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VitalityLife Life Cover Plan Provisions.

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VITALITYLIFE LIFE COVER
PLAN PROVISIONS

This document is *your plan* provisions. It explains how *your plan* works. It includes details about the covers and options in the *plan*, how *you* pay *your plan premiums*, and how to make a claim if *you* need to. It explains how taking steps to improve *your* health can reduce *your plan premium*.

If there is anything that is not clear, please speak to *your* financial adviser, if *you* have one. *You* can also email *us* at lifeenquiries@vitality.co.uk or call *us* on 0345 601 0072. If *you* call *us*, please have *your plan* number to hand. To help *us* improve *our* service, *we* may record or monitor phone conversations with *you*.

In these provisions, *we*, *us* or *our*, means Vitality Life Limited. *You* or *your* means the person or people covered under the *plan*, unless stated otherwise. *We* have put some otherwords in italics. *We* explain what *we* mean by these words in the Definitions section.

PLEASE CONTACT US ON 0345 601 0072
OR SPEAK TO YOUR ADVISER IF YOU WOULD LIKE THIS DOCUMENT IN LARGE PRINT OR BRAILLE.

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A. HOW YOUR PLAN WORKS

A1. YOUR PLAN ACCOUNT

When *you* take out Life Cover, *we* set up a *plan account* for *you*.

For a *single life plan*, the amount of *your plan account* will be the same as *your* amount of Life Cover. For a *joint life plan*, the amount of *your plan account* will be the same as the amount of Life Cover held by the *first person covered*.

You can also choose whether the value of *your plan account* increases over time, decreases over time or stays level. For more about this, please see the information on '*Your plan account* structure' below.

Your plan account structure

Your plan account has one of these three structures, as shown in *your plan schedule*:

YOUR PLAN ACCOUNT STRUCTURE	WHAT THIS MEANS
LEVEL	The value of the *plan account* is designed to stay the same over the life of the *plan*. It will only change if something happens such as *you* make a claim or change a cover.
INDEXED	The value of the *plan account* increases on each *plan anniversary*, in line with the *Retail Prices Index* (RPI) rounded to the next 0.25%. Each increase is limited to a minimum of 0% and to a maximum of 10%. *We* use the RPI figure that applies five months before each *plan anniversary*. *Your plan account* cannot exceed £18,000,000, including any increases as a result of indexation. If *your* cover lasts for the whole of *your* life then the increases will be applied automatically until the *plan anniversary* immediately before *your* 80th birthday. If *your plan* is a *joint life plan* this will be based on the younger of the two *persons covered*. At this point *we* will write to *you* and ask *you* to confirm whether *you* want *your plan account* to continue to be indexed. If *you* do not tell *us* that *you* want *your plan account* to be indexed *we* will automatically change it to a level *plan account*.
DECREASING	The value of the *plan account* decreases over the life of the *plan*. It decreases in the same way that the outstanding capital on a repayment mortgage would if the mortgage had: • A 7% annual equivalent interest rate • The same term as the *plan* *You* can only have a *decreasing account* if *your plan* has a *fixed term*.

Your plan account may change if *we* pay a *benefit*, or because of a change to *your plan*. There is more about changes to *your plan* in provision D.

A2. HOW OTHER COVERS WORK

The other covers *you* may have in *your plan* are not linked to the *plan account*. The amounts of these covers are set individually.

A3. HOW LONG YOUR PLAN LASTS

Your Life Cover in *your plan* lasts for a defined term. This term can be up to a fixed date – this is called a *fixed term*. Life Cover can instead be for the whole of *your* life – this is called *whole of life*. *Your plan schedule* shows the date on which each of *your* covers terminates.

Once *your plan* has started, *you* cannot change the term of any cover from *whole of life* to *fixed term*, or from *fixed term* to *whole of life*.

B. LIFE COVER

B1. LIFE COVER

Life Cover pays a lump sum if the *person covered* dies, or is diagnosed with a *terminal illness*. This cover may be for a *fixed term* or for *whole of life*.

B1.1 When we will pay the benefit

When *we* pay the *benefit* depends on whether *your plan* is a *single life plan*, *joint life first death* or *joint life second death*.

SINGLE OR JOINT LIFE?	WHEN WE WILL PAY THE BENEFIT
SINGLE LIFE PLAN	*We* will pay the *benefit* if the *person covered* dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit*, the *plan* ends.
JOINT LIFE FIRST DEATH	With a *joint life first death plan*, there are two people covered. If both people have Life Cover, *we* will pay the *benefit* if one of those people dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* for one *person covered*, *we* cancel all the covers for that person. *We* also cancel the Life Cover for the remaining *person covered*. If the remaining person has other covers in the *plan*, the *plan* continues. The remaining person can apply to *us* for new Life Cover under a new *plan*.
JOINT LIFE SECOND DEATH	This option is only available if *you* have chosen *Whole of Life* Cover, see provision A3. With a *joint life second death plan*, there are two people covered. *We* will pay the Life Cover *benefit* after both of the people covered have died, or have been diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* the *plan* will come to an end.

B1.2 How much we will pay

If both people covered in a *joint life plan* die, and it is not possible to determine who died first, *we* will pay the total amount of the *plan account*.

The maximum amount of Life Cover *we* will pay for each *person covered* under all policies issued by *us* is £18,000,000. In all other circumstances *we* will pay the *current benefit amount*.

B1.3 When we will not pay

We will not pay the *benefit* if the death or diagnosis of *terminal illness* happens after the Life Cover's *date of expiry*. *Your plan schedule* shows this date.

Under certain circumstances, *we* may also not pay the *benefit* if the claim is due to *suicide*. For more about this, see provision D5.5.

B1.4 What happens if you need to claim while we are still assessing your application for Life Cover

If *you* have applied for Life Cover on either a *single life plan* or *joint life first death plan* but *we* are still assessing *your* application, *we* automatically give *you* some limited Life Cover. This is called Immediate Cover. Immediate Cover is free of charge.

We will pay a *benefit* under Immediate Cover as long as all of the following apply:

- *We* have received a completed application from *you*
- *We* have received a completed direct debit instruction from *you*
- The claim is for death – *terminal illness* is not covered
- *You* are under the age of 50 when *we* receive *your* application
- *You* are a *resident* of the *United Kingdom*
- *You* are not applying for Life Cover with any other company
- *You* have appropriately answered 'no' to all *our* medical and health questions, and would normally be accepted on standard rates
- *You* do not take part in any hazardous pursuits or sports or have an *occupation* that *we* would exclude or charge *you* extra for.

Immediate Cover stops when one of these happens:

- *We* accept *your* application
- *We* decline *your* application
- *Your* application is cancelled
- 90 days pass since *we* received *your* application.

The amount of Immediate Cover is equal to the amount of Life Cover *you* applied for, up to a maximum of £500,000 across all *plans you* have applied with *us*.

Please note that Immediate Cover does not apply to *plans* which have been arranged on a *joint life second death plan* basis.

B1.5 LifestyleCare Cover

LifestyleCare Cover allows *you* to access some or all of *your* Life Cover if *you* are diagnosed with an illness or condition that *we* cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. *We* set these out in this provision and Appendix 2.

LifestyleCare Cover is only available if *you* have chosen *Whole of Life* Cover. It is available on *single life plans* only.

B1.5.1 When we will pay

Your claim must meet the following criteria before *we* will pay it:

- *You* must be diagnosed with a condition that *we* cover. *Your* condition must meet one of the definitions set out in Appendix 2. *We* will use the criteria in Appendix 2 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have, *we* will not pay a claim for that condition.

We will ask *your* General Practitioner, and any *appropriate medical specialists* who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness. For more about this, see Appendix 2. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid. *Benefits* under LifestyleCare Cover will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

B1.5.2 How much we will pay

Your plan schedule shows *your* amount of LifestyleCare Cover. If *your plan account* structure is indexed, *your* LifestyleCare Cover will increase in the same way as the *plan account* at each *plan anniversary*. For more about indexation see provision A1.

The amount *we* will pay depends on:

- How severe *your* condition is, and
- The amount of LifestyleCare Cover *you* have

The lump sum *we* will pay *you* will be a percentage of *your* amount of LifestyleCare Cover. The percentage depends on how severe *your* condition is.

There are two severity levels:

SEVERITY LEVEL	WHAT PERCENTAGE OF YOUR AMOUNT OF LIFESTYLECARE COVER WE PAY
LEVEL 1	20%
LEVEL 2	100%

Appendix 2 shows which conditions are covered under Severity Level 1 and Severity Level 2.

B1.5.3 When we will not pay

We will not pay the *benefit* for LifestyleCare Cover if:

- *You* suffer from a condition that *we* do not cover
- *You* suffer from a condition that *we* excluded from *your* cover after assessing *your* application
- *Your* condition does not meet *our* definition for that condition
- *You* are making a subsequent claim that does not meet the criteria for a further payment
- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*
- *We* believe the condition that led to *your* claim was one *you* were already experiencing before *your plan* started and which *you* should have disclosed to *us* when *you* first applied
- *You* have selected LifestyleCare Cover Protector, and *you* do not survive for at least 14 days after the date that *you* meet a severity level 2 definition.

B1.5.4 What happens if you need to make a subsequent claim

We will only make one Severity Level 1 payment.

If *we* have paid *you* a claim under Severity Level 1 *you* can make a subsequent claim for a Severity Level 2 condition. This can be for the same underlying condition, or a different one.

For the subsequent Severity Level 2 condition, *we* will pay the remaining amount of *your* LifestyleCare Cover.

B1.5.5 How your cover continues after a claim for LifestyleCare Cover

The way *your* cover continues after a claim will depend on whether *you* have chosen LifestyleCare Cover Protector.

There are two types of LifestyleCare Cover Protector - LifestyleCare Cover Protector (level 1) and LifestyleCare Cover Protector (level 1 & 2). *Your plan schedule* will indicate whether *you* have selected LifestyleCare Cover Protector and if so which type.

LifestyleCare Cover Protector not selected

If *we* make a payment to *you* for a Severity Level 1 condition, the amount of *your* Life Cover and LifestyleCare Cover will reduce by the amount *we* have paid *you*.

If *we* pay *you* a claim for a Severity Level 2 condition, LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1)

If *you* have chosen LifestyleCare Cover Protector (level 1) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future Life Cover or LifestyleCare Cover claims.

If *we* pay *you* a claim under Severity Level 2, LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1 & 2)

If *you* have chosen LifestyleCare Cover Protector (level 1 & 2) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future Life Cover or LifestyleCare Cover claims.

If *you* meet the definition for a Severity Level 2 condition and *you* survive for at least 14 days after *you* meet the definition *we* will pay *your* remaining LifestyleCare Cover amount. LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will not reduce. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

C. OTHER COVERS AND OPTIONS

C1. MORTGAGE FREE COVER

Mortgage Free Cover is temporary Life Cover that covers *you* before *your plan* starts. It may be relevant to *you* if:

- *Your plan* is to cover a loan to buy or improve *your* home
- *You* do not want *your plan* to start until *you* start paying back *your* loan

We offer *you* Mortgage Free Cover in this situation because *you* might be legally committed to the loan before *you* start paying it back – for example, if *you* have exchanged contracts to buy a new home.

We do not charge *you* any premium for Mortgage Free Cover.

C1.1 When you are eligible for Mortgage Free Cover

To be eligible for Mortgage Free Cover, *your plan* application must meet all of the following criteria:

- *You* are using *your plan* to cover a loan arranged through a recognised financial institution
- *You* are using *your* loan to buy or improve *your* home
- *You* are not using *your* loan to pay for a remortgage
- *Your* loan is not covered by another life assurance policy or free cover arrangement like this one
- *We* have accepted *your* application for Life Cover and told *you* which of *your* covers the Mortgage Free Cover applies to
- The period from when *you* applied for *your plan* to when *you* are legally committed to a loan for buying or improving *your* home – for example when *you* exchange contracts – is less than four months
- *You* and any other *person covered* must be younger than 50 on the date *we* issue *your acceptance letter*
- *You* have a *single life plan* or a *joint life first death plan*

C1.2 When Mortgage Free Cover starts

Mortgage Free Cover starts when either of the following events happen:

- *We* issue *your acceptance letter*
- *You* become legally committed to a loan for buying or improving *your* home – for example this might be when *you* exchange contracts

You can only have Mortgage Free Cover in the period immediately before *your plan* starts. *You* cannot have it when *you* are changing *your plan* at a later stage.

C1.3 When we will pay

If *you* need to make a claim under Life Cover while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision B1.1.

C1.4 How much we will pay

The amount of Life Cover *benefit we* pay will be the lowest of:

- The amount of cover that *we* state on *your acceptance letter*
- The amount of *your* mortgage or loan
- £300,000

C1.5 When the cover ends

The *date of expiry* of Mortgage Free Cover is when the first of any of these events happen:

- Three months pass since *we* issue *your acceptance letter*
- *Your* mortgage starts
- *Your plan* starts; or
- *You* are no longer legally committed to the loan, for any reason.

C2. WAIVER OF PREMIUM ON INCAPACITY

Waiver of Premium on Incapacity means that if *you* become incapacitated, *we* stop charging the *plan premium* for *your plan*.

- If *you* have a *single life plan*, *you* can choose to add this cover
- If *you* have a *joint life plan*, *you* can choose to add this cover for just one *person covered*, or both people can have it separately

Your plan schedule shows if *your plan* includes this cover. *You* can add or remove this cover at any time. If *you* apply to add it, *we* will *underwrite your* request.

C2.1 When we will waive your plan premium

We will waive *your plan premium* if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. These are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

A special definition means the loss of the physical ability through an illness or injury to do at least three of the six *tasks designed to assess whether you can look after yourself*. *We* list these activities in provision C2.6. *We* use this definition to assess *houseperson* claims, see provision C2.6.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

When we will start waiving your plan premium

We will start waiving *your plan premium* on the day after *your deferred period* ends. The *deferred period* starts on the date *you* become incapacitated according to the definition that applies to *your plan*. It ends when *you* have been continuously incapacitated for one of:

- Seven days (this is only an option if *you* are self-*employed*)
- One month

- Two months
- Three months
- Six months
- Twelve months

You choose *your deferred period* when *you* set up this cover. If *you* have a *joint life plan*, each *person covered* can choose their *own deferred period*. For some *own occupations you* cannot choose a *deferred period* of seven days or one month. *We* will tell *you* if this applies to *you*.

Your plan schedule shows which *deferred period* applies to *your* Waiver of Premium on Incapacity.

Telling us that you want to claim

If *you* become incapacitated and need to claim, *you* need to give *us* written notice within a specified period of time. This notification period depends on the *deferred period you* have chosen. If *you* have a *deferred period* of:

- Seven days, *you* should notify *us* immediately
- One or two months, *your* notification period is two weeks
- Three, six or twelve months, *your* notification period is two months

If *we* don't receive notice of *your* incapacity within the specified period, *we* may treat the *deferred period* as if it started on the date *we* actually receive notice.

If *we* receive notice more than 90 days after the end of the *deferred period*, *we* may decline *your* claim.

Providing us with evidence for your claim

We will need to be satisfied that *your* claim is valid in order to waive *your plan premium*.

