Critical Illness policy

User guide - including general terms

Critical Illness policy

User guide

This document:

- Explains the main features of our Critical Illness product
- Includes the general terms which contain the detail of the insurance contract between the policyholder and Unum. The general terms and the policy document including the policy coverage document should be read as if they were one document. If parts of the user guide are referred to in the general terms or the policy coverage document, those parts also become part of the policy. If there is any difference between them or any ambiguity, the terms in the policy coverage document will apply
- Is designed for use by commercial customers

Critical Illness policy

User guide

The policy:

- Is for employers who wish to cover UK employees. the employer must be a UK entity or a non-UK entity with a UK branch registered at Companies House
- 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
- Automatically provides cover for a member's children at no additional cost
- Provides the option of covering the spouses and partners of employees included in the policy
- Offers a choice of base cover which insures against some of the most common critical illnesses, or base and extra cover, which includes a number of additional conditions
- Complies with the Association of British Insurers (ABI) guide to minimum standards for Critical Illness cover 2022

Unless specified, any references to employees include the equity partners of a partnership or members of a limited liability partnership.

Any reference to employer is also intended to refer to the equity partners of a partnership, members of a limited liability partnership.

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Your commitment

By taking out a policy with us, you agree to:

- Pay premiums on time
- Give us accurate and complete information when we ask for it
- Identify any discretionary entrants
- Notify us if there are significant changes to your business
- Notify us of claims within the time limits set out in this document

Risk factors

You should be aware of the following risks:

- The rates used to calculate the premiums and the terms of this policy are usually guaranteed for 2 years and are then reviewed. However, we can amend the terms if there is a significant change to your business. Please see section 8 for more information
- A pre-existing conditions exclusion applies to cover under this policy
- Cover will end if you do not comply with the policy terms or if premiums are not paid
- If you do not notify us of a claim promptly, benefit payments may be delayed or declined
- The way that HMRC tax benefits may change in the future

How your policy works

1. Who can be covered?

We will agree this with you at the start of the policy:

- We can cover all your employees or a clearly defined group of employees
- You can choose different eligibility conditions for different groups of employees
- We can provide cover up to an employee's 70th birthday.
- You can also choose to provide cover for the spouses and partners of all employees covered under the policy
- We automatically provide cover for a member's children from birth until their 18th birthday (or 21st birthday if they are in full-time education)
- Member's children are automatically provided with the same type of cover as the member, and are covered for a number of children's specific critical illnesses

You can choose:

- The categories of employee you want to be covered
- Minimum and maximum ages for joining the policy
- Whether cover starts immediately or after an employee has been employed for a certain amount of time

In practice

You can set up the policy to cover members of your pension scheme. If you want to do this, you will need to provide us with the eligibility conditions for the pension scheme.

You also decide when new members join the policy and increases in benefit take place. This is usually on a daily basis but there are monthly, quarterly, half-yearly or yearly options.

General terms

Membership

The eligibility conditions and the dates that employees can join the policy are shown in the policy coverage document.

An employee includes:

- Permanent and fixed-term UK employees, including directors, employed by you or another UK employer included in this policy
- A UK based equity partner. A partner is defined as a person entitled to a share in the profits of the business
- A member of a Limited Liability Partnership who is working in the business

All employees must have a UK contract of employment

Eligible employees will be covered from the policy start date.

Employees who become eligible later will be covered from the joining date shown in the policy coverage document.

You must:

- Include all employees in the policy when they first become eligible
- At the start of the policy and at each policy anniversary provide us with details of all employees who meet the eligibility conditions

If we do not receive the necessary information about an eligible employee, they will not become a member until the information is received and we have confirmed cover.

A spouse must be the legal spouse or civil partner of the employee and living with the employee

A partner must be living with the employee in a partnership which resembles marriage for at least six months and financially dependent on or mutually financially dependent with the member

A member's child is covered if they are:

- Up to 18 years of age (or 21 if in full-time education), and
- The biological offspring of the member, or the member's stepchild, or
- Legally adopted by the member, or
- Financially dependent on the member

Discretionary entrants

You must tell us if you want to include an employee who is a discretionary entrant under your policy.

You can ask us to include a discretionary entrant at any time. We will let you know:

- The information we need to assess if cover can be provided, and
- The date that cover will start

Cover during temporary absence

Absence due to illness or injury

You can choose whether members who are absent due to illness or injury are covered until the cover cease age or for up to 3 years.

Other absence or unpaid leave

We can provide cover for up to 3 years for those on unpaid leave - eg. reservists or those on sabbaticals.

Cover during statutory leave

Cover for a member can continue during any period of statutory leave as long as they remain employed by you. The terms of this policy will apply in exactly the same way as if the member was still actively following their occupation.

General terms

Discretionary entrants

A discretionary entrant is an employee you want us to cover who does not satisfy the eligibility conditions.

We will provide a period of temporary cover while we assess if we can provide full cover. Please see section 6 for more information about temporary cover.

Cover during temporary absence

Cover continues during absence due to illness or injury to the cover cease age or for up to 3 years, as shown in the policy coverage document.

Cover for a member can continue during a period of agreed absence such as:

- A sabbatical or compassionate leave, or
- If they are serving as a regular or volunteer reservist

Cover is provided as long as:

- The member remains employed by you
- The period of absence is determined at the start and is less than 3 years
- You have given written consent, including the date of return, within one month of the absence starting

During a period of temporary absence due to illness or injury:

- Unless otherwise stated in your policy coverage document, salary-related increases are covered in line with the employer's general pay increases
- The insured benefit cannot be increased due to a change in benefit basis or due to members moving between categories or policies

During unpaid leave, the insured benefit does not increase.

Cover for a member on a fixed-term contract of employment will end if their contract of employment expires during a period of temporary absence.

Can cover be provided for someone who is based outside the UK?

We can usually offer cover for an employee who is based overseas but you will need to provide some additional information.

In practice

You must tell us about an employee who is based outside the UK, including their nationality and countries they work in.

If a member is not paid in sterling we will convert their salary to sterling to calculate the premium.

Can cover be provided for someone who is on a zero-hours contract?

We can usually agree to do this. You must tell us if you want to include an employee on a zero-hours contract so that we can agree the terms on which we can provide cover.

In practice

We can usually provide cover if the definition of earnings takes account of the variation in earnings.

General terms

Overseas cover

An employee who is based overseas must have a contract of employment with you or a UK based subsidiary company.

