INTRODUCTION

Words that appear in blue bold are explained in the section headed ‘Definitions’.

This Policy Booklet shows you the features, benefits and exclusions (things that are not covered) that apply to this product.

WHO IS COVERED?

The life insured is covered.

PREMIUMS

Premiums can be paid either monthly or annually and start on the policy start date.

Guaranteed premiums

You may have the option to choose guaranteed premiums. The policy premiums will not change unless you make changes to the policy using the options available in section headed ‘Changing your policy’.

Reviewable premiums

You may have the option to choose reviewable premiums. We will not change the premiums for the first five years of the policy. Reviews will be carried out to determine whether the premiums will be changed at the fifth anniversary and every five years thereafter. This is to establish the amount of premium needed to continue to provide the amount of cover selected.

At a review we will assess the underlying assumptions relating to the expected future number and timing of claims made for this type of policy.

We will assess any change to premiums fairly. When we review the premiums, the factors we look at are:

- Number, timing and cost of claims we have paid;
- Number, timing and cost of claims we expect to pay in the future;
- Insurance industry claims experience;
- Expected impact of future medical advances; and
- Changes to applicable laws, regulations or tax treatment.

Your state of health or individual circumstances won’t be a factor at the review.

We will contact you about the outcome of the premium review and tell you at least three months in advance about the options you have and what action you may have to take. If, after the premium review we recalculate your premium to within 5% of what you have already been paying, your premium will not change. Any change in the premium not taken into account at the premium review will be taken into account at future premium reviews.
Options at your premium review:

a) **Your** premium reduces or stays the same. If the premium has reduced, **you** don’t need to take any action and **your** direct debit will automatically be updated. If **your** premium stays the same **your** direct debit will remain unchanged.

b) The premium increases.

If **your** premium increases **you** can choose to:

- Accept the increased premium. If **you** choose this option, **you** don’t need to take any action and **your** direct debit will automatically be updated; or

- Keep **your** premiums the same but reduce the level of cover. If this is the option **you** want to take you will need to contact **us** within 30 days of being notified of a review by **us**. This will ensure there is sufficient time for **us** to process **your** request prior to **your** review date.

It is important to ensure the level of cover still meets **your** needs, as the option **you** select at each premium review cannot be changed. Regardless of the decision **you** make, **your** premiums will continue to be reviewed throughout the period of cover and **you** will be able to select a different option at any future premium review if **your** premium increases.

**Increasing cover**

**You** may have the option to choose an increasing policy, the premiums will increase in line with the changes in the Retail Prices Index (RPI) multiplied by 1.5 subject to a maximum increase of 15% per annum.

The RPI provides an indication of inflation on a monthly basis. The RPI measures and tracks the average change in the purchase price of goods and services such as housing expenses and mortgage interest payments.

**WHAT HAPPENS IF THE PREMIUMS ARE NOT PAID?**

**We** are entitled to cancel the policy if any premiums are not paid within 30 days of their due date. If **we** cancel the policy, **your** cover will end and no further premiums will be payable. **We** will not refund any premiums already paid.

**WHAT HAPPENS TO AN ANNUAL PREMIUM IF A CLAIM IS PAID?**

If the premium is paid annually and a claim is paid under full cover, **we** will pay a pro-rata refund of the premium for the remaining months of that year. The policy will end when a claim is paid under full cover, see the section headed ‘What you are covered for’ for further details.
AMOUNT OF COVER

Level cover
If you choose level cover the amount of cover will stay the same unless you change it using the options available in the section headed ‘Changing your policy’ during the period of cover.

Decreasing cover
If you choose decreasing cover the amount of cover will reduce during the period of cover. Decreasing cover is often used to help protect a repayment mortgage. We apply an interest rate to the original amount of cover to estimate the amount that you repay each month on your repayment mortgage and the amount you are covered for will decrease accordingly.

If the interest rate we apply is less than the interest rate that is actually applied to your mortgage, or your mortgage changes, the amount we pay out may not be enough to repay your mortgage in full.

The interest rate applied will be shown in your Policy Booklet.

To ensure that the amount paid out will cover the amount of your outstanding mortgage you should check regularly that the interest rate applied to the policy is equal to or higher than the interest rate applied to your mortgage by your lender.

Increasing cover
You may have the option to choose increasing cover, the amount of cover will increase in line with changes in inflation on each policy anniversary with no need to answer further questions about your health.

The amount of cover, including any increases you have already accepted, will increase in line with the changes in the Retail Prices Index (RPI) over a 12 month period. If we cannot use the RPI, we will use an index comparable to the RPI instead.

We will contact you at least three months before the policy anniversary to tell you what the increase in the amount of cover and premium will be.

If the change in the RPI is less than or equal to 1% we will not increase the amount of cover.

If the change in the RPI is more than 10% we will only increase the amount of cover by 10% per annum.

Your options
Accept the increase
If you choose to accept the increase you do not need to take any action. We will increase the amount of cover and the premium and update your direct debit.

Decline the increase
When we notify you of an increase, we will also give you the option to decline the increase. To decline an increase, you must complete and return the form in the letter we send to you by the date shown.

If you choose to decline the increase to the amount of cover and premium, then we will withdraw the option and you will not be given the option to increase the amount of cover in the future.
HOW LONG IS COVER FOR?