When *you* first make *your* claim, *we* will ask for evidence to substantiate it. This evidence may include, but is not limited to:

- A report from *your* General Practitioner
- Copies of *your* medical records
- A report from any other *appropriate medical specialist*
- *Your* hospital records, including copies of the results of any clinical tests or investigations
- Information from *your* employer, including details of the duties of *your employment*
- *Your* human resources records, including details of sickness absence

We may also need *you* to have a medical examination with an examiner that *we* choose, at *our* expense. *We* may appoint a disability counsellor or someone who represents *us* to talk to *you* about any aspect of *your* claim.

At reasonable intervals *we* may also ask *you* to fill in a claim form, to confirm that *you* are still entitled to Waiver of Premium on Incapacity.

If *you* do not give consent for *us* to access *your* medical information, or to get any other assistance or information that *we* need to assess *your* claim, then *we* may decline, suspend, or stop paying *you* any *benefits* under Waiver of Premium on Incapacity Cover.

C2.2 How long we will waive your plan premium for

When we will start waiving your plan premium

We will start waiving *your plan premium* on the day after *your deferred period* ends. For more about the *deferred periods*, see provision C2.1.

When we stop waiving your plan premium

We will continue to waive *your plan premium* until the first of the following occurs:

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work
- *You* perform any kind of work for profit or *reward*
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury
- *You* fail to provide *us* with satisfactory proof that *you* are entitled to the *benefit* within 30 days of *us* asking for it, or *you* do not have a physical examination and medical tests – at *our* expense – when *we* ask
- *You* fail to provide *us* with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*
- *Your* Waiver of Premium on Incapacity Cover reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover
- *You* are removed from the *plan*
- The *plan* is cancelled
- *Your* death

C2.3 Which premium increases we will waive

While *we* are waiving *your plan premium*, *we* will waive any increases that happen because:

- *You* have an indexed *plan account*
- *Your plan premium* increases as a result of Vitality Optimiser, Wellness Optimiser, Premium Optimiser, or Interest Rate Optimiser
- *We* review *your* premium

While *we* are waiving *your plan premium*, *you* will have to pay any increases that happen because:

- *You* add more covers to *your plan*
- *You* increase the amount of any of *your* covers

C2.4 When we will not waive your plan premium

We will not waive *your plan premium* if the *life-changing event* which causes *your* claim occurs after the *date of expiry* for this cover.

C2.5 What happens if you need to claim again

If *you* recover and return to work but then need to make another claim under this cover, *we* will waive the *deferred period* for this subsequent claim. This waiver only applies if the subsequent claim is:

- Caused by the same *life-changing event* as the previous claim
- Within three months of the original waiver of premium ending

C2.6 What happens if you are not in employment when you make a claim

If you are unemployed or on a career break

If *you* become *unemployed* – or take a *career break* – and claim under Waiver of Premium on Incapacity Cover within a month of leaving work, *we* will assess *your* claim against *your* previous *own occupation*.

If *you* claim more than one month after leaving work, *we* will assess *you* as a *houseperson*. *We* may also change the *deferred period* that applies to *your* Waiver of Premium on Incapacity Cover. For more about the *deferred period* for Waiver of Premium on Incapacity Cover, see provision C2.1.

Houseperson claims

We will use the *houseperson* category to assess claims for anyone who is:

- A *houseperson*
- A student
- Retired
- Working less than 16 hours a week
- *Unemployed* – and has been for at least one month

When we will accept your claim

If *you* become ill or injured to the extent that *you* cannot perform three out of the six *activities of daily living*, described below, *we* will accept *your* claim. *You* will not need to give *us* details of *your* earnings when *you* claim.

ACTIVITIES OF DAILY LIVING (WE ALSO REFER TO THESE AS TASKS DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF)	HOW WE DEFINE THIS ACTIVITY
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
Getting dressed and undressed	The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
Feeding yourself	The ability to feed *your*self when food has been prepared and made available
Maintaining personal hygiene	The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function
Getting between rooms	The ability to get from room to room on a level floor
Getting in and out of bed	The ability to get out of bed into an upright chair or wheelchair and back again

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

How long we will pay for

We will stop waiving *your plan premium* under the *houseperson* category if:

- *You* start work in any *employment* or *occupation* for profit or *reward*
- *You* no longer fail three out of the six *activities of daily living*

If *you* start or return to work for profit or *reward you* need to tell *us* immediately. If *you* don't do this, *we* may:

- Stop waiving *your plan premium*
- Cancel *your plan*

C2.7 What happens if you change your occupation

You do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed.

If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *activities of daily living* to assess *your* claim. For more about *activities of daily living* assessments, see provision C2.6.

C3. WAIVER OF PREMIUM ON SERIOUS ILLNESS

Waiver of Premium on *Serious Illness* means that if *you* get a *serious illness* that *we* class as severity A, *we* stop charging the *plan premium* for *your plan*.

If *you* have a *joint life plan, yo*u can choose to add this cover for just one *person covered*, or both people can have it separately. *You* can add or remove this cover at any time. If *you* apply for this cover, *we* will *underwrite your* request.

Your plan schedule shows if *your plan* includes this cover.

C3.1 When we will waive your plan premium

We will waive all further *plan premiums* if *your* claim meets all of the following criteria:

- *You* are diagnosed with a *serious illness* that meets *our* definition and which is classed as severity level A. For more about the illnesses *we* cover, see Appendix 1.
- *We* receive written notice of *your* claim within six months of the *life-changing event* that caused the claim
- *Your* GP and any relevant specialist treating *you* give *us* any medical evidence *we* ask for.
- *You* survive for at least 14 days from the date of the *life-changing event*. *We* may waive this condition under some circumstances.
- If *your* claim is in the *permanent* disability category, *you* survive to the date when *we* agree that *you* are totally and *permanently* disabled

C3.2 When we will start waiving your plan premium

We will start waiving *your plan* premium 15 days from the date of the *life-changing event* that caused *your* claim. However, if *your* claim is under the *permanent* disability category, *we* will start waiving *your plan premium* when *we* agree that *you* are totally and *permanently* disabled.

C3.3 Which premium increases we will waive

While *we* are waiving *your plan premium*, *we* will waive any increases that happen because:

- *You* have an indexed *plan account*
- *Your plan premium* increases as a result of Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser
- *We* review *your* premium

While *we* are waiving *your plan premium*, *you* will have to pay any increases that happen because:

- *You* add more covers to *your plan*
- *You* increase the amount of any *your* covers

C3.4 When we will stop waiving your plan premium

We will stop waiving *your plan premium* when any of the following events happen:

- *Your* Waiver of Premium on *Serious Illness* reaches its *date of expiry*
- *Your* cover reaches its *date of expiry*
- *You* are removed from the *plan*
- The *plan* is cancelled
- *Your* death

C4. WAIVER OF PREMIUM ON DEATH

This cover is only available if *you* have a *joint life plan*.

C4.1 When we will waive your plan premium

Waiver of Premium on Death means that if one *person covered* dies or is diagnosed with a *terminal illness*, *we* stop charging the *plan premium* for the other *person covered* by *your plan*. *You* can include this cover for either or both people covered.

Your plan schedule shows if *your plan* includes this cover and who is covered for Waiver of Premium on Death.

C4.2 When we will start waiving your plan premium

We will start waiving *your plan premium* from the date the *person covered* dies, or the date of the diagnosis of a *terminal illness*. However, *we* will not waive *your plan premium* if this date is after the *date of expiry* of the Waiver of Premium on Death.

C4.3 Which premium increases we will waive

While *we* are waiving *your plan premium*, *we* will waive any increases that happen because:

- *You* have an indexed *plan account*
- *Your plan premium* increases as a result of Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser
- *We* review *your* premiums

While *we* are waiving premium, *you* will have to pay any increases that happen because:

- *You* add covers to *your plan*
- *You* increase the amount of *your* cover

C4.4 When we will stop waiving your plan premium

We will stop waiving *your plan premium* when any of the following events happen:

- The Waiver of Premium on Death reaches its *date of expiry*
- *Your* cover reaches its *date of expiry*

- The *plan* is cancelled
- The death of the remaining *person covered*

C5. GUARANTEED INSURABILITY OPTIONS

Guaranteed Insurability options allow *you* to increase *your* Life Cover when particular events happen in *your* life, without giving *us* any more information about *your* health.

Guaranteed Insurability options are automatically included in *your plan* as long as:

- *We* accepted *you* and any other *person covered* at normal rates
- *We* have not added any special exclusions to *your plan*

Your plan schedule shows if *your plan* includes Guaranteed Insurability options.

C5.1 When you can use Guaranteed Insurability options

EVENT	THE COVER YOU CAN INCREASE
	Life Cover
Childbirth or adoption	✓
Marriage or civil partnership	✓
New or increased mortgage	✓
Increase in value of estate leading to an increase in inheritance tax liability*	✓
Legislative change leading to an increase in inheritance tax liability*	✓

* Only available where Life Cover is arranged on a *whole of life* basis.

You can apply to increase *your* cover using Guaranteed Insurability options at any time, as long as *your* application meets all of the following criteria:

- *You* already have the relevant cover
- One of the events shown in the adjacent table has happened in the last three months
- *You* give *us* the evidence *we* ask for to show that the event has happened within the last three months
- *You* have not reached the *plan anniversary* immediately before *your* 55th birthday for;
  - *Childbirth* or *adoption*
  - *Marriage* or *civil partnership*
  - New or increased mortgage
- *You* have not reached *your* 70th birthday for;
  - Legislative change leading to increase in inheritance tax liability options
  - Increase in value of estate leading to an increase in inheritance tax liability options
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1

If *you* want to use a Guaranteed Insurability option to increase *your* cover in line with an increase in *your* mortgage, *your* application must meet all of the following criteria:

- *You* are using *your plan* to cover a mortgage or mortgages on *your* main residence
- *Your* mortgage has increased, or *you* have taken out a new mortgage
- Any increase in *your* total mortgage payments is solely to pay for a new main residence or to improve *your* existing main residence

We will increase *your* cover as soon as *we* have accepted *your* application.

Legislative change leading to an increase in inheritance tax liability

If *your plan* has been arranged on a *whole of life* basis, *you* can also increase *your* cover if a change in legislation increases the inheritance tax liability on *your* estate. A legislative change is limited to a change in inheritance tax rate, inheritance tax rate bands, inheritance tax reliefs and exemptions.

In order to exercise this option there must be evidence that the death *benefit* under the *plan* is in force to cover the potential inheritance tax liability on *your* estate.

VitalityLife reserves the right to request evidence of the increased potential inheritance tax liability.

Increase in value of estate option

If *your plan* has been arranged on a *whole of life* basis, *you* can also increase *your* cover if the potential inheritance tax liability on *your* estate increases as a result of an increase in the value of the estate due to receipt of a gift or inheritance.

VitalityLife reserves the right to request evidence of the event and the increase in inheritance tax liability before allowing the Guaranteed Insurability *benefit* to be exercised.

Splitting a joint life plan into two single life plans upon divorce or dissolution of a civil partnership

You can split a *joint life first death plan* into two separate *single life plans* upon getting divorced or dissolving *your civil partnership*.

You can apply to split *your joint life plan* using the Guaranteed Insurability option at any time, as long as *your* application meets all of the following criteria:

- *You, your* spouse or *your* civil partner must be both persons covered under the original *plan*
- The original *plan* was used for the purpose of protecting a mortgage where:
  - The mortgage has been rearranged to be in the name of just *you*, *your* spouse or *your* civil partner or
  - *You, your* spouse or *your* civil partner have taken out a new mortgage
- The divorce or dissolution of *your civil partnership* has happened in the last three months, and *you* can provide the necessary evidence *we* request
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1
- The two new *plans* must each meet *our* minimum premium requirements

The two new *plans* will be subject to all the provisions that applied to the original *plan* and each *plan* term must be at least as long as *our* minimum term requirements. Additionally, the amount of cover and term must not be greater than the amount of cover and term *you* had on the original *plan*.

We will adjust the *plan premium* for each *plan*, to take into account:

- What it would have been if *you* had taken out a *single life plan* when *your plan* started
- Any premium reviews *we* have carried out
- Any changes to *your* premium due to *your Vitality Status* or both *your Vitality Status* and *your Wellness Status*
- Any premium increases as a result of indexation
- Any changes to *your* premium due to Premium Optimiser or Interest Rate Optimiser

If either *person covered* wants to add to or increase their cover or increase the *date of expiry* they had under the original *plan*, *we* will need to *underwrite* their request. The *plan premium* will be calculated using premium rates applicable at the time of the request.

We will also:

- Remove any Waiver of Premium on Death
- Remove any Waiver of Premium on *Serious Illness*

C5.2 Limits to using Guaranteed Insurability options

There are limits to the amount *you* can increase *your* Life Cover certain covers by, and the number of times *you* can increase it:

Limits to each cover

EVENT	LIFE COVER
Childbirth or adoption	The limit is 50% of the initial level of cover. *You* cannot increase it more than twice.
Marriage or civil partnership	The limit is 50% of the initial level of cover. *You* cannot increase it more than once.
New or increased mortgage	The limit is the amount of the new mortgage or the increase in the mortgage.
Legislative change leading to an increase in inheritance tax liability	The limit is 50% of the initial level of cover or the increase in the inheritance tax liability on the portion of *your* estate covered by the *plan* which is a direct result of the legislative change.
Increase in value of estate option	The limit is the lower of: • 50% of the initial level of cover • The increase in the inheritance tax liability on the portion of *your* estate covered by the *plan*. This increase must be as a direct result of the receipt of the gift or inheritance • £50,000 This option can only be exercised once.

The maximum *you* can increase *your* Life Cover by using any of the Guaranteed Insurability options, described in this provision, is £150,000. This maximum applies across the whole life of *your plan*.

If *you* use a Guaranteed Insurability option to split a *joint life first death plan* into two *single life plans* upon divorce or dissolution of a *civil partnership*, the maximum cover for the *second person covered* is £500,000.

C5.3 How using Guaranteed Insurability options affects your plan

If *you* use Guaranteed Insurability options to increase a cover, *we* will increase *your* premium for that cover. *We* will work out the amount of the premium increase using *your* age and the rates that applied at the time of the increase.

If *your plan* includes the Waiver of Premium on Incapacity Cover, *we* will work out new premiums for this. *We* do this using the rates that apply at the time of the increase.

We will apply the same provisions to an increase in cover as those *we* applied when that cover was added to *your plan*.

C5.4 When your Guaranteed Insurability options end

If you make a claim

If *you* make a claim *we* will cancel *your* Guaranteed Insurability options. If *you* have a *joint life plan*, the other *person covered* can still use their Guaranteed Insurability options, but only for covers that are not attached to the *plan account*.

Date of expiry

Your Guaranteed Insurability options end on the *plan anniversary* immediately before *your*:

- 55th birthday for *childbirth* or *adoption*, *marriage or Civil Partnership, divorce or dissolution of Civil Partnership,* or new or increased mortgage options
- 70th birthday for legislative change leading to increase in inheritance tax liability or, increase in value of estate leading to an increase in inheritance tax liability options

D. MANAGING YOUR PLAN

D1. PAYING YOUR PREMIUMS

Your plan premium is made up of the individual premiums for each of the covers in *your plan*. *Your plan schedule* shows the details of *your plan premium*.