The following additional requirements apply if the employee is seconded abroad:

- The UK employer must retain control of where and for who the employee works
- The employee and their UK employer must have a written agreement that the employee will return to work with the UK employer when the secondment ends

If you are a non-UK entity we may refuse to offer cover for the employee while seconded abroad

For the purposes of this policy the UK means England, Northern Ireland, Scotland, Wales, the Channel Islands and the Isle of Man.

2. When will cover for a member end?

Cover for a member will end in the circumstances shown in the general terms.

General terms

Cover for a member ending

Cover for a member will end when they:

- Reach the cover cease age
- No longer meet the eligibility conditions
- Are no longer employed by you or an employer covered by the policy
- Do not return to work following a period of temporary absence

Cover for a member will also end when the policy ends.

Cover for a member's spouse, partner or child will end when the member's cover ends or earlier under the terms of this policy.

Spouse or partner cover also ends when the spouse or partner reaches the cover cease age.

Children's cover also ends when the child no longer satisfies the definition of a child.

3. What types of cover are available?

When setting up the policy, you will be able to make a number of decisions about the type and level of cover to be provided.

The choices you make will affect the premiums we charge and there may be occasions when some options are not available.

Decision 1 - who to cover

When deciding the categories of employee to be covered under your policy, you can choose to provide:

- The same benefit basis for all members covered by the policy, or
- Different benefit levels for different categories
- Cover for members' spouses and partners

The benefit basis must be the same for all members within a category.

Decision 2 - how long to provide cover for

You can choose the age at which cover for a member (and their spouse or partner, if covered) will stop. We call this the cover cease age. This is usually the State Pension Age (SPA) but can be any age up to a member's 70th birthday.

If you want to change the cover cease age on an existing policy, an eligible employee who was over the previous cover cease age will be treated as a new joiner.

General terms

Coverage choices

The policy coverage document will contain the choices of cover you have made for each category including:

- The eligibility conditions
- The cover cease age
- The definition of insured salary
- The benefit
- Type of cover
- The duration of cover while absent due to illness or injury
- Whether cover is provided for members' spouses and partners

The details shown in the policy coverage document will apply to your policy.

Decision 3 - the salary to be used to calculate the benefit

The benefit is usually expressed as a multiple of salary. This means we will need to agree the definition of salary to be used when calculating benefits. We call this the insured salary.

Examples include:

- Basic annual salary
- Basic annual salary plus variable payments averaged over the last 12 months or 3 years
- Total earnings averaged over the last 12 months or 3 years
- P60 earnings

If you operate a salary sacrifice arrangement, we use the pre-sacrifice salary.

In practice

Where earnings are averaged over a period of time:

- Variable payments can be:
  - Averaged over 12 months, capped at 20% of basic salary, or
  - Averaged over 3 years
- If a member has been employed for less than that period of time, we will average earnings over the time they've been employed
- If a member has been on pre-arranged temporary absence during that period of time, we will average earnings over the time they were working

For partners the normal definition is the average of the last 3 years' earnings after partnership/chambers expenses have been deducted.

General terms

Insured salary

The benefit will be calculated based on the member's insured salary at the date of their critical illness event.

Decision 4 - the level of benefit you want to provide

You can provide a multiple of between 1 and 5x each member's insured salary or a fixed amount of benefit for all members of a category.

If a fixed amount of over £250,000 is chosen, benefits will be limited to a maximum of 5x each member's salary.

There is an overall maximum benefit limit of £500,000 for each member.

Children's benefit is 25% of the member's benefit up to a maximum of £25,000.

You can also choose to provide cover of up to £250,000 for the spouses and partners of employees covered under the policy.

General terms

Benefit

The benefit will be shown in the policy coverage document.

If a fixed amount of over £250,000 is chosen, benefits will be limited to a maximum of 5x each member's salary. There is an overall maximum benefit limit of £500,000 for each member.

Each of a member's children is covered for a benefit of 25% of the member's benefit up to a maximum of £25,000.

The maximum benefit that can be provided for spouses or partners is the lower of:

- The member's insured benefit; or
- £250,000

Decision 5 - the type of cover you want to provide

We offer two types of cover – base cover or base and extra cover.

The full list of conditions covered under each option is given in the general terms. No other conditions are covered.

Member's children are automatically provided with the same type of cover as the member, and are covered for a number of children's specific critical illnesses.

When choosing base and extra cover, you will also need to decide the definition of total permanent disability which will apply to the members. The choices are:

- Unable to do your own occupation ever again
- Unable to do any suited occupation ever again
- Unable to look after yourself ever again

For spouses and partners' cover, the total permanent disability definition will be 'unable to look after yourself ever again'.

Children's cover includes total permanent disability - permanently unable to look after yourself.

General terms

Critical illness covered

Base cover

- Cancer – excluding less advanced cases*
- Cancer - second and subsequent
- Cardiac arrest – with insertion of a defibrillator
- Coronary artery bypass grafts*
- Creutzfeldt-Jakob disease – resulting in permanent symptoms
- Dementia including Alzheimer's disease – resulting in permanent symptoms
- 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*

Extra cover

- Aorta graft surgery*
- Aplastic anaemia – of specified severity
- Bacterial meningitis – resulting in permanent symptoms
- Benign brain tumour* – with permanent symptoms or specified treatments
- Benign spinal cord tumour – with permanent symptoms or specified treatments
- Blindness* – permanent and irreversible
- Cardiomyopathy – of specified severity
- Coma – with associated permanent symptoms
- Coronary angioplasty – to 2 or more coronary arteries
- Deafness – permanent and irreversible
- Encephalitis – resulting in permanent symptoms
- Heart valve replacement or repair*
- HIV infection – caught within specified geographic limits from a blood transfusion, physical assault or at work
- Liver failure – of specified severity
- Loss of hand or foot – permanent physical severance
- Loss of speech – total, permanent and irreversible
- Paralysis of limb – total and irreversible
- Primary pulmonary arterial hypertension – of specified severity
- Pulmonary artery surgery – for disease
- Respiratory failure – of specified severity
- Rheumatoid arthritis – of specified severity
- Structural heart surgery – with surgery to divide the breastbone
- Terminal illness – where death is expected within 12 months
- Third degree burns* – covering 20% of the body or face
- Total permanent disability – of specified severity
- Traumatic brain injury – resulting in permanent symptoms

Children's cover

- Cerebral palsy
- Child's intensive care benefit – requiring mechanical ventilation for 7 days
- Cystic fibrosis
- Hydrocephalus – treated with the insertion of a shunt
- Muscular dystrophy
- Spina bifida myelomeningocele
- Total permanent disability - permanently unable to look after yourself

Please be aware that these headings are a guide only and the full definitions are contained in section 10.

