

Technical Guide

Group Critical Illness

Product Overview

- A policy taken out by the employer to provide a lump sum benefit to be paid to an employee who is diagnosed with one of a number of defined medical conditions or undergoes one of the listed surgical procedures; collectively, the Critical Illness events.
- The policy benefit is paid once the employee survives for at least 14 days after the Critical Illness event or 6 months in the case of PTD benefit.
- To offer employers the choice of providing Base Cover (which insures against some of the most serious Critical Illness events) or Extra Cover (which covers a number of additional serious conditions).

Technical Guide

- Technical Guide for ‘Commercial customers’ and their advisers.
- This product is only available from appropriately authorised intermediaries who have signed our Terms of Business Agreement.
- This document is a guide to the features of our Group Critical Illness product and should be read in conjunction with the quotation which accompanies it. If anything stated in the quotation differs from what is in this guide, then what is stated in the quotation overrides the guide.
- In the event of a discrepancy between the policy document, the quotation and the content of this guide, the wording of the policy document will prevail.
- Full details of the insurance cover will be contained in the policy document.
- The policy is issued subject to the Laws of England and any dispute shall be subject to the exclusive jurisdiction of the English Courts.
- We have classed the customers for this product as “Commercial” within the context of the Financial Services Authority’s (FSA) Insurance: New Conduct of Business sourcebook (ICOBS).

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This document does not provide definitive tax advice that can be relied upon in the specific circumstances of a particular Policyholder or in respect of any member insured under the policy. This includes but is not limited to any potential liability to corporation tax and income tax. Policyholders should take advice from their own professional advisers to ensure that they understand the impact of tax and legislation.

A. Terms explained

Automatic Entry Limit (AEL) means a level of benefit which will normally be granted to an individual regardless of their state of health provided they are otherwise eligible to become a member, subject to the pre-existing conditions exclusion (see Section E 2.3 'What is not covered?').

A **Critical Illness event** is the occurrence of one of a number of defined medical conditions or listed surgical procedures covered under the policy.

Commencement date is the date from when we have agreed to provide the quoted cover.

Conditional cover is the cover by which we agree to provide from the required commencement date for a period of up to 30 days pending receipt of the information detailed in Section E 1.2 'When will cover commence?'.

Discretionary entrants are employees who are to be included in the policy outside the usual eligibility criteria.

Early entrants are employees who are to be included in the policy before completing the service qualification period.

A **late entrant** is an employee who wishes to join the policy after the date of their first opportunity to do so. Where eligibility is linked to membership of the employer's pension scheme; a late entrant is an employee who wishes to join the pension scheme more than 6 months after their first opportunity to do so.

Permanent Total Disability (PTD) is defined as a permanent disability caused by any illness (not just a Critical Illness event) or any injury.

The **policy accounting date** is the date with effect from which the premium due for the next policy accounting period is calculated.

The **policy accounting period** is defined as the period from the commencement date of the policy up to the first policy accounting date and from one policy accounting date to the next policy accounting date.

The **policy review date** is the date when the premium rate and terms of the policy are reviewed and guaranteed for a further period (typically 2 years).

QAAF is the acronym for Quotation Acceptance and Application Form.

Spouse means the legal husband or wife or the civil partner of the member.

The policy **Terminal Age** is the age at which cover under the policy ceases. The maximum Terminal Age is 70. Cover can cease at any pre-agreed point within the month during which the member reaches Terminal Age, such as the last day of the month. Unless otherwise stated cover will cease at 23:59 on the day prior to the member reaching Terminal Age.

B. Your commitment as the Policyholder

- You must provide us with all the information we ask for when you apply for your policy, at each policy accounting date and policy review date or when you make a claim. You must advise us if these details change. If you do not provide this information, we may not be able to pay your claims
- You agree to pay premiums on time in sterling.
- You choose at the outset the conditions of eligibility that govern who can be covered by the policy.
- You agree to notify us in writing if you wish to amend the eligibility criteria of the policy, for example; by closing the policy to new entrants.
- You agree to notify us in writing if you acquire another company and you wish to cover the employees of the new company under the policy.
- You agree to notify us in writing if you dispose of a company whose employees are covered under the policy and will no longer be covered under the policy.
- You agree to identify any discretionary entrants (see Section A 'Terms explained').
- If you wish to make a claim, you agree to notify us within 90 days of a Critical Illness event having occurred or having been diagnosed.
- You agree to supply us with all the information we ask for at a policy review date.

C. Risk factors

The policy carries the following risks:

- You should take legal advice on the need to outline the benefits provided by the policy in employees' contracts of employment and that the benefits, as promised, are not discriminatory.
For example, the Employment Equality (Age) Regulations 2006 that came into effect on 1 October 2006 made it unlawful for an employer to discriminate directly or indirectly against an employee on any aspect of their employment or benefits, based on their actual age or their apparent age. The Regulations do not directly apply to insurance policies.
- You will not be covered if you fail to comply with the terms and conditions of the policy or if you stop paying premiums. If you terminate the policy, we will continue to pay valid claims that occurred during the period of cover for which premiums have been paid.
- Certain types of claim may be excluded (see Section E 2.3 'What is not covered?').
- For all policies, the premium rate and policy terms and conditions will usually be guaranteed for 2 years. However, we reserve the right to amend these terms if, in the opinion of Unum, there is a significant change in the risk profile, the factors we take into consideration for this type of policy are:
 - A variance of 25 per cent or greater in the number of members or benefit insured
 - The inclusion of a new subsidiary
 - The disposal of a participating company or closure of a part of the employers business
 - The inclusion of a new member category
 - A change in policy design such as an alteration of benefit level, terminal age or terms of eligibility
 - A significant overall change in the occupations of the members or where they work;
 - A major change to the level or basis of the social security or income tax systems.

- In the case of quotes for new or existing policies we reserve the right to review the terms offered if there is a 15 per cent or more change to the data provided to produce the quote.
- If the number of members drops below 5 at any time, we reserve the right to cancel the policy at any subsequent policy accounting date.