You pay *your plan premiums* either monthly or annually, in advance. *Your* selected payment frequency is shown in *your plan schedule*. If *you* have selected monthly, *your plan premiums* will be paid by direct debit. If *you* have selected annually, the *plan premium* will be paid for by either direct debit, Electronic Fund Transfer (EFT) or Telegraphic Transfer (TT).

The premiums for any Waiver of Premium on Incapacity Cover depend on the premiums *you* pay for the other covers *you* have in *your plan*.

D1.1 What happens if you do not pay your plan premium

If *you* do not pay *your plan premium* by the due date, *we* will suspend all the covers in *your plan*. However, *you* can ask *us* to reinstate *your plan* within thirteen months of the date of the first unpaid *plan premium* as long as:

- *You* pay all of the outstanding *plan premium*. If *your* premium would have increased in the time that *you* have not been paying it, *you* will need to pay the increased amounts
- *You* provide *us* with a new direct debit instruction so *we* can collect future *plan premium*
- *You* and any other *person covered* by the *plan* completes a reinstatement application form. This is so that *we* can *underwrite your* request. *We* may offer *you* revised terms, or decline *your* request.

D1.2 When your premiums end

Your plan schedule shows the *date of expiry* of each of *your* covers. It also shows whether *your* premium will increase automatically. The *date of expiry* will be different for each *person covered* by the *plan*.

We will collect *your* final premium for each cover on the last due date before the *date of expiry*.

D1.3 Indexed premium increases

If the *benefit* for *your* cover is indexed, *we* will increase *your* premiums annually. The amount by which *we* will increase *your* premiums will depend on *your* age at the time *your* cover increases. For *joint life plans* this will be based on the age of the younger of the two people covered.

If *you* have not reached the *plan anniversary* immediately before *your* 80th birthday the amount by which *we* increase *your* premiums will also depend on the percentage rise in the *Retail Prices Index*, rounded to the next 0.25% at the time *your* cover increases.

Your premiums will increase in one of three ways:

THE PERCENTAGE INCREASE IN THE *RETAIL PRICES INDEX*	PREMIUM INCREASE AMOUNT
Above 0% up to and including 1.75%	Total of the percentage increase in the *Retail Prices Index* plus 1.5%
2% up to and including 7.75%	Total of the percentage increase in the *Retail Prices Index* plus 2.5%
8% and above	Total of the percentage increase in the *Retail Prices Index*, to a maximum of 10%, plus 3.5%

If the percentage change in the *Retail Prices Index* is 0% or less, then there will be no change in *your* cover amount or premium.

Once *you* have reached the *plan anniversary* immediately before *your* 80th birthday the premiums will increase by the total of:

- The percentage rise in the *Retail Prices Index* rounded to the next 0.25%, from a minimum of 0% to a maximum of 10%; and
- 5%

If the *Retail Prices Index* is not suitable, *we* will use another index that measures retail price inflation.

We will increase indexed premiums on each anniversary of *your plan*. *We* will send *you* a new *plan schedule* one month before the increase is due to take effect. The *plan schedule* will show *you* how much the premiums are going to increase by. It will also show any changes to *your* premiums as a result of the *Vitality Programme,* Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser. For more about the *Vitality Programme*, see provision E. For more about how *your* premiums change with Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser, see provision D.

You do not have to accept the increase to *your* premiums. However, if *you* do not want to accept them, *you* need to notify *us* before the date that the increases are due to take effect. *You* can ask *us* not to apply indexation in any year. If *you* decline indexation, then *your* premium and cover amount will not increase due to indexation for that year. If *you* do this for three consecutive years for any individual cover, *we* will cancel the indexation for that cover.

If *your* cover continues beyond *your* 80th birthday, then at the *plan anniversary* immediately before *your* 80th birthday (for *joint life plans* this will be based on the age of the younger of the two people covered) *we* will write to *you* and ask *you* to confirm whether *you* want *your* covers to continue to be indexed. If *you* do not tell *us* that *you* want *your* covers to be indexed *we* cancel indexation on *your plan* and *your* premiums and cover amounts will no longer increase due to indexation.

There will be no change to *your* premiums or *your* cover amounts if *we* cancel indexation.

If *we* have removed indexation, *you* can apply for *us* to reintroduce it. However, *we* will need to repeat the *underwriting* process for all the *persons covered*.

D1.4 How your Vitality Status , or both your Vitality Status and your Wellness Status, affect your premiums

Your plan premium may change as a result of *your Vitality Status*, or both *your Vitality Status* and *your Wellness Status*. *We* will apply these changes on *your plan anniversary* in addition to any other changes that are due. *We* apply any changes as a result of *your Vitality Status,* or both *your Vitality Status* and *your Wellness Status,* after any changes that result from indexation, a review of *your* premiums, or if *you* have chosen Premium Optimiser or Interest Rate Optimiser.

We will tell *you* if *your* premium is going to change at least one month before *your plan anniversary*.

For more about how the *Vitality Programme* may affect *your* premium, see provision E2.

For more about how Wellness Optimiser may affect *your* premium, see provision E3.

D1.5 Premium Optimiser

Premium Optimiser is only available if *you* have selected *Whole of Life* Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Premium Optimiser *your* initial *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium starts lower than an equivalent *Whole of Life* premium that does not include Premium Optimiser.

At each *plan anniversary your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium will increase by 2.5%.

We will apply any change in *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium as a result of Premium Optimiser before any change as a result of indexation or *your Vitality Status,* or both *your Vitality Status* and *Wellness Status. Your plan schedule* indicates whether *you* have chosen Premium Optimiser.

D1.6 Interest Rate Optimiser

Interest Rate Optimiser is only available if *you* have selected *Whole of Life* Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Interest Rate Optimiser *your* initial *Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover premium starts lower than an equivalent *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium that does not include Interest Rate Optimiser.

At each *plan anniversary your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium will increase.

Your Whole of Life Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium increase will depend on the *Long Term Interest Rate* that is published on the first working day of the calendar quarter 65 days before *your plan anniversary* e.g. 1st January.

The table below shows how *your* annual *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premiums can change:

LONG TERM INTEREST RATE	PREMIUM INCREASE
2% or lower	*2.75%*
2.25%	*2.6875%*
2.50%	*2.625%*
2.75%	*2.5625%*
3%	*2.5%*
3.25%	*2.375%*
3.50%	*2.25%*
3.75%	*2.125%*
4%	*2%*
4.25%	*1.875%*
4.50%	*1.75%*
4.75%	*1.625%*
5%	*1.5%*
5.25%	*1.375%*
5.50%	*1.25%*
5.75%	*1.125%*
6% or higher	*1%*

We will apply any change in *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium as a result of Interest Rate Optimiser before any change as a result of Indexation, *your Vitality Status,* or both *your Vitality Status* and *your Wellness Status*.

Your plan schedule indicates whether *you* have chosen Interest Rate Optimiser. Further information regarding the *Long Term Interest Rate* can be found at vitality.co.uk/wholeoflife.

D2. GUARANTEED PREMIUMS

Your plan schedule shows whether any of *your* covers have guaranteed premiums.

D2.1 A guaranteed premium is one that will only change

- If *you* change *your plan*
- If *you* make a claim
- Depending on *your Vitality Status*, or both *your Vitality Status* and *your Wellness Status* (See provision E)
- If *your* premiums are indexed
- At each *plan anniversary* if *you* have chosen either Premium Optimiser (See D1.5) or Interest Rate Optimiser. (See D1.6)

D3. REVIEWABLE PREMIUMS

We will review *your* premiums periodically if *your plan schedule* shows that any of *your* covers have reviewable premiums.

D3.1 How we review your premiums

When *we* review *your* premiums, *we* do not look at *your* individual circumstances such as *your* health. *We* look at the premiums *we* are charging to everyone *we* insure.

We will look at:

- *Our* claims experience, and the experience of the whole insurance industry
- Medical trends and advances, including treatments and diagnostic techniques that could affect *our* claims experience for any of the covers that *we* provide
- The potential future costs to *us* of settling claims
- Changes in applicable law or taxation

A review will affect each type of cover in *your plan* separately. It will apply to the full amount for each cover in *your plan*, including any changes *you* have made to *your* cover since *you* set *your plan* up. The date for each review will be based on the *start date* of the cover for each *person covered*, even if *you* have made later additions to the cover.

For some premiums, any change following a review could affect other covers in *your plan*. For more about this, see provision D1.

If *your* premium changes because of the *Vitality Programme*, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser this does not count as a review.

D3.2 Reviewing premiums for a Whole of Life plan account

Unless *your plan schedule* shows that *you* have guaranteed premium rates *we* will review *your* premiums for *your Whole of life plan account* on the tenth anniversary of that cover. *We* may then review them every year. However, if *we* change one of *your* premiums as a result of a review, *we* will not review that premium again for another ten years.

The exception to this is *we* will also review the premium on the 75th birthday of each *person covered*. Even if *we* change the premium, *we* will review it each subsequent year.

If *you* have a *joint life plan*, *we* will review the premiums for each *person covered* separately.

There is no limit on the amount *we* might increase or reduce *your* premium by after a review.

D3.3 Reviewing premiums for a fixed term plan account

If *you* did not choose guaranteed premiums on a *fixed term plan account we* will review *your* premiums on the fifth anniversary of *your plan*. *We* may then review them every year.

However, if *we* change one of *your* premiums as a result of a review, *we* will not review that premium again for another five years. If *you* have a *joint life plan*, *we* will review the premiums for each *person covered* separately.

There is no limit on the amount *your* premium could increase or reduce by after

a review.

D3.4 Telling you if your premium needs to change

If *your* premium needs to change as a result of a review, *we* will tell *you* at least one month before the date the change is due to take effect. *We* will also explain *your* options.

D3.5 Your options if your premium needs to change as a result of a review

This table shows *your* options if *your* premium needs to change as the result of a review.

IF YOUR PREMIUM NEEDS TO:	YOU CAN CHOOSE TO:	WHAT YOU NEED TO DO:
Increase	Accept the increased premium	*You* do not need to do anything
	Keep *your* current premium and have less cover	Tell *us* in writing within 30 days of receiving *our* notification. If *your* current premium is below *our* allowable minimum, *we* will ask *you* to increase *your* premium to the minimum level.
	Cancel *your* cover	For how to cancel a cover, see provision F
Decrease	Accept the decreased premium	*You* do not need to do anything
	Ask to keep *your* current premium and have more cover	Apply to *us* in writing within 30 days of receiving *our* notification. *We* may need to *underwrite your* request.
	Cancel *your* cover	For how to cancel a cover, see provision F

D4. CHANGING YOUR COVERS

There are several ways *you* can change *your* covers. *You* can:

- Add or increase covers
- Remove or reduce covers
- Remove a *person covered* from a *joint life plan*
- Change the *fixed term* of *your* covers
- Change *your deferred period*
- Lower *your* premiums because of a change in *your* circumstances
- Remove Vitality Optimiser
- Remove Wellness Optimiser
- Remove Premium Optimiser
- Remove Interest Rate Optimiser

We explain below when and how *you* can make these changes.

If *you* want to make a change, *you* need to make it on the same day of the month as the *start date* of *your plan*. If *your plan* is suspended, *you* cannot make any changes to it.

D4.1 Adding or increasing covers

You can apply to add covers to *your plan*, or increase *your* existing levels of cover, at any time – subject to the restrictions explained below. *We* will increase *your* premium based on the increase in cover and the age of the *person covered* at the time the change is made.

Any addition or increase *you* make will be subject to *our* terms and conditions when *you* make the change.

Restrictions on adding or increasing covers

- *You* cannot make an addition or increase if it would be beyond the limits that apply to *your plan*
- *We* may subject *your* request for an addition or increase to *underwriting*
- *You* cannot add or increase covers if *you* are *resident* outside the *United Kingdom*
- If *your plan premium* is being waived at the time *you* ask to add or increase covers, *you* will need to pay the *plan premium* for the increased amount

D4.2 Removing or reducing covers

You can apply to reduce *your* existing levels of cover, at any time.

We will reduce *your plan premium* to take into account:

- What it would have been if *you* had the reduced cover when that cover started
- Any premium reviews *we* have carried out
- Any changes to *your* premium due to *your Vitality Status* or both *your Vitality Status* and *your Wellness Status*

Reducing a cover might also reduce other covers in *your plan*. *Your* premiums might also change. For more about this, see provision D1. For information on how *your* premium will change if *you* remove Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser see provision D4.6, D4.7 and D4.8.

If *your plan premium* drops below the minimum *plan premium we* allow, *we* may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher *plan premium*.

D4.3 Removing a person covered from a joint life plan

If *you* have a *joint life first death*, *you* can remove either of the people covered from it. If *you* do, the *plan* will continue as a *single life plan* for the remaining *person covered*. The remaining person's Life Cover will set the amount of the *plan account*.

When *we* remove a person from *your plan*, *we* will remove all the covers from the *plan* that apply to that person. *We* will recalculate the premium payable as the amount that would have applied if the *plan* had originally been taken out as a *single life plan*, adjusted for any premium reviews or changes in premium as a result of the *Vitality Programme,* Wellness Optimiser, Premium Optimiser, Interest Rate Optimiser or indexation premium increases.

If *your* new premium drops below the minimum premium *we* allow, *we* may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher premium.

This option is not available on *joint life second death plan*.

D4.4 Changing the fixed term of your covers

You can change the *fixed term* of *your* Life Cover at any time, as long as *your* new total *plan premium* does not drop below *our* minimum allowable *plan premium*. If *you* have a decreasing *plan account, you* cannot change the term of individual covers within it; all the covers must have the same term.

If *you* reduce a *fixed term*, *your* new *plan premium* will be the same as or less than the one *you* are currently paying. If *you* want to increase a *fixed term*, *we* will need to *underwrite your* request. *Your* new *plan premium* will be calculated using the rates applicable at the time of the change.

If a *fixed term* cover pays a lump sum, *you* cannot extend the *fixed term* beyond the *date of expiry* of *your plan account*.

If *you* make a change to certain covers, other covers in *your plan* could be affected. For more about this, see provision D.

Changing your deferred period

You can change *your deferred period* for Waiver of Premium on Incapacity Cover.

If *you* increase *your deferred period*, *your* new *plan premium* will be the same as or less than the one *you* are currently paying. If *you* want to decrease *your deferred period*, *we* will need to *underwrite your* request.

D4.5 Lowering your premiums because of a change in your circumstances

If a change in *your* circumstances could lead to a lower premium, it is in *your* interest to tell *us*. *We* will then offer *you* a new premium, as long as:

- *You* complete a declaration of health form, if *we* ask *you* to, that confirms *you* are in good health
- The new *plan premium* is lower than *your* current one

Examples of changes in circumstances that *we* will consider are giving up smoking or stopping hazardous activities.

D4.6 Removing Vitality Optimiser

If *your plan schedule* shows that *you* have chosen Vitality Optimiser, *you* can apply to remove this option at any time.

You are only eligible for Vitality Optimiser under this *plan* if *you* also have *Vitality Plus* or *Vitality Select*. For more information on *Vitality Plus* or *Vitality Select* please see *your* separate *Vitality Programme* terms and conditions. If *your Vitality Plus* or *Vitality Select* is cancelled, Vitality Optimiser will be removed from *your plan*.

If Vitality Optimiser is removed *your* premiums will change as follows:

If *you* want to keep *your* premium at the same level until the *date of expiry*, the level of cover will be reduced. *We* will calculate the new level of cover for each of the covers in *your plan*.