The Association of British Insurers produces a guide to minimum standards for Critical Illness cover. Conditions or procedures marked with * provide wider cover than the guide to minimum standards.

4. Flex and voluntary policies

Flex and voluntary

This critical illness policy can be included in a flexible or voluntary benefits package

When the policy is set up you can choose:

- The options to be offered to your employees to increase their benefit (we call these flex steps)

Flex policies

You choose:

- The level of cover you wish to provide (we call this the core benefit)
- Whether there is a default benefit for new joiners
- Which lifestyle events apply (from the list on the next page in the general terms)

Benefits above the core benefit are typically taken in lieu of other benefits, or are funded by the employee.

Voluntary policies

Your employees choose whether to join the policy and their level of cover within the limits you set.

Employees fund their own cover.

In practice

For flex and voluntary policies, our quote will be guaranteed for 3 months.

- The quote can be accepted at any time during the 3 month guarantee period
- We will then confirm that the flex step option rates are guaranteed for up to 3 more months until the start date

General terms

Flex and voluntary policies

The policy coverage documents will show if the policy is a flex or voluntary policy.

You must give us:

- Membership data at the start of the policy and each month after that
- Premiums based on the membership and the rates we have provided to you

Our quote will show the rates offered, agreed flex steps and lifestyle events.

For flex policies, we will quote a unit rate to calculate the premium for the core or default benefit. We will quote a table of age-related rates for the flex steps.

For voluntary policies, we will quote a table of age-related rates for the benefit steps.

The choices you make will affect the premiums we charge and there may be occasions when some options are not available.

Minimum number of eligible members	150
Minimum core benefit (flex only)	1x salary or £10,000
Maximum benefit (core+flex)	As chosen by the employer, up to £500,000. If a maximum of over £250,000 is chosen, benefits will be limited to a maximum of 5x each member's salary
Flex step options	1x salary or fixed amounts - eg. £10,000
Flex selection options	Employees joining at their first opportunity can choose any level of cover. Employees joining at any other time can only select the lowest level of cover. Employees can then: • Flex up (increase their benefit) one step at a time up to twice a year. The options to change the benefit selection are: • Once on a set day each year (this is usually the policy anniversary) • Once a year if their circumstances change - eg. if they marry, divorce or have children – we call these lifestyle events. Any benefit changes must be made within 2 months of the lifestyle event • Flex down (decrease their benefit) by any number of steps at a time A new pre-existing conditions exclusion will apply to increases in benefit. For flex policies, employees cannot reduce their benefit below the core benefit.

General terms

Lifestyle events

A member will be able to increase their benefit by one flex step in the event of one of the lifestyle events shown in your policy coverage document, chosen from the following:

- The birth of a child of the member
- The member or their spouse or partner becoming pregnant
- The member starting or returning to work after maternity, paternity or parental leave
- The adoption of a child by the member
- The member starting or returning to work after adoption leave
- The death of an adult or child dependant of the member
- The marriage of a member or the member entering a civil partnership, or the member being in a relationship with a partner for 6 months
- Divorce of a member, dissolution of the member's civil partnership or the member separating from a spouse, civil partner or partner of 6 months or more
- The member being seconded to work overseas or returning to work after the completion of an agreed secondment
- An increase in the member's contractual working hours of at least 20%
- A decrease in the member's salary of at least 5%, as long as the decrease is not due to illness or injury
- An increase in the member's salary of at least 5% or the member being promoted
- The member moving to a new permanent home
- The members spouse or partner being made redundant

Increases in benefit resulting from a lifestyle event are restricted to one per policy year. The increase in benefit must take place within 2 months of the lifestyle event.

For flex and voluntary policies, a pre-existing conditions exclusion applies to benefit increases.

Flex steps will be shown in the policy coverage document.

5. Starting cover and policy servicing

So we know who you want us to cover under the policy, you must send us an up-to-date membership list:

- When we prepare a quote
- At the policy start date
- At the start and end of each policy year so we can prepare an account

For policies with fewer than 10 members, you should tell us about any new members joining the policy during the year.

You must also tell us as soon as you want us to cover any discretionary entrants.

In practice

The membership list should give the following information for each employee to be covered:

- Full name
- Date of birth
- Gender
- Membership category
- Date of joining or date of leaving if applicable
- Benefit/insured salary
- Occupation
- Work location postcode

We will also need the following if employees' spouses and partners are covered:

- Spouse or partner's, Full name, Date of birth, Gender

General terms

Information to be provided

You must provide us with the information we need to calculate premiums, administer the policy and assess and pay claims.

All information must be provided in the form and timescales we specify. We are not responsible for any errors or omissions in any information provided to us.

The information we need and the time that it is needed are more fully described in the user guide. That information is part of the policy terms.

Quote

Your broker will ask us for a quote. The request should include:

- Your company details including industry and locations
- An up-to-date membership list
- Details of the cover required
- Scheme history for the last 6 years (if previously insured) – the total number of members, total insured salary, or total insured benefit and a list of the claims you have made

If your policy has fewer than 100 members, your broker will be able to get a quote for a range of cover options online.

Our quote will show the premium and total benefits. Quotes are usually guaranteed for 3 months.

The quote will also tell you if there is anything else we need to know. It includes any assumptions we have made and any special terms.

The premium shown in our quote includes the commission payable to your broker.

Starting the cover

Your broker will need to email us to confirm the quote you are accepting and the date you want cover to start. We cannot backdate cover.

We will provide cover for up to 30 days from the policy start date - called a conditional cover period - while the following information is provided:

- An up-to-date membership list
- Deposit premium or direct debit mandate
- Evidence that a customer verification has been completed

For online quotes, your broker will be able to start cover online.

General terms

Start of cover

The policy start date will be shown in the policy coverage document.

Cover will not begin until we receive confirmation of our quote from you or your broker, and will cease if the information and documents detailed in the user guide on the opposite side of this page are not provided on time.

Our quote will have been based on the information you provided at that time. You will need to let us know if there are any significant changes to that information between the time we quoted and the date you want the policy to start.

Premiums and policy accounting

We will calculate the premium for each policy accounting period based on:

- The total insured benefit
- The premium rates or unit rate applying
- Any underwriting loadings

Premiums are payable yearly or monthly in advance by Direct Debit. Please note, we add a loading for non-annual premiums.