D. How does the policy work?

- We require a minimum of 5 lives for a Group Critical Illness policy.
- A lump sum benefit is paid to employees covered by the policy who suffer one of the Critical Illness events listed in the policy. For those events that are medical conditions, the date of the event is the date that formal diagnosis is made; for the surgical procedures, the date is the date of actually undergoing the procedure. The employee must survive the event by 14 days or by 6 months for PTD.
- You decide the level of benefit you want your employees to receive.
- You decide which type of cover you require. You can select Base Cover or Extra Cover (see Section E 1.4 'What choice of cover is available?').
- Employees' spouses may be covered (see Section E 1.6 'Can employees' families be covered?').
- Employees' children (including stepchildren and legally adopted children) aged between 6 months and 18 years are automatically covered at no extra cost. There is no upper limit to the number of children we will cover (see Section E 1.6 'Can employees' families be covered?').
- While you are paying premiums, we provide cover no matter how many claims you make. If you terminate your cover, we will continue to consider and pay claims where the Critical Illness event occurred during the period for which premiums were paid.
- You will pay all the premiums and, for tax purposes, the cost is usually treated for tax purposes as a trading expense. Premiums are normally taxed as a benefit in kind for employees.

- You must make the claim on behalf of your employee. Benefit is paid by cheque directly to an employee free of tax.
- You should provide us with the information we require when you make a claim (see Section E 6 'Claiming benefits').
- The guarantee period advised in your quotation applies to both the premium rate and the terms and conditions applicable to the policy. When the guarantee expires at the policy review date, both the premium rate and the terms and conditions of the policy are subject to review.

- the first day of the month (monthly), or
- immediately, if all other eligibility requirements of the policy are satisfied (daily).

If cover is dependent on membership of the employer's pension scheme, the current eligibility requirements of the pension scheme must also be specified.

The definition of eligibility must be clearly stated in all cases. Membership is compulsory for all employees within a defined category or categories. Eligibility conditions covering entry ages, entry dates and service requirements must be the same for each employee within a defined category.

Part-time employees and fixed-term employees may also be included in the policy if they satisfy the above conditions.

E. Product details

1. What factors should be considered in deciding what benefits to provide?

Our Group Critical Illness policy offers a range of options, allowing cover to be designed that is consistent with your business needs and budget.

1.1 Who can be covered?

An employee can become a member if they satisfy the conditions of eligibility defined in the policy. Cover for children is automatically provided and Spouses' cover is an option.

1.1.1 Conditions of eligibility

Conditions of cover for the policy must be selected. For example:

- the minimum and maximum entry ages allowed for new entrants
- if a minimum number of years' service is required
- the categories of employee you wish to be covered and what benefits you want each category to be entitled
- the date on which new entrants will be covered
 - and when existing members will be eligible for increases in insured benefits; this might be:
 - the policy accounting date (annually), or

1.1.2 Actively at Work

As cover up to the AEL is subject to a pre-existing condition exclusion and any benefit above AEL is medically underwritten, an actively at work requirement is not applied.

1.1.3 Early and late entrants

You may add employees to the scheme at any time but you must notify us in writing in advance of each early or late entrant's inclusion and confirm the date of joining. Cover may not be backdated. Depending on the scheme basis, you must also tell us the employee's scheme defined salary or the required cover level. If cover is to exceed the AEL, a Scheme Members Application form will be required.

1.1.4 Otherwise discretionary entrants

You must contact us to discuss your wish to include anyone who does not meet scheme eligibility requirements (other than early or late entry). If we agree to the person becoming a member, we shall let you know our requirements, which may include completion of a Scheme Member's Application form.

1.1.5 Switch Terms

Where cover is being transferred from another insurer to Unum and on the same policy basis, an individual will not normally be subject to stricter underwriting terms than those imposed by the previous insurer.

This is referred to as providing No Worse Terms. We will require details of employees whose cover has been subject to special terms by the previous insurer showing for each member:

- name
- date of birth
- gender
- full underwriting decision (including loadings and amount of benefit above which the Loading or restriction applied)
- sum assured 'on risk' on transfer

Special terms refer to adverse medical underwriting decisions and include premium loadings, exclusions, restrictions (where imposed for non-provision of medical evidence) and declinatures.

1.2 When will cover commence?

We will provide Conditional Cover on receipt of:

- written instructions from your intermediary to assume risk from the commencement date, and
- satisfactory written answers to any Risk Relevant and any Price Relevant caveats that were included in our quotation.

This is subject to receiving a fully completed QAAF signed by the Policyholder and Deposit premium or Direct Debit mandate during the period of Conditional Cover. The QAAF incorporates a Direct Debit mandate to be signed by the Policyholder and a Customer Verification Statement that, if requested, should be signed by your intermediary.

In order to continue cover after the period of Conditional Cover, in addition to the fully completed QAAF, we require membership data as at the commencement date.

1.3 When will cover cease?

1.3.1 Under normal circumstances

We cannot cancel the policy unless the number of employees insured under the policy is fewer than 5, premiums are overdue or you fail to provide all the information we ask for when applying for the policy,

administering the policy or when claiming for benefit in respect of a member.

You can cancel the policy at any time, provided you do so in writing. Cover will then cease and you will not be liable to make payments for any period after this date. Cancellation cannot be backdated.

If the policy is cancelled, we will still consider and pay claims for a Critical Illness event arising during the period we provided cover and for which premiums had been paid.

A member's cover will cease on leaving service.

Provided the employer continues to make the respective premium payments, the benefit may be maintained:

- in cases of illness or injury and during Statutory absences such as maternity, adoptive, paternity, unpaid parental leave - for a maximum period of 36 months not exceeding the Terminal Age.
- for any other reason such as sabbaticals, unpaid, compassionate leave - subject to prior agreement by Unum, for a maximum period of 36 months not exceeding the Terminal Age.

At the start of the policy you can choose to extend this period to the policy Terminal Age, in respect of absence due to a prolonged illness or injury.

1.3.2 Ceasing Conditional Cover

The fully completed QAAF and Deposit premium or Direct Debit mandate and membership data must be provided as requested within the 30 day period of Conditional Cover. Cover will cease if this has not been provided within this period.

A premium will be charged for the 30 day period of Conditional Cover provided. This premium will be calculated on a pro-rata basis, based on the time we have provided cover.

1.4 What choice of cover is available?

We offer two types of cover, namely Base Cover and Extra Cover.

