

Budget Income Protection Reviewable Premiums

Policy Conditions

These policy Conditions tell you how our Budget Income Protection policy works in more detail. Together with your application, any declarations you've made, your Policy Schedule and any documents we send you confirming changes to your policy and the amount of cover – they form the terms and conditions of your insurance (the contract between you and LV=). Please take the time to read them carefully and keep them in a safe place.

LV= Budget income Protection is provided by Liverpool Victoria Friendly Society, which is part of LV=.

Find out how we use your personal information, and what rights you have by visiting LV.com/dataprotection. Please let us know if you'd like us to send you a copy, or have any questions. This includes who we are, how long we hold your information, what we do with it and who we share it with.

You'll see some of the words in this document are in bold text. This is because they may have different meanings in everyday use, we've explained them in more detail in the definitions section on page 31.

Contents

Why choose LV= Budget income Protection	2	Section C – The claim limit	15
Section A – What you're covered for	2	C1 – What happens when you reach your claim limit?	15
A1 – Own occupation cover	2	C2 – What happens if you need to make a claim in the future, but we've paid your previous claim up to the limit?	15
A2 – Homemaker cover	4	Section D – Other conditions	15
Section B – claims and payments	6	D1 – Inflation-linked cover	15
B1 – When you need to tell us about your accident or sickness	6	D2 – Guaranteed Increase Options	16
B2 – What we need from you to assess your claim	6	D3 – Changing your policy	17
B3 – How we pay you	7	D4 – What happens if I'm not working before I claim?	17
B4 – How much do we pay out?	7	D5 – Paying your premiums	18
B5 – How we work out the maximum amount we can pay you	8	D6 – Stopping your premiums	18
B6 – Claim payments from this policy and state benefits	8	D7 – Restarting your premiums	18
B7 – £1500 Benefit Guarantee	9	D8 – When we can change your premium (reviewable premiums)	18
B8 – Helping you get back to a healthier you	9	D9 – Proof of age and name	19
B9 – What happens if you go back to work part-time in your normal occupation?	10	D10 – When you can cancel your policy	19
B10 – What happens if you recover but not enough to go back to your occupation?	10	D11 – When we can cancel your policy	19
B11 – What happens if you become ill again (sometimes called linked claims)?	11	D12 – Financial crime and terrorist financing	20
B12 – What happens if you're insuring someone else?	11	D13 – When your policy ends	20
B13 – Fracture cover	12	D14 – Transferring the policy to someone else	20
B14 – Death benefit	13	D15 – The law that applies to your policy	20
B15 – Payment of premiums during unemployment (payment holiday)	13	D16 – How to make a complaint	20
B16 – Parent and child cover	14	Appendix A – Special conditions for doctors and surgeons	21
		Appendix B – NHS dentists, doctors and surgeons sick pay guarantee	22
		Appendix C – Teachers sick pay guarantee	23
		Appendix D – Parent and child cover	25
		Definitions	31



Why choose LV= Budget Income Protection

Budget Income Protection is designed to pay you a monthly income for a maximum of 24 months if you fall ill or have an accident that leaves you **unable to work**.

You can apply for Budget income Protection if you're:

- Permanently living in the UK
- A UK resident for at least the last 2 years
- Aged between 17 and 59
- Registered with a UK doctor for at least 2 years

When you apply for Budget Income Protection we'll let you know the type of cover we can offer you, based on your job.

We are unable to offer you cover if you're claiming Jobseekers Allowance.

We offer two types of cover under our Budget Income Protection plan - own occupation and homemaker cover.

- **Own occupation cover** - This pays out if, because of an accident or sickness, you are unable to do your usual **occupation**. This is explained in more detail in section A1.
- **Homemaker cover** - This pays out if, because of an accident or sickness, you are unable to prepare a meal or do basic housework. This is explained in more detail in section A2.

Section A – What you're covered for

There are two ways we can measure whether you're **Unable to work**; we call these own occupation and homemaker cover.

We tell you which cover we can offer before your **policy** starts. Once your **policy** has started this information will be on your Policy Schedule. If you haven't applied yet you may have this information on your quote. Make sure you check your cover when your acceptance terms are sent to you, in case it has changed from your quote.

You only need to read the section that applies to the type of cover shown on your Policy Schedule. So, if your Policy Schedule shows that you have own occupation cover, you only need to read section A1 and if it shows you have homemaker cover, read section A2.

A1 - Own occupation cover

What you're covered for

- ✓ **Unable to work due to sickness or accident**
In this section, the words '**Unable to work**' and '**inability to work**' mean that we will pay a claim if, following your **waiting period** because of sickness or accident, you're unable to carry out the main tasks of your **occupation** and aren't doing any other paid or unpaid work.

By main tasks we mean the things which can't reasonably be left out of your role, or changed by you or your employer.

We'll also use this measure to determine whether you're **unable to work** if you claim within the first 12 months from:

- Becoming unemployed
- Becoming a **homemaker**
- Taking a career break

If you have been out of work for longer than 12 months when you claim we'll use the measures under homemaker cover (which is explained in section A2) to work out whether to pay your claim.

- ✓ **You recover but you're not able to fully return to work.**
If we have been paying a claim on your **policy** and you have recovered, but not enough to fully return to your **occupation**, or you have to go back to a different type of job because you aren't fully recovered, we may be able to still pay you a proportion of your **amount of cover**. We explain this in more detail in sections B8, B9 and B10.
- ✓ **All types of sickness or accident**
We don't have any restrictions on the type of sickness or accident that leaves you **unable to work**, unless we have told you about any before your **policy** starts. We will list any exclusions on your Policy Schedule under the heading 'Special Provisions'.
- ✓ **Sickness or medical conditions that you had before you applied**
As we ask you for all your medical history before we offer you a **policy** we'll cover all illnesses unless we've told you that we won't, before your **policy** starts. If there are any exclusions then we'll list them under the heading Special Provisions on your Policy Schedule.
We will tell you about any exclusions before we ask you for the first **premium**.
- ✓ **Changing your occupation**
You don't need to tell us if you change your occupation as it won't affect your **policy** and you'll still be covered. However you might find that by telling us it could reduce how much you pay for your **amount of cover**. More information on how you can change your **policy**, if you change your occupation, can be found in section D3.

✓ Travelling Abroad

We'll pay you after your **waiting period**, if you have a valid claim and you're in any of the following countries:

Australia, Austria, Belgium, Bulgaria, Canada, Channel Islands, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, UK or USA.

If you're anywhere else in the world we would only pay you for a maximum of 26 weeks.

If, at the end of the 26 weeks, you have returned to one of the countries above we'll continue to pay you if you still have a valid claim. Please note we will stop paying a claim if you travel from one of the countries listed above to stay in one that is not listed for more than two weeks, even if this is just for a holiday.

✓ Fracture cover

We'll pay a lump sum if you're diagnosed with a specified bone fracture. This is in addition to any payments we're paying you if you're **unable to work**. The amount we'll pay depends on the type of fracture you suffer and you can claim for fracture cover even if the fracture doesn't stop you from working. We'll only pay for one fracture diagnosed within a 12 month period. If you suffer more than one fracture at the same time, we'll only pay for the fracture with the highest amount of fracture cover. More details about fracture cover can be found in section B13.

✓ Death

If you die before the **end date** of your **policy** we'll pay a fixed lump sum of money up to a maximum of £10,000. The amount we'll pay depends on when your **policy** started and depending on how your **policy** is set up, may form part of your estate for tax purposes. This means the money may be subject to inheritance tax under current legislation, depending on your personal circumstances. If you are not the policy owner, we'll pay this money to the policy owner instead. More details about death benefit can be found in section B14.

✓ Payment of premiums during unemployment

If you become unemployed through no fault of your own (we call this involuntary unemployment), you can claim for up to six months **premiums** to be paid by us. This means we'll take care of those **premiums** for you, you don't need to pay them and your insurance will stay in place. You can only claim for a maximum of six months **premiums** to be paid by us during the whole period that your **policy** lasts for. There is an initial exclusion period for this benefit of 90 days, which means if you become unemployed within the first 90 days of your **policy** starting you cannot claim for any of your **premiums** that relate to that whole period of unemployment to be paid by us. More details about payment of premiums during unemployment (payment holiday) can be found in section B15.

✓ Parent and child cover

We'll pay a lump sum equal to 6 times your **amount of cover** to you if your **child** is diagnosed with a specified illness. This is in addition to any payments we're paying you if you're **unable to work**. A full list of illnesses covered can be found in appendix D. We'll only make one payment per **child**, per **policy** up to a maximum £25,000. If you have more than one income protection **policy** with us we'll still only pay up to £25,000 in total. More details about parent and **child** cover can be found in section B16.

What you're not covered for

✗ Unemployment

This **policy** will only pay out if you're unable to do your **occupation** (paid or unpaid), because of sickness or accident. This means we won't pay a claim if you're not working for a different reason, for example if you have chosen not to work or you have become unemployed. This would also apply if you're employed by your own limited company but have no actual contracts or work.

If you are unemployed at the time you have an accident or sickness, that prevents you from taking paid or unpaid work, you're still covered. We have explained this under the 'What you're covered for' section.

If you've been made involuntarily unemployed you may be able to claim for up to six months **premiums** to be paid by us, see section B15 for more details.

✗ Sickness or accident and still working

You cannot generally claim under this **policy** if you're sick or have had an accident and are still able to work in your **occupation** or are doing other paid work. The only exceptions are when you recover, but we're already paying a valid claim. We explain this in more detail in sections B8, B9 and B10. If you have more than one job it's worth checking that you're covered for both, otherwise you may find you won't be covered if you're able to do one job, but not the other. The only exceptions are if you're claiming for fracture cover or parent and child cover and you're still **able to work**. In this situation being **able to work** will not affect your claim. For more information on fracture cover see section B13 and parent and child cover B16.

✗ If we have already made payments to you up to the Claim limit

We'll stop paying your claim, once we've paid you up to the **claim limit**. This is explained in more detail in section C.

✗ Getting home if you have an accident or fall ill abroad

This **policy** does not cover you for the costs of returning home if you are abroad, for example if you need special medical assistance or special seating arrangements on a plane.

✗ Financial crime and deliberate misrepresentation

If we find someone has deliberately withheld information from us or has intentionally provided us with false information, when they applied, when they claimed, or if they applied to restart their **policy** after missing **premiums** we will cancel the policy, and not pay a claim. We explain this in more detail in sections D11 & D12.

A2 - Homemaker cover

What you're covered for

✓ Unable to work due to sickness or accident

In this section, the words '**Unable to work**' and '**inability to work**' mean that we will pay a claim if, following your **waiting period**, because of sickness or accident, you're unable to prepare a meal or do basic housework and aren't doing any other paid or unpaid work.

✓ All types of sickness or accident

We don't have any restrictions on the type of sickness or accident that leaves you **unable to work**, unless we have told you about any before your **policy** starts. We will list any exclusions on your Policy Schedule under the heading 'Special Provisions'.

✓ Sickness or medical conditions you had before you applied

As we ask you for all your medical history before we offer you a **policy** we'll cover all illnesses unless we've told you that we won't, before your **policy** starts. If there are any exclusions then we'll list them under the heading Special Provisions on your Policy Schedule.

We will tell you about any exclusions before we ask you for the first **premium**.

✓ Changing your occupation

You don't need to tell us if you change your occupation as it won't affect your **policy** and you'll still be covered. However you might find that by telling us, we may be able to switch you over to own occupation cover. More information on how you can change your **policy**, if you change your occupation, can be found in section D3.

✓ Travelling abroad

We'll pay you after your **waiting period**, if you have a valid claim and you're in any of the following countries:

Australia, Austria, Belgium, Bulgaria, Canada, Channel Islands, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, UK or USA.

If you're anywhere else in the world we would only pay you for a maximum of 26 weeks.

