Generali Worldwide

Life and Disability

Policy Document

Policyholder Name:	Cubico Sustainable Investments Ltd
Policy Number:	803.898, 899 & 900

INTRODUCTION

The **Policy** is issued by **Generali Worldwide Insurance Company Limited ("we" or "us")** to the **Policyholder** named in the **Policy Particulars**, in response to the acceptance of a **Quotation**, and completion of an **Application Form**.

The **Policy Document** (together with the **Policy Particulars**, **Quotation** and **Application Form**, and any endorsements or written statements that we agree in writing to be incorporated in the **Policy**) sets out the terms and conditions of the legal contract between you (the **Policyholder**) and us.

The **Policy** does not create, and is not intended to create, any legal relationship between any **Member** and us.

The information provided to us by you or a **Member** in order to issue the **Policy Document** shall be true to the best of those persons' knowledge and belief and no material facts should be withheld. **Generali Worldwide** shall be entitled to rely upon and shall have no liability in relation to any material fact or statement that is subsequently found to be untrue or misleading, whether intentionally or otherwise.

The **Policy Document** is divided into the following sections:

SECTION ONE	**Definitions and Interpretation**
SECTION TWO	**Entry Criteria for Members**
SECTION THREE	**Cover Options Available**
SECTION FOUR	**Claims Acceptance Process**
SECTION FIVE	**Premium Payment and Policy Administration**
SECTION SIX	**Policy Exclusions**
SECTION SEVEN	**Cancellation Rights and General Conditions**

The cover(s) chosen by the **Policyholder** for their Life and Disability insurance shall be set out in the **Policy Particulars**.

The cover options available for selection, detailed under **Section Three**, are:

- **Group Life & Dependant's Pension**
- **Group Accidental Death and/or Dismemberment**
- **Group Long Term Disability**
- **Group Critical Illness**
- **Group Total Permanent Disability**

It is important that you read all the documents comprising the **Policy** carefully, and keep these in a place of safety for future reference.

Signed for and on behalf of **Generali Worldwide Insurance Company Limited**:

Authorised Signatory:

Date: 1 6 0 8 1 7

Authorised Signatory:

Date: 1 6 0 8 1 7

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SECTION ONE

DEFINITIONS AND INTERPRETATION

1. DEFINITIONS

Technical terms used for the Life and Disability insurance are displayed in bold and defined alphabetically below:

Accident

A sudden, unforeseen and unintended, identifiable event, causing death, dismemberment or **Incapacity**, within 180 days of that event. In addition, a dismemberment or **Incapacity** resulting from the following will also be considered as an **Accident**:

i) a pyogenic infection arising from such an event;
ii) a surgical operation made necessary solely by such an event and performed within 90 days of the event.

Self-inflicted injury or suicide will not be considered as an **Accident**.

Actively At Work

The **Member** is deemed to be **Actively At Work** on a relevant date if the **Member**:

i) is working their contracted number of hours and undertaking their **Own Occupation**;
ii) is mentally and physically capable of undertaking their **Own Occupation**; and
iii) is not working contrary to any medical advice received.

Activities of Daily Living

Activities that can be carried out without the assistance of another person throughout, or with the use of special equipment or prescribed medication.

The **Activities of Daily Living** are:

i) washing in the bath or shower and maintaining adequate personal cleanliness;
ii) full dressing or undressing, including putting on and taking off medically necessary surgical appliances;
iii) getting to and from the toilet, getting on and off the toilet and maintaining adequate levels of personal hygiene;
iv) voluntarily controlling bowel and bladder function;
v) moving into and out of a chair or bed;
vi) drinking or eating prepared food.

Any Occupation

An occupation or activity which provides an income or any engagement in any business for remuneration or profit. The occupation is not required to reference the **Member's** age, education, training, experience or status of career or **Own Occupation**.

Application Form

The form bearing our name and the title '**Application Form**', completed by you in order to apply for a **Policy**.

Associated Condition

A medical condition which is related to an **Insured Condition**. The list of **Associated Conditions** is set out in the **Policy Particulars** under the Group Critical Illness cover.

Benefit

The insured amount calculated by us in accordance with the **Policy Particulars**, for which a **Member** is covered under the **Policy** including **Core Benefit** and, where applicable, **Supplementary Benefit**. The **Core Benefit** may be based on a multiple of **Earnings** or a flat monetary amount. The **Benefit** may be payable by us as a **Lump Sum Benefit** and/or a **Regular Payment Benefit**. Where a **Member** is accepted on non-standard terms, this is the agreed restricted **Benefit**.

Cancellation Period

The period of 30 days from the **Commencement Date**.

Catastrophe
A single unforeseen and unavoidable event or accidental occurrence including but not limited to a natural disaster, earthquake, storm or flood, which triggers more than one **Claim** for **Benefit** under the **Policy**. The timeframe of a catastrophic event is limited to a period of 72 consecutive hours, as determined by us in our discretion.

Catastrophe Limit
The maximum amount we will pay under the **Policy** in the event of a **Catastrophe**, as set out in the **Policy Particulars**.

Chief Medical Officer (CMO)
A medical advisory board, comprising of qualified and experienced **Physicians**, appointed by us to provide independent advice on **Medical Underwriting** and **Claims** assessment.

Child/Children
An unmarried individual who is under 18 years old (unless otherwise specified in the **Policy Particulars**); and who is either:

i) a natural or legally adopted son or daughter of an **Eligible Employee**; or

ii) is deemed by us in our sole discretion, to be financially dependent on the **Eligible Employee**.

Claim
Insured event giving rise to a **Benefit** payment.

Claim Forms
The forms produced by us for completion by you and the **Member**, bearing our name and the title '**Claim Form**'.

Claimant
A **Member** who meets the **Claim** acceptance terms.

Commencement Date
The date on which the **Policy** becomes effective as specified in the **Policy Particulars**.

Congenital Condition
Any congenital abnormality for which the **Member** has received medical treatment or has been attended to by a **Physician** or has been prescribed drugs or the symptoms of which have occurred or have manifested or which have been diagnosed by a **Physician**, before the **Member** attained the age 18.

Core Benefit
The primary **Benefit** insured under the **Policy**, as set out in the **Policy Particulars**.

CPI
The Consumer Prices Index applicable to the **Policy Currency** as determined in our sole discretion.

Deferred Period
The period of time commencing on the date that a **Member** was first absent from work due to **Incapacity** until the date the **Member's Benefit**, under this **Policy**, first becomes payable by us.

Definition of Disability
The definition selected by the **Policyholder** to determine the level of working **Incapacity** of a **Member** under the Group Long Term Disability cover.

Diagnosis
The definitive **Diagnosis** made by a **Physician**, based upon radiological, clinical, histological or laboratory evidence acceptable to us. Under the Group Critical Illness cover, this is the specific evidence as referred to in the definition of the diagnosed illness.

Discretionary Entrant
An individual who:

i) is not an **Eligible Employee**, **Eligible Spouse** or **Eligible Child**, but who is covered under the **Policy** with our written agreement; or

ii) is an **Eligible Employee**, **Eligible Spouse** or **Eligible Child**, but who is covered under the **Policy** with our written agreement from a different date to their **Normal Inclusion Date**.

Earnings
Basic annual salary (excluding bonuses, commissions, overtime payments and other supplements) unless specified otherwise in the **Policy Particulars**. Inclusion of fluctuating emoluments will be recorded in the **Policy Particulars** and may be subject to averaging or other adjustment in our sole discretion.

Eligibility
A set of criteria that **Employees**, **Spouses and Children** must satisfy in order to become a **Member**. The criteria normally relates to age, entry dates and length of employment. The criteria are provided by you, agreed by us and set out in the **Policy Particulars**.

Eligible Child
A **Child** who meets the **Eligibility** conditions.

Eligible Employee
An **Employee** who meets the **Eligibility** conditions.

Eligible Spouse
A **Spouse** who meets the **Eligibility** conditions.

Employee
An individual employed by the **Employer** or seconded to work for the **Employer**, or who has established an equivalent working relationship with the **Employer** by way of a written contract.

Employer
You as the **Policyholder** and any associated company, firm, partnership or organisation that we have agreed in writing to include as an '**Employer**' in the **Policy**.

Escalation
The annual increase to be applied to **Regular Payment Benefits**. The applicable rate is set out in the **Policy Particulars**.

Evidence of Insurability
Any documentation that we may request from an **Employer**, including but not limited to medical evidence, to enable us to assess individual acceptance of a **Member** under the **Policy**.

Exclusions
Provisions that state the circumstances under which **Benefit** payment will not be made under the **Policy**.

Fixed Period
A pre-determined period during which a **Regular Payment Benefit** will be paid in relation to a potential **Claim**. If applicable, the **Fixed Period** will be set out in the **Policy Particulars**.

Forward Underwriting Bar
An increase in **Benefit** of up to 20%, unless specified otherwise in the **Policy Particulars**, which does not require **Evidence of Insurability**. The **Forward Underwriting Bar** does not apply to any **Member** accepted on non-standard terms.

Free Cover Limit
The threshold of **Benefit** below which **Evidence of Insurability** is not required. The **Free Cover Limit** will be set out in the **Policy Particulars**.

Generali Worldwide (or 'we', 'us' or 'our')
Generali Worldwide Insurance Company Limited.

Guarantee Period
The period during which the **Unit Rate** and the **Underlying Rate Table** are fixed. This will be two years unless specified otherwise in the **Policy Particulars**.

Hereditary Condition
A diagnosed medical condition that is inherited genetically, and may develop at birth or in subsequent years.

Incapacity
The inability of a **Member**:

i) to work, irrespective of availability or location of work; or

ii) to carry out a pre-defined number of **Activities of Daily Living**;

as a result of an **Accident**, illness or injury.

Insured Condition
A core illness or extended illness included under the Group Critical Illness cover and listed in Tables 7 and 8.

Irreversible Condition
A diagnosed medical condition that cannot be reasonably improved upon by medical treatment and/or surgical procedures at the time of the **Claim** as confirmed by a **Physician**.

Lump Sum Benefit
A single payment **Benefit**.

Material and Substantial Duties
Tasks that have to be performed for the role to exist or have value. These would be outlined as core duties on a job description or employment contract and would occupy the majority of the **Employee's** working hours.

Maternity Leave
The period of absence for a female **Member** that immediately precedes and follows the conclusion of her pregnancy, during which she has the right to return to work for an **Employer** and includes any continuation of such absence which the **Employer** decides shall be treated as **Maternity Leave** and agreed to in writing.

Medical Underwriting
The process whereby **Evidence of Insurability** is obtained and assessed by us to determine in our sole discretion the appropriate premium and, where necessary, the non-standard terms that need to be applied to an **Eligible Employee** or **Eligible Spouse** for cover under the **Policy**.

Member
An **Eligible Employee** who meets the standard acceptance terms and is covered under the **Policy** from their **Normal Inclusion Date**, or a **Discretionary Entrant** who we have agreed in writing to accept at non-standard terms under the **Policy**.

Where agreed by us, and set out in the **Policy Particulars**, a **Member** may also be an **Eligible Spouse** or **Eligible Child** meeting the same terms as above.

Natural Causes
A naturally occurring illness that causes death without being hastened or aggravated by outside influences such as an adverse response to treatment, lack of care, drugs or injury.

Normal Inclusion Date
The first date on which an **Eligible Employee**, **Eligible Spouse** or **Eligible Child** qualifies for inclusion in the **Policy**.

Normal Retirement Age (NRA)
The retirement age specified in the **Policy Particulars**.

No Worse Terms
The individual **Medical Underwriting** or **Member** acceptance terms, comparable to those provided by a previous insurer, in relation to the same cover.

Onset Date
The date on which the **Claim** occurred or the **Incapacity** first manifested itself.

Orphan
A **Child** who is left orphaned on the death of the **Member**. Orphaned means that both the **Employee** and **Spouse** are deceased.

Own Occupation
The role or working activity in which the **Member** was employed and remunerated for by the **Employer** immediately before the **Onset Date** of the **Incapacity** or the commencement of the period of **Permitted Temporary Absence**. This includes the **Material and Substantial Duties** required to be performed in carrying out that occupational activity, as defined in their job description or employment contract.

Permanent Condition
A diagnosed medical condition that is expected to last throughout the **Member's** life, irrespective of when cover ends or the **Member** retires.

Permanent Neurological Deficit
The **Member** is deemed to suffer at least one of the following neurological deficits, 180 days after the date of **Diagnosis** of an **Insured Condition** and is confirmed as a **Permanent Condition** by a registered neurologist acceptable to us:

i) complete and permanent loss of use of two or more limbs;

ii) inability to perform without assistance at least four of the **Activities of Daily Living**;

iii) the organic or functional disturbance of the mastication and swallowing which renders the **member** incapable of eating a solid diet, but excluding dental causes.

Permitted Temporary Absence
An agreed period of absence from work during which a **Member** may be permitted to remain covered under the **Policy.**

Physician
A medically qualified duly licensed **Physician**; in relation to any period of **Incapacity** where the **Member** is disabled primarily because of mental, psychoneurotic or personality disorder, the **Physician** must either specialise in the practice of psychiatric medicine or have by reason of training and/or experience, a specialised competency in the field of psychiatric medicine sufficient to render the necessary evaluation and treatment of mental illness.

Policy
The insurance contract between us and the **Policyholder**, comprising this **Policy Document**, the **Policy Particulars**, the **Quotation** and the **Application Form** and any endorsements or written statements that we agree to incorporate in the **Policy**.

Policy Currency
The currency of the **Policy** as specified in the **Policy Particulars**.

Policy Document
This document.

Policy Particulars
The schedule attached to the **Policy Document** which details items specific to this **Policy**.

Policyholder (or 'you' or 'your')
The legal owner(s) of the **Policy**, named as the **Policyholder** in the **Policy Particulars**.

Pre-Existing Medical Conditions
In relation to a **Member**, any medical condition or related condition and/or complication for which symptoms first appeared and were first diagnosed, treated, or known to be in existence or in respect of which advice was sought from a **Physician** within the five years immediately preceding the provision of **Evidence of Insurability**.

Quotation (including Quote Front)
The initial 'Life and Disability Quotation' pricing and **Benefit** indication provided by us and signed by the **Policyholder** prior to **Commencement Date**.

