AVIVA

Income Protection+
Policy conditions

Keep this document safe

These **policy conditions** are written confirmation of your contract with Aviva Life & Pensions UK Limited. It's important that you read them carefully together with your **policy schedule** and then keep both documents in a safe place.

The words in **bold** are defined terms with specific meanings. We explain these in the definitions section.

Any questions?

Call us on:

0800 285 1098

If you're outside the UK, call:

+44 1603 603 479

Lines are open Monday to Friday 8.00am-8.00pm, Saturday 8.30am-5.00pm and Sunday 10.00am-4.00pm.

Need to make a claim?

Please read our 'Making a claim' section first, then call us on:

0800 158 3105

Lines are open Mon to Fri 8:30am to 5:00pm.

Your cover

Your policy includes the core benefits, any optional benefits that you've selected and any additional benefits that you are eligible for.

Core benefits

Your policy includes four core benefits, these are:

Main benefits

Restricted benefit

Back to work benefit

Waiver of premium

You can choose between two different types of cover:

Full cover to term

We'll pay your benefit for the full duration of your **incapacity**.

Limited payment term

We'll pay your benefit for a maximum of 24 months for each **incapacity**. If you've gone back to work for six consecutive months, you're able to claim again for the same illness or injury.

For either type of cover, there's no limit to the number of claims you can make.

Additional benefits

The following benefits will automatically be added to your policy:

Hospital benefit

Family carer benefit

Trauma benefit

Special arrangements for NHS doctors, surgeons, nurses and midwives

Life change benefit

You may be eligible for life change benefit. If you are, we'll automatically add it to your policy. Your **policy schedule** will show if it has been included.

Optional benefits

You can choose to add three optional benefits to your policy when you take it out. These are:

Fracture cover

Global treatment

Increasing cover

Your **policy schedule** will show exactly which optional benefits you've chosen. We'll send you your **policy conditions**, which will include a description of increasing cover. Your policy conditions will only cover fracture cover and/or global treatment if you have selected these.

Contents

Core Benefits

The core benefits available under this policy are set out below and are only payable if we accept a claim.

For each of the core benefits below, a set number of weeks must have passed before you're entitled to receive **benefit**. This is known as the **deferred period.** This is selected by you at outset and will be shown in your **policy schedule.** If you wish to make a claim, you must contact us as soon as possible from the onset of your **incapacity**, regardless of the **deferred period** you've selected.

Main benefit

We'll pay this if immediately before **incapacity** you were either:

- in an **occupation**, or
- made redundant from your **occupation** up to three months before **incapacity**, or
- on maternity leave (which commenced up to 52 weeks before **incapacity**), or parental leave for the other parent (and the child was born up to 52 weeks before **incapacity**), or
- on adoption leave (and the **child** had been legally adopted up to 52 weeks before **incapacity**).

We'll only pay if after the start of **incapacity**, you weren't in any other **occupation**.

What do we pay?

We'll pay the **full benefit**, subject to the **maximum yearly amount**. We'll deduct from that amount any continuing income you receive from other sources. Please see the "Calculation of your **benefit**" section below.

When do we start paying your benefit?

If your claim is accepted, you'll be eligible for **benefit** when your **deferred period** ends. **Benefit** will be paid monthly in arrears after the end of your **deferred period**. If your **claim period** starts or ends part way through a month, we'll pay a daily amount for that period.

When do we stop paying your benefit?

We'll stop paying your **benefit** when:

- your **incapacity** ends, or
- you're no longer suffering a loss of **earnings**, or
- the policy ends, or
- the **limited payment term** ends, or
- you're remanded in custody (we'll pay the **benefit** retrospectively if you're not convicted of the offence) or receive a custodial sentence, or
- you die.

Points to note

To calculate the **maximum yearly amount**, we'll use your gross annual **earnings** in the 12 months immediately before **incapacity** unless:

- you were made redundant up to three months before **incapacity** – in which case, your gross annual income will be based on the 12 months **earnings** immediately before being made redundant. We won't take into account any lump sum amount you have received as a redundancy payment from your employer.
- you were on maternity, parental or adoption leave at the time of **incapacity** - in which case, your gross annual income will be based on the 12 months **earnings** immediately before your leave started.

Restricted benefit

We'll pay this if immediately before **incapacity** you were:

- not working and
- not eligible for, or were outside of, the period of redundancy, maternity, parental or adoption leave applicable to the main benefit above.

  We'll only pay if after the start of **incapacity**, you weren't in any other **occupation**.

What do we pay?

We'll pay the **full benefit**, subject to the **maximum yearly amount**. We'll deduct from that amount any continuing income you receive from other sources. Please see the "Calculation of your **benefit**" section below.

When do we start paying your benefit?

If your claim is accepted, you'll be eligible for **benefit** when your **deferred period** ends. **Benefit** will be paid monthly in arrears after the end of your **deferred period**. If your **claim period** starts or ends part way through a month, we'll pay a daily amount for that period.

Core Benefits

When do we stop paying your benefit?

We'll pay this **benefit** for a maximum of 12 months, either as one claim or several shorter claims throughout the **policy term**.

We will not pay this benefit if any of the below apply before the 12 months period is up:

- your **incapacity** ends, or
- you're no longer suffering a loss of **earnings**, or
- the policy ends, or
- the **limited payment term** ends, or
- we've paid restricted **benefit** for a total of 12 months over the **policy term**, or
- you're remanded in custody (we'll pay the **benefit** retrospectively if you're not convicted of the offence) or receive a custodial sentence, or
- you die.

At the end of the **claim period** the policy will continue and your **premiums** will restart.

Points to note

To calculate the maximum yearly amount, we'll use your gross annual **earnings** in the 12 months immediately before you stopped working.

If you make a claim under this **benefit** during a period of unemployment, you must return to an **occupation** for at least six consecutive months before you can make a claim under the main **benefit**.

Back to work benefit

We'll pay this if, immediately before **incapacity**, you were in an **occupation** and, following your **incapacity**, your **earnings** are reduced because:

- you're in a different **occupation** due to your continued **incapacity**, or
- you've returned to your **occupation** but you've had to restrict your **duties** or hours worked because of your **incapacity**.

What do we pay?

We'll pay a percentage of the **full benefit**.

To calculate the percentage of the **full benefit** that we'll pay, we'll work out the percentage reduction in your **earnings**. When doing this, we'll take into account any increase in the **Retail Prices Index** between the start of **incapacity** and the date when the back to work benefit becomes payable.

When do we start paying your benefit?

Back to work benefit can be paid when your **deferred period** ends, or this can be paid after you've received **full benefit** and have made a partial return to work due to your **incapacity**.

We'll pay your **benefit** monthly in arrears. If your **claim period** starts or ends part way through a month, we'll pay a daily amount for that period.

When do we stop paying your benefit?

We'll stop paying your **benefit** when:

- you no longer satisfy the requirements for payment of **benefit**, or
- you're no longer suffering a loss of earnings, or
- the policy ends, or
- the limited payment term ends, or
- you're remanded in custody (we'll pay the **benefit** retrospectively if you are not convicted of the offence) or receive a custodial sentence, or
- you die.

Waiver of premium

If we accept your claim for one of the core benefits we'll pay your premiums from the earlier of:

- the end of your **deferred period**, or
- 13 weeks after the start of your **incapacity**.

We'll start to collect your premiums again, once the **claim period** has ended.

Calculation of your Core Benefit

If we accept your claim, we need to work out what we will pay you.

We'll calculate what your full benefit will be in three steps:

1 working out your maximum yearly amount,

2 applying any benefit guarantee (if applicable), and

3 making adjustments for any income you receive.