If, at the end of the 26 weeks, you have returned to one of the countries listed in this section we'll continue to pay you if you still have a valid claim.

Please note we will stop paying a claim if you travel from one of the countries listed in this section to stay in one that is not listed for more than two weeks, even if this is just for a holiday.

✓ Fracture cover

We'll pay a lump sum if you're diagnosed with a specified bone fracture. This is in addition to any payments we're paying you if you're **unable to work**. The amount we'll pay depends on the type of fracture you suffer and you can claim for fracture cover even if the fracture doesn't stop you from working. We'll only pay for one fracture diagnosed within a 12 month period. If you suffer more than one fracture at the same time, we'll only pay for the fracture with the highest amount of fracture cover. More details about fracture cover can be found in section B13.

✓ Death

If you die before the **end date** of your **policy** we'll pay a fixed lump sum of money up to a maximum of £10,000. The amount we'll pay depends on when your **policy** started and depending on how your **policy** is set up, may form part of your estate for tax purposes. This means the money may be subject to inheritance tax under current legislation, depending on your personal circumstances. If you are not the policy owner, we'll pay this money to the policy owner instead. More details about death benefit can be found in section B14.

✓ Payment of premiums during unemployment

If you become unemployed through no fault of your own (we call this involuntary unemployment), you can claim for up to six months **premiums** to be paid by us. This means we'll take care of those **premiums** for you, you don't need to pay them and your insurance will stay in place. You can only claim for a maximum of six months **premiums** to be paid by us during the whole period that your **policy** lasts for. There is an initial exclusion period for this benefit of 90 days, which means if you become unemployed within the first 90 days of your **policy** starting you cannot claim for any of your **premiums** that relate to that whole period of unemployment to be paid by us. More details about payment of premiums during unemployment (payment holiday) can be found in section B15.

✓ Parent and child cover

We'll pay a lump sum equal to 6 times your **amount of cover** to you if your **child** is diagnosed with a specified illness. This is in addition to any payments we're paying you if you're **unable to work**. A full list of illnesses covered can be found in appendix D. We'll only make one payment per **child**, per **policy** up to a maximum £25,000. If you have more than one income protection **policy** with us we'll still only pay up to £25,000 in total. More details about parent and child cover can be found in section B16.

What you're not covered for

✘ Unemployment

This **policy** will only pay out if you're unable to prepare a meal or do basic housework, because of sickness or accident. This means we won't pay a claim if you're not working for a different reason, for example if you have chosen not to work or you have become unemployed.

✘ Sickness or accident and still working

You cannot claim under this **policy** if you are sick or have had an accident and are still able to prepare a meal or do basic housework or are doing other paid or unpaid work.

The only exceptions are if you're claiming for fracture cover or parent and child cover and you're still **able to work**. In this situation being **able to work** will not affect your claim. For more information on fracture cover see section B13 and parent and child cover B16.

✘ If we have already made payments to you up to the claim limit

We will stop paying your claim, once we have paid you up to the **claim limit**. This is explained in more detail in section C. Also if you're a **homemaker** and we've paid a single claim up to the **claim limit** then your **policy** will automatically end. We explain this in more detail in section D11.

✘ You recover and go back to work

If you recover and are then able to prepare a meal or do basic housework, or go back to a different **occupation**, then your claim will stop.

✘ Getting home if you have an accident or fall ill abroad

This **policy** does not cover you for the costs of returning home if you are abroad, for example if you need special medical assistance or special seating arrangements on a plane.

✘ Financial crime and deliberate misrepresentation

If we find someone has deliberately withheld information from us or has intentionally provided us with false information, when they applied, when they claimed, or if they applied to restart their **policy** after missing **premiums** we will cancel the **policy**, and not pay a claim. We explain this in more detail in sections D11 & D12.

Section B - Claims and payments

In this section we explain when we will pay your amount of cover and how much we will pay you.

B1 - When you need to tell us about your accident or sickness

It's important to tell us as soon as you can if you're **unable to work** due to accident or sickness. If you don't tell us within the times below this may affect when we can start paying you. You can let us know by email, over the phone or by post.

- **If you're in paid or unpaid work and your waiting period is two months or less** - You need to let us know within two weeks after your accident or illness. If we don't hear from you within these two weeks we will still pay your claim, but we will treat your **waiting period** as only starting two weeks before you let us know about your accident or illness, rather than when you became **unable to work**.
- **If you're in paid or unpaid work and your waiting period is three months or more** - You need to let us know within eight weeks after your accident or illness. If we don't hear from you within these eight weeks we will still pay your claim, but we will treat your **waiting period** as only starting eight weeks before you let us know about your accident or illness, rather than when you became **unable to work**.
- **If you are not in paid or unpaid work when you make a claim** - Your **waiting period** starts from the date your accident or sickness meant you were unable to do your last **occupation** or were unable to either prepare a meal or do basic housework. We explain in more detail what happens if you're not working when you make a claim in section D4.

Once you've contacted us we'll need to take some details from you, check your name, age and also check that you were a UK resident and had been registered with a UK doctor (general practitioner) for at least 2 years at the time you applied for the **policy**. We'll explain how we can help you with your claim and we'll try and make life as easy as possible for you and help you through the process.

B2 - What we need from you to assess your claim

To start assessing your claim, we'll need you to:

- Request a claim form from us, either by phone, email or post.
- Complete the claim form, telling us about your accident or illness, your **occupation** and your **Income**.
- Send it back to us as soon as possible and ideally within 14 days.

We will need evidence of your **income**, and we may need to get medical reports from your doctor. If we do, we will send you a consent form to fill in, which fully explains your rights under the Access to Medical Reports Act 1988.

All claims are different, so we won't know what information we'll need from you until you make a claim. If we do need anything extra, we'll let you know and will explain the reasons why.

Whilst we're paying your claim, we'll need to carry out regular reviews of your situation and as part of this we may ask you to complete extra declarations about you being **unable to work**. We may also need routine medical reports from your doctor, as well as information from other medical or health specialists, and also your employer. We will tell you what we need and supply the forms for you and your doctor(s) to fill in. If your doctor charges for routine medical reports, you'll have to pay for them, as we do not cover this cost. However, we will pay for all other non-routine medical reports or any other evidence we ask for.

We may also ask you to be examined by a doctor we have chosen.

The types of evidence we'll ask for, to confirm that you're still **unable to work**, usually consist of:

- A doctor's report (or any alternative medical practitioner) who has treated or examined you.
- A report from a member of our staff or a person acting on our behalf who has visited you in your own home to discuss the claim.

This information is really important to ensure your claim continues to be paid, if you're still **unable to work**. If we don't receive this information, unless there is a good reason, we could pause your payments or even stop paying your claim altogether.



B3 - How we pay you

If you're **unable to work** due to an accident or sickness, once your claim has been approved, we'll pay you a month in arrears. This means that your payments will start being made at the end of the month after your **waiting period** ends. For example for a **waiting period** of two months, if you were **unable to work** in January, we would make the first payment at the end of March.

You will need to be **unable to work** for the whole of your **waiting period** before we start to make payments to you.

Special conditions apply if you are a dentist, doctor, surgeon or teacher, and you've chosen a 12 month **waiting period**. This means we might be able to start paying some of your claim before your waiting period ends. More information can be found in the appendix for special conditions for your particular occupation at the back of these policy Conditions.

If you're **unable to work** for less than a whole calendar month, we work out how much to pay you by dividing the number of days you couldn't work by the number of days in the month.

For example:

Rosie makes a claim. Her policy has a two month waiting period. The waiting period ends on 15 March.

Rosie's first payment would be calculated as follows:

$$31 - 15 = 16$$

(As there are 31 days in March and the first 15 are not eligible for payment, it leaves 16 days eligible)

$$(16 / 31) \times 100 = 52\%$$

This means Rosie will receive 52% of the full monthly amount payable at the end of March.

We make payments directly into your bank or building society account.

We will continue to pay you until one of the following happens:

- You're able to go back to work (as defined under the type of cover you have)
- Your **policy** reaches its **end date**
- You die
- You are not following the advice of your doctor or refuse to follow any reasonable treatment request.

For details of payments for fracture cover claims see section B13, for death benefits claims see section B14 and parent and child cover see section B16.

B4 - How much do we pay out?

If you're **unable to work** due to an accident or sickness how much we'll pay you depends on the type of cover you have at the time you make a claim.

Own occupation cover

We use this measure if you're working or have been out of work for less than 12 months at the time you become **unable to work**.

We'll pay you the lower of:

- Your **amount of cover** at the time of your claim.
- The maximum monthly claim amount (which we explain in section B5).

Homemaker cover

We use this measure if you're a **homemaker** or have been out of work for more than 12 months at the time you become **unable to work**.

We'll pay you the lower of:

- Your **amount of cover** at the time of your claim.
- £1,500 a month (less the monthly payments from any other accident and sickness insurance policies that you're receiving payments from at the same time).

If we increase this limit of £1,500 in the future we'll let you know.

If we don't pay your **amount of cover** in full we won't be able to refund any **premiums** you've paid for it.

For details of payments for fracture cover claims see section B13, for death benefits claims see section B14 and Parent and child cover see section B16.

B5 - How we work out the maximum amount we can pay you

The maximum **amount of cover** you can have under this **policy** is 60% of your **income**.

When you come to make a claim because you're **unable to work**, we'll check to make sure that the amount we're paying you is not more than 60% of your **monthly income before the claim**.

We work this out as follows:

We take 60% of your **monthly income before the claim**.

- If this is less than £1,500 and you qualify for the £1,500 benefit guarantee, we'll use £1,500 instead to work out your monthly payments. We explain how the benefit guarantee works in section B7.
- For doctors and surgeons the benefit guarantee is £3000. We explain how the benefit guarantee for doctors and surgeons works in section 1 of appendix A at the back of these policy Conditions.

Then we take off the following payments:

- Payments from any other sickness or accident insurance you're claiming. For example this could be mortgage protection, insurance or credit card protection.
- 60% of any sickness benefit or ill health retirement payments you're receiving.
- 60% of any continuing **income** or pension payments that you're still receiving whilst you're claiming (we don't take into account any **income** earned before you became **unable to work** – for example a bonus that is paid at the end of the year).

This amount is called your maximum monthly claim amount.

We'll compare this maximum monthly claim amount to your **amount of cover**.

- If this is less than your **amount of cover**, we'll pay you the maximum monthly claim amount instead.
- We offer a promise that if the difference is less than 10% of your **amount of cover**, we'll ignore that difference and simply pay you your **amount of cover** instead.

If you have inflation-linked cover we'll increase the amount of your **monthly income before the claim** each year, in line with **inflation** while we are paying you.

We may change the way we work out your maximum monthly amount, if any of the following change:

- The way payments from Income Protection policies are taxed.
- The way any of the payments we take into account, when working out your monthly amount are taxed.

If we decide we need to change the way we work this out, we'll tell you at least 30 days before we make any changes. We'll also make sure that the changes we make are reasonable and fair, compared to the change in tax.

B6 - Claim payments from this policy and state benefits

We won't reduce payments from this **policy** to reflect any state benefits you may be entitled to. However, payments made from this **policy** may affect the amount of state benefits you might receive. For example, payments from this **policy** will reduce your Universal Credit entitlement, unless you're using the money to fund your regular mortgage payments.

When you make a claim, we'll provide you with support to work out how your **policy** might affect state benefits at that time, confirm your mortgage details and help you decide the most appropriate way for us to make **policy** payments.

At claim, we'll pay the whole amount to you, unless you've got a mortgage which qualifies under our '**pay my mortgage**' facility. If your mortgage qualifies, we can pay an amount equal to the monthly mortgage payment you are liable to pay, straight to your mortgage provider, and pay the rest to you.

