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Simplicity
Critical Illness
by Unum

Simplicity Critical Illness

User guide - including general terms

Contents - user guide

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1. Product Overview

The policy:

- Meets the demands and needs of an employer who wishes to provide a tax-free lump sum benefit if a member is diagnosed with one of the defined medical conditions or undergoes (or, where applicable is placed on an NHS waiting list for) one of the surgical procedures covered under the policy. For benefit to be payable:
  - The condition or surgical procedure must meet the policy definition, and
  - The member must survive for at least 14 days after the critical illness event
- Covers member's children aged from 30 days until 18 years (21 if in full-time education) for 25% of the member's benefit while the member is insured - at no extra cost
- Is entirely funded by you - the employer - to provide cover for your employees
- Can provide fixed or flexible benefits
- Requires a minimum of 50 members
- Complies with the Association of British Insurers (ABI) guide to minimum standards for Critical Illness cover 2018

Critical illness events:

The complete list of conditions we cover is set out below. These headings are only a guide and the full definitions of the illnesses covered are given in the appendix to this document.

- Benign brain tumour* - with permanent symptoms or specified treatments
- Cancer - excluding less advanced cases
- Coronary artery bypass grafts*
- Heart attack*
- Kidney failure - requiring permanent dialysis
- Major organ transplant* - from another donor
- Motor neurone disease - resulting in permanent symptoms
- Multiple sclerosis* - with persisting symptoms
- Parkinson's disease* and Parkinson plus syndromes - resulting in permanent symptoms
- Stroke*

Conditions or procedures marked with * provide wider coverage than the ABI guide to minimum standards for critical illness cover.

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2. How the policy works

Fixed benefits

The chosen flat benefit of between £10,000 and £60,000 applies to all members within your defined eligibility categories.

Flexible benefits

All members are covered for a chosen core benefit of at least £10,000 and have the option to increase their cover by defined benefit steps (typically £10,000 per step). Members who are actively at work can choose any available level of cover when first joining, if not at first opportunity then only the lowest level of cover can be selected. Employees can choose to increase their benefit each year by one step, or decrease their benefit by any number of steps, during their flexible benefits selection window. Any increase will apply from the next annual renewal.

Eligibility

You should clearly state a defined eligibility for each membership category, including:

- The categories of member you want covered and the benefits required
- The minimum and maximum entry ages allowed for new members (between 16 and 69)
- If a minimum service requirement is in place and the duration
- If cover is dependent on membership of your pension scheme, you will also need to provide the pension scheme's current eligibility requirements

Actively at work

Membership is compulsory for all employees who are eligible and are actively at work on joining. New employees are covered from the day they become eligible.

Actively at work means the employee has not been advised to stop working or to reduce their contracted hours and is working their contracted hours in their normal occupation, at their normal place of work.

Temporary absence

If a member becomes absent from work after joining, cover continues:

- In cases of illness or injury - until age 70
- For statutory absences such as parental leave - for the duration of leave, not exceeding age 70
- For any other reason such as sabbaticals, unpaid leave or compassionate leave - for a maximum of 36 months, not exceeding age 70

Members based overseas

Cover can continue for an employee working and living outside of the UK if their contract of employment with the UK policyholder is maintained.

3. Putting cover in place

Quote

Your broker will ask us for a quote. The request should include your company details, including industry and location, and specify the cover required - whether you need fixed or flexible benefits, and the level of benefit required, including the core benefit and size of any steps.

For the quote, at the start date and at each policy accounting date, we require a list of all members showing:

- Name
- Date of birth
- Gender
- Membership category
- Benefit
- Date of joining or date of leaving (if applicable)
- Occupation
- Work location

We will provide a quote including the rates that apply, and premium based on the total benefits. Quotes are guaranteed for 3 months. If accepted, rates are guaranteed for 2 years unless there is a significant change to the size or nature or your business. The premium shown in our quote includes the commission payable to your broker. The terms and conditions applying to the policy are shown on the quote and apply for the duration of the rate.

Starting cover

Your broker will contact us to let us know you have accepted the quote and advise us when you want cover to start.