Regular Payment Benefit
A **Benefit** which is payable monthly in arrears (unless specified otherwise in the **Policy Particulars**).

Renewal Date
The date specified in the **Policy Particulars**, on which the **Policy** terms are renewable.

Review Date
The end of the **Guarantee Period** or the date that a material change occurred.

SIB
The standard 'State Incapacity Benefit' or 'State Invalidity Benefit', single person allowance applicable or equivalent payment in a particular territory. If applicable, the relevant **SIB** will be set out in the **Policy Particulars**.

Spouse
An individual who meets one of the following criteria:

i) is legally married to the **Eligible Employee**; or

ii) is the recognised cohabitant of the **Eligible Employee** irrespective of the person's gender (i.e. a person who lives with the **Eligible Employee**, as a couple in an intimate and committed relationship for a period of two years or more, and is not a relative).

Statutory Leave
Maternity Leave, paternity leave, adoption leave or parental leave as defined by local legislation. This leave of absence must comply with the relevant legislation which is applicable in the location of employment at the time.

Suited Occupation
A role or working activity which provides an income or any engagement in any business for remuneration or profit for which an individual is suited by reference to education, training, experience or status of career. Where we assess the duties of a **Suited Occupation**, they will be those performed in that occupation generally. Level of **Earnings** and place of work are not a relevant factor when determining a **Suited Occupation**.

Supplementary Benefit
An additional amount of **Benefit** insured under the **Policy** in addition to the **Core Benefit**, as set out in the **Policy Particulars**.

Survival Period
A 14 day period during which a **Member** needs to remain alive in order to become a **Claimant** under the Group Critical Illness cover.

Take-Up Rate
When membership of the **Policy** is linked to another scheme (e.g. a group pension scheme) this is the percentage of **Eligible Employees** that joined that other scheme as communicated at **Quotation** stage and agreed by us.

Temporary Cover
A period of 90 days from the date that **Evidence of Insurability** is required to complete **Medical Underwriting**.

Terminal Illness
Under the Group Life cover, this is the **Diagnosis** of an illness that satisfies both of the following:

i) the illness either has no known cure or has progressed to the point where it cannot be cured;

ii) in the opinion of the attending **Physician**, the illness is expected to lead to death within the earlier of 12 months and the remaining term of cover.

Termination Age
The **Normal Retirement Age** or the agreed age at which a **Member** is no longer eligible for cover, as specified in the **Policy Particulars**.

Total Permanent Disability
Permanent loss of physical or mental ability through **Incapacity**. The resulting disability must be a **Permanent Condition** and an **Irreversible Condition**, and result in the **Member** not being able to carry out **Any Occupation** ever again.

Unit Rate/Underlying Rate Table
The rate or rate tables, set out in the **Quotation**, used to calculate the premium:

i) a **Unit Rate** is normally used to price schemes of 20 **Members** or more which are 'unit rated' (i.e. the same premium rate, derived from the characteristics of the scheme as a whole, is used for every **Member**);

ii) single premium 'costed' schemes, normally below 20 **Members** are priced using the **Underlying Rate Table** (i.e. a different premium rate, reflecting the characteristics of the **Member**, is used for each **Member**).

2. INTERPRETATION

In this **Policy** any reference to:

i) words in the singular shall include words in the plural and vice versa;

ii) the masculine gender shall include the feminine and the neuter and vice versa;

iii) any enactment or a provision of any enactment and the rules and regulations made thereunder includes a reference to such enactment, provision, rules or regulations as amended, re-enacted or replaced from time to time. It also includes references to any statutory instruments or regulations made or in force under that law; and

iv) save where expressly provided otherwise, any power which may be exercised, opinion which may be expressed or determination which may be made by us may be exercised or made in our sole, absolute and unfettered discretion and we shall not be obliged to give reasons thereunder.

SECTION TWO

ENTRY CRITERIA FOR MEMBERS

1. SWITCHING COVER FROM A PREVIOUS INSURER

1.1. Previously insured on an identical basis

If, immediately prior to the **Commencement Date**, the **Policyholder** held a policy, which insured the **Members** with an identical level of benefit to this **Policy**, then we will accept the previously insured level of benefit in respect of a medically underwritten **Member** on **No Worse Terms** provided by the previous insurer, subject to the following provisions:

i) evidence being provided of the previous level of benefit covered and the **Medical Underwriting** terms applicable to the **Member**;

ii) any subsequent increase in such **Member's Benefit** where the **Forward Underwriting Bar** is exceeded will be subject to **Medical Underwriting**; and

iii) if our **Free Cover Limit** is higher than the previous insurer's equivalent limit, then in relation to any **Member** whose cover under the previous insurer's policy had been subject to adverse underwriting decisions, or who had previously had any benefit restricted due to non-completion of **Medical Underwriting**, our **Free Cover Limit** will be restricted to the previous insurer's lower equivalent limit. For such **Members**, further increases in **Benefit** will be subject to **Medical Underwriting**.

1.2. Previously insured on a non-identical basis

If, immediately prior to the **Commencement Date**, the **Policyholder** held a policy, which insured the **Members** with a different level of benefit to this **Policy**, then we will accept the previously insured level of benefit in respect of a medically underwritten **Member** on **No Worse Terms** provided by the previous insurer, subject to the following provisions:

i) evidence being provided, of the previous level of benefit covered and the **Medical Underwriting** terms applicable to the **Member**;

ii) any subsequent increase in such **Member's Benefit** will be subject to **Medical Underwriting**;

iii) if our **Free Cover Limit** is higher than the previous insurer's equivalent limit, then in relation to any **Member** whose cover under the previous insurer's policy had been subject to adverse underwriting decisions, or who had previously had any benefit restricted due to non-completion of **Medical Underwriting**, our **Free Cover Limit** will be restricted to the previous insurer's lower equivalent limit. For such **Members**, further increases in **Benefit** will be subject to **Medical Underwriting**;

iv) **No Worse Terms** will only apply in relation to any **Member** in respect of whom **Medical Underwriting** was completed less than 36 months before the **Commencement Date**. We reserve the right not to offer **No Worse Terms** in respect of any **Member** whose previous underwriting decision was made more than 36 months prior to **Commencement Date**;

v) **No Worse Terms** will only apply in relation to any **Member** whose previous medical ratings following any **Medical Underwriting** decision were up to +300% loading;

vi) where a **Member's** previously insured benefit had been restricted to the previous insurer's free cover limit, we will undertake **Medical Underwriting** on the **Member** for their full **Benefit** before the **Member** is considered for cover under the **Policy**; and

vii) where a **Member** was declined cover by the previous insurer, we will undertake **Medical Underwriting** on the **Member** for their full **Benefit** before the **Member** is considered for cover under the **Policy**.

The **Free Cover Limit** under the **Policy** (if any) will not apply to **Members** under (vi) or (vii).

1.3. Information on previous policy

You must provide any information or documentation requested by us in our sole discretion to confirm previous underwriting terms applied by the previous insurer immediately prior to the date on which you switch cover to us. If you fail to provide all such information and documentation we may, in our sole discretion, refuse to offer **No Worse Terms**.

2. MEMBER ACCEPTANCE

2.1. Standard Member Acceptance Terms

Eligible Employees and, where agreed and set out in the **Policy Particulars**, **Eligible Spouses** and **Eligible Children** will be accepted as **Members** and eligible for full **Benefit** at **Normal Inclusion Date**, subject to the following requirements:

2.1.1. Actively At Work Requirements – Eligible Employee

Provided an **Eligible Employee** is **Actively At Work** on the relevant date, that **Eligible Employee** will be accepted as a **Member** and included for **Benefit** under the **Policy** from that date.

Where the **Policy** covers 50 or more **Eligible Employees**, the **Actively At Work** requirement shall be waived unless stated otherwise in the **Policy Particulars**.

The relevant date on which **Actively At Work** applies is:

i) the **Commencement Date** for schemes not previously insured; or

ii) the last working day under the previous policy for schemes switching insurer; or

iii) for **Eligible Employees** to be covered after **Commencement Date**, their **Normal Inclusion Date**; or

iv) for **Benefit** increases, the date when the **Member** becomes eligible for the increase.

Where the requirement to be **Actively At Work** falls on a day:

i) which is not a working day; or

ii) on which the **Eligible Employee** is not **Actively At Work** due to **Permitted Temporary Absence** (see '**Permitted Temporary Absence**' under Article 3 below);

an **Eligible Employee** will be treated as if they were **Actively At Work** unless their medical records show that the **Eligible Employee** was suffering from a medical condition which would reasonably have prevented them from working normally on that day.

Any **Eligible Employee** who is not **Actively At Work** on the relevant date will not be accepted as a **Member** unless cover is explicitly granted by us. In order to consider offering cover we will require written evidence confirming the cause of absence from work and the dates of the corresponding absence. **Member** acceptance may be subject to **Medical Underwriting** (see below).

Where cover is granted, the **Eligible Employee** will be covered from the day they return to work to perform their **Own Occupation**.

2.1.2. Actively At Work Requirements – Eligible Spouse and Eligible Child

There are no **Actively At Work** requirements for **Eligible Spouses** and **Eligible Children**. Therefore, when applicable, all **Eligible Spouses** and **Eligible Children** will be automatically accepted as **Members** for their full **Benefit** at **Normal Inclusion Date**, subject to any **Medical Underwriting** requirements.

2.1.3. Medical Underwriting Requirements

Acceptance of any **Member** may be subject to **Medical Underwriting** in our sole discretion.

Medical Underwriting will be required if:

i) the **Benefit** exceeds the **Free Cover Limit**;
ii) you have not confirmed **Eligibility** to our satisfaction; or
iii) the **Take-Up Rate** (if applicable) has not been met.

There is no **Medical Underwriting** requirement under the Group Accidental Death cover and/or Group Accidental Dismemberment cover.

Whilst **Medical Underwriting** is being carried out, the **Member** will be covered for their full **Benefit** (excluding **Pre-Existing Medical Conditions**) for the duration of **Temporary Cover**. We may, in our sole discretion, agree in writing to an extension of **Temporary Cover** and continue cover for their full **Benefit** (excluding **Pre-Existing Medical Conditions**).

Benefit increases occurring during **Temporary Cover** are subject to our written acceptance.

If at expiry of **Temporary Cover** (including any extension) **Medical Underwriting** is still not completed, **Benefit** will be restricted to:

i) the **Free Cover Limit**; or
ii) in the absence of a **Free Cover Limit**, cover against **Claims** arising from an **Accident** only.

The restriction will apply until such a time that **Medical Underwriting** is complete and acceptance terms are confirmed.

In order for us to undertake **Medical Underwriting**, you must provide us with any **Evidence of Insurability** we may in our sole discretion, require. Failure to provide any **Evidence of Insurability** required by us may result in the **Member** being excluded from cover or accepted on non-standard terms (see 'Non-Standard Member Acceptance Terms' below).

Any **Evidence of Insurability** provided to us, whether by you, an **Employer**, a **Member** or any other person, must be true and complete to the best of the person's knowledge and belief and no material facts are to be withheld. Provision of false or incomplete **Evidence of Insurability** or withholding of material facts could result, in our sole discretion, in the acceptance of the relevant **Member** being declared null and void from their **Normal Inclusion Date**.

Once we have completed **Medical Underwriting** we may, in our sole discretion, agree to accept the **Member** for full **Benefit** with effect from their **Normal Inclusion Date** or to offer non-standard terms (see 'Non-Standard Member Acceptance Terms' below). We may, in our sole discretion, refuse to provide cover where we are not satisfied with the results of the **Medical Underwriting**.

We will advise you of our **Medical Underwriting** decision and any non-standard terms in writing.

2.2. Non-Standard Member Acceptance Terms

We may, in our sole discretion, accept a **Member** on non-standard terms for either the full **Benefit** or any part thereof.

Non-standard terms may include:

i) restricting the **Core Benefit** to the **Free Cover Limit**;

ii) restricting the **Benefit** to the previously insured amount;

iii) restricting the **Benefit** to **Claims** arising from an **Accident** only;

iv) charging an additional premium;

Where we determine that an additional premium is payable in relation to any particular **Member**, it will attach to that part of the premium that relates to the **Benefit** underwritten for the relevant **Member**.

If you or the **Member** do not wish to pay the additional premium, you should advise us in writing within 15 days of receiving notice of our decision to accept the **Member** on non-standard terms. We reserve the right to require reimbursement for any costs incurred in relation to **Medical Underwriting** if you, or the **Member**, do not wish to proceed with cover.

v) adding a specific **Exclusion**;

Full details of the **Exclusions** will be confirmed in writing. The **Exclusions** will remain in place unless the **Member** is subject to further **Medical Underwriting** and a new, overriding, decision is made by us and advised to you in writing;

vi) a postponement of the acceptance until such a time as we determine, in our sole discretion.

Where a postponement is applied, cover will be restricted to the **Free Cover Limit** or to the previously insured amount or to **Claims** arising from an **Accident** only. This will be the case until such time new medical evidence is received to indicate their condition has improved or stabilised and a new, overriding, decision is made by us.

Any non-standard terms will remain in place until a new, overriding, decision is made by us and advised to you in writing.

We may in our sole discretion reconsider non-standard terms from time to time, subject to provision of updated **Evidence of Insurability**. We will give you 30 days' notice in writing of any variation of non-standard terms.

2.3. Discretionary Entrant AcceptanceCCEPTANCE

We may in our sole discretion (in writing and subject to any special terms we specify) agree to:

i) the inclusion of an **Employee**, **Spouse** or **Child** who does not meet the definition of **Eligibility** as a **Member**;

ii) the inclusion of an **Employee** who has been absent from work for a period exceeding the period of **Permitted Temporary Absence** as a **Member**;

iii) the inclusion of an **Eligible Employee**, **Eligible Spouse** or **Eligible Child** as a **Member** at a date other than their **Normal Inclusion Date**; or

iv) a larger or smaller **Benefit** than the specified **Benefit** for a particular **Member**.

Discretionary Entrants will not be eligible for any **Free Cover Limit**, and therefore their full **Benefit** is subject to **Medical Underwriting**. In addition, **Discretionary Entrants** who are **Employees** must meet **Actively At Work** requirements.