If the amount we pay your lender under our **pay my mortgage** facility is less than your monthly mortgage payment it will be up to you to make up the difference. It is our understanding that payments made directly to your mortgage lender won't be included when the Government assess your entitlement to Universal Credit. Any payments we pay to you will be paid directly into your bank or building society account. It is our understanding that these payments will be taken into account for means-tested assessment by the Government and will reduce any Universal Credit entitlement you may have.

If your mortgage payment amount changes whilst you are claiming, please let us know, so we can ensure we continue to pay the correct amount directly to your mortgage provider.

It is your responsibility to declare any payments from this **policy** to the Department of Work and Pensions if you are applying for or receiving state benefits.

The treatment of the payments from this **policy** for Universal Credit and other state benefits is based on our understanding of the current state benefits, means-testing and treatment of claim payments from insurance policies, which can change in the future.

B7 - £1500 Benefit Guarantee

We understand that your **income** goes up and down. If when you come to make a claim your **income** has fallen compared to when your **policy** started, it's possible your **amount of cover** might be more than 60% of your **monthly income before the claim**.

As we have explained in sections B4 and B5 this can mean you might get paid less than your **amount of cover**.

To make sure we can support you with the right tools and information we'll ask you for some information on your current financial situation when you start your claim. If, when we review this information, we realise that 60% of your **monthly income before the claim** is less than your **amount of cover**, we guarantee to pay you £1500 a month minus the following payments:

- Payments from any other sickness or accident insurance you are claiming. For example this could be mortgage protection, insurance or credit card protection.
- 60% of any sickness benefit or retirement payments you're receiving.
- 60% of any continuing **income** or pension payments that you're still receiving whilst you're claiming (we don't take into account any **income** earned before you became **unable to work** - for example a bonus that is paid at the end of the year).

To qualify for this guarantee you must have been working for at least 16 hours a week if you're self-employed, or 25 hours a week if you're employed at the time you became **unable to work**.

You can still receive state benefits (for example, Employment and Support Allowance) on top of the guarantee.

For doctors and surgeons we offer you a £3000 benefit guarantee instead. This is explained in more detail in appendix A at the back of these Policy Conditions.

B8 - Helping you get back to a healthier you

If you're **unable to work** through illness or injury it's important that you tell us as soon as possible. Even if you have a long **waiting period**, the sooner you talk to us, the sooner we can look to help you.

Where we think it will help you in your recovery we'll arrange for treatment or services to help you get better and return to work. These are wide ranging, but could include physiotherapy, psychological services or return to work services.

We'll take the worry from you and directly find and pay for the treatment or service provider. We'll arrange to carry out an initial assessment over the phone to assess your needs with the aim of supporting your recovery and developing a return to work plan with you. We will need to agree any costs and services before arranging them. This will involve taking advice from your doctor as well as our own specialists.

We don't even have to be paying a claim for us to help you and you may still be within your **waiting period** when these services or treatment are provided.

Where we agree to offer these services we'll pay up to a maximum of 3 times the **amount of cover** per claim in order to provide these services.

Please note if you're not following the advice of your doctor or refuse to follow any reasonable treatment request then we'll stop any payments including payments made by us to help you get better and return to work.

B9 - What happens if you go back to work part-time in your normal occupation

If you have homemaker cover, or we paid your claim under homemaker cover this section doesn't apply. Also this section doesn't apply if we have already paid your claim up to the **claim limit**.

If you have a valid claim and you recover and return to work, but haven't recovered enough to work as many hours as you did before you became unable to work we will pay you some of your payments as long as:

- Your **waiting period** has ended and you were **unable to work** for all of your **waiting period**
- When you return to work it's for less than 30 hours a week.
- Before you became **unable to work** you were working 30 or more hours a week.
- Your new monthly income is less than your **monthly income before the claim**.

If you're self-employed we realise it's often difficult to prove what your weekly working hours are. If this is the case, we'll work with you to try to find out what your typical working hours are, so we can process your claim.

It's important to understand that we will only pay you some of your payments. We work out how much we'll continue to pay you as follows:

- We take your **monthly income before the claim** and subtract your new monthly **income** now that you are back at work.
- We multiply this figure by the amount we were paying you before you returned to work.
- Then we divide this figure by your **monthly income before the claim**.

$$\begin{aligned} & \text{(Monthly income before the claim} \\ & \quad \text{– new monthly income)} \\ & \quad \times \text{ amount we were paying you} \end{aligned}$$

Monthly income before the claim

We will need evidence of your new monthly **income**, such as your P60, payslip, written confirmation from your employer, invoices or your accounts.

We will review how much we are paying you if any of the following change:

- Your **amount of cover**
- Your new monthly **income**
- The maximum monthly claim amount (which we explain in section B5)

We will stop the payments:

- If your new monthly **income** is more than your **monthly income before the claim**
- If you are **able to work** for more than 30 hours a week
- If your **policy** reaches its **end date**
- Once we have paid your claim up to the **claim limit**
- If you die
- If you are not following the advice of your doctor or refuse to follow any reasonable treatment request.

B10 - What happens if you recover but not enough to go back to your occupation

If you have homemaker cover, or we paid your claim under homemaker cover this section doesn't apply. Also this section doesn't apply if we have already paid your claim up to the **claim limit**.

If you have a valid claim and you recover from your sickness or accident, but aren't fit enough to go back to your original **occupation** we will pay you some of your payments as long as:

- Your **waiting period** has ended, and you were **unable to work** for all of your **waiting period**
- You are unable to carry out the main tasks of your original **occupation**
- You start a new job as a consequence of not being able to do your original **occupation**
- Your **income** from your new job is less than your original **occupation**

It's important to understand that we will only pay you some of your payments. We work out how much we'll continue to pay you as follows:

- We take your **monthly income before the claim**, and subtract your new monthly **income** now that you are back at work.
- We multiply this figure by the amount we were paying you before you returned to work.
- Then we divide this figure by your **monthly income before the claim**.

$$\begin{aligned} & \text{(Monthly income before the claim} \\ & \quad \text{– monthly Income from new job)} \\ & \quad \times \text{ amount we were paying you} \end{aligned}$$

Monthly income before the claim



So that we can pay you we will need evidence of:

- Details of your new job.
- Details of your new employer.
- Your monthly **income** from your new job, such as your P60, payslip, written confirmation from your employer, invoices or your accounts.

We will review how much we are paying you if any of the following change:

- Your **amount of cover**.
- Your monthly **income** from your new job.
- The maximum monthly claim amount (which we explain in section B5).

We will stop the payments:

- If your monthly **income** from your new job is more than your **monthly income before the claim**
- If we believe (based on the evidence we receive) that you're now fit enough to carry out the main tasks of your original **occupation**
- If your **policy** reaches its **end date**
- Once we have paid your claim up to the **claim limit**
- If you die
- If you are not following the advice of your doctor or refuse to follow any reasonable treatment request.

If we have stopped paying you because your **income** from your new job is more than your previous **occupation**, and it falls below that amount again, we may be able to re-start paying you again.

This is only if:

- It is within 52 weeks of us stopping your payments
- You have remained continuously unable to carry out the main tasks of your original **occupation**
- We haven't already paid you up to the **claim limit**
- The evidence we receive confirms or shows that the drop in your income is directly due to the symptoms of your illness or accident that left you **unable to work** originally.

B11 - What happens if you become ill again (sometimes called linked claims)?

If you've returned to work after recovering from an illness or injury, but unfortunately have become **unable to work** again, please let us know as soon as possible because we may be able to start your income protection payments again straight away, without having to wait for your **waiting period**.

If you have to stop working within 6 months of returning to work, we will treat this as a **related claim** and will re-start your payments straight away, as long as:

- You're **unable to work** due to the same illness or injury that we originally paid your claim for.
- Your **occupation** is the same as it was when you were first **unable to work**.
- You let us know within 2 weeks of the date you stop working.

However if we paid your previous claim up to the **claim limit** and the reason you're **unable to work** is the same, we will treat this as a **related claim**, and you won't receive any more payments from us. All **related claims** count towards the **claim limit**.

If you're **unable to work** because of a different reason, we will treat your claim as a new claim. This means your claim will start from the beginning again and you will need to wait for your **waiting period** to end before your payments start.

B12 - What happens if you're insuring someone else?

If you're insuring someone else, we will look at their **occupation**, health and leisure activities to work out what cover we can offer when you take out a **policy** or if you want to change the **amount of cover** under sections D2, D3 and D4. We will only pay you if they are **unable to work**, as defined in the relevant sections of these conditions, and when we work out the amount we will pay you, we look at their situation and not yours. This also applies to the fracture cover, death benefit and parent and child cover features included within this **policy**.

If you're making a sickness, fracture cover or parent and child cover claim, the person you are insuring will need to complete the questionnaire about their **occupation**, health, leisure activities and **income**, the information about their fracture for fracture cover claims or evidence from the **child's** consultant that has made the diagnosis for a parent and child cover claim.

If we need any doctor's reports, these will need to be provided by the doctor of the person you are insuring and the person you're insuring will need to give us their consent for us to ask for these.

If you're making a death claim we'll only ask for the information we need about the person insured to help us pay the claim as quickly as possible. If we need any doctor's reports, these will need to be provided by the doctor of the person you are insuring.

B13 - Fracture cover

We'll pay a lump sum if you're diagnosed with a bone fracture shown in the table below. This is in addition to any payments we're paying you if you're **unable to work**.

The amount we'll pay depends on the type of fracture you suffer and the amount for each type of fracture is shown in the following table:

Type of fracture	Amount of fracture cover LV= will pay
Closed fracture of the skull	£1,250
Open fracture of the skull	£2,200
Fracture of the vertebra	£1,000
Fracture of the shoulder blade	£1,000
Fracture of the jaw	£1,000
Fracture of the sternum	£1,000
Fracture of the pelvis	£1,250
Fracture of the wrist	£1,000
Fracture of the hand (excluding fingers and thumbs)	£1,000
Fracture of the upper leg	£2,200
Fracture of the knee	£2,200
Fracture of the lower leg	£1,250
Fracture of the arm	£1,250
Fracture of the cheekbone	£1,000
Fracture of the foot (excluding toes)	£1,000
Fracture of the ankle	£1,250
Fracture of one or more ribs	£650
Fracture of the collar bone	£650

If you're diagnosed with more than one of the fractures shown in this table at the same time, we'll only pay fracture cover for one of the fractures. If this happens the amount we'll pay will be for the fracture with the highest amount of fracture cover.

We will only pay fracture cover for one fracture diagnosed within a 12 month period. The first 12 month period will begin on the **start date** of your **policy** and then each new 12 month period will start on the next **start date** anniversary.

Please remember the amounts we'll pay for fracture cover are fixed when your **policy** starts and won't increase as the cost of things go up in the future. This means you'll be able to buy less with this money in the future.

You're not covered and we won't pay a claim for fracture cover if the fracture happens when taking part in any of the following sports or hobbies.

- Boxing or martial arts
- Extreme sports including, but not limited to mountain boarding, parkour, cliff jumping, coasteering or base jumping
- Gaelic football or hurling
- Horse riding
- Motor car or motor cycle sport
- Off road mountain biking or BMX
- Mountaineering, rock climbing, abseiling, caving or potholing
- Private flying, gliding, paragliding or parachuting
- Rugby
- Skiing or snowboarding
- If the fracture is classified as fatigue, stress or hairline, it will not be covered.

To make a claim for fracture cover you must:

- Let us know you want to claim as soon as possible (and make your claim within 2 months of your injury)
- Be able to provide evidence of the fracture in the form of proof from the consultant who diagnosed the fracture
- Submit any additional information that we request

If you're unable to make your claim within two months of the injury or you're unable to provide any of the information/evidence requested, we will not be able to pay your claim.

We will usually pay fracture cover claims directly into your bank or building society account.

If you are insuring someone else please refer to section B12.

B14 - Death benefit

If you die before the **end date** of your **policy**, we'll pay a fixed lump sum of money. The amount we'll pay depends on when your **policy** started.