We provide conditional cover for up to 30 days while you provide the following information:

- Updated membership data at the start date
- Deposit premium or direct debit mandate
- A customer verification statement signed by your broker

If we do not receive this information within 30 days, cover will stop. We will then charge a premium based on the time we have provided cover.

If you have chosen a flexible benefit policy, the start date should coincide with your employees' flexible benefits selection window so we receive details of each member's selected level of cover within 3 months of the start date.

We will issue your policy documents once cover starts.

Premiums

Premiums are paid annually or monthly by Direct Debit or Direct Credit. Please note, we add an extra 3% for monthly payments.

Standard/core cover - Premiums are recalculated each year based on the unit rate, and the total benefit at each policy accounting date.

Flex top up benefits - Premiums are recalculated each year based on the age of each member and their chosen level of benefit.

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Ending cover

A member's cover ends on the earliest of the following dates:

- They no longer meet the eligibility conditions
- They reach age 70
- A claim is paid for one of the critical illness events

You can cancel the policy at any time by asking us in writing. Cover will then end and you will not be liable for payments after this date. Cancellation cannot be backdated. If the policy is cancelled, we will still consider claims for events which happened before the cancellation date - provided there are no outstanding premiums.

We may close the policy:

- By giving 31 days' notice if:
  - The number of employees falls below 50
  - Any premiums due are not paid
- Immediately if continuing the policy would break any UK, US or European sanction controls.

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4. Making a claim

Members with previous medical history

An employee who has suffered or been diagnosed with a critical illness event before joining the policy cannot claim for an insured event that has already happened, but they can receive benefit if it happens again. They can also receive a payment if they have a medical condition that did not meet the event definition before but, because it has become more serious, it now does, for example:

Heart attack - If an employee had a heart attack before becoming a member, they are not covered for that event. They are covered if they have another heart attack after they become a member.

Cancer - If an employee has cancer that would meet the event definition when they become a member, and while they continue to have cancer, they are not covered for any type of cancer.

If they have cancer that does not meet the event definition, they are covered for any cancer that does fully qualify.

Once they are a member and the cancer has gone (they have been given the 'all clear'), they are covered if the cancer comes back or they get an unrelated cancer.

A full explanation of how cover works for members with a previous medical history for each of the critical illness events is in the appendix to this document.

How to claim

You should tell us about a claim as soon as possible and no more than 90 days after your employee is diagnosed with a medical condition or operation covered under the policy. We may not consider claims made later than 90 days.

You can obtain claim forms by calling our claims helpline on 01306 873243 (Monday to Friday from 9 to 5) or by downloading them from our website.
We will need:

- A claim form completed by you, the employer
- A claim form completed by the member, together with their consent allowing us to ask for medical information or evidence so we can fully consider their claim

Once the claim is accepted, we will pay the benefit directly to the member, tax-free.

Once a claim has been paid for a critical illness event, that member's cover will end.

If you or your employee are unsure about any part of your claim at any point, please call the above number. A Unum claims specialist will be on hand to help you provide the details needed and will take time to explain anything that is unclear to you.

5. General terms

The policy

The policy conditions and terms apply until the Policy Review Date. However, if there is a significant change in the law or the tax system we have the right to make reasonable changes sooner. The changes will be limited to those necessary to remedy any problems caused by the change in law/tax system.

Insurance cover

Eligible Employees and their children are covered from the day the employee becomes eligible and is Actively at Work.

Actively at Work means the employee; has not been advised to stop working or to reduce their contracted hours; is capable of working their contracted hours (even if, on the day they become eligible, they are not contracted to work or are on a statutory absence) in their normal occupation, at their normal place of work.

Cover can continue for an Eligible Employee working and living outside of the UK if they have a current contract of employment with the UK Policyholder.

If, following the start of cover, an Eligible Employee is temporarily absent from work, cover will continue:

- Until their Terminal Age - for absence due to ill health, or
- For a maximum of 3 years for any other absence

Ending cover

An Eligible Employee's cover ends when:

- They are no longer an employee (for whatever reason); or
- They no longer meet the Eligible Employee conditions; or
- They reach the Terminal Age; or
- A claim is paid for one of the Critical Illness events; or
- The policy ends

Cover for an Eligible Employee's child ends when:

- The employee's cover ends
- The child reaches age 18, or 21 if they are in full-time education
- A claim is paid for the child for one of the Critical Illness events

The Policyholder may cancel the policy at any time by giving 31 days' notice.