This will be done as follows:

1 Working out the maximum yearly amount

Your **maximum yearly amount** will be:
65% of the first £10,000 of your gross **earnings**, plus 55% of your gross **earnings** between £10,000 and £100,000, plus 45% of your gross **earnings** above £100,000.

The maximum **benefit** available is £20,000 per month or £240,000 per year.

If you've selected the increasing cover option, the maximum **benefit** can increase above £20,000 per month or £240,000 per year.

We'll never pay more than the **benefit amount** shown on your **policy schedule**.

2 Applying the benefit guarantee (if applicable)

If immediately before **incapacity** you were working at least 16 hours a week and your **maximum yearly amount** is lower than the **benefit amount** shown in your **policy schedule** we'll apply the **benefit guarantee**:

(a) We'll pay the **benefit amount** if it's up to £1,500 a month.

(b) We'll pay the **benefit amount** if:

- it's over £1,500 a month, and
- your **maximum yearly amount** is equal to, or more than, 90% of your **benefit amount**.

(c) We'll pay the higher of £1,500 a month and the **maximum yearly amount** if:

- the **benefit amount** is more than £1,500 a month, and
- your **maximum yearly amount** is less than 90% of your **benefit amount**.

3 Making adjustments for other income you receive

If you have income from other sources, which when added to the **full benefit** calculated above, would exceed the **maximum yearly amount**, we may have to reduce your **benefit**. We'll work this out by deducting income from the **full benefit** to work out the amount we pay you.

Once you stop receiving that income, we'll increase the amount we pay you to ensure you receive the **full benefit**.

If any of this income is taxable, we'll deduct the net amount received.

Income from other sources includes:

- continuing income from your business, including earned dividends from that business
- continuing income from an employer, including benefits in kind and sick pay
- income from a pension which is paid as a result of **incapacity** (excluding any lump sum payments)
- any income received because of your illness or injury (excluding state benefits)
- regular income or benefits from other insurance policies which cover you for **incapacity** due to illness or injury (whether held with us or not), or insurance policies that make regular payments on your behalf, which exceeds £50 per month in total, including:
  - credit card protection
  - loan protection
  - income protection/permanent health insurance
  - mortgage payment protection
  - pension premium protection.

If we reduce the **full benefit** because it exceeds the **maximum yearly amount**, we won't refund any premiums. You'll need to regularly review your cover to ensure that it meets your needs.

Additional benefits

The following **benefits** are automatically included in your policy.

Hospital benefit

We'll pay this for each night you're in hospital due to **incapacity** during the **deferred period**. You need to be in hospital for at least six consecutive nights.

We'll pay it for each night you have spent in **hospital** as a patient and received treatment overseen by an **attending consultant**.

What do we pay?

£100 a night for a maximum of 90 nights during the **policy term**. We'll stop paying hospital benefit if we're paying you **full benefit** even if you're still in hospital.

Family carer benefit

We'll pay this if your spouse, civil partner or **child** meets the **activities of daily living** definition for at least three consecutive months. We'll cover any **child** up to the age of 18 (or 21 if in full time education).

What do we pay?

We'll pay the amount shown on your **policy schedule** or £1,500 per month, whichever is lower.

When do we start paying your benefit?

After we have accepted a claim for this **benefit**.

When do we stop paying your benefit?

We'll pay this benefit for a maximum of 12 months during the **policy term**.

We'll stop paying this **benefit** before the 12 months has elapsed if:

- your spouse, civil partner or **child** becomes able to carry out at least four of the six specified **activities of daily living**, or
- your spouse, civil partner or **child** dies, or
- you're claiming any other **benefit**, or
- the policy ends, or
- you die.

When won't we pay benefit?

For civil partners and spouses, we won't pay family carer benefit if:

- the condition was diagnosed or they suffered symptoms (whether diagnosed or not) before the policy **start date** or before you married or entered into a civil partnership, or
- if the illness being claimed for was **related** to a condition which was previously diagnosed, or
- you cause the condition by intentionally harming your spouse or civil partner, or
- the condition occurs during any periods when your spouse or civil partner is permanently or temporarily **resident** outside the **countries**, or
- we don't receive enough medical evidence from either you or your spouse or civil partner, or
- you're already claiming for one of the core benefits.

For your **child**, we won't pay family carer benefit if:

- the condition was diagnosed or they suffered symptoms (whether diagnosed or not):
  - before the policy **start date**, or
  - if the illness being claimed for was **related** to a condition which was previously diagnosed, or
  - before you legally adopted the **child** or became guardian, or
  - before you became a step parent of the **child**, or
- either parent received counselling or medical advice for the condition affecting the **child** before the **policy start date**, or
- you cause the condition by intentionally harming the **child**, or
- the condition occurs during any periods that your **child** is permanently or temporarily **resident** outside the **countries**, or
- we don't receive enough medical evidence from you on your **child's** behalf, or
- you're already claiming for one of the core benefits.

Additional benefits

Trauma benefit

We'll pay this if you suffer from one of the following traumatic events:

Blindness

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

Deafness

- **permanent** and **irreversible** loss of hearing to the extent that the quietest sound that can be heard in the better ear is 70 decibels across all frequencies using a pure tone audiogram.

Loss of hand or foot

- **permanent** physical severance of a hand or foot at or above the wrist or ankle joint.

Loss of speech

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

Paralysis of limb

- total and **irreversible** loss of muscle function to the whole of the limb.

Loss of independence

- the total and **permanent** loss of the ability to perform routinely at least three of the specified six **activities of daily living** without the continual assistance of someone else, even with the use of special devices or equipment.

What do we pay?

We'll make one payment for six times the **benefit amount**, or £40,000, whichever is lower.

We'll only pay the trauma benefit once during the **policy term**. We'll pay trauma benefit in addition to any other **benefit** that you claim for during the **policy term**.

When won't we pay benefit

If the condition was diagnosed or you suffered symptoms (whether diagnosed or not) before the policy **start date**, or

If you have an exclusion on your policy for the condition.

Special arrangements for NHS doctors, surgeons, nurses and midwives

If you're a doctor or surgeon employed by the NHS in the UK and registered with the General Medical Council, or a nurse or midwife employed by the NHS in the UK and registered with the Nursing & Midwifery Council, we'll start paying benefit to cover your NHS earnings when your sick pay from the NHS reduces or stops.

At the date of **incapacity** you must have a single deferred period of 52 weeks. **Benefit** will not be paid if your **incapacity** lasts less than 4 weeks..

This won't cover:

- income you receive from private practice, or
- income you receive from employment by General Practitioners partnerships, or
- any **benefit** you are eligible for under Aviva's Protection Promise.

The **maximum yearly amount** will apply.

Income from other sources may reduce the **benefit amount** paid during the **claim period**.

NHS sick pay arrangements may change so you should regularly review your cover.

Life change benefit

This benefit will only be included if we accepted your policy on **standard terms**.

Life change benefit

You can take out more cover through an additional policy without any further health and lifestyle questions being asked, if your circumstances change in one of the ways described below.

You can do this at any time six months after your policy **start date**.

The extra cover will be a new policy in addition to this policy.

We'll need to see evidence of your life change event as shown below.

Life change	Evidence needed
Marriage or civil partnership	Marriage or civil partnership certificate
Divorce or dissolution of civil partnership	Decree absolute or dissolution order
Separation	Evidence of new mortgage, mortgage transfer or new separate addresses
Becoming a parent	Birth or adoption certificate
Increased mortgage due to a house move or purchase, or carrying out home improvements	Evidence of new mortgage or increase on existing mortgage, or builder's receipts for work carried out
Change of employer or promotion	Copy of recent payslips dated within 90 days of each other

How much benefit can be selected?

The maximum benefit you select for each life change event is the lower of:

- 50% of the original **benefit amount**, and
- £9,000 per year.