We'll pay:

- £5,000 if you die within 4 years of the **start date** of the **policy**.
- £10,000 if you die after 4 or more years after the **start date** of the **policy**.

These amounts are fixed when your **policy** starts and won't increase as the cost of things go up in the future. This means it will buy less in the future. The amount paid will form part of your estate for tax purposes, unless you are insuring someone else then please see section B12. If it does form part of your estate the money may be subject to inheritance tax. This depends on your personal circumstances, and is based on current legislation which may change.

The maximum amount we'll pay is up to £10,000 per person. If you have more than one income protection policy with us we will still only pay up to £10,000 benefit in total, the maximum limit is per person not per **policy**. We won't pay the benefit once your **policy** reaches its **end date**. We usually pay death benefit claims direct to a bank account or by cheque.

How to make a claim for death benefit

The person making the claim should tell us about your death as soon as they can.

The claim can be made to us, by phone, email, fax or in writing. For details of how best to contact us, please visit our website www.LV.com.

We appreciate that this will be a difficult time, so we'll only ask for the information we need to help us pay the claim as quickly as possible. We'll be able to help the person making the claim if they have any questions about the information we need.

If you were claiming on your **policy** at the time of your death, we would deduct any overpayments (payments we made since your death) from the death benefit lump sum paid. Overpayments are most likely to happen when we continue to pay your income protection benefit because we haven't been informed of your death.

For example, if we hadn't been told about your death and we continued to pay your income protection benefit for two months after you died, the money paid since your death would be deducted from the death benefit paid. So if you were receiving £1,000 a month benefit and you had been paid two months benefit after your death, £2,000 would be deducted from the total death benefit paid.

This could mean that no death benefit is paid if your overpayment exceeds the amount of death benefit you are entitled to.

This benefit forms part of your **policy** and because it isn't a separate policy it can't be assigned to anyone else or placed in trust.

B15 - Payment of premiums during unemployment (payment holiday)

If you become unemployed through no fault of your own (we call this involuntary unemployment), you can claim for up to six months **premiums** to be paid by us. This means we'll take care of those **premiums** for you, you don't need to pay them and your insurance will stay in place. You can only claim for a maximum of six months **premiums** to be paid by us during the whole period that your **policy** lasts for, however the six months doesn't have to be in one continuous period. So for example, if you claimed for two months **premiums** to be paid by us, you could then claim for up to another four months **premiums** to be paid by us during the rest of your policy - as long as the amount of **premiums** paid by us doesn't exceed six months in total.

There is an initial exclusion period for this benefit of 90 days, which means if you become unemployed within the first 90 days of your **policy** starting you cannot claim for any of your premiums that relate to that whole period of unemployment to be paid by us.

We'll pay your premiums if:

- You're in permanent employment and you're made involuntarily redundant at least 90 days after your **policy** has started.
- You're self-employed and you've been declared bankrupt, your business becomes insolvent or goes into liquidation at least 90 days after your **policy** has started.
- If you've been made involuntarily unemployed because you have stopped work to become a carer, you can make a claim if you are receiving carer's allowance.

We won't pay your premiums if:

- Your unemployment starts after you reach the normal or agreed retirement age for your occupation or the state retirement age (whichever comes first).
- If unemployment is a regular recurrent feature of your **occupation**.
- If you are a temporary worker, by a temporary worker we mean someone who is employed, but not in permanent employment or self-employed.
- You've taken voluntary redundancy.
- You or any member of your family are a director or a majority shareholder in the company that makes you unemployed. Family members mean your husband, wife, civil partner, parent, child, brother, sister, or any other relative by blood or marriage. However, you'll continue to be covered, and we would pay a claim if a liquidator or administrator has been appointed in respect of the company by its creditors.

- If you become unemployed because:
 - Of your own performance, conduct, fraud or dishonesty or you haven't successfully completed any probationary period as part of your job.
 - Of your involvement in strike action or a labour dispute.
 - Of your direct or indirect involvement in a riot or a war.
 - You are sent to prison.
- If you're a carer and you're not receiving carer's allowance.

If you become unemployed it's important that you tell us as soon as possible and within 1 month of it happening. We'll start paying your **premiums** as quickly as possible and we will backdate any **premiums** you may have already paid while unemployed by up to 1 month.

To make a claim you need to:

- Tell us that you wish to make a claim
- Submit any information that we request
- Provide evidence of your unemployment.

Evidence of involuntary unemployment could include:

- Evidence from your previous employer that you've been made involuntarily unemployed.
- Evidence that you are receiving Jobseekers Allowance or National Insurance Credits.
- Evidence confirming that you are registered for work at a job centre, that you attend the job centre every two weeks and that you're actively looking for work in the UK.
- Where you are unemployed because you've become a carer, evidence that you're receiving carer's allowance.

You must inform us immediately if you return to work, so we don't continue to pay your **premiums** and use up your 6 month allowance. If you go back to work mid-month, we will continue to pay the full month's **premium**.

If we're paying your **premiums** because you're unemployed and you then become sick or have an accident that makes you **unable to work**, you would still need to wait until the end of your chosen **waiting period** before we start to pay your claim.

For plans that include our Waiver of premium policy:

If we're paying your **premiums** because you're unemployed and you then become sick or have an accident that would make you **unable to work**, we will count the start date of your sickness as the date that you became unemployed, which means we can continue to pay your **premiums** for you.

B16 - Parent and child cover

We'll pay a lump sum equal to 6 times your **amount of cover** to you if your **child** is diagnosed with one of the specified illnesses.

For a full list of illnesses covered please see appendix D.

It covers your **child** (from birth to age 21). '**Child**' or '**children**' means all of your natural children, stepchildren and legally adopted children.

Please note this cover pays out on diagnosis of a specified illness and will not pay out if your **child** dies. You don't have to be **unable to work** yourself to make a claim on this feature and this payment is in addition to any payments we're paying you if you're **unable to work** due to sickness. We'll only make one payment per **child**, per **policy** up to a maximum £25,000. If you have more than one income protection policy with us we'll still only pay up to £25,000 in total.

To make a claim for parent and child cover you must:

- Let us know you want to claim as soon as possible
- Be able to provide evidence from the consultant that your **child** has been diagnosed with one of the illnesses listed above or undergone the surgical procedure.
- Submit any additional information that we request to support or confirm the diagnosis, and when it was diagnosed. If you're unable to provide any of the information/evidence requested, we will not be able to pay your claim. We will usually pay claims directly into your bank or building society account.

We won't pay a claim for parent and child cover if:

- You were aware of an increased risk of your **child** suffering one of the listed illnesses before the **start date** of your **policy** (for example you had received medical advice or counselling in relation to the illness before your **policy** started),
- Or – symptoms relating to the illness had arisen before the **start date** of your **policy**. However if your **child** had already suffered the illness, and had been discharged from follow-up, and had not consulted any medical practitioner, or received treatment or advice for the condition for at least five years before the diagnosis of the listed illness, then they would still be covered.
- The condition is caused as a direct result of you harming the **child**.

Also we will not pay a claim if the illness your **child** has been diagnosed with, or the reason they need to have an operation is caused by any of the following:

- alcohol or solvent abuse,
- or
- the taking of drugs (unless prescribed by a doctor),
- or
- failing to follow medical advice. We would only not pay a claim for this, if the reason that you chose not to follow medical advice is unreasonable.



Section C - The claim limit

This section explains what happens if we have been paying a claim, and we have made payments to you up to the **claim limit**. The **claim limit** is the maximum period for which we will make payments to you, after your **waiting period** for any one single claim. This period is 24 months.

C1 - What happens when you reach your claim limit?

If you're **unable to work** due to accident or sickness, once we have made payments up to the **claim limit** (which is 24 months) for your claim, your payments will stop, even if you are still **unable to work**.

However unless you are a **homemaker** you'll continue to be covered and your **policy** will remain in force. If you are a **homemaker**, if we have paid any single claim up to the **claim limit** your **policy** will be cancelled, and you will no longer be covered. If this happens you won't be entitled to any refund of the **premiums** you've paid.

The **claim limit** doesn't apply to claims for fracture cover, death benefit, payment of premiums during unemployment and parent and child cover. For limits that apply to these claims please see the following sections; for fracture cover B13, for death benefit B14, for payment of premiums during unemployment B15 and Parent and child cover B16.

C2 - What happens if you need to make a claim in the future, but we've paid your previous claim up to the limit?

If we've already paid you up to the **claim limit** and you've become **unable to work** again due to the same reason, we will treat this as a **related claim**.

This means you won't be able to make a claim until you've been back at work for six months (with no breaks) working the same amount of hours.

If you have been back at work for a continuous period of at least six months and you then become **unable to work** again, we'll treat this as a new claim. This means when your claim is accepted, we will start making payments to you again after the end of your **waiting period**.

If the reason you're **unable to work** is not the same as your previous claim, we will treat this as a new claim. This means when your claim is accepted, we will start making payments to you after the end of your **waiting period**.

Section D - Other conditions

This section tells you about other things you need to know, such as how to pay your **premiums**, and how to cancel your **policy**.

D1 - inflation-linked cover

This section only applies if your Policy Schedule confirms you have inflation-linked cover.

We will increase the **amount of your cover** in line with **inflation** every 12 months from the **start date** of your **plan**. This date is called your **plan anniversary**.

Where we apply this increase, your **amount of cover** will go up in line with the increase in **inflation**. The **premium** will increase in line with **inflation** multiplied by 1.5. The **inflation** increase will be based on the 12 month period ending three months before your **plan anniversary**.

If your **plan anniversary** is less than three months after the **start date** of this **policy**, the first increase will be made on the next **plan anniversary**.

We aim for the **premium** you pay to only be changed as explained above each year, but it may be changed at other times. More information on when we can change your **premium** can be found in section D8.

If we are paying a claim when an increase is due, we limit the increase to a maximum of 12% for that year.

Any Special Provisions that apply to your **policy** will also apply to any inflation-linked increases. These Special Provisions will be shown in your Policy Schedule. If the increases mean that the **amount of your cover** becomes more than three times the initial amount of your cover (shown in your Policy Schedule), we can stop increasing it.

The good news is that we won't do this if we are paying a claim when an increase is due. This allows us to protect ourselves if there has been very high inflation, as you benefit from the fact that the increases to your **premium** are based partly on the age you were when you bought this **policy**.

You can ask us not to increase the **amount of your cover**, but you must let us know before the **plan anniversary** when an increase is due. We then won't make any further increases to the **amount of your cover** for the rest of the term of your **policy**.

Please note if you ask us not to increase the **amount of your cover**, but later on decide that you want us to start increasing it again, you will need to re-apply for inflation-linked cover. We can't guarantee that we will be able to offer you inflation-linked cover again, as it will depend on your health, occupation and leisure activities and whether we are offering the same type of insurance at that time.

D2 - Guaranteed Increase Options

You can increase your **amount of cover** (other than the automatic increases that happen if you have inflation-linked cover) without having to complete a full application form, if certain events happen. The event must happen to the person insured and you can only do this within three months of it happening.

Whilst you can use these options more than once, you can't use them at the same time. Once you've used an option you must wait at least three months before you use another.

The significant career progression increase option can only be used once during the life of your **policy**.

We call these Guaranteed Increase Options, because we guarantee that you can increase your **amount of cover** without further health questions – for other types of increase you would need to answer health questions. Because of this we limit when and by how much you can increase your cover. We've explained this in more detail below.

Unfortunately you won't be able to increase the **amount of your cover** by a Guaranteed Increase Option if you are **unable to work**. This will also be the case if you have already suffered an accident or sickness but you haven't yet made a claim or you are still in the **waiting period**.

Your **premium** will go up to reflect the increase in the **amount of your cover**. The additional **premium** will be based on your age, whether you smoke or not and your occupation at the time you increase the **amount of your cover**. Any special terms that apply to your original **policy** will also apply to the increased **amount of cover**.

