Omnilife

Critical Illness Terms and Conditions

GCI / TS / 0419

Group Critical Illness Policy Terms and Conditions

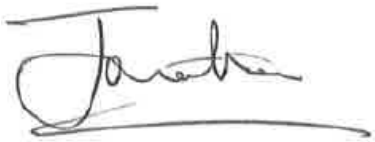
This Policy witnesses that the Trustee(s) have effected this assurance with the Company and in consideration of the payment of premiums the Company will pay the Benefit payable in accordance with this Policy, when it comes payable, to the Trustee(s) as described in the Policy

The Benefits payable are non-assignable.

The completed Proposal Form, together with the Schedule, any health questionnaire, medical statement and/or other written statement which has been provided or made by or on behalf of the Policyholder or any Member in relation to the Policy shall form the basis of the contract.

The Policyholder is under a duty to disclose facts material to the risk being insured and undertakes that all the information given by the Policyholder to the Company is true, accurate and complete. If the Policyholder is unsure about whether a fact is material, the Policyholder must disclose the fact to the Company. If the Policyholder does not disclose all material facts, the cover under the Policy may be void and any claim under the Policy may be declined.

Signed for and on behalf of Omnilife Insurance Company Limited:



Jonathan Plumtree

Chief Executive Officer

Dan High

Administration Manger

Group Critical Illness Policy Terms and Conditions

In this Policy, unless the context indicates otherwise, the following words or expressions have the meanings shown opposite them. The singular is deemed to include the plural.

Actively at Work means that an employee has not received medical advice to refrain from work and is not only present at their place of work on the prescribed day, but is mentally and physically capable of discharging fully the normal regular duties associated with the job for which they are employed and working their normal contracted number of hours, either at their normal place of business or at a location to which the business requires them to travel.

Adjustment Premium has the meaning given to it in section 8.3.2.

Anniversary Date means the anniversary date shown in the schedule.

Benefit means the sum insured in respect of an individual Member in accordance with the Benefit Basis.

Benefit Basis means the basis for determining the Benefit for each Member as set out in the "Benefit Summary" section of the Schedule.

Company means Omnilife Insurance Company Limited.

Commencement Date means the date on which the Policy takes effect.

Defined Conditions means the illnesses and conditions under which Benefits are payable, as defined in these Terms and Conditions.

Discretionary Member has the meaning given to it in section 1.4.2.

Eligibility Conditions means the eligibility conditions for entry into the Scheme as shown in the "Benefit Summary" section of the Schedule and includes the following terms: service qualification, entry frequency, minimum entry age, maximum entry age, Expected Retirement Age and whether or not late and / or early retirement are covered by the Policy.

Eligible Employee means an employee who meets the requirements for inclusion in the Scheme.

Employer means the Principal Employer and any Participating Employer shown in the Schedule.

Endorsement means any special provisions added to the Terms and Conditions and/or the Schedule by the Company in order to amend cover under the Policy. In the event of any conflict or inconsistency between the Terms and Conditions, the Schedule and the Endorsement, the Endorsement will prevail.

Expected Retirement Age means the expected retirement age shown in the Schedule.

Extra Premium means additional amounts required by the Company as a result of the health or lifestyle of a Member who has been Medically Underwritten.

Forward Underwriting Limit means the maximum amount by which a Medically Underwritten Member's Benefit may be increased without the need for further Medical Underwriting and is shown in the Schedule.

Free Cover Limit means the amount below which a Member does not need to be Medically Underwritten as a condition to receiving his/her full Benefit. Unless otherwise indicated in the Policy, a Member does not need to provide Evidence of Health whilst his/her Benefit remains below this amount. The Free Cover Limit is shown in the Schedule.

HMRC means Her Majesty's Revenue and Customs.

Insurance Company means an insurance company registered and authorised in the UK by the Prudential Regulation Authority.

Insured Person means any person covered under this policy.

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

Late Entrant has the meaning given to it in section 1.4.3.

Long Term Absentee means a Member who has been absent from their place of work, or is not mentally or physically capable of discharging fully the normal regular duties associated with the job for which they are employed, or are not working their normal contracted number of hours, either at their normal place of business or at a location to which the business requires them to travel for a period of greater than three months at the relevant time. Any Member who is currently an income protection (also known as permanent health insurance or PHI) claimant will also be a Long Term Absentee.

Lump Sum Benefit means the Benefit insured in terms of a lump sum, calculated in accordance with the Benefit Basis.

Medical Underwriting has the meaning given to it in section 4.

Member means an employee who has been admitted to membership of the Scheme.

Permanent means 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 means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the Insured Person's 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 and coma.

The following are not covered:

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

Policy means the legal contract between the Company and the Policyholder and comprises the following:

- these Terms and Conditions;
- the Schedule; and
- any Endorsements to the Policy (including any acceptance terms issued in writing by the Company in respect of particular Members and any special terms, exclusions and limitations specified in the final quotation).

Policyholder means legal owner of the policy, as named in the Schedule.

Policy Year means the period from the Commencement Date or from an Anniversary Date to the day immediately preceding the next following Anniversary Date or Termination Date of the Policy if sooner, both days inclusive.

Premium Due means the total amount of premiums due by the Policyholder per Policy Year for cover under the Policy, as set out in section 8.3.

Premium Payable has the meaning given to it in section 8.

Premium Rate means the premium rate shown in the Schedule.

Proposal Form means the application form for cover, completed and signed by the Policyholder.

Rate Guarantee Period means the period between the first date and last date of the Guarantee shown in the Schedule, both days inclusive.