Base Cover

Base Cover provides cover for some of the most serious Critical Illness events. The following conditions are covered:

- Alzheimer's Disease*
- Cancer*
- Coronary Artery Bypass Grafts*
- Creutzfeldt-Jakob Disease (CJD)
- Heart Attack*
- Hodgkin's Disease
- Kidney Failure*
- Major Organ Transplant*
- Motor Neurone Disease*
- Multiple Sclerosis*
- Parkinson's Disease*
- Pre-senile Dementia
- Stroke*

Extra Cover

Extra Cover covers all the conditions listed under Base Cover plus a wide range of additional Critical Illness events. These are:

- Aorta Graft Surgery*
- Balloon Angioplasty
- Balloon Valvuloplasty
- Benign Brain Tumour*
- Blindness*
- Coma*
- Chronic Lung Disease, including Emphysema
- Deafness*
- Heart Valve Replacement or Repair*
- HIV Infection/AIDS (though only as a result of the instances described in Section E 2.2 'Defined conditions - Extra Cover')*

- Loss of Hands or Feet*
- Loss of Speech*
- Open Heart Surgery
- Paralysis of Limbs*
- Permanent Total Disability (PTD)
- Pulmonary Artery Surgery
- Rheumatoid Arthritis
- Terminal Illness
- Third Degree Burns*
- Traumatic Head Injury*

*The Association of British Insurers (ABI) produced a model definition for many Critical Illness events. Where an ABI model definition exists, our Group Critical Illness Cover matches, or provides wider cover than, the ABI's definition.

Section E 2 'Definitions' of this Technical Guide contains a full description of all these Critical Illness events.

1.4.1 Levels of benefit

Benefit may be provided as a fixed amount or as a multiple of earnings. The maximum benefit payable per employee is currently four times earnings to a maximum of £500,000.

Fluctuating earnings such as commission and bonuses can normally be included when calculating benefit levels. If these fluctuating earnings are more than 20 per cent of the employee's basic salary, a 3 year average will be taken.

Requests to include salary sacrifice within the earnings definition can be considered on a case by case basis.

The level of benefit must be clearly defined for each category of employee included in the policy.

An AEL is usually included as part of the policy.

1.5 When is the lump sum payment due?

The employee, spouse or child, as appropriate, must survive 14 days (6 months for PTD benefit) from the Critical Illness event, after which we will process the claim.

1.6 Can employees' families be covered?

1.6.1 Cover for Spouses

Spouse's cover is available as an option under both Base and Extra Cover.

The maximum benefit payable is currently the lower of the employee's benefit or £100,000.

Spouse's cover will cease when the Spouse reaches the Terminal Age applicable to the insured employee.

The Spouse must be:

- the legal spouse or civil partner of the employee, and
- living with the employee.

The Spouse will benefit from the same type of cover (i.e. Base or Extra Cover) as the employee. In respect to a PTD claim, benefit will be payable if the Spouse satisfies the conditions under the PTD (Activities of Daily Living) basis.

A pre-existing condition clause will apply to the full amount of Spouse's cover.

1.6.2 Cover for children

Cover for children aged 6 months to 18 years (including stepchildren and those who are legally adopted) is automatically provided under both Base Cover and Extra Cover. There is no upper limit to the number of children we will cover. The 14 day survival clause will apply to children's cover.

The benefit for each child is currently 25 per cent of the employee's benefit up to a maximum of £20,000.

Under Extra Cover, children are also covered under the PTD option. In the event of a claim, benefit will be payable if, by treating the child as an adult, they were unable to perform the activities under the definition Any Occupation. The 6 month survival period will apply to children's PTD cover.

A pre-existing condition clause will apply to the full amount of children's cover.

1.7 What if a member is temporarily absent?

The provision of cover varies depending on whether

the member is under Terminal Age or is in Extended Cover (see section E 1.8).

1.7.1 Temporary absence - not during Extended Cover (see section E 1.8).

Where an absent member is still regarded by the employer as remaining in service, benefit may be maintained:

- in cases of illness or injury – you have the option to continue cover for either a maximum period of 36 months (not exceeding the Terminal Age) or until the Terminal Age;
- during Statutory absences such as maternity, adoptive, paternity, unpaid parental leave - for a maximum period of 36 months not exceeding the Terminal Age;
- for any other reason such as sabbaticals, unpaid leave or compassionate leave for up to 1 month without prior agreement, and for periods longer than 1 month subject to prior agreement by Unum, for a maximum period of 36 months not exceeding the Terminal Age.

For increases to benefit during absence for illness or injury, maternity, adoptive, paternity and unpaid parental leave; salary increases will be accepted under Unum's cover provided that:

- the increase is in line with general pay increases for the employer subject to a maximum of 5 per cent per annum compound; and
- the increase is salary related, i.e. we will not cover increases for a flat benefit.

For increases to benefit during absence for sabbaticals, unpaid and compassionate leave; salary increases will not usually apply in these circumstances; this can be considered on a case by case basis when considering cover for this type of absence.

1.7.2 Temporary absence during Extended Cover (see section E 1.8)

Where extended cover has been provided to a member working past the Terminal Age, if the member becomes absent from work due to;

- illness or injury
- Statutory absences such as maternity, adoption, paternity and unpaid parental leave

- any other reasons such as sabbaticals, unpaid leave or compassionate leave - subject to prior agreement by Unum

Cover will be continued up to the earlier of;

- the end of their contract current on the day before the absence began; or
- 1 year from the date the absence began.

1.8 Extended cover

If a member works beyond the policy Terminal Age cover may be continued up to age 70 subject to medical underwriting. An additional premium would be charged based on the Single Premium costing method.

Members with Extended Cover do not benefit from an AEL; the total benefit at Terminal Age and all subsequent increases in cover must be medically underwritten.

Members with Extended Cover do not benefit from temporary cover pending completion of medical underwriting.

Note: Requests for Extended Cover should be made as soon as possible after extended employment has been agreed, to ensure cover is accepted and in place at the extension start date. We will confirm the terms of that cover in writing, if granted.

2. Definitions

2.1 Defined conditions - Base Cover

The following are the defined conditions under which benefits are payable and which must be established to the satisfaction of Unum's Chief Medical Officer.

Alzheimer's Disease

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember
- reason; and

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

For the above definition, the following are not covered:

- Other types of dementia.

Cancer

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, lymphoma and sarcoma.

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 greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

Coronary Artery Bypass Grafts

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

Creutzfeldt-Jakob Disease

Diagnosis of Creutzfeldt-Jakob Disease or New Variant

CJD made by a Consultant Neurologist, evidenced by a significant reduction in mental and social functioning so that permanent supervision or assistance by a third party is required.

Heart Attack

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

- Typical clinical symptoms (for example, characteristic chest pain).
- new characteristic electrocardiographic changes;
- the characteristic rise of cardiac enzymes, or troponins recorded at the following levels or higher;
 - Troponin T > 1.0 ng/ml
 - AccuTnl > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes including but not limited to angina.

Hodgkin's Disease

Covered as part of the Cancer definition.