You are covered from the **policy start date** until the **policy expiry date** unless one of the following occurs first:

- The amount of cover is paid out, or
- If the policy is cancelled by **you** or **us**.

Cover will stop when the policy ends and no further premiums will be payable.

WHAT IS COVERED?

Full Cover

The amount of cover, subject to the exclusions defined in the section headed ‘What you are not covered for’ is paid if, before the **policy expiry date**, the **life insured**:

- dies
- is diagnosed with an illness or undergoes a medical procedure as defined in the section headed:
  - ‘Critical Illness Definitions’
- is diagnosed with a terminal illness

whichever occurs first.

If **you** choose a joint life policy, the amount of cover is paid when either **life insured** dies or is diagnosed with a terminal or critical illness.

If the **life insured** has a critical illness it must be verified by a medical specialist who holds an appointment as a consultant at a hospital in the UK and whose specialism we reasonably consider is appropriate to the critical illness.

Terminal Illness Cover

This is an advance payment of the amount of cover where the **life insured** has a terminal illness.

Terminal illness is defined as a definite diagnosis by **your** hospital 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 **your** hospital consultant and **our** Medical Officer (a qualified doctor employed by Legal & General), the illness is expected to lead to death within 12 months.

No terminal illness claim can be made after the death of the **life insured**.