If *you* want to keep *your benefit* at the same level until the *date of expiry*, the premium will increase. *We* will calculate the premium for each of the covers in *your plan*.

If *you* have *Vitality Select* and *you* remove Vitality Optimiser, *your Vitality Select* will also be removed from *your plan*.

If *you* have *Vitality Plus* and remove Vitality Optimiser from *your plan, your Vitality Plus* will continue in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change.

D4.7 Removing Wellness Optimiser

If *your plan schedule* shows that *you* have chosen Wellness Optimiser, *you* can apply to remove this option at any time.

You are only eligible for Wellness Optimiser under this *plan* if *you* also have *Vitality Plus* or *Vitality Select*. For more information on *Vitality Plus* or *Vitality Select*, please see *your* separate terms and conditions. If *your Vitality Plus* or *Vitality Select* is cancelled, Wellness Optimiser will be removed from *your plan*.

If Wellness Optimiser is removed, *your plan* will change as follows:

- *You* can keep *your* premium at the same level and reduce *your* level of cover
- *You* can keep *your* cover amounts at the same level and *your* premium will increase.

If *you* have *Vitality Select* and *you* remove Wellness Optimiser, *your Vitality Select* will also be removed from *your plan*.

If *you* have *Vitality Plus* and remove Wellness Optimiser from *your plan, your Vitality Plus* will continue in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change.

D4.8 Removing Premium Optimiser or Interest Rate Optimiser

If *your plan schedule* shows that *you* have chosen Premium Optimiser or Interest Rate Optimiser, *you* can apply to remove these options at any time.

If Premium Optimiser or Interest Rate Optimiser are removed *your* premiums will change as follows:

- If *you* want to keep *your* premium for *Whole of Life* Cover or *Whole of Life* Cover with Lifestyle Cover at the same level, the level of cover will be reduced
- If *you* want to keep *your Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover at the same level, the premium will increase.

D5. CLAIMING A BENEFIT

This provision explains:

- How and when *you* can claim a *benefit* under *your plan*
- Who *we* will pay the *benefit* to
- The exclusions to claiming a *benefit*

D5.1 Who we will pay the benefit to

We will pay the *benefit* to the person legally entitled to receive it.

D5.2 Telling us about a claim

If a claim needs to be made under *your* cover, *we* need *you* to tell *us* as soon as possible. *We* describe the exact notification requirements for each type of cover in the individual cover sections of these *plan* provisions.

D5.3 What we need before we can settle a claim

For the purpose of complying with *our* Anti-Money Laundering obligations, *we* may require a claim recipient to give *us* satisfactory proof of their identity.

For a Life Cover claim, *we* will need proof that the *person covered* has died. If *your plan* is arranged on a *joint life second death* basis *we* will need proof that both people covered have died. *We* may also need proof of the age(s) of the person(s) covered, if *we* have not already received it. For each type of cover, *we* describe what *we* need before *we* can settle a claim in the individual cover sections of these *plan* provisions.

If *your plan* has been placed in trust, *we* will require a copy of the original trust deed. Please ensure that the trustees keep this in a safe place.

D5.4 Confirming that you are incapacitated

For some types of cover, *we* may need to assess whether *you* are incapacitated. To make this assessment, *we* will need an *appropriate medical specialist* to confirm that *you* have an ongoing inability to perform a series of *functional activity tests*. *You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. *We* explain these tests below. The individual cover sections in these provisions will explain which tests in section C2.6.

D5.5 Making a claim when you are abroad

If *you* are outside the *United Kingdom*, the Channel Islands or the Isle of Man when *you* make a claim for anything other than Life Cover, *we* will need an *appropriate medical specialist* to confirm all *your* information and *your* diagnosis. *We* will consider information from *appropriate medical specialists* in *permitted countries*.

D5.6 Exclusions

General exclusions

If the illness, condition or procedure *you* are claiming for is a consequence of an excluded condition, *we* will not pay any *benefit* under Waiver of Premium on Incapacity, LifestyleCare Cover or Mortgage Free Cover.

This applies to the exclusions that were included in *your* acceptance terms at the start of the *plan*.

We will not pay any *benefits* for Waiver of Premium on Incapacity, LifestyleCare Cover or Mortgage Free Cover if *your* claim arises, either directly or indirectly, because *you* unreasonably do not seek or follow medical advice.

Exclusions for Life Cover

We will not pay a claim for Life Cover if one of the people covered dies as a result of *suicide* within 12 months of:

- The *start date* of the Life Cover
- The date they were added to the *plan*
- The date the *plan* was re-instated if it was suspended because *your plan premium* was not paid

If *you* have increased the Life Cover under *your plan*, and any of the people covered dies as a result of *suicide* within 12 months of the increase, *we* will not normally pay the additional amount as part of the claim.

Exclusions for LifestyleCare Cover

Appendix 2 explains the exclusions that apply to claims for specific illnesses under LifestyleCare Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 2. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* LifestyleCare Cover. If *we* have, and *you* make a claim *we* will not pay a *benefit* if *our* Chief Medical Officer believes that the illness is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to *us* when *you* applied for cover.

Exclusions for Mortgage Free Cover and Immediate Cover

Mortgage Free Cover and Immediate Cover provide limited Life Cover depending on *your plan*. For more about these, see provision C1 and provision B1.4. The exclusions that apply to Life Cover apply in the same way to Mortgage Free Cover and Immediate Cover, as appropriate.

Exclusions under Waiver of Premium on Incapacity

If the person making the claim is temporarily based outside the *permitted countries*, *we* will only waive a maximum of 12 months' *plan premium* for Waiver of Premium on Incapacity.

Exclusions for Guaranteed Insurability options

If *you* used *your* Guaranteed Insurability options to increase or add to *your* cover, *we* will not pay a claim if the illness or disability causing the claim:

- Was known when *you* used *your* Guaranteed Insurability options
- Would have resulted in *us* paying a *benefit* before *you* used *your* Guaranteed Insurability options

E. HOW VITALITY REWARDS YOU FOR BEING HEALTHY

The *Vitality Programme* helps the *person covered* improve their health – and saves *you* money at the same time. It encourages them to be healthy by offering all adults on the *plan* discounts with a range of health partners. By taking steps to improve their health they can increase their *Vitality Status*. They start on Bronze. By taking steps to look after their health, they can increase their status to Silver, Gold or even Platinum. The higher their status the greater the discounts and rewards. Some Vitality rewards and *benefits* are only available to those who are over the age of 18.

The *Vitality Programme* is provided to *you* by Vitality Corporate Services Limited.

Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

E1. YOUR VITALITY STATUS

When *you* take steps to look after *your* health, *you* could improve *your Vitality Status*. There are four *Vitality Statuses*:

VITALITY STATUS	EFFORT THRESHOLD
BRONZE	*You* start at this level on *your plan*'s *start date*. *You* may return to this level on each anniversary of *your plan*, depending on the *Vitality Status* rules at that time
SILVER	*You* will be able to achieve Silver *Vitality Status* between *plan* anniversaries if *you* make a moderate but regular effort to look after *your* health
GOLD	*You* will be able to achieve Gold *Vitality Status* between *plan* anniversaries if *you* make a strong and regular effort to look after *your* health
PLATINUM	*You* will be able to achieve Platinum *Vitality Status* between *plan* anniversaries if *you* make a very strong and regular effort to look after *your* health

E2. VITALITY OPTIMISER

With Vitality Optimiser *your* initial *plan premium* starts lower than an equivalent *plan* that does not include Vitality Optimiser and *your plan premium* may change on each *plan anniversary*. *Your plan schedule* indicates whether *you* have chosen Vitality Optimiser.

Vitality Optimiser can be added at any time during the term of *your plan* and once added, will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select* on *your plan*. Please see provision E4 for more information on *Vitality Benefits*.

We will recalculate *your plan premium* on each *plan anniversary* until the *date of expiry* of each cover.

E2.1 How we calculate the change in your plan premium

Where *you* have chosen Vitality Optimiser, *we* will recalculate *your plan premium* based on *your Vitality Status* at each *plan anniversary*. The following table shows *you* how *your plan premium* can change:

VITALITY STATUS	PREMIUM CHANGE
BRONZE	+2%
SILVER	+1%
GOLD	No change
PLATINUM	-1%

If the premiums for *your* covers change, the premiums for any waiver or premium cover could also change (see provision D1).

The premium changes in this table do not apply if *you* have Wellness Optimiser and *you* are below age 70. For more information on how Wellness Optimiser affects *your* premiums, see provision E3. After the *person covered* reaches age 70, *their plan premium* will change in the same way that a *plan* with Vitality Optimiser would change.

We will apply any change in premium as a result of Vitality Optimiser after any changes as a result of indexation, Premium Optimiser, Interest Rate Optimiser or a review of *your* premiums. This table does not apply if *you* have Wellness Optimiser. For more information on how Wellness Optimiser affects *your* premiums, see provision E3. For more about how indexation could affect *your* premiums, see provisions D1.3. For more about how a review of *your* premiums could affect *your* premiums, see provision D3. For more information about how Premium Optimiser or Interest Rate Optimiser could affect *your* premiums, see provision D1.5 and D1.6.

The maximum amount your premium can reduce

The maximum premium reduction *you* can have due to Vitality Optimiser on each of *your* covers, over their respective terms, is 5%. This means *your plan premium* for each cover can only ever reduce by a maximum of 5% compared to *your plan premium* at the start of *your* cover with Vitality Optimiser. If *you* have a *joint life plan,* this will apply to each *person covered*.

This maximum premium reduction only applies to premium changes due to Vitality Optimiser. It excludes:

- The upfront discount *you* receive due to Vitality Optimiser
- Any changes *you* make to *your* cover or *plan*
- Any premium changes that may also apply due to indexation, a review of *your* premium, or if *you* have chosen Interest Rate Optimiser or Premium Optimiser

E2.2 Premium Discounts

If *your plan* includes Vitality Optimiser or Wellness Optimiser, Premium Discounts will not apply to *your plan*. *Your plan schedule* will indicate whether *you* have chosen these options. If *your plan* does not include Vitality Optimiser or Wellness Optimiser, Premium Discounts will apply.

If *your plan* includes Premium Discounts *your plan premiums* may decrease at each *plan anniversary*.

How we calculate the decrease in your plan premium

We will recalculate *your plan premium* based on *your Vitality Status* at *plan anniversary*. The following table shows *you* how *your plan premium* can change:

VITALITY STATUS	PREMIUM CHANGE
BRONZE	No change
SILVER	-1%
GOLD	-1.5%
PLATINUM	-3%

If the premiums for *your* covers change, the premiums for any waiver or premium cover could also change (see provision D1).

We will apply any change in premium because of *your Vitality Status* after any changes as a result of indexation, Premium Optimiser, Interest Rate Optimiser or a review of *your* premiums. For more about how indexation could affect *your* premiums, see provision D1.3. For more about how a review of *your* premiums could affect *your* premiums, see provision D3. For more information about how Premium Optimiser or Interest Rate Optimiser could affect *your* premiums, see provision D1.5 and D1.6.

The maximum amount your premium can reduce

The maximum premium reduction *you* can have due to Premium Discounts on each of *your* covers, over their respective terms, is 30%. This means *your plan premium* for each cover can only ever reduce by a maximum of 30% compared to *your plan premium* at the start of *your* cover with Premium Discounts. If *you* have a *joint life plan*, this will apply to each *person covered*.

This maximum premium reduction only applies to premium changes due to Premium Discounts. It excludes:

- Any changes *you* make to *your* cover or *plan*
- Any premium changes that may also apply due to indexation, a review of *your* premium, or if *you* have chosen Interest Rate Optimiser or Premium Optimiser
- The upfront discount *you* receive if *you* later add Vitality Optimiser or Wellness Optimiser

We will allow *your plan premium* to reduce below *our* normal allowable minimum if the reduction is a result of Premium Discounts.

E3. WELLNESS OPTIMISER

With Wellness Optimiser, *your* initial *plan* premium starts lower than the premium of an equivalent *plan* that does not include Wellness Optimiser.

Wellness Optimiser can be added at any time during the term of *your plan* and once added, will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select* on *your plan*. Please see provision E4 for more information on *Vitality Benefits*.

At each *plan anniversary your* premiums will change according to both *your*:

- *Wellness Status,* and
- *Vitality Status*

Please see provision E1 for details regarding *your Vitality Status*.

E3.1 Your Wellness Status

There are three *Wellness Statuses:*

- Select
- Healthy
- Everyday

Your Wellness Status is based on *your* clinical health factors. Please see *your* Vitality Terms and Conditions for information on how *we* define *your Wellness Status*.

E3.2 How your Wellness Status and Vitality Status affect your plan premium

The following table shows *you* how *your plan premium* can change each year depending on *your Wellness Status* and *your Vitality Status*.

WELLNESS STATUS	VITALITY STATUS			
	BRONZE	SILVER	GOLD	PLATINUM
Select	+2%	+1%	0%	-1%
Healthy	+3%	+2%	+1%	0%
Everyday	+4%	+3%	+2%	+1%

Your plan premium will change at each *plan anniversary* depending on both *your Vitality Status* and *your Wellness Status* until the *plan anniversary* immediately before *your* 70th birthday. After *your* 70th birthday, *your plan premium* will only change by *your Vitality Status* at each *plan anniversary*. If *you* have a *joint life plan*, this will affect each person separately. This means for each *person covered*, their Wellness Optimiser premiums will only change by their *Vitality Status* at each *plan anniversary* after their 70th birthday. This will work the same way as Vitality Optimiser works. Please see provision E2.1 'How *we* calculate the change in *your plan premium*' for more information on this.

The maximum amount your premium can reduce

The maximum premium reduction *you* can have due to Wellness Optimiser on each of *your* covers, over their respective terms, is 5%. This means *your plan premium* for each cover can only ever reduce by a maximum of 5% compared to *your plan premium* at the start of *your* cover with Wellness Optimiser. If *you* have a *joint life plan*, this will apply to each *person covered*.

This maximum premium reduction only applies to premium changes due to Wellness Optimiser. It excludes:

- The upfront discount *you* receive due to Wellness Optimiser
- Any changes *you* make to *your* cover or *plan*
- Any premium changes that may also apply due to indexation, a review of *your* premium, or if *you* have chosen Interest Rate Optimiser or Premium Optimiser

E3.3 When your premium will not increase

If *you* get a *serious illness* that *we* class as Severity A, *we* will not increase *your plan premium* due to Wellness Optimiser. However, if *you* are eligible for a premium reduction, *we* will continue to apply this to *your plan premium*. *You* do not need to have Serious Illness Cover for this to apply.

Your plan premium may continue to increase if *you* have selected indexation, Premium Optimiser or Interest Rate Optimiser, or due to a review of *your* premiums.

Please see Appendix 1 for a full list of the severity A *serious illnesses we* cover. Please see provision D1.3 for more information on how *your plan premium* changes due to indexation, D1.6 for how *your plan premium* changes due to Premium Optimiser, or D1.7 for how *your plan premium* changes due to Interest Rate Optimiser. Please see provision D3 for more information on reviewable premiums.

