Document reference: MIMICI21LG

Keep me safe

Combined Life & Critical Illness Guaranteed Premiums

Policy Conditions

These Policy Conditions tell you how LV= Combined Life & Critical Illness Guaranteed Premiums 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= Combined Life & Critical Illness protection is provided by Liverpool Victoria Friendly Society Limited, which is part of LV=. Our illness and medical conditions definitions meet the ABI Statement of Best Practice for Critical Illness cover (December 2014). If you'd like a copy please let us know.

Find out how we use your personal information, and what rights you have by visiting LV.com/dataprotectionlife. 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 28.

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LV=

Why choose LV= Combined Life & Critical Illness Guaranteed Premiums?

This **policy** is designed to pay out a cash sum if you die before the **end date** of your **policy**, or, if earlier, you are diagnosed with a **critical illness** which is covered under this **policy**. The diagnosis or operation must occur between the **start date** and the **end date** of your **policy**. If you're diagnosed with a **critical illness**, we will pay a claim, provided you live for at least 14 days or more, after the diagnosis, or undergoing the operation. For claims relating to children's cover, your **child** doesn't need to have survived for 14 days after their diagnosis or having their operation.

If we pay out the cash sum before the **end date**, the **policy** will normally end unless we pay a claim for an **additional payment condition** or children's cover. However you can choose to have more life cover than critical illness cover. If you choose to do this, and we have paid a critical illness claim, for a **full payment condition** you will continue to be covered for the amount of extra life cover you have chosen.

We've included a list of all the illnesses, medical conditions and operations covered in Section A1, and more detailed information including an explanation of when we will pay out for each one is detailed in the Appendix at the back of these Policy Conditions.

Choosing the critical illnesses to be covered for

When you apply you can choose to be covered for the following options:

- All of the **critical illnesses** including total permanent disability

  or
- All of the **critical illnesses** excluding total permanent disability

More details can be found in Section A1 and your chosen option is shown on your Policy Schedule.

Choosing the type of cover

You can also choose whether you want the **amount of cover** to stay the same, increase, or decrease, during the term of your **policy**. This will be shown on your personal quote if you haven't yet taken out a **policy**, and once your **policy** has started you will find this on your Policy Schedule.

You can choose:

- Level cover - This means your **amount of cover** and the **premium** you pay is fixed when your **policy** starts, and doesn't change.
- Inflation-linked cover - This means that your **amount of cover** and the **premium** you pay will go up each year in line with **inflation**. This may be shown on your personal quote as Increasing amount of cover, or Index-Linked amount of cover.
- Decreasing cover - You would generally take out this type of cover to provide the money to pay off a capital and interest repayment mortgage in the event of your death, or if earlier being diagnosed with a **critical illness**. Your **amount of cover** goes down each month, but the **premium** remains the same.

These choices are explained in more detail in Section A2.

Section A – Your Combined Life & Critical Illness Guaranteed Premiums policy

This section tells you about:

- What you're covered for
- The types of cover available
- When we will pay the **amount of cover**
- How to make a claim
- How much we will pay
- Who the money will go to

A1 – What you're covered for

There are three different options available. You will find which of the following you are covered for on your Policy Schedule. More detailed information can be found in the Appendix. In some cases we may not be able to provide cover for all of the illnesses or operations listed in each section. If this happens, this will be noted on your Policy Schedule under the heading of Special Provisions.

On the following pages we explain the different options available in more detail, and explain what you're covered for, and what you're not covered for.

You only need to read the section that applies to the cover shown on your Policy Schedule.

So, if your Policy Schedule shows that you are covered for all **critical illnesses** including total permanent disability, you only need to read Section A1(a). If it shows that you are covered for all **critical illnesses** excluding total permanent disability, read Section A1(b).

A1(a) – All critical illnesses including total permanent disability

What's covered

✔ Death or diagnosis of a critical illness

We will normally pay out the **amount of cover** if you die or are diagnosed with one of the **critical illnesses** listed in Section A1(a) between the **start date** and the **end date** of your **policy**.

We have split the **critical illnesses** into **full payment conditions** and **additional payment conditions**.

For a **full payment condition** we will normally pay out the full **amount of your cover**.

For an **additional payment condition** we will only pay out an amount equal to part of your **amount of cover**. The amount we pay for each **additional payment condition** is shown in the list of **additional payment conditions**, and more detail can be found in the Appendix under the additional payment conditions section.

If we pay a claim for an **additional payment condition**, we don't reduce your **amount of cover**, and your **policy** continues for your full **amount of cover**. If you make a claim that meets the definition for both an **additional payment condition** and a **full payment condition** at the same time, then we will only pay a claim for the **full payment condition** and not the **additional payment condition** as well.

For example if we paid a claim for the **full payment condition** for blindness (condition no. 7) we won't also pay a claim for the **additional payment condition** for partial loss of sight (condition no. 58). Similarly if you had one of the lobes of your lung removed as a result of being diagnosed with lung cancer and we agreed to pay the a claim for the **full payment condition** for cancer (condition no. 8), then we won't also pay a claim for the **additional payment condition** for removal of a lobe or lobes of the lung (condition no. 61).

Once we have paid a claim on this **policy** (unless we've paid a claim for an **additional payment condition** or for children's cover which is explained in Section A3), it will normally end. There is an exception. If when your **policy** started you chose to have more life cover than critical illness cover, and we have paid a critical illness claim for a **full payment condition**, you will continue to be covered for the amount of extra life cover you have chosen. Your **policy** will continue, and if you die before the **end date** of your **policy** we will pay the amount of extra life cover. This is shown as 'amount of extra life cover' on your Policy Schedule.