We will send you an account detailing the premium due at the start of the policy and at each policy anniversary.

The way we calculate premiums depends on the number of members at the start of the policy year.

Policies with up to 9 members	Policies with 10 or more members
At the start of the policy year we calculate a premium	
We use a rate table to calculate the premium for each member and then add them together. The premium rate for a member will depend on their age at the start of the policy year.	We work out a rate that applies for all benefits – we call this a unit rate. The premium is calculated by multiplying the total insured benefit by the unit rate.
At the end of the policy year, we calculate an adjustment to allow for new members, leavers and changes in benefit during the year	
The adjustment takes account of the amount of benefit and period we have provided cover for each member.	The adjustment assumes that any changes took place halfway through the accounting period.

General terms

Premiums

Premiums must be paid from a UK bank account in pounds sterling on receipt of our invoice.

If you do not pay premiums when they are due, we may:

- Charge interest for late payment and/or
- Cancel the policy

We will give you at least 30 days' notice before we do this.

We have the right not to pay claims if the critical illness event occurred in a period for which premiums have not been paid.

Calculating premiums

At the start of the policy and at each policy anniversary, you must provide us with the information we need to calculate the premium.

If we do not have all the information we need to work out the premium, we will calculate:

- A deposit premium based on the details we have at that time
- The actual premium when we have full information. Any refund or outstanding premium will then become payable

If we do not receive the information we need to calculate the premium within 2 months of the policy anniversary, we can vary the terms of, or cancel, the policy. We will give you at least 30 days' notice before we do this.

At the end of a policy accounting period, we will work out an adjustment to allow for changes during the period including:

- New members
- Leavers
- Changes in benefit

Any refund or outstanding premium will then become payable.

Will there be any unexpected extra premium?

Premium rate tables, unit rates and the policy terms are usually guaranteed for 2 or 3 years from the start of the policy, or the last review of premium rates. We call this the review date.

They will then be reviewed and may change at that time.

We can also change the rates and terms if:

- You do not provide the information we request within 2 months
- There is a change in legislation or taxation which affects the cost of cover
- There is a significant change to your business as described in section 8

If you cancel the policy mid-year, will premiums paid in advance be lost?

No. We will produce a final account for the cover provided up to the date the policy is cancelled. We will either pay a refund or request any outstanding premiums.

General terms

Changing premium rates

We can change the terms and conditions of the policy and the rates or unit rate at any review date. Any change will apply with effect from the review date.

We can also change the rates and policy terms as described in the user guide on the opposite side of this page. These terms are incorporated into the policy.

We will give you at least 30 days' notice before any such change to the terms and conditions of the policy and the premium rates or unit rate comes into effect. The change in terms will have effect from the date of the change in legislation or taxation, or the change in your business.

6. Pre-existing and related conditions exclusions and medical underwriting

Pre-existing conditions

We are normally able to provide cover for all members without medical underwriting and subject to the pre-existing conditions exclusion.

In practice

Where a member has experienced a critical illness before joining the policy, or when they have made a claim under the policy, other than for the cancer - second and subsequent event, they will not be able to claim for a recurrence of that condition or certain other critical illnesses.

A member will not be able to claim for a critical illness where they were aware of, or being treated for, a related condition on or before cover started. Some related conditions are disregarded once the member has been covered under the policy for 2 years.

The pre-existing and related conditions exclusions apply from:

- When the member joins the policy
- After a successful claim, and
- To all increases in benefit that are not related to an increase in salary

If a policy is moved to us from another insurer on the same benefit basis, the pre-existing conditions exclusions will start from the date the member's cover started with the previous insurer.

The pre-existing and related conditions exclusions also apply to employees' children, spouses and partners covered under the policy.

Full details of the pre-existing and related conditions exclusions are described in the general terms on the opposite side of this page and in section 10.

General terms

Pre-existing and related conditions exclusions

A pre-existing conditions exclusion applies to members' and children's benefits up to the automatic entry limit.

The terms described in the user guide on the opposite side of this page are incorporated into the policy.

Pre-existing conditions: The pre-existing conditions exclusion means that if a member has suffered from a medical condition, or undergone one of the surgical procedures before they joined the policy, they will not be able to claim for any further incidence of that critical illness.

Related conditions: Under the related conditions exclusion, a member will not be able to claim for a critical illness event which is linked to a related condition which the member was aware of, or received treatment or advice for, on or before the date they joined the policy.

The related conditions for each group of critical illnesses are listed in section 10. The related conditions either apply indefinitely or are limited to the 2 years after joining, as shown in section 10.

Heart and circulatory diseases: For this exclusion, if a member experiences any of the heart and circulatory diseases, they may not claim later for any critical illnesses in that group.

Cancer: If a member suffers or has previously suffered any malignant tumour under the cancer critical illness, they will not be able to claim for a recurrence of cancer, other than under the cancer- second and subsequent event.

Terminal illness and total permanent disability: If a member has previously suffered any critical illness, no benefit is payable under terminal illness or disability critical illnesses groups.

A member who qualifies under the terminal illness event will not be able to claim again under any other critical illness event.

General terms

Pre-existing and related conditions exclusions

Ongoing investigations: No benefit will be paid for any medical condition or surgical procedure where the member was undergoing ongoing medical investigations or monitoring before the date of becoming a member, which led to the later diagnosis of a critical illness or related condition.

Children's cover: No benefit will be paid in respect of a child if symptoms first arose or the underlying condition was first diagnosed before the member joined the policy.

No benefit will be paid for any subsequent critical illness event related to a child-specific critical illness for which benefit has been paid

Medical underwriting

The quote and policy coverage document will show the maximum amount of benefit we can provide for a member without information about the member's health and lifestyle. We call this the automatic entry limit. The automatic entry limit is usually the same as the maximum benefit limit, in which case eligible employees will not need to be medically underwritten.

In practice

Forward underwriting

Where we have underwritten a member and cover is in place we will only underwrite again if the increase in benefit for the member is more than 10% per annum. We call this the forward underwriting bar.

Medical underwriting

If an employee does not benefit from, or their cover is above the automatic entry limit, you must let us know as soon as you want the cover to start. We will underwrite the whole benefit.

You must take reasonable steps to ensure that we are provided with any information we request as part of the medical underwriting process.

Underwriting outcomes

We will let you know if the benefit being underwritten can be accepted on standard terms or special terms and/or restrictions apply. In some cases we will be unable to provide cover.