We may cancel the policy by giving 31 days' notice if:

- The number of Eligible Employees falls below 50
- Any premiums due are not paid
- Important information concerning Eligible Employees has not been given to us or the information that has been given was not accurate and complete - and a reasonable person would have known that to be so

We may cancel the policy immediately if continuing the policy would contravene any UK, US or European sanction controls.

Claiming benefit

The Benefit is payable to the Eligible Employee:

- In full if the Eligible Employee survives; and
- For 25% of the Benefit if their child survives:

for 14 days following a Critical Illness event and meets the requirements for an Eligible Employee (or their child) with a previous medical history, as listed in the appendix of this document.

We will require completed claim forms from the Policyholder and the employee and a consent form to obtain the necessary records or information from the employee's or child's medical practitioner, within 90 days from the Critical Illness event.

The Policyholder can get claim forms by calling our claims helpline on 01306 873243 (Monday to Friday from 9 to 5) or by downloading them from our website.

We may not consider a claim if we receive the claim or consent forms later than 90 days after the Critical Illness event.

We may request medical evidence from the employee's or child's medical practitioners or consultants to substantiate the Critical Illness event to our satisfaction. The employee or child may be required to have a medical examination.

We will pay the cost of any medical evidence or examination we require.

A claim will be determined on the terms and conditions of the policy in force at the date of the Critical Illness event.

Benefit is payable to the Eligible Employee's UK bank account in pounds sterling.

Benefit will not be paid if payment would contravene any UK, US or European sanction controls.

Premiums

The premium is based on the total Benefits and Premium Rate and is payable at the start date and for following years at the Policy Accounting Date. It must be paid from a UK bank account in pounds sterling by the Policyholder.

At the Policy Accounting Date, we will calculate an adjustment to the premium for the expiring year, using the Premium Rate to take account of any employees whose cover started or ended during the year.

The Premium Rate is guaranteed until the Policy Review Date unless:

- The number of Eligible Employees covered or their total Benefits changes by more than 30%
- There is a significant change in the nature or location of the Policyholder's business

the Policyholder must notify us of any such changes as soon as possible.

6. Complaints

If you are not completely happy with our service or a claims decision, you can make a complaint to our Customer Resolution Team.

Phone: 01306 644761

Email: CustomerResolution@unum.co.uk

Letter: Customer Resolution Team,
Unum, Milton Court, Dorking, Surrey RH4 3LZ

Fax: 01306 873635

Please include your preferred contact details.

We will do our best to resolve your complaint, but if your complaint has not been resolved within 8 weeks, we will explain why it remains unresolved and inform you of your right to refer the matter to the Financial Ombudsman Service (FOS).

Once we have finished investigating your complaint we will issue a Final Response letter. If you remain dissatisfied you will have the right to refer the matter to the FOS. You must refer any complaint to the FOS within 6 months of the date of the Final Response letter. Please note that some cases may not be eligible for referral to the FOS.

The Financial Ombudsman Service
Exchange Tower London E14 9SR

Consumer helpline: 0800 023 4567

For mobiles: 0300 123 9 123

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

Web: www.financial-ombudsman.org.uk

7. Further information

Tax

Premiums paid by you are a trading expense and can be offset against Corporation Tax. You may be liable for Class 1A National Insurance Contributions on the premiums.

The employee is taxed on the amount of the premium you pay, as a benefit in kind.

A tax-free lump sum is paid direct to the employee in the event of a claim.

This document should not be considered as tax, legal or financial advice for Policyholders or any member insured under the policy. This includes, but is not limited to, corporation tax and income tax. You should take advice from your own professional advisers on the potential impact of tax and legislation.

Regulation

The policy is only available through authorised brokers.

The policy is issued according to the Laws of England and any dispute will fall under the exclusive jurisdiction of the English Courts.

Customers for this product are classed as "Commercial" as defined by the Financial Conduct Authority's (FCA) Insurance: Conduct of Business sourcebook (ICOBS).