E4. VITALITY BENEFITS ON YOUR PLAN

E4.1 Vitality Benefits for plans without Vitality Optimiser or Wellness Optimiser

For *plans* without Vitality Optimiser or Wellness Optimiser, *you* are able to add *Vitality Plus* to *your plan*. *You* can choose to include *Vitality Plus* on *your plan* from the *plan's start date*, or within three months of the *plan's start date*. Outside of this period, *Vitality Plus* can only be added at each anniversary of the *plan*.

You will be subject to a minimum *plan premium* to add *Vitality Plus* to *your plan*. Please contact *your* financial advisor for further details.

E4.2 Vitality Benefits for plans with Vitality Optimiser or Wellness Optimiser

For both Vitality Optimiser and Wellness Optimiser *your plan* will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select*. *Your plan schedule* indicates whether *your plan* includes *Vitality Plus* or *Vitality Select*.

Your initial *plan premium* will define which *Vitality Benefits your plan* includes, either *Vitality Plus* or *Vitality Select*. If *your* initial *plan premium* is:-

- Below £45* for a *single life plan* or £60* for a *joint life plan* then *Vitality Select* will automatically be included on *your plan*,
- £45* or above for a *single life plan* or £60* or above for a *joint life plan* then *Vitality Plus* will automatically be included on *your plan*.

** This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Select) you will receive on your plan. This applies to all plans that have selected Vitality Optimiser or Wellness Optimiser now. If you later choose to add Vitality Optimiser or Wellness Optimiser, the premium requirements which determine your Vitality Benefits may have changed.*

E4.3 How my Vitality Benefits may change during the duration of my plan

There will be no change to *your Vitality Benefits* as a result of a change to *your* premiums for any of the following:-

- *Vitality status* premium adjustments, or
- *Wellness status* premium adjustments, or
- Indexation, or
- Premium Optimiser adjustments, or
- Interest Rate Optimiser adjustments, or
- Review of *your* premiums, or
- Existing covers expire, or
- A valid claim on existing cover.

However, the *Vitality Benefits you* have access to may change if *you* make one or more of the following changes to *your plan*:-

- Add or increase covers,
- Remove or reduce covers,
- Remove a *person covered* from a *joint life plan* or add a *person covered* to *your* existing *plan*,
- Split a *joint life plan* into two *single life plans*,
- Change the *fixed term* of *your* covers,
- Change *your deferred period*,
- Reduce *your* premiums because of a change in *your* circumstances.

The *Vitality Benefits you* have access to will only change if, as a result of one of the above, *your plan premium* changes. This will only happen in one of following ways:-

1. *Your plan* is a Vitality Optimiser or Wellness Optimiser *plan* including *Vitality Select* and *you* make a change to *your plan* such that *your plan premium* increases to £45* (single life) or £60* (joint life) or more. In this case *Vitality Select* would be removed from *your plan* and replaced with *Vitality Plus*.
2. *Your plan* is a Vitality Optimiser or Wellness Optimiser *plan* including *Vitality Plus* and *you* make a change to *your plan* such that *your plan premium* reduces below £45* (single life) or £60* (joint life). In this case *Vitality Plus* would be removed from *your plan* and replaced with *Vitality Select*.
3. *Your plan* includes *Vitality Plus* (and is not a Vitality Optimiser or Wellness Optimiser *plan*) and *you* make a change to *your plan* such that *your plan premium* reduces below £45* (single life) or £60* (joint life). In this case *Vitality Plus* would be removed from *your plan*.

** This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Select) you will receive on your plan. This applies to all plans that have selected Vitality Optimiser or Wellness Optimiser now. If you later choose to add Vitality Optimiser or Wellness Optimiser, the premium requirements which determine your Vitality Benefits may have changed.*

E4.4 Cancelling your Vitality Benefits

E4.4.1 Vitality Select

If *your Vitality Select* is cancelled, Vitality Optimiser or Wellness Optimiser will be removed from *your plan* and *your* premiums will change as described in provision D4. Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

If *you* cancel *Vitality Select, you* may not be able to add it again to *your plan* after it has been cancelled.

E4.4.2 Vitality Plus

If *your plan* is not a Vitality Optimiser or Wellness Optimiser *plan* and *Vitality Plus* is cancelled, it will be removed from *your plan* and there will be no change to *your* premiums.

If *your plan* is a Vitality Optimiser or Wellness Optimiser *plan* and *your Vitality Plus* is cancelled, Vitality Optimiser or Wellness Optimiser will be removed from *your plan* and *your* premiums will change as described in provision D4. If *you* remove Vitality Optimiser or Wellness Optimiser from *your plan, your Vitality*

Plus will continue in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change. Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

If *you* cancel *Vitality Plus you* can apply to add it again at a future *plan anniversary*, provided that *you* do this at least six months after the date *Vitality Plus* was cancelled. However, *you* may not be able to add Vitality Optimiser or Wellness Optimiser to *your plan* again after it has been removed.

E5. THE VITALITY COMMITMENT

The *Vitality Programme* will give *you* access to discounts and rewards for the duration of *your plan*. Because *your plan* could last many years, the discounts and rewards offered to *you* may need to be revised from time to time.

As new opportunities and technologies emerge, the way *you* are rewarded for being healthy will change over time. The discounts and rewards depend on relationships with third party providers and the range of services these providers offer.

Please refer to the separate terms and conditions for more information on the *Vitality Programme*. This includes changes to the way *you* are awarded *Vitality Programme* points, the eligible activities, incentives and partners offered, and how *your Vitality Status or Wellness Status* could change as a result.

If *you*'re not satisfied with the changes, *you* may cancel *your plan* in accordance with the information in provision F3.

If *you* would like details of the incentives and rewards that are in effect at any time, *you* can call *us* on 0345 601 0072.

F. GENERAL TERMS AND CONDITIONS

F1. WHEN YOUR PLAN ENDS

Your plan will end when the first of the following occurs:

- The death of the *person covered* in a *single life plan*, or one of the *persons covered* in a *joint life first death plan* or both *persons covered* in a *joint life second death plan*
- All covers under *your plan* have reached their *date of expiry*
- *You* cancel *your* plan

F2. WHEN WE CAN MAKE CHANGES TO YOUR PLAN

We may change the terms of *your plan* for any of the following reasons:

a. To respond, in a proportionate manner, to changes in the way *we* administer plans of this type.

b. To respond, in a proportionate manner, to changes in technology or general practice in the life and pensions industry.

c. To respond, in a proportionate manner, to changes in taxation, the law or interpretation of the laws of England and Wales, decisions or recommendations of an Ombudsman, regulator, *UK* Court, the European Court of Justice, or similar person, or any code of practice with which *we* intend to comply (with the exception of Guaranteed Premiums, unless such change in required by the Financial Services Regulator from time to time).

If *we* consider any variation to these conditions is to *your* advantage or is necessary to meet regulatory requirements, *we* may make the change immediately and will tell *you* at a later date.

We will tell *you* in writing of any change *we* consider is to *your* disadvantage (other than any change necessary to meet regulatory requirements) at least 60 days before the change becomes effective, unless it is not possible for *us* to do this, in which case *we* will give *you* as much notice as *we* can.

F3. CANCELLING YOUR PLAN

When you may cancel your plan

You can cancel *your plan* at any time.

If *you* cancel within 30 days of receiving *your plan* details, *we* will refund *your plan premium*, as long as *you* have not made a claim.

If *you* pay *your* premiums monthly and *you* cancel *your plan* after 30 days, *we* will not refund *your plan premium*.

If *you* pay *your* premiums annually and *you* cancel *your plan* after 30 days, *we* will calculate *your* premium as though it were monthly and will refund *you* for the remainder of the *plan year* from the cancellation date.

To cancel *your plan*, *you* will need to contact *us* via one of the following methods:

Phone:	0800 030 4903
Email:	VitalityLife_CreditControl@vitality.co.uk
Post:	VitalityLife, Sheffield, S95 1BW

When we may cancel your plan

FRAUD

We may cancel *your plan* if *you*:

- Make any untrue statements to *us*
- Fail to disclose any material facts relevant to *your plan* or a claim
- Act fraudulently in any other way

If *we* cancel *your plan* because of fraud, *your plan* will become void.

OTHER REASONS

The Financial Conduct Authority (FCA) publishes an Insurance Conduct of Business Sourcebook that sets out the rules to do with when it is reasonable for a company to cancel a *plan* like this one. *We* will apply these rules to *your plan*. *We* will apply these rules to the *plan* as a whole, rather than to each type of cover separately. The FCA may update their rules during the life of *your plan*. For the latest rules, please contact the FCA at consumer.queries@fca.org.uk or by phoning 0800 111 6768. *You* can also download the Conduct of Business Sourcebook at www.fca.org.uk.

F4. CASH VALUE

Your plan does not have any cash value.

F5. MIS-STATEMENT OF AGE

If any *person covered* under the *plan* did not state their age accurately when they applied, *we* will change the terms of the *plan* in a way that *we* consider to be just and reasonable.

F6. ASSIGNMENT

If *you* assign any of *your* legal rights under the *plan* to someone else, including changing who is entitled to the *plan*, *you* need to give *us* written notice. Please do this by writing to: Vitality Life Limited, Sheffield, S95 1BW.

We will not change who is entitled to *benefits* under *your plan* until *we* receive this notice.

F7. PAYMENTS AND CURRENCY

All payments *we* make to *you* will be to a bank account registered in the *United Kingdom*. In addition, all payments made to *us* must be from a bank account registered in the *United Kingdom*. *You* must also be the registered account holder of the bank account; alternatively there must be an *insurable interest* between *you* and the registered account holder of this bank account.

We cannot make any payments to *you*, nor accept any payments from *you* if the bank account is registered outside the *United Kingdom*.

All payments must be in pound sterling (GBP).

F8. IMPACT ON MEANS TESTED BENEFITS

Payments of *benefits* from this *plan*, including LifestyleCare Cover may affect *your* entitlement to receive means tested *benefits* from the government or *your* local authority. *We* recommend that *you* seek professional advice if *you* are concerned about this.

F9. COMPLAINTS

Our commitment to you

We understand that sometimes things can go wrong. *You* are important to *us*, so if *you* have reason to complain *we* want to know. *We* will try to resolve *your* complaint quickly in a professional and helpful way.

How to contact us

You can contact *us* by letter, phone or email. It will help if *you* give *your* name, address and *plan* number. Either send *us* a secure message via *our* Member Zone at vitality.co.uk/member. Call *us* on the number shown on *your* certificate of insurance.

Or you can write to us at:

VitalityLife Customer Services, Sheffield, S95 1BW

How we will deal with your complaint

The time it takes to resolve *your* complaint will depend on how complex it is and how much investigation *we* have to do. *We* will always try to resolve *your* complaint as quickly as possible, keeping *you* informed of *our* progress.

We will:

- Acknowledge *your* complaint promptly
- Tell *you* who is dealing with *your* complaint so contacting *us* is easier. This person will be a trained complaint handler not directly involved with *your* case before the complaint
- Fully investigate *your* complaint and send *you* a detailed report about *our* findings. *We* will clearly explain the reasons behind *our* decision and what action *we* will take to put things right, if appropriate
- Update *you* every four weeks if the investigation is not complete and explain the reason for the delay

What to do if you are still not happy with the outcome

We want to resolve complaints to *your* satisfaction whenever possible. If *we* cannot reach agreement with *you*, *you* can refer *your* complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms. If *you* are going to ask the Financial Ombudsman to review *your* case, *you* should

do so within six months of *our* giving *you our* final decision on *your* complaint. *You* can contact the Financial Ombudsman in the following ways:

The Financial Ombudsman Service,

Exchange Tower,

London, E14 9SR

Enquiry line: 0800 023 4567

Fax number: 020 7964 1001

Website: www.financial-ombudsman.org.uk

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

If *you* contact the Financial Ombudsman Service, this does not affect *your* right to take legal action if *you* are dissatisfied with and do not accept the outcome of the review.

F10. IF WE CANNOT MEET OUR OBLIGATIONS

We are covered by the Financial Services Compensation Scheme (FSCS). *You* may be entitled to compensation from the scheme if *we* cannot meet *our* obligations. Whether or not *you* are able to claim and how much *you* may be entitled to will depend on the specific circumstances at the time.

For further information about the scheme please contact the FSCS at: www.fscs.org.uk.

F11. INSURABLE INTEREST

You must have an *insurable interest* in the *person covered* when *you* take out the *plan*. If *insurable interest* does not exist, *your plan* will become void.

F12. LAW

We will govern and interpret *your plan* according to the applicable laws and regulations of England and Wales. Where *we* are required to change *your plan* under these laws and regulations *we* will do so. *Your plan* will be subject to the exclusive jurisdiction of the English courts.

Anyone who is not party to this contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this *plan*. *We* include the *planholder* and any other *person covered* as party to the *plan*.

Sanctions

We will not be responsible or liable to make any payment to *you* or any third party covered under *your plan* howsoever arising (including, but not excluding, payment of any *benefit*) when doing so would put *us* in breach of any applicable economic sanctions, laws and regulations of the European Union, the *United Kingdom*, the United Nations or any other legal regime or code of practise *we* may consider applicable.

Economic sanctions are subject to changes and include prohibiting the transfer of funds to a sanctioned country, freezing the assets of a government, the corporate entities and residents of a sanctioned country, or freezing the assets of specific individuals or corporate entities.

If *you*, or any third party who is covered under *your plan*, are the subject of sanctions, *we* may not be able to provide cover under *your plan* and *we* may terminate *your plan* with *us*.

F13. DATA PROTECTION NOTICE

Why should you read this notice?

We think it is important for all of *our* members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that *we* comply with the data protection legislations. The following is a summary of *our* Privacy Policy. For details of the full Privacy Policy (effective from 25 May 2018) please visit vitality.co.uk/privacy.

Who Vitality are

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of Vitality Health Limited ("VitalityHealth"), Vitality Life Limited ("VitalityLife") and ("VitalityInvest"). Together "Vitality" arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. Vitality Corporate Services Limited is the data controller for the management of interactions between *us* and *you*; VitalityHealth and VitalityLife and VitalityInvest respectively are the data controllers for the personal data and special category data that *you* or *your* representative provide to *us*.

Sharing your personal data

We may need to share *your* personal data for legal or regulatory purposes, with *your* authorised representative where *you* have appointed an insurance or financial adviser or with other companies in order provide *our* products and services.

Processing claims

In the event of a claim *we* may require a medical report from *your* GP. Such a report will only be requested with *your* consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from *your* GP will be limited to only the information relevant to *your* claim. *You* have the right to request to see the GP's report and to request any amendments be made by the GP where *you* consider the data to be inaccurate. The GP may agree to this at his/her discretion. *You* will be informed about the AMRA process at the time *we* request *your* consent to enable *us* to ask *your* GP for a report.

We may have to give some information about *your plan* and about *your* health or medical status to those involved in *your* treatment or care, (and/or *your* representative if *you* have consented to *us* doing this). Any such disclosure will be done confidentially unless *you* specifically instruct *us* otherwise.

If the claimant is aged 13 or over *we* will address any correspondence to the claimant in order to protect their right to confidentiality. The *planholder* will be informed only that a claim has been made and the value of the payment *we* have made; no details about the medical condition or treatment provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform *us* at the time the claim is made.

If *you* have another insurance *plan* that covers the same costs that *you* are claiming from *us* then *we* may also disclose *your* relevant personal data to that other insurer so that *we* can ensure *we* only pay *our* proportion of the claim.