This is subject to the **maximum yearly amount** applicable at the time extra cover is taken out. The new policy will be subject to our minimum premium limits.

In addition to the above, if your salary increases by 20% or more from the policy **start date** (either from one pay rise or cumulative pay rises) you can also apply for the extra cover. This can only be used once during the **policy term** and you can increase the **benefit amount** by up to £20,000 per year. You must be in employment (not self-employed) at the time you apply for the extra cover.

How many times can life change benefit be used?

You can use the life change benefits as many times as you like provided you meet the eligibility requirements stated below.

Eligibility requirements

- You must take out the new policy before you turn 55, and
- The new policy must end before you turn 71, and
- You must take out the new policy within 90 days of the life change happening, and
- You must send us the evidence we need, and
- You must not be within five years of the original **policy end date**.
- You must not be in claim or eligible to make a claim on your original policy.

The new policy

The following restrictions will apply to the new policy:

- The new policy can't have a shorter **deferred period** than the original policy.
- The new policy can't end more than five years later than the original policy.
- For **limited payment term** policies, the new policy can't have a longer **limited payment term** than the original policy.
- The combined total **benefit amount**, including this extra cover, must not be more than the **maximum yearly amount** applying to this policy and the new policy.
- We won't cover you for any **incapacity** which arises prior to the start of the new policy or prior to the life change event occurring.
- We won't cover you if the condition was diagnosed or you suffered symptoms (whether diagnosed or not) before the start of the new policy or prior to the life change occurring.

The new policy won't be subject to any maximum premium limits and won't include the life change benefit.

The benefits, restrictions and options applying to the new policy will depend on what is available at the time and the policy conditions in force at the time will apply to the new policy. If we don't have a suitable policy available at the time then we can refuse your request.

The premium you'll pay for any new policy will be based on the rates available at the time of the request and your **personal circumstances**.

Optional benefits
Fracture cover

Your **policy schedule** will show any optional benefits you've chosen to add to your policy.

Fracture cover

Fracture cover is subject to our acceptance following underwriting.

You can only add fracture cover to your policy if you don't already have it on any other policy taken out with Aviva Life & Pensions UK Limited.

We'll cover you for the fractures listed opposite. We'll only pay out if the fracture happens at least seven days after the **start date** and before the policy **end date**.

We only pay out a successful claim once in each policy year for a fracture which occurs in that year. A policy year runs from the **start date** to the day before the **anniversary date** shown in your **policy schedule**.

If you suffer from more than one fracture at the same time we'll only pay for one of them. You can choose which one you claim for.

All fractures must be diagnosed by an **attending consultant**.

We won't cover a fracture which is classed as fatigue, stress, hairline, avulsion, chip or microfracture.

We won't cover a fracture that happens when taking part in any of the following: mountain biking or BMX; boxing, cage fighting or martial arts; rugby or Gaelic football; horse riding; or motor cycle sport.

If you make a claim for this benefit, all medical certificates and results of medical examinations must be provided by an **attending consultant**.

You can cancel the fracture cover option at any time six months after the **start date**. However, you won't be able to reinstate it and we won't refund any premiums.

If we accept a claim under this benefit, it won't affect the other **benefits** under your policy.

Fracture	Amount
If you suffer from any one of the following fractures, we'll pay:	
Skull (open fracture)	£6,000
Skull (closed fracture)	£4,000
Cheekbone	£1,500
Jaw	£3,000
Collar bone	£1,500
Shoulder blade	£2,000
Sternum	£2,000
Arm	£3,500
Ribs	£1,500
Vertebra	£2,500
Pelvis	£2,500
Wrist (we define the wrist as including the carpal bones, the distal radius or distal ulna)	£2,000
Upper leg	£6,000
Lower leg	£4,000
Ankle (we define the ankle as including the medial, posterior or lateral malleous)	£2,500
Knee	£6,000
Hand (excluding fingers and thumbs)	£1,500
Foot (excluding toes)	£2,000

Optional benefits
Global treatment

Your **policy schedule** will show any optional benefits you've chosen to add to your policy.

Global treatment

Global treatment has extra definitions which we use in this section. These definitions are in **bold** and have specific meanings. We explain these in the definitions for global treatment section.

You can only add the global treatment option to your policy if you don't already have the option on any other policy with an Aviva group company.

This option is provided in conjunction with **Best Doctors**, responsible for the **second opinion** service, and **BDUI**, responsible for medical and non-medical services for overseas treatment.

We'll pay the cost of treatment outside of the **territory** if, during the **policy term**, you or your **child** is diagnosed with any one of the **serious illnesses**, or requires a **medical procedure** set out below. The treatment must be recommended by the **second opinion** service.

Best Doctors will confirm the diagnosis. **BDUI** will recommend appropriate doctors and treatment centres and manage all necessary medical and administrative arrangements for treatment overseas.

It includes **expenses** that have been incurred for the treatment from the date of issue of the **preliminary medical certificate**. We cover the medical, **medication**, travel, accommodation and miscellaneous **expenses** set out in the **expenses** section below.

It covers any **child** from birth up to their 18th birthday (or 21st birthday if in full time education) at the date of starting the **second opinion** process.

If you're no longer **resident** in the **territory**, we'll cancel this option and your policy will continue without global treatment. If a **child** is no longer **resident** in the **territory**, they will need to return to the **territory** for confirmation of the initial diagnosis before you can claim for them under this option.

It won't affect any of the other benefits chosen under the policy.

What do we pay?

We'll pay a maximum of £1,000,000 (including all **expenses**) in every 12 month period from the issue of the **preliminary medical certificate**), up to an overall maximum of £2,000,000 over the **policy term**.

Once the maximum limit has been reached, this benefit under the policy will end.

Start and end of cover

Global treatment covers you and your **child** for three years from the **start date**. At the end of this three year period, we'll renew it automatically, unless before that next **renewal date**:

(a) the **policy term** ends, in which case it will end on the **end date** of the policy, or

(b) you turn 71, in which case it will end on your 71st birthday, or

(c) you have reached the maximum benefit of £2,000,000 available under this option, or

(d) your policy cannot be renewed because:

- you are **resident** outside of the **territory**, or
- our relationship with **Best Doctors** and/or **BDUI** comes to an end, or
- there has been any change of law, regulatory requirement or taxation which means that we are no longer able to offer global treatment.

Renewal of cover

We'll contact you at least 30 days before the **renewal date** and will tell you that either:

(a) the key features of global treatment won't change. If this happens, we'll automatically renew the option from the next **renewal date**. Please be aware that we'll automatically renew global treatment if we change the amount you pay for it, or

(b) the key features of global treatment will change. If this happens, we'll offer you the opportunity to renew from the **renewal date** and we'll ask you to confirm that the option can be automatically renewed at further **renewal dates**, or

(c) we won't renew the option. If this happens, the policy will continue without inclusion of global treatment and we'll remove the charge for it from your premium.

If you don't wish to renew global treatment, you must tell us before the **renewal date** and the change will apply from that **renewal date**. You can cancel the option at any time six months after the **start date**. However, you won't be able to reinstate it later and we won't refund your premiums.

Any new premium and any changes will come into effect upon renewal.

Optional benefits
Global treatment

Global treatment continued

Indemnity period

A claim could still be made after the policy has ended in the following circumstances:

(a) If the policy ends as a result of a successful claim, you can claim under the global treatment option after the policy has ended (for a maximum of 36 months from the date the policy ended). To do this, the **serious illness** or **medical procedure** for which you are claiming under this global treatment option must be directly related to the earlier claim under your policy.