Data Protection

This section explains how we and you comply with Data Protection laws including the Data Protection Act 1998 and the General Data Protection Regulations (GDPR) in connection with the processing of members' personal data.

We are a Data Controller for insurance purposes.

We have the right to request the members' personal data we need to quote for and administer the policy. We will:

- Record the data accurately
- Keep the data confidential and secure
- Use the data solely for the purpose of quoting for, providing and administering the policy and for marketing other Unum products to you
- Retain the data only for as long as is necessary
- Only process, transfer or permit access to any personal data outside of the European Economic Area in compliance with applicable data protection legislation

You are a Data Controller for employment purposes. You must:

- Obtain the necessary consents from, and provide all relevant policy information to members before providing us with any personal data
- Ensure that the data is correct at the time it is provided to us and that alterations are notified to us in reasonable time

You and we will each provide reasonable assistance to the other as necessary to enable the other to comply with Data Protection laws including responding to Data Subject Requests, complaints or other queries received from members or other third parties in relation to members' personal data.

The legal definitions and data protection information contained in our data protection document at **http://resources.unum.co.uk/downloads/data-protection-document-UP4031-052018.pdf** are incorporated into the general terms of this policy.

Appendix - Conditions covered

Condition	Definition	Members with a previous medical history
Benign brain tumour with permanent symptoms or specified treatments	A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in any of the following: • permanent neurological deficit with persisting clinical symptoms, or • undergoing invasive surgery to remove part or all of the tumour, or • undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells For the above definition, the following are not covered: • tumours in the pituitary gland, • tumours originating from bone tissue, • angioma and cholesteatoma.	If you have a brain tumour which would meet the event definition when you become a member, you are not covered for any brain tumour. Once you are a member and the brain tumour has been successfully treated and cannot be detected upon review, You are covered if the tumour comes back or you get an unrelated tumour. If you have a brain tumour that does not meet the event definition, you are covered for any brain tumour that does fully meet the definition.

Appendix - Conditions covered

Condition	Definition	Members with a previous medical history

Cancer
excluding less advanced cases
	Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.
	The term malignant tumour includes leukaemia, sarcoma, and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).
	For the above definition, the following are not covered:
	• All cancers which are historically classified as any of the following:
	  • pre-malignant,
	  • non-invasive,
	  • cancer in situ,
	  • having borderline malignancy, or
	  • having low malignant potential.
	• All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0.
	• Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
	• Any skin cancer (including cutaneous lymphoma) other than:
	  • malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin), or
	  • basal cell carcinoma or squamous cell carcinoma that has spread to lymph nodes or metastasized to distant organs.
		If you have cancer that would meet the event definition when you become a member, you are not covered for any type of cancer until there is evidence of complete remission being achieved.
		Complete remission means that following a response to treatment, the cancer cannot be detected upon review by physical examination, scan, X-rays or blood tests.
		Once you are a member and there is evidence of complete remission you are covered if the cancer comes back or you get an unrelated cancer.
		If you have cancer that does not meet the event definition, you are covered for any cancer that does fully meet the definition.

Appendix - Conditions covered

Condition	Definition	Members with a previous medical history
Coronary artery bypass grafts	The undergoing of surgery or inclusion on an official UK waiting list for surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.	If you underwent surgery or are on a waiting list for surgery before becoming a member, you are not covered for that surgery. Once you are a member, and that surgery has been completed, you are covered if you undergo further surgery which meets the event definition.
Heart attack	Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction: • new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests. • the characteristic rise of cardiac enzymes or Troponins. The evidence must show a definite acute myocardial infarction. For the above definition, the following are not covered: • other acute coronary syndromes, or • angina without myocardial infarction.	If you had a heart attack before becoming a member, you are covered if you have another heart attack after becoming a member.
Kidney failure requiring permanent dialysis	Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.	If you have kidney failure that would meet the event definition when you become a member, you are not covered for kidney failure. If you have kidney failure that does not meet the event definition you are covered if the condition gets worse so that it does fully meet the definition.