The events which are covered by our Guaranteed Increase Options are:

- **Mortgage increase as a result of moving house or home improvement** - You can use this option if you increase the amount of your mortgage because you're moving home or are planning home improvements. You can increase the **amount of your cover** by up to 50% of the original **amount of cover** shown in your Policy Schedule. The maximum increase to your **policy** is limited to the increase of your mortgage repayments.
- **Marriage or civil partnership** - You can use this option if you marry or enter a civil partnership (as defined by the Civil Partnership Act 2004). You can increase the **amount of your cover** by up to 50% of the original **amount of cover** shown in your Policy Schedule.

- **Childbirth or legal adoption of a child** - You can use this option if you have a child or have legally adopted a child (this must be legally recognised in the UK). You can increase the **amount of your cover** by up to 50% of the original **amount of cover** shown in your Policy Schedule.

- **Increase in basic salary received from an employer** - You can use this option if you're employed (not self-employed) and your salary has increased by at least 10% because of a promotion, an award from a recognised qualification or both a change of employment and employer. You can increase the **amount of your cover** by up to 50% of the original **amount of cover** shown in your Policy Schedule.

This option cannot be used if you are self-employed.

- **Significant career progression increase** - You can only use this option once during the lifetime of your **policy**. You can use this option if you're employed and have an increase in basic salary of at least 20%. This could be as a result of a promotion or a change of employment or employer. If you have had an increase of 20% you can also include any other salary increases since the start date of your **policy**.

You can increase your **amount of cover** by up to a maximum of £20,000 a year. This option can only be used once during the life of your **policy**.

This option can't be used if you (or a member of your family) are the owner, director or partner in the company you're employed by. By member of your family we mean your husband, wife, civil partner, parent, child, brother, sister, or any other relative by blood or by marriage.

Also this option cannot be used if you are self-employed.

General limits for Guaranteed Increase Options

There are some limits for how much you can change the **amount of cover** by. The total of all the Guaranteed Increase Options you use can't be more than £10,000 a year or 50% of the original **amount of cover** shown on your Policy Schedule (the only exception being the significant career progression increase - see above). However, if you're not in paid or unpaid work then the maximum **amount of cover** you can have is limited to £18,000 a year (£1,500 a month). For more information, see section D4.

In addition there is an overall limit of £35,000 a year for the Guaranteed Increase Options you can use over the life of your **policy**. Once this limit has been reached you may still be able to increase your cover, you can't use one of the Guaranteed Increase Options.

The total cover after using the Guaranteed Increase Options must not be more than the maximum monthly claim amount. We explain how we work this out in sections B4 and B5.



The table below explains the limits in more detail. It also shows the maximum age at which you can make use of these options. In all cases you can only use these within three months of the event occurring. Whilst all of these options can be used more than once (with the exception of the significant career progression option) you can't use them at the same time. Once you've used an option you must wait at least three months before you use another.

If you want to use one of the Guaranteed Increase Options, we'll ask you for evidence of the change of your circumstances, such as:

- A copy of your mortgage offer, and details of your previous mortgage amount
- Your child's original birth certificate, or adoption certificate
- Your original marriage certificate or civil partnership registration certificate
- A letter from your employer outlining your increase in basic salary
- Copies of your payslips, to demonstrate the increase in your salary

Event	Increase limit	Maximum increase	Maximum age
Mortgage increase	The lower of 50% of the original amount of cover shown in your Policy Schedule, or, the increase in your mortgage repayments	£10,000 a year*	54
Marriage/ civil partnership	50% of the original amount of cover shown in your Policy Schedule	£10,000 a year*	54
Childbirth/ legal adoption	50% of the original amount of cover shown in your Policy Schedule	£10,000 a year*	54
Increase in basic salary	50% of the original amount of cover shown in your Policy Schedule	£10,000 a year*	54
Significant career progression increase (you can only use this option once)	None other than maximum increase	£20,000 a year*	54

*If you're not in paid or unpaid work, then the maximum **amount of cover** you can have is limited to £18,000 a year (£1500 a month).

D3 - Changing your policy

You can change the amount you're covered for (other than using inflation-linking or a Guaranteed Increase Option – more information on this is in sections D1 and D2), your **waiting period** or the length of your **policy** at any time. You can also apply to change your **policy** if you've changed your job, by requesting a special application form from us.

We can't guarantee that you'll be able to do this, until you've sent back the application form, as we have to look at your age, health, medical history, occupation, leisure activities and whether you have any other LV= insurance policies with us before we can make any changes.

It's important that you don't cancel your existing **policy**. We'll confirm the changes you've requested to you and if you wish to proceed with them we'll tell you if your existing **policy** needs to be cancelled. If it does, we'll do this automatically for you.

D4 - What happens if I'm not working before I claim?

- **If you've been out of work for less than 12 months -**
We'll pay your claim if you're unable to do the last occupation you held before you stopped working, due to sickness or accident. We'll also need to work out what your **income** was to understand how much we can pay you. We base this on what you've earned in the last 12 months that you were actually working. More details of how much we will pay out if you make a claim are explained in section B4.
- **If you've been out of work for more than 12 months -**
We'll pay your claim if you're unable to either prepare a meal or do basic housework, due to an accident or illness. The amount of income you'll receive from your **policy** will be limited to a maximum of £1500 a month. It's important that you tell us if you've been out of work for more than 12 months so that we can change your monthly **premium**. More details on this can be found in section B4.

If you go back to work again within 24 months, you can change your cover back to what it was before and your **premium** will change back to what you were paying before you stopped working.

We'll ask you to confirm your new occupation, but we won't ask you any additional medical questions provided that no claim was made whilst you weren't working. You'll need to be back in paid work for at least two months before you can make a claim (if your claim was in the first two months after you went back to work we'd look at whether you could prepare a meal or do basic housework).

If you're off work longer than 24 months and go back to work, you'll need to tell us what your new occupation is. We will ask you to complete a special application form which asks you details about your new occupation and your health and medical history. Your **premium** may not be the same as what you were paying before you stopped working and will be based on your age, if you smoke, your job and your health at the time.

If you're a doctor or surgeon registered with the General Medical Council and are licensed to practice in the UK, then we have options to allow you to take a sabbatical break, whilst keeping your cover in place. More information on this can be found in appendix A at the back of these policy Conditions.

D5 - Paying your premiums

You are responsible for paying **premiums** on the date shown in your Policy Schedule. They can only be paid by direct debit.

If we're paying a claim under this **policy**, you will still need to pay the **premiums**. If you don't do this then we could stop paying you as your **policy** would eventually be cancelled.

If you've been made involuntarily unemployed you may be able to claim for up to six months of your **premiums** to be paid by us, see section B15 for more details.

D6 - Stopping your premiums

You have 60 days to pay your **premium** from its due date. If we haven't received a **premium** from you, we'll send you a reminder to let you know. If you fail to pay within 60 days then we'll stop and cancel your **policy** and you will not be eligible for any refunds.

D7 - Restarting your premiums

If your **policy** has been cancelled because you didn't pay a **premium**, we can start it up again, as long as you let us know within six months of your first missed payment. Once we've confirmed you can restart your cover we'll need you to pay all the **premiums** you've missed and you'll need to fill in a health questionnaire.

Occasionally when a **policy** is restarted it may be different to what we originally offered you. For example your health may have changed from when you originally took out your **policy**. In these cases we'll explain to you why.

Sometimes it's not possible to restart policies when they have been cancelled. If this happens you'll need to contact your financial adviser and reapply for cover.

D8 - When we can change your premium (reviewable premiums)

The **premiums** you pay are reviewable. This means they are not guaranteed to stay the same throughout the term of your **policy**. They could go up, go down, or remain the same – however they will not change within the first 5 years of the **start date** of your **policy**.

When you first apply for your **policy** we work out the **premium** that you need to pay for the **amount of your cover**, using a number of different assumptions. These include:

- How many claims we think we'll get
- How much we think we'll pay out in claims
- How long we think we'll pay those claims for
- What we think our administration costs, including costs for processing claims will be
- The law, regulations and current tax rules

We will set our assumptions based on the information available at the time we work out your **premium**, and we don't expect them to change during the term of your **policy**.

We review these assumptions on an on-going basis.

This means that we look to see whether we still expect our assumptions not to change throughout the term of your **policy**.

We will only change our assumptions if, having looked at our own data and insurance industry data and information, it clearly indicates that there has been a change. If this happens we will check to see if we need to change your **premium**.

We guarantee not to change the **premium** for your **policy** for the first five years from the **start date**. However after this it could be changed every year.

There's no limit to the amount we can change your **premium** by, it could go up, down or stay the same.

We can change your **premium** for any of the following reasons:

- If the way policies are taxed or the law or regulations changes.
- If our claims experience has been different to what we assumed it would be and we expect this to continue in the future.
- If our reasonable costs for administering policies including processing claims have been different to what we thought they would be, and we expect this to continue to be the case.

We can't change your **premium** for any of the following reasons:

- To increase our profits
- To make up for any losses we've made in the past
- If you've made a claim
- If there have been any changes in your health since the **start date** of your **policy**



If your **premium** is going to change we will let you know at least 60 days before we change it and it will happen on your **plan anniversary**.

If we tell you your **premium** is going to go up, you are able to choose to pay the previous amount instead and we will reduce your **amount of cover** instead. If you'd like to do this, we need to know at least 30 days before the change is due.

You could instead decide to cancel your **policy**. If you want to do this, please let us know. However you should think carefully before doing this, as your **policy** will end immediately, you'll no longer be covered, and you won't get any of the money paid that you have already paid us.

D9 - Proof of age and name

How much you pay for your cover is based on how old you are, so we need evidence of your date of birth before we can pay your claim. We'll accept your original birth certificate or passport as evidence (no photocopies).

We recognise that these are valuable, so we aim to look after them and return them to you as quickly as possible.

It's really important to check that your date of birth is correct on your Policy Schedule, as it affects how much you'll be paid if you claim. If your date of birth is wrong on your Policy Schedule, please let us know as soon as possible so we can amend it.

If you make a claim and your name is different than what's on your Policy Schedule please let us know. We'll require evidence of this, for example a marriage certificate.

D10 - When you can cancel your policy

You can cancel your **policy** at any time. If you cancel your **policy** within 30 days of it starting we will refund any **premiums** you've paid. If you cancel at any other time we won't refund anything.

If you decide to do this, please let us know, so that we don't ask you to pay any more **premiums**.

D11 - When we can cancel your policy

If you're a **homemaker** and we have paid you any one claim up to the **claim limit** (the **claim limit** is 2 years) we won't be able to pay you any more claims and we'll cancel your **policy**, so you don't end up paying for a **policy** you can't claim on.

Other than if you're a **homemaker**, if you don't pay all of the **premiums** that are due for your **policy**, we'll cancel it. We have explained this in more detail in section D6.

If you don't pay all of the **premiums** that are due for your **policy**, we'll cancel it. We've explained what happens if you stop paying **premiums** in section D7.

We do need to protect ourselves against the effects of financial crime so we can also cancel your **policy** in the following situations:

- We can cancel your **policy**, or not pay your full **amount of cover** if either you or anyone you are insuring act fraudulently, or provides untrue, inaccurate or misleading information when applying for the **policy**, when making a claim, when applying to change your **policy**, or if applying to re-start your **premiums** (this is explained in section D7).
- We can cancel your **policy** and pass details to crime prevention and law enforcement agencies if we identify your involvement or association with financial crime.
- We might reduce the amount we pay out, or cancel your policy if we determine that you or anyone you're insuring would have known, or ought to have reasonably known, the true answer to a question we ask you, but have provided a false answer.
- We may also cancel your **policy**, or may not pay the **amount of cover** in full if, had you answered the questions we asked you honestly and in full, it would have meant we'd made a different decision about the **amount of cover**. For example if:
 - A higher **premium** would have applied for the **amount of cover**
 - The **amount of cover** would have been lower for the same **premium**
 - We would have restricted the types of claims we paid out on
 - The term of your **policy** would have been restricted
 - Your application would have been deferred, for example, pending the outcome of a medical investigation
 - Your application would have been declined.