Your information, and that of others also covered by the *plan*, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Marketing

Vitality Corporate Services Limited would like to send *you* information about *our* products and future products, which currently include health and life insurance, investments and general insurance. *We* are focused on bringing exciting new products to *you* and to enhance those already available by offering improved services and *benefits* as a Vitality member.

When *you* purchase a product from Vitality *you* will be provided with access to the Member Zone where *you* can manage *your* marketing preferences and choose *your* preferred method of receiving information about *our* products, services and the *benefits* at any time.

You can manage *your* marketing preferences and choose *your* preferred method of receiving information about *our* products, services and the *benefits* at any time by calling *our* customer services team.

Data protection complaints

We want all of *our* members to be happy with the way their personal data, health data and medical information has been processed by *us*. If *you* are unhappy about the way *we* have managed *your* personal data *we* would like to know about it as *we* are constantly striving to ensure *we* do the right thing and *we* would like to be able to put things right.

You'll find the contact details for *our* complaints teams at:

vitality.co.uk/legal/complaints

However, if *you* are still dissatisfied *you* have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at:

ico.org.uk

You can also call the ICO on 0303 123 1113 or 01625 545 745, or write to them at:

Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

If *you* have any queries in respect of *your* data protection rights or the way *your* personal data is processed by Vitality, please call *us* on 0207 133 8600, or write to *us* at:

Data Protection Officer
Vitality
70 Gracechurch Street
London
EC3V 0XL

All information about data protection and privacy can be found at vitality.co.uk/privacy.

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G. DEFINITIONS

ACCEPTANCE LETTER

The letter *we* send *you* when *we* accept the application for a *plan* that names *you* as a *person covered*. This letter includes the terms of the *plan*, and any special conditions.

ACTIVITIES OF DAILY LIVING (ALSO REFERRED TO AS TASKS

DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF)

A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4.

ADOPTION

For a *single life plan*, the legal *adoption* of a *child* or *children* by the *Person Covered*.

For a *joint life plan*, the legal *adoption* of a *child* or *children* by both people covered.

ALCOHOL OR DRUG ABUSE

Inappropriate use of alcohol or drugs, including but not limited to:

- Drinking too much alcohol
- Taking controlled drugs as defined by the Misuse of Drugs Act 1971, unless they are legally prescribed
- Taking an overdose of drugs, whether legally prescribed or not

APPROPRIATE MEDICAL SPECIALIST

Someone who is:

- A medical consultant or equivalent at a hospital in the *United Kingdom* or any of the *permitted countries*
- A specialist appropriate to the cause of the claim
- Registered in the *United Kingdom* or any of the *Permitted countries*
- Not related by blood or *marriage* to the person or people covered
- Accepted by *our* Chief Medical Officer

BENEFIT

Money *we* pay to *you* if *you* make a successful claim under the *plan*.

BODY SYSTEM CATEGORY

The category of *serious illnesses* that affect a particular body system, as outlined in the appendices.

CAREER BREAK

A specific period that *you* take away from *your own occupation*, after which *you* intend to return to the same position.

CHILD/CHILDREN

A person who:

- Has not reached the first *plan anniversary* after their 18th birthday (23rd birthday if they are in full-time education), and
- Is *your* natural *child*, adopted *child* or *step-child*, and
- Is looked after by, or financially dependent on, *you*.

CHILDBIRTH

For a *single life plan*, the birth of a *child* or *children* to the *person covered*.

For a *joint life plan*, the birth of a *child* or *children* to both people covered.

CIVIL PARTNERSHIP

This applies to same sex *marriages* only, registered in terms of the Civil *Marriages* Act 2004. For a *single life plan*, a partnership between the *person covered* and another person, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

For a *joint life plan*, a partnership between the two people covered, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

CONFIRMED EXPENDITURE

This is the expenditure *we* will take into account when determining the Spend Protector *Benefit* which *we* will pay *you* in the event of a claim. *We* reserve the right to ask for documentary evidence at the time of *your* claim to enable *us* to calculate the amount of Spend Protector *Benefit* that *we* will pay *you*.

Documentary evidence includes, but is not limited to:

- Copies of bills for regular household expenditure.
- 3 months bank statements covering the period immediately before *your* claim.

If *we* have not received documentary evidence *we* will calculate the *confirmed expenditure* with reference to the most recent edition of the Family Spending survey, published by the Office for National Statistics.

CURRENT BENEFIT AMOUNT

The *current benefit amount* is the amount on which *we* would base any payments for a successful claim.

The *current benefit amount* can change over time. It can change because *you* have chosen an *Indexed account* or a *Decreasing account*. It can also change because *you* have made a successful claim or because *you* have asked *us* to change *your plan*.

The *current benefit amount* will be shown on the most recent *plan schedule*, servicing schedule or anniversary letter.

DATE OF EXPIRY

The date a cover ends. The *date of expiry* of each of *your* covers is shown on the *plan schedule*.

DECREASING ACCOUNT

A *plan account* that decreases in value over the life of the *plan*. It decreases in the same way as a repayment mortgage that has a 10% annual equivalent interest rate. If the *plan* is *fixed term*, *you* can choose to have a *decreasing account*. If *you* have Disability Cover, *you* can also choose for it to decrease in this way.

DEFERRED PERIOD

The period during which an insured person must be ill or disabled before *we* will pay any *benefit*.

EMPLOYED/EMPLOYMENT

Paid work under a contract of *employment* and paying Class 1 National Insurance contributions.

FIRST PERSON COVERED

For a *single life plan*, this is the insured person. For a *joint life plan*, this is the insured person with the highest amount of Life Cover when the *plan* starts. If there is no Life Cover in the *plan*, then it is the insured person with the highest amount of Serious Illness Cover or Income Protection Cover when the *plan* starts. If the amounts of these covers are the same for both people, the *first person covered* is the first person named on the application form.

FIXED TERM

The term of a cover is how long the cover lasts. A *fixed term* has a defined *date of expiry*.

FUNCTIONAL ACTIVITY TESTS

Specific sets of everyday physical or functional activities that help to show how able someone might be to work or look after themselves. The two kinds of tests are called *work tasks* and *activities of daily living* (sometimes *we* refer to these as *tasks designed to assess whether you can look after yourself ever again). We* may refer to these activities if *you* make a claim to do with incapacity.

FULL-TIME OCCUPATION

An *occupation* that normally takes up at least 16 hours a week on a regular basis.

HOUSEPERSON

A person who has a *full-time occupation* maintaining the home or caring for one or more dependants

INDEXED ACCOUNT

A *plan account* that is designed to increase in value on each *plan anniversary*. The increase is a percentage of the current *plan account*. This percentage will be equal to the *Retail Prices Index* that applies exactly five months before the *plan anniversary*, subject to a maximum of 10% and a minimum of 0%.

If *you* have Optional Serious Illness Cover for *Children*, Disability Cover or Income Protection Cover or Family Income Cover, *you* can also choose for any of these covers to increase in this way.

INSURABLE INTEREST

The following conditions must be satisfied for an *insurable interest* to exist:

- The person taking out the *plan* must stand to be financially worse off if the life assured dies or becomes seriously ill (to a degree capable of valuation); and
- There must be a *legally recognised relationship* between the person taking out the *plan* and the life assured.

IRREVERSIBLE

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

JOINT LIFE PLAN

A *plan* that provides cover for two people. *We* call these two people the *first person covered* and the *second person covered*.

JOINT LIFE FIRST DEATH

A cover where the payment is made when the first of the *persons covered* dies or is diagnosed with a *terminal illness*.

JOINT LIFE SECOND DEATH

A cover where the payment is made when the last of the *persons covered* dies or is diagnosed with a *terminal illness*.

LEGALLY RECOGNISED RELATIONSHIP

A *legally recognised relationship* includes:

- An individual has an unlimited *insurable interest* in their own life;
- Legally married couples, or registered civil partners, have unlimited *insurable interest* in each other's lives;
- Employee/employer relationship provided there would be detrimental financial impact to an employer in the event that the employee dies or becomes seriously ill;
- A partner, of a partnership, has *insurable interest* in the life of a co-partner;
- Trustees accountable to pay the inheritance tax on the death of a beneficiary have an *insurable interest* in that beneficiary; and
- Creditor on the life of a debtor, however, only up to the amount of the debt.

LEVEL ACCOUNT

A *plan account* that stays the same unless *you* make a successful claim or change a cover. If *you* have Optional Serious Illness Cover for *Children*, Disability Cover or Income Protection Cover, *you* can also choose one or more of these covers to stay level in this way.

LIFE-CHANGING EVENT

A single identifiable event or condition that causes *you* to make a claim.

LONG TERM INTEREST RATE

The 20 year rate from the Bank of

England's *UK* government liability nominal spot rate curve. This is the rate which is used to determine annual premium changes if the Interest Rate Optimiser option is selected.

MARRIAGE

For a *single life plan*, the *marriage* of the *person covered*, excluding re-*marriage* to a former spouse.

For a *joint life plan*, the *marriage* of the two people covered to each other, excluding their re-*marriage*.

MAXIMUM MONTHLY BENEFIT AMOUNT

- Income Protection Cover
- Income Protection Cover and Category C Disability Cover combined

The actual amount depends on whether *you* have Short Term or Primary or Comprehensive Income Protection Cover. There is more about this in provision B3.2.

NON-INVASIVE

A description of malignant or cancerous cells that have not spread into surrounding healthy cells or tissue.

OPTIMAL THERAPY

Therapy that is currently recommended by:

- The National Institute for Clinical Excellence
- NHS Prodigy Guidelines
- British (or European) Cardiac or Hypertension Societies

OCCUPATION

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

OWN OCCUPATION

The *full-time occupation you* had immediately before the start of the illness or injury (or incapacity for the purposes of Income Protection Cover).

PERMANENT/PERMANENTLY

Expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

PERMANENT NEUROLOGICAL DEFICIT WITH PERSISTING CLINICAL SYMPTOMS

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout *your* life. Symptoms that are covered include:

- Numbness
- Hyperaesthesia (increased sensitivity)
- Paralysis
- Localised weakness
- Dysarthria (difficulty with speech)
- Aphasia (inability to speak)
- Dysphagia (difficulty in swallowing)
- Visual impairment
- Difficulty in walking
- Lack of coordination
- Tremor
- Seizures
- Lethargy
- Dementia
- Delirium
- 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.

PERMITTED COUNTRIES

Andorra, Australia, Austria, Belgium, Canada, Channel Islands, Denmark, Finland, France, Germany, Gibraltar, Greece, Isle of Man, Italy,

Liechtenstein, Luxembourg, Malta, Monaco, The Netherlands, New Zealand, Norway, Portugal, Republic of Ireland, San Marino, Spain, Sweden, Switzerland, *United Kingdom* and United States of America.

PERSON COVERED

The *first person covered* or the *second person covered* as appropriate.

PLAN

The VitalityLife *plan*.

PLANHOLDER

The owner of the *plan*.

PLAN ACCOUNT

An amount that determines how much *we* can pay out if *you* make a claim under Life Cover or Serious Illness Cover. There are special rules for *simultaneous claims* under Serious Illness Cover. For more about this, see provisions B2.4 to B2.6.

PLAN ANNIVERSARY

The anniversary of the *start date* of the *plan*.

PLAN PREMIUM

This is the total premium payable in respect of the covers in *your plan*. This does not include any fee which *you* may be charged for *Vitality Plus*, Vitality Optimiser or Wellness Optimiser in accordance with the separate Vitality terms and conditions for the healthy living part of *your plan*.

PLAN SCHEDULE

A document that shows:

- The cover or covers in the *plan*
- The amount of each cover
- The premium for each cover
- The *date of expiry* of each cover, unless the cover is *whole of life*
- Any special conditions

PRE-EXISTING MEDICAL CONDITION

A medical condition (whether or not a diagnosis was made or any symptoms were evident) which existed before any of these dates, as appropriate:

- The *start date* of the *plan*
- The *start date* of the relevant cover
- The relevant *child* reaching the age of one month (only for Optional Serious Illness Cover for *Children*, Core Serious Illness Cover for *Children*, Family Income Cover (Serious Illness Cover for *Children*) and Education Cover (Serious Illness Cover for *Children*)
- The legal *adoption* of the relevant *child* (only for Optional Serious Illness Cover for *Children*, Core Serious Illness Cover for *Children*, Family Income Cover (Serious Illness Cover for *Children*) and Education Cover (Serious Illness Cover for *Children*)
- The date that the *plan* is reinstated following non-payment of *plan premiums*

PRE-INCAPACITY EARNINGS

This depends on whether *you* are *employed* or *self-employed*, as explained below:

IF YOU ARE EMPLOYED

Your average gross monthly earnings for PAYE purposes from *your own occupation* in the 12 months before the incapacity. This includes:

- The last 12 months' payslips or the last P60 certificate.*
- Salary before any tax or national insurance contributions have been taken off.
- Regular commission or bonus payments.
- Regular overtime payments.
- P11D *benefits* in kind as long as these will be lost in the event of incapacity.
- Dividend income from this *employment* as long as:
  - It is paid directly to *you* in lieu of salary
  - It ceases in the event of incapacity
  - It is consistent with the salary, and
  - The company's trading position reasonably allows *you* to receive it on a continuing basis.

*(Please note that if *you* make a claim for Income Protection Cover and *you* have not verified *your* earnings *we* will require *your* last 12 months, payslips or *your* most recent P60 certificate as evidence of *your* income.)

IF YOU ARE SELF-EMPLOYED

Your average gross monthly taxable earnings from *your* business in the 12 months before the incapacity. *You* can take off from this figure any amounts allowable as expenses against income tax. *You* must not take off from this figure any income tax or national insurance contributions.

When *you* work out *your pre-incapacity earnings*, do not include any of these:

- Income from savings
- Income from rental of property or goods
- Dividends which are not included in the box above

PRE-MALIGNANT

A description of abnormal or cancerous cells that might develop into a malignant tumour but have not yet done so.

PROGRESSIVE CLAIM

A second claim that happens in the following way:

1. A *person covered* has a *life-changing event* that causes a *serious illness*
2. They make a first successful claim for that *serious illness*
3. They later make a second claim which is for the same *serious illness* or another *serious illness* that was caused by the same *life-changing event*

PROMOTION OR CHANGE IN JOB LEADING TO A SALARY INCREASE

An increase in basic salary as a direct result of one of these single events:

- A promotion
- The award of a recognised professional qualification
- A change of both *employment* and employer

RESIDENT OF THE UNITED KINGDOM

A person who legally lives in the *United Kingdom* for at least 183 days in any 365 day period.

RESIDUAL DEFICIT

Persisting loss or incapacity that is expected to last throughout *your* life.

RETAIL PRICES INDEX

The measure of *UK* inflation known as the *Retail Prices Index* (all items), as published by the Office for National Statistics. If the *UK* Government replaces that index with another index of *UK* retail price increases, *we* shall use that replacement index.

SECOND PERSON COVERED

If two people are insured on a *plan*, this is the insured person who is not the *first person covered*. This person cannot be a *child*.

SELF-EMPLOYED

- Actively working alone, with others in a partnership, or as a member of a limited liability partnership
- Paying Class 2 National Insurance contributions
- Assessable for income tax under Schedule D Case I or II

SERIOUS ILLNESS

An illness or condition that:

- Is defined in Appendix 1
- Meets *our* criteria for that illness or condition

The *serious illnesses* are divided into body system categories. These categories are set out in Appendix 1.

