is available from the Financial Conduct Authority and the Financial Services Compensation Scheme.

10.4 Law

The construction, validity and performance of the Policy will be governed by English law. If there is any dispute between the parties about anything to do with the Policy, the English Courts are the only courts which may make a judgement about the dispute.

Any person or company who is not a party to this Policy does not and shall not have or acquire any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Policy. But after a claim has been made by the Policyholder for a member, that member can pursue that claim as if they were the Policyholder.



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Registered Office: Canada Life Place, Potters Bar, Hertfordshire EN6 5BA

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