✔ You're covered for the following critical illnesses:

Full payment conditions

1. **Alzheimer's disease or other forms of dementia** – resulting in permanent symptoms
2. **Aorta graft surgery** – for disease or traumatic injury
3. **Aplastic anaemia** – complete
4. **Bacterial meningitis** – resulting in permanent symptoms
5. **Benign brain tumour**
6. **Benign spinal cord tumour** – resulting in permanent symptoms
7. **Blindness** – permanent and irreversible
8. **Cancer** – excluding less advanced cases
9. **Cardiac arrest**
10. **Cardiomyopathy** – of specified severity
11. **Coma** – with associated permanent symptoms
12. **Coronary artery bypass grafts**
13. **Creutzfeldt-Jakob disease**
14. **Deafness** – permanent and irreversible
15. **Encephalitis** – resulting in permanent symptoms
16. **Heart attack** – of specified severity
17. **Heart valve replacement or repair**
18. **HIV infection** – caught in a specified list of countries from a blood transfusion, a physical assault or at work
19. **Idiopathic pulmonary arterial hypertension** – of specified severity
20. **Kidney failure** – requiring permanent dialysis
21. **Liver failure**
22. **Loss of hands or feet** – permanent physical severance
23. **Loss of independent existence** – unable to look after yourself ever again
24. **Loss of speech** – permanent and irreversible
25. **Major organ transplant** – from another person
26. **Motor neurone disease** – resulting in permanent symptoms
27. **Multiple sclerosis** – with persisting symptoms
28. **Multiple system atrophy** – resulting in permanent symptoms
29. **Neuromyelitis optica (Devic's disease)** – with persisting symptoms
30. **Open heart surgery** – with surgery to divide the breastbone
31. **Paralysis of a limb** – total and irreversible
32. **Parkinson's disease** – resulting in permanent symptoms

33. **Parkinson plus syndromes** – resulting in permanent symptoms
34. **Pneumonectomy** – Removal of an entire lung
35. **Progressive supranuclear palsy** – resulting in permanent symptoms
36. **Pulmonary artery surgery** – for disease only
37. **Severe lung disease**
38. **Stroke** – of specified severity
39. **Surgical removal of an eyeball**
40. **Systemic lupus erythematosus**
41. **Terminal illness** – where death is expected within 12 months
42. **Third degree burns** – covering 20% of the body's surface area or affecting 50% of the area of the face or head
43. **Traumatic brain injury** – resulting in permanent symptoms
44. **Total permanent disability** – of specified severity

Additional payment conditions

45. **Accident hospitalisation cover** (lower of 25% of cover or £25,000)
46. **Arteriovenous malformation (AVM) of the brain** – with specified treatment (lower of 12.5% of cover or £12,500)
47. **Carcinoma in-situ of the cervix uteri** – requiring treatment with hysterectomy (lower of 12.5% of cover or £12,500)
48. **Carcinoma in-situ of the urinary bladder** (lower of 12.5% of cover or £12,500)
49. **Carotid artery stenosis** – treated by endarterectomy or angioplasty (lower of 12.5% of cover or £12,500)
50. **Cerebral aneurysm** – with surgery or radiotherapy (lower of 12.5% of cover or £12,500)
51. **Central retinal artery or vein occlusion** – resulting in permanent visual loss (lower of 12.5% of cover or £12,500)
52. **Coronary artery angioplasty** (lower of 25% of cover or £25,000)
53. **Diabetes mellitus type 1** — requiring permanent insulin injections (lower of 12.5% of cover or £12,500)
54. **Ductal or lobular carcinoma in-situ of the breast** – with specified treatment (lower of 25% of cover or £25,000)
55. **Non-severe cardiomyopathy** – definite diagnosis (lower of 25% of cover or £25,000)
56. **Ovarian tumour of borderline malignancy/low malignant potential** – with surgical removal of an ovary (lower of 12.5% of cover or £12,500)
57. **Partial loss of hearing** – of specified severity (lower of 12.5% of cover or £12,500)
58. **Partial loss of sight** – permanent and irreversible (lower of 12.5% of cover or £12,500)
59. **Partial third degree burns** – covering 10% of the body's surface area or affecting 25% of the area of the face or head (lower of 12.5% of cover or £12,500)
60. **Prostate cancer** (lower of 25% of cover or £25,000)
61. **Removal of one or more lobe(s) of the lung** – for disease or trauma (lower of 12.5% of cover or £12,500)
62. **Severe Crohn's disease** – surgically treated (lower of 12.5% of cover or £12,500)
63. **Severe ulcerative colitis** – with operation to remove the entire large bowel (lower of 12.5% of cover or £12,500)
64. **Testicular carcinoma in situ** – requiring surgery to remove at least one testicle (lower of 12.5% of cover or £12,500)

To help you understand what these **critical illnesses** cover, please refer to the explanation in the Appendix at the back of this document.

For ten of our **full payment conditions**, if the cause of your claim was as a direct result of an accident we will pay twice the **amount of cover**.

For six of our **full payment conditions** if you're under 45 years of age at the time you are diagnosed with the illness or condition, we will pay 1 ½ times your **amount of cover**.

In both cases the maximum payment you can receive on top of your **amount of cover** is limited to £200,000.

More details on which **full payment conditions** are included, and how we define what an accident is can be found in the Appendix at the back of these Policy Conditions.

✔ Existing illness or medical condition that you had before you applied

As we ask you for all your medical history before we offer you the **policy**, you are covered for all the **critical illnesses** listed in Section A1(a) unless we have told you that you're not before your **policy** starts. We will list any exclusions on your Policy Schedule under the heading of Special Provisions.

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

✔ Travelling abroad

You're covered if you die anywhere in the world. However if you're diagnosed with one of the **critical illnesses** listed in Section A1(a) we will only pay your claim if the diagnosis has been confirmed by a doctor who practices in one 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 are diagnosed in a country not listed above, you will need to go to one of the countries listed, to have that diagnosis confirmed, or to have the operation.