SIMULTANEOUS CLAIMS

Two or more *serious illness* claims that meet all of the following criteria:

- They are being made by more than one *person covered* or *child* under a *plan*
- They are a result of the same *life-changing event*
- They are within three calendar months of that *life-changing event*

SINGLE LIFE PLAN

A *plan* that provides cover for one person only, referred to in this *plan* as the *person covered*. This does not include any cover provided for *children*.

START DATE

The date when cover under the whole *plan* begins or, where relevant, when a particular cover begins.

SUICIDE

An event where, in *our* reasonable opinion, the life insured took their own life voluntarily and intentionally or through intentional self-inflicted injury.

SURVIVAL PERIOD

The period after an insured event that the insured person has to survive before a claim becomes valid.

TASKS DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF EVER AGAIN

A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4. *We* also call these *activities of daily living*.

TERMINAL ILLNESS - WHERE DEATH IS EXPECTED WITHIN 12 MONTHS

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

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

UNDERWRITE/UNDERWRITING/ UNDERWRITTEN

The process *we* use to assess *your* application to include or change a cover. *Underwriting* may lead *us* to:

- Accept *your* application
- Reject *your* application
- Amend one or more terms

UNEMPLOYED/UNEMPLOYMENT

Ceasing to follow *your own occupation* for more than one month, and not following any other *occupation*.

UNITED KINGDOM/UK

The *United Kingdom* of Great Britain and Northern Ireland. This excludes the Channel Islands and the Isle of Man.

UNRELATED CLAIM

A second claim that happens in the following way:

1. A *person covered* has a *life-changing event* that causes a *serious illness*
2. They make a first claim for that *serious illness*
3. They later make a second claim for another *serious illness* that was caused by a different lifechanging event

UK UNIVERSITY

Any tertiary education institution which offers a recognised *UK* qualification that meets the criteria listed in provision C7.2.

VERIFIED EARNINGS

A figure for *your* earnings that *we* verify when *you* make *your* application for Income Protection Cover or, where appropriate, for an increase to this cover. *You* may need to provide *us* with evidence of these earnings. There is more information about this in provision B3.1.

VITALITY BENEFITS

Vitality Benefits are the additional *benefits* provided to *you* under the *Vitality Programme*. They are either *Vitality Plus* or *Vitality Select* and are automatically included if *you* have Vitality Optimiser or Wellness Optimiser.

VITALITY SELECT

Vitality Select provides the opportunity to earn additional points and a number of rewards when *you* look after *your* health. *Vitality Select* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

VITALITY PLUS

Vitality Plus provides the opportunity to earn additional points and rewards when *you* look after *your* health. *Vitality Plus* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

VITALITY PROGRAMME

The discounts and rewards available to all adults on the *plan*. These are provided by Vitality Corporate Services Limited. Please refer to the separate terms and conditions for more information.

VITALITY STATUS

Your Vitality Status is a measure of how much *you*'ve done to look after *your* health. There are four statuses: Bronze, Silver, Gold and Platinum. *We* work out *your Vitality Status* using the activities *you*'ve recorded between each *plan anniversary* - the harder *you* work, the higher *your* status.

WE/US/OUR

Vitality Life Limited.

WELLNESS STATUS

Your Wellness Status is a measure of *your* current health. There are three statuses: Everyday, Healthy and Select. *We* work out *your Wellness Status* at *plan anniversary* using the valid results of the health checks *you* have recorded between each *plan anniversary* - the healthier *your* results, the higher *your* status.

WHOLE OF LIFE

The term of a cover that lasts from the cover's *start date* to the death of the insured person for *joint life first death* or the death of both *persons covered* for *joint life second death*.

WORK TASKS

A specific set of everyday physical or functional activities that help to show how able someone is to work. *We* may refer to these activities if *you* make a claim to do with incapacity. *We* list these activities in provision D5.4.

YOU/YOUR

The person named on the *plan schedule* as the *person covered*. For a *joint life plan*, either or both people covered, as appropriate.

APPENDIX 1

ILLNESSES AND CONDITIONS - DEFINITIONS FOR SEVERITY A SERIOUS ILLNESS

This *plan* follows the ABI Guide to Minimum Standards for Critical Illness Cover (2018). All model illness definitions are included.

The full definitions of the illnesses covered and the circumstances in which *you* can claim to have *your* premiums or premium increases waived are given in this Appendix. These definitions typically use medical terms to describe the illnesses and severities and how they are measured. In some cases the cover may be limited, for example some types of cancer are not covered and to make a claim for some illnesses, *you* need to have *permanent* symptoms.

Only one *benefit* will be paid under a condition where *you* have been included on an official *UK* waiting list for a procedure and have undergone surgery for the same procedure.

Functional Activity Tests

For some illness and conditions, *we* will waive *your* premium if *you* become *permanently* unable to perform certain *functional activity tests.*

To make this assessment, *we* will need an *appropriate medical specialist* to confirm that *you* have an ongoing inability to perform a series of *functional activity tests. You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. *We* explain these tests below. The individual definitions in this appendix will explain which tests are relevant to a claim under that cover.

There are two types of *functional activity tests:*

- tasks designed to assess whether *you* can look after *yourself* (*we* also refer to these as *activities of daily living* in these *plan provisions*)
- *Work tasks*

Types of functional activity tests

TASKS DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF EVER AGAIN (ALSO CALLED ACTIVITIES OF DAILY LIVING)	HOW WE DEFINE THIS ACTIVITY
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
Getting dressed and undressed	The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
Feeding yourself	The ability to feed *your*self 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.

WORK TASKS	HOW WE DEFINE THIS ACTIVITY
Walking	The ability to walk more than 200 metres on a level surface
Climbing	The ability to climb up a flight of 12 stairs and down again, using the handrail if needed
Lifting	The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table
Bending	The ability to bend or kneel to touch the floor and straighten up again
Getting in and out of a car	The ability to get into a standard saloon car, and out again
Writing	The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard

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

1.A CANCER CATEGORY - SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Advanced Cancer

An advanced malignant tumour that has progressed to at least Group Stage II of the TNM Classification of Malignant Tumours as described in the 7th edition of the International Union against Cancer (pub.Wiley-Liss). For the above definition the following are not covered:

- Stage II non-melanoma skin cancer

Advanced Chronic Lymphocytic Leukaemia

For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood. Chronic Lymphocytic Leukaemia is covered when it has progressed to Binet Stage C.

Advanced Hodgkin's Disease

This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver characterised by Reed-Sternberg cells in the abnormal lymph tissue. The staging must have progressed to at least Stage III of the Ann-Arbor system.

Advanced Non-Hodgkin's Lymphoma

This is an advanced malignant condition of the reticuloendothelial system, which includes the lymph nodes, spleen and liver. The staging must have progressed to at least Stage III of the Ann-Arbor system.

Multiple Myeloma

A malignant proliferation of plasma cells in the bone marrow with destruction of surrounding tissue on bone marrow examination. It must also cause a high level of abnormal proteins in the blood called paraproteinaemia demonstrated on protein electrophoresis. Monoclonal gammopathy of unknown significance will be excluded.

Severe Aplastic Anaemia

There must be bone marrow cellularity less than 25% plus two of the following present for a minimum of three months:

- Neutrophils less than 0.5 x 10^9/L
- Platelets less than 20 x 10^9/L
- Reticulocytes less than 20 x 10^9/L.

2. SEVERITY LEVELS

How is severity measured?

The severity of cancer is measured by staging at diagnosis, so the higher the stage at diagnosis the higher the initial *benefit*. If a cancer progresses, *we* will assess the progression of the cancer using the same staging criteria as will be used at diagnosis.

For example, if *you* are diagnosed with stage 1 breast cancer, this is stage 1 disease at diagnosis. If this metastasises (spreads, or invades different organs or parts of the body) *we* will reclassify the staging, even if *your* medical records still state 'stage 1 but with metastases to the bones'. In this example *we* will reclassify the claim as stage 4. Please tell *us* if *you* believe that the cancer has spread to other organs or parts of the body, *we* will then liaise with *your* Oncologist and/or other specialist.

For the purpose of this *plan we* will assess the staging of cancer using The International Union against Cancer TNM Classification of Malignant Tumours 7th edition (Pub.Wiley-Liss). *We* will use the group stages 1–4 as defined within this reference book to allocate the severities.

Leukaemia:

The severity of Chronic Lymphocytic is measured by the Binet classification which covers stages A to C.

Hodgkin's Disease and Non-Hodgkin's Lymphomas:

The severity is measured by staging and uses the Ann-Arbor system which covers stages I to IV.

The following are the Severity Level A conditions:

Severity Level A:

- Acute Lymphoblastic Leukaemia
- Acute Myeloid Leukaemia
- Severe Aplastic Anaemia
- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified Ann-Arbor Stage III or above
- Chronic Myeloid Leukaemia
- Multiple Myeloma

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Confirmation of the diagnosis by an *appropriate medical specialist* and copies of the specialist and hospital reports
- Relevant CT/MRI scans, histological evidence and Full Blood Count results where appropriate

4. SPECIFIC EXCLUSIONS

- All tumours which are histologically described as *pre-malignant*, as *non-invasive* or cancer in-situ (other than those stated as covered in this document and *your plan schedule*)
- Cervical, vaginal, vulval or prostatic intraepithelial neoplasia (dysplasia) with histology showing CIN-1, CIN-2,VAIN-1, VAIN-2, VIN-1, VIN-2, PIN-1 or PIN-2
- Lesions where there has been no invasion of tissue including, but not limited to, papillary micro-carcinoma of the thyroid or papillary cancer of the bladder histologically described as TisN0M0,TaN0M0 or of lesser classification (other than those stated as covered in this document and *your plan schedule*)
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.B HEART AND ARTERY CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Any Cardiac Condition resulting in a Reduced Ejection Fraction

Any cardiac condition causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

Cardiomyopathy resulting in a Reduced Ejection Fraction

A disease of the heart muscle causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

Congestive Heart Failure

The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and *optimal therapy* must have been established for at least 6 months. There must be at least 4 signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound
- Jugular venous pressure above 6 cms

- Rales present in both bases on auscultation
- Cardiomegaly on chest x-ray
- Grade 3, or gross ascites, associated with marked abdominal distension
- Severe oedema to a level above the knee

Heart Attack resulting in a Reduced Ejection Fraction

A heart attack causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. The measurement must be performed at least one month after an acute heart attack. The heart attack must have been diagnosed according to the criteria stated under the Heart Attack definition in provision 1 b) 1 above for a claim to be considered.

Hypertrophic Cardiomyopathy - of specified severity

A disease of the heart muscle which results in thickening and enlargement of the interventricular septum or any myocardial segment. There must be a maximal LV wall thickness of at least 25mm in any myocardial segment confirmed via cardiac imaging and the diagnosis of hypertrophic cardiomyopathy must be confirmed by a consultant cardiologist.

For the above definition the following are not covered:

- Cardiomyopathy secondary to *alcohol or drug abuse*

Severe Peripheral Vascular Disease

A definite diagnosis of peripheral vascular disease by a consultant cardiologist or vascular surgeon with objective evidence from imaging of obstruction in the arteries requiring, or being included on the NHS waiting list for, bypass graft surgery to an artery of the legs.

The following is not covered:

- Angioplasty

Severe Vascular Disease affecting Multiple Systems

Severe vascular disease affecting the heart, kidney and/or brain. There must be at least 2 of the following:

- Stroke*
- Left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3
- Renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/lGrade 4 retinopathy combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase greater than 110mmHg on *optimal therapy*.
- *For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be *residual deficit* with a Modified Rankin Scale of 2 or above.

2. SEVERITY LEVELS

How is severity measured?

Reduction in ejection fraction:

The ejection fraction is a measure of the efficiency of the pumping action of the

heart; in a healthy heart this is typically greater than 50%. Damage to the muscle of the heart (myocardium) such as that sustained during myocardial infarction or cardiomyopathy, impairs the heart's ability to eject blood and therefore reduces ejection fraction. Where a severity is measured by the *permanent* reduction in ejection fraction it is measured by the percentage of the contents of the left ventricle that is expelled in each contraction of the ventricle. This can be measured by echocardiography or through radioisotope measurements. It must be measured in a cardiac laboratory, which has regular quality control audits available to *us*, and be supervised by a Consultant Cardiologist.

The disease or disorder causing the reduction in ejection fraction must be established as being *permanent* and *irreversible* and the measurement must be taken whilst the patient is on optimal treatment.

The following are the Severity Level A conditions:

Severity Level A:

- Cardiomyopathy resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25 mm
- Heart attack resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- Any cardiac condition resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- At least 4 signs of congestive heart failure on *optimal therapy* for at least 6 months
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 110mmHg on *optimal therapy*
- Severe peripheral vascular disease

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- History of signs and symptoms compatible with the condition claimed
- Full cardiologist's, cardiothoracic, neurosurgeon or vascular surgeon's assessment and operation notes
- Relevant electrocardiographs, angiograms, aortograms, thallium scans, echocardiograms, X-rays, CT scans or any other relevant test results and reports
- Cardiac enzyme results for heart attacks. Raised serum CKMB fraction or positive Troponin-T or I, if performed. Raised creatine kinase and LDH alone are not considered.

4. SPECIFIC EXCLUSIONS

- Any acute coronary syndromes which do not completely satisfy any of the definitions listed in the Definitions section of this illness category including, but not limited to, angina
- Alcoholic Cardiomyopathy
- Only one procedure is covered for transplants of the heart and/or lungs by the

plan regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.C STROKE AND NERVOUS SYSTEM CATEGORY– SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Loss of Manual Dexterity to age 70

Total and *irreversible* loss of the ability to use the hands and fingers with precision to perform daily activities of work such as picking up or manipulating small objects, operating a range of equipment manually or communicating through writing or typing. The disability must be *permanent* and supported by appropriate neurological evidence.

Loss of Muscle Power resulting in the inability to grip to age 70

Total and *irreversible* loss of all muscle power in both hands resulting in the inability to grip any tool, utensil or assistive device. The disability must be *permanent* and supported by appropriate neurological evidence.

Loss of Speech

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

There must also be evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Neurological Diseases

For the purpose of this *plan* this includes any *permanent irreversible* disease affecting the basal ganglia, cerebellum, neurones, horn cells or myelin sheaths that produce identifiable *permanent* neurological deficit.

If the disease, disability or symptom is not defined as a named condition in these definitions *we* will waive *your* premiums only when there is an inability to perform the *functional activity tests*. *Alcohol or drug abuse* is excluded.

Paralysis of limbs

Total and *irreversible* loss of muscle function to the whole of any two limbs.

Persistent Vegetative State to age 70

A severe neurological condition of decreased consciousness where there must be all of the following:

- The loss of an awareness of surroundings
- The lack of speech
- The lack of response to commands
- The lack of any purposeful movements

This condition must be *permanent* and supported by appropriate neurological

evidence.

Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting clinical symptoms lasting for at least 24 hours. For the above definition, the following are not covered:

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

2. SEVERITY LEVELS

How is severity measured?

Modified Rankin Scale:

Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

Functional Activity Tests (FATs):

For neurological diseases (including those not specifically stated under this *benefit*) *we* will pay a *benefit* if *you* become *permanently* unable to perform certain *functional activity tests*. Please see the beginning of this Appendix for details of *functional activity tests*.