Kidney Failure

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

Major Organ Transplant

The undergoing as a recipient of a transplant of bone marrow or a complete heart, kidney, liver, lung or pancreas, or inclusion on an official UK waiting list for such a procedure.

For the above condition, the following is not covered:
Transplant of any other organs, parts of organs, tissues or cells.

Motor Neurone Disease

A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent

clinical impairment of motor function.

Multiple Sclerosis

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

Parkinson's Disease

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be a permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability.

For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse.

Pre-senile Dementia

Progressive deterioration in mental function of at least 6 months duration resulting in abnormal behaviour or deterioration of intellectual capacity such that permanent supervision or assistance is required to maintain existence. The deterioration must be due to organic brain disease, diagnosed by an appropriate consultant who is satisfied there is no other discernible cause.

Stroke

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

For the above definition, the following is not covered:

- Transient ischaemic attack.
- Traumatic injury to brain tissue or blood vessels.

2.2 Defined conditions - Extra Cover

The following are the defined conditions under which benefits are payable and which must be established to the satisfaction of Unum's Chief Medical Officer.

Aorta Graft Surgery

The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased 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.
- Surgery following traumatic injury to the aorta.

Balloon Angioplasty

The undergoing of any interventional technique, on the advice of a Consultant Cardiologist, involving the use of transluminal coronary catheters to correct significant stenosis of at least 50 per cent diameter narrowing of two or more coronary arteries as part of a single procedure. Angiographic evidence to support the necessity for the above operation will be required.

Balloon Valvuloplasty

The actual insertion on the advice of a Consultant Cardiologist of a balloon catheter through the orifice of one of the valves of the heart and the inflation of the balloon to relieve valvular abnormalities.

Benign Brain Tumour

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Angiomas.

Blindness

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

Coma

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
- results in permanent neurological deficit with

persisting clinical symptoms.

For the above condition, the following is not covered:

- Coma secondary to alcohol or drug misuse.

Chronic Lung Disease, including Emphysema

Severe and permanent restrictive lung disease where there is dyspnoea at rest with markedly abnormal pulmonary function tests. The diagnosis must be evidenced by all of the following:

- the need for continuous daily oxygen therapy.
- Vital Capacity being less than 50 per cent of normal.
- FEV1 (Forced Expiratory Volume at 1 second) being less than 50 per cent of normal.

Deafness

Total 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.

Heart Valve Replacement or Repair

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

HIV Infection/AIDS contracted in the E.C., North America or Australasia from a blood transfusion, a physical assault or at work in an eligible occupation

Infection by any Human Immunodeficiency Virus (HIV) resulting from:

- a blood transfusion given as part of a 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 the 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.

Loss of Hands or Feet

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

Loss of Speech

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

Open Heart Surgery

The undergoing of open heart surgery, on the advice of a Consultant Cardiologist, to correct valvular and structural abnormalities.

Paralysis of Limbs

Total and irreversible loss of muscle function to the whole of any two limbs.

Permanent Total Disability (PTD)

PTD is defined as a permanent disability caused by any illness (not just a Critical Illness event) or any injury. PTD cover is automatically provided with the Extra Cover option and, subject to our agreement, you can choose under what circumstances you want claims to be paid.

Benefit will not be paid under PTD if the disability is directly or indirectly as a result of infection by any Acquired Immune Deficiency Syndrome (AIDS) or any Human Immunodeficiency Virus (HIV) or any similar or related condition or syndrome.

Any Occupation

Employees will be entitled to benefit under PTD if, as a result of illness or injury, they have been unable to perform any occupation for a continuous period of 6 months and will remain unable to do so for the remainder of their life.

- Activities of Daily Living Employees will be entitled to benefit under PTD if, as a result of illness or injury, they satisfy one of the following four Activities of Daily Living for a continuous period of 6 months and with the benefit of the medical technology available at the date of diagnosis will continue to do so for the remainder of their life:

- permanent confinement to a wheelchair
- permanent hospitalisation/residence in a nursing home on the advice of a medical practitioner
- severe intellectual impairment as a result of an organic disease or trauma as determined by standard tests resulting in the employee being unable to perform everyday activities, such as, recognising the transactional value of money, handling basic household finances, taking prescribed medication, being able to answer the telephone and reliably taking a message; or
- being permanently unable to fulfil 3 of the following activities unassisted by another person:
 - walk 100 metres
 - get into and out of a vehicle
 - put on and take off all necessary items of clothing
 - using normal cutlery, eating food that has already been prepared
 - wash themselves all over
 - climb stairs.

Current Occupation

Employees will be entitled to benefit under PTD if, as a result of illness or injury, they have been unable to perform the material and substantial duties of their own occupation for a continuous period of 6 months and with the benefit of the

medical technology available at the date of diagnosis will remain unable to do so for the remainder of their life. If this option is selected, your premium will increase according to the occupation in question. It is not available for all types of occupation.

For a member aged 60 or over the definition of PTD switches to Any Occupation as defined above.

Pulmonary Artery Surgery

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

Rheumatoid Arthritis

Widespread joint destruction with major clinical deformity of three or more of the following joint areas; hands, wrists, elbows, cervical spine, knees, ankles, metatarsophalangeal joints in the feet. The severity of the disease shall be such that the employee will have been unable to perform the material and substantial duties of their own occupation and any other to which suited by education, training or experience for a continuous period of 6 months.

Terminal Illness

Advanced or rapidly progressing incurable illness where, in the opinions of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months. We shall not consider a claim for this event submitted after the death of the member.

Third Degree Burns

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

Traumatic Head Injury

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

2.3 What is not covered?

If a member's benefit is at or within AEL, a pre-existing condition exclusion will apply to the whole benefit.

Where the pre-existing condition exclusion applies:

- A member who, prior to joining the scheme or to having any increase in benefit, has had a Critical Illness event will not be able to claim for any further incidence of that condition.
- A member who, prior to joining the scheme or to having any increase in benefit, has had a heart attack, coronary artery bypass surgery, a heart transplant or a stroke will not be able to claim for any of these Critical Illness events: Heart Attack, Coronary Artery Bypass Grafts, Major Organ Transplant and Stroke.
- A member who, prior to joining the scheme or to having any increase in benefit, has been diagnosed as having diabetes mellitus will not be able to claim for any of these Critical Illness events:

Base Cover

Heart Attack, Coronary Artery Bypass Grafts, Major Organ Transplant, Stroke and Kidney Failure.