(b) If you or your **child** have a **serious illness** or require a **medical procedure** for which a **second opinion** has been requested, but the policy subsequently ends as a result of a successful claim, the claim under global treatment can continue for a maximum of 36 months from the date the policy has ended.

If one of the above indemnity periods applies, all other benefits under the policy will have stopped when the policy ended and you won't be required to pay premiums.

Provided treatment has started within 36 months of the policy ending as described above, we'll cover the cost of any treatment you receive outside of the **territory** and the travel and accommodation **expenses** associated with that until you or your **child** return to the UK. We'll cover the cost of any medication **expenses** that are incurred in the **territory** after the return of you or your **child** to the **territory**, provided they are incurred during the indemnity period.

Serious illnesses and medical procedures

Bone marrow transplant

Bone marrow transplantation (BMT) or peripheral blood stem cell transplantation (PBSCT) of bone marrow cells to you or your **child** originating from:

- you or your **child** (autologous bone marrow transplant), or
- a living compatible donor

Cancer treatment

The treatment of:

- any malignant tumour including leukaemia, sarcoma and lymphoma, characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissues;
- any in situ cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues;
- all cancers which are histologically classified as any of the following:
  - pre-malignant;
  - having borderline malignancy;
  - having low malignant potential .

Coronary artery bypass surgery

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

Heart valve replacement or repair

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

Live-donor organ transplant

A surgical transplant in which you or your **child** receive a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.

Neurosurgery

Any surgical intervention, including minimally or non-invasive techniques of:

- the brain (or any intracranial structures), or
- benign tumours located in the spinal cord.

What don't we pay for?

We won't pay for:

- any diagnosis that leads to a medical procedure that has not been confirmed by the **second opinion** service.

Optional benefits
Global treatment

- any initial diagnosis that came from a hospital or **consultant** outside of the **territory**.
- any treatment that is not **medically necessary**.
- any **experimental treatment**
- any medical procedures needed as a result of AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or any condition arising from them (including Kaposi's sarcoma), or any treatment for AIDS or HIV, with the exception of HIV infection (occurring after the policy **start date**) resulting from a blood transfusion, physical assault or an incident occurring during the course of performing **duties** of employment.
- any medical procedures in connection with or derived from **cosmetic surgery**.

The following limits apply to these specific serious illnesses and medical procedures:

Coronary artery bypass surgery

- We won't provide cover for any correction of narrowing or blockage of coronary arteries which is treated using techniques other than bypass **surgery** eg angioplasty **surgery**.

Live-donor organ transplant

We won't cover any of the following:

- organs listed under the live-donor organ transplant definition that involves stem cell treatment
- any organ transplant when the transplant is conducted as a self-transplant
- any transplant when you or your **child** is a donor for a third party, unless the recipient is also insured under global treatment
- if the transplant is made possible by the purchase of donor organs
- any disease which has been caused by an organ transplant, unless it is a **serious illness** or requires a **medical procedure**. For clarity, complications directly associated with transplant **surgery** covered by the global treatment option occurring during **surgery** or post-**surgery** recovery outside of the **territory** will be covered as it will be considered a continuation of the transplant procedure.

Treatment for your child

In order for a successful claim to be made for your **child**:

- the symptoms must not have started, and/or
- diagnosis of the illness or condition must not have occurred, and/or
- neither parent must have received counselling or medical advice in relation to the condition or have been aware of the increased risk of the condition before the policy **start date** or before the legal adoption of the **child**.

Medical expenses

What we cover

Hospital charges

Relating to:

- accommodation, meals and general nursing services provided during your, or your **child's** stay in a room, ward or section of the hospital or in an intensive care or monitoring unit;
- other hospital services including those provided by a hospital outpatient department, as well as expenses relating to the cost of an extra or **travelling companion's** bed if the hospital provides this service;
- the use of an operating room and all related services.

Day clinic

Day clinic or independent welfare centre expenses, but only if the treatment, **surgery** or prescription would have been covered by us if provided in hospital.

Consultant treatment

Consultant expenses relating to examination, treatment, medical care or **surgery**.

Stay in hospital

Expenses relating to **consultant** visits during your, or your **child's** hospitalisation.

Medication

For **medication** applied by medical prescription while you or your **child** are hospitalised for treatment of a covered illness or medical procedure. **Medication** prescribed for post-operative treatment is covered for 30 days from the date you or your **child** have completed the treatment received outside of the **territory** and only when these are purchased prior to returning to the **territory**. Please see below for separate benefits for **medication expenses** incurred in the **territory**.

Hospital transfers

For transfers and transportation by ground or air ambulance for you or your **child** where their use is indicated and prescribed by a **consultant** and pre- approved by **BDUI**.

Optional benefits
Global treatment

Medical treatments

Expenses relating to the following medical and surgical services including **reconstructive surgery**, treatments or prescriptions:

- for anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist;
- laboratory analysis and pathology;
- x-rays for diagnostic purposes;
- radiotherapy;
- radioactive isotopes;
- chemotherapy;
- electrocardiograms (ECG);
- echocardiography (ECHO);
- myelograms;
- electroencephalograms (EEG);
- angiograms;
- computerised tomography (CT scan);
- blood transfusions;
- administration of plasma and serum;
- expenses relating to the use of oxygen, application of intravenous solutions and injections.
- other similar tests and treatments required for the diagnosis and treatment of a covered illness or **medical procedure**, when performed by a **consultant** or under medical supervision

Living donor

For services provided to a living donor during the process of removal of an organ or tissue to be transplanted to you or your **child** arising from:

- the investigation procedure for the location of potential donors;
- hospital services provided to the donor, including accommodation in a hospital room, ward or section, meals, general nursing services, regular services provided by hospital staff, laboratory tests and use of equipment and other facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted);
- **surgery** and medical services for the removal of a donor's organ or tissue to be transplanted to you or your **child**.

Bone marrow transplant

- For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to you or your **child**.

Medical expenses

What we don't pay for:

Any medical **expenses** (with the exception of medication **expenses** set out below) that are incurred in the **territory**.

Any treatment that is not arranged under the **preliminary medical certificate**.

Expenses incurred in the purchase or hire of any of the following equipment or similar items:

- orthopaedic appliances; corsets; bandages; crutches; artificial members or organs; wigs (even where their use is considered necessary during chemotherapy treatment), orthopaedic footwear; trusses, or other similar equipment or items.
- wheelchairs; special beds; air conditioning appliances; air cleaners, or any other similar equipment or items.

Any type of prosthesis that:

- are not fully inserted into the body, and
- are not required as a direct result of the damage to a structure made by the **medical procedure**(s) arranged under this global treatment option.

Alternative medicine:

Any charges made for the use of alternative medicine, even where specifically prescribed by a **consultant**.

Any expense incurred in a different hospital from the authorised hospital stated in the **preliminary medical certificate**.

Any expense incurred in respect of confinement services, home health care, or services provided in a convalescence centre or institution, hospice or nursing home, even where such services are required or necessary as a result of a **serious illness** or **medical procedure**.

Cerebral syndrome or impairment

Any charges for medical attention or confinement in cases of:

- cerebral syndrome (presence of a cerebral disorder or damage to the brain resulting in the partial or total impairment of the brain functions), or
- senility, or
- cerebral impairment

regardless of the status of their development.

Any charges made for any treatment, service, supply or medical prescription for a disease for which the best treatment is a transplant covered by global treatment.

Optional benefits
Global treatment

Medication expenses

What we cover

If treatment of any of the **serious illnesses** or **medical procedures** which are paid for under this option resulted in a hospital stay for three nights or more, we'll pay for the cost of **medication** purchased in the **territory**. The maximum limit for this is £50,000 over the **policy term**.