Restricted Person means a person or entity subject to any sanctions, prohibitions or restrictions under the United Nations' resolutions, treaties or conventions, or trade or economic sanctions, laws or regulations of the European Union, United Kingdom, Canada or United States of America.

This includes, but is not limited to the following and their equivalents in force from time to time:

- United Kingdom HM Treasury's Office of Financial Sanctions Implementation Consolidated List of
- Financial Sanctions Targets in the UK (designated by the United Nations, the European Union and the United Kingdom relating to current financial sanctions regimes); or
- United Kingdom Home Office's List of Proscribed International Terrorist Groups; or
- United Kingdom Home Office's List of Proscribed Groups Linked to Northern Ireland Related Terrorism; or
- Office of Foreign Assets Control (OFAC) List of Specifically Designated Nationals and Other Blocked Persons (including terrorists).

Schedule means the Schedule attached hereto as amended from time to time and forming part of this Policy. In the event of any conflict or inconsistency between these Terms and Conditions and the Schedule, the Schedule will prevail.

Scheme means the scheme for whose benefit this Policy has been agreed, as named in the Schedule.

Scheme Benefit Category means a group of Members with the same Scheme Benefit Rules. Where Eligibility Criteria and Benefit Basis differ across Members, for example due to grade, additional Scheme Benefit Categories will be required. There must be a minimum of two Members in each Scheme Benefit Category at the Commencement Date of the Policy.

Single Premium. A Scheme is Single Premium if there is no Premium Rate in the Schedule. This will typically be the case if a Scheme has 19 or fewer Members.

State Pension Age means the earliest age at which a Member can claim his/her UK government pension.

Termination Date means the date on which cover under the Policy ceases.

Terms and Conditions means these terms and conditions governing and setting out the standard terms of the Policy.

Unit Rated. A Scheme is Unit Rated if there is a Premium Rate shown in the Schedule. This will typically be the case if a Scheme has 20 or more Members.

1. WHEN COVER STARTS

1.1 Policy set-up

Within 30 days of the Commencement Date, the Policyholder must provide to the Company

- a fully completed Proposal Form and any other information requested by the Company at the proposal stage;
- full Scheme data required by the Company, which includes full employee data at the start of the cover including but not limited to location, names, gender, salaries and dates of birth; and
- written answers given by the Policyholder to the questions asked by the Company.

If these requirements are not met within 30 days of the Commencement Date (or such later date as has been agreed in writing by the Company), the Company shall be entitled to terminate the Policy in accordance with section 10 (Termination of Policy).

1.2 Membership

To be covered under this Policy, an employee must meet the criteria for membership of the Scheme as set out in the Eligibility Criteria.

Membership entitles an employee to be covered for Benefits, as set out in the Schedule, subject to:

- appropriate premiums being paid in respect of the Member; and
- meeting the "Actively at Work" criteria set out in this section; and
- completion of any Medical Underwriting as may be required in accordance with the Terms and Conditions, and subsequent acceptance by the Company.

1.3 Cover for Members at Commencement Date

1.3.1 New Schemes and Schemes Insuring for the first time

Any Member who will be covered by the Policy from the Commencement Date must be Actively at Work on that date.

If a Member is absent from work on the Commencement Date on account of ill health or incapacity, cover will commence once such Member has been Actively at Work for 5 consecutive working days.

1.3.2 Existing Insured Schemes switching to Omnilife

Unless otherwise stated, if the Scheme is already insured by another Insurance Company prior to the Commencement Date, cover will commence as described below:

(i) The Company will insure an existing Member's Benefits up to the amount Medically Underwritten by the previous Insurance Company under the same terms of Medical Underwriting - i.e. Extra Premiums, exclusion clauses, or other special terms - as applied by the previous Insurance Company in cases where the following situation applies:

- the Scheme was previously insured with the other Insurance Company on the day prior to the Commencement Date; and
- there has been no change in the Benefit Basis or Eligibility Conditions and no significant change in the membership of the Scheme occurring on the Commencement Date; and
- the Company has been supplied, prior to the Commencement Date, with full details of Members who have had cover rated or declined and, subsequently, with proof as the Company may require of the previous Insurance Company's decisions; and

- the Company has been supplied, prior to the Commencement Date, with full details of Members who are Long Term Absentees.

(ii) This will only apply to any amounts of Benefit in excess of the Free Cover Limit where such amounts have been notified to and explicitly accepted by the previous Insurance Company. For the avoidance of doubt, mid-year increases in Benefit which have not been notified to and accepted by the previous Insurance Company are not covered by paragraph (i).

(iii) Where the Eligibility Criteria allow cover to continue for an existing Member who is early retired, ill health retired or a Long Term Absentee, cover under will only be accepted where the Company has been supplied, prior to the Commencement Date, with details of such Members, including age, gender, date of retirement or start of claim, reason for retirement or claim and Benefit to be covered. The Company may also require proof that these Members were insured by the previous Insurance Company.

(iv) An existing Member who originally entered the Scheme on a Discretionary Member basis will continue to be treated by the Company as a Discretionary Member, unless the previous Insurance Company had explicitly agreed to treat the Member as not a Discretionary Member. In this case, the Company will also agree to treat the Member as not a Discretionary Member, in which case the Member will be treated as a normal Member for all purposes.

1.4 New Members joining after Commencement Date

1.4.1 Normal Members

Members who join the Scheme on the first date on which they become eligible and who are Actively at Work will be immediately covered for Benefits up to the Free Cover Level. Members who have Benefits in excess of the Free Cover Level will require Medical Underwriting for the proportion of the Benefit that exceeds the Free Cover Level.