Extra Cover (in addition to the base cover events)

Balloon Angioplasty, Blindness, Coma, Open Heart Surgery, Permanent Total Disability

- A member who, prior to joining the scheme or to having any increase in benefit has or has had a malignant tumour, will not be able to claim for Cancer whether or not it is connected or associated with the prior diagnosis.
- A member who has previously had a Critical Illness event or a related condition will not be able to claim for PTD or for Terminal Illness. (See Section E 2.4 'Definitions of related conditions for Base Cover and Extra Cover').
- Except for PTD, Paralysis of Limbs and Terminal Illness, where a member will never be able to claim if he was treated for or was aware of a related condition prior to inception of cover, we shall disregard related conditions (see Section E 2.4 'Definitions of related con-

ditions for Base Cover and Extra Cover') if the member does not have a Critical Illness event within 2 years from the date of inclusion in the policy. In the case of increases in benefits in line with earnings increases, the 2-year exclusion period for related conditions will not be imposed for the amount of the increase.

- Where we have agreed to switch cover from another insurer on no worse terms and where the date of joining the previous scheme is clearly recorded, we shall disregard related conditions for all Critical Illnesses except PTD and Paralysis of Limbs if the member does not have a Critical Illness event within 2 years from the date of inclusion in the previous insurer's policy. In the case of increases in benefits in line with earnings increases, the 2-year exclusion period for related conditions will not be imposed for the amount of the increase. A member will never be able to claim for PTD, Paralysis of Limbs and for Terminal Illness if he was treated for or was aware of a related condition before the date of inclusion in the previous insurer's policy. (See Section E 2.4 'Definitions of related conditions for Base Cover and Extra Cover'.)

2.4 Definitions of related conditions for Base Cover and Extra Cover

2.4.1 The defined related conditions for Base Cover are:

Alzheimer's Disease

Organic brain disease, circulatory brain disorder, disease of the central nervous system, Parkinson's Disease, epilepsy, depression, dementia, amnesic (memory) disorder, aphasia, psychosis.

Cancer

Polyposis coli, papilloma of the bladder, or any carcinoma-in-situ.

Creutzfeldt-Jakob Disease

Organic brain disease, circulatory brain disorder, disease of the central nervous system, Parkinson's

Disease, epilepsy, depression, dementia, amnesic (memory) disorder, aphasia, psychosis.

Heart Attack and Coronary Artery Bypass Grafts

- Any disease or disorder of the heart including obstructive or occlusive arterial disease
- • Diabetes mellitus (applicable indefinitely – see 2.3 What is not covered?)
- Blood pressure or cholesterol treated at any time (whether controlled or not) by prescribed medication
- Three blood pressure readings at least 7 days apart and exceeding by more than 10% the normal limit for the age of the member and according to health guidelines applicable at the time of recording.
- Two total cholesterol levels recorded at least 7 days apart and exceeding by more than 20% the normal limit for the age of the member according to health guidelines applicable at the time of recording.
- Height:weight ratio equivalent to a BMI of more than 40 recorded by a healthcare practitioner.

Hodgkin's Disease

There are no related conditions.

Kidney Failure

- Blood pressure treated at any time (whether controlled or not) by prescribed medication
- Three blood pressure readings at least 7 days apart and exceeding by more than 10% the normal limit for the age of the member and according to health guidelines applicable at the time of recording.
- Diabetes mellitus (applicable indefinitely – see 2.3 What is not covered?)
- Any chronic renal disease or disorder.

Major Organ Transplant

- Cardiomyopathy
- coronary artery disease
- cardiac failure
- chronic liver disease
- chronic pancreatitis

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- pulmonary hypertension
- chronic lung disease
- chronic kidney disease
- Diabetes mellitus (applicable indefinitely – see 2.3 What is not covered?)

Motor Neurone Disease

Progressive muscular atrophy, primary lateral sclerosis, progressive bulbar palsy.

Multiple Sclerosis

Any form of neuropathy, encephalopathy or myelopathy (disorders of function of the nerves) including but not restricted to the following:

- abnormal sensation (numbness) of the extremities, trunk or face
- weakness or clumsiness of a limb
- double vision
- partial blindness
- ocular palsy
- vertigo (dizziness)
- difficulty of bladder control
- optic neuritis
- spinal cord lesion
- abnormal MRI scan.

Parkinson's Disease

Treatment with psychotropic medication, tremor, extra pyramidal disease.

Pre-senile Dementia

Organic brain disease, circulatory brain disorder, disease of the central nervous system, Parkinson's Disease, epilepsy, depression, dementia, amnesic (memory) disorder, aphasia, psychosis.

Stroke

- Diabetes mellitus (applicable indefinitely – see 2.3 What is not covered?)
- Blood pressure or cholesterol treated at any time (whether controlled or not) by prescribed

medication

- Two blood pressure readings at least 7 days apart and exceeding by more than 10% the normal limit for the age of the member and according to health guidelines applicable at the time of recording.
- Two total cholesterol levels recorded at least 7 days apart and exceeding by more than 20% the normal limit for the age of the member according to health guidelines applicable at the time of recording.
- Height:weight ratio equivalent to a BMI of more than 40 recorded by a healthcare practitioner.
- Atrial fibrillation.
- Transient ischaemic attack.
- Intracranial aneurysm.
- Occlusive arterial disease.

2.4.2 The defined related conditions for Extra Cover are:

Aorta Graft Surgery, Balloon Angioplasty, Balloon Valvuloplasty, Heart Valve Replacement or Repair and Open Heart Surgery

- Any disease, or disorder of the heart
- Blood pressure treated at any time (whether controlled or not) by prescribed medication
- Three blood pressure readings at least 7 days apart and exceeding by more than 10% the normal limit for the age of the member and according to health guidelines applicable at the time of recording.
- any obstructive or occlusive arterial disease.

Benign Brain Tumour

Neurofibromatosis (Von Recklinghausen's Disease), haemangioma (Von Hippel-Lindau Disease).

Blindness

- Glaucoma
- Pituitary tumour
- Optic atrophy
- Papilloedema
- Retrobulbar neuritis
- Sarcoidosis

- Malignant exophthalmos
- Diabetes mellitus (applicable indefinitely – see 2.3 What is not covered?),
- Transient ischaemic attack
- Stroke
- Multiple sclerosis
- Uveitis.

Coma

Self-inflicted injury or misuse of drugs or alcohol.

Chronic Lung Disease, including Emphysema

Chronic obstructive airways disease.

Deafness

Acoustic nerve tumour, neurofibromatosis (Von Recklinghausen's Disease).