What's not covered

✘ Death as a result of taking your own life in the first 12 months of your policy

We won't pay a claim if you die as a result of intentionally taking your own life in the first 12 months from the **start date** of your **policy**. If this happens we'll cancel your **policy** and refund all the **premiums** that you've paid.

✘ All types of illness

You are only covered for the **critical illnesses** listed in the 'What's covered' section. If you are diagnosed with any other illness, medical condition or have an operation that is not listed, then we will not pay a claim under this **policy**. Also, if your illness, medical condition, or operation does not meet our definition of one of the **critical illnesses** we cover then we will not pay a claim. For example some types of cancer are not covered.

You are not covered for any exclusions listed on your Policy Schedule under the heading of Special Provisions.

✘ If we've paid a claim for an additional payment condition.

We'll only pay one claim for each **additional payment condition** under the **policy**. However, you can make a claim under any of the other **critical illnesses** covered by this **policy**.

For severe Crohn's disease (condition no. 62) and severe ulcerative colitis (condition no. 63) we will only make one additional payment. So if we've paid an additional payment for one of them, you won't then be covered for the other one.

For example if we pay a claim for severe Crohn's disease, you won't then be covered for severe ulcerative colitis.

✘ Death within 14 days of the critical illness being diagnosed, or having the operation.

If you die within 14 days of being diagnosed with one of the **critical illnesses** or having the operation, then we will not pay a **critical illness** claim under this **policy**. However if this happens before the **end date** of your **policy**, we will pay a death claim.

If you die after the **end date** of your **policy** then we won't pay a claim.

✘ Fraud and misrepresentation

Please understand that whilst we know that the vast majority of our customers are honest, we do have to protect ourselves (and our customers) against the effects of fraud.

For this reason we can cancel the **policy** and not pay a claim if we find you or anyone you're insuring has deliberately withheld information from us or has intentionally provided us with false information or lied to us, when they applied, when they claim, or when they apply to re-start their **premiums** (see Section C3). More detailed information on when we can cancel the **policy** can be found in Section C7.

A1(b) – All critical illnesses excluding total permanent disability

What's covered

✔ Death or diagnosis of a critical illness

We will normally pay out the **amount of cover** if you die or are diagnosed with one of the **critical illnesses** listed in Section A1(b) between the **start date** and the **end date** of your **policy**. We have split the **critical illnesses** into **full payment conditions** and **additional payment conditions**. For a **full payment condition** we will normally pay out the full **amount of your cover**.

For an **additional payment condition** we will only pay out an amount equal to part of your **amount of cover**. The amount we pay for each **additional payment condition** is shown in the list of **additional payment conditions**, and more detail can be found in the Appendix under the additional payment conditions section.

If we pay a claim for an **additional payment condition**, we don't reduce your **amount of cover**, and your **policy** continues for your full **amount of cover**. If you make a claim that meets the definition for both an **additional payment condition** and a **full payment condition** at the same time, then we will only pay a claim for the **full payment condition** and not the **additional payment condition** as well.

For example if we paid a claim for the **full payment condition** for blindness (condition no. 7) we won't also pay a claim for the **additional payment condition** for partial loss of sight (condition no. 58). Similarly if you had one of the lobes of your lung removed as a result of being diagnosed with lung cancer and we agreed to

pay the a claim for the **full payment condition** for cancer (condition no. 8), then we won't also pay a claim for the **additional payment condition** for removal of a lobe or lobes of the lung (condition no. 61).

Once we have paid a claim on this **policy** (unless we've paid a claim for an **additional payment condition** or for children's cover which is explained in Section A3), it will normally end. There is an exception. If when your **policy** started you chose to have more life cover than critical illness cover, and we have paid a critical illness claim for a **full payment condition**, you will continue to be covered for the amount of extra life cover you have chosen. Your **policy** will continue, and if you die before the **end date** of your **policy** we will pay the amount of extra life cover. This is shown as 'amount of extra life cover' on your Policy Schedule.

✔ You're covered for the following critical illnesses:

Full payment conditions

1. **Alzheimer's disease or other forms of dementia** – resulting in permanent symptoms
2. **Aorta graft surgery** – for disease or traumatic injury
3. **Aplastic anaemia** – complete
4. **Bacterial meningitis** – resulting in permanent symptoms
5. **Benign brain tumour**
6. **Benign spinal cord tumour** – resulting in permanent symptoms
7. **Blindness** – permanent and irreversible
8. **Cancer** – excluding less advanced cases
9. **Cardiac arrest**
10. **Cardiomyopathy** – of specified severity
11. **Coma** – with associated permanent symptoms
12. **Coronary artery bypass grafts**
13. **Creutzfeldt-Jakob disease**
14. **Deafness** – permanent and irreversible
15. **Encephalitis** – resulting in permanent symptoms
16. **Heart attack** – of specified severity
17. **Heart valve replacement or repair**
18. **HIV infection** – caught in a specified list of countries from a blood transfusion, a physical assault or at work
19. **Idiopathic pulmonary arterial hypertension** – of specified severity
20. **Kidney failure** – requiring permanent dialysis
21. **Liver failure**
22. **Loss of hands or feet** – permanent physical severance
23. **Loss of independent existence** – unable to look after yourself ever again
24. **Loss of speech** – permanent and irreversible
25. **Major organ transplant** – from another person
26. **Motor neurone disease** – resulting in permanent symptoms
27. **Multiple sclerosis** – with persisting symptoms
28. **Multiple system atrophy** – resulting in permanent symptoms
29. **Neuromyelitis optica (Devic's disease)** – with persisting symptoms
30. **Open heart surgery** – with surgery to divide the breastbone
31. **Paralysis of a limb** – total and irreversible
32. **Parkinson's disease** – resulting in permanent symptoms
33. **Parkinson plus syndrome** – resulting in permanent symptoms
34. **Pneumonectomy** – Removal of an entire lung
35. **Progressive supranuclear palsy** – resulting in permanent symptoms
36. **Pulmonary artery surgery** – for disease only
37. **Severe lung disease**
38. **Stroke** – of specified severity
39. **Surgical removal of an eyeball**
40. **Systemic lupus erythematosus**
41. **Terminal illness** – where death is expected within 12 months
42. **Third degree burns** – covering 20% of the body's surface area or affecting 50% of the area of the face or head
43. **Traumatic brain injury** – resulting in permanent symptoms