If a Member is absent from work on the first date on which they become eligible on account of ill health or incapacity, cover will commence once the Member has been Actively at Work for 5 consecutive working days.

Every employee who satisfies the Eligibility Conditions and Actively at Work requirements must be included in the Policy automatically.

1.4.2 Discretionary Members

Discretionary Members are employees who do not satisfy the normal rules for joining the Scheme. These Members will be subject to evidence of good health for their full Benefit and cover will be at our discretion. The employee will be required to complete an employee declaration form and further Medical Underwriting may be required.

Unless otherwise agreed by the Company, such a Member will not be entitled to a Free Cover Limit at date of joining or at any time thereafter.

1.4.3 Late Entrants

Late Entrants are Members who do not join the Scheme on the first date on which they become eligible for membership of the Scheme. Late Entrants will be required to complete a late entrant form for consideration and may be subject to further Medical Underwriting.

2. WHEN COVER ENDS, EXTENDING COVER AND OPTIONAL COVER

2.1 When does cover end?

A Member's cover will cease on the earlier of:

- reaching their Expected Retirement Age; or
- no longer satisfying the Eligibility Conditions; or
- their contract of employment ending; or
- reaching age 75.

2.2 Membership during temporary absence

A Member who is absent from work may continue to be covered for Benefits, as if still at work, subject to the following conditions:

- the maximum period of Temporary Absence is as specified in the Schedule; and
- the amount of the Member's Benefits will be the amount applying on the day prior to commencement of absence; and
- premiums must continue to be paid throughout the period in respect of these Benefits.

2.3 Continuing Membership in Late Retirement

This cover will only apply if indicated in the Schedule.

At the Policyholder's request, cover may be continued for Members who defer retirement past the Expected Retirement Age specified in the Schedule. The premiums in respect of this cover may be costed on age specific rates. The Member must be Actively at Work on the day they reach their Expected Retirement Date and an Actively at Work Declaration must have been supplied. If the Member is not Actively at Work at this date, Medical Underwriting will be required before allowing cover to resume.

The maximum period of continuous absence for a Member in late retirement is one year. If a Member returns to work after a period of one year, Medical Underwriting will be required before allowing cover to resume.

2.4 Spouse's cover

This cover will only apply if indicated in the Schedule.

At the Policyholder's request, cover may be included for the spouse or civil partner of a Member. This cover will start on the same date as the relevant Employee's cover and end on the earlier of the Member's cover ending and the spouse or civil partner reaching the Scheme's Expected Retirement Age.

The maximum Benefit for Spouse's cover is the lower of

- the Employee's Benefit; and
- £150,000.

A maximum of one claim is payable in respect of each spouse or civil partner, regardless of whether this claim is paid by the Company or has been paid by a previous Insurance Company.

2.5 Children's cover

This cover will only apply if indicated in the Schedule.

At the Policyholder's request, cover may be included for any natural or legally adopted children of a Member who are at least 30 days old but less than 18 years old. This cover will start and end on the same dates as the relevant Member's cover.

The Benefit for any one child will be the lower of

- 25% of the Employee's Benefit; and
- £20,000.

A maximum of one claim is payable in respect of each child, regardless of whether this claim is paid by the Company or a previous Insurance Company. Where a child has two parents covered under the Policy, the amount we will pay for a child's claim will be based on the greater of the parents' Benefit amounts.

3. INCREASES IN BENEFIT

3.1 When does cover commence for the Increase in Benefit?

Only an increase in Benefit arising in accordance with the Scheme's Benefit Basis will be covered.

A Member becomes eligible for such an increase in Benefit at the date specified in the Benefit Basis (the "**Increase Date**"). The Member will be covered from the Increase Date for the increase in Benefit provided the Member is Actively at Work at the Increase Date. If an employee is absent from work on the Increase Date on account of ill health or incapacity, they will become eligible for the increase once they become Actively at Work.

3.2 When is Medical Underwriting required?

Medical Underwriting is required if the Member's Benefit is above the Free Cover Limit or if they are a Discretionary Member.

For Unit Rated Schemes, when the date a Member becomes eligible for an increase in Benefit is other than the Anniversary Date, such an increase in the Member's Benefit will be covered automatically and without the need for Medical Underwriting for the period until the next Anniversary Date, provided the increase is in line with the general level of increases across the membership for that Policy Year. Where any exclusions or Extra Premiums have previously been placed on the Member's existing Benefit, the same exclusions and Extra Premiums will apply to the increase in Benefit up to the next Anniversary Date.

3.3 Forward Underwriting

To avoid frequent Medical Underwriting, the Company will accept some increases to Members' Benefits on the same terms as the most recently Medically Underwritten Benefits for the relevant Members. This will apply where a Member's Benefits immediately following an increase do not exceed his/her previously Medically Underwritten Benefits by more than the Forward Underwriting Limits shown in the Schedule.

When, following subsequent increases in the Member's Benefits, further Medical Underwriting is required, any resulting exclusions or Extra Premiums will be applied to the whole portion of his/her Benefits in excess of the Benefit insured on the day before the increase in benefit.

3.4 Changes to Free Cover Level

If the Free Cover Level increases, we will not automatically enhance the Free Cover Level applicable to a Member who has been Medically Underwritten or who has had their Benefit restricted to a previous Free Cover Level.

4. MEDICAL UNDERWRITING

Medical Underwriting is the process by which the Company determines the terms on which a Member can be covered. Other than for Discretionary Members, Medical Underwriting will only apply to the proportion of Benefit that is above the greater of the Free Cover Level and Benefit insured on the day before the increase in benefit.