If within a reasonable period we do not receive all the information we request to medically underwrite an employee we can:

- Refuse to cover the employee (if the automatic entry limit does not apply to them)
- Refuse to cover an increase in benefit for the member
- Attach conditions to the benefit

Full cover will not be in place until we have confirmed our terms in writing.

Forward underwriting

The forward underwriting terms in the box opposite are incorporated into policy terms.

Temporary cover during underwriting

We will provide temporary cover while a member is being underwritten.

In practice

Temporary cover starts from the date we are asked to cover the member. Some exclusions and restrictions apply during temporary cover and these are explained in the general terms on the opposite side of the page.

If, within 90 days, the member makes an appointment for a telephone call to provide us with the health and lifestyle information we need (or returns a completed form to us), we will provide temporary cover until we have underwritten the member and written to you with our terms. If we don't receive all the information we require, we may stop temporary cover. We will advise you in writing if this happens.

If, after 90 days of the account being issued, the member has not engaged in the underwriting process, we will stop temporary cover.

Policies switching to us from another insurer

If the policy is moved to us from another insurer we will need to know the automatic entry limit offered by the previous insurer and the underwriting terms for each member whose benefit exceeds our automatic entry limit.

In practice

A copy of the previous insurer's underwriting decision letter will provide us with the information we need about a member.

We will generally match the underwriting terms applied by the previous insurer.

The extra premium we charge may be different from that charged by the previous insurer because the underlying rates may be different.

General terms

Temporary cover

If temporary cover applies, we will provide cover for the amount of benefit that is being underwritten.

During temporary cover the pre-existing and related conditions exclusions will apply to the full amount of benefit being underwritten.

In addition for any benefit in excess of the automatic entry limit or the member's previously insured benefit the following exclusions will apply:

- Benefits will not be paid for conditions resulting from hazardous sports and pastimes, attempted suicide or self-inflicted injury
- We will not pay benefit for a critical illness event arising from a medical condition for which the member:
  - Received treatment, care or services (including diagnostic measures) or
  - Took prescribed drugs or medicines

  in the 12 months before temporary cover started.

If you have selected total permanent disability cover this will be provided on the unable to look after yourself ever again basis.

The temporary cover terms in the box opposite are incorporated into the general policy terms.

7. Making a claim

When to tell us about a claim

Please notify us of a claim within 21 days of an employee, their child or, if covered, their spouse or partner being diagnosed with a medical condition or undergoing or, where applicable being placed on an NHS waiting list for a surgical procedure covered under the policy.

How to tell us about a claim

To enable us to assess a claim, you must ensure that we are provided with:

- A completed employer claim form
- A completed employee claim form
- A signed employee consent form
- Information we request to assess the claim

In practice

You can get our claim forms by:

Website: Download the forms at www.unum.co.uk/claims/group-critical-illness

Phone: Call our claims team on **0345 600 6761**

Email: Contact us at ClaimsUK@unum.co.uk

You can return completed claim forms to us by post or email.

Post: Claims Department, Unum, Milton Court, Dorking, Surrey, RH4 3LZ.

Email: ClaimsUK@unum.co.uk

General terms

Late notification

If we are notified of a claim more than 90 days after the member is diagnosed with one of the medical conditions or undergoes a surgical procedure covered under your policy we have the right not to pay benefit.

Claim assessment

We will request information to assess if the member satisfies the critical illness definition.

The information we request may include, but is not limited to, medical evidence, proof of membership, details of the insured occupation, personnel, medical and occupational health records held by you, proof of earnings, a birth certificate, information relevant to the claim from any person the member has consulted in connection with their condition, and the member attending a medical examination when requested to do so.

We will pay for any medical evidence we request in the UK.

Benefit payments

We will pay the benefit to the employee.

What happens to claims if the policy is cancelled?

We will pay any claims for members where the critical illness event occurred during the period of cover.

General terms

Claims assessment

The policy terms in force at the date of a member's critical illness event will apply to the claim.

You must provide the evidence, information and access to information we need to assess the claim. For benefit to be payable, a critical illness must be established to the satisfaction of Unum's Chief Medical Officer.

We can decline a claim or adjust the benefit payable for a member if we do not receive the information that is described or listed in the user guide.

Benefit payments

We will pay benefits in sterling by direct credit.

Your business ceases trading

If your business ceases trading this policy will end immediately.

8. Amendment and cancellation

General terms

Amendment and cancellation by us

We can withhold or restrict cover for an employee who is not included in the data or the information is inaccurate or incomplete.

We can amend the policy terms:

- At any time the premium rate is reviewed
- If there is any change in the legislation (including the introduction of new legislation) which affects the premium rate or the payment of benefit under this policy
- If there is any change in the taxation system which affects this policy
- If there is a significant change to your business

You must tell us immediately if there is a significant change to your business including:

- A merger or acquisition
- The sale of part of your business
- A change to your normal business locations or overseas travel patterns
- Changes to the occupations of the members

We have the right to change the terms or premium rate to reflect any additional risk.

We will give you at least 30 days' notice before we make any changes to the policy terms.

We can cancel the policy or amend the policy terms if:

- You do not provide us with the information we request
- You do not pay the premiums when they are due
- Your business stops trading
- The number of members falls below 3

We will give you at least 30 days' notice before we cancel the policy. We will charge a premium for the cover we have provided up to the cancellation date.

Amendment or cancellation by you

You can ask us to consider a change to the policy at any time. Changes cannot be backdated. The following changes will have an impact on the terms of the policy and/or the premiums payable:

- A change to the benefit basis, cover cease age or eligibility conditions
- If you wish to remove an existing employer from cover under the policy or add a new employer for cover under the policy

You can cancel the policy at any time by letting us know in writing. Cancellation cannot be backdated and we will charge a premium for the cover we have provided up to the cancellation date.

Trade sanctions

We can also cancel the policy immediately if:

- You or an employer or the beneficial owner of either becomes a restricted person
- We believe that you may expose us to the risk of being or becoming subject to any sanction, prohibition or adverse action by the government of the United Kingdom, the United States of America, the United Nations, European Commission or Council of the European Union

We can deny payment of benefit in respect of a member who is a restricted person.

9. Taxation

This section is based on our understanding of UK tax rules applying to Critical Illness policies and is not intended to give definitive advice. You should take advice from an independent financial adviser to ensure you understand the impact of tax on your policy and the benefits it provides.