Additional payment conditions

45. **Accident hospitalisation cover** (lower of 25% of cover or £25,000)
46. **Arteriovenous malformation (AVM) of the brain** – with specified treatment (lower of 12.5% of cover or £12,500)
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55. **Non-severe cardiomyopathy** – Definite diagnosis (lower of 25% of cover or £25,000)
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60. **Prostate cancer** (lower of 25% of cover or £25,000)
61. **Removal of one or more lobe(s) of the lung** – for disease or trauma (lower of 12.5% of cover or £12,500)
62. **Severe Crohn's disease** – surgically treated (lower of 12.5% of cover or £12,500)
63. **Severe ulcerative colitis** – with operation to remove the entire large bowel (lower of 12.5% of cover or £12,500)
64. **Testicular carcinoma in situ** – requiring surgery to remove at least one testicle (lower of 12.5% of cover or £12,500)

To help you understand what these **critical illnesses** cover, please refer to the explanation in the Appendix at the back of this document.

For ten of our **full payment conditions**, if the cause of your claim was as a direct result of an accident we will pay twice the **amount of cover**.

For six of our **full payment conditions** if you're under 45 years of age at the time you are diagnosed with the illness or condition, we will pay 1 ½ times your **amount of cover**.

In both cases the maximum payment you can receive on top of your **amount of cover** is limited to £200,000.

More details on which **full payment conditions** are included, and how we define what an accident is can be found in the Appendix at the back of these Policy Conditions.

What's covered (continued)

✔ Existing illness or medical condition that you had before you applied

As we ask you for all your medical history before we offer you the **policy**, you are covered for all the **critical illnesses** listed in Section A1(b) unless we have told you that you're not before your **policy** starts. We will list any exclusions on your Policy Schedule under the heading of Special Provisions.

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

✔ Travelling abroad

You're covered if you die anywhere in the world. However if you're diagnosed with one of the **critical illnesses** listed in Section 1A(b) we will only pay your claim if the diagnosis has been confirmed by a doctor who practices in one 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 are diagnosed in a country not listed above, you will need to go to one of the countries listed, to have that diagnosis confirmed, or to have the operation.

What's not covered

✘ Death as a result of taking your own life in the first 12 months of your policy

We won't pay a claim if you die as a result of intentionally taking your own life in the first 12 months from the **start date** of your **policy**. If this happens we'll cancel your **policy** and refund all the **premiums** that you've paid.

✘ All types of illness

You are only covered for the **critical illnesses** listed in the 'What's covered' section. If you are diagnosed with any other illness, medical condition or have an operation that is not listed, then we will not pay a claim under this **policy**. Also, if your illness, medical condition, or operation does not meet our definition of one of the **critical illnesses** we cover then we will not pay a claim. For example some types of cancer are not covered.

You are not covered for any exclusions listed on your Policy Schedule under the heading of Special Provisions.

- ✘ If we've paid a claim for an additional payment condition.

  We'll only pay one claim for each **additional payment condition** under the **policy**. However, you can make a claim under any of the other **critical illnesses** covered by this **policy**.

  For severe Crohn's disease (condition no. 62) and severe ulcerative colitis (condition no. 63) we will only make one additional payment. So if we've paid an additional payment for one of them, you won't then be covered for the other one.

  For example if we pay a claim for severe Crohn's disease, you won't then be covered for severe ulcerative colitis.

- ✘ Death within 14 days of the critical illness being diagnosed, or having the operation.

  If you die within 14 days of being diagnosed with one of the **critical illnesses** or having the operation, then we will not pay a **critical illness** claim under this **policy**. However if this happens before the **end date** of your **policy**, we will pay a death claim.

  If you die after the **end date** of your **policy** then we won't pay a claim.

- ✘ Fraud and misrepresentation

  Please understand that whilst we know that the vast majority of our customers are honest, we do have to protect ourselves (and our customers) against the effects of fraud.

  For this reason we can cancel the **policy** and not pay a claim if we find you or anyone you're insuring has deliberately withheld information from us or has intentionally provided us with false information or lied to us, when they applied, when they claim, or when they apply to re-start their **premiums** (see Section C3). More detailed information on when we can cancel the **policy** can be found in Section C7.

A2 – What are the types of cover available?

There are three different types of cover available. You will find which type of cover you have on your Policy Schedule.

You only need to read the section that applies to the type of cover you have.

A2(a) – Level amount of cover

This means that your **amount of cover** does not change between the **start date** and the **end date** of your **policy**. It won't keep up with **inflation** and you will be able to buy less with it in the future. The **premium** you pay each month will not change.

A2(b) – Inflation-linked amount of cover

This means that your **amount of cover** increases each year in line with **inflation**. We may also refer to this as index-linked or increasing cover on your personal quote. If you're unsure whether this applies to you, you will find whether or not this is included, on your Policy Schedule.

What inflation-linked means

We will increase your **amount of cover** on each **plan anniversary**.