Appendix - Conditions covered

Condition	Definition	Members with a previous medical history
Major organ transplant from another donor	The undergoing as a recipient from another donor, or inclusion on an official UK waiting list for a transplant of any of the following: • bone marrow, or • a complete heart, kidney, liver, lung or pancreas, or • a lobe of liver, or • a lobe of lung. For the above definition, the following are not covered: • transplant of any other organs, parts of organs, tissues or cells.	If, before you become a member, you received a transplant of any of the listed organs or parts of organs, you are not covered for that transplant. If, when you become a member you are on the waiting list for a transplant of any of the listed organs or parts of organs, you are not covered for any type of organ transplant. Once you are a member and are no longer on the waiting list because you have received a transplant, you are covered if you need another transplant which meets the event definition.
Motor neurone disease resulting in permanent symptoms	A definite diagnosis of one of the following motor neurone diseases by a Consultant Neurologist: • amyotrophic lateral sclerosis (ALS) • primary lateral sclerosis (PLS) • progressive bulbar palsy (PBP) • progressive muscular atrophy (PMA) There must be permanent clinical impairment of motor function.	If you have motor neurone disease that would meet the event definition when you become a member, you are not covered for motor neurone disease. If you have motor neurone disease that does not meet the event definition you are covered if the condition gets worse so that it does fully meet the definition.
Multiple sclerosis with persisting symptoms	A definite diagnosis of multiple sclerosis by a Consultant Neurologist that has resulted in either of the following: • clinical impairment of motor or sensory function, which must have persisted from the time of diagnosis, or • two or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on Magnetic Resonance Imaging (MRI scan). All of the evidence must be consistent with multiple sclerosis.	If you have multiple sclerosis that would meet the event definition when you become a member, you are not covered for multiple sclerosis. If you have multiple sclerosis that has never met the event definition, you are covered if the condition gets worse so that it does fully meet the definition.

Appendix - Conditions covered

Condition	Definition	Members with a previous medical history
Parkinson's disease and Parkinson plus syndromes resulting in permanent symptoms	A definite diagnosis of Parkinson's disease or one of the following Parkinson plus syndromes by a Consultant Neurologist or Geriatrician: • multiple system atrophy • progressive supranuclear palsy • Parkinsonian-dementia-amyotrophic lateral sclerosis complex • corticobasal ganglionic degeneration • diffuse Lewy body disease There must also be permanent clinical impairment of motor function with at least one of the following: • associated tremor; muscle rigidity; postural instability or dementia. For the above definition, the following are not covered: • Parkinsonian syndromes/Parkinsonism associated with conditions other than those mentioned above.	If you have Parkinson's disease or one of the listed Parkinson's plus syndromes that would meet the event definition when you become a member, you are not covered for Parkinson's disease or Parkinson's plus syndromes. If you have Parkinson's disease that does not meet the event definition, you are covered if the condition gets worse so that it does fully meet the definition.
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that has resulted in all of the following evidence of stroke: • Neurological deficit with persisting clinical symptoms lasting at least 24 hours, and • Definite evidence of death of tissue or haemorrhage on a brain scan. For the above definition, the following are not covered: • transient ischaemic attack, • traumatic injury to brain tissue or blood vessels, • death of tissue of the optic nerve or retina/eye stroke.	If you had a stroke before becoming a member, you are covered if you have another stroke after becoming a member.

About Unum

Unum is a leading employee benefits provider offering financial protection through the workplace including: Life insurance, Critical Illness, and Dental cover.

We are committed to workplace wellbeing for both employees and employers, and have a wide range of tools designed to help businesses create or enhance their employee wellbeing strategy.

At the end of 2017, Unum protected over 1.6 million people in the UK and paid claims of £306 million - representing in excess of £5.9 million a week in benefits to our customers - providing security and peace of mind to individuals and their families.

Unum Group has a financial strength rating of A (Excellent) from A.M Best with a stable outlook.

Our parent company, Unum Group, is a provider of employee benefits products and services in the United States, including group and individual disability insurance. Premium income for Unum Group and its subsidiaries totaled $8.6bn in the year ended 31 December 2017, with reported revenues for the group totalling $11.3bn and total assets of $64bn. For more information please visit www.unum.co.uk

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