If decreasing cover is chosen the amount payable will be the amount of cover we calculate on the date that it is established that the **life insured** has met **our** definition of terminal illness.
### CRITICAL ILLNESS DEFINITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Aorta graft surgery** – requiring surgical replacement | The undergoing of 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** – with permanent bone marrow failure | A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia. |
| **Bacterial meningitis** – resulting in permanent symptoms | A definite diagnosis of bacterial meningitis by a hospital consultant resulting in permanent neurological deficit with persisting clinical symptoms. For the above definition, the following are not covered:  
- all other forms of meningitis other than those caused by bacterial infection. |
| **Benign brain tumour** – resulting in either surgical removal or permanent symptoms | A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in either surgical removal or permanent neurological deficit with persisting clinical symptoms. For the above definition, the following are not covered:  
- tumours in the pituitary gland;  
- tumours originating from the bone tissue;  
- angioma and cholesteatoma. |
| **Blindness** – permanent and irreversible | Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart. |
| **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, pseudomyxoma peritonei, merkel cell cancer and lymphoma except cutaneous lymphoma (lymphoma confined to the skin). For the above definition, the following are not covered:  
- All cancers which are histologically classified as any of the following:  
  - pre-malignant;  
  - non-invasive;  
  - cancer in situ;  
  - having either 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.  
- Malignant melanoma unless it has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).  
- Any other skin cancer (including cutaneous lymphoma) unless it has been histologically classified as having caused invasion in the lymph glands or spread to distant organs. |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Cardiac arrest – with insertion of a defibrillator** | Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness, requiring resuscitation and resulting in either of the following devices being surgically implanted:  
- implantable cardioverter-defibrillator (ICD); or  
- cardiac resynchronisation therapy with defibrillator (CRT-D).  
For the above definition, the following are not covered:  
- insertion of a pacemaker;  
- insertion of a defibrillator without cardiac arrest; or  
- cardiac arrest secondary to illegal drug intake. |
| **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’s classification of functional capacity*.  
For the above definition, the following are not covered:  
- cardiomyopathy secondary to alcohol or drug intake;  
- all other forms of heart disease, heart enlargement and myocarditis.  
* NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain. |
| **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; and  
- has 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 intake. |
| **Coronary artery by-pass grafts – with surgery to divide the breastbone or thoracotomy** | The undergoing of surgery to divide the breastbone (median sternotomy) or thoracotomy on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.  
For the above definition, the following is not covered:  
- any other surgical procedure or treatment. |
| **Creutzfeldt-Jakob disease (CJD) – resulting in permanent symptoms** | A definite diagnosis of Creutzfeldt-Jakob disease made by a consultant neurologist. There must be permanent clinical loss of the ability in mental and social functioning to the extent that permanent supervision or assistance by a third party is required. |
| **Deafness – permanent and irreversible** | Permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram. |
| **Dementia including Alzheimer’s disease – resulting in permanent symptoms** | A definite diagnosis of dementia, including Alzheimer’s disease by a consultant neurologist, psychiatrist or geriatrician. The diagnosis must be supported by evidence of progressive loss of ability to do all of the following:  
- remember;  
- reason; and  
- to perceive, understand, express and give effect to ideas. |
| **Encephalitis – resulting in permanent symptoms** | A definite diagnosis of encephalitis by a consultant neurologist resulting in permanent neurological deficit with persisting clinical symptoms. |
| **Heart attack – of specified severity** | Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:  
· the characteristic rise of biochemical cardiac specific markers such as troponins or enzymes;  
· new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests.  
The evidence must show a definite acute myocardial infarction.  
For the above definition, the following are not covered:  
· other acute coronary syndromes;  
· angina without myocardial infarction. |
| **Heart valve replacement or repair – with surgery** | The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves. |
| **HIV infection – caught from a blood transfusion, physical assault or accident at work** | Infection by Human Immunodeficiency Virus 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 start of the policy and satisfying all of the following:  
· the incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.  
· where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.  
· there must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.  
· the incident causing infection must have occurred in one of the following countries: Australia, Austria, Belgium, Bulgaria, Canada, the Channel Islands, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, the Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the United States of America.  
For the above definition, the following is not covered:  
· HIV infection resulting from any other means, including sexual activity or drug intake. |
| **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. |
| **Liver failure – of advanced stage** | Liver failure due to cirrhosis and resulting in all of the following:  
· permanent jaundice;  
· ascites; and  
· encephalopathy.  
For the above definition, the following is not covered:  
· liver disease secondary to alcohol or drug intake. |
<p>| <strong>Loss of hand or foot – permanent physical severance</strong> | Permanent physical severance of either a hand or foot at or above the wrist or ankle joints. |
| <strong>Loss of speech – total permanent and irreversible</strong> | Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease. |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
</table>
| Major organ transplant – from another donor          | The undergoing as a recipient of a transplant from another donor, of bone marrow or of a complete heart, kidney, lung, pancreas, liver, or lobe of the liver, or inclusion on an official UK, Channel Islands or Isle of Man waiting list for such a procedure. For the above definition, the following is not covered:  
• transplant of any other organs, parts of organs, tissues or cells. |
| Motor neurone disease – resulting in permanent symptoms | A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist:  
• amyotrophic lateral sclerosis (ALS);  
• primary lateral sclerosis (PLS);  
• progressive bulbar palsy (PBP);  
• progressive muscular atrophy (PMA); or  
• spinal muscular atrophy (SMA).  
There must also be permanent clinical impairment of motor function. |
| Multiple sclerosis – where there have been symptoms   | A definite diagnosis of multiple sclerosis by a consultant neurologist. There must have been clinical impairment of motor or sensory function caused by multiple sclerosis.                                             |
| Multiple system atrophy – resulting in permanent symptoms | A definite diagnosis of multiple system atrophy by a consultant neurologist. There must be evidence of permanent clinical impairment of either:  
• motor function with associated rigidity of movement; or  
• the ability to coordinate muscle movement; or  
• bladder control and postural hypotension. |
| Open heart surgery – with median sternotomy           | The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiologist to correct any structural abnormality of the heart.                                  |
| Paralysis of limb – total and irreversible             | Total and irreversible loss of muscle function to the whole of any limb.                                                                                                                                  |
| Parkinson’s disease – resulting in permanent symptoms | A definite diagnosis of Parkinson’s disease by a consultant neurologist or consultant geriatrician. There must be permanent clinical impairment of motor function with associated tremor or muscle rigidity. For the above definition, the following are not covered:  
• other Parkinsonian syndromes;  
• Parkinsonism. |
| Primary pulmonary hypertension – of specified severity | A definite diagnosis of primary pulmonary hypertension. 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’s classification of functional capacity*. For the above definition, the following is not covered:  
• pulmonary hypertension secondary to any other known cause i.e. not primary.  
* NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain. |
| Progressive supranuclear palsy – resulting in permanent symptoms | A definite diagnosis of progressive supranuclear palsy by a consultant neurologist. There must be permanent clinical impairment of eye movements and motor function. |
| Removal of an eyeball – due to injury or disease       | Surgical removal of an eyeball as a result of injury or disease. For the above definition, the following are not covered:  
• self inflicted injuries. |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition/description</th>
</tr>
</thead>
</table>
| **Respiratory failure – of advanced stage**                               | Advanced stage emphysema or other chronic lung disease, resulting in all of the following:  
  - The need for regular oxygen treatment on a permanent basis; and  
  - The permanent impairment of lung function tests as follows:  
    - Forced Vital Capacity (FVC) and Forced Expiratory Volume at 1 second (FEV1) being less than 50% of normal. |
| **Spinal Stroke – resulting in symptoms lasting at least 24 hours**       | Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal canal resulting in neurological deficit with persisting clinical symptoms lasting at least 24 hours. |
| **Stroke – resulting in symptoms lasting at least 24 hours**             | Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit with persisting clinical symptoms lasting at least 24 hours.  
  For the above definition, the following are not covered:  
  - transient ischaemic attack;  
  - death of tissue of the nerve or retina/eye stroke. |
| **Systemic lupus erythematosus – with severe complications**              | A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:  
  - permanent neurological deficit with persisting clinical symptoms; or  
  - the permanent impairment of kidney function tests as follows:  
    - Glomerular Filtration Rate (GFR) below 30 ml/min. |
| **Third degree burns – covering 20% of the surface area of the body or 20% of the face or head** | 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 covering 20% of the area of the face or head. |
| **Total and permanent disability* – of specified severity**              | **Total and 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 life insured 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 life insured’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 life insured expects to retire.  
  For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.  
  The definition of a clear prognosis is where a relevant specialist is able to provide the likely outcome of the illness, condition or disease.  
  If the life insured is not in paid employment at the time of a claim, your claim will be assessed under the Specified Work Tasks definition described in the definition headed ‘Total and Permanent Disability (Specified Work Tasks)’.* |
| **Total and permanent disability**<sup>*</sup> – of specified severity (Specified work tasks) | **Total and permanent disability** – unable to do three Specified Work Tasks ever again.  
Loss of the physical ability through an illness or injury to do at least three of the six work 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 life insured expects to retire.  
The life insured 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 Specified Work Tasks are:  
**Walking:**  
The ability to walk more than 200 metres on a level surface.  
**Climbing:**  
The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.  
**Lifting:**  
The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.  
**Bending:**  
The ability to bend or kneel to touch the floor and straighten up again.  
**Getting in and out of a car:**  
The ability to get into a standard saloon car, and out again.  
**Writing:**  
The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.  
For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.  
The definition of a clear prognosis is where a relevant specialist is able to provide the likely outcome of the illness, condition or disease. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traumatic brain injury – resulting in permanent symptoms</strong></td>
<td><strong>Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.</strong></td>
</tr>
</tbody>
</table>