If you apply for the **policy** online, we'll send you your a summary of the questions we ask and the answers given. We'll also do this, if, when you apply, we telephone you to ask some further questions about the application. When you receive this summary it's very important that you check the answers given, as we rely on this information to set up your **policy**.

If we cancel your **policy** you won't be entitled to any refund of **premiums** or payment from it.

D12 - Financial crime and terrorist financing

The personal information we have collected from you will be shared with crime prevention agencies who will use it to prevent financial crime and money-laundering and to verify your identity. If financial crime is detected, you could be refused certain services, finance or employment. Further details of how your information will be used by us and these fraud prevention agencies, and your data protection rights, can be found by contacting us at GFC LV=, County Gates, Bournemouth BH1 2NF.

We use your information to make sure we comply with any financial sanctions that apply in the UK and overseas.

This includes;

- checking your information against sanctions lists
- Sharing your information with HM Treasury and international regulators if required.

We will contact you if more information is needed to comply with any financial sanctions.

D13 - When your policy ends

On the **end date** shown in your Policy Schedule, your **policy** will stop and no further **premiums** will be due. Your **policy** will also end if you die. If we're paying a claim at the time, we won't make any further payments and your claim will automatically end. You won't receive anything back when your **policy** ends.

If you die before the **end date** of your **policy** you will still be eligible for a death benefit, please see section B14 for more details.

D14 - Transferring the policy to someone else

You can't assign or transfer any payment in the event of a claim under your **policy** or the **policy** to anyone else. This means you can't give it to anyone else or put it in Trust.

We will pay all payments due under your **policy** to you. These payments, to coin a legal phrase, will be a full and proper discharge of our liability. This means we won't owe anything to anyone else, once we have paid you.

No person, or company, apart from you and us can have any rights under, or may enforce, this agreement.

D15 - The law that applies to your policy

Budget Income Protection – Reviewable premiums and its terms and conditions are governed by the laws of England and Wales. In the unlikely event of any legal disagreement, it would be settled exclusively by the courts of England and Wales. We'll always communicate in English.

D16 - How to make a complaint

If you have a complaint about any part of the service you receive from us, it's important that we know about it, so we can help to put things right. You can let us know by calling us on 0800 678 1906 (for textphone, dial 18001 first). Or, you can write to us at: Box 2, LV=, County Gates, Bournemouth BH1 2NF.

Your complaint will be dealt with promptly and fairly and in line with the Financial Conduct Authority's requirements. If you'd like more information on how we handle complaints, please contact us or visit LV.com/complaints.

We hope that we will be able to resolve any complaint that you have. If you're unhappy with the outcome of your complaint, the Financial Ombudsman Service may be able to help you free of charge. You'll need to contact them within six months of receiving our final response letter. Their website is www.financial-ombudsman.org.uk which includes more information about the service, including details of the various ways they can be contacted. If you make a complaint it won't affect your right to take legal action.

Appendix A - Special conditions for doctors and surgeons

In this appendix we explain some special conditions that we offer to doctors and surgeons. These will only apply to you, if at the time you become **unable to work**:

- You are registered (or provisionally registered) with the General Medical Council
- You are licensed to practice in the UK

These guarantees won't apply, if at the time you become **unable to work**:

- Your licence to practice in the UK has been suspended
- You have been removed from the General Medical Council register

Please see each special condition for more details on when you will be eligible to benefit from them.

1 - Doctors and surgeons £3000 Benefit Guarantee

The £3000 benefit guarantee only applies if you are a doctor or surgeon registered (or provisionally registered) with the General Medical Council with a licence to practice in the UK, at the time you become **unable to work**.

This guarantee won't apply if you are working less than 32 hours a week at the time you become **unable to work**.

Please note if you do not qualify for this guarantee, you may still qualify for the £1500 benefit guarantee, which is explained in section B7.

We understand that your **income** goes up and down and that when you come to claim it's possible that your **income** may have dropped. If your **income** drops but your **amount of cover** stays the same, it's possible that your **amount of cover** might be more than the 60% of income allowed. If this happened we would usually reduce the amount we pay you to the maximum monthly claim amount – more information can be found in section B5.

When you make a claim we will ask for information on your financial situation to help us understand how we can best help you with your claim. If when we do we find your income no longer supports the **amount of cover** you chose, under this guarantee we'll pay you at least £3000 a month (or the **amount of cover** you chose if it was less than £3000). We'll deduct the following from your Budget Income Protection payments:

- Payments from any other sickness or accident insurance you have (for example any mortgage payment protection or credit card proportion that you are claiming on).
- 60% of sickness benefits or retirement payments you receive from any source (except NHS sick pay if you're claiming under the NHS Doctors or Surgeons Sick pay Guarantee).
- 60% of any continuing income or pension payments that you are still receiving whilst you're claiming (we don't take into account any **income** earned before you became **unable to work** – for example a bonus that is paid at the end of the year).

You can still receive state benefits (for example, Employment and Support Allowance) on top of this guarantee.

To qualify for this guarantee you must have been working at least 32 hours a week at the time you became **unable to work**.

If we have agreed to pay the claim under sabbatical break cover, as long as you were working at least 32 hours a week before you took your sabbatical break then you'll still qualify for this £3000 benefit guarantee.

The aim of the benefit guarantee is to protect you against a genuine drop in your **income** after you take out your **policy**. If you weren't earning enough when your **policy** started to support the **amount of cover** you chose, then we reserve the right not to apply the benefit guarantee.

2 - Doctors and surgeons sabbatical break cover

This sabbatical break cover only applies if you are a doctor or surgeon registered (or provisionally registered) with the General Medical Council, with a licence to practice in the UK, at the time you become **unable to work**.

This sabbatical break cover won't apply if the date you become **unable to work** is within 12 months of the **start date** of your **policy**.

We realise that during the term of your **policy**, you may want to take a sabbatical break.

If you do we will treat you as if you are remaining in full time employment for up to two years. This means that if, during your sabbatical break, you suffer an accident or sickness that means you're **unable to work**, we will base your claim on the **income** you received in the 12 months before you took your sabbatical break.

- It's important to be aware that this cover only lasts for a period of two years for each sabbatical break. If you haven't returned to work within two years and want to make a claim, the limits in section D4 will apply.
- You will still need to continue paying **premiums** for your **policy** whilst you're on your sabbatical break. If you don't then your **policy** will end and we won't pay any claim.
- If you take a sabbatical break and then return to work, there has to be a period of 12 months between sabbatical breaks. If you take another sabbatical break within 12 months of returning to work, we won't pay a claim and the limits in section D4 will apply to your claim instead.

You don't need to tell us that you're taking a sabbatical break. However if you make a claim whilst on a sabbatical break we will need you to provide us with documented evidence that you had arranged and formally agreed a guaranteed position as a doctor or surgeon to return to at the end of your break.

If this evidence cannot be provided, then we won't be able to pay a claim under this condition, and the limits explained in section D4 will apply to your claim instead.

Appendix B - NHS dentists, doctors and surgeons sick pay guarantee

This sick pay guarantee only applies if you're a dentist, doctor or surgeon and your sick pay arrangements match the NHS sick pay arrangements. It doesn't apply to any other dentists, doctors or surgeons.

As with the other conditions you need to be registered (or provisionally registered) with the General Medical Council or General Dental Council, with a licence to practice in the UK, at the time you become **unable to work**.

Sick pay arrangements

The NHS sick pay entitlement is as follows:

- **during the first year of service** – one month's full pay and two months' half pay;
- **during the second year of service** – two months' full pay and two months' half pay;
- **during the third year of service** – four months' full pay and four months' half pay;
- **during the fourth and fifth years of service** – five months' full pay and five months' half pay;
- **after completing five years of service** – six months' full pay and six months' half pay.

Please be aware it is your responsibility to check your contract and ensure your employers have adopted these sick pay arrangements.

The sick pay guarantee only applies if you've chosen a 12 month **waiting period** for your policy, if you haven't this doesn't apply.

We guarantee:

- When you claim we will start paying you as early as possible, providing your claim is valid. How soon we start paying you will depend on how long you have been employed as a dentist, doctor or surgeon at the time you become **unable to work**.
- We won't deduct your sick pay when we work out the maximum monthly claim amount we can pay you, but we will take into account other continuing income that you may be receiving. This is explained in more detail in section B5.

If you've chosen a **waiting period** of 12 months for your **policy** and you become **unable to work**, once we've agreed to pay your claim we'll start paying it before the end of your 12 month **waiting period**, as explained in the table below:

Length of NHS service	LV= sick pay guarantee, 50% of cover paid after	LV= sick pay guarantee, 100% of cover paid after
During the first year of service	1 month	3 months
Second year of service	2 months	4 months
Third year of service	4 months	8 months
During the fourth and fifth years of service	5 months	10 months
After completing five years of service	6 months	12 months

The sick pay guarantee also applies to dentists, doctors and surgeons where their employers have adopted the NHS sick pay arrangements, as set out in the sick pay arrangements section to the left. This guarantee doesn't apply to any other dentists, doctors or surgeons with different sick pay arrangements.

This sick pay guarantee only applies to the **income** you earn from the occupation that is covered by NHS sick pay. Any other **income** you receive which doesn't entitle you to NHS sick pay is not covered within this sick pay guarantee.

If you've chosen a different **waiting period** or your sick pay arrangements don't match those shown, this sick pay guarantee won't apply, which means you would have to wait until the end of your chosen **waiting period** before we pay a claim. We would also take into account any sick pay in working out how much we can pay you as explained in section B5.

Appendix C - Teachers sick pay guarantee

The teachers sick pay guarantee only applies if you're a teacher and your sick pay is set out in one of the appropriate Conditions of Service for School Teachers shown below at the time you become **unable to work**:

- The Conditions of Service for School Teachers in England and Wales (informally referred to as the 'Burgundy Book')
- The Department of Education, Teachers Terms and Conditions for Northern Ireland.
- Or if you are in Scotland, The Scottish Negotiating Committee for Teachers (SNCT) handbook of Conditions of Service for School Teachers in Scotland.

It also applies to teachers where their employers have adopted these sick pay arrangements, as set out in the sick pay arrangements section. This guarantee doesn't apply to any other teachers with different sick pay arrangements.

The sick pay guarantee only applies if you've chosen a 12 month **waiting period** for your **policy**. If you've chosen a different **waiting period** this guarantee won't apply, which means you would have to wait until the end of your chosen **waiting period** before we pay a claim.

We guarantee:

- When you claim we will start paying you as early as possible, providing your claim is valid. How soon we start paying you will depend on how long you have been employed as a teacher at the time you become **unable to work**.
- We won't deduct your teacher's sick pay when we work out the maximum monthly claim amount we can pay you, but we will take into account other continuing **income** that you may be receiving. This is explained in more detail in section B5.

If you've chosen a 12 month **waiting period** for your **policy**, become **unable to work** and we've agreed to pay your claim, when we will start to pay you is explained in the following tables:

England, Wales and Northern Ireland

Length of service	LV= sick pay guarantee, 50% of cover paid after	LV= sick pay guarantee, 100% of cover paid after
During the first year of service (Up to 4 months)	-	25 working days
During the first year of service (between 4 and 12 months)	25 working days	75 working days
Second year of service (between 1 and 2 years)	50 working days	100 working days
Third year of service (between 2 and 3 years)	75 working days	150 working days
Fourth and successive years of service (more than 3 years)	100 working days	200 working days

(A working day for a teacher is defined within the School teachers' pay and conditions document)

Sick pay arrangements

The Conditions of Service for School Teachers in England and Wales (Burgundy Book) and the Department of Education, Teachers Terms and Conditions for Northern Ireland confirm sick pay entitlement in working days as follows:

- **During the first year of service** - Full pay for 25 working days and, after completing four calendar months' service, half pay for 50 working days.
- **During the second year of service** - Full pay for 50 working days and half pay for 50 working days.
- **During the third year of service** - Full pay for 75 working days and half pay for 75 working days.
- **During the fourth and subsequent years** - Full pay for 100 working days and half pay for 100 working days.