While primarily focussed on the health of the Member, Medical Underwriting will also consider the lifestyle of the Member including any dangerous activities that they undertake.

4.1 Outcome of Medical Underwriting

When we have received all the necessary evidence that we need to decide whether we can accept a person's total Benefit our decision letter will be issued showing what cover can be provided and whether any special terms will be applied.

We may:

- accept the total Benefit at standard terms; or
- decline the amount of Benefit that was being Medically Underwritten; or
- charge an Extra Premium for the amount of Benefit that has been Medically Underwritten; or
- exclude certain health conditions or activities.

4.2 Cover during Medical Underwriting

We will provide cover from the first date we are advised of a Member who requires Medical Underwriting for a period of up to 90 days to enable the completion of the Medical Underwriting process.

We provide this temporary cover for the Member's full Benefit, provided they have not previously been declined by us or another Insurance Company, in which case no cover will be provided. Cover for the proportion of the Member's Benefit that requires Medical Underwriting will be subject to the following additional conditions:

- no claim will be paid that is linked to a medical condition that we could reasonably have expected the Member to know about on or before the first date we are advised of a Member who requires Medical Underwriting;
- no claim will be paid in respect of any exclusions that we would have applied had we completed Medical Underwriting; and
- cover will cease after 90 days from the date we are first advised of the requirement for Medical Underwriting or on the date we inform you of the outcome of Medical Underwriting, whichever is earlier.

5. BENEFITS

The maximum Benefit under the Scheme must not exceed the lower of five times gross annual salary at last renewal and £500,000.

5.1 When are Benefits payable?

The Benefit will be payable on survival of the Member 14 days after the date of first diagnosis of one or more of the illnesses covered and following receipt by the Company of the evidence detailed in 5.2. The Benefit will be payable to the Policyholder, who will be responsible for payment to the Member.

5.2 Evidence required at time of claim

Evidence of the following is required by the Company for a claim to be admitted:

- the membership of the Scheme;
- the Doctor's report detailing the diagnosis and any related medical history;
- the Age of the Member.

The Company will require a claim form - obtainable from the Company - to be completed and submitted at the time of claim. The Company may require evidence of the Member's level of earnings, as necessary for determining his/her Benefits.

If the age of the Member previously notified to the Company proves to have been incorrect, the Company reserves the right to make an adjustment to the Benefit payable.

5.3 Notification of a claim

The Company reserves the right not to pay a claim where the Policyholder fails to notify the Company of a claim or likely claim, without reasonable justification, within twelve months of the date of first diagnosis of the insured illness.

5.4 World-wide cover

Members are covered on a world-wide basis, provided the Company has been informed at the time of setting the Premium Rate, of any Members resident overseas or who undertake regular business travel outside of the UK, the EU or North America.

In all cases, we will require satisfactory medical evidence (in English) to support a claim. Any Member seconded overseas may be required to return to the UK, at their own expense, in order for us to obtain this.

6. DEFINED CONDITIONS

The following are Defined Conditions under which benefit is payable and which must be established to the satisfaction of the Company:

6.1 Core Conditions

These definitions apply to all Policies.

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; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Other types of dementia.

Cancer – *excluding less advanced cases*

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

The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following: - pre-malignant;
  - non-invasive;
  - cancer in situ;
  - having borderline malignancy; or
  - having low malignant potential;

- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification T2bN0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).
- All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0.

Coronary artery by-pass grafts – *with surgery to divide the breastbone*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

Creutzfeldt Jakob Disease

A definite diagnosis of Creutzfeldt Jakob Disease (CJD) by a Consultant Neurologist. There must be Permanent clinical impairment of motor function and loss of the ability to:

- remember
- reason, and
- perceive, understand, express and give effect to ideas.

Under the CJD definition, we do not cover other types of dementia.

Heart Attack – *of specified severity*

The death of a portion of heart muscle, due to inadequate blood supply that has resulted in all of the following evidence of acute myocardial infarction:

- Typical clinical symptoms (for example, characteristic chest pain).
- New characteristic electrocardiographic changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
  - Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L)
  - Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L)

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes
- Angina without myocardial infarction

Heart attack – of specified severity

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- Typical clinical symptoms (for example, characteristic chest pain).
- New characteristic electrocardiographic changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
  - Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L)
  - Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L)

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes.
- Angina without myocardial infarction.

Kidney Failure – *requiring Permanent dialysis*

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

Major Organ Transplant – *from another donor*

The undergoing as a recipient of a transplant from another donor, of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, 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.

Motor neurone disease – *resulting in Permanent symptoms*

A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)

There must also be Permanent clinical impairment of motor function.

Multiple Sclerosis – *with persisting symptoms*

A definite diagnosis of Multiple Sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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.

Pre-Senile Dementia

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be Permanent clinical loss of the ability to:

- remember
- reason and
- perceive, understand, express and give effect to ideas

For the above definition, dementia secondary to alcohol or drug abuse is not covered.

Stroke – *resulting in Permanent symptoms*

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Transient ischaemic attack.
- Traumatic injury to brain tissue or blood vessels.
- Death of tissue of the optic nerve or retina / eye stroke.

6.2 Additional Conditions

These definitions apply in where the Schedule states that additional condition definitions are included

Aorta graft surgery – *for disease*

The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the affected aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, the following is not covered:

- any other surgical procedure, for example the insertion of stents or endovascular repair.

Aplastic anaemia – *with Permanent bone marrow failure*

A definite diagnosis of aplastic anaemia by a Consultant Haematologist. There must be Permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.