HIV Infection/AIDS (contracted in the course of duty or contracted due to a blood transfusion or other specified transfusion therapies)

No benefit will be payable under the AIDS Critical Illness event conditions in respect of an employee who, at any time prior to the date of entry into the policy, has been infected with any Human Immunodeficiency Virus (HIV) or has demonstrated any antibodies to such virus.

Loss of Hands or Feet

- Peripheral vascular disease
- Bone Cancer
- Soft tissue cancer.

Loss of Speech

Stroke, transient ischaemic attack, motor neurone disease, brain or throat tumour, laryngeal polyps.

Paralysis of Limbs

Multiple sclerosis, muscular dystrophy, motor neurone disease, or any disease or disorder of the brain, spinal cord or column.

Permanent Total Disability (PTD)

The following related conditions for PTD remain applicable indefinitely (see 2.3 What is not covered?);

- Multiple Sclerosis
- Muscular dystrophy
- Motor Neurone Disease
- Any disease or disorder of the brain, spinal cord or column
- Chronic or recurrent mental illness
- Fatigue
- Back, neck, joint or muscle pain
- Arthritis.

Pulmonary Artery Surgery

Pulmonary valve stenosis, Fallot's tetralogy, patent ductus arteriosus.

Rheumatoid Arthritis

Inflammatory polyarthropathy.

Terminal Illness

All Critical Illness events.

Third Degree Burns

There are no related conditions.

Traumatic Head injury

There are no related conditions.

3. Setting up the policy

3.1 Process for setting up the policy

We prepare a quotation based upon the risk specification supplied by your intermediary together with the membership data, claims history over the last 5 years if previously insured, the occupation and location profile of the members to be covered and details of any members who have had benefits declined or have had adverse underwriting decisions. We require the membership data to be as up-to-date as

possible and to show details that relate to a date within the last 12 months of the quotation request date.

Your intermediary must contact us in writing to advise us that you wish us to commence risk for your policy with effect from a specified date in line with our quotation. We will accept risk immediately after midnight, for example, for a 1st January commencement date we will assume risk at 00.01 a.m. of 1st January, subject to satisfactory answers to any specific caveats shown in our quotation.

Once you have accepted our quotation, you will need to provide the following to enable us to set up your policy:

- a fully completed QAAF, signed by the Policyholder
- membership data at the commencement date
- details of any employees with benefits in excess of the AEL
- Deposit premium or Direct Debit mandate.

Where the basis of risk differs from our quotation, we will advise you of any additional requirements and the revised premium.

We will not agree to backdate acceptance of risk.

3.2 Evidence of health to be provided

An AEL is normally offered below which no evidence of health is required for eligible members to be covered. The AEL is reviewed from time to time. Benefit up to the AEL is subject to a pre-existing condition exclusion (see Section E 2.3 'What is not covered?').

If members are provided with cover that is greater than the AEL, the benefit will be subject to medical underwriting. Each member with cover over the AEL will be required to complete a Scheme Member's Application form. A report from a member's General Practitioner and/or a medical examination may also be required.

Where a member's benefit is subject to medical underwriting, one of the following will happen:

- The member completes an application form and we accept the risk without restriction, either at standard rates or with a premium loading. Any

premium loading applies to the whole benefit amount but the policy-level pre-existing conditions and related conditions exclusions do not apply. Benefit increases are allowable on the same terms without further medical underwriting as long as they are in line with policy rules and the amount of any increase remains within our forward underwriting bar. Where a member's benefit again becomes subject to medical underwriting, our new underwriting terms only apply to the excess of the on-risk benefit level.

- The member completes an application form and we accept the risk, either at standard rates or with a premium loading, but we exclude a specific Critical Illness event, medical condition or hazardous activity from the cover. This member-specific exclusion and any premium loading apply to the whole benefit but the policy-level pre-existing conditions and related conditions exclusions do not apply. Benefit increases are allowable on the same terms without further medical underwriting as long as they are in line with policy rules and the amount of any increase remains within our forward underwriting bar. Where a member's benefit again becomes subject to medical underwriting, our new underwriting terms only apply to the excess of the on-risk benefit level.
- The member does not complete an application form or the member completes a form but we view the risk as uninsurable. We allow benefit to be insured equal to the AEL and the general pre-existing conditions and related conditions exclusions apply. If the AEL later increases, benefit may increase up to the lesser of the member's new benefit entitlement and the new AEL but conditions existing before the benefit increased will be excluded in respect of claims for this part of the benefit only.

If the AEL increases to an amount exceeding the current benefit level of a member who has previously been medically underwritten and accepted, one of the following will happen the next time his benefit increases:

- The policyholder will have confirmed in writing that all members whose benefits exceeded the

previous AEL should preserve their existing medical underwriting terms, including forward underwriting bars, so the process outlined above for benefit subject to medical underwriting will apply.

- The policyholder will not have given us specific instructions, so the process outlined above for benefit subject to medical underwriting will apply.
- The policyholder will have confirmed in writing that all members whose benefits exceeded the previous AEL should preserve their existing medical underwriting terms, but all new benefit should be allowed without medical underwriting. Benefit may then increase up to the lesser of the member's new benefit entitlement and the new AEL but conditions existing before the benefit increased will be excluded in respect of claims for this part of the benefit only.

3.3 What happens if a claim arises before we have agreed full cover?

A member whose benefit entitlement does not exceed the AEL is covered in full on joining the scheme.

If a member whose benefit entitlement exceeds the AEL becomes a claimant before we have agreed full cover, benefit is restricted to:

In the case of new business

The AEL, or, if the cover was previously insured, any different amount that the member was covered for and which we have agreed to accept on no worse terms without additional medical underwriting.

In the case of renewal business

The amount on risk with us immediately prior to the effective date of the increase being underwritten.

3.3.1 Temporary cover

Where medical underwriting is required, we shall cover the full amount of benefit being underwritten for up to 2 months from

- either the date the member joins the policy with benefits above the AEL, or
- the effective date of an increase in benefit above the AEL.

Most medical underwriting decisions will be made

before the end of this temporary cover period, in which case temporary cover ceases on notification of our acceptance terms.

3.3.2 Exclusions from temporary cover

The pre-existing conditions exclusion will apply to the full amount of benefit being underwritten in the event of a claim during the temporary cover period.

Benefits will not be paid under temporary cover arrangements for conditions resulting from hazardous pursuits, attempted suicide or self-inflicted injury.