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

If you have added this **policy** to an existing **plan** and your **plan anniversary** is less than 3 months after the **start date** of this **policy**, the first increase to your **amount of cover** will be made on the next **plan anniversary**.

We'll tell you what we'll increase your **amount of cover** to and what your new **premium** will be before we increase them.

Any Special Provisions that apply to your **policy** are shown in your Policy Schedule and will also apply to any inflation-linked increases.

You can ask us not to increase your **amount of cover**. If you don't want us to increase your **amount of cover**, you must let us know before the **plan anniversary** when the increase is due. We then won't make any further increases to your **amount of cover** for the rest of the term of your **policy**. This means your cover will change to a level amount of cover (as explained in A1(a)) for the rest of the term of your **policy**.

Please note if you ask us not to increase your **amount of 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.

A2(c) – Decreasing amount of cover

You would generally take out this type of cover to provide the money to pay off a capital and interest repayment mortgage in the event of your death or being diagnosed with a **critical illness**. Your **amount of cover** goes down each month, but the **premium** remains the same.

Example

In this example we have used approximate figures to try and make it easier to follow. They do not reflect the precise amounts that would be outstanding and payable in this case.

Mark and Sarah took out a capital and interest repayment mortgage for £100,000 over a term of 25 years. Their monthly repayments are £780 a month, and the interest on the amount they borrowed is calculated at the end of each year of their mortgage. When they took out their mortgage, they chose to protect it with a Combined Life & Critical Illness policy, with a decreasing amount of cover. The amount of cover is £100,000 for a term of 25 years, which is the same as their mortgage. They are both insured on the policy, and they are both policy owners.

10 years after taking out their mortgage and their policy, Sarah is diagnosed with cancer, and Mark and Sarah make a claim. They complete their claim form, and as the cancer that Sarah is diagnosed with meets the definition for the full payment condition for cancer we agree to pay their claim.

The amount remaining on their mortgage at that time is £80,000. They have paid their mortgage each and every month, on time, and there are no arrears outstanding.

They have not increased the amount borrowed on their mortgage, and have not made any changes to their policy.

First we calculate the amount that would be outstanding on the mortgage if the interest rate they had been paying was fixed at 12%. This is to work out the maximum amount we would pay out. In this example this is £87,000.

Then we calculate how much would have been outstanding on the same mortgage if they had been paying an interest rate fixed at 6%. This is to work out the minimum amount we would pay out. In this example this is £76,000.

Therefore as the amount outstanding on their mortgage is less than £87,000 (the maximum we would pay out) and more than £76,000 (the minimum we would pay out), we would pay out the amount outstanding on their mortgage when Sarah was diagnosed with a critical illness, which was £80,000.

If Mark and Sarah had made any changes to their mortgage since it started, without making any changes to their policy then we would have paid out at least £76,000 as this was the minimum payout.

We will normally pay out the amount of the outstanding mortgage on the date of your death, or the date you're diagnosed with a **critical illness** (including any interest that has built up since that date) as along as:

- there is still a mortgage in place that is repayable by equal monthly instalments

  and
- the mortgage was taken out no later than three months after the **start date** of your **policy** (you will find this on your Policy Schedule),

  and
- the mortgage is a capital and interest repayment mortgage which is on track to be fully repaid at the end of the term of the mortgage

  and
- the term of the mortgage is the same as the term of your **policy**,

  and
- the outstanding mortgage is not more than it would have been had you borrowed the same amount on the **start date** of your **policy** with the same term, and interest rates had been 12% compounded annually.

For the purposes of this section, if you have changed your **amount of cover**, since the **start date**, we treat the **start date** of your **policy** as being the date that you made the changes to the **amount of cover**. If you have changed the term of your **policy**, this means the **end date** of your **policy** will have changed, so for the purposes of this section, we will use this new **end date**. More details about how you can change your **amount of cover**, or the term of your **policy** can be found in Section B.

However if we only pay a claim for one of the **additional payment conditions** then we'll only pay out the amount shown for that condition, and not the full **amount of cover**. Please see the **additional payment conditions** section of the Appendix for more details on the amounts we'll pay out for each **additional payment condition**.

We must have written confirmation from the mortgage lender of the mortgage details and the amount outstanding, before we pay a claim for decreasing cover.

There are some exceptions.

We won't pay any mortgage repayment arrears.

If, during the term of the mortgage, the mortgage repayments have reduced or stopped for any period (other than as a result of an interest rate reduction), we may reduce the amount we pay out. We will pay the amount that you would have owed if the repayments had not been changed, or had been paid in full and on time.

If the amount of your mortgage was more than the **amount of your cover** at the **start date** of your **policy** we will reduce the amount we will pay out proportionately.

Example

Assume you had a £100,000 mortgage and you insured it for £90,000 at the start of the policy. Your cover is 10% less than the mortgage. On the your death or on the date you were diagnosed with a critical illness the outstanding mortgage was £80,000.

We would pay out £72,000 which is 10% less than the outstanding mortgage.

We realise that it is quite possible that you will have changed your mortgage or even paid all of it off, without changing or stopping your **policy**. So, as a minimum we will payout the amount that would have been outstanding if a capital and interest mortgage, which is repaid by equal monthly payments had been taken out:

- for the same amount as the **amount of cover**,

  and
- that started on the same date as the **start date**,

  and
- that ends on the same date as the **end date**,

  and
- the interest rate on that mortgage had been 6% each year compounded annually.

For the purposes of this section, if you have changed the **amount of cover** since the **start date**, we treat the **start date** of your **policy** as being the date that you made the changes to your **amount of cover**. If you have changed the term of your **policy**, this means the **end date** of your **policy** will have changed, so for the purposes of this section, we will use this new **end date**. More details about how you can change your **amount of cover**, or the term of your **policy** can be found in Section B.