We'll only cover the **medication expenses** if:

- the **medication** has been recommended through **BDUI** by the international **consultant** that is treating you or your **child**, as necessary for on-going treatment;
- the **medication** recommended by the international **consultant** has been licensed and approved by the corresponding medical authority or agency in the **territory** and its prescription and administration is regulated;
- the **medication** is available for purchase in the **territory**;
- the **medication** is required under prescription by a **consultant** in the **territory**, and
- no single prescription exceeds a dose for consumption longer than two months.

What we don't pay for:

The cost of **medication** which is funded by the NHS or that is covered by any other insurance policy held by you.

Any costs associated with the administration of the **medication**.

Any **medication expenses** which you incurred which had not been sent to us within 180 days of the purchase.

Any **medication** that is not **medically necessary**.

Travel, accommodation and miscellaneous expenses

What we cover

Travel and accommodation

We'll pay for expenses for travel, in economy class, to and from the agreed hospital indicated in the **preliminary medical certificate**, and any necessary accommodation, arranged by us for:

- you and a **travelling companion** or
- you, your **child**, and another **travelling companion** (if it is your **child** that is receiving the treatment under the global treatment option), and/or
- a living donor (if applicable).

We'll also pay you a daily allowance of £100 for every day you or your **child** spend in hospital outside of the **territory** in respect of treatment arranged under the **preliminary medical certificate**, up to a maximum of 60 consecutive days for each claim under the global treatment option under the **policy**.

Repatriation expenses

If you or your **child** or a living donor dies whilst receiving treatment approved by the **preliminary medical certificate**, we'll pay the costs of transporting the body home, as well as the minimum costs necessary for administrative formalities, embalmment and the coffin in which the body is transported back to the **territory**

What we don't pay for:

- Any travel arrangements which are not associated with travel from and to a permanent address in the **territory**.
- Any expenses for accommodation or transportation arranged by you, a **travelling companion** or a living donor.
- Any interpreter's fees, telephone and other charges for items for personal use or which are not of a medical nature, or for any other service provided to relatives or **travelling companions**.
- Any breakfast, meals and incidental costs incurred at the hotel. If you pay for an upgrade to your hotel accommodation, you will bear the full cost of the upgrade.
- You, your **child** or a **travelling companion** to obtain a passport to enable travel outside of the **territory**.

Optional benefits
Global treatment

Making a claim under the global treatment option

You can make a claim at any time during the **policy term**, or within the indemnity period described above. You can make a claim regardless of whether you have made any other claims under your policy.

Your claim will initially be dealt with by **Best Doctors** who can be contacted at **0800 085 6605**.

Best Doctors will then refer you to **BDUI** who will assess whether you or your **child's** initial diagnosis is covered under the global treatment option. This initial diagnosis must come from a **consultant** in the **territory**.

If it is covered, **BDUI** will arrange for a **second opinion** to be carried out by **Best Doctors** to confirm the diagnosis and the cover provided under this option.

Following this confirmation, you'll be given a copy of the **second opinion** report. If the report confirms that the diagnosis concerns a **serious illness** or a **medical procedure**, and you or your **child** want to receive treatment outside of the **territory** you must tell **BDUI. BDUI** will then begin to arrange treatment under the global treatment option.

Optional benefits
Increasing cover

Your **policy schedule** will show any optional benefits you've chosen to add to your policy.

Increasing cover

This benefit allows you to automatically increase your **benefit amount** each year without any further health and lifestyle questions being asked. Increasing cover can only be selected when you take out your **policy**.

There are three increasing cover options:

1. Your **benefit amount** will increase based on the percentage increase in the **Retail Prices Index (RPI)** over the 12 month period ending 12 weeks before the start of the month of your policy's **anniversary date**. The maximum increase in your **benefit amount** will be 10% each year.
2. Your **benefit amount** will increase by 3% on each **anniversary date** of your policy
3. Your **benefit amount** will increase by 5% on each **anniversary date** of your policy.

If your **benefit amount** increases your premiums will also increase. We'll calculate the increase in premium by multiplying the percentage increase in the **benefit amount** by 1.5. We'll then multiply that amount by the current premium to work out what the new premium will be.

If you've chosen the **RPI** option above:

- Your premium won't increase by more than 15%, unless you have also chosen reviewable premiums where a combined increase in premium could exceed 15%.
- If the change in **RPI** is 0% or below, your **benefit amount** – and your premium – will stay the same.

When will I be told about any increase?

We'll write to you at least eight weeks before the **anniversary date** to tell you how much your **benefit amount** and premiums will increase by.

You can choose not to increase your **benefit amount** if you don't want to pay the higher premium. If you do this, your **benefit amount** and your premiums will stay the same. You must tell us as soon as possible before the **anniversary date** if you want us to cancel the increase. We'll reinstate the increasing cover option the following year.

If we accept your claim, we'll pay the **benefit amount** as increased under this option. The **benefit amount** will continue to increase throughout any **claim period**.

Making a claim

If you need to make claim, please contact us on **0800 158 3105** (from outside of the UK, please call **+44 1603 202 500, option 1**). Our claims line is open Monday to Friday 8.30am-5.00pm.

For claims under the global treatment option, please read that section of these **policy conditions**.

When you need to tell us you want to make a claim

If you wish to make a claim, you must contact us as soon as possible from the onset of your **incapacity**. You need to tell us you want to make a claim before the:

- period of **incapacity** has lasted eight weeks, or
- **deferred period** ends, if it's shorter than eight weeks.

If you don't tell us within these time limits, we may be unable to confirm the **incapacity**. This may mean we have to refuse the claim or we may treat the **deferred period** as not having started until the date we are notified of the claim.

Before we can pay a claim, we need to assess it

We assess your claim from when your **incapacity** has started. We need satisfactory evidence to support this. To assess the claim we'll ask for some important information, consents and documents.

Apart from any medical evidence we ask for, you'll have to pay for the information. The kind of things we need may include, but aren't limited to:

- A claim form signed by you.
- Proof that you're ill or have been injured.
- Written consent that lets us:
  - access your medical records or reports
  - receive the results of any medical examinations or tests
  - apply for evidence and information from other third parties.
- Conversations with, and reports from, third parties such as **medical practitioners** and employers.

All evidence that is provided to us will need to be in English.

Evidence of earnings

The evidence of earnings that we need depends on whether you are employed, a director, or self-employed:

Employed

- your last 12 months payslips immediately before **incapacity**, or
- your last P60 certificate, and
- your P11d (or replacement) if benefits in kind are covered.

Director

In addition to the employed evidence:

- evidence of your dividends during the 12 months immediately before **incapacity** as assessed for income tax and declared to/agreed by HMRC, and
- the corresponding profit and loss accounts.

Self-employed

- evidence of your personal earnings during the 12 months immediately before **incapacity** as assessed for income tax and declared to/agreed by HMRC, and
- the profit and loss accounts which relate to your personal earnings.

Paying your claim

We may postpone or refuse a claim if we don't receive the information, consents or documents we need.

You must take whatever steps are necessary to help your recovery, including meeting, and working, with disability counsellors and/or advisers appointed by us.

If we need you to undergo any medical examinations or tests, we'll pay for them. We'll also appoint the medical examiner.

When we assess a claim, we rely on the information we're given. If any of the information isn't true or complete we may not be able to pay a claim. If we've already paid a claim it may mean we can reclaim the money and we won't make any further payments. Where any of the information isn't true or complete we may also cancel the policy without refunding any premiums.

This doesn't affect any other legal rights we have.

If we accept a claim, we'll make any relevant payment to you in the currency of the UK to a UK, Channel Islands, Isle of Man or Gibraltar bank account.

Making a claim

Recurring incapacity and subsequent incapacity

You can make more than one claim over the **policy term**.