If you selected PTD Any Occupation or PTD Current Occupation (see section E 2.2 Defined conditions – Extra Cover), neither will apply in the event of a claim during the temporary cover period. If a member becomes disabled because of an illness commencing or an injury sustained during the temporary cover period, a claim for PTD will be payable if the member satisfies the Activities of Daily Living conditions in section E 2.2 Defined conditions – Extra Cover.

4. What premiums will be charged for the cover?

4.1 How will premiums be calculated?

4.1.1 What factors determine the rate used to calculate premiums?

The premium calculated depends on factors which include the nature and amount of the benefits to be provided and details of the employees to be insured. The information used to calculate premiums includes, but is not limited to:

- level of benefits
- whether Base or Extra Cover is chosen
- the type of PTD cover chosen under Extra Cover
- whether spouse's cover is chosen
- eligibility and entry conditions
- age and gender of the eligible employees
- age at which cover ceases
- occupation, industry and locations of eligible employees
- claims history over the last 5 years if the cover has been insured previously

- an eligible employee's annual business mileage, if in excess of 20,000 miles per annum
- our then current minimum annual premium.

4.1.2 Single Premium policies (policies insuring between 5 and 19 members):

To obtain the cost at the beginning of the policy accounting period, we calculate the individual premium applicable to each member's cover using current age-related premium rates and then add up all the individual premiums. This method is known as Single Premium Costing and means that the annual cost will be affected by any changes in the amount of benefit insured and the age profile of the members.

The underlying rate table is guaranteed for up to 2 years and is subject to review thereafter. A new rate table may apply at the end of this period.

If the number of lives insured under an existing policy increases to 20 or more, we reserve the right to calculate the cost on the Unit Rated basis outlined below from the following policy accounting date.

4.1.3 Unit Rated/Simplified Administration policies (policies insuring 20 or more members)

The policy accounting is based on the Unit Rate method using Simplified Administration. This means that an annual rate of premium applicable to all members (referred to as the Unit Rate or Flat Rate) is calculated at the policy review date.

The first year premium at the commencement date of the policy with Unum is a provisional premium based on the total sum assured at the commencement date multiplied by the Unit Rate (which is expressed as per thousand pounds of sum assured).

Consequently, details of individual employees who join or leave mid-year are not required. The only information required at a mid-rate guarantee is the total number of members and total benefit roll at that date. Individual details are only required for a member whose benefit exceeds the AEL or who are joining outside the normal eligibility conditions of the policy.

Unit Rates are usually guaranteed for up to 2 years and are subject to review thereafter. A new rate may apply at the end of these periods.

If the number of lives insured under an existing policy falls below 20, we reserve the right to calculate the premium on the Single Premium basis outlined above from the following policy accounting date.

4.2 Will there be any unexpected extra premiums?

You may be asked to pay additional premiums if:

- you have employees who have been subject to medical evidence because their cover exceeds the AEL, or
- you have employees who are joining outside the normal eligibility conditions, such as early or late entrants.

These additional premiums may be due to a particular medical condition or hazardous pursuits the employee may undertake. If applicable, these additional premiums will become payable from the date the medical underwriting decision is made and acceptance terms are issued.

4.3. Is there a discount for good claims experience?

Past claims experience is a factor in assessing the premium applicable to an existing policy and therefore, for a large policy, a good claims history will usually be reflected in the premiums charged.

4.4 What commission is allowed for in the premium?

Any commission paid to your intermediary is a percentage of the gross premiums paid; the premium shown in our quotation includes the level of commission payable.

5. How does the policy accounting work?

The policy usually operates on a 1 year policy accounting period.

Premiums are normally paid annually or monthly by Direct Debit.

Our quotation states an estimated first year cost assuming an annual premium is paid and that all members can be accepted for their full benefit entitlement at ordinary rates. The annual premium shown in our quotation excludes any additional premiums as a result of medical loadings for members whose cover is subject to special terms due to adverse medical underwriting and non-medical loadings for members with hazardous pursuits.

Our quotation also states the expected first monthly premium assuming payment is monthly by Direct Debit, and that all members can be accepted for their full benefit entitlement at ordinary rates.

There is a standard adjustment of 3% for all non-annual payments. Our preferred payment method is by Direct Debit.

Adjustments for all non-annual payments:		
Frequency	Payment by Direct Debit	Payment by Standing Order
Monthly	3%	3%
Quarterly	3%	3%
Half-Yearly	3%	3%

5.1 What information is required for policy accounting purposes?

5.1.1 Single Premium Costed policies (between 5 and 19 members):

At the commencement date and at each policy accounting date, a list of all members will be required showing:

- name, date of birth, gender, salary, sum assured, spouse's benefit (if applicable), date of joining and date of leaving (if applicable).

5.1.2 Unit Rated policies (20 or more members):

This type of policy has been designed so that it is simple for you to manage.

At each policy accounting date (other than a policy review date), we require the following:

- total number of members
- total salaries

- total sums assured
- total sums assured for spouse's benefits (if applicable).

We will need individual information for any employees whose benefit exceeds the AEL or who are joining outside the normal eligibility conditions.

More detailed information will be needed at a policy review date.

5.2 How are accounts adjusted for members who join, leave or have benefit increases during the year?

If a member's earnings increase, this will normally be reflected in the benefit, provided it remains below the AEL.

Where requested, increases in benefit arising from salary increases during the policy accounting period can be covered automatically but if benefit exceeds the AEL, satisfactory evidence of health will be required before Unum can consider the increase.

Details of new entrants will be required at the time of joining if their benefit exceeds the AEL or if they are not joining within the normal eligibility conditions of the policy.

5.2.1 Single Premium Costed policies

A premium adjustment will be calculated reflecting the level and duration of cover we provided during the policy accounting period. Any premium adjustment for members who join or leave or whose benefit increases is applied at the beginning of the next policy accounting period.

5.2.2 Unit Rated policies

A premium adjustment will be calculated at the end of the current policy accounting period based on the average total benefit roll for all members covered by the policy during this period. Effectively this means salary changes and changes in membership are treated as if they occurred half way through this period. Any premium adjustment for members who leave, join or whose benefit increases is applied at the next policy accounting period.

6. Claiming benefits

This section deals with common questions that arise when a member suffers from one of the insured Critical Illness events.

For a claim to be valid, the following criteria must be met:

- the Critical Illness event, which occurs or is diagnosed, must be in the list of Critical Illnesses covered by your policy.
- the employee or spouse or child (if applicable) must survive for 14 days after the date that a Critical Illness event is diagnosed, or the listed surgical procedure is undergone, or 6 months for PTD benefit provided under Extra Cover.