<sup>*</sup>If you have Total and Permanent Disability it will be shown in your Policy Booklet. The definition applied will depend on your personal circumstances and will be confirmed in your Policy Booklet.
ADDITIONAL COVER INCLUDED FOR CRITICAL ILLNESS COVER

Claims paid under additional cover will not reduce your amount of cover or change your premiums.

However, we will not pay a claim under additional cover where more than one diagnosis is made within the same period of investigation or treatment and you are eligible for payment of full cover for a critical illness.

If the life insured or a relevant child has an illness covered by additional cover, it must be verified by a medical specialist who holds an appointment as a consultant at a hospital in the UK and whose specialism we reasonably consider is appropriate to the illness.

We will pay the lower of:
- £25,000,
- 25% of the amount of cover, or
- £25,000 or 25% of the decreasing amount of cover at the time our definition is met (if decreasing cover is chosen),

If the life insured, or if you choose a joint life policy the first of the lives insured, or a relevant child meets one of the following definitions (only one claim per policy can be made):

<table>
<thead>
<tr>
<th>Carcinoma in situ of the breast - treated by surgery</th>
<th>The undergoing of surgery on the advice of a hospital consultant to remove a tumour following the diagnosis of carcinoma in situ of the breast.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For the above definition the following is not covered:</td>
</tr>
<tr>
<td></td>
<td>- Any other type of treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low grade prostate cancer - requiring treatment</th>
<th>The undergoing of treatment on the advice of a hospital consultant following diagnosis of a malignant tumour of the prostate positively diagnosed and histologically classified as having a Gleason score between 2 and 6 inclusive and having progressed to a clinical TNM classification between T1N0M0 and T2aN0M0.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For the above definition, the following are not covered:</td>
</tr>
<tr>
<td></td>
<td>- prostatic intraepithelial neoplasia (PIN)</td>
</tr>
<tr>
<td></td>
<td>- observation or surveillance</td>
</tr>
<tr>
<td></td>
<td>- surgical biopsy</td>
</tr>
</tbody>
</table>

ADDITIONAL BENEFITS

Accident Hospitalisation Benefit

We will pay £5,000 if the life insured is admitted to hospital with physical injuries for a minimum of 28 consecutive days immediately following an accident. Physical injury must have resulted solely and directly from unforeseen, external, violent and visible means and must be independent from any other cause.

We will only pay one claim in respect of each life insured. This benefit is not payable if a valid claim has been made for:
- A terminal illness.
- A critical illness.
CHILDREN’S CRITICAL ILLNESS COVER
Automatically included if Critical Illness Cover is chosen.

We will pay this cover if a relevant child is diagnosed with any of the following during the period of cover:

- Any critical illness as defined in the section headed ‘Critical Illness Definitions’, apart from total and permanent disability;
- Carcinoma in situ of the breast – treated by surgery, or

The amount payable per relevant child under the policy will be the lower of:

- 50% of the amount of cover;
- £25,000.

Claims paid under Children’s Critical Illness Cover will not reduce your amount of cover or change your premiums.

The relevant child must be diagnosed on or before the policy expiry date and must be at least 30 days old and survive for 14 days from the date of diagnosis. We will pay a claim if the relevant child survives these 14 days, even if this is:

- after the policy expiry date, or
- after the relevant child’s 18th birthday, or 21st birthday if in full-time education.

Only one claim per relevant child, to a maximum of two relevant children will be paid under the policy. After the second claim has been paid, the Children’s Critical Illness Cover will end.

If the same relevant child is covered by more than one policy issued by us, we will pay a maximum of £50,000 for that relevant child.

When we will not pay a Children’s Critical Illness claim
We will not pay a claim if:

- The relevant child’s condition was present at birth;
- The symptoms first arose before the relevant child was covered;
- The relevant child dies within 14 days of meeting our definition of the critical illness;
- It is for total and permanent disability; or
- It is for Terminal Illness Cover.

ADDITIONAL BENEFITS FOR CHILDREN’S CRITICAL ILLNESS COVER

Child Accident Hospitalisation Benefit
We will pay £5,000 if the relevant child is admitted to hospital with physical injuries for a minimum of 28 consecutive days immediately following an accident. Physical injury must have resulted solely and directly from unforeseen, external, violent and visible means and must be independent from any other cause.

We will only pay this benefit if the accident doesn’t result in us paying out under Children’s Critical Illness Cover as described in the section headed ‘Children’s Critical Illness Cover’.

We will only pay one claim per relevant child, to a maximum of two relevant children. If the same relevant child is covered by more than one policy issued by us, we will pay a maximum of £10,000 for that relevant child under this benefit.