3. PERMITTED TEMPORARY ABSENCE

Provided that payment of premium continues, we may agree to **Members** continuing to be covered under the **Policy** whilst they are temporarily absent from work in the following circumstances:

i) any kind of temporary agreed **Statutory Leave**. This leave of absence must comply with the relevant legislation which is applicable in the location of employment at the time;

ii) compassionate/unpaid leave or sabbatical (excluding voluntary or compulsory military training or service);

iii) any period of illness or injury.

Under **(i)** and **(ii)** the period of **Permitted Temporary Absence** must have a pre-defined start and end date. For cover to continue, any changes to these dates must be agreed by us in writing.

The maximum period of **Permitted Temporary Absence** for each of the circumstances is set out in 'Table 1 - Permitted Temporary Absence Table' below.

Table 1 - Permitted Temporary Absence Table

Cover		Circumstances	Maximum Period
1	Group Life & Dependant's Pension	(i) and (ii)	24 months
		(iii)	Until **NRA**
2	Group Accidental Death and/or Dismemberment	(i), (ii) and (iii)	24 months
3	Group Long Term Disability	(i) and (ii)	36 months
4	Group Critical Illness	(i), (ii) and (iii)	12 months
5	Group Total Permanent Disability	(i), (ii) and (iii)	12 months

Written consent from the **Policyholder** to the **Member** detailing the specific reason for the absence and the agreed duration must be supplied to us at the earliest opportunity. Details of **Members** on **Permitted Temporary Absence** must be must be supplied to us at **Renewal Date**. The specific reason for absence will need to be provided to us in the event of a **Claim**.

Members are considered to be **Actively At Work** and continue to be covered under the **Policy** for the entire period of **Permitted Temporary Absence**, unless they meet one of the criteria under 'Termination of Individual Member Cover' under Article 5 below. Cover is also subject to provision of any information or documentation that we may request at any time during the period of **Permitted Temporary Absence**.

Unless otherwise agreed between us in writing, the amount of **Benefit** will remain unchanged throughout the period of **Permitted Temporary Absence**.

Cover will cease if premiums are not paid in respect of a temporarily absent **Member**. Cover can be reinstated without the need to provide further **Evidence of Insurability**, subject to resumed premium payment, only if the **Member** is **Actively At Work** on the date cover is due to recommence, otherwise see 'Actively At Work Requirements' under Article 2 above.

4. INCREASE IN BENEFIT

The level of **Benefit** for which a **Member** is covered under the **Policy** may fluctuate to correspond to movements in the **Earnings** of that **Member** until the maximum **Benefit** allowed under the **Policy** is reached.

A **Member** must be **Actively At Work** at the time of any increase in **Benefit**. If the **Member** is not **Actively At Work** at that time, a **Benefit** increase will only be included for cover under the **Policy** where explicitly agreed by us in writing. In order to consider cover, we will require written evidence confirming the cause of absence from work, and dates of corresponding absence. Acceptance of a **Benefit** increase by us may be subject to **Medical Underwriting** in our sole discretion.

Any increase in **Benefit** during a period of **Permitted Temporary Absence** can only be agreed by us if it relates to a general increase in the **Earnings** awarded by an **Employer** to all its **Employees** in the specific location. We reserve the right to request **Medical Underwriting** for any **Benefit** increase during a period of **Permitted Temporary Absence** in our sole discretion.

Evidence of Insurability will be required for any **Member** whose increase in **Benefit**:

i) causes their **Benefit** to exceed the **Free Cover Limit** for the first time; or

ii) is greater than the **Forward Underwriting Bar**.

5. TERMINATION OF INDIVIDUAL MEMBER COVER

A **Member** will cease to be covered under the **Policy** immediately upon:

i) reaching the **Termination Age** (unless agreed otherwise in the **Policy Particulars**);

ii) ceasing to be a **Member**;

iii) withdrawal of our consent to be included as a **Discretionary Entrant**;

iv) ceasing to be actively engaged in the employment of the **Employer**, other than by way of a **Permitted Temporary Absence**;

v) discontinuance of payment of premiums;

vi) exceeding the maximum period of **Permitted Temporary Absence** as per Table 1;

vii) retiring under the **Employer's** occupational pension plan;

viii) death.

Where the **Member** is an **Eligible Spouse** or **Eligible Child**, their cover will terminate immediately upon the termination of cover for the related **Eligible Employee**.

We do not offer a continuation option following termination of employment.

SECTION THREE

COVER OPTIONS AVAILABLE

GROUP LIFE & DEPENDANT'S PENSION

The **Benefit** and cover options available under the **Policy** are set out below. Full details of the options selected by the **Policyholder** will be set out in the **Policy Particulars**.

Standard cover is for **Eligible Employees** only. We may in our sole discretion and for an additional premium agree to offer cover for **Eligible Spouses** or **Eligible Children**. This will be set out in the **Policy Particulars**, if applicable.

1. BENEFIT ELIGIBILITY

Group Life Insurance includes Group Life cover and/or Group Dependant's Pension cover, payable upon death of a **Member** due to an **Accident** or **Natural Causes**. **Benefit** eligibility occurs as follows:

Cover			Claim Event
Group Life			— Death of the **Member**; or — **Diagnosis** of a **Terminal Illness**
Group Dependant's Pension	A	**Spouse's** pension	Death of the **Eligible Employee**
	B	**Children's** pension	
	C	**Orphan's** pension	

The **Benefit** under Group Life cover is a **Lump Sum Benefit**.

The **Benefit** under Group Dependant's Pension cover is a **Regular Payment Benefit**.

2. BENEFIT OPTIONS

2.1. Cause of death

The **Policyholder** can choose to provide a **Lump Sum Benefit** in the event of death of **Member** caused by:

i) **Natural Causes** only;

ii) all causes (**Accident** and **Natural Causes**).

3. GROUP LIFE WITH TERMINAL ILLNESS

The **Policyholder** can choose the option where 50% of the **Lump Sum Benefit** under the Group Life cover is payable immediately upon the **Diagnosis** of a **Member's Terminal Illness**. The residual **Lump Sum Benefit** will subsequently be payable upon the death of the **Member**, as long as the **Member** does not meet any of the criteria 'Termination of Individual Member Cover' under Section Two, Article 5.

4. ESCALATION – GROUP DEPENDANT'S PENSION

The **Policyholder** can choose to apply **Escalation** to the Group Dependant's Pension. If **Escalation** is chosen, then the **Regular Payment Benefit** payable will increase annually on each anniversary of the month that **Benefit** payment commenced. This will remain applicable in the following circumstances:

i) standard **Regular Payment Benefit**;

ii) restricted **Regular Payment Benefit** where a 'Benefit Maximum' is set out in the **Policy Particulars**; and

iii) restricted **Regular Payment Benefit** due to non-standard acceptance terms.

Where there is no **Escalation**, the **Regular Payment Benefit** will remain unchanged for the duration of the **Claim**.

5. MAXIMUM BENEFIT RESTRICTION

Under the Group Life cover, the maximum **Lump Sum Benefit** payable in respect of a **Member** is £2.5 million (or currency equivalent) unless stated otherwise in the **Policy Particulars**.

6. BENEFIT PAYMENT

Subject to the acceptance of a **Claim**, the **Benefit** will be payable as follows:

Cover	Claim Event	Benefit Payable
Group Life	On death	100% of the **Lump Sum Benefit**
Group Life with **Terminal Illness**	On **Diagnosis**	50% of the **Lump Sum Benefit**
	On death	Residual 50% **Lump Sum Benefit**
Group Dependant's Pension	On death	**Regular Payment Benefit**

7. BENEFIT TERMINATION FOR GROUP DEPENDANTS' PENSION

The **Benefit** payable under the Group Dependant's Pension cover will terminate as follows:

Cover	Benefit Payable
Spouse's pension	The **Regular Payment Benefit** will be payable until the death of the **Spouse** unless stated otherwise in the **Policy Particulars**.
Children's pension **Orphan's** pension	The **Regular Payment Benefit** will be payable until the earlier of: — The **Child** reaching age 18, unless stated otherwise in the **Policy Particulars** — Death of the **Child**

GROUP ACCIDENTAL DEATH AND/OR DISMEMBERMENT

The **Benefit** and cover options available under the **Policy** are set out below. Full details of the options selected by the **Policyholder** will be set out in the **Policy Particulars**.

Standard cover is for **Eligible Employees** only. We may in our sole discretion and for an additional premium agree to offer cover for **Eligible Spouses** or **Eligible Children** under the **Policy**. This will be set out in the **Policy Particulars**, if applicable.

1. BENEFIT ELIGIBILITY

Group Accidental Death and/or Dismemberment Insurance provides a **Lump Sum Benefit** payable in the event of a **Member** dying or suffering a dismemberment as a result of an **Accident**. The amount of **Lump Sum Benefit** payable will be dictated by the chosen Dismemberment Benefit Scale set out in Tables 2 and 3. **Benefit** eligibility occurs as displayed below:

Cover	Claim Event
Group Accidental Death	Death of a **Member**
Group Accidental Dismemberment	Dismemberment suffered by a **Member**

The **Core Benefit** under the Group Accidental Death and/or Dismemberment cover is a **Lump Sum Benefit**.

2. BENEFIT OPTIONS

2.1. Work Related Accident

The **Policyholder** can choose to:

i) include an additional **Lump Sum Benefit** payable if the **Member** dies or suffers a dismemberment due to a work related accident, or

ii) restrict the **Benefit** to a **Lump Sum Benefit** payable solely if the **Member** dies or suffers dismemberment due to a work related accident.

'Work related accident' will be as defined in the **Policy Particulars**.

2.2. Dismemberment Benefit Scale

The **Policyholder** can choose between Short Scale Cover and Long Scale Cover as detailed under Tables 2 and 3. The chosen scale will be set out in the **Policy Particulars**.

Table 2 – Dismemberment Benefit Scale - Short Scale

Short Scale	Events (Loss of)	Benefit %
i)	One Hand or One Foot or sight of one Eye	50%
ii)	Any two of the losses in **i)**	100%

Table 3 – Dismemberment Benefit Scale - Long Scale

	Long Scale Events (Loss of)	Benefit %
Lower Limbs	Amputation of thigh (upper half)	60%
	Amputation of thigh (lower half and leg)	55%
	Total loss of foot (tibio-tarsal disarticulation)	50%
	Partial loss of foot (sub-ankle bone disarticulation)	40%
	Partial loss of foot (medio-tarsal disarticulation)	35%
	Partial loss of foot (tarso-metartarsal disarticulation)	30%
	Total paralysis of lower limb (incurable nerve lesion)	60%
	Complete paralysis of the external poplitic sciatic nerve	30%
	Complete paralysis of the internal poplitic sciatic nerve	20%
	Complete paralysis of two nerves (poplitic sciatic external and internal)	40%
	Anchylosis of the hip	40%
	Anchylosis of the knee	20%
	Loss of osseous substance from the thigh or both bones of the leg (incurable condition)	60%
	Loss of osseous substance of the knee-pan with considerable separation of the fragments and considerable difficulty of movements in stretching the leg	40%
	Loss of osseous substance of the knee-pan while the movements are preserved	20%
	Shortening of the lower limb by at least 5cm	30%
	Shortening of the lower limb by 3 to 5 cm	20%
	Shortening of the lower limb by 1 to 3 cm	10%
	Total amputation of all the toes	25%
	Amputation of four toes including big toe	20%
	Amputation of four toes	10%
	Anchylosis of the big toe	10%
	Amputation of two toes	5%
	Amputation of one toe, other than the big toe	3%

Table 3 – Dismemberment Benefit Scale - Long Scale (Continued..)

	Long Scale Events (Loss of)		Benefit % Right	Benefit % Left
Upper Limbs	Loss of one arm or one hand		60%	50%
	Considerable loss of osseous substance of the arm (definite and incurable lesion)		50%	40%
	Total paralysis of the upper limb (incurable lesion of the nerves)		65%	55%
	Total paralysis of the circumflex nerve		20%	15%
	Shoulder anchylosis		40%	30%
	Elbow anchylosis	In favourable position (15 degrees round the right angle)	25%	20%
		In unfavourable position	40%	30%
	Extensive loss of osseous substance of the two bones of the forearm (definite and incurable lesion)		40%	30%
	Total paralysis of the median nerve		45%	35%
	Total paralysis of the radial nerve at the torsion cradle		40%	35%
	Total paralysis of the forearm radial nerve		30%	25%
	Total paralysis of the hand radial nerve		20%	15%
	Total paralysis of the cubital nerve		30%	25%
	Anchylosis of the wrist in favourable position (straight and in pronation)		20%	15%
	Anchylosis of the wrist in unfavourable position (flexion or strained extension of supine position)		30%	25%
	Total loss of thumb		20%	15%
	Partial loss of thumb (ungual Phalanx)		10%	5%
	Total anchylosis of thumb		20%	15%
	Total amputation of forefinger		15%	10%
	Amputation of two phalanges of forefinger		10%	8%
	Amputation of the ungual phalanx of forefinger		5%	3%
	Simultaneous amputation of thumb and forefinger		35%	25%
	Amputation of thumb and a finger other than forefinger		25%	20%
	Amputation of two fingers other than thumb and forefinger		12%	8%
	Amputation of three fingers other than thumb and forefinger		20%	15%
	Amputation of four fingers including thumb		45%	40%
	Amputation of four fingers excluding thumb		40%	35%
	Amputation of the median finger		10%	8%
	Amputation of a finger other than thumb, forefinger and median		7%	3%

Table 3 – Dismemberment Benefit Scale - Long Scale (Continued..)