A3 – Children's cover

Children's cover is automatically included in your **policy** at no extra cost. It covers your **children** (from birth to age 21) for all of our **critical illnesses** listed in Section A1, except for total permanent disability (condition no. 44) and diabetes mellitus type 1 (condition no. 53). We do apply some limits to children's cover which are explained in the What's not covered section.

Please note children's cover only pays out on diagnosis of a **critical illness** and will not pay out if your **child** dies. For claims relating to children's cover, your **child** doesn't need to have survived for 14 days after their diagnosis or having their operation.

If you need to make a claim under children's cover we will pay the lower of:

- 50% of your **amount of cover**

  or
- £25,000

We will only pay one claim for a **full payment condition** for each child under this policy. If we pay any child claims against our **additional payment conditions**, they'll be limited to 50% of the amount we would pay if you made an additional payment condition claim (see Section A1 for details).

We also include an enhanced claim payment for children's claims for ten specified conditions where the claim is made as a result of an accident. The payment will be the lower of:

- 100% of your **amount of cover**

  or
- £50,000

If your **child** has children's cover under more than one policy with us, the most we would pay out for a claim made as the result of an accident is £100,000 in total, across all of the policies they are covered under.

You will find further information on the illnesses that qualify for enhanced payments in the appendix at the back of these Policy Conditions.

What's covered

✔ Travelling abroad

If your **child** is diagnosed with one of the **critical illnesses** listed in Section A1, excluding total permanent disability (condition no.44) and diabetes mellitus (condition no.53), we will pay a claim provided the diagnosis has been confirmed by a doctor who practices in one 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 your **child** is diagnosed in a country not listed above, they will need to go to one of the countries listed, to have the diagnosis confirmed, or have the operation.

What's not covered

✘ All types of illness

Your **child** is only covered for the **critical illnesses** listed in the Appendix, apart from total permanent disability (condition no. 44) and diabetes mellitus type 1 (condition no. 53). If they are diagnosed with any illness, medical condition, or have an operation that is not listed, then we will not pay a claim for children's cover.

If the illness, medical condition, or operation does not meet our definition of one of the **critical illnesses** we cover then we will not pay a claim. For example some types of cancer are not covered.

Unlike the main policy, **children** are not covered for an enhanced payment of 1 ½ times the **amount of cover** for six of our neurological conditions.

✘ All causes of critical illness

We won't pay a claim for children's cover if:

– you were aware of an increased risk of your **child** suffering the **critical illness** before the **start date** of your **policy** (for example you had received medical advice or counselling in relation to the **critical illness** before your **policy** started),

or

– symptoms relating to the **critical illness** had arisen before the **start date** of your **policy**. However if your **child** had already suffered the **critical 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 **critical illness**, then they would still be covered.

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

– intentional self-inflicted injury,

or

– 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.

A4 – How to make a claim if the person insured has died

We expect you will leave instructions about who you want to receive the cash payment (for example, in your Will).

The person making the claim will usually be the person you name in your Will to deal with your affairs when you die. This person is called your 'executor'. In some circumstances, the person making the claim could be your husband or wife, or another friend or relative.

The person making the claim should tell us about your death as soon as they can. They can tell us in writing, by phone, by email, or by fax. For details of how best to contact us, visit our website www.LV.com

When we're informed of your death, we will ask the person making the claim to send us the original death certificate (not a photocopy). If we need any further information from them, we'll write to them to explain what we need and why we need it.

Examples of further information we may need are:

- Proof of your age, for example your birth certificate if this was not provided when you applied for the **policy**

  and

- evidence of the right of the person to make the claim (for example, evidence that you have named them in your will as the executor of your estate).

  and

- if you have put your **policy** in trust, we'll need to see a copy of the trust deed.

We appreciate that this will be a difficult time, and we'll only ask for the information we need to pay the claim as quickly as possible.

A5 – When you need to tell us about your critical illness

To help us process your claim quickly, if you're diagnosed with a **critical illness** please tell us as soon as you can after your diagnosis, or the date the operation took place. You can tell us in writing, by phone, by email or by fax. For details of how best to contact us, please visit www.LV.com

A6 – What you need to do to make a critical illness claim

Once you've told us about your **critical illness**, we'll ask you to complete a claim form (which we'll send you at the time). This allows us to collect the information we need from you about your **critical illness**.

We want to make sure that your claim is dealt with quickly, and to help us with this, it is important that you complete and return the form to us as soon as you can. If you need help completing the form, please let us know.

We'll need evidence from the doctor (or the medical practitioner who is treating you) confirming that you have been diagnosed with a **critical illness**. We may also need to get medical reports from your doctor. If we do, we'll send you a consent form to complete. The form explains your rights under the Access to Medical Reports Act 1988.

We don't know exactly what evidence we'll need until you make a claim, as all claims are looked at individually. We appreciate this is a difficult time, so we won't ask for anything unreasonable or unnecessary, and we will explain why we need anything we ask for.

We may need you to be examined by a doctor of our choice. We may also ask for other evidence to consider your claim, such as:

- a report from your doctor, or any other doctor who has treated or examined you, or any alternative medical practitioner
- a report on tests or investigations carried out to make the diagnosis
- a report from a consultant that we appoint, confirming the diagnosis.

We'll pay for the cost of all medical reports and other evidence we ask for.

Because we rely on the information we're given to assess your claim, if any of the information is untrue or incomplete you may not be covered and we may not be able to pay your claim.

Please understand that whilst the vast majority of our customers are honest, we do have to protect ourselves (and our customers) against the effects of fraudulent claims. Therefore if we ask for additional information, please do not take this as a reflection of our opinion of you.