Premiums

For tax purposes, premiums paid by you to cover your employees are treated as a business expense and can be offset against Corporation Tax. You may be liable for Class 1A National Insurance Contributions on the premiums.

Employees are taxed on the amount of the premium paid by you on their behalf as a benefit in kind (P11D). This will include any premium for spouses and partners cover.

If you are collecting the premiums on behalf of your employees under a flex or voluntary arrangement:

- The premiums will already have been subject to tax including any Class 1A National Insurance liability.
- You cannot offset the premiums as a trading expense.
- For the employee there is no tax relief on the premium paid.

There is no tax relief on premiums paid by equity partners or LLP members.

Lump sum Benefits

Lump sum benefits are paid tax-free to the employee.

10. Defined conditions

General terms

Critical illness definitions – base cover

The complete list and definitions of medical conditions and surgical procedures covered under base cover is set out below. No other conditions or procedures are covered.

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 those that arise from and are confined to the skin (including cutaneous lymphomas and sarcomas).

For this definition of cancer, the following are not covered:

- All cancers which are histologically classified as any of the following:
  - pre-malignant,
  - cancer in situ,
  - having borderline malignancy, or
  - having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate).
- All urothelial tumours unless histologically classified as having progressed to at least TNM classification T1N0M0.
- Malignant melanoma skin cancers that are confined to the epidermis (outer layer of skin).
- All skin cancers (other than malignant melanoma) that arise from and are confined to one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin (including cutaneous lymphomas and sarcomas).
- All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0.
- Neuroendocrine tumours without lymph node involvement or distant metastases unless classified as WHO Grade 2 or above.
- Gastrointestinal stromal tumours without lymph node involvement or distant metastases unless classified by either AFIP/Miettinen and Lasota as having a moderate or high risk of progression, or as UICC/TNM8 stage II or above.

Cancer - second and subsequent

This provides some cover for employees who have been previously diagnosed with cancer. A benefit would be payable for a diagnosis of a new, unrelated cancer as defined by the general terms.

The pre-existing condition exclusion applies in the normal manner to subsequent cancer claims unless:

- the member has been treatment free for a period of 5 years from the date of the most recent previous diagnosis of cancer, and
- there is no evidence, confirmed by appropriate up-to date investigations and tests, of any continuing presence, recurrence or spread of the previous cancer, and
- the new cancer:
  - affects an organ that is physically and anatomically separate to any previous cancer, and
  - is not a secondary cancer or histologically related to any previous cancer; or
  - for haematological cancers, the new cancer is categorised or divided according to defined cell characteristics in a distinctly different manner to any previous cancer.

Treatment includes chemotherapy, radiotherapy, monoclonal antibody therapy, and invasive or non-invasive surgery, but does not include long term maintenance hormone treatment.

In addition to the above, in no circumstances will a claim for subsequent cancer be payable if the employee has:

- any signs, symptoms or investigations, that lead to a subsequent diagnosis of cancer regardless of when the diagnosis is made, or
- a subsequent diagnosis of cancer, which gives rise to a claim during the 120 days following:
  - the policy start date, or
  - their meeting the eligibility conditions for being a member (which may have been during cover with a previous insurer), or
  - an increase in benefit (claims will still be considered for the pre-increase amount).

Critical illness definitions – base cover

Cardiac arrest - with insertion of a defibrillator

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

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

For the above definition the following are not covered:

- Insertion of a pacemaker

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.

Creutzfeldt-Jakob disease - resulting in permanent symptoms

A definite diagnosis of Creutzfeldt-Jakob disease by a consultant neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

Dementia including Alzheimer's disease – of specified severity

A definite diagnosis of Dementia, including Alzheimer's disease, by a Consultant Geriatrician, Neurologist, Neuropsychologist or Psychiatrist or supported by evidence including neuropsychometric testing.

There must be permanent cognitive dysfunction with progressive deterioration in the ability to do all of the following:

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

For the above definition, the following are not covered:

- Mild cognitive Impairment (MCI)

Heart attack

A definite diagnosis of acute myocardial infarction with death of heart muscle, as evidenced by all of the following:

- New characteristic electrocardiographic changes or new diagnostic imaging changes.
- 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:

- Myocardial injury without myocardial infarction
- Angina without myocardial infarction.

Kidney failure - requiring permanent dialysis

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

Major organ transplant - from another donor

The undergoing as a recipient 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

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.

Critical illness definitions – base cover

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.

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 be permanent clinical impairment of motor function with associated tremor and muscle rigidity.

For the above definition, the following are not covered:

- Any other Parkinsonian syndromes/Parkinsonism

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

Critical illness definitions - children's cover

Children's cover provides cover for the following medical conditions in addition to base or base and extra cover (and no others)

Cerebral palsy

A definite diagnosis of cerebral palsy by an attending consultant.

Children's intensive care benefit

Sickness or injury resulting in continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more.

For the above definition the following is not covered:

- Sickness or injury as a result of premature birth (before 37 weeks).

Cystic fibrosis

A definite diagnosis of cystic fibrosis by an attending consultant.

Hydrocephalus – treated with the insertion of a shunt

A definite diagnosis of hydrocephalus by an attending consultant that is treated with the insertion of a shunt.

Muscular dystrophy

A definite diagnosis of muscular dystrophy by a consultant neurologist.

Spina bifida myelomeningocele

A definite diagnosis of spina bifida myelomeningocele by a paediatrician.

For the above definition the following are not covered:

- Spina bifida meningocele
- Spina bifida occulta

Total permanent disability - permanently unable to look after yourself

Permanent physical inability through an illness or injury to do at least 3 of the 6 tasks listed below.

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement.

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

The tasks are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
- Feeding yourself – the ability to feed yourself when food has been prepared and made available
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function
- Getting between rooms – the ability to get from room to room on a level floor
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again

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

Critical illness definitions – extra cover

Extra cover provides cover for the following medical conditions and surgical procedures (and no others).