	Long Scale Events (Loss of)	Benefit %
100% Benefit	Total and irrevocable loss of sight, both eyes	100%
	Loss of both arms or both hands	100%
	Complete and permanent deafness of both ears, of traumatic origin	100%
	Removal of lower jaw	100%
	Permanent loss of speech of traumatic origin	100%
	Loss of one arm and one leg or one foot	100%
	Loss of one hand and one foot or one leg	100%
	Loss of both legs or both feet	100%

	Long Scale Events (Loss of)		Benefit %
Head	Loss of osseous substance of the skull in all its thickness	Surface of at least 6 sq cm	40%
		Surface of 3 to 6 sq cm	20%
		Surface of less than 3 cm sq	10%
	Partial removal of the lower jaw, rising section in its entirety or half of the maxillary bone		40%
	Loss of one eye		50%
	Complete and permanent deafness of one ear		30%

The following statements apply in reference to Long Scale Events:

i) for left-handed **Members**, the percentages set out for the various disabilities of the right upper limb and left upper limb will be transposed;

ii) anchylosis of the fingers and toes (other than thumb, forefinger and big toe) shall only entitle the **Member** to 50% of the compensation which would be due for the loss of the said digits;

iii) permanent disabilities not mentioned in the table shall be compensated in accordance with their seriousness as compared with that of those mentioned. For such purpose the occupation of the **Member** will not be taken into consideration; and

iv) the partial or total 'functional' disablement of a limb or an organ, (where not specifically dealt with below) is treated like the partial or total loss of the said limb or organ.

3. MAXIMUM BENEFIT RESTRICTION

The maximum **Benefit** payable in respect of a **Member** is £2 million (or currency equivalent) unless stated otherwise in the **Policy Particulars**.

4. BENEFIT PAYMENT

Subject to the acceptance of a **Claim**, the **Lump Sum Benefit** will be payable as follows:

Cover	Benefit Payable
Group Accidental Death	100% of **Benefit**
Group Accidental Dismemberment	Sliding scale depending on severity of event
Group Accidental Death and Dismemberment	100% of **Benefit** in the event of death and a sliding scale in the event of a dismemberment

For Group Accidental Dismemberment **Claims**, multiple **Claims** can be made under this **Policy** until 100% of the **Lump Sum Benefit** has been paid and no further **Claim** can be made under this **Policy** for that **Member**. The table below shows how the **Lump Sum Benefit** will be split between the **Claims**:

Cover	Benefit Payable
A single **Accident** causing multiple dismemberments	The **Benefit** scale for each dismemberment are added together to determine the total **Lump Sum Benefit** payable, subject to a maximum of 100% of the **Benefit**.
Multiple Accidents causing multiple dismemberments	The **Benefit** scale will be applied to the **Lump Sum Benefit** to determine the amount payable for each dismemberment: • if less than 100% of the **Benefit** is paid, for subsequent dismemberments the **Benefit** scale will be applied to the residual **Benefit** to determine the amount payable; • once 100% of the **Benefit** is paid, the **Member** has exhausted their **Benefit** entitlement and no further **Claims** can be made against the **Policy** in respect of that **Member**.
An **Accident** causing a dismemberment, followed by a subsequent **Accident** which causes death	If less than 100% of the **Benefit** is paid, the residual **Benefit** will be payable, in full, on death. If 100% of the **Benefit** is paid, the **Member** has exhausted their **Benefit** entitlement and no further **Claims** can be made against the **Policy** in respect of that **Member**.

GROUP LONG TERM DISABILITY

The **Benefit** and cover options available under the **Policy** are set out below. Full details of the options chosen by the **Policyholder** will be set out in the **Policy Particulars**.

Standard cover is for **Eligible Employees** only. We may in our sole discretion and for an additional premium agree to offer cover for **Eligible Spouses** under the **Policy**. If chosen, this will be set out in the **Policy Particulars**.

1. BENEFIT ELIGIBILITY

Group Long Term Disability Insurance (LTD) provides income protection in the event that a **Member** suffers an **Incapacity**. The level of **Benefit** is set as a proportion of a **Member's Earnings** at the time of the **Claim**.

Benefit eligibility occurs when all of the following criteria are met:

i) the **Member** has completed the **Deferred Period**;
ii) the **Member** is assessed as meeting the **Definition of Disability**, as set out in the **Policy Particulars**;
iii) the **Member** has been and remains under the medical care and supervision of a **Physician**;
iv) the **Member** is co-operating with medical care and supervision of that **Physician**;
v) the **Member** is not unreasonably refusing to follow any appropriate course of treatment or therapy for the **Incapacity** which is the ground of the **Claim**; and
vi) the **Member** continues to be treated as an **Employee** of the **Policyholder**.

The **Benefit** under the Group Long Term Disability cover is a **Regular Payment Benefit**.

This **Policy** shall not cover **Members** against loss of professional licenses. The loss of a professional or occupational licence or the inability to obtain one or qualify for one due to **Incapacity** will not, in itself, constitute a **Claim**.

2. BENEFIT OPTIONS

2.1. Integration with SIB

The **Policyholder** can choose to integrate the **Core Benefit** payable with **SIB**. There are three levels of integration available to the **Policyholder** as set out in Table 4.

Table 4: LTD Benefit - Integration with SIB

1.	No Integration	**Core Benefit** does not take account of **SIB**. In the event of a **Claim**, the full **Core Benefit** will be payable regardless of any **SIB** that the **Claimant** may be in receipt of.
2.	Partial Integration	**SIB** is always deducted from the **Core Benefit** whether payable or not. The **SIB** deduction will be based on the local applicable single person allowance (unless specified otherwise in the **Policy Particulars**). In the event of a **Claim**, this is the level of **Benefit** that will be paid, regardless of their actual **SIB** receipts.
3.	Full Integration	**SIB** is fully integrated and based on the **Claimant's** actual **SIB** receipts. In the event of a **Claim**, the **Core Benefit** will be determined based on the **Claimant's** actual **SIB** receipts. The level of **Core Benefit** will be adjusted over time, as the **SIB** receipts change.

The **SIB** shall be deducted from the **Core Benefit** prior to any maximum **Benefit** being considered.

2.2. Supplementary Benefit Cover

The **Policyholder** can choose to add **Supplementary Benefit** cover to the **Policy**, subject to payment of an additional premium. The options available include cover in respect of:

i) waiver of premiums for other policies held with **Generali Worldwide**, such as Group Life, Group Accidental Death and/or Dismemberment etc.;
ii) waiver of **Employer** contributions for occupational pension scheme;
iii) waiver of local social security **Employer** and/or **Employee** contributions (such as national insurance contributions in the United Kingdom);
iv) waiver of medical insurance premiums.

Other options may be available with our agreement.

2.3. Benefit Payment Term

The **Policyholder** can choose from the following **Benefit** payment terms set out in Table 5.

Table 5: LTD Benefit – Payment Term

Option 1: LTD to Termination Age:	**Option 2: LTD Fixed Duration:**	**Option 3: LTD Capital Solution:** (Available for **Eligible Employees** only)		
Regular Payment Benefit paid until **Benefit** termination.	**Regular Payment Benefit** paid for a **Fixed Period** or until **Benefit** termination if earlier.	**Regular Payment Benefit** paid for a **Fixed Period** or until **Benefit** termination if earlier plus, where the **Claim** remains valid, a **Lump Sum Benefit** paid at the end of the **Fixed Period**.		
	Fixed Period Options	**Fixed Period Options**	+	**Corresponding Lump Sum Options**
	1, 2, 3, 4 or 5 years	2 years	+	3 x annual **Benefit**
		3 years	+	2 x annual **Benefit**

2.4. Definition of Disability

The **Policyholder** can opt for varying levels of cover by choosing a **Definition of Disability** as set out in Table 6.

Table 6: LTD Benefit – Definition of Disability

Eligible Employee Disability		Definition of Disability Option
A	**Own Occupation**	A **Member** is considered disabled if they are unable to carry out the **Material and Substantial Duties** of their **Own Occupation** due to **Incapacity** and are not following any other occupation
B	**Own Occupation for 24 months** **then** **Suited Occupation after 24 months**	During the first 24 months of a **Claim**, a **Member** is considered disabled if they are unable to carry out the **Material and Substantial Duties** of their **Own Occupation** due to **Incapacity** and are not following any other occupation. At the end of 24 months, a **Member** is considered disabled if they are unable to carry out any **Suited Occupation** due to continued **Incapacity**.
C	**Own Occupation for 24 months** **then** **Any Occupation after 24 months**	During the first 24 months of a **Claim**, a **Member** is considered disabled if they are unable to carry out the **Material and Substantial Duties** of their **Own Occupation** due to **Incapacity** and are not following any other occupation. At the end of 24 months, a **Member** is considered disabled if they are totally unable to carry out **Any Occupation** due to continued **Incapacity**.
D	**Any Occupation**	A **Member** is considered disabled if they are totally unable to carry out **Any Occupation** due to **Incapacity**.
E	**Suited Occupation**	A **Member** is considered disabled if they are unable to carry out any **Suited Occupation** due to **Incapacity**.

If LTD Capital Solution cover is chosen, then Definition A: **Own Occupation** will be used as the **Definition of Disability**.

If **Eligible Spouse** cover is included under the **Policy**, then one of the following **Definitions of Disability** will apply:

Eligible Employee Disability		Definition of Disability Option
F	**Any Occupation**	As per **D** above, where the **Eligible Spouse** has not been working immediately prior to the **Employee's** assignment.
G	**Suited Occupation**	As per **E** above, where the **Eligible Spouse** has been working immediately prior to the **Employee's** assignment and can provide a job description and proof of training.

Where a **Member** is subject to non-standard terms, the definition of **Incapacity** may be restricted to injury arising from an **Accident** only.

2.5. Deferred Period

The **Policyholder** can choose from a 13 week, 26 week or 52 week **Deferred Period**.

The **Deferred Period** commences on the first day the **Member** is unable to work due to **Incapacity**. The **Deferred Period** may be extended by us in writing in the event of late **Claim** notification as detailed under Table 9 in Section Four under Article 1.

If, during the **Deferred Period;**

i) a **Member** returns to work and subsequently suffers from a recurrence of the same **Incapacity**, we will allow any absence from work for periods lasting at least 15 days each to be linked for purposes of calculating the end of the **Deferred Period**. This is provided that the total time from the first day of absence to the end of the **Deferred Period** does not exceed 12 months.

ii) a **Member** returns to work on a reduced basis due to **Incapacity** (as described under Article 4), we will consider this period of reduced working as part of the **Deferred Period**. The **Deferred Period** will be considered continuous if the period of working on a reduced basis is uninterrupted.

We may also consider linked periods of absence such as periods of working part time or periods of working in a lower paid role, provided these periods comply with medical advice and are due to the same underlying cause of **Incapacity**.

If the **Member** meets one of the 'Termination of Individual Member Cover' criteria under Section Two Article 5, whilst serving their **Deferred Period**, they will immediately cease to be a **Member**. Their cover under the **Policy** will cease immediately and no **Benefit** will be payable.

2.6. Escalation

The **Policyholder** can choose to apply **Escalation** to the **Regular Payment Benefit**, which becomes effective when the **Claim** is in payment (available options ranging from 0.5% to 5.0% each year). **Escalation** is designed to compensate for the effects of inflation on **Earnings** remaining at pre-**Incapacity** level for the duration of the **Claim**.

If **Escalation** is chosen, then the **Regular Payment Benefit** will increase annually on each anniversary of the month **Benefit** payments commenced. This will remain applicable in the following circumstances:

i) standard **Regular Payment Benefit**;

ii) restricted **Regular Payment Benefit** where a 'Benefit Maximum' is set out in the P**olicy Particulars**;

iii) restricted **Regular Payment Benefit** due to non-standard **Member** acceptance terms; and

iv) partial **Benefit** payment.

When a **Benefit** in payment breaches the stated 'Maximum Benefit Restriction' stated under Article 3 below, no further **Escalation** shall apply.

Where there is no **Escalation**, the **Regular Payment Benefit** will remain unchanged for the duration of the **Claim**.

3. MAXIMUM BENEFIT RESTRICTION

The **Benefit** payable under the **Policy**, as set out in the **Policy Particulars**, is subject to the maximum **Benefit** restrictions detailed in the table below:

Benefit Restriction In Pounds Sterling (or currency equivalent)		**Maximum Percentage of Earnings**	**Maximum Benefit Amount**
Regular Payment Benefit	**Core Benefit**	80% of adjusted **Member's Earnings** (see below)	£350,000 p.a
	Supplementary Benefit	21% of adjusted **Member's Earnings** (see below)	
Lump Sum Benefit (under LTD Capital Solution)		**Benefit** payable is restricted to the monthly **Benefit** in payment, at the time the **Lump Sum Benefit** is due, multiplied by the number of complete months to **Termination Age**.	£900,000

Adjusted **Member's Earnings** take the following into account:

i) integration with **SIB** (where applicable);
ii) receipt of sickness or accident benefit from any external source; and
iii) continuing income from any employment.

Where the **Benefit** chosen is a fixed monetary amount, we may in our sole discretion request evidence of **Earnings** and ensure that the maximum **Benefit** restriction, detailed above, is applied.

4. PARTIAL BENEFIT

If a **Member's Incapacity** means they can only work on a reduced basis, a partial **Benefit** may be payable. Working on a reduced basis means that the incapacitated **Member** can either:

i) perform the **Material and Substantial Duties** of their **Own Occupation** or **Suited Occupation** with reduced hours; or
ii) perform some, but not all of the **Material and Substantial Duties** of their **Own Occupation** or **Suited Occupation**.

A partial **Benefit** is payable:

i) if working on a reduced basis results in the **Member's Earnings** being at a lower level than their pre-**Incapacity Earnings** (adjusted for **CPI**);
ii) such reduction in **Earnings** is solely as a direct consequence of the **Member's** on-going **Incapacity**;
iii) the **Member** remains an **Employee**;
iv) the **Employer** pays a salary or equivalent remuneration to the **Member** for their work that is reasonable and appropriate in the circumstances.

Partial **Benefit** is determined by us in our sole discretion and will never be greater than the full **Benefit**. There is no requirement for the full **Benefit** to be paid for partial **Benefit** to become payable.

No partial **Benefit** is payable under the '**Any Occupation**' **Definition of Disability**.

Partial **Benefit** will apply in the same way to **Core Benefit** and **Supplementary Benefit** covering **Employer** contributions. No partial **Benefit** is payable for **Supplementary Benefit** covering waiver of premiums.

In order to calculate the partial **Benefit**, you must provide us with details of a **Member's** reduced **Earnings** and income received from any source at any time.