Benign brain tumour – *resulting in Permanent symptoms or removed via craniotomy*

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

- Permanent Neurological Deficit with Persisting Clinical Symptoms
- removal of the tumour by craniotomy (surgical opening of the skull).

For the above definition the following are not covered:

- Tumours in the pituitary gland.
- Tumours originating from bone tissue.
- Angioma and cholesteatoma.

Benign spinal cord tumour – *resulting in Permanent symptoms or removed via surgery*

A non-malignant tumour in the spinal canal or spinal cord, resulting in either of the following:

- Permanent Neurological Deficit with Persisting Clinical Symptoms; or
- invasive surgery to remove the tumour.

For the above definition, the following is not covered:

- tumours treated with radiotherapy
- granulomas, haematomas, abscesses, disc protrusions and osteophytes.

Blindness – *Permanent and Irreversible*

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

Cardiac Arrest – *with implantation of defibrillator*

Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- Implantable Cardioverter-Defibrillator (ICD); or
- Cardiac Resynchronization Therapy with Defibrillator (CRT-D)

Coma – *with associated Permanent symptoms*

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

- requires the use of life support systems for a continuous period of at least 96 hours; and
- with associated Permanent Neurological Deficit with Persisting Clinical Symptoms.

For the above definition, the following are not covered:

- Medically induced coma
- Coma secondary to alcohol or drug abuse.

Deafness – *Permanent and Irreversible*

Permanent and Irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

Encephalitis – *resulting in Permanent symptoms*

A definite diagnosis of encephalitis by a Consultant Neurologist. There must be Permanent Neurological Deficit with Persisting Clinical Symptoms.

Heart valve replacement or repair – *with surgery to divide the breastbone*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

HIV infection – *caught from a blood transfusion, a physical assault or at work*

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment; or
- a physical assault; or
- an incident occurring during the course of performing normal duties of employment;

after the start of the policy and satisfying all of the following:

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

For the above definition, the following is not covered:

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

Liver failure – *of advanced stage*

Liver failure due to cirrhosis and resulting in:

- Permanent jaundice; and
- ascites; and
- encephalopathy

For the above definition, the following is not covered:

- liver disease secondary to alcohol or drug abuse.

Loss of independent existence – *Permanent and Irreversible*

Loss of the physical ability through an illness or injury to do at least 3 of the 6 tasks listed below ever again. 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 the Insured Person expects to retire.

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

The tasks are:

1. 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.
2. 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.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. 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.

Loss of speech – *total Permanent and Irreversible*

Total Permanent and Irreversible loss of the ability to speak as a result of physical injury or disease.

Loss of hands or feet – *Permanent physical severance*

Permanent physical severance of any combination of 2 or more hands or feet at or above the wrist or ankle joints.

Open Heart Surgery – *with surgery to divide the breastbone*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist, to correct any structural abnormality of the heart.

Paralysis of limbs – *total and Irreversible*

Total and Irreversible loss of muscle function to the whole of any 2 limbs.

Primary pulmonary arterial hypertension

A definite diagnosis of pulmonary arterial hypertension of unknown cause. There must be clinical impairment of heart function resulting in the Permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity (marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain).

For the above definition, Pulmonary hypertension secondary to any other known cause (i.e. not primary) is not covered.

Progressive supranuclear palsy – *resulting in Permanent symptoms*

A definite diagnosis of progressive supranuclear palsy by a Consultant Neurologist. There must be Permanent clinical impairment of eye movements and motor function.

Pulmonary artery graft surgery

The undergoing of surgery on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

For the above definition, the following is not covered:

- any other surgical procedure, including endovascular repairs or the insertion of stents.

Respiratory failure – *of advanced stage*

Advanced stage emphysema or other chronic lung disease, resulting in:

- the need for regular oxygen treatment on a Permanent basis; and
- the Permanent impairment of lung function tests where Forced Vital Capacity (FVC) and Forced Expiratory Volume at 1 second (FEV1) are less than 50% of normal.

Systemic lupus erythematosus – *with severe complications*

A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following:

- Permanent Neurological Deficit with Persisting Clinical Symptoms; or
- the Permanent impairment of kidney function tests with Glomerular Filtration Rate (GFR) below 30 ml/min.

Terminal illness

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; and
- in the opinion of the attending Consultant, the illness is expected to lead to death within the earlier of 12 months and the Insured Person's Expected Retirement Age.

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

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

Traumatic head injury – *resulting in Permanent symptoms*

Death of brain tissue due to traumatic injury resulting in Permanent Neurological Deficit with Persisting Clinical Symptoms.

6.3 Total Permanent Disability (TPD)

These definitions apply where the Schedule states that TPD is included. The Schedule will also state which definition has been used.

A benefit will only be payable under the Policy as a result of Total Permanent Disability if the Insured Person:

- survives for more than six months from the date of Total Permanent Disability; and
- suffers Total Permanent Disability throughout this period.

If Children's cover is included, the Loss of Independence Existence definition will apply to any child's claim.

Disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

The definitions of Total Permanent Disability are shown below

Unable to do their own occupation ever again (Own Occupation)

Loss of the physical or mental ability through an illness or injury before the age of 65 to the extent that the Insured Person is unable to do the material and substantial duties of their 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 the person's own occupation that cannot reasonably be omitted or modified.

Own occupation means the Insured Person's trade, profession or type of work done 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 the Insured Person expects to retire.