The SNCT handbook of Conditions of Service for school teachers in Scotland confirms sick pay entitlement in months as follows:

- **During the first year of service** - No pay for the first 18 weeks, after completing 18 weeks but less than a year's service, full pay for 1 month and half pay for 1 month.
- **During the second year of service** - Full pay for 2 months and half pay for 2 months.
- **During the third year of service** - Full pay for 4 months and half pay for 4 months.
- **During the fourth year of service** - Full pay for 5 months and half pay for 5 months.
- **Fifth and subsequent years** - Full pay for 6 months and half pay for 6 months.

Scotland

Length of service	LV= sick pay guarantee, 50% of cover paid after	LV= sick pay guarantee, 100% of cover paid after
During the first year of service (Up to 18 weeks)	-	1 month
During the first year of service (between 18 weeks and 12 months)	1 month	2 months
Second year of service (between 1 and 2 years)	2 months	4 months
Third year of service (between 2 and 3 years)	4 months	8 months
Fourth year of service (more than 3 years, less than 5 years)	5 months	10 months
Fifth and successive years of service	6 months	12 months

(A month for a teacher is defined within the School teachers' pay and conditions document)

Please be aware it is your responsibility to check your contract and ensure your sick pay arrangements are set out in the appropriate Conditions of Service for School Teachers document, or your employers have adopted these sick pay arrangements.

What will happen if I move to an independent school?

You will need to check the terms in your contract of employment as independent schools may have their own sick pay schemes. You cannot normally carry over your sick pay entitlement to the independent sector. This would mean you're no longer eligible for the guarantee and the **policy** would pay out after a 12 month **waiting period**.

What happens if my school becomes an academy?

If a school becomes an academy you are normally protected by the Transfer of Undertakings (Protection of Employment) Regulations 2006. This means most of your existing terms and conditions, including the entitlement to sick pay and leave, should transfer over to the academy. If your school does become an academy you will need to check the terms in your contract of employment.

If at the time you become **unable to work** your school has become an academy and your sick pay entitlement no longer matches the arrangements set out in the appropriate Conditions of Service for School Teachers document you will no longer be eligible for this sick pay guarantee.

This would normally mean your **waiting period** would revert to 12 months. However in order to try and be fair we will then look to pay your claim on the following basis: 50% of cover after 6 months, then 100% of cover after 12 months. This is subject to the restrictions on the maximum monthly amount we can pay you which we explain in Section B5. You can apply to change your **waiting period**, but we will need additional health and lifestyle information from you, and depending on the information provided it's possible that we might not be able to do this for you. This is explained in more detail in Section D3.

Appendix D – Parent and child cover

We'll pay a lump sum equal to 6 times your **amount of cover** to you if your **child** is diagnosed with one of the below listed illnesses or undergoes one of the listed procedures.

1. Aorta graft surgery – for disease or traumatic injury

Having surgery for disease or trauma to the aorta with excision and surgical replacement of a portion of the diseased or damaged aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For this definition, the following are not covered:

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

2. Aplastic anaemia – complete

A definite diagnosis by a Consultant Haematologist of complete bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents;
- Bone marrow transplant.

For this definition, the following are not covered:

- Other forms of anaemia.

3. Bacterial meningitis – resulting in permanent symptoms

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

For this definition, the following are not covered:

- All other forms of meningitis other than those caused by bacterial infection.

4. Benign brain tumour

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull.

For this definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angiomas and cholesteatoma.

5. Benign spinal cord tumour – resulting in permanent symptoms

A non malignant tumour within the spinal canal and originating in, or arising from the meninges or spinal cord.

The tumour must be interfering with the function of the spinal cord which results in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must be made by a medical specialist and must be supported by appropriate evidence.

For this definition the following are not covered:

- Cysts
- Granulomas

- Malformations in the arteries or veins of the spinal cord
- Haematomas
- Abscesses
- Disc protrusion
- Osteophytes.

6. 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 3/60 or worse in the better eye using a Snellen eye chart.

If your claim doesn't meet this definition you may still be able to claim on partial loss of sight. Please see condition no. 7 below.

7. Partial loss of sight – 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, or visual field is reduced to 20% or less of arc as certified by an Ophthalmologist.

8. Cancer – excluding less advanced cases

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, sarcoma, and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For this 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 thyroid tumours unless histologically classified as having progressed to at least TNM classification T2NOMO.
- Malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin).
- Any non-melanoma skin cancer (including cutaneous lymphoma) that has not spread to lymph nodes or metastasised to distant organs.

If your claim doesn't meet this definition you may still be able to claim if your **child** has suffered from one of the following:

- Carcinoma in-situ of the cervix (condition no. 9)
- Carcinoma in-situ of the Urinary bladder (condition no. 10)
- Ductal or lobular Carcinoma in-situ of the breast (condition no. 11)
- Ovarian tumour (condition no. 12)
- Testicular carcinoma in-situ (condition no. 13)

Please see the relevant numbered condition below.

9. Carcinoma in-situ of the cervix uteri – requiring treatment with hysterectomy

Being diagnosed with carcinoma in-situ of the cervix uteri (cervix) that requires treatment with hysterectomy.

The hysterectomy must have been performed on the advice of a specialist to treat carcinoma in-situ of the cervix.

The following are excluded:

- All grades of dysplasia
- Cervical squamous epithelial lesion (SIL) and Cervical intra-epithelial neoplasia (CIN), unless carcinoma in-situ is present
- Carcinoma in-situ of any other gynaecological organ (for example the ovary, or the fallopian tube)
- Any other disease or disorder of the cervix or other gynaecological organs that is treated with hysterectomy.

10. Carcinoma in-situ of the urinary bladder

Being diagnosed with carcinoma in-situ of the urinary bladder that has been histologically confirmed on a pathology report.

The following conditions are not covered:

- Non-invasive papillary carcinoma
- Stage Ta bladder carcinoma
- All other forms of non-invasive carcinoma.

11. Ductal or lobular carcinoma in-situ of the breast – with specified treatment

Being diagnosed with ductal or lobular carcinoma in-situ of the breast, that is histologically confirmed, and results in you having surgical removal on the advice of your **child's** hospital consultant.

12. Ovarian tumour of borderline malignancy / low malignant potential – with surgical removal of an ovary

Being diagnosed with an ovarian tumour of borderline malignancy / low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.

For this definition the following are not covered:

- Removal of an ovary due to a cyst.

13. Testicular carcinoma in-situ – requiring surgery to remove at least one testicle

Being diagnosed with, and having specified treatment of carcinoma in-situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU), histologically confirmed by biopsy, and as a result treated with orchidectomy (complete surgical removal of the testicle).

14. Cardiac arrest

Confirmation by an appropriate medical specialist of a definite diagnosis of sudden cardiac arrest that results in unconsciousness, loss of effective circulation and the undergoing of cardio-pulmonary resuscitation to sustain life.

There must be permanent insertion of an implantable cardiac defibrillator (ICD) or Cardiac Resynchronization Therapy with Defibrillator (CRT –D).

For this definition, the following are not covered:

- Cessation of cardiac function induced to perform a surgical or medical procedure.

15. Cardiomyopathy – of specified severity

A definite diagnosis by a Consultant Cardiologist of Cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 35% or less for at least 6 months when stabilised on therapy advised by the Consultant.

The diagnosis must be evidenced by:

- Electrocardiographic changes; and
- Echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy.

For this definition, the following are not covered:

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

If your claim doesn't meet this definition you may still be able to claim on Non-severe cardiomyopathy. Please see condition no. 16 below.

16. Non-severe cardiomyopathy – definite diagnosis

Being diagnosed with cardiomyopathy by a Consultant Cardiologist resulting in permanently impaired ventricular function such that the ejection fraction is more than 35%.

The diagnosis must be evidenced by:

- Electrocardiographic changes
- Echocardiographic abnormalities

The evidence must be consistent with the diagnosis of cardiomyopathy.

For this definition the following are not covered:

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

17. 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
- with associated permanent neurological deficit with persisting clinical symptoms.

18. Creutzfeldt-Jakob disease

Confirmation by a Consultant Physician of a definite diagnosis of Creutzfeldt-Jakob disease.

19. Deafness – permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies in the better ear using a pure tone audiogram.

If your claim doesn't meet this definition you may still be able to claim on partial loss of hearing. Please see condition no.20 below.



20. Partial loss of hearing – of specified severity

Permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels but less than 90 decibels across all frequencies in the better ear using a pure tone audiogram.

21. Encephalitis – resulting in permanent symptoms

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

For this definition the following are not covered:

- chronic fatigue syndrome and myalgic encephalitis.

22. 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:

- New characteristic electrocardiographic changes (or findings on a heart scan); and
- The characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction.

For this definition, the following are not covered:

- Other acute coronary syndromes or angina without myocardial infarction.

23. Heart valve replacement or repair

The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.

24. HIV infection – caught in a specified list of countries from a blood transfusion, a physical assault or at work.

Infection with 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 this definition, the following is not covered:

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

25. Idiopathic pulmonary arterial hypertension – of specified severity

A definite diagnosis of idiopathic pulmonary arterial hypertension that has caused permanent and irreversible impairment of heart function which is classified by a Consultant Cardiologist as at least class III on the New York Heart Association (NYHA) scale of functional capacity.

26. 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.

27. Liver failure

A definite diagnosis, by a Consultant Physician or other appropriately qualified medical professional, of irreversible end stage liver failure due to cirrhosis resulting in all of the following:

- Permanent jaundice,
- Ascites, and
- Encephalopathy.

For this definition, the following is not covered:

- Liver failure secondary to alcohol or drug abuse.

28. Loss of hands or feet – permanent physical severance

Permanent physical severance of any hand or foot at or above the wrist or ankle joints.

29. Loss of independent existence – unable to look after yourself ever again

Confirmation by a Consultant Physician and our Chief Medical Officer of loss of independent existence through illness or injury resulting in a permanent inability to perform at least three of the six tasks listed ever again.

The Consultant Physician and our Chief Medical Officer must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends.

Your **child** 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 medication.

The tasks are:

- **Washing** – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- **Getting dressed and undressed** – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- **Feeding** – the ability for your **child** to feed themselves when food has been prepared and made available.
- **Maintaining personal hygiene** – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

- **Getting between rooms** – the ability to get from room to room on a level floor.
- **Getting in and out of bed** – the ability to get out of bed into an upright chair or wheelchair and back again.

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

For a **child** under the age of 5 years, the incapacity must be entirely due to illness or injury and result in the need for continuous health care throughout the day and night. This means the provision of care throughout the day and night for what is necessary for the health, welfare and protection of the **child** compared to a child of a similar age who does not have any illness or injury.

30. Loss of speech – permanent and irreversible

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

31. Major organ transplant – from another person

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

For this definition, the following is not covered:

- Transplant of any other organs, parts of organs (other than those specified), tissues or cells.

32. Multiple sclerosis – with persisting symptoms

A definite diagnosis of multiple sclerosis by a Consultant Neurologist that has resulted in either of the following:

- clinical impairment of motor or sensory function, which must have persisted from the time of diagnosis; or
- two or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on magnetic resonance imaging (MRI scan).

All of the evidence must be consistent with multiple sclerosis.

33. Neuromyelitis optica (Devic's disease) – with persisting symptoms

A definite diagnosis of neuromyelitis optica by a Consultant Neurologist. There must current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 3 months.