Child Funeral Benefit
On the death of a relevant child, we will contribute £4,000 towards their funeral.

Up to a maximum of two claims per policy. We will not pay the claim if:

- The relevant child’s condition was present at birth.
- The cause of death first arose before the relevant child was covered.
- We have paid a children’s critical illness claim for the relevant child.
Childcare Benefit

If we pay a claim under the policy due to the diagnosis of the life insured with any critical illness as defined in the sections headed ‘Critical Illness Definitions’ and ‘Additional Cover Included for Critical Illness Cover’:

- We will pay up to £1,000 towards childcare with a registered childminder if you have a natural child, legally adopted child or stepchild under 5 years old at the time of your diagnosis.
- We will only pay the childcare benefit when we have received receipts or proof of payment from the registered childminder. This benefit covers childcare that takes place in the 18 months following the life insured’s diagnosis.

Family Accommodation Benefit

For every night a relevant child spends in hospital, in the three months immediately following diagnosis of one of the critical illnesses covered in the section headed ‘Children’s Critical Illness Cover’, we will pay you £100 per night up to a maximum of £1,000.
COUNTRIES WHERE CRITICAL ILLNESS COVER IS PROVIDED

The life insured or relevant child is covered if they are resident in the United Kingdom, any part of the countries that form the European Union, USA, Canada, Australia, New Zealand, the Isle of Man or the Channel Islands. We will also accept a claim from other countries if we can confirm the claim is valid. We will act reasonably when reviewing evidence to support the validity of a claim.

WHAT YOU ARE NOT COVERED FOR

- **Death in the first year**
  The policy will be cancelled if within the first year of the policy, the life insured dies as a result of:
  - Suicide, or
  - Intentional and serious self-injury, or
  - An event where, in our reasonable opinion, the life insured took their own life.

Assessing a claim for death in the first year
If a suicide verdict is not given we may decide in our reasonable opinion that the life insured has taken their own life. We will take into account:
- The method and timing of death.
- The evidence available from the time and place of death.
- Any documentation left by the deceased or available from others.
- Previous medical history that we are reasonably entitled to obtain.

- **You** will not be eligible to make a claim under the policy chosen if:
  - the life insured doesn’t meet the definitions for cover as described in the section(s) headed:
    - ‘What is Covered’
    - ‘Critical Illness Definitions’
    - Waiver of Premium
    - or ‘When we will not pay a Children’s Critical Illness claim’ applies.
  - the premiums under the policy are not up to date.
  - The policy is offered or issued subject to the cancellation of a specified policy(ies), and you did not cancel it (them).
  - During the application process we will ask you questions about your personal circumstances and we may request additional information from you in order to make an assessment and offer you a policy. The life insured is required to answer all of our questions honestly and accurately.

a) If you (or an agent acting on your behalf) deliberately or recklessly provide inaccurate information we are entitled to cancel the policy and refuse to pay the amount of cover. In these circumstances we may not refund any premiums you have already paid.

b) If you (or an agent acting on your behalf) provide inaccurate information through carelessness, we are entitled to amend the policy to reflect the terms that would have been offered had the accurate information been known. In these circumstances:

i. if we would not have issued the policy had the accurate information been provided, we are entitled to cancel the policy, however we will refund any premiums you have already paid;

ii. if we would have issued the policy on different terms and conditions (other than those relating to premiums) had the accurate information been provided, we may make changes to the policy terms and conditions and treat the policy as if it had been issued on the different terms and conditions;

iii. in addition, if we would have issued the policy with higher premiums had the accurate information been provided, we may reduce the amount of cover to reflect the higher premiums that would have applied had the accurate information been provided. The following formula will be used in these circumstances:

$$\text{New amount of cover} = \frac{\text{Premium actually charged} \times \text{original amount of cover}}{\text{Higher premium}}$$
**WAIVER OF PREMIUM**

**You** may have the option to choose Waiver of Premium at the start of the policy, it will be an additional cost.

If the **life insured** meets our definition of incapacity for 26 consecutive weeks, **you** won’t have to pay premiums. This benefit will start after the 26th consecutive week of incapacity and continue until the earlier of:

- The end of the period of incapacity, or
- Payment of the amount of cover, or
- On the **policy expiry date**.

**Incapacity**

Depending on the **life insured’s** employment status when a claim is made, incapacity is defined as:

The **life insured** is totally incapable of carrying out their normal occupation by reason of an illness or injury which occurred after the **policy start date**, necessitating medical or surgical treatment and is not carrying out any other occupation or paid employment.

Or

If the **life insured** is not in paid employment and they are unable to do three or more of the following Specified Work Tasks as a direct result of an illness or injury which occurred after the **policy start date**:

The Specified Work Tasks are:

<table>
<thead>
<tr>
<th>Task</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>The ability to walk more than 200 metres on a level surface.</td>
</tr>
<tr>
<td>Climbing</td>
<td>The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.</td>
</tr>
<tr>
<td>Lifting</td>
<td>The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.</td>
</tr>
<tr>
<td>Bending</td>
<td>The ability to bend or kneel to touch the floor and straighten up again.</td>
</tr>
<tr>
<td>Getting in and out of a car</td>
<td>The ability to get into a standard saloon car, and out again.</td>
</tr>
<tr>
<td>Writing</td>
<td>The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.</td>
</tr>
</tbody>
</table>

The **life insured** may be required to have a medical examination by an appropriate medical specialist appointed by us regardless of the incapacity definition applied at claim.