Partial **Benefit** is not intended to compensate for:

i) reductions in the amount of **SIB** received; or

ii) removal of additional allowances paid by the **Employer** over and above the **Member's** basic level of **Earnings**, such as location subsidies or 'Danger Pay' should the **Member** no longer be eligible to receive them.

4.1. Partial Benefit Calculation

Partial **Benefit** is based on the **Member's** percentage income loss, taking account of inflation, as measured by the percentage change in **CPI**. The 'Partial Benefit Factor' is calculated as follows:

$$\text{Partial Benefit Factor} = \left[\frac{(\text{Adjusted Earnings} - \text{Reduced Earnings})}{\text{Adjusted Earnings}} \right]$$

The partial **Benefit** is calculated by multiplying the full **Benefit** by the Partial Benefit Factor.

Where integration with **SIB** has been chosen, **SIB** will not be deducted from the full **Benefit** when determining the partial **Benefit**.

Where applicable, partial **Supplementary Benefit** is calculated by multiplying the Partial Benefit Factor by the full **Supplementary Benefit** payable.

Adjusted **Earnings** are calculated on the first occasion that partial **Benefit** becomes payable. The **Member**' **Earnings** are increased by the percentage increase in **CPI** from the end of the **Deferred Period** to the date the partial **Benefit** becomes payable.

If there is a change in the nature of **CPI**, or if it ceases to exist, the **Member's** adjusted **Earnings** will be calculated by us on such other reasonable and comparable basis as we consider appropriate.

If the **Member's Benefit** is capped due to the maximum **Benefit** restriction, the restricted **Benefit** will be used to determine the partial **Benefit**.

For 'LTD Capital Solution', when a partial **Benefit** has been paid during the **Fixed Period** and a **Lump Sum Benefit** is approved, a new Partial Benefit Factor will be determined at the time the **Claim** is assessed and applied to the **Lump Sum Benefit**.

Example – No SIB Integration – Member returns to work on reduced Earnings

Data	
Adjusted **Earnings**	£60,000
Reduced **Earnings**	£30,000
Full **Benefit**	£40,000

Calculation
Partial Benefit Factor = [£60,000 - £30,000] / £60,000 = 50% Partial **Benefit** = £40,000 x 50% = £20,000

5. BENEFIT PAYMENT

Subject to the acceptance of a **Claim**, the **Benefit** will be paid for any eligible period of **Incapacity** suffered by a **Member**. **Benefit** payment will commence from the end of the **Deferred Period** until such time that they meet any of the 'Benefit Termination' criteria under Article 6 below. The first and final payment shall be calculated on a daily pro-rata basis. No **Benefit** shall be payable in respect of the **Deferred Period** itself.

Where a **Member** is serving a period of **Permitted Temporary Absence**, **Benefit** payment will only commence on the later date of:

i) the end of the **Deferred Period**; or
ii) the end date of the period of **Permitted Temporary Absence**.

Partial **Benefit** payment will start from the date that the **Member's** employment on reduced **Earnings** commenced or the first payment date following the expiry of the **Deferred Period**, whichever is the later.

Under LTD Capital Solution, the **Regular Payment Benefit** will continue to be paid until the earliest of the end of the **Fixed Period** and **Benefit** termination. At the expiry of the **Fixed Period**, the **Claim** will be assessed and the **Lump Sum Benefit** will be paid if the applicable **Definition of Disability** is still met.

6. BENEFIT TERMINATION

The payment of any **Benefit** will cease upon the occurrence of any of the **Benefit** termination conditions set out below.

For **Regular Payment Benefits**, **Benefit** payment will cease on whichever of the following events occurs first:

i) death of the **Member**;
ii) reaching the end of the **Fixed Period**;
iii) on attaining the **Termination Age**;
iv) on failing to meet the **Definition of Disability**;
v) failure or refusal to provide any evidence reasonably requested by us to substantiate a **Claim**, or refusal to be medically examined or attend a medical exam when requested by us;
vi) on ceasing to be in the employment of the **Employer** unless the **Claimant** is an **Eligible Spouse**.

In addition, payment of partial **Benefit** will cease if we determine on reasonable grounds or in the absence of proof to the contrary that the reduction in the **Claimant's Earnings** is no longer solely as a result of the original **Incapacity**.

Under 'LTD Fixed Duration', once the **Fixed Period** has expired, **Benefit** payment will cease and no further **Claim** can be made under this **Policy** in respect of that **Incapacity** or any associated condition.

Under 'LTD Capital Solution', **Benefit** is terminated once the **Lump Sum Benefit** has been paid, and the **Member** is no longer eligible for cover under the **Policy**.

7. REINSTATEMENT OF BENEFIT PAYMENT

7.1. Linked Claims

Where **Benefit** has been paid and the **Member** subsequently suffers from a recurrence of **Incapacity** due to the same underlying cause, which led to the original payment of **Benefit**, payment of **Benefit** will recommence without the **Member** having to serve a further **Deferred Period**, subject to:

i) the recurrence happening within a six-month period of **Benefit** termination under the original **Claim**;

ii) the recurrence lasting at least four weeks; and

iii) receipt of satisfactory supporting medical evidence.

This is referred to as a 'Linked Claim'.

The level of **Regular Payment Benefit** will be calculated as though the original **Claim** had never terminated and the **Benefit** will be paid until **Benefit** termination.

7.2. Suspended Claims

Where a **Claim** has been suspended due to non-provision of medical evidence, the **Claim** can be reinstated from the date when the medical evidence or other satisfactory evidence of the **Claim** validity has been received. Any **Escalation** due in the meantime will apply effective from the date **Benefit** is reinstated.

No **Benefit** is payable for any period during which satisfactory evidence of **Claim** validity is not held by us.

7.3. Policy Termination

If this **Policy** has terminated and the insurance cover has switched to another insurer without any interruption in cover, we will:

i) continue to pay **Claims** that were accepted before the **Policy** ceased, whilst they remain valid; and

ii) consider **Claims** where **Incapacity** occurred before the **Policy** ceased.

If a **Claimant** in respect of whom we are paying **Benefit** returns to work after cover is switched all future **Claims** will be the responsibility of the new insurer except where we subsequently accept that a 'Linked Claim' has occurred in which case the following will apply:

i) if the individual meets the new insurer's actively at work criteria, we will reinstate **Benefit** payments for a maximum period equivalent to new insurer's deferred period; or

ii) if the individual fails to satisfy the new insurer's actively at work criteria, we will reinstate **Benefit** payments subject to the **Claimant** meeting the **Benefit** eligibility conditions as stated under '**Benefit Eligibility**' in Article 1 above, until such time as the new insurer's actively at work criteria is satisfied.

We will not consider any 'Linked Claim' where premiums are due under this **Policy**.

8. LONG TERM DISABILITY CLAIMS MANAGEMENT

8.1. Change in Circumstances

The **Claimant** must notify the **Policyholder** immediately of any changes in their medical condition or working capacity. We will also require the **Member** to declare all earned income from any source while **Benefit** is payable.

You, the **Policyholder** must notify us immediately if you are made aware of any change in the medical condition or working capacity of the **Claimant** or any other circumstances which may affect payment or eligibility for **Benefit**, including the **Claimant** undertaking any paid or unpaid work, any change in their medical health or condition and any change in their residential address.

Where there is a delay or failure in notification of a change in circumstances, which results in an increased working capacity of the **Claimant** and in a consequent overpayment of a **Regular Payment Benefit**, we will require the **Policyholder** to refund immediately any such overpayment as calculated by us.

8.2. Claim Review

To ensure the continued validity of a **Claim**, **Claimants** must comply with the '**Benefit Eligibility**' criteria under Article 1 above, and will need to provide us with medical evidence at their own expense at review dates, determined by us in our sole discretion, which establishes the medical grounds as to why they are unable to return to work due to their **Incapacity**.

In addition, we may require the **Claimant** to be examined by a medical expert appointed by us. In this case, medical fees shall be borne by us. In the absence of cooperation with any reasonable request made by us or our appointed medical expert to provide us with this evidence or attend the independent medical examination will result in payments being suspended and **Benefit** termination.

8.3. Result of Claim Review

We reserve the right to review any **Claim** at any time.

If the **Claim** review determines, in our sole discretion, that the **Claimant** meets the '**Benefit Eligibility**' criteria under Article 1 above, we will continue to pay the **Benefit**. The **Claim** will be reassessed at the next **Claim** review.

If the **Claim** review determines, in our sole discretion, that the **Claimant** no longer meets the '**Benefit Eligibility**' criteria under Article 1, or now meets one of the criteria for '**Benefit** Termination' under Article 6, we will cease **Benefit** payment with immediate effect and would seek to recover any overpayment.

If the **Claim** review determines, in our sole discretion, that the **Claimant** can return to work in either a full or reduced capacity, we will either terminate or reduce the **Benefit** payable accordingly (see 'Partial Benefit Eligibility' under Article 4 above). This will apply regardless of whether the **Policyholder** is able to accommodate the **Claimant** in a suitable role.

Should we discover at any point in time that the **Claimant** has already returned to work, the **Policyholder** will be required to refund any overpayment, as calculated by us.

8.4. Rehabilitation

At any time during the period of **Incapacity**, whether the **Deferred Period** has expired or not, we may mutually agree with you to appoint an organisation or individual to manage, discuss and/or agree a rehabilitation programme for the **Claimant**, with the objective that the **Claimant** should return to work with you in their original capacity or in an alternative capacity depending on the particular circumstances.

Our liability to pay any **Benefit** is subject to you and the **Claimant** taking all reasonable and appropriate steps to aid the **Claimant's** recovery from **Incapacity** and to return to work for you in a capacity that is appropriate to their ability to work.

Where medical evidence demonstrates that the **Member's** level of working capacity and functional ability is such that the **Claimant** could return to work in a reduced basis but does not, we will apply a reduction in **Benefit** in our sole discretion, based on a **Physician's** assessment of the **Claimant's** 'Level of Disability'. Further details can be supplied on request.

We will continue to pay the **Benefit** if we are provided with independent medical opinion to our satisfaction that any form of rehabilitation is impossible or the nature of the treatment or therapy is either life threatening or inappropriate.

GROUP CRITICAL ILLNESS

The **Benefit** and cover options available under the **Policy** are set out below. Full details of the options chosen by the **Policyholder** will be set out in the **Policy Particulars**.

Our standard cover is for **Eligible Employees** and their **Children** (who are included under the **Policy** for no additional charge). We may in our sole discretion and for an additional premium agree to offer cover for **Eligible Spouses** under the **Policy**. If chosen, this will be set out in the **Policy Particulars**.

1. BENEFIT ELIGIBILITY

Group Critical Illness Insurance provides cover payable in the event of a **Member** being diagnosed with one of the **Insured Conditions**, subject to meeting the '**Benefit Eligibility**' criteria below.

Benefit eligibility occurs when:

i) the **Member** is diagnosed as suffering from an **Insured Condition**;
ii) the **Member** has completed the **Survival Period** as detailed below;
iii) the **Pre-Existing Medical Condition** and **Associated Condition** exclusion does not apply;
iv) the **Member** has been and remains under the medical care and supervision of a **Physician**;
v) the **Member** is co-operating with medical care and supervision of that **Physician**;
vi) the **Member** is not unreasonably refusing to follow any appropriate course of treatment or therapy;
vii) the **Member** is younger than age 65 (Group Critical Illness cover ceases at age 65, regardless of **NRA**).

The **Survival Period** commences:

i) on the day of the **Diagnosis** of the **Insured Condition** or on which the insured medical procedure was carried out;
ii) for Coronary Artery Bypass Surgery, the date of the surgery;
iii) for Major Organ Transplant, the earlier of the date of surgery or the date the **Member** was first accepted onto an official waiting list for the organ to be transplanted;
iv) for Multiple Sclerosis, the date at which continuous impairment has persisted for 6 months, as confirmed by the attending **Physician** or verified by our **Chief Medical Officer**;
v) for **Terminal Illness**, the date of the opinion made by an attending **Physician** or our **Chief Medical Officer**.

The **Benefit** under the Group Critical Illness cover is a **Lump Sum Benefit**.

2. PRE-EXISTING MEDICAL CONDITION AND ASSOCIATED CONDITION EXCLUSION

No **Benefit** will be payable under the **Policy** if:

i) the diagnosed **Insured Condition** is a **Pre-Existing Medical Condition**;

ii) the **Member** suffered from an **Associated Condition** prior to joining the **Policy**, regardless of whether any treatment had been administered and/or **Diagnosis** made in respect thereof;

This exclusion only applies if the **Member** suffers a related **Insured Condition** within two years of joining the **Policy** (this excludes **Associated Condition**s for paralysis and **Terminal Illness**, as these remain applicable indefinitely).

For the purpose of this exclusion, the onset or occurrence of aorta graft surgery, coronary angioplasty, coronary artery by-pass graft, heart attack, heart transplant, heart valve replacement or repair, stroke or valvuloplasty will all be considered to be directly linked.

iii) the diagnosed **Insured Condition** is either blindness, coma, deafness, loss of speech, paralysis of limbs or terminal illness and is linked directly or indirectly to a previously diagnosed **Insured Condition**;

iv) a **Member** suffers from any malignant tumour(s) defined as 'Cancer' under Core Illnesses Definitions – Table 7, whilst covered under this **Policy** or has suffered from cancer at any time in the past;

No **Benefit** shall be paid in respect of any subsequent cancer whether or not such cancer is connected or associated with the prior **Diagnosis** of cancer.

v) the illness is a **Hereditary Condition** or a **Congenital Condition**.

The above apply from the **Commencement Date**.

3. BENEFIT OPTIONS

The **Policyholder** can choose between the following two levels of cover:

i) Core Illness Cover as set out in Table 7; or

ii) Core Illness Cover plus Extended Illnesses Cover as set out in Tables 7 and 8.

The **Benefit** will be payable if a **Member** is diagnosed with one of the illnesses, as defined in Tables 7 and 8 by us in our sole discretion.