Notification of Claim

Please notify us of a claim under this policy as promptly as possible after the event or diagnosis, ideally within 21 days, by telephoning our Customer Care department on telephone number **01306 873243**.

We will issue you with the appropriate claim forms.

We will not consider a claim notified to us more than 90 days after the event of diagnosis.

6.1 How are claims made?

The evidence we require includes the following:

- evidence of inclusion in the policy and earnings
- a claim form completed by the policyholder
- a claim form completed by the claimant which includes the claimant's consent under the Access to Medical Reports Act granting us the authority to obtain further information from the claimant's doctors
- claimant's original birth certificate
- confirmation of claimant's survival for 14 days from the date of diagnosis or surgery (6 months for PTD)
- if cover is provided for a spouse and/or children, the spouse and/or children's original birth certificates and an original marriage certificate for the spouse.

6.2 Claims processing

Upon receipt of all the necessary documentation, we will process the claim.

We will review the medical evidence to ensure the diagnosis satisfies the policy conditions. The benefit will be paid if the claimant survives the event by 14 days (6 months for PTD).

Claims are paid by cheque direct to the claimant tax free.

6.3 Can a further claim be made if the member suffers from a recurrence of the same event?

Once a claim has been admitted for a specific Critical Illness event, no further claims can be made in respect of that event. Cover will automatically continue and the pre-existing condition exclusion will apply as if they have just joined the scheme.

6.4 How to complain about a claim decision

In the event of the claim decision not being to the policyholder's satisfaction, the policyholder may refer the matter to the Customer Feedback Department. This is a separate Department, independent of the Claims Department that will review the claim decision afresh and in line with Unum's complaint handling process. The Customer Feedback Department will issue Unum's final decision on the claim. If the policyholder remains dissatisfied The Financial Ombudsman Service provides an independent dispute resolution service for eligible complainants. Where you remain dissatisfied with the outcome of your complaint, you can contact the Financial Ombudsman Service at the address below within 6 months of Unum's final decision being made. Your legal rights and those of the member are not affected if this organisation is contacted

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London
E14 9SR

Tel: 0845 080 1800

7. Can cover be provided for an employee who is not in the UK?

We are prepared to cover members travelling or working overseas or seconded to other organisations, provided that:

- they meet the eligibility conditions of cover for the policy, and
- they have a contract of employment with a UK registered company (which is covered by the policy), and
- if seconded, then the period overseas must not exceed 3 years or 10 years if seconded to another company within the same group of companies as their UK employer; we may be prepared to extend the cover period on a case by case basis, and
- all premiums must be paid in sterling by the Policyholder.

Cover is subject to full details being provided of where each overseas employee will be working and for how long. We will then assess individual cases.

The nationality and countries worked in need to be declared for each employee at policy commencement and review. This affects the premium rate quoted.

Benefit will be paid to eligible employees, provided that we can obtain satisfactory medical evidence in English.

If we require a claimant located overseas to undergo a medical examination, we will contribute an amount towards the cost of the examination in the foreign country, normally the equivalent cost of a similar examination in the UK.

8. Taxation

Employer

Premiums paid by the Policyholder (i.e. the employer) to insure employees against Group Critical Illness events are a trading expense and can be offset against Corporation Tax. The employer is liable for Class 1A National Insurance Contributions on the premiums.

Employee

The employee is taxed on the amount of the premium paid on their behalf by their employer as a benefit in kind. Benefits are paid to the member tax free.

This information is based on our understanding of current tax legislation. Employers should refer to their professional advisers for advice on the tax implications for themselves and their employees.

Currently the taxation under Equity Partners CI policies is as follows:

Benefit

The benefit is tax free and is paid gross directly to the Equity Partner who has a valid claim.

Premiums

Each Equity Partner (not taxed under PAYE) pays for their own cover. There is no tax relief on the premium paid.

This information is based on our understanding of current tax legislation. However, the Partners should refer to their local HMRC office for clarification on the tax position or speak to their professional advisors for advice on the tax implications.

9. Continuation Option

This option is not available under our policy.

10. Third Party Rights

Third Party Rights under the Contracts (Rights of Third Parties) Act 1999 do not apply.

11. Surrender value

The policy does not acquire a surrender value.

12. Complaints handling

We want you to be entirely satisfied with your Group Critical Illness policy. If you do have a query or complaint, please contact the intermediary who arranged the policy for you. If you have not appointed an intermediary, please contact Unum directly.

If this does not resolve the matter then please write to:

Head of Customer Feedback

Unum

Milton Court

Dorking

Surrey

RH4 3LZ

Tel: 01306 887766

If the matter remains unresolved, you may be eligible to contact the Financial Ombudsman Service at the address below. Your legal rights are not affected if you contact this organisation.

The Financial Ombudsman Service

South Quay Plaza

183 Marsh Wall

London

E14 9SR

Tel: 0845 080 1800

13. Compensation

If we cannot meet our liabilities you may be entitled to compensation under the UK Financial Services and Markets' Act 2000. Information about this is available on request from us.

14. Further Information

About Unum

Unum is one of the UK's leading Group Risk providers, with almost four decades of experience.

For employers, our Group Income Protection policies help keep their people, and their businesses, working when illness or injury strike. We provide insurance cover for employees' salaries during long-term absence and offer crucial rehabilitation support, safeguarding a business's most valuable resources by helping employees return to work.

Our critical illness and life insurance products enable our Group Risk customers to purchase complementary protection solutions that together make up a comprehensive protection package for today's workforce.

In 2008 Unum was voted 'Best Group Income Protection Provider' by intermediaries for an unprecedented eleventh year running at the Health Insurance Awards.

At the end of 2008, Unum protected almost 1.6 million lives through more than 15,200 schemes. During 2008 we paid total benefit claims of £263 million – of which more than £201 million related to income protection claims.

Our US parent company, Unum Group, traces its history back to 1848 and is one of the leading providers of employee benefits products and services, and the largest provider of group and individual disability income protection insurance in the United States. Premium income for Unum Group and its subsidiaries totalled \$7.8 billion in the year ended 31 December 2008, with reported revenues for the group totalling \$10.0 billion. Total assets were \$49.4 billion at 31 December 2008.

For more information please visit

www.unum.co.uk

unum.co.uk

Unum Limited is authorised and regulated by the Financial Services Authority.
Registered in England 983768.

We monitor telephone conversations and e-mail communications from time to time for the purposes of training and in the interests of continually improving the quality of service we provide.

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