Unable to do a suited occupation ever again (Suited Occupation)

Loss of the physical or mental ability through an illness or injury before the age of 65 to the extent that the Insured Person is unable to do the material and substantial duties of a suited 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 a suited occupation that cannot reasonably be omitted or modified.

A suited occupation means any work the Insured Person could do for profit or pay taking into account their employment history, knowledge, transferable skills, training, education and experience, and is irrespective of location and availability. 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 the Insured Person expects to retire.

Loss of Independent Existence

Loss of the physical ability through an illness or injury before the age of 65 to do at least 3 of the 6 tasks listed below ever again. 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 the Insured Person expects to retire.

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

The tasks are:

1. 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.
2. 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.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

7. EXCLUSIONS

7.1 Pre-existing conditions

No Benefit is payable for any Defined Condition which, in the opinion of the medical adviser appointed by the Company, has resulted either directly or indirectly from any condition or related condition for which the Insured Person has received treatment, or suffered symptoms of, or received advise on, or was aware existed at the time of, or prior to becoming an Insured Person under this policy.

Unless otherwise indicated, this exclusion will only apply for the first two years that the Insured Person is covered. Where Benefits were insured with another Insurance Company on the day before cover started under this Policy, we will backdate this two year period to the day that the Employee first became eligible under any previous policies held by the Employer.

The following tables contain examples of related conditions where the exclusion applies for two years and a complete list of related conditions where the exclusion applies indefinitely.

Group 1: Cardiovascular	Related Conditions
• Coronary artery by-pass grafts • Heart attack • Heart transplant (under major organ transplant) • Heart valve replacement or repair • Stroke • Aorta graft surgery* • Cardiac arrest* • Open heart surgery* • Primary pulmonary arterial hypertension* • Pulmonary artery graft surgery*	Applies for two years: • Any disease or disorder of the heart • Any obstructive or occlusive arterial disease • High or Low Blood Pressure treated at any time by prescribed medication Applies indefinitely: • Diabetes mellitus

Group 2: Cancer	Related Conditions
• Cancer • Aplastic anaemia* • Benign brain tumour* • Benign spinal cord tumour*	Applies for two years: • Polyposis coli • Papilloma of the bladder • Any invasive carcinoma in situ • Crohn's Disease or Ulcerative Colitis • Abnormal smear test.

Group 3: Neurological	Related Conditions
• Alzheimer's disease • Creutzfeldt-Jakob disease • Motor neurone disease • Multiple Sclerosis • Parkinson's disease • Pre-Senile Dementia • Paralysis of limbs • Progressive supranuclear palsy*	Applies for two years: • Any disease or disorder of the brain or central nervous system

Group 4: Major organs	Related Conditions
• Kidney failure • Kidney or liver transplant (under major organ transplant) • Liver failure*	Applies for two years: • Any chronic renal disease or disorder • Any chronic liver disease • Chronic pancreatitis Applies indefinitely • Chronic leukaemia • Diabetes mellitus

Group 5: Respiratory diseases	Related Conditions
• Lung transplant (under major organ transplant) • Respiratory failure*	Applies for two years: • Any chronic lung disease

Group 6: Disability, HIV infection and Terminal Illness	Related Conditions
• Total Permanent Disability** • Blindness* • Deafness* • HIV infection* • Loss of hands or feet* • Loss of independent existence* • Loss of speech* • Paralysis of limbs* • Terminal Illness*	Applies for two years: • Peripheral vascular disease • Inflammatory polyarthropathy Applies indefinitely • All other Defined Conditions covered by this Policy • Diabetes mellitus • Any disease or disorder of the brain or central nervous system • Chronic or recurring mental illness • Chronic symptoms of fatigue, back, joint or muscle pain

* these conditions only apply if "additional conditions" are shown in the Policy Schedule

** Total Permanent Disability only applies if shown in the Policy Schedule

In addition, no child Benefit will be paid for any condition that the child suffered from prior to the start of cover or if the child's condition was present at birth.

7.2 Multiple claims

No claim shall be paid for any Defined Condition in each of the groups in section 7.1 above, where the Member has already suffered from a Defined Condition in that group.

For example, where a Member has suffered a heart attack (found in group 1) then no Benefit shall be payable in respect of any subsequent stroke claim, or any other condition in group 1.

No claim shall be paid for any condition in group 6: Disability and Terminal Illness which, in the opinion of the medical adviser appointed by the Company, has resulted either directly or indirectly from a condition or related condition for which the Member has already received a Benefit, whether under this policy or any previous policies.

Upon payment of a claim any condition in group 6: Disability and Terminal Illness for a Member, all cover for that Member will end and no further claims will be payable.

7.3 General exclusions

No Benefit will be payable if the Defined Condition is caused directly or indirectly from any of the following:

7.3.1 Alcohol or drug abuse

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

- Consuming too much alcohol.
- Taking an overdose of drugs, whether lawfully prescribed or otherwise.
- Taking Controlled Drugs (as defined by the Misuse of Drugs Act 1971) otherwise than in accordance with a lawful prescription.

7.3.2 Unreasonable failure to follow medical advice

Unreasonable failure to follow or seek medical advice.

7.3.3 Hazardous Pursuits

Unless the Company has been fully informed of an Insured Person's involvement in any of the following hazardous pursuits then no Benefit shall be payable if a Defined Condition is suffered and was caused directly or indirectly from:

i. Taking part in any flying activity, other than as a passenger in a commercially licensed aircraft.

ii. Taking part in (or practising for) boxing, caving, climbing, horse-racing, jet skiing, martial arts, mountaineering, off-piste skiing, pot-holing, power-boat racing, underwater diving, yacht racing, or any race, trial or timed motor sport.