**Countries where this benefit is provided**

The **life insured** is covered for Waiver of Premium if they:

a) reside or travel within the European Union, or

b) travel outside of the European Union for no more than three consecutive months in any 12 months.

If the **life insured** travels outside of the European Union for more than three consecutive months in any 12 months we will act reasonably when assessing whether the **life insured** meets the definition of incapacity.

For details about how to make a Waiver of Premium claim, please see the section headed ‘Making a claim’.
CHANGING YOUR POLICY

On the occurrence of specified events you have the option to increase the amount of cover without the need for further medical information. To do this the policy must be taken out before your 45th birthday and we must not have applied a premium increase to your cover.

If the following do not apply when you want to change your cover then there are alternative ways outlined in the section headed ‘Other Changes’.

You can increase the amount of cover without answering any more medical information in the event of:

a) the life insured entering into marriage or a registered civil partnership, or
b) the birth of the life insured’s child, or
c) the life insured legally adopting a child, or
d) an increase in the life insured’s earnings due to a change of employment or promotion, or
e) an increase to the life insured’s mortgage by reason of a house move or undertaking major home improvements.

This option must be used within six months of the event and if we request relevant documents in relation to the events, you must provide them to us.

The amount of cover can increase by

For all increases, the amount of cover may only be increased on each occasion by the lower of:

- 50% of the original amount of cover, or
- £150,000, or
- if d) above applies, the amount equal to the original amount of cover multiplied by the percentage increase in earnings
- If e) above applies, the amount of the increase in the mortgage.

The option may only be used three times in total, and only once in respect of either entering into marriage or a registered civil partnership. The maximum total of all increases permitted is £200,000.

How we provide cover for an increase

If you use this option an additional policy will be issued in respect of the increase, which will:

- not allow you to increase your cover without additional medical evidence,
- not extend beyond the life insured’s 65th birthday or one year after the policy expiry date of this original policy, whichever is earlier,
- only have increasing cover if this was selected when the policy was taken out and the option to increase has been accepted by you at all policy anniversary dates, and
- be subject to the premiums, terms and conditions for such policies at the time the additional policy is issued.

In circumstances where we no longer offer the chosen policy at the time you wish to use this option, we will offer you a reasonable available alternative.

When this option is not available

This option will not be available to you:

- After the life insured’s 55th birthday. If two people are covered this applies to the older life insured.
- If a claim under Waiver of Premium has been made, until the end of the period of incapacity,
- If the life insured has been diagnosed with or is receiving or has received medical treatment for our definition of:
  - A terminal illness
  - A critical illness listed under the sections headed:
    - ‘Critical Illness Definitions’,
    - ‘Additional Cover Included For Critical Illness Cover’.
- If the life insured has symptoms of or is having tests for a condition covered by the policy.

In these circumstances, this option will only be available to the life insured where the test results confirm that the life insured does not have a condition covered by the policy.

JOINT LIFE POLICY SEPARATION

If you take out a joint life policy you can separate it if:

a) you divorce, or
b) you dissolve your registered civil partnership, or
c) either of you
Life Insurance with Critical Illness Cover

i. take over an existing mortgage in one name, or
ii. take out a new mortgage in one name.

We will cancel this policy and start a new single life policy for each life insured.

You must make the request within six months of the event being finalised.

Joint life policy separation is not available if either of the lives insured has had a valid claim for a critical illness listed under the section headed ‘Additional Cover Included For Critical Illness Cover’.

What we need to process your request

a) Evidence to support your request in the form of:
   i. A decree absolute if you get divorced, or
   ii. A final order for the dissolution of your registered civil partnership, or
   iii. Proof of ownership of the relevant mortgage.

b) The consent of both lives insured by completing and returning an amendment form issued by us, which includes a short questionnaire about the life insured’s health, medical history, residency and leisure activities.

c) If either life insured answers ‘yes’ to any of the questions in the amendment form, we will require you to complete a full application form in order to set up a single life policy. Where we undertake a full medical and lifestyle assessment, depending on the answers there may be circumstances where we may not be able to offer cover to both of the lives insured.

How we will provide cover

a) The new single life policies will include the same cover as the original policy. We will not change the cover in any other way, other than making it a single life policy.

b) The new single life policies will be subject to premiums, terms and conditions available at the time you make the change.

c) The maximum amount of cover for each new policy will be the lower of:
   • The amount of cover on the original joint life policy, or
   • £1,000,000.

d) The term of each new policy will not extend beyond the life insured’s 70th birthday or one year after the policy expiry date, whichever is earlier.
OTHER CHANGES

You can request any of the following changes to the policy:

- Increase or decrease the amount of cover.
- Extend or reduce the period of cover.
- Remove a life insured, if joint life cover is chosen.
- Change the frequency of your premiums between annually and monthly.

What we may need to process your request

a) Your consent to the changes by completing and returning an amendment form issued by us, which includes a short questionnaire about the life insured’s health, medical history, residency and leisure activities.

b) If the life insured answers ‘yes’ to any of the questions in the amendment form, we may require you to complete a full application in order to make the changes to the policy. Where we undertake a full medical and lifestyle assessment, depending on the answers there may be circumstances where we may not be able to offer cover to both of the lives insured.

c) Any documents reasonably required by us to support your request.