34. Open heart surgery – with surgery to divide the breastbone

Having open heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct a disease or defect of the heart,

For this definition, the following are not covered:

- any percutaneous, transluminal or other procedure that does not involve median sternotomy
- investigative procedures.

35. Paralysis of a limb – total and irreversible

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

36. Pneumonectomy – removal of an entire lung

Having surgery to remove an entire lung for disease or trauma.

The following are not covered:

- Partial removal of a lung (lobectomy) or lung resection or incision.

If your claim doesn't meet this definition you may still be able to claim on removal of one or more lobe(s) of the lung. Please see condition no. 37 below.

37. Removal of one or more lobe(s) of the lung – for disease or trauma

The removal of the whole of one or more lobes of the lung due to underlying disease or trauma. The surgery must be carried out on the advice of a Consultant Physician.

38. Progressive supranuclear palsy – resulting in permanent symptoms

A definite diagnosis, by a Consultant Neurologist, of progressive supranuclear palsy. There must be permanent clinical impairment of eye movement and motor function with associated tremor, rigidity of movement and postural instability.

39. Pulmonary artery surgery – for disease only

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

40. Severe lung disease

Confirmation by a Consultant Physician of severe lung disease where there is permanent impairment of lung function evidenced by all of the following:

- The need for daily oxygen therapy for at least 15 hours per day for a minimum of six months, and
- Forced vital capacity (FVC) being less than 50% of normal, and
- Forced expiratory volume at 1 second (FEV1) being less than 40% of normal.

41. Stroke – of specified severity

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that has resulted in all of the following evidence of stroke:

- Neurological deficit with persisting clinical symptoms lasting at least 24 hours; and
- Definite evidence of death of tissue or haemorrhage on a brain scan.

For this definition, the following are not covered:

- Transient ischaemic attack
- Death of tissue of the optic nerve or retina / eye stroke.

42. Surgical removal of an eyeball

Surgical removal of a complete eyeball as a result of injury or disease.

For this definition the following is not covered:

- Self inflicted injuries.

43. Systemic lupus erythematosus

A definite diagnosis of systemic lupus erythematosus (SLE) by a Consultant Rheumatologist resulting in:

- permanent impaired renal function evidenced by a glomerular filtration rate below 30ml/min/1.73m² and
- urinalysis showing proteinuria or haematuria; or
- permanent neurological deficit evidenced by one of the following persisting clinical symptoms – paralysis, localised weakness, dysarthria (difficulty with speech), dysphagia (difficulty in swallowing), difficulty in walking or lack of co-ordination.

For the purposes of this definition:

- seizures, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin will not be accepted as evidence of permanent neurological deficit.

44. Terminal illness – where death is expected within 12 months.

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

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

45. Third degree burns – covering 20% of the body's surface area or affecting 50% of the area 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 affecting 50% of the area of the face or head.

If your claim doesn't meet this definition you may still be able to claim on partial third degree burns. Please see condition no. 46 below.

46. Partial third degree burns – covering 10% of the body's surface area or affecting 25% of the area 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 10% of the body's surface area or affecting 25% of the area of the face or head.

47. Traumatic brain injury – resulting in permanent symptoms

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

48. Accident hospitalisation cover

If **you** suffer a physical injury due to an accident, which under the advice of a specialist requires a stay in hospital in one of a number of listed countries for at least 28 consecutive days.

The following are not covered:

- Any accident caused by a self-inflicted act
- Any accident caused by taking alcohol or drugs, or where it was a contributing factor
- Any accident caused by natural causes, or a disease or illness of any kind.

The listed countries are:

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.

49. Arteriovenous malformation (AVM) of the brain – with specified treatment

Having surgery, embolisation or radiosurgery to treat an arteriovenous malformation (AVM) of the brain.

The following are not covered:

- Cerebral aneurysm or any other malformations in the brain.

50. Carotid artery stenosis – treated by endarterectomy or angioplasty

Having endarterectomy or therapeutic angioplasty to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

51. Cerebral aneurysm – with surgery or radiotherapy

Having treatment for a cerebral aneurysm using any one of the following:

- Craniotomy
- Stereotactic radiotherapy
- Endovascular treatment by using coils to cause thrombosis (embolisation).

For this definition the following are not covered:

- Cerebral arteriovenous malformation.

52. Central retinal artery or vein occlusion – resulting in permanent visual loss

Death of the optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in permanent visual impairment of the affected eye.

For this definition the following are not covered:

- Branch retinal artery or vein occlusion or haemorrhage
- Traumatic injury to tissue of the optic nerve or retina.

53. Severe Crohn's disease – surgically treated

Being diagnosed with Crohn's disease with fistula formation and intestinal strictures.

A definite diagnosis must have been confirmed by a Consultant Gastroenterologist of Crohn's disease, with fistula formation and intestinal strictures.

There must have been two or more bowel segment resections on separate occasions. There must also have been evidence of continued inflammation with ongoing symptoms, despite optimal therapy with diet restriction, medication use, and surgical interventions.

54. Severe ulcerative colitis – with operation to remove the entire large bowel

Being diagnosed with severe ulcerative colitis and having undergone an operation to remove the entire large bowel (total colectomy).

A definite diagnosis of ulcerative colitis must have been confirmed by a Consultant Gastroenterologist.

It covers your **child** (from birth to age 21). '**Child**' or '**children**' means all of your natural children, stepchildren and legally adopted children.

Please note this cover pays out on diagnosis of a specified illness or if your **child** undergoes one of the listed procedures and will not pay out if your **child** dies. You don't have to be **unable to work** yourself to make a claim on this feature and this payment is in addition to any payments we're paying you if you're **unable to work** due to sickness.

We'll only make one payment per **child**, per **policy** up to a maximum £25,000. If you have more than one income protection policy with us we'll still only pay up to £25,000 in total.

To make a claim for parent and child cover you must:

- Let us know you want to claim as soon as possible
- Be able to provide evidence from the consultant that your **child** has been diagnosed with one of the illnesses listed above or undergone the surgical procedure.
- Submit any additional information that we request to support or confirm the diagnosis, and when it was diagnosed'. If you're unable to provide any of the information/ evidence requested, we will not be able to pay your claim. We will usually pay claims directly into your bank or building society account.

We won't pay a claim for parent and child cover if:

- The condition is caused as a direct result of you harming the **child**.
- You were aware of an increased risk of your **child** suffering one of the listed illnesses before the **start date** of your **policy** (for example you had received medical advice or counselling in relation to the illness before your **policy** started),
- Symptoms relating to the illness had arisen before the **start date** of your **policy**. However if your **child** had already suffered the illness, and had been discharged from follow-up, and had not consulted any medical practitioner, or received treatment or advice for the condition for at least five years before the diagnosis of the listed illness, then they would still be covered.

Also we will not pay a claim if the illness your **child** has been diagnosed with, or the reason they need to have an operation is caused by any of the following:

- alcohol or solvent abuse,
- or
- the taking of drugs (unless prescribed by a doctor),
- or
- failing to follow medical advice. We would only not pay a claim for this, if the reason that you chose not to follow medical advice is unreasonable.

Definitions

We explain these terms because this is a legal document. In some cases the words may have other meanings in everyday use. So you know when they apply, we've highlighted them in bold (other than personal terms such as 'you' and 'we').

'**You**' means the person who applied for this **policy**, the person who is insured and the person legally entitled to the payment from it. Where we use 'your' it has the same meaning.

'**We**', '**us**' or '**our**' means Liverpool Victoria Friendly Society Limited (LV=).

'**Amount of your cover**' and '**amount of cover**' means the amount you're insured for, which is shown on your Policy Schedule.

'**Child**' or '**children**' means all of your natural children, stepchildren and legally adopted children.

'**Claim limit**' is the maximum period of time we'll pay you for any one single claim after your **waiting period** ends if you're **unable to work** because of accident or sickness. For Budget Income Protection the maximum time is 24 months. All claims within six months of each other for the same accident or sickness will be treated as a **related claim** and count as one single claim.

'**End date**' means the date when your **policy** with us finishes. This date is shown on your Policy Schedule.

'**Homemaker**' – we will treat you as a homemaker if you stay at home to look after your family, or are a carer and are not doing any paid or unpaid work. If you are claiming Jobseekers Allowance when you apply for your **policy** we will treat you as unemployed instead. We are unable to offer a **policy** to people who are unemployed.

'**Income**' means your personal taxable earned income before any income tax is paid, minus any expenses which are allowable against income tax. If you are employed you'll find this on your P60. If you are self-employed and registered with HM Revenue and Customs as self-employed, you'll find this figure on your tax return.

If you own a limited company then your income can also include dividend income from your business as long as:

- The dividend income is clearly related to your work activities.
- The frequency of dividend payments must be of an established pattern, rather than irregular one-off payments.
- The dividends are paid from annual profits net of tax. If the dividends are higher than the profit figure, we will use the net profit figure instead.

Your income can also include dividends paid to your spouse or civil partner as long as:

- They are also a shareholder
- They don't take over the running of the business if you are **unable to work**.
- They haven't already used the same dividend **income** for their own Income Protection cover

'**Inflation**' means the rising cost of goods and services, such as your weekly shopping, gas and electricity. We measure **inflation** using the Retail Price Index (RPI). If this stops being used we will use a similarly published index. If this happens we will let you know.

'**Monthly income before the claim**' is the **income** you received from your **occupation** each month averaged over the 12 months before you become **unable to work**. If you are not working when you claim, and have been **unable to work** for less than 12 months, we'll average your **income** from the last 12 months when you were working. If you have been **unable to work** for 12 months or more when you claim then we will treat you as a **homemaker**.

If you are self-employed, we will base your claim on your share of net profit in the 12 months before you became **unable to work**.

If we cannot pay you your full **amount of cover** based on your **income** over the last 12 months then we may agree to average your **income** over a longer period of up to 36 months, if this would more accurately reflect your usual **income**. You will need to request this at the time of your claim. If we agree to your request, this will be confirmed to you in writing.

'**Occupation**' is the type of job you were doing at the point you became **unable to work**.

'**Pay my mortgage**' is a facility that allows us to pay directly to your lender at point of claim. It's entirely up to you whether you wish to use this facility, and you can change your mind at any time. This facility applies to residential mortgages on UK properties only. It also only applies to mortgages on your main residence (by main residence we mean the property that you currently live in, or spend the majority of your time living in). It doesn't apply to mortgages on other properties such as buy-to lets, second properties, holiday homes or commercial properties.

'**Plan**' means your LV= Flexible Protection Plan, your Policy Schedule and any policies (including this **policy**) which are included in it.

'**Plan anniversary**' is the 12 month anniversary from the start of your **plan**. This will be the same as the 12 month anniversary from the start of your **policy** unless you have added a new **policy** to an existing **plan**. You can check this on your Plan Schedule.

'**Policy**' means these conditions, your Policy Schedule, any Special Provisions listed in your Policy Schedule and any documents we send you to confirm changes to your policy, or to the **amount of your cover**. We will apply a Special Provision when we are not able to offer you a **policy** based on the terms detailed in these conditions. This may be because of your **occupation**, your health or your hobbies. We will let you know if this applies to you before we start asking you for any money.

'**Premium**' and '**premiums**' mean the monthly amount you pay for the **amount of cover** provided by your **policy**.

'**Related claim**' means you are **unable to work** because of the same accident or sickness that we have originally agreed to pay a claim for.

'**Start date**' is the date when your **policy** started. This date is shown in your Policy Schedule.

'**Unable to work**', '**inability to work**', '**able to work**', '**ability to work**' - the way we measure these under this **policy** depends on whether you have own occupation cover, or homemaker cover.

We explain this in detail in section A1 for own occupation cover and section A2 for homemaker cover.

'**Waiting period**' is the number of months you've decided to wait, from when you are **unable to work** to when we start to pay you. You choose this when you apply for your **policy** and it is shown on your Policy Schedule.

You can get this and other documents from us in Braille or large print by contacting us.



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