If the Company has been fully informed of an Insured Person's involvement in such a pursuit and has agreed in writing to provide such cover then this cover will be subject to any restrictions and exclusions as the Company may stipulate.

7.3.4 Self-inflicted injury

Intentional self-inflicted injury

8. PREMIUM PAYABLE

At the Commencement Date and each Anniversary Date thereafter a Deposit Premium, as determined by the Company, will be payable.

At these dates and at the Termination Date, the Policyholder will provide to the Company such data as the Company may reasonably require to calculate the actual Premiums Due, which shall be calculated in accordance with section 8.3. A Premium Payable will then be determined, which becomes due upon notification to the Policyholder and shall be payable in advance at the frequency shown in the Schedule.

The Premium Payable will consist of any outstanding Premiums Due plus any Extra Premiums arising from Medical Underwriting, loadings for premium frequency or other charges

8.1 Days of Grace

If any premium or any other sum which the Company has determined to be payable is not paid within 30 days of the date such a sum became payable, the Policy will be deemed, at the sole discretion of the Company, to have terminated.

However, if the Company is satisfied that the Policyholder acknowledges its intention to pay the unpaid sums referred to above, the Policy may be deemed, at the Company's sole discretion, to remain in force. In this case, any amounts due to it under the Policy may be offset against any claim payments.

8.2 Minimum Premium

A minimum premium of £1800 per annum applies to the Policy. This reduces to £500 when the premium frequency is annual.

8.3 Calculation of Premium Due for Policy Year

The Premium Due falls due in two parts:

8.3.1 Initial Premium

An Initial Premium is due at the start of the Policy Year and is calculated using the Scheme's membership at the start of the Policy Year.

For Unit Rated Schemes, this is

Premium Rate multiplied by the **total Scheme Benefit on first day of Policy Year**,

For Single Premium Schemes or Members, this is the sum of

Premium rate applicable to the Member

multiplied by the **Member's Benefit on the first day of the Policy Year**,

In both cases, this takes account of the number of days in the Policy Year.

Schemes which are Single Premium Costed will show "Single Premium" as the Premium Rate on the Schedule.

8.3.2 Adjustment Premium

An Adjustment Premium is due at the end of the Policy Year and is calculated by:

> **Premium Due for Policy Year** minus **Initial Premium**

Where **Premium Due for Policy Year** is

For Unit Rated Schemes,

> **Premium Rate** multiplied by the **Average total Scheme Benefit on first and last days of Policy Year**

For Single Premium Schemes or Members, this is the sum of

> **Premium rate applicable to the Member** multiplied by **the Member's Benefit,**
>
> taking account of the number of days in the Policy Year during which the Member was insured for this amount of Benefit.

In both cases, if the Adjustment Premium is negative the Initial Premium in respect of the following Policy Year will be offset by this amount.

8.4 The information we need to calculate the Premium Payable

At the Commencement Date and each Anniversary Date, the Policyholder must provide the Company with a complete list of Members. The list must include for each Member:

- name;
- gender;
- date of birth;
- salary or Lump Sum Benefit;
- Scheme Benefit Category (if more than one Benefit category exists);
- occupation;
- postcode of normal work location (this will be home postcode if the Member normally works from home), or overseas location; and
- details of any regular business travel taken in the last 12 months, or anticipated in the next 12 months, outside the UK, the EU or North America.

For Single Premium Schemes or Members we will also require:

- for any Members who have joined or left the Scheme, the date of joining or leaving; and
- date of increase in Scheme salary, if the increase was not on the annual revision date.

The Policyholder must also clearly show all Members:

- who are not Actively at Work on the Anniversary Date, including any who are early retired, ill health retired or a Long Term Absentee;
- whose Aggregate Benefit exceeds the Free Cover Limit;
- who have previously been Medically Underwritten (either by the Company or a previous Insurance Company);
- who are provided with cover after being made redundant; and
- whose cover is to be provided beyond the Expected Retirement Age of the Policy.

If these Members are not clearly identified we may not be able to provide cover for them. We do not need this information in respect of spouses, civil partners or children who are to be insured under this policy.

You must ensure that the data you give us accurately reflects the Eligibility Criteria and Benefit Basis. We will use the Eligibility Criteria and Benefit Basis to determine the amount of any Benefit payable and may limit the amount of the Benefit payable if this does not match with the data provided.

You must notify use of any errors you become aware of as soon as practicable. We are entitled to make any appropriate adjustment to the premiums and/or the terms of the Policy to take account of any corrected errors.

9. RATE GUARANTEE

The Premium Rate - applicable to Unit Rated Schemes - and the age specific rates are guaranteed not to change during the Rate Guarantee Period stated in the Schedule. This is referred to below as "the Guarantee".

9.1 Validity of the Guarantee

In determining the Guarantee, the Company shall rely, without further inquiry, on the information provided by the Policyholder being complete and accurate. The Company reserves the right to declare the Guarantee invalid in the event of either:

- the number of Members or total Aggregate Benefit at the start of the Rate Guarantee Period varying by more than 10% from that stated in the corresponding quotation issued by the Company; or
- if any of the information relied on for the quotation is found to be inaccurate or incomplete or if the information changes between the quotation and the start of the Rate Guarantee Period. Such information includes:
  - the Eligibility Criteria and Benefit Basis;
  - details of existing Members who are early retired, ill health retired, Long Term Absentees or income protection claimants;
  - details of existing Members who were restricted or loaded by the previous Insurance Company;
  - the percentage take-up of membership by Eligible Employees;
  - the history of claims and Benefits amounts under the previous Insurance Company; and
  - changes in Benefit Bases during the period for which the history of claims and Benefit amounts is available.