For full cover to term policies

If you need to make another claim for the same cause of **incapacity** within 12 months of the end of the previous **claim period**, we won't re-apply the **deferred period**.

If you need to make another claim more than 12 months after a claim for the same cause of **incapacity**, we'll apply the **deferred period**.

If you need to make another claim which is not **related** to a previous claim, you can do this. We'll apply the **deferred period** to this separate claim.

We will only pay one claim at a time.

For limited payment term policies

If you've selected **limited payment term**, we'll pay the **benefit** for the **limited payment term**.

Once you've come to the end of your **limited payment term** or the **incapacity** ends (whichever is the earlier), the **claim period** will end. However, the **policy** will continue and premiums will restart.

If you need to make a claim for the same medical condition which has led to **incapacity** within 12 months of the end of the previous **claim period**:

- If you've already received 24 months payments you'll need to have returned to an **occupation** for at least six consecutive months and we'll apply the **deferred period**. A new limited payment term would apply. We'll assess your **incapacity** on the **occupation** you've been doing since your return to work after the end of the previous **claim period**, not the **occupation** you were assessed against in any previous claim, or
- If the previous limited payment term has not been fully used, the remaining months can be used, provided it does not exceed the **policy term**. We won't reapply the **deferred period**.

If you need to make a claim which is not **related** (directly or indirectly) to an **incapacity** within 12 months of the end of the previous **claim period**:

- We'll apply the **deferred period** and a new limited payment term would apply.
- We'll assess your **incapacity** on the **occupation** you've been doing since your return to work after the end of the previous **claim period**.

If you need to make a claim more than 12 months after the end of the previous **claim period** we'll apply the **deferred period** and a new limited payment term would apply.

We'll only pay one claim at a time.

Paying a claim if you are overseas

- If you claim whilst you are living, travelling or working outside the list of **countries**, we'll only pay a **benefit** for up to three months after the **deferred period** has ended.
- You may need to return to the UK, at your own cost, to undergo a medical examination arranged by us in order for us to fully assess your **claim**.
- If you return to live in one of **countries** listed and are still incapacitated, we'll start paying the **benefit** to you again.
- We won't backdate any **benefit** we didn't pay when you were outside the list of **countries**.

Making changes to your policy

You can make certain changes to your policy six months from the **start date**, unless marked in the table below with a ✶. You can't make changes if you are unable to work due to **incapacity**.
If we can make any changes, they'll apply from the date your next premium is due and your premiums may change.

Depending on the type of change, we may need to ask you some more health and lifestyle questions. Where we do this, depending on your answers, we may not be able to carry out the change.

No further health and lifestyle questions
Decrease the **benefit amount** ✶ ▲
Decrease policy term ▲
Increase deferred period ✶ ▲
Remove increasing cover
For dual **deferred periods** only: Remove shortest **deferred period** (to wait longer before we pay benefit) ▲
Change to dual **deferred period** (to wait longer before we pay benefit) ▲

Further health and lifestyle questions may be required
Increase **benefit amount**
Increase the policy term ■
Decrease deferred period ■
Change **occupation** ▲
For dual **deferred periods** only: Remove longest **deferred period** (to wait less time before we pay benefit) ■
Change to dual **deferred period** (to wait less time before we pay benefit) ■

✶ Change available in the first six months.

▲ We'll use the premium rates and smoker status available at the time you took out your original policy, based on your age at the start of the policy.

■ We'll use the premium rates and smoker status available when we make the change, based on your current age.

Points to note

You can't make any changes to your policy if you're claiming or eligible to make a claim.

After you've made any of the above changes, your premium can't be lower than the minimum premium limit which applies at the time we agree to your request.

You can't have a dual **deferred period** if you have chosen reviewable premiums.

Your premium won't change if you remove the increasing cover option.

If you have selected increasing cover, we can remove this from your policy at any time. However, we can't make any other changes in the 10 weeks before the **anniversary date** unless you confirm that you don't want the increase to apply.

For the above changes, we'll amend your policy and these **policy conditions** will continue to apply to your amended policy. The exception to this is if you want to increase the **benefit amount**.

Increasing the benefit amount

For this type of change, we'll issue a new policy for the additional **benefit amount**. The total monthly **benefit amount** will be subject to the **maximum yearly amount** which applies when we agree to your request. The new policy will be subject to our minimum premium limits and the **policy conditions** in force at the time will apply to the new policy.

If we increase the **benefit amount**, we'll use the premium rates and smoker status available when we issue the new policy, based on your current age.

You will also need to answer further health, lifestyle and financial questions.

Your premiums

For your policy to be maintained, you need to pay your premiums.

You must pay premiums monthly by Direct Debit. All Direct Debits need to come from a bank or building society in the UK, the Channel Islands, the Isle of Man or Gibraltar, in the currency of the UK.

Your **policy schedule** will show the initial premium you'll pay, together with the date it and subsequent premiums are due. You have 60 days from each due date to pay your premium. If you have to make a claim during this period, we'll deduct the unpaid premium from any **benefit amount** we pay.

If you don't pay your premiums within the 60 day period, we'll cancel your policy. If this happens, you won't be able to make a claim.

Your premiums can be guaranteed or reviewable. Your **policy schedule** will show which premiums you have.

Guaranteed premiums won't increase over the **policy term**, unless:

- you make changes to your policy, or
- you have selected the increasing cover option, or
- you have selected the global treatment option.

Your **policy schedule** will show which options you have.

Reviewable premiums

Your **policy schedule** will confirm confirm whether you have reviewable premiums.

We review your premiums every five years over the **policy term** to determine if you're paying the right price for the **benefit amount** you've chosen.

If our review shows your premium needs to change, we'll assess the change fairly. We'll use certain assumptions to work out what the new premium should be. We won't look at the **personal circumstances**.

These assumptions will be based on our view of the following factors:

- The expected impact of medical advances and trends which may affect our expectation of future claims.
- Industry developments and claims experience.
- Changes to legislation, taxation and regulation.
- The amount, timing and cost of claims we're paying now, and those we may pay in the future.

Your premium may increase or decrease based on our assumptions at the review date. There are no limits on how much your premium can change by.

Following our five yearly review, we'll write to you to let you know the outcome of the review at least 30 days before the **anniversary date** and:

- if the change is less than 2% or 50p, your premium will stay the same
- if your premium goes down, we'll automatically change your Direct Debit
- if your premium goes up, you have two options:

  (a) you can pay the increased premium and we'll automatically change your Direct Debit.

  (b) you can keep your premium the same and reduce your **benefit amount**. If you want to do this, you need to let us know before the **anniversary date**. If you don't tell us, we'll increase your premium. It is up to you to check that the **benefit amount** is right for you.

Any changes to your premium, or your **benefit amount**, will apply from the fifth anniversary of your policy and every five years thereafter.

General

Changing your details

You need to let us know if your contact details change.

Acceptance of instructions

We can't accept any instruction, request or notice from you until we receive all the information we need. We'll tell you what kind of information or documentation we need.

Cancelling your policy

You have a 30 day cooling off period to change your mind. If you cancel within this period, we'll refund any premiums you've paid. The cooling off period begins on the later of:

- the day we tell you when your policy will start, and
- the day you receive your policy documents.

You can still cancel the policy after the cooling off period ends, but we won't refund your premiums. If you do this, you won't be able to make a claim.

You can also remove any of the options (some of these can only be removed six months from the **start date**).