Aorta graft surgery

The undergoing of surgery, or inclusion on an official UK waiting list for surgery, to the aorta with excision and surgical replacement of a portion of the aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:

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

Aplastic anaemia - of specified severity

Complete bone marrow failure which results in anaemia, neutropenia and thrombocytopenia and requires as a minimum one of the following treatments:

- Blood transfusion
- Bone-marrow transplantation
- Immunosuppressive agents
- Marrow stimulating agent

Bacteria meningitis - resulting in permanent symptoms

A definite diagnosis of bacterial meningitis by a consultant neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- All forms of non-bacterial meningitis

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

Benign spinal cord tumour – with permanent symptoms or specified treatments

A non-malignant tumour originating from the spinal cord, spinal nerves or meninges, resulting in any of the following:

- Permanent neurological deficit with persisting clinical symptoms, or
- Undergoing invasive surgery to remove the tumour, or
- Undergoing stereotactic radiotherapy to the tumour

For the above definition, the following are not covered:

- Granulomas, haematomas, abscesses, disc protrusions or osteohytes

Blindness - permanent and irreversible

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

Cardiomyopathy - of specified severity

A definite diagnosis of cardiomyopathy by a consultant cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity (marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain). The diagnosis must be supported by echocardiogram.

For the above definition, the following are not covered:

- All other forms of heart disease, heart enlargement and myocarditis
- Cardiomyopathy secondary to alcohol or drug abuse

Critical illness definitions – extra cover

Coma - with associated permanent symptoms

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

- Requires the use of life support systems for a continuous period of at least 96 hours, and
- With associated permanent neurological deficit with persisting clinical symptoms

For the above definition, the following are not covered:

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

Coronary angioplasty - to 2 or more coronary arteries

The undergoing of balloon angioplasty, including atherectomy, laser treatment or stent insertion on the advice of a consultant cardiologist to two or more main coronary arteries as a single procedure to correct:

- Narrowing or blockages of at least 70%, or
- Narrowing or blockages where there is a fractional flow reserve ratio of <0.8

The main coronary arteries for this purpose are defined as right coronary artery, left main stem, left anterior descending and (left) circumflex.

Angiographic evidence will be required.

Deafness - permanent and irreversible

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

Encephalitis - resulting in permanent symptoms

A definite diagnosis of encephalitis by a consultant neurologist resulting in a permanent neurological deficit with persisting clinical symptoms.

Heart valve replacement or repair

The undergoing of surgery, or inclusion on an official UK waiting list for surgery, (including balloon valvuloplasty) on the advice of a consultant cardiologist to replace or repair one or more heart valves.

HIV Infection - caught within specified geographic limits from a blood transfusion, physical assault or at work

Infection by Human Immunodeficiency Virus (HIV) resulting from:

- A blood transfusion given as part of medical treatment
- A physical assault, or
- An incident occurring during the course of performing normal duties of employment, after the date of becoming a member and satisfying all of the following:
  - The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures
  - Where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident
  - There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus
  - The incident causing infection must have occurred in the E.C., North America or Australasia

For the above definition the following is not covered:

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

Liver failure – of specified severity

End-stage liver failure resulting in all of the following:

- Permanent jaundice
- Ascites (fluid retention in the abdominal cavity)
- Encephalopathy (mental confusion due to nitrogenous substances not being removed by the liver)

For the above definition, the following are not covered:

- Liver disease secondary to alcohol or drug misuse

Loss of hand or foot - permanent physical severance

Permanent physical severance of a hand or foot at or above the wrist or ankle joint.

Loss of speech - total, permanent and irreversible

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

Paralysis of limb - total and irreversible

Total irreversible loss of muscle function to the whole of any limb.

Critical illness definitions – extra cover

Primary pulmonary arterial hypertension - of specified severity

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

For the above definition, the following are not covered:

- Pulmonary hypertension secondary to any other known cause i.e. not primary

Pulmonary artery surgery - for disease

The undergoing of surgery, or inclusion on an official UK waiting list for surgery, on the advice of a consultant cardiothoracic surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

Respiratory failure - of specified severity

Confirmation by a consultant physician of severe lung disease which is evidenced by the need for continuous daily oxygen therapy on a permanent basis and that has either of the following:

- Carbon monoxide diffusion capacity (DLCO) of less than 40% of normal, or
- Lung function tests persistently showing Forced Expiratory Volume in 1 second 1 (FEV1) less than 50% and Forced Vital Capacity (FVC) less than 50% of normal

Rheumatoid arthritis - of specified severity

A definite diagnosis by a consultant rheumatologist of chronic rheumatoid arthritis as evidenced by widespread joint destruction with major clinical deformity.

In addition the member must permanently satisfy three of the four following criteria:

- Bending - The inability to bend or kneel to pick up something from the floor and stand up again and the inability to get into and out of a standard saloon car
- Dexterity - The inability to use hands and fingers to pick up and manipulate small objects such as cutlery, including being unable to write using a pen or pencil
- Lifting - The inability to lift, carry or otherwise move everyday objects by hand. Everyday objects include a kettle of water, a bag of shopping and an overnight bag or briefcase
- Mobility - The inability to walk a distance of 200 metres on flat ground, with or without the aid of a walking stick and without having to rest or experiencing severe discomfort

Structural heart surgery - with surgery to divide the breastbone

The undergoing of surgery, or inclusion on an official UK waiting list for surgery, requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiologist to correct any structural abnormality of the heart.

Terminal illness - where death is expected within 12 months

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

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

Third degree burns - covering 20% of the body or face

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

For the purposes of this definition the face includes the forehead and ears.

Traumatic brain injury - resulting in permanent symptoms

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

Critical illness definitions – extra cover

Total permanent disability - of specified severity

The policy coverage document will show which total permanent disability basis has been selected for each eligibility category.

The bases of total permanent disability which may apply are:

- **Unable to do your own occupation ever again**
- **Unable to do any suited occupation ever again**
- **Unable to look after yourself ever again**

In respect of a total permanent disability claim for a member's spouse or partner benefit will be payable if the member's spouse or partner satisfies the conditions under the total permanent disability unable to look after yourself ever again basis.

Total permanent disability - unable to do your own occupation ever again

Loss of the physical or mental ability through an illness or injury to the extent that the member is unable to do the material and substantial duties of their own occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of the person's own occupation that cannot reasonably be omitted or modified.

Own occupation means your trade, profession or type of work you do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability.

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

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

Total permanent disability - unable to do any suited occupation ever again

Loss of the physical or mental ability through an illness or injury to the extent that the member is unable to do the material and substantial duties of a suited occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of a suited occupation that cannot reasonably be omitted or modified.