In the event of the Guarantee being declared invalid the Company may, at its sole discretion, either:

- leave the Premium Rate unchanged and reinstate the Rate Guarantee Period applying before the Guarantee was withdrawn; or
- revise the Premium Rate and / or other terms and issue a new Rate Guarantee Period, applicable with effect from the start of the Rate Guarantee Period, unless otherwise agreed in writing by the Company.

9.2 Withdrawal of the Guarantee

The Company reserves the right to withdraw the Guarantee and end the Rate Guarantee Period immediately in the event of any of the following:

- the number of Members or total Aggregate Benefit varying by more than 25% from that at the commencement of the Rate Guarantee Period; or
- if an alteration is made to the Benefit Basis or the Eligibility Conditions; or

- if an associated or subsidiary employer joins or leaves the Scheme; or
- if there is any material change in the nature of trade or business carried out by the Employer or in the geographical location of the Members; or
- if a relevant transfer under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) or a group employment transfer takes place (either into or out of the Policy); or
- if any new regulation (or change in legislation or HMRC practice) comes into force which affects the way that premiums and / or Benefits are treated for tax purposes for the Employer, the Company, the Members or any recipient of Benefits.

In the event of the Guarantee being withdrawn the Company may, at its sole discretion, either:

- leave the Premium Rate unchanged and reinstate the Rate Guarantee Period applying before the Guarantee was withdrawn; or
- revise the Premium Rate and / or other terms of the Policy and issue a new Rate Guarantee Period, applicable with effect from the day following the withdrawal of the Guarantee, unless otherwise agreed in writing by the Company; or
- in the case of alterations to the Benefit Basis or Eligibility Conditions, we may be unable to accept the change. In this case, the Rate Guarantee Period and other Terms and Conditions will remain unaltered.

Where we agree to make changes which you have requested, we will provide you with a Policy Endorsement that confirms the changes and the date on which they become effective. Any claims that occurred before the date the Endorsement becomes effective will not be subject to the terms of the Endorsement.

9.3 Expiry of the Guarantee

Upon expiry of the Rate Guarantee Period the Company will review the Premium Rate and issue a new Rate Guarantee Period. These will apply with effect from the day following the expiry of the guarantee, unless otherwise agreed in writing by the Company.

9.4 New Rate Guarantee Periods

Whenever a new Rate Guarantee Period is issued, the Company may decide, at its sole discretion, to issue revised Policy Terms and Conditions.

10. TERMINATION of POLICY

10.1 Termination by the Policyholder

The Policy can be terminated at any time by written notice from the Policyholder to the Company. Any such notice must specify the future date on which termination is to take effect. Cancellation cannot be retrospective.

10.2 Termination by the Company

The Company shall be entitled to terminate the Policy or to amend its terms in any of the following circumstances:

- if the Policyholder fails to provide information as required by the Policy; or
- if any claim under this Policy is in any respect fraudulent or if any fraudulent means or devices have been used, regardless of whether this was by the Policyholder, a Member or anyone acting on the behalf of the Policyholder or Member; or
- if any war or act of war occurs which, in the reasonable opinion of the Company, could adversely affect the Policy or the operation of the Policy.

In this case, the Company will write to the Policyholder to confirm the Termination Date.

10.3 Termination for any other reason

Cover under the Policy shall immediately cease upon any of the following events:

- discontinuance of payment of premiums; or
- at expiry of the period for which premiums have previously been received by the Company, following the liquidation of the Employer.
- new regulation and / or legislation are introduced, or changes are made to existing legislation which affect the Scheme so it is no longer being treated a registered group life scheme.
- you or any Employer or any Eligible Employee is or becomes a Restricted Person.

In this case, the Company will write to the Policyholder to confirm the Termination Date.

10.4 Premium due on termination

Any premium paid or payable in respect of the period in which termination occurs will be calculated pro-rata on a time basis and an adjusting payment may be due between the Company and the Policyholder on the date on which termination takes effect.

11. DATA PROTECTION

For the purposes of this clause the terms "data controller", "personal data" and "process" shall have the meanings given to them under the General Data Protection Regulation.

You agree that the Company is the data controller in respect of personal data it receives from you in relation to this Policy. The Company will process all personal data received in relation to this Policy in accordance with its obligations under the General Data Protection Regulation.

You will be responsible for making any notifications to or obtaining any necessary consents from Members and / or Dependants before providing us with any personal data.

You must notify us of any errors you become aware of as soon as practicable. We are entitled to make any appropriate adjustment to the premiums and/or the Policy to take account of any corrected errors.

12. GENERAL

The terms of the Policy depend upon the information provided by the Policyholder. Failing to disclose information, giving false information or failing to tell us where any facts have changed since they were provided gives us the right to cancel or amend the Policy.

If you fail to comply with all of the Policy Terms and Conditions (including any Endorsements), we may not pay claims. We may also cease to accept further premiums, meaning cover under the Policy will cease.

The Policy will not have or accrue any surrender value.

This Policy may not be assigned unless agreed in writing by the Company prior to any assignment taking place.

All Premiums and Benefits will be denominated in pounds sterling.

The construction, validity and performance of the Policy will be governed by the Law of England and Wales and the Policyholder accepts that any dispute shall be subject to the exclusive jurisdiction of the English Courts. Under the Policy, Members do not have any rights under the Contracts (Rights of Third Parties) Act 1999.

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