A7 – Who we'll pay the claim to

Once your claim has been approved, we'll pay it to the legal owner of your **policy**. This will usually be one of the following:

- you, or if you are not the policy owner, the person named as the policy owner in your Policy Schedule.

  or

- if you have died, and you are also the policy owner, we will pay the claim to the person named in your Will to look after their affairs if you die. This person is called your executor.

  or

- if you have died, and you haven't made a Will we will pay the claim to the person appointed by the courts to look after your affairs. This person is called your administrator.

  or

- if you have arranged for your **policy** to be put in trust, we will pay the claim to the trustees.

  or

- if you have assigned your **policy** to someone else (this is where you have legally signed over the ownership of your **policy** to someone else), then we will pay the claim to them.

If we pay out the amount of life cover on death of the person insured the **policy** will end. If we pay a critical illness claim for a **full payment condition** the **policy** will end unless the Policy Schedule shows that you have an 'amount of extra life cover' (see Section A8), or if we pay a critical illness claim for an **additional payment condition** or for children's cover. We explain what we do in relation to claims for children's cover in Section A3, and what we do for claims for an **additional payment condition** in Section A9.

When we pay a claim, we'll try to do this as quickly as possible. Sometimes it's not possible to pay straight away, so if it takes longer than 60 days from the date of diagnosis of the insured event for a **critical illness** claim and from the date of death for a life claim, we'll add interest to the amount we pay, from day 61, to the date of payment. If this changes we will let you know at the time of claim.

A8 – What happens when a critical illness claim has been paid, and you have extra life cover?

If your Policy Schedule shows that you have an 'amount of extra life cover' then if we have paid a critical illness claim for one of the **full payment conditions**, you will continue to be covered for the amount of extra life cover you have chosen. Your **policy** will continue, and if you die before the **end date** of your **policy** we will pay the amount of extra life cover.

If we pay a claim because you have died, then your **policy** will end.

A9 – What happens when a claim has been paid for an additional payment condition?

If we pay a claim for an **additional payment condition**, your **policy** will continue in full, for your full **amount of cover**. We don't reduce the **amount of cover** by the amount of the additional payment we've paid. This is as long as you continue to pay the **premiums** for your **policy** as and when they are due.

If you make a claim that meets the definition for both an **additional payment condition** and a **full payment condition** at the same time, then we will only pay a claim for the **full payment condition** and not the **additional payment condition** as well.

For example if we paid a claim for the **full payment condition** for blindness (condition no. 7) we won't also pay a claim for the **additional payment condition** for partial loss of sight (condition no. 58). Similarly if you had one of the lobes of your lung removed as a result of being diagnosed with lung cancer and we agreed to pay a claim for the **full payment condition** for cancer (condition no. 8), then we won't also pay a claim for the **additional payment condition** for removal of a lobe or lobes of the lung (condition no. 61).

We will only pay out one claim for each **additional payment condition** for each person insured. However you can still make a claim for any other **critical illnesses** covered by the **policy**.

If you die before the **end date** of your **policy** we will pay the full **amount of cover**, and your **policy** will then end.

A10 – What if you're insuring someone else?

If you are insuring someone else, you will be the policy owner, and they will be the person insured. We will pay a claim to you (or the legal owner explained in Section A7) if the person insured dies or if earlier, is diagnosed with a **critical illness**, before the **end date** of your **policy**.

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.

A11 – What if are two people insured on the policy?

If there are two people insured on the **policy**, we will pay a claim if either of you die or if earlier, are diagnosed with a **critical illness** before the **end date** of your **policy**. If we have paid a claim for life cover or a **full payment condition** for a **critical illness** claim, the **policy** will end. If you are also both policy owners, and one of you dies, we will normally pay the claim to the surviving policy owner.

However your **policy** won't end if the claim we've paid relates to children's cover (which we've explained in Section A3) or if we pay a claim for an **additional payment condition** (see Section A9). If we have paid a claim for a **full payment condition**, and your Policy Schedule shows that you have an 'amount of extra life cover' (See Section A8) your **policy** also won't end.

Section B – Options to change your policy

This section tells you about how you can change the **amount of your cover** or the term of your policy.

If you have chosen for the **amount of your cover** to increase in line with **inflation** this is explained in Section A2(b).

However you can also choose to change the **amount of your cover**, or the term of your **policy** between the **start date** and the **end date**.

If you want to do this, please let us know, and we'll send you an application form to complete. We'll let you know what information we need at the time, and if you want us to, we'll be able to help you complete the application.

It is very important that you don't cancel your existing **policy**. We will 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 need to be cancelled, we'll automatically do this for you.

B1 – Guaranteed Increase Options for personal cover

You can increase your **amount of cover** and in some cases replace your **policy** with a new policy, without completing a full application, if certain events happen. We call these Guaranteed Increase Options, because we guarantee that you can change your **policy**, within certain limits, as long as you are eligible.

These options apply separately to life cover and critical illness cover.

Occasionally, due to your medical history, or your personal circumstances you may not be able to take advantage of these options. If this applies to you, we will tell you before your **policy** starts. This will be detailed on your Policy Schedule under the heading of Special Provisions.

The event must happen to the person insured. This means that if you're insuring someone else then it's their circumstances we'll consider, not yours.

Unfortunately you won't be able to use these options if:

- The person insured has been diagnosed with a **critical illness** or had an operation covered by this **policy**.
- The person insured has been advised by a medical practitioner to have an operation covered by this **policy**.

You don't need to have told us that you intend to make claim.

Your **policy** must be current with all **premiums** paid to date.

If you want to change your **policy** using one of the Guaranteed Increase Options, you won't have to provide any additional medical information at that time. This means we do have to apply some limits to the amount you can change your cover by. Please see the table on page 16 for more details.