Eligibility

To apply for this policy you must:

- be at least 18 years of age and no older than 59 when we accept your application,
- at the time you apply, be physically living in the UK, the Channel Islands, the Isle of Man or Gibraltar and:
  - be a citizen of that territory or a British Overseas Territory citizen, or
  - have been granted permission to settle permanently in the named territory.
- have been working in the UK, the Channel Islands, the Isle of Man, Republic of Ireland or Gibraltar for the past 12 months and are able to provide evidence of your **earnings** for that period, and
- have been registered with a doctor in the UK, the Channel Islands, the Isle of Man or Gibraltar for at least the past 2 years and/or able to provide a minimum of the last 2 years medical history from a doctor in the UK, the Channel Islands, the Isle of Man or Gibraltar.

What to do if your circumstances change

We use the information you give us in your application to determine the cover we can offer and how much you'll pay for the policy. If any of the information changes before your policy starts, you must tell us. If, based on the new answer, our original decision would have been different we have the right to change the terms of, or withdraw, our offer of cover. If we discover later that you failed to tell us any of this information, we may also cancel the policy without refunding any premiums.

You should review the level of cover if you:

- become unemployed
- reduce your working hours or choose to stop working
- change your planned retirement date
- take out any other insurance for illness or injury
- have a change made to continuing income from an employer or business
- move to live outside of the list of **countries**
- have a reduction in **earnings**.

If you don't review your cover, we won't backdate any refunds if you choose to reduce your cover at a later date, or if you discover that you are subsequently not eligible for any benefits.

General conditions

Policy amendments

We may alter these **policy conditions** for any of the following reasons:

- to respond, in a proportionate manner, to changes in:
  - the way we administer these type of policies
  - technology or general practice in the life and pensions industry
  - taxation, law or the interpretation of the law, decisions or recommendations of an ombudsman, regulator or similar body, or any code of practice with which we intend to comply.
- to correct errors if it is fair and reasonable to do so.

If we think any alteration to these **policy conditions** is to your advantage, we'll make it immediately and tell you at a later date. We'll also do this if the alteration is due to regulatory requirements.

General

If any alteration is to your disadvantage, we'll aim to tell you in writing at least 60 days before we make it. However, external factors beyond our control may mean we have to give you less notice.

If you're not happy with any alteration we make to your policy, you can cancel it.

Incorrect information

If your date of birth is wrong, we'll base the payment we make for any successful claim on the correct date of birth. We'll tell you if this happens.

If, using the correct date of birth, your age when you took out your policy would have been outside our limits, we'll cancel your policy. If this happens, we'll tell you. You won't be able to make a claim after we've cancelled your policy. However, we'll refund all your premiums (without interest).

We rely on the information provided to us. If any of it is not true or complete and would have affected our decision to provide your policy, we may:

- change the terms of your policy
- change the premiums you have to pay
- cancel your policy and refund the premiums you've paid (without interest).

If we cancel your policy, you won't be able to make a claim.

We may at any time, in line with reasonable underwriting and insurance practice (and retrospectively where appropriate), change your policy terms or cancel your cover without refunding your premiums if you have:

- misled us, for example telling us incorrect information or not telling us something that we have asked for
- defrauded or attempted to defraud us
- agreed to any attempt by someone else to defraud us
- not acted openly and honestly in dealings with us
- unreasonably refused to comply with these **policy conditions**.

Third party rights

This policy does not give any rights to anyone except you and us.

We may, with your agreement, amend or cancel this policy without reference to, or consent from, any other person.

Fairness of terms

We'll always act reasonably and with regard to the need to treat you and all of our customers fairly.

These **policy conditions** will apply to your policy so long as they are not held by a relevant court, or viewed by the Financial Conduct Authority or by us, to be unfair contract terms. If a term is unfair it will, as far as possible, still apply but without any part of it which causes it to be unfair.

General

You may not transfer ('assign') the policy to someone else. The policy shall only be assigned if there is a requirement to do so by law.

Law

You and we have a free choice about the law that can apply to a contract. This policy is issued in England, under English law. By entering into this contract you agree that English law applies.

The Courts of England and Wales shall have non-exclusive jurisdiction over any claim, dispute or difference which may arise out of, or in connection with this contract.

Definitions

Throughout these **policy conditions** we've highlighted defined terms in bold type (except for personal terms like "we" and "you") so you know when they apply.

The meanings of these words are set out below.

You or your refers to the **policyholder** named in the **policy schedule**, who will be the person covered under the policy.

We, us or our means Aviva Life & Pensions UK Limited.

Activities of daily living

The following assessment will be made to determine eligibility for family carer benefit and loss of independence covered under trauma benefit:

The total loss of the ability to routinely perform at least three of the specified six **activities of daily living** without the continual assistance of someone else, even with the use of special devices or equipment. The inability being entirely due to illness or injury and not the age of the claimant.

The following are **activities of daily living**:

- Washing – being able to wash and bathe unaided, including getting into and out of the bath or shower.
- Dressing – being able to put on, take off, secure and unfasten all necessary items of clothing.
- Feeding – being able to eat pre-prepared foods unaided.
- Continence – being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances.
- Moving – being able to move from one room to another on level surfaces.
- Transferring – being able to get on and off the toilet, in and out of bed and move from a bed to an upright chair or wheelchair and back again.

For a **child** under the age of five years, the **incapacity** must be entirely due to illness or injury and result in the need for continuous health care throughout the day and night. This means the provision of care throughout the day and night for what is necessary for the health, welfare and protection of the **child** compared to a **child** of a similar age who does not have any illness or injury.

Anniversary date

The anniversary of the **start date** shown in the **policy schedule**.

Attending consultant

A surgeon, anaesthetist or physician who is legally entitled to practice medicine or surgery. They must have attended a recognised medical school, and be recognised by the relevant authorities in the country in which the treatment takes place as having a specialised qualification in the field.

Benefit

The main benefit, restricted benefit, back to work benefit, family carer benefit, hospital benefit, trauma benefit or waiver of premium described in the "Core benefits" and "Additional benefits" sections of these **policy conditions**. **Benefit** will refer to any one or more of the **benefits** unless specifically mentioned otherwise in these **policy conditions**.

Benefit amount

The amount set out in your **policy schedule** and is subject to the **maximum yearly amount** payable if a claim is made under the policy.

Benefit guarantee

The guarantee we may apply when calculating the **benefit amount** if you make a claim.

Child

Your natural, step, legally adopted and/or future children.

Claim period

The period under which the policyholder claims for a **benefit** under the **policy**. Each claim under the **policy** shall have its own **claim period**.

Countries

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

Deferred period

The number of consecutive weeks of **incapacity** which must pass before you become entitled to receive the **benefit**. The **deferred period**(s) will be shown in your **policy schedule**.

Duties

The material and substantial activities and tasks that are normally required for, and form a significant and integral part of, the performance of your **occupation** that cannot be reasonably omitted or modified.

Duties do not include:

- activities and tasks which aren't necessary to perform the **occupation** within the trade/profession (eg **duties** that are not necessary with another employer or within another business) or;
- the commute to and from your place(s) of work.

Definitions

Earnings

Your employed salary or self-employed **earnings**.

- Employed salary
  Your **earnings**, salary or wage (including benefits in kind, regular and consistent bonus and commission) before income tax from your employment in the 12 months immediately before **incapacity**.
- Benefits in kind
  The following benefits in kind to a combined taxable total of up to £10,000 and evidenced on HMRC form P11D will be accepted as forming part of employed salary:
  - Company car.
  - Living accommodation.
  - Private medical insurance.
- Dividends
  If income from your trade or business is received in the form of company dividends or distributions, we'll include this amount as **earnings** under this policy as long as they are:
  1. paid directly to you instead of/as well as regular wages or salary in the 12 months immediately before **incapacity**
  2. paid to your spouse or civil partner and they:
     a. do not contribute to the profit of the business
     b. would no longer receive such income as a result of your **incapacity**
     c. do not have separate income protection for themselves on their share of the dividends.
  3. paid from the net trading profit of the business and not retained profit and are consistent with the level of regular wages or salary that the paying company's trading position reasonably allows on a continuing basis.