The following are the Severity Level A conditions:

Severity Level A:

- A Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform four out of six *functional activity tests* (see the beginning of this Appendix for details of these *functional activity tests*).
- Loss of Speech
- Paralysis of limbs
- Loss of Manual Dexterity
- Loss of muscle power resulting in the inability to grip
- Persistent Vegetative State

*these conditions can be continually re-assessed as they progress in severity by use of the Modified Rankin Scale or *functional activity tests* as described in 'How is severity measured' above.

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results

- Diagnosis made by an *appropriate medical specialist*
- Loss of neurological function compatible with area of damage of the brain involved

4. SPECIFIC EXCLUSIONS

- Any condition where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Chronic Fatigue Syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free Disease.
- Pituitary tumours – specified treatments are covered within the Endocrine *benefit*
- Transient Ischaemic Attacks
- Benign intracranial hypertension
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.D GASTROINTESTINAL CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Fulminant Hepatic Necrosis

Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

Permanent Faecal Incontinence to age 70

There must be *permanent* incontinence of faeces with constant soiling, despite *optimal therapy* for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

Severe Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy. To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/litres;
- Abnormal protein production marked by decreased albumin levels below 27 G/L;
- Abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR)

test above 2.0

2. SEVERITY LEVELS

The following are the Severity Level A conditions:

Severity Level A:

- Fulminant Hepatic Necrosis
- *Permanent* Faecal Incontinence
- Severe Cirrhosis of the Liver

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Diagnosis and treatment by an *appropriate medical specialis*t
- Relevant investigations, results, copies of hospital and histology reports signed by suitably qualified Consultant Histopathologist

4. SPECIFIC EXCLUSIONS

- Any condition where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- *Alcohol or drug abuse*
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any exclusion contained within the definition of any named condition
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion applied specifically to *your plan*

1.E CONNECTIVE TISSUE DISEASES CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

For the purposes of this *plan* other diseases which are not specifically named such as sero-negative arthritis, sero-negative rheumatoid arthritis, psoriatic arthritis or osteoarthritis are not covered by this *plan*, but complications of these diseases may be paid out should criteria be met under any of the other categories of illnesses.

Giant Cell Arteritis

The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Polyarteritis Nodosa

The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Polymyositis

Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this illness category there must be all of the following:

- Elevated serum muscle enzymes (CK, aldolase)
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM)
- Muscle biopsy findings typical of PM or DM (as defined immediately above)
- Compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation

Rheumatoid Arthritis

The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Lupus Erythematosis (SLE)

The definite diagnosis of Systemic Lupus Erythematosis (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Sclerosis (Scleroderma)

The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Wegener's Granulomatosis

The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rhematic Diseases.

2. SEVERITY LEVELS

How is severity measured?

Connective Tissue Diseases:

Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. For the purposes of this *plan* the severity of

Connective Tissue Diseases will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, can be found at the beginning of this appendix.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's

granulomatosis causing the *permanent* inability to perform at least four out of six *functional activity tests*. Please see the beginning of this Appendix for details of *functional activity tests*.

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant blood tests and tissue biopsies which satisfy the relevant defined diagnostic criteria
- Histological proof of the presence of the disease

4. SPECIFIC EXCLUSIONS

- Fibromyalgia, or any synonym including, but not limited to, fibromyositis, fibrositis, muscular rheumatism, myofascial pain syndrome
- Osteoarthritis, wear and tear or any other subjective, non-diagnosed condition
- Chronic fatigue syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free disease
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category or not meeting the stated minimum required severity
- Any exclusion contained within the definition of any named condition.
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion applied specifically to *your plan*

1.F UROGENITAL TRACT AND KIDNEY CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Kidney Failure

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

2. SEVERITY LEVELS

How is severity measured?

Renal function:

Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Kidney Failure

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category

- Diagnosis and treatment by an *appropriate medical specialist*
- Copies of all available specialist reports
- Details of current and historic renal function tests
- Histology of biopsies and any other relevant investigations must be available

4. SPECIFIC EXCLUSIONS

- Kidney transplant. This is covered in the Major Organ Transplant category
- Kidney donation
- Elective gender reassignment
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any exclusion contained within the definition of any named condition
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion applied specifically to *your plan*

1.G RESPIRATORY DISEASE TO AGE 70 CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Cor Pulmonale
Irreversible right ventricular failure due to a lung disease producing raised pulmonary artery pressure (Pulmonary Arterial Hypertension). There must be evidence of raised pulmonary artery pressure of at least 30mmHG (mm of mercury) and there must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

Fibrotic Lung Disease
For the purpose of this *plan* fibrotic lung disease is defined as one of the following only:

- Sarcoidosis
- Fibrosing Alveolitis
- Aspergilosis

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

There must be radiological evidence of fibrosis and there must be a *permanent* and *irreversible* restriction of Vital Capacity (VC), the maximum total volume of air that can be expelled from the lung after maximum inhalation, to below 75% of predicted. There must also be a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less.

These tests must be performed under the direction of a specialist respiratory physician whilst on *optimal therapy*. They must be measured in a respiratory laboratory, which has regular quality control audits available to *us*, and be supervised by the treating specialist.

Home Oxygen Therapy
Chronic hypoxaemia on a *permanent* basis with a concentration of oxygen in the

arteries of less than 8 kPa. Supplemental oxygen therapy must be used at home for at least 13 hours each day.

Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

A definite diagnosis of one of the following by a consultant cardiologist or consultant respiratory physician:

- idiopathic pulmonary arterial hypertension
- chronic thrombo-embolic pulmonary hypertension

With either:

- The measurement reported at the average level measured by cardiac catheterisation at 30mmHG (mm of mercury) or higher at rest. There must also be right ventricular dilation and hypertrophy on echocardiogram with characteristic ECG changes; or
- The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist for the disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

2. SEVERITY LEVELS

How is severity measured?

Fibrotic Lung Disease:

The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor.

The following are the Severity Level A conditions:

Severity Level A:

- Fibrotic Lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less
- Home Oxygen Therapy
- Cor Pulmonale
- Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant pulmonary and cardiac investigations must be done and be available
- Histology report must be available if needed

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1g) above where the required permanence has not

been established before the cover terminates or at age 70 where stated, if sooner

- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any exclusion contained within the definition of any named condition
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion applied specifically to *your plan*

1.H ACCIDENTAL HUMAN IMMUNODEFICIENCY VIRUS (HIV) CATEGORY - MEETING SPECIFIED CRITERIA

1. DEFINITIONS

HIV infection

Infection by HIV resulting from:

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

After the start of the *plan* and satisfying all of the following:

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures
- Where HIV infection is caught through a physical or sexual assault or as a result of an incident occurring during the course of performing normal duties of *employment*, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus
- The incident causing infection must have occurred in one of the countries in the list of *permitted countries*

For the above definition, the following is not covered:

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

2. SEVERITY LEVELS

Severity Level A:

- HIV infection resulting from:
- A blood transfusion given as part of medical treatment
- A physical or sexual assault

- An incident occurring during the course of performing normal duties of *employment*
- An organ transplant

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

We will require evidence of a negative HIV test within 5 days of the incident and the subsequent positive HIV antibody test with a confirmatory Western Blot test within 12 months of the incident.

4. SPECIFIC EXCLUSIONS

- Any method of infection of HIV or AIDS that is not stated above
- No cover under this *benefit* is effective unless there is shown to be a negative HIV test within five days of the incident causing the claim
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.I MUSCULOSKELETAL TRAUMA CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Loss of hands or feet

Permanent physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

Extensive Skin Burns

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue, covering at least 20% of the body's surface area or 25% of the surface area of the face.

Face is the surface area of the front of the head from the top of the hairline to the base of the chin and from ear to ear.

2. SEVERITY LEVELS

How is severity measured?

Extensive Skin Burns:

Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area. Adding up the injured areas provides an assessment of burn percentage.

The following are the Severity Level A conditions:

Severity Level A:

- Extensive Skin Burns
- Loss of hands or feet

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

Either or both of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Appropriate investigations and reports must be available

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.J EYE TO AGE 70 CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Blindness

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

Severe Visual Impairment

Permanent and *irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/36 after correction.

2. SEVERITY LEVELS

How is severity measured?

Visual acuity:

The Snellen rating is the measurement of visual acuity using a standard Snellen chart at 6 metres. This must be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at 6 metres letters that people with normal vision can read at 18 or 36 metres.

The following are the Severity Level A conditions:

Severity Level A:

- Blindness
- Severe Visual Impairment

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Signs and symptoms must be compatible with the condition claimed
- The Consultant Ophthalmologist's report must be available with details of corrected visual acuity
- Relevant investigations must be performed

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1j) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner

- Any temporary reduction in sight
- If a Consultant considers that a device or implant could result in the improvement of sight
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.K EAR TO AGE 70 CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1. DEFINITIONS

Deafness

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.

2. SEVERITY LEVELS

How is severity measured?

Hearing loss:

Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry.

The following are the Severity Level A conditions:

Severity Level A:

- Deafness

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant investigations and reports must be available
- Must be diagnosed and treated by an *appropriate medical specialist*
- Must have relevant signs and symptoms

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1k) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.L MAJOR ORGAN TRANSPLANT CATEGORY

1. DEFINITIONS

Major Organ Transplant

The undergoing as a recipient of a transplant of bone marrow; or of a complete heart, kidney, liver, lung, pancreas; or of a lobe of lung or liver from another donor; or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

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

Only one procedure is covered for transplants of the heart and/or both lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

2. SEVERITY LEVELS

Severity Level A:

- Major Organ Transplant

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed
- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigation results and any other supporting specialist reports required
- Histology report must be available if needed

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.M PERMANENT DISABILITY

1. DEFINITIONS

Cauda equina

The compression of the nerve roots in the lumbar spine causing the loss of sensation and movement to the bladder, bowel and both legs. The disability must be *permanent* and supported by appropriate neurological evidence.

Mental and Behavioural Disorder: Persistent Confusional State to age 70

An individual shall be considered to be in a persistent confusional state where the individual cannot:

i) Follow simple instructions

ii) Perform simple daily tasks including eating, drinking and washing

iii) Have any insight into his or her disability

AND

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force.

Mental and behavioural disorder: total lack of social interaction to age 70

An individual shall be considered to have a total lack of social interaction where the individual has:

- Ongoing medical treatment from a psychiatrist for more than two years
- And more than two in-patient admissions, each greater than one week
- And total lack of social interaction of any kind
- And the *permanent* inability to carry out all of the following:
  - Answering the telephone
  - Holding a face to face conversation for at least five minutes
  - Travelling fifty metres outside using all available aids

Total permanent disability

Your plan schedule indicates which of the following definitions apply.

a) Total *permanent* disability – *own occupation*

i. Total *permanent* disability – unable before age 70 to do *your own occupation* ever again

Loss of the physical or mental ability through an illness or injury before age 70 to the extent that *you* are unable to do the material and substantial duties of *your own occupation* ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of *your own occupation* that cannot reasonably be omitted or modified. *Own occupation* means *your* trade, profession or type of work *you* do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability.

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

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

b) Total *permanent* disability – *permanent* failure of functional activity

i. Total *permanent* disability Unable, before age 65 to do at least four work tasks ever again (a list of these tasks is provided at the beginning of this Appendix).

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

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

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

ii. Total *permanent* disability – unable to do at least four *tasks designed to assess whether you can look after yourself ever again*

Loss of the physical ability through an illness or injury to do at least four *tasks designed to assess whether you can look after yourself ever again* (listed at the beginning of this Appendix).

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

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

2. SEVERITY LEVELS

How is severity measured for total *permanent* disability – unable before age 65, to do a specified number of *work tasks* ever again or total *permanent* disability – unable to do a specified number of *tasks designed to assess whether you can look after yourself ever again*?

The severity of a condition claimed under either of these *benefits* will be determined by the *permanent* inability to perform a number of tasks ever again.

The inability to perform a particular task or number of tasks has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided at the beginning of this Appendix.

Severity Level A:

- Cauda equina
- Mental and behavioural disorder – persistent confusional state to age 70
- Mental and behavioural disorder – total lack of social interaction to age 70
- Total *permanent* disability – unable before age 70 to do *your own occupation* ever again
- Total *permanent* disability – unable, before age 65, to do at least four *work tasks* ever again
- Total *permanent* disability – unable to do at least four *tasks designed to assess whether you can look after yourself ever again*

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in conjunction with provision C3.1 and D5.

Any of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigations and reports must be available
- Signs and symptoms must be compatible with the condition claimed

In order for a total *permanent* disability claim to be paid, *we* will require that the extent of permanency has been established to *our* satisfaction.

4. SPECIFIC EXCLUSIONS

- Any condition stated in 1n) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated under 'Exclusions' in provision D5.
- Any exclusion within the definition of any named condition
- Any exclusion applied specifically to *your plan*

APPENDIX 2

LIFESTYLECARE COVER DEFINITIONS

1. DEFINITIONS

Severity Level 1

The amount of the claim depends on the severity of the illness *you* suffer. In order to meet the criteria for Severity Level 1, *you* must meet one of the following definitions:

Alzheimer's Disease - resulting in permanent symptoms

A definite diagnosis of Alzheimer's Disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

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

For the above definition, the following are not covered:

- Other types of Dementia

Dementia - resulting in permanent symptoms

A definite diagnosis of Dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

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

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's Disease by a Consultant Neurologist. There must be *permanent* clinical impairment of motor function with associated tremor and muscle rigidity. For the above definition, the following are not covered:

- Parkinsonian syndromes/Parkinsonism

Severity Level 2

In order to meet the criteria for Severity Level 2, *you* must meet one of the following three definitions:

i) *Permanent* inability to perform three out of six *tasks designed to assess whether you can look after yourself ever again*.

There must be *permanent* clinical loss of the ability to perform three or more of the following tasks. To make this assessment *we* will need an *appropriate medical specialist* to confirm that *you* are *permanently* unable to perform these tasks. *You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

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.

Getting between rooms – The ability to get from room to room on a level floor.

Feeding *your*self – The ability to feed *your*self when food has been prepared and made available.

Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again.

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

Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

ii) Persistent Confusional State

An individual shall be considered to be in a Persistent Confusional State where the individual cannot:

i. Follow simple instructions;

ii. Perform simple daily tasks including eating, drinking and washing

iii. Have any insight into his or her disability, and

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force.

iii) Severe Stroke - resulting in *permanent* symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in a *permanent* residual neurological deficit measuring 4 or above on the Modified Rankin Scale.

For the above definition, the following are not covered:

- Transient Ischaemic Attack
- Death of tissue of the optic nerve or retina / eye stroke

2. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results
- Diagnosis made by an *appropriate medical specialist*

- Loss of neurological function compatible with the area of damage of the brain involved

We will use the Modified Rankin Scale (van Swieten et al. 1988) to measure the severity of a Stroke. This is an internationally accepted measure of disability for Stroke, It is scored from 0 to 5 with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

3. SPECIFIC EXCLUSIONS

- Any condition stated in paragraph 1 above where the required permanence has not been established before the cover terminates
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in provision D5.5 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

Find out more.

For more information please speak to your adviser or visit our website vitality.co.uk/life

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