How we will provide cover

We will confirm if the change you have requested means the original policy has to be cancelled and a new policy issued, which may have different terms and conditions.

Any changes you make may affect the premiums that are payable.

We will confirm the change you have made.

GENERAL CONDITIONS

- We may make changes to the policy terms and conditions that we reasonably consider are appropriate due to a change in any applicable legislation, regulation or taxation. In such circumstances, we will notify you in advance of any changes being made.

- We have the right by notifying you to:
  
  i. cancel this policy; and
  
  ii. not pay a claim on this policy; and
  
  iii. take other reasonable action

  in order to comply with laws, regulations, sanctions regimes, international guidance and/or demands from any authorities, relating to Financial Crime Risk Management Activity.

- The policy is governed by English Law.

- All communication in relation to the policy will be in English.

- The right to exercise any option under the policy or to exercise any right conferred by the policy is limited to such as are allowed in the terms of the policy and as are compatible with the requirements of Paragraph 19(3) of Schedule 15 of the Income and Corporation Taxes Act 1988 for a qualifying policy.
MAKING A CLAIM

Notifying us of a claim
To make a claim under the policy, please notify us using our claims contact details in the section headed 'How to Contact us'. When claiming we will need the policy number, the life insured’s GP/Doctors contact details and your contact details.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>What we need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life cover</td>
<td>The date of death</td>
</tr>
<tr>
<td>Critical Illness Cover</td>
<td>Details of the illness and diagnosis</td>
</tr>
<tr>
<td>Terminal Illness Cover</td>
<td>Details of the illness and diagnosis</td>
</tr>
<tr>
<td>Accident Hospitalisation Benefit</td>
<td>Details of the physical injury and hospital admission</td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>You must notify us of a claim within 16 weeks of the start of the life insured’s incapacity, otherwise we will consider the start of their incapacity to be 16 weeks before the date we are told. We may not insist on this if there are exceptional medical or other reasons why you cannot tell us within 16 weeks of the start of incapacity.</td>
</tr>
</tbody>
</table>

ASSESSING YOUR CLAIM
We may send you a claim form to complete and return to us. In order to assess your claim we will require different evidence depending on the type of claim you are making.

We may also ask for the Policy Booklet and any other documents we may reasonably require for the claim you are making.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Evidence required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Cover</td>
<td>The death certificate of the life insured</td>
</tr>
<tr>
<td>Critical Illness Cover</td>
<td>Proof that the definition has been met</td>
</tr>
<tr>
<td>Terminal Illness Cover</td>
<td>Proof that the definition has been met</td>
</tr>
<tr>
<td>Accident Hospitalisation Benefit</td>
<td>Proof that the definition has been met</td>
</tr>
<tr>
<td>Additional Cover For Critical Illness Cover</td>
<td>Proof that the definition has been met</td>
</tr>
<tr>
<td>Children’s Critical Illness Cover</td>
<td>Evidence of the relevant child in the form of: the birth certificate, for a natural child, or the legal adoption certificate, for a legally adopted child, or the marriage certificate or certificate of a registered civil partnership, for a stepchild, and proof that the relevant definition has been met.</td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>Proof that the relevant incapacity definition has been met</td>
</tr>
</tbody>
</table>

If you do not provide any information or documentation that would reasonably be required to assess the claim, we will not process the claim until the information or documentation is made available.

Assessing a claim for Total and Permanent Disability
If Total and Permanent Disability is shown in your policy booklet and the life insured is not in paid employment at the time of a claim, your claim will be assessed under the Specified Work Tasks definition described in the section headed 'Critical Illness Definitions'.
WHO WE PAY THE COVER TO

The amount of cover is paid to you. In most cases, this means that we will make payment directly to the legal owner of the policy, or if that person is dead, to their personal representative (usually the executor named in their will). This also means that if the policy has been placed in trust, we will make payment to the trustees, and if the policy has been assigned, we will make payment to the assignees.

PAYMENT OF COVER

We will pay a claim for any of the cover described in the section headed ‘What is covered’ as a lump sum. Cover can only be paid in pound sterling (GBP) to a bank account in the UK. If you wish to receive payments outside the UK, then arrangements for such transfers must be made at your own expense.

REPLACEMENT COVER

If you choose to take out a joint life policy and one of the lives insured makes a valid claim under full cover, as defined in the section headed ‘What is covered’, you can request to continue cover for the other life insured as a new single life policy.

You must request this option within six months of a valid claim under full cover being paid.

This option is not available if the life insured requesting replacement cover has had a valid claim for a critical illness listed under the section headed ‘Additional Cover Included For Critical Illness Cover’.

What we need to process your request

a) The consent of the life insured who hasn’t claimed under full cover, by completing and returning a replacement cover form issued by us, which includes a short questionnaire about the life insured’s health, medical history, residency and leisure activities.

b) If the life insured who hasn’t claimed under full cover, answers ‘yes’ to any of the questions in the replacement cover form, we will require you to complete a full application form in order to set up a single life policy. Where we undertake a full medical and lifestyle assessment, depending on the answers there may be circumstances where we may not be able to offer cover to the life insured.