3.1. Core Illness Cover

Table 7: Group Critical Illness – Core Illnesses Definitions

	Core Illnesses
Cancer	Presence of a malignant tumour, characterised by the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue. **Diagnosis** of cancer must be made by a pathologist and supported by histopathological evidence of malignancy. The following tumours are excluded: **i)** tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant or non-invasive; **ii)** melanomas of Stage IA in the TNM classification (maximum thickness <= 1.0 mm, no ulceration) according to the new American Joint Committee of Cancer classification of 2010; **iii)** all skin cancers, including hyperkeratoses, basal cell carcinomas, squamous cell carcinomas; **iv)** any cancer in the presence of any HIV.
Coronary Artery Bypass Surgery	The undergoing of an open heart surgery to correct the narrowing of, or blockage to, two or more coronary arteries by means of a by-pass graft. Percutaneous coronary interventions such as angioplasty and all other intra-arterial, catheter based techniques or laser procedures are excluded.
Heart Attack	Death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The **Diagnosis** shall be supported if three of the following four criteria are present: **i)** history of typical chest pain; **ii)** confirmatory new electrocardiogram (ECG) changes diagnostic for myocardial necrosis; **iii)** diagnostic elevation of cardiac enzymes or Troponins recorded at the following levels or higher • Troponin T > 1.0 ng/ml • Accu TnI > 0.5 ng/ml, or equivalent thresholds with other Troponin I methods; Left ventricular ejection fraction less than 50% measured three months or more after the event. The evidence must show a definite acute myocardial infarction and the **Diagnosis** must be confirmed by a consultant cardiologist. The following are excluded: **i)** angina; and **ii)** other acute coronary syndromes.
Kidney Failure	End-stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular and long term renal dialysis is instituted.

Core Illnesses	
Major Organ Transplant	The actual undergoing as a recipient of a human-to-human transplant of: **i)** human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or **ii)** one of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end stage failure of the relevant organ; or **iii)** inclusion on an official waiting list for such a procedure. The transplant must be medically necessary and based on objective confirmation of organ failure. The transplantation of all other organs, parts of organs or any other tissue or cells transplant is excluded.
Multiple Sclerosis	Multiple Sclerosis is characterised by areas of demyelisation of the central nervous system. The **Diagnosis** must be made by a consultant neurologist. **Diagnosis** has to be confirmed by CT or MRI evidence of lesions of the central nervous system. Diseases of the central nervous system due to other causes (e.g. diseases of blood vessels or bacterial or viral diseases) must be unequivocally excluded. Documentation of the disease by the neurologist must show **Permanent Neurological Deficit**, which must be diagnosed no sooner than 180 days from the date of first occurrence.
Stroke	An abrupt onset of focal neurological deficit due to a cerebrovascular incident including infarction of brain tissue, haemorrhage from an intracranial vessel or embolisation from an extracranial source resulting in all of the following: **i)** symptoms lasting more than 24 hours; **ii)** permanent loss of motor or sensory function, or loss of speech; and **iii)** **Permanent Neurological Deficit**. A neurologist must confirm evidence of **Permanent Neurological Deficit** at the earliest of 180 days from the date of of first occurrence and no **Claims** can be admitted earlier. **Claims** must be confirmed by imaging studies such as CT or MRI evidence. The following situations are excluded: **i)** transient ischaemic attacks; **ii)** incidents resulting in changes in memory or personality; **iii)** cerebral symptoms due to migraine; **iv)** cerebral injury resulting from trauma or hypoxia; and **v)** ischaemic vascular disease affecting the eye, optic nerve or vestibular system.

3.2. Extended Illness Cover

Table 8: Group Critical Illness – Extended Illnesses Definitions

	Extended Illnesses – Core Illnesses plus:
Aorta Graft Surgery	The actual undergoing of surgery via a thoracotomy or laparotomy for disease of the aorta needing repair or surgical replacement of the diseased aorta with a graft. For the purposes of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta and surgery performed using endarterial techniques only are specifically excluded.
Alzheimer's Disease/ Dementia	Deterioration or loss of intellectual capacity or abnormal behaviour due to irreversible global failure of brain functioning, as evidenced by the clinical state and accepted standardized questionnaires or tests, arising from Alzheimer's Disease or irreversible organic disorders of the brain, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the **Member**. The **Diagnosis** must be clinically confirmed by an appropriate consultant and at least one of the following diagnostic criteria must be met: **i)** entire atrophy of the cerebral cortex confirmed by CT or MRI; **ii)** permanent inability of the **Member** to perform without assistance at least four of the **Activities of Daily Living**, certified and still existing after at least 180 days from the date of first occurrence.
Benign Brain Tumour	A non–malignant tumour of the brain giving rise to characteristic signs of increased intracranial pressure such as papilledema, mental symptoms, seizures and motor or sensory impairment as confirmed by a consultant neurologist, resulting in life-threatening and/or **Permanent Neurological Deficit**. The presence of the underlying tumour must be confirmed by imaging studies such as CT Scan or MRI. Cysts, calcifications, granulomas, malformations in or of the arteries or veins of the brain, haematomas, and tumours in the pituitary gland or spinal cord are excluded.
Blindness	Total, permanent and irreversible loss of sight in both eyes. The blindness must be confirmed by an ophthalmologist appointed by us. No **Benefit** will be payable if any aid, device, or implant results in the partial or total restoration of sight.
Coma	A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for a period of at least one month and resulting in **Permanent Neurological Deficit. Diagnosis** must be supported by a consultant neurologist. Coma caused by the alcohol, drug or medicine abuse is specifically excluded.
Creutzfeldt-Jacob Disease	Becoming permanently disabled through acquiring Creutzfeldt-Jacob disease to the extent of being unable to perform four of the six **Activities of Daily Living**.

Extended Illnesses – Core Illnesses plus:	
Deafness	Means the total loss of hearing for all sounds in both ears. Medical evidence is to be supplied by an appropriate ear, nose and throat specialist **Physician** and to include audiometric and sound-threshold test. No **Benefit** will be payable if a hearing aid, device, or implant results in the partial or total restoration of hearing.
Heart Valve Replacement or Repair	The actual undergoing of open-heart surgery to replace or repair one or more of cardiac valves as a consequence of heart valve defects or abnormalities. All non-open heart surgeries and replacement of prosthetic valves are specifically excluded. The **Diagnosis** of heart valve abnormality must be supported by cardiac catheterisation or echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.
Loss of Limbs	The total and permanent loss by physical separation of at least two limbs above the wrist or ankle. Injuries that are self-inflicted are excluded.
Loss of Speech	Total permanent and irreversible loss of the ability to speak as a result of an **Accident** or disease, which must be established for a continuous period of 12 months. Medical evidence is to be supplied by an appropriate ear, nose and throat specialist **Physician** and to confirm injury or disease to the vocal cords. All psychiatric related causes are specifically excluded. The condition must not be able to be corrected by medical procedure.
Motor Neurone Disease	Motor Neurone Disease of unknown aetiology as characterized by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones, including spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. **Claims** will only be admitted if the condition is confirmed by a neurologist as progressive and resulting in irreversible damage to the nervous system. MRI may be required to exclude other diseases.
Paralysis/Paraplegia	The permanent and total loss of function of two or more limbs as a result of injury to, or disease of the spinal cord or brain (limb is defined as the complete arm or the complete leg). The disability must be permanent, established for a continuous period of 180 days from the date of first occurrence and be supported by appropriate neurological evidence. Self-inflicted injuries are excluded.
Parkinson's Disease	Slowly progressive degenerative disease of the central nervous system as a result of loss of pigment containing neurones of the brain (substantia-nigra). Unequivocal **Diagnosis** of Parkinson's Disease by a consultant neurologist must be provided stating that the condition cannot be controlled with medication and that it shows signs of progressive impairment. Moreover, **Activities of Daily Living** assessment must confirm the permanent inability of the **Member** to perform without assistance at least four of the **Activities of Daily Living**, certified and still existing after at least 180 days from the date of first occurrence. Only idiopathic Parkinson's Disease is covered. Drug-induced, toxic or other causes of Parkinsonism are excluded.

Extended Illnesses – Core Illnesses plus:	
Terminal Illness	Advanced or rapidly progressing incurable disease where, in the opinion of an attending Consultant and our **Chief Medical Officer**, the life expectancy is no greater than 12 months. Acquired Immune Deficiency Syndrome (AIDS) is specifically excluded and not included in this definition.
Third Degree Burns	Tissue injury caused by thermal, electrical or chemical agents causing third degree or full thickness burns to at least 20% of the body surface area as measured by 'The Rule of 9' or the 'Lund and Browder Body Surface Chart'. Third degree burn means full thickness burn involving all the epithelial elements of the skin requiring skin graft.

4. MAXIMUM BENEFIT RESTRICTION

The maximum **Benefit** payable in respect of a **Member** is as follows (unless specified otherwise in the **Policy Particulars**):

Cover in respect of	Restriction (or currency equivalent)
Eligible Employee	£1,000,000
Child of **Eligible Employee**	£15,000
Eligible Spouse	£20,000

5. BENEFIT PAYMENT

Subject to the acceptance of a **Claim**, the **Benefit** will be payable as follows:

Claim Event	Member Covered	Benefit Payable
On **Diagnosis** of an **Insured Condition**	**Eligible Employee**	100% of **Benefit**
	Child of **Eligible Employee**	25% of the **Eligible Employee's Benefit**
	Eligible Spouse	£20,000 or currency equivalent

Where a **Benefit** has been paid under this **Policy** for a **Member** suffering an **Insured Condition**, the **Benefit** will be considered as having been paid in full and no further **Claim** can be made under this **Policy**.

GROUP TOTAL PERMANENT DISABILITY

The **Benefit** and cover options available under the **Policy** are set out below. Full details of the options chosen by the **Policyholder** will be set out in the **Policy Particulars**.

Standard cover is for **Eligible Employees** only. We may in our sole discretion and for an additional premium agree to offer cover for **Eligible Spouses** under the **Policy**. If chosen, this will be set out in the **Policy Particulars**.

1. BENEFIT ELIGIBILITY

Group Total Permanent Disability Insurance provides a **Lump Sum Benefit** payable in the event that a **Member** suffers an **Incapacity** which is considered by a **Physician** to be both a **Permanent Condition** and an **Irreversible Condition**.

Benefit eligibility occurs when:

i) the **Member** is assessed as meeting the definition of **Total Permanent Disability**;
ii) the **Member** has been and remains under the medical care and supervision of a **Physician**;
iii) the **Member** is co-operating with medical care and supervision of that **Physician**; and
iv) the **Member** is not unreasonably refusing to follow any appropriate course of treatment or therapy for the **Incapacity** which is the ground of the **Claim**.

The **Benefit** under the Group Total Permanent Disability cover is a **Lump Sum Benefit**.

1.1. Benefit Options

The **Policyholder** can choose to cover **Total Permanent Disability** due to the following underlying causes:

i) **Natural Causes** only;
ii) **Accident** only;
iii) all causes (**Accident** and **Natural Causes**).

1.2. Maximum Benefit Restriction

The maximum **Benefit** payable in respect of a **Member** is £2 million (or currency equivalent) unless stated otherwise in the **Policy Particulars**.

1.3. Benefit Payment

Subject to the acceptance of a **Claim**, the **Benefit** will be payable as follows:

Cover	Claim Event	Benefit Payable
Group Total Permanent Disability	Confirmation of **Total Permanent Disability** by our **Chief Medical Officer**	100% of the **Benefit**

Where a **Benefit** has been paid under this **Policy** for a **Member** suffering a **Total Permanent Disability**, **Benefit** will be considered as having been paid in full and no further **Claim** can be made under this **Policy** for that **Member**.

SECTION FOUR

CLAIMS ACCEPTANCE PROCESS

1. CLAIMS NOTIFICATION

The **Policyholder** shall notify us of a **Claim** by supplying us with the following information in respect of the **Member**:

i) name;
ii) date of birth;
iii) nature and extent of the **Claim**;
iv) **Claim Onset Date**; and
v) annual **Earnings** or **Benefit** amount.

The **Claim** must be notified to us within the notification period set out in Table 9 "Claims Notification" Failure to do so will lead to consequences set out under "Consequence of late notification" under Table 9.

Table 9 - Claims Notification

Cover		Notification Period	Consequence of late notification
1	Group Life & Dependant's Pension	Notification and **Claim Form** submission must occur within 2 years of the **Claim Onset Date**.	**Claim** rejection
2	Group Accidental Death and /or Dismemberment		
3	Group Long Term Disability	Notification must occur when: — An **Eligible Employee** has been continuously absent from work or working on a reduced capacity due to an **Incapacity** for four weeks. — An **Eligible Spouse** has been continuously suffering from an **Incapacity** for four weeks. Submission of the **Claim Forms** must occur no later than four weeks before the **Deferred Period** is due to expire.	The **Deferred Period** will be deemed to end four weeks after the date the **Claim Forms** are received.
4	Group Critical Illness	Notification and **Claim Form** submission must occur within 1 year of the **Onset Date** of the original **Incapacity**.	**Claim** rejection
5	Group Total Permanent Disability		

A **Claim** for **Benefit** must be submitted by the **Policyholder** on the appropriate **Claim Forms** requested by us together with the required additional documentation. For **Claim** notification in the event of a **Catastrophe**, please refer to Section Five, Article 4.

2. CLAIM ASSESSMENT

Following a **Claim** notification, the **Policyholder** must provide us with all requested information and documentation to enable us to fully assess the **Claim**:

Such information shall be provided without cost to us and may include but not be limited to the following:

All Claims	**i)**	proof of **Eligibility** under the **Policy**;
	ii)	an **Employer Claim Form** completed by you, the **Policyholder**;
	iii)	proof of **Member's Earnings**, satisfactory to us;
	iv)	proof of **Member's** age. (A certified copy of the **Member's** birth certificate, passport, or ID card would be acceptable proof);
	v)	a certified copy of the **Member's** marriage certificate where proof of age only shows the **Member's** maiden name; and
	vi)	all information as we may reasonably require enabling us to satisfactorily assess the **Claim**.
Eligible Spouse or Eligible Child Benefit	**i)**	proof of relationship with a **Member** in order to claim **Benefit**;
	ii)	certified copy of marriage certificate or proof of cohabitation;
	iii)	certified copy of birth or adoption certificate; and
	iv)	proof of continuance of full time education or financial dependence.
In the event of death	**i)**	certified copy of the death certificate;
	ii)	**Physician's** confidential statement of death; and
	iii)	original or certified copy of Police report in the event of accidental death.
In the event of dismemberment	**i)**	an **Employee Claim Form** completed by the **Member**; and
	ii)	a dismemberment report completed by **Physician**.
In the event of Long Term Disability	**i)**	an **Employee Claim Form** completed by the **Member**;
	ii)	a General Practitioner's Report completed by **Physician** detailing the illness or injury, treatment received or proposed, and a prognosis;
	iii)	a current job description;
	iv)	an up to date record of employment history and qualifications;
	v)	if full **SIB** integration is chosen, details of the **Member's** actual **SIB** receipts; and
	vi)	any details necessary to calculate partial **Benefit**.
In the event of Critical Illness	**i)**	an **Employee Claim Form** completed by the **Member**; and
	ii)	a medical report specific to condition completed by **Physician**.
In the event of Total Permanent Disability	**i)**	a medical report completed by **Physician** detailing the illness or injury, treatment received and **Diagnosis**.