  You must be an employed director of, and play an active role in, the private limited company that pays the dividends.
- Self-employed **earnings**
  The income from your business before income tax, in the 12 months immediately before **incapacity**, less any allowable expenses against income tax. This means your share of pre-tax profits from your insured **occupation** after trading expenses.

End date

The date on which entitlement to **benefits** under this policy end. This is shown in your **policy schedule**.

Full benefit

The amount payable under this policy in the event of a claim after calculating the **maximum yearly amount** and after any **benefit guarantee** has been applied.

Hospital

Any NHS or private hospital which has facilities for major surgery or which exists principally for the provision of treatment by **attending consultants**.

Incapacity

The inability, caused by illness or injury, to perform the **duties**, of each and every **occupation** you've been following in the 12 months before that illness or injury.

Or, if you weren't working, the inability, caused by illness or injury, to perform the **duties** of last **occupation** you followed.

Occupations that formed less than 10 hours of your average working week will be ignored for the purposes of determining **incapacity**.

Irreversible

Cannot reasonably be improved upon by medical treatment and/or surgical procedures used by the NHS at the time of the claim.

Limited payment term

If selected, a period of 24 months which may either be a single continuous period or a collection of shorter periods during which the **benefit amount** will be paid.

Maximum yearly amount

The maximum amount you could be entitled to at the time of claim when considering your **earnings** in the 12 months immediately before **incapacity**.

Medical practitioner

A medical practitioner on the List of Registered Medical Practitioners with the UK General Medical Council, or in the case of **benefit** paid for temporary overseas residence, the equivalent body in the relevant country.

Occupation

Occupation means work undertaken for profit, pay or reward.

Permanent

Expected to last throughout your life.

Personal circumstances

These can include your age, smoker status (both previous and current), occupation, health and lifestyle.

Policy conditions

This document, which forms our contract of insurance with you.

The application (that you made and we accepted) and the **policy schedule** also form part of the contract and must be read together with these **policy conditions**.

Definitions

Policy schedule

This will show the specific detail of your policy, such as whom it covers, the **benefit amount**, how much it will cost and any optional **benefits** and additional **benefits** included. The **policy schedule** also includes any subsequent amendments to your policy, which we confirm to you in writing.

Policy term

This relates to the period your policy is in force, from the **start date** until the **end date**.

Related

Any illness or condition you had symptoms of, sought advice for, received treatment for, or were aware of, that directly or indirectly contributed towards your absence from work during any previous **claim period**.

Resident

At the time you complete the application you must be physically living in the named territory (UK, Channel Islands, Isle of Man or Gibraltar) and you:

- are a citizen of that territory or a British Overseas Territory citizen, or
- have been granted permission to settle permanently in the named territory.

Retail Prices Index (RPI)

The monthly index calculated by the government that demonstrates the movement of retail prices in the UK, or an equivalent replacement of that index.

Standard terms

The premium and **benefits** we quote before the underwriting process is completed. If the premium and **benefits** for your policy are the same after the underwriting process, you will be on **standard terms**. If, following our underwriting process, we can only offer cover with a higher premium than first quoted, or with certain benefits excluded, or both, this would not be **standard terms**. We will have told you whether you were accepted on **standard terms** when confirming our decision on your application.

Start date

The date on which cover under this policy starts. It's shown in the **policy schedule**.

Definitions for global treatment only

In addition to the main definitions in these **policy conditions**, the following definitions apply only in relation to the global treatment option:

Alternative medicine

Includes medical and health care systems, practices and products that are not presently considered to be part of conventional medicine or the standard treatments including but not limited to acupuncture, aromatherapy, chiropractic medicine, homeopathic medicine, naturopathic medicine and osteopathic medicine.

Best Doctors

Best Doctors UK Limited, part of Best Doctors Inc. **Best Doctors** specialises in providing the provision of care services and specialised medical information. Best Doctors Services SL at C/Almagro 36, 1 planto, 28010, Madrid, Spain, registered in the Mercantile Registry in Madrid under hoja m-554734, tomo 30823, folio 126 and tax number (CIF) B86661857.

BDUI

BDUI Underwriting International SLU. It is a company specialised in the development of both insurance products and the management of overseas treatment for serious medical conditions. BDUI Underwriting International S>L>U at C/ Hortaleza 104, 28004, Madrid, Spain, registered in the Mercantile Registry in Madrid under hoja m-327635, tomo 18794, folio 76 and tax number (CIF) ESB83644484 ("BDUI").

Consultant

An **attending consultant** that has a specialised qualification in the field of, or expertise in the treatment of, the disease or illness.

Cosmetic surgery

Procedures enhancing, reducing, lifting or removing a part of the body performed to improve and correct a structural defect. This includes removal of scars, birthmarks or normal evidence of ageing.

Expenses

Means the medical, **medication**, travel, accommodation and miscellaneous **expenses** we cover under this global treatment option.

Definitions for global treatment only

Experimental treatment

A treatment, procedure, course of treatment, equipment, medicine or pharmaceutical product, intended for medical or surgical use, which has not been universally accepted as safe, effective and appropriate for the treatment of illnesses or injuries by the various scientific organisations recognised by the international medical community, or which is undergoing study, research, testing or is at any stage of clinical experimentation.

Medically necessary

Health care services and supplies which are:

- necessary to meet your, or your **child's** basic health needs, and
- rendered in the most medically appropriate manner and type of setting appropriate for the delivery of the health service, taking into account both cost and quality of care, and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of medical, research or health care coverage organisations or governmental agencies that are accepted by **BDUI**, and
- consistent with the diagnosis of the condition or illness, and
- required for reasons other than the convenience of you, your **child** or **consultant**, and
- demonstrated through prevailing pre-reviewed medical literature to be either:
  - effective for treating or diagnosing the condition or illness for which its use is proposed, or
  - efficient for treating a life threatening condition or illness in a clinically controlled research setting.

Medical procedure

A medical procedure which we cover in this global treatment option.

Medication

Any single substance or combination of substances, which may be used or administered to you or your **child** with a view to restoring, correcting or modifying physiological functions.

Preliminary medical certificate

Written approval relating to a claim issued by **BDUI** and/or us prior to any treatment, services, supplies or prescriptions being performed. The **preliminary medical certificate** will include confirmation of your global treatment benefit and the hospital outside of the **territory** authorised for your, or your **child's** treatment.

Prosthesis

A device which replaces all or part of an organ, or replaces all or part of the function of an inoperative or malfunctioning part of the body.

Reconstructive surgery

Procedures that are intended to rebuild a structure in order to correct its loss of function where **medically necessary**, exclusively when the structure has been damaged or removed.

Renewal date

The third anniversary of the **start date** and the end date of every following three year period.

Second opinion

A structured second medical opinion, based on an in-depth review of the medical information relating to you or your **child**. This service is provided by **Best Doctors**.

Serious illness

A serious illness which we cover in this global treatment option.

Surgery

All operations with a diagnostic or therapeutic purpose, carried out through incision or other means of internal entry, by a **consultant** at a hospital and which normally requires the use of an operating theatre.

Territory

England, Northern Ireland, Scotland, Wales, Jersey, Guernsey, the Isle of Man and Gibraltar.

Travelling companion

The person you choose to accompany you or your **child** while travelling and receiving treatment overseas.

Braille, large font, audio material

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or email **protection@aviva.com** to tell us:

- the format you need
- your name and address
- the name or code of the document (found at the bottom of the back page of most documents).

Lines are open Monday to Friday 8.00am-8.00pm, Saturday 8.30am-5.00pm and Sunday 10.00am-4.00pm.

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