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

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

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

Total permanent disability - unable to look after yourself ever again

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

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

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

The tasks are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
- Feeding yourself – the ability to feed yourself when food has been prepared and made available
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function
- Getting between rooms – the ability to get from room to room on a level floor
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again

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

Related conditions

The specific related conditions exclusions which apply to each group of critical illness events are shown in the table below:

Group	Critical Illness Events	Related conditions
Cancer	**Base cover** Cancer – excluding less advanced cases Cancer – second and subsequent	**Applies for 2 years** Polyposis coli Papilloma of the bladder Any carcinoma-in-situ
Heart and circulatory diseases	**Base cover** Cardiac arrest – with insertion of a defibrillator Coronary artery bypass grafts Heart attack Stroke **Extra cover** Aorta graft surgery Cardiomyopathy – of specified severity Coronary angioplasty – to 2 or more coronary arteries Heart valve replacement or repair Primary pulmonary arterial hypertension – of specified severity Pulmonary artery surgery – for disease Structural heart surgery – with surgery to divide the breastbone	**Applies for 2 years** Any disease or disorder of the heart Any obstructive or occlusive arterial disease Blood pressure treated at any time by prescribed medication Diabetes mellitus

Related conditions

Group	Critical Illness Events	Related conditions
Organ failure	**Base cover** Kidney failure – requiring permanent dialysis Major organ transplant – from another donor **Extra cover** Aplastic anaemia – of specified severity Liver failure – of specified severity	**Applies for 2 years** Any chronic renal disease or disorder Any chronic liver disease Any chronic lung disease Any disease or disorder of the heart Chronic pancreatitis Chronic leukemia Diabetes mellitus
Diseases of the brain and central nervous system	**Base cover** Creutzfeldt-Jakob disease – resulting in permanent symptoms Dementia including Alzheimer's disease – resulting in permanent symptoms Motor neurone disease – resulting in permanent symptoms Multiple sclerosis – with persisting symptoms Parkinson's disease and Parkinson plus syndromes – resulting in permanent symptoms **Extra cover** Bacterial meningitis – resulting in permanent symptoms Benign brain tumour – with permanent symptoms or specified treatments Benign spinal cord tumour – with permanent symptoms or specified treatments Coma – with associated permanent symptoms Encephalitis – resulting in permanent symptoms	**Applies for 2 years** Any disease or disorder of the brain or central nervous system
Respiratory diseases	**Extra cover** Respiratory failure – of specified severity	**Applies for 2 years** Any chronic lung disease

Related conditions

Group	Critical Illness Events	Related conditions
Accidents	**Extra cover** HIV infection – caught within specified geographic limits from a blood transfusion, physical assault or at work Third degree burns – covering 20% of the body or face Traumatic brain injury – resulting in permanent symptoms	There are no related conditions
Terminal illness	**Extra cover** Terminal illness – where death is expected within 12 months	**Applies indefinitely** All other critical illness events
Disability group 1	**Extra cover** Blindness – permanent and irreversible Deafness – permanent and irreversible Loss of hand and foot – permanent physical severance Loss of speech – total, permanent and irreversible Rheumatoid arthritis – of a specified severity	**Applies for 2 years** Any disease or disorder of the brain or central nervous system Diabetes mellitus Peripheral vascular disease Inflammatory polyarthropathy **Applies indefinitely** All other critical illness events
Disability group 2	**Extra cover** Paralysis of limb - total and irreversible Total permanent disability - of specified severity	**Applies indefinitely** All other critical illness events Any disease or disorder of the brain or central nervous system Chronic or recurring mental illness Chronic symptoms of fatigue, back, joint or muscle pain Diabetes mellitus

11. Further information

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: 0345 600 6763

Email: complaints@unum.co.uk

Letter: Complaints Team Manager
Unum
Milton Court, Dorking, Surrey
RH4 3LZ

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 9123

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

Web: www.financial-ombudsman.org.uk

Law

The policy is subject to English Law, and by taking out the policy, you accept that any dispute shall be subject to the exclusive jurisdiction of the English Courts.

The policy is not assignable.

Employees do not have any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any terms of this policy. This means that there is no requirement to involve employees in day-to-day decisions on the administration and insurance of the policy. However, following a final decision by us concerning a claim, the employee may engage directly with us in order to ensure that the terms of the policy are met regarding the claim

Financial Services Compensation Scheme

If we cannot meet our liabilities, you may be entitled to compensation under the Financial Services Compensation Scheme (FSCS)*.

* Please note that the FSCS does not cover firms based in the Channel Islands or the Isle of Man

Data Protection

This section explains how we and you comply with Data Protection laws including the General Data Protection Regulations (GDPR) and UK Data Protection Act 2018 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 general terms of this policy.

About Unum

Unum is a leading employee benefits provider offering financial protection through the workplace including: Group Income Protection, Life Insurance, Critical Illness, and Corporate Dental cover.

We are committed to workplace wellbeing for both employees and employers and have a wide range of tools designed to help businesses of all sizes create or enhance their employee wellbeing strategies. This includes our award-winning Help@hand app powered by Square Health, which offers employees fast, direct access to a total health and wellbeing solution with high quality, personalised services including remote GPs, mental health support and a fully integrated employee assistance programme.

We support people when they're vulnerable and need us the most - physically, emotionally, and financially. We feel what we do is good for society and our mission is to help more people. Yet it's more than helping people in need - it's about operating in the right way as a business. Unum is proud to be a values-driven, purpose-led organisation. We're committed to doing the right thing for our customers, our colleagues, and our communities - as well as the planet we all share. Being a socially responsible and sustainable business is at the heart of our "We are Unum" values.

We are signatories of the HM Treasury Women in Finance Charter, Business in the Community Race at Work Charter, and the Armed Forces Covenant, where we hold the Silver Employer Recognition Scheme Award. We are also a Disability Confident Leader, Stonewall Diversity Champion, PlanetMark Certified Business, and have been awarded the Gold Payroll Giving Quality Mark for our charitable initiatives by the Charities Aid Foundation.

At the end of 2022, Unum insured more than 2.1 million employees* across all products in the UK and paid claims of £395 million - representing £7.5 million a week in benefits to our customers - providing security and peace of mind to individuals and their families.

Our parent company, Unum Group provides a broad portfolio of financial protection benefits and services in the workplace through its Unum US, Unum UK, Unum Poland, and Colonial Life businesses. In 2022, Unum Group reported revenues of US$12 billion and paid US$7.9 billion in benefits.

For more information, please visit www.unum.co.uk.

Unum Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Registered Office: Milton Court, Dorking, Surrey RH4 3LZ. Registered in England 983768. Unum Dental is a trading name of Unum Limited.

*Unum internal data as at end of 2022. Figure represents the total number of lives under all policies, and includes the total number of policies for an individual employee where they are insured under more than one product.