Original versions or original certified copies of evidence are required. We may, in our sole discretion, request information in addition to that required above.

3. CLAIMS ACCEPTANCE

3.1. Standard Claim Acceptance

A **Member** shall be accepted as a **Claimant** and the **Benefit** shall become payable once we are satisfied that the **Member** meets the criteria for '**Benefit Eligibility**' for the relevant cover option under Section Three and has complied with the **Claim** notification and assessment processes under this Section.

3.2. Claim Acceptance by us during Temporary Cover

If an insured event occurs in respect of an **Eligible Employee** during the period of **Temporary Cover**, their **Claim** will be assessed as though **Evidence of Insurability** is not required, provided that:

i) the **Claim** event occurred within the period of **Temporary Cover**; and

ii) the **Claim** is not directly or indirectly linked to any **Pre-Existing Medical Condition**.

If we have agreed non-standard **Member** acceptance terms, these terms will be applied to any agreed **Benefit** increases during the period of **Temporary Cover**.

4. MEDICAL EXAMINATION

Evidence to substantiate a **Claim** is supplied at no cost to us. We shall not be liable for any costs incurred by the **Employer** or **Member** due to the **Member** attending a routine examination or in supplying any other information for the purposes of the **Claim**.

We may require the **Member** to be examined by, or obtain medical reports from one or more **Physicians** appointed or approved by us. The **Member** will provide appropriate samples for any tests, which may include blood, urine and saliva tests.

Any medical examination required or arranged by us will be paid for by us. Where a **Member** fails to attend such medical examination without reasonable excuse, we will seek to recover any cost incurred by deduction from the **Claim** payment.

The **Employer** must take all reasonable steps to ensure that the **Member** attends any examination when notified to do so and co-operates with any request by us within 30 days of the date of our request. Failure by the **Member** to attend an examination and/or to cooperate with a reasonable request or, failure by the **Employer** to provide requested information within the time notified may result in the **Claim** being declined by us for that **Member** or, when a **Regular Payment Benefit Claim** has been admitted, further **Benefit** payment may be discontinued.

5. CLAIM PAYMENT

Once the **Claim** is accepted by us, the **Policyholder** will be notified in writing. The **Member** will become a **Claimant** and **Benefit** will be payable as stated below:

5.1. Standard Benefit payment

Benefit is paid by us to the **Policyholder** in the **Policy Currency**. **Benefit** will be paid gross of tax or any other deductions. It is the responsibility of the **Policyholder** and **Claimant** to ensure that their respective obligations are satisfied in relation to the deduction or payment of any tax, or other such deductions (see Section Seven, Article 2.15). The receipt by the **Policyholder** of any **Benefit** paid under this **Policy** shall be a valid discharge of our liability.

Benefit payment will be based on the information supplied to us at either **Commencement Date** or **Renewal Date** or at any other time (see Section Five, Article 2.1). Should this information be different to that provided at the time of **Claim** notification, then we may agree, in our sole discretion, to use any new information provided for the purpose of **Benefit** calculation.

The terms under the **Policy** applicable at **Claim Onset Date** shall remain applicable for the duration of that **Claim**. Any change in terms would only be applied in our sole discretion.

The **Policy** has been taken out by you, the **Policyholder**, to provide cover for your **Members**. You are required to exercise any rights available under the **Policy** in such a way as to ensure that any **Benefit** paid to you is applied for the benefit of any **Members** who become **Claimants** in accordance with the provisions of the **Policy**. However, we shall have no interest, responsibility or liability and shall not enquire as to how any **Benefit** paid to you is applied.

5.2. Benefit Payment in the event of Policyholder insolvency

If the **Policyholder** goes into voluntary or involuntary liquidation, or ceases to trade for reasons of insolvency, all covers under the **Policy** will terminate with immediate effect (see Section Five, Article 4). We will continue to honour **Claims** that have been notified to us or are in payment at the time the **Policy** terminates. In this situation, we will pay **Benefit** directly to the **Claimant** or their estate, subject to receipt of the necessary due diligence information, in accordance with the **Policy** terms.

6. CLAIM DECISION ARBITRATION

If you disagree with our decision in relation to a **Claim**, the **Claim** decision arbitration process is set out below:

6.1. Disagreement on medical grounds:

i) the **Claim** will be referred to our **Chief Medical Officer** who will review all the evidence received by us as part of the assessment process and on which our decision was made;

ii) the **Member** or **Claimant** whose **Claim** is under consideration will be invited to produce any further evidence that has yet to be passed to us, which might influence our decision;

iii) the **Chief Medical Officer** may, in their sole discretion, request any further information as deemed appropriate to help with their assessment of the **Claim**;

iv) the **Chief Medical Officer** may seek an opinion from a consultant **Physician**, or otherwise similarly positioned medical expert treating the **Member** as to the validity of the **Claim**; and

v) the **Chief Medical Officer** will make his decision based on the findings from these steps. We will follow the decision reached by our **Chief Medical Officer**.

Costs of this referral would be met by us.

6.2. Disagreement not on medical grounds:

We may in our sole discretion reject any **Claim** or terminate the payment of any **Regular Payment Benefit** at any time where we have reasonable grounds to deem the **Claim** to be materially defective for any reason. We will inform you of such a decision in writing and if you disagree with our decision, you may lodge a complaint with us. Details of our complaints procedure can be found under Section Seven, Article 2.4.

7. FRAUDULENT CLAIMS

If any **Claim** under this **Policy** is in any respect fraudulent or if any fraudulent means or devices are used by you or the **Employer** or anyone acting on their behalf, or by a **Member** or a **Claimant** or their agent to obtain **Benefit** under this **Policy**, we shall have no liability in respect of such **Claim**. We shall have the right (without prejudice to any other legal rights) to reclaim all **Benefit** paid and expenses incurred in respect of such **Claim**, to include those paid or incurred prior to the fraudulent act, omission, means or device.

In the event of any fraudulent **Claim**, or fraudulent means or device to obtain **Benefit** under this **Policy** by a **Member** or **Member's** agent, that **Member** shall automatically cease to be a **Member** or a **Claimant**.

We may in our sole discretion inform the appropriate authorities of any activity which in our sole opinion constitutes or represents a suspicion of criminal activity, money laundering or the financing of terrorism in accordance with our statutory and regulatory obligations.

You are under a continuing obligation to disclose any material fact or alteration to any previously disclosed facts which could influence our decision to accept a **Claim** or pay a **Benefit**.

SECTION FIVE

PREMIUM PAYMENT AND POLICY ADMINISTRATION

1. PREMIUM PAYMENT

Your **Policy** has a reviewable premium. This means that the **Unit Rate** or the **Underlying Rate Table** used to calculate your premium may be altered in the future to reflect the updated cost of providing your cover.

We commit to maintain the rates upon which the inception premium is calculated until either the **Guarantee Period** expires or one of the conditions under Article 2.6 'Policy Review' below applies.

1.1. When and how premiums are payable

Premiums are payable by the **Policyholder**, the inception premium being due on the **Commencement Date** and subsequent premiums being payable annually on each **Renewal Date** or at such other frequencies (monthly, quarterly, or half yearly) as specified in the **Policy Particulars**. We will give you 30 days' grace to pay a premium (or longer if agreed by us in writing and set out in the **Policy Particulars**).

Premiums must be paid in the **Policy Currency**. Where premium payment is not in the **Policy Currency** see 'Currency Conversion' under Section Seven Article 2.14., any premium adjustment arising from a currency conversion will be included in the account as at the following **Renewal Date**.

On the **Commencement Date** and each subsequent **Renewal Date**, we will calculate a separate premium in respect of each **Member** who has not then reached **Termination Age**. This premium is for the **Member's** cover under the **Policy** during the period from the relevant calculation date until the next **Renewal Date**.

The premium may be calculated by reference to the **Unit Rate** or the **Underlying Rate Table** allowing for the **Member's** age, sex, nationality, residence, occupation and sum assured at the date in question.

No refund of premium will be made for **Claimants**. Under Group Long Term Disability cover, premiums in relation to **Claimants** are waived from the **Renewal Date** following **Benefit** commencement and will be waived for as long as the **Claim** continues to be valid.

1.2. Consequences of Late or Non-Payment

If any premium is not paid when due, premiums will be deemed to have been discontinued from the date they were due. In this event, cover under the **Policy** will also be discontinued from that date without notice and in our sole discretion.

If you require longer to arrange payment of a premium or if you wish to resume payment of premiums where premiums have been deemed to be discontinued, you will need our consent. Our consent may be granted subject to any terms and conditions that we may require, including our right to charge interest on any premiums that are paid after the date they fall due for payment.

2. POLICY IMPLEMENTATION AND RENEWAL ADMINISTRATION

2.1. Required Information

You, the **Policyholder** must supply us with any information and/or documentation we may in our sole discretion consider necessary to operate the **Policy**. This includes details of **Members** as well as the information required to calculate **Benefit** for each **Member** as follows:

- Surname and first name
- Annual Earnings or Benefit amount in Policy Currency
- Payroll Number or ID number set by Employer
- Details of any Member on Permitted Temporary Absence
- Date of Birth
- Gender
- Nationality
- Location/ Residence
- Occupation

Where applicable, you must also provide:

- Billing destination (where sub-billing required)
- Dependant's details including dates of birth
- Marital Status
- Membership Category

This data file will need to be supplied to us in a spreadsheet format at **Commencement Date** and within 30 days (or longer if agreed in writing) immediately following **Renewal Date**.

Where the data file is not supplied to us within the required timescales:

i) at **Commencement Date**, we will assume you have exercised your cancellation rights (see 'Cancellation Rights' in Section Seven Article 1).

ii) at **Renewal Date**, we will proceed with the renewal (subject to payment of the deposit premium) based on the current membership data held. This means that **Benefit** will be payable only for the **Members** and **Benefit** amounts we hold on record. We may in our sole discretion decline membership or restrict cover for any **Member** concerned.

You, the **Policyholder**, are responsible for all information and/or documentation provided to us in connection with the **Policy** whether by you, an **Employer** or any other person, which must be true and complete to the best of that person's knowledge and belief with no material facts to be withheld. Provision of false or incomplete information and/or documentation and/or the non-disclosure of material facts may result, in our sole discretion, in the **Policy** being terminated, the acceptance of any **Member** being declared null and void or a **Claim** being declined.

The terms shown in the **Policy Particulars** and the premiums payable by the **Policyholder** in respect of each **Member** are dependent upon information you have provided. You are under a continuing obligation to disclose any material fact or alteration to any previously disclosed facts which could influence our decision to accept the risk of the **Policy** or to offer renewal terms. We reserve the right, upon becoming aware of any failure to disclose or misstatement or alteration to material fact to amend or discontinue the **Policy** at any point during its lifetime.

2.2. Policy Commencement Date

The **Policy** takes effect from the **Commencement Date** subject to provision of the data file as set out in the 'Required Information' under Article 2.1 above.

We will send you an inception premium invoice and a statement of account as at the **Commencement Date** setting out the premium payable in respect of the **Policy**, which must be paid when due. The terms under Article 1 'Premium Payment' above apply.

Any additional premium or refund of premium arising from an event occurring since the **Commencement Date** (i.e. mid-term adjustments) will normally be included in the account as at the following **Renewal Date**. Where a different frequency has been agreed, this will be set out in the **Policy Particulars**.

2.3. Mid-term Adjustments

Mid-term adjustments can be calculated under the following methods. The chosen method is set out in the **Policy Particulars**.

2.3.1. Full administration basis

We will require full details of any membership change occurring during the year. This information can be supplied to us ad hoc or at an agreed frequency.

If a **Member** joins or has an increase in **Benefit** at a date other than the **Commencement Date** or **Renewal Date**, we will calculate a pro-rata premium in respect of that **Member** to cover the period between their **Normal Inclusion Date** (or date of increase in **Benefit**) and the next **Renewal Date**.

If a **Member** ceases to be included in the **Policy**, or has a decrease in **Benefit** at a date other than the **Renewal Date**, we will calculate a refund of premium in respect of that **Member** for the period from the date they ceased to be included in the **Policy** (or had a decrease in **Benefit**) to the next **Renewal Date**.

If a **Member** becomes a **Claimant** during the year, no refund of premium will be made in respect of that **Claimant**.

Any additional premium or refund of premium due under the **Policy** will be calculated on a daily pro-rata basis.

2.3.2. Simplified administration basis

We will only require full membership data at the **Renewal Date** as set out in the 'Required Information' under Article 2.1 above.

This method can only apply where a **Unit Rate** has been quoted under the **Policy**. This method assumes all adjustments due to joiners/ leavers/ salary changes occur halfway through the period of cover:

Premium Adjustment = (total sum assured at **Renewal Date** – total sum assured at previous **Renewal Date**) x **Unit Rate** / 2

2.4. Premiums in respect of non-standard acceptance

Additional premiums or refunds for **Members** accepted on non-standard terms will be payable by the **Policyholder** from the date the **Medical Underwriting** decision is made, on a daily pro-rata basis.

2.5. Policy Renewal Date

The **Policy** is renewed annually on the **Renewal Date**. If a **Policy** review is due our terms may be revised (see Article 2.6 'Policy Review' below).