How we will provide cover

a) The new single life policy will include the same cover as the original policy. We will not change the cover in any other way, other than making it a single life policy.

b) The amount of cover will be the same as the original policy. If Decreasing Life Insurance is chosen, the amount of cover will be the remaining amount of cover at the time a valid claim under full cover was paid on the original policy.

c) The term of the new policy will not extend beyond the life insured’s 70th birthday or one year after the policy expiry date, whichever is earlier.

d) The new single life policy will be subject to premiums, terms and conditions available at the time you make the change.
## USEFUL CONTACTS

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone number</th>
<th>Contact Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Enquiries</td>
<td>0370 010 4080*</td>
<td>Legal &amp; General Assurance Society Limited City Park The Droveway Hove East Sussex BN3 7PY</td>
</tr>
<tr>
<td>Change the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancel the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death or Terminal Illness Cover</td>
<td>0800 137 101*</td>
<td>Legal &amp; General Assurance Society Limited City Park The Droveway Hove East Sussex BN3 7PY</td>
</tr>
<tr>
<td>Critical Illness claims</td>
<td>0800 068 0789*</td>
<td></td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>0800 068 0789*</td>
<td></td>
</tr>
<tr>
<td>Make a complaint</td>
<td>0370 010 4080*</td>
<td>Legal &amp; General Assurance Society Limited Knox Court 10 Fitzalan Place Cardiff CF24 0TL</td>
</tr>
</tbody>
</table>

*We may record and monitor calls. Call charges will vary.

### HOW TO CANCEL THE POLICY

You can cancel the policy at any time. Once the policy starts we will provide you with a notice of your right to cancel.

If you cancel the policy within 30 days of receiving both the notice and the policy, we will refund any premiums paid.

If you cancel the policy after 30 days, you will not get any money back.

If you cancel the policy, the cover will end and no further premiums will be payable.

### HOW TO MAKE A COMPLAINT

If you wish to complain about the service you receive from us, or you would like us to send you a copy of our internal complaints handling procedure, please contact us.

If you remain dissatisfied, you can complain to:

The Financial Ombudsman Service

Exchange Tower
London
E14 9SR

Telephone:
• 0800 023 4567
• 0300 123 9 123

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

Making a complaint will not affect your legal rights.

### ONLINE DISPUTE RESOLUTION PLATFORM (ODR Platform)

The European Commission has established an Online Dispute Resolution Platform (ODR Platform) https://ec.europa.eu/consumers/odr/main/?event=main.home.show that is specifically designed to help EU consumers who have bought goods or services online from a trader based elsewhere in the EU and subsequently has a problem with that online purchase. The ODR platform will refer your complaint to the Financial Ombudsman Service who will pass it on to us.
THE FINANCIAL SERVICES COMPENSATION SCHEME (FSCS)

The FSCS is designed to pay compensation if a firm is unable to pay claims, because it has stopped trading or been declared in default.

So, if we run into financial difficulties, you may be able to claim via the FSCS, for any money you’ve lost. However, before looking to pay compensation, the FSCS will first see if they can arrange for the continuity of your current policy. The FSCS may arrange for the policy to be transferred to another insurer or arrange for a new policy to be provided.

Most of our customers, including most individuals and small businesses, are covered by the FSCS. Whether or not you can claim, and the amount you could claim, will depend on the specific circumstances of your claim. The FSCS will pay 100% of the value of the claim.

You can find out more about the FSCS, including eligibility to claim, by visiting its website www.fscs.org.uk or calling 0800 678 1100.

The rules of the FSCS might change in the future and the FSCS may take a different approach on their application of the above, depending on what led to the failure.

SOLVENCY AND FINANCIAL CONDITIONS REPORT (SFCR)

We are required to publish an annual Solvency and Financial Condition Report (SFCR) describing our Business and its Performance, our System of Governance, Risk Profiles, Valuation for Solvency Purposes and Capital Management. Our latest SFCR is available at: www.legalandgeneralgroup.com/investors/library.
DEFINITIONS

**Full-time education** - Attendance at a full-time course at a school, college or university. This includes work placements that are part of a full-time course but excludes breaks from education, for example gap years.

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

**Life insured** - The person whose life is covered under the policy. If there is more than one life covered then this definition covers all lives insured.

**Neurological deficit with persisting clinical symptoms** - Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last at least 24 hours. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

**Ours, us or we** - Legal & General Assurance Society Limited.

**Permanent** - Expected to last throughout the life insured’s life, irrespective of when the cover ends or the life insured retires.

**Permanent neurological deficit with persisting clinical symptoms** - Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the life insured’s life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:
- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.
- Symptoms of psychological or psychiatric origin.

**Policy expiry date** - The date that cover under the policy will end.

**Policy start date** - The start date of the policy.

**Relevant child/children** - A natural child, legally adopted child (from the date of adoption) or stepchild (by marriage or registered civil partnership) of the life insured, where that child is:
- at least 30 days old, and
- younger than 18 years, or
- younger than 21 years if in full-time education, during the period of cover.

**You or your** - The owner(s) of the policy who is/are legally entitled to receive the amount of cover when a valid claim is made. This may include trustee(s), assignee(s) or personal representative(s) (where appropriate) and may be the life insured.