We will issue a deposit premium invoice prior to the **Renewal Date** based on the current membership data held. The deposit premium invoice must be paid when due for cover to continue. Failing this, no new **Claim** will be accepted.

You must supply us with the data file as set out in the 'Required Information' under Article 2.1 above. A renewal premium will be calculated to take into account any changes in membership during the year. We will send you a renewal statement of account and an invoice or credit note based on the deposit premium paid, which must be settled when due. The terms set out in Article 1 under 'Premium Payment' above apply.

2.6. Policy Review

The **Unit Rate**, or the **Underlying Rate Table**, will remain in force for the **Guarantee Period**. On the **Review Date** we may in our sole discretion review and adjust the **Unit Rate**, **Underlying Rate Table** and the terms and conditions of this **Policy**.

We may revise or add to the **Policy** terms at any time, subject to us giving you 30 days written notice of our intention to do so. However, we will not make any revisions that we might reasonably consider to affect your interests adversely under the **Policy** until the **Guarantee Period** has elapsed unless:

i) the number of lives or total **Benefit** changes by more than 20% to that insured at **Commencement Date** or last **Review Date**;

ii) there is a change in the nature of an **Employer's** business which makes any **Member's** job more hazardous. This includes a change in location or country of residence of any **Member** to a country in a high risk area, such as a war zone or territory where political or social unrest exists, for a period exceeding three months for any **Member**;

iii) you wish to include cover for an additional group of **Employees** into the **Policy** whose nature of business, location or nationality is different to that of the **Members** currently insured;

iv) there is a material change in the basis used for calculating any **SIB** taken into account when calculating a **Member's Benefit**, or if the terms and conditions for payment of **SIB**, or their taxation treatment, should alter materially;

v) any new legislation (or change in existing legislation) comes into force on or after the **Commencement Date** which affects the way that premiums and/or **Benefits** are treated for tax purposes for you, your **Members**, **Claimants** or us, or the way that our life assurance fund (into which premiums are paid) is treated for tax purposes; or

vi) the number of insured lives falls below our minimum, as determined by us in our sole discretion.

In such circumstances, we reserve the right to:

i) amend the **Unit Rate** or **Underlying Rate Table** used to calculate the premium retrospectively to the **Commencement Date** or last **Renewal Date**;

ii) withdraw cover completely giving 30 days written notice to you. In the event of notice to withdraw cover, we will issue a pro-rata adjustment invoice for the period from the last **Renewal Date** to the end of the notice period; or

iii) to impose a minimum premium (in the circumstance of (vi) only).

We may also revise the **Policy** if circumstances outside our control have changed in any way which could not have been reasonably predicted by us at the **Commencement Date** and where, if we were not to revise the **Policy**, the results would be unfair to you and/or to us. Such circumstances would include, but are not limited to, a change in the law or tax environment under which your **Policy** operates. Any such changes will be notified to you in writing. Where possible, we will aim to give you 30 days written notice of the changes taking effect.

When revised terms are agreed, new **Policy Particulars** or an endorsement to the existing **Policy Particulars** will be issued.

3. CATASTROPHE CLAUSE

In the event of a **Catastrophe**, the maximum amount of **Benefit** we will pay for all **Claims** arising from that **Catastrophe** will be restricted to the **Catastrophe Limit**.

The **Catastrophe Limit** applicable to all cover options chosen under this **Policy** is set out in the **Policy Particulars**.

When determining the maximum **Benefit** payable, we will consider all **Claims** that occurred as a direct result of the **Catastrophe** in the order they have been notified to us. This will be compared to the **Catastrophe Limit**. Once the **Catastrophe Limit** has been reached, we will cease to accept **Claims** and no further **Benefit** will be payable in respect of that event, under this **Policy**.

For **Regular Payment Benefits**, the total capital value of the **Benefit** will be used to determine the total **Benefit** payable in relation to the **Catastrophe Limit**.

It is at the **Policyholder's** discretion how the **Benefit** paid is distributed between the **Claimants**.

We will not be liable to accept any **Claim** which arises as a result of a **Catastrophe** and which has not been advised to us before the expiry of twelve calendar months from the occurrence of the **Catastrophe**. This overrides the **Claim** notification period rules as set out in Table 9 under Section Four.

4. POLICY TERMINATION

The **Policy** may be cancelled by the **Policyholder** at any time in writing.

The **Policy** may be terminated by us, immediately and without notice in our sole discretion:

i) in the event that you fail to pay the invoiced premium when due;

ii) upon us becoming aware of the **Policyholder** failing to disclose, misstating or altering any material fact at any point during the **Policy** lifetime; or

iii) should the **Policyholder** cease to trade.

Where the number of **Members** falls below our minimum level of membership (as determined by us in our sole discretion), we will give 30 days' written notice of our intention to terminate the **Policy**.

We are entitled to receive all premiums due and payable to the date of termination. We will issue a pro-rata statement as to the premium payable for the period from the last **Renewal Date** to the end of the notice period and will make the necessary premium adjustment. No return of premium will be made if the **Policy** is terminated within one year of the **Commencement Date** (unless terminated within the **Cancellation Period**).

SECTION SIX

POLICY EXCLUSIONS

In the event that we determine that any **Claim** is subject to an **Exclusion** and is not covered by the **Policy**, the burden of proving to the contrary shall be upon you, the **Policyholder**, and/or the **Member**.

1. MEMBER SPECIFIC EXCLUSIONS

Unless specified in the **Policy Particulars**, no cover will be granted under this **Policy** for:

i) **Employees** on fixed term contracts;

ii) **Employees** who retire before **Termination Age** or who continue to work beyond **Termination Age**;

iii) extension of a **Regular Payment Benefit** beyond **Termination Age**; or

iv) **Eligible Spouse** and **Eligible Children** except where specifically stated in the **Policy Particulars**.

Members may have non-standard terms applied to them resulting in further **Exclusions** of cover.

2. ADDITIONAL EXCLUSIONS

Unless stated otherwise in the **Policy Particulars**, we shall not be liable to pay any **Benefit** in respect of a **Member** in the event of a **Claim**, directly or indirectly, attributable to or consequential upon:

i) nuclear transmutation, or radiation, resulting from the artificial acceleration of atomic particles, or

ii) chemical or biological substances which are not used for peaceful means.

Additional **Exclusions**, if applicable, are detailed in the **Policy Particulars**.

SECTION SEVEN

CANCELLATION RIGHTS & GENERAL CONDITIONS

1. CANCELLATION RIGHTS

If you are not satisfied with the **Policy** or our service, you can choose to cancel the **Policy** at any time during the **Cancellation Period** by sending us a written cancellation notice. We will refund all premiums paid within the **Cancellation Period** less an adjustment for the cost of administering the **Policy** during the **Cancellation Period**. We also reserve the right to deduct any **Medical Underwriting** costs incurred by us up to the time that the cancellation notice is received.

2. GENERAL CONDITIONS

2.1. Governing Law

The **Policy** shall be governed and construed in accordance with the laws of the Island of Guernsey. Each party submits to the exclusive jurisdiction of the Royal Court of Guernsey in connection with the **Policy**.

2.2. Regulator

Generali Worldwide is licensed under the Insurance Business (Bailiwick of Guernsey) Law, 2002 and regulated by the Guernsey Financial Services Commission.

They can be contacted at The Guernsey Financial Services Commission, P.O. Box 128, Glategny Court, Glategny Esplanade, St Peter Port, Guernsey, GY1 3HQ.

2.3. Data Protection

Generali Worldwide is registered with the Data Protection Commissioner in Guernsey for the purposes of the Data Protection (Bailiwick of Guernsey) Law, 2001 (the "DP Law"). For the purposes of this clause, "data subject", "personal data" and "sensitive personal data" shall have the meaning attributed to them in the DP Law.

Generali Worldwide may hold, record and process data relating to the **Policy**, **Policyholder**, **Members** and **Claimants** (including all forms of personal data) on computer and/or manual systems in respect of any insurance dealings with **Generali Worldwide** both now and in the future for administrative, identification, **Medical Underwriting**, customer care, service and marketing purposes.

You accept and consent that **Generali Worldwide** may pass data associated with the operation of the **Policy** (including all forms of personal data) to:

i) **Generali Worldwide's** ultimate holding company or any company which is a subsidiary of such ultimate holding company; and

ii) underwriters, medical practitioners/ experts, reinsurers and any agent, contractor or third party service provider who provides services to **Generali Worldwide** in connection with the **Policy** wherever they are located in the world.

The above applies irrespective of whether any insurance policy is concluded between us or whether you exercise your right to cancel the **Policy** during the **Cancellation Period**.

It may be necessary to maintain personal data for a significant period of time. However, when your personal data is no longer required by **Generali Worldwide**, all reasonable steps will be taken to ensure that it will be disposed of securely.

In providing **Generali Worldwide** with information, you confirm that you have obtained the consent of the data subjects to the processing of their personal data in the manner and for the purposes set out above (including the explicit consent of data subjects for the processing of any sensitive personal data).

Individual data subjects have the right to obtain access to and request correction of any personal data concerning them held by **Generali Worldwide**. This can be done by contacting our Data Protection Officer at our business address in Guernsey, which is provided at the back of this **Policy Document**. Please note that there may be a charge for such requests.

It is important that the information **Generali Worldwide** holds is accurate and up to date. You should keep us informed of any change in the data (including personal data) that we hold and let us know if there are any errors or omissions in that data.

2.4. Complaints

All complaints should be directed in writing to the Customer Services Manager at **Generali Worldwide** Insurance Company Limited, PO Box 613, Generali House, Hirzel Street, St Peter Port, Guernsey, Channel Islands GY1 4PA. A formal complaints procedure is operated by us, details of which can be provided on request.

2.5. Non-liability for errors and omissions

We shall not be liable for any errors or omissions on our part arising from any errors or omissions from any data, information or evidence given to us by you, the **Employer**, any **Member**, any **Claimant** or anyone acting on their behalf of any intermediary or third party administrator.

2.6. Documents Requiring Translation

All documents must be provided to us in the English language. Documents requiring translation into English must be translated by a certified translator before submitting them to us. If they are sent directly to us without translation, the **Policyholder** will be invoiced for the associated costs.

2.7. Confidentiality

We shall not disclose to any person any information and/or data relating to the **Policy**, the **Policyholder**, an **Employer** any **Member**, or any **Claimant** of a confidential nature provided that we may disclose such confidential information and data:

- **i)** where compelled or required or permitted to do so by law, regulation or by order of a court or governmental or administrative tribunal;
- **ii)** where disclosure is made with consent of the relevant party, or is permitted or envisioned by the **Policy**; or
- **iii)** in order to facilitate or otherwise assist in the provision of the terms and conditions of the **Policy**, renewal of the **Policy** or for the purposes of **Claims** handling;
- **iv)** otherwise in accordance with DP Law (see Article 2.3 above).

2.8. Correspondence

We will send all correspondence to the most recent address given to us by you (or your designated intermediary) and you should inform us immediately in writing of any change of address. If you do not, correspondence sent to your most recent address held on our records shall be deemed to be validly received by you at the time it would normally be expected to have reached that address.

Any correspondence from you to us should be made in writing and directed to our registered office in Guernsey for the attention of the Life and Disability Customer Services Department. Correspondence intended for our attention will only become valid upon receipt by us.

2.9. Giving Notice

Notice shall be given by:

- **i)** a delivery service with delivery charge prepaid and return receipt requested;
- **ii)** electronic email, with confirmation copy sent by delivery service, no later than 24 hours after the time and date of the electronic mail transmission.

Notice will be effective on:

- **i)** the date of receipt of the notice from the delivery service (or date first delivery attempt was made if initial delivery was unsuccessful);
- **ii)** the date on the electronic email (subject to the requirements in (ii) above having been met).

We will confirm the effective date of the notice in writing.

2.10. Assignment

The **Policy** and any **Benefits** payable under the **Policy** shall not be assigned or otherwise transferred by the **Policyholder** without our written consent, and we shall not be affected by any notice of assignment, trust, charge, lien or other dealing with the **Policy** or any **Benefits** payable under the **Policy**.

2.11. Waiver

We may in our sole discretion, waive any term or condition of the **Policy**. Such discretionary waiver shall not set a precedent and cannot be relied upon as a precedent. Once such waiver has been confirmed by way of a written endorsement to the **Policy**, it shall be binding upon us.

2.12. Severance

If any term or condition of the **Policy** shall be determined by a court or other competent authority to be illegal, void or unenforceable, such determination shall not abrogate the **Policy** or any term or condition thereof, other than such term or condition as is determined to be illegal, void, or unenforceable, and all other terms and conditions of the **Policy** shall remain in full force and effect.

2.13. Legal Contract

This **Policy Document** (together with the **Policy Particulars**, **Quotation**, **Application Form** and any endorsements we agree in writing are to be incorporated in the **Policy**) constitutes the entire agreement between you and us relating to the **Policy** and supersedes all prior agreements, negotiations, representations and proposals between you and us, whether written or oral.

2.14. Currency Conversion

Where currency conversion is required, to convert **Earnings** for determining **Benefit** into the **Policy Currency**, we will, in our sole discretion, use the applicable exchange rate in force at the **Commencement Date** or **Renewal Date**, unless agreed otherwise in the **Policy Particulars**. Where appropriate, the exchange rate on the **Member's Normal Inclusion Date** or the effective date of a change in **Earnings** may also be used.

All premiums are payable in the **Policy Currency**. If the premium is paid in a currency other than the **Policy Currency**, any shortfall due to fluctuations in the respective exchange rate will be owed to us and will be included in the account as at the following **Renewal Date**.

Benefit is paid in the **Policy Currency**. We will not accept liability for any loss in the **Benefit** paid, due to currency conversion or bank charges.

2.15. Tax

We do not accept responsibility or liability whatsoever for any tax consequences or other similar obligations imposed upon the **Policyholder**, **Employer**, **Member**, **Claimant** or any other party arising from the payment of any **Benefit**. It is strongly advised that professional tax advice is taken in relation to the **Policy** and potential **Benefits** payable hereunder.

Registered Head Office address: Generali Worldwide Insurance Company Limited, Generali House, Hirzel Street, St Peter Port, Guernsey, Channel Islands GY1 4PA.

Incorporated in Guernsey under Company Registration No. 27151.

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