The events which are covered by our Guaranteed Increase Options for personal cover are:

- Marriage or civil partnership - You can use this option if you marry or enter a civil partnership. You can increase the **amount of cover** by up to 50% of the **amount of cover** shown on your Policy Schedule, at the time you wish to use this option.

Example

James has a Combined Life & Critical Illness policy for £200,000. He and his partner Susan decide to marry, so James wants to increase his cover to make sure his new wife is protected financially, if he dies, or, if earlier he's diagnosed with a critical illness. He can use this option to increase the amount of cover.

The maximum amount that James can increase his cover by is £100,000, which means he could increase the amount of cover to a maximum of £300,000.

£200,000 x 50% = £100,000
£200,000 + £100,000 = £300,000

James is able to increase his cover using this Guaranteed Increase Option without having to complete another full application, or providing any additional medical information.

- Childbirth or legal adoption of a child - You can use this option if you have a child, or you legally adopt a child. You can increase the **amount of cover** by up to 50% of the **amount of cover** shown on your Policy Schedule, at the time you wish to use this option.
- Divorce or dissolution of civil partnership - You can use this option if you divorce or your civil partnership is dissolved. You can increase the **amount of cover** by up to 50% of the **amount of cover** shown on your Policy Schedule, at the time you wish to use this option.
- Mortgage increase - You can use this option if you take out a new mortgage or an additional loan under an existing mortgage on your main residence to make home improvements.

  You can increase the **amount of cover** by the lower of:

  – the increase in your mortgage amount,

  or

  – 50% of the **amount of cover** shown on your Policy Schedule at the time you wish to use this option.

- Mortgage extension - You can use this option if you extend the repayment term of your mortgage or take out a new mortgage and the new repayment date is more than one year after the **end date** of your **policy**.

  You can extend the term of your **policy** by replacing it with a new policy as long as at the time:

  – The **amount of cover** for the new policy is the same as or less than the **amount of cover** on your current **policy**,

  and

  – the **amount of cover** for the new policy is the same as or less than the amount outstanding under your mortgage,

  and

  – the **end date** of the new policy is not later than the repayment date of the mortgage,

  and

  – the new policy ends before you (or both of you, if there is more than one person insured) reach the age of 70.

- Increase in basic salary received from an employer - You can use this option if you are employed and your salary has increased by at least 10%. Your basic salary must have increased because of a promotion, the award of a recognised professional qualification or both a change of employment and employer. You must be employed immediately before and after the increase in your basic salary.

  You can increase the **amount of cover** by the lower of:

  – Five times the increase in your basic salary

  or

  – 50% of the **amount of cover** shown in your Policy Schedule at the time you wish to use this option.

  This option isn't available if you're self-employed.

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

- Splitting a joint life policy on separation

This option only applies if there are two people insured under the policy, and you have taken it out for the purpose of protecting a mortgage.

If you get divorced or have your civil partnership dissolved, or you separate you can each replace your current **policy** with a new policy.

Example

Stuart and Natalie are married. They originally took out a policy for £100,000 a few years ago, and increased their cover to £150,000 using one of the Guaranteed Increase Options. They're both insured under the policy.

Stuart and Natalie decide to get a divorce, but they each want to keep £150,000 of cover. They can use this option to split their existing plan into two separate plans. Each plan would include a Combined Life & Critical Illness policy with cover of £150,000 (the most cover allowed). They'd each own one policy, and be the insured person on that policy.

This will only be possible if:

- the original mortgage has been rearranged to be in the name of one of you only,

  or

- if either of you has taken out a new mortgage

The **amount of cover** cannot be more than what's shown on your Policy Schedule for your current **policy**, at the time you wish to use this option.

If you choose to use this option, your current **policy** will be cancelled and we will issue a new policy for each of you in its place.

The **premium** you pay for the new policy will depend on your age, whether you smoke, and the **premium** rates available at the time. If you had to pay any extra **premiums** on your current **policy**, because of your health, occupation or leisure activities, then this extra premium may also be applied to your new policy.

General limits for Guaranteed Increase Options for personal cover

There are some limits to how much you can change the **amount of cover** by. These limits depend on which option you use. The total of all the Guaranteed Increase Options you use can't be more than 50% of the **amount of cover** shown on your Policy Schedule, at the time you wish to use the option. The limits apply separately to life cover and critical illness cover. Also the total amount that you can increase your **amount of cover** by over the lifetime of your **policy** using these Guaranteed Increase Options can't be more than £200,000.

The table below explains these limits in more detail. It also shows the maximum age at which you can make use of these options. If you're insuring two people, it's the older of them that the maximum age limit applies to. You can use these options as many times as you need to, however the increase can't be more than the limits shown below.

In all cases you can only use these options within three months of the event occurring.

Event	Increase limit	Maximum increase	Maximum age of person insured
Marriage/Civil Partnership	50% of your **amount of cover** at the time you wish to use the option.	£150,000	54
Childbirth/Legal adoption of a child	50% of your **amount of cover** at the time you wish to use the option.	£150,000	54
Divorce/Dissolution of Civil Partnership	50% of your **amount of cover** at the time you wish to use the option.	£150,000	54
Mortgage Increase	The lower of: the increase in mortgage amount, or 50% of your **amount of cover** at the time you wish to use the option.	£150,000	54
Mortgage extension	The new amount of cover cannot be more than the lower of: the **amount of your cover** on your original **policy** at the time you wish to use the option, or the amount outstanding under your mortgage at the time.	Not applicable	54
Increase in basic salary received from an employer	The lower of: 5 times the increase in your basic salary, or 50% of your **amount of cover** at the time you wish to use the option.	£150,000	54
Splitting a joint life policy on separation	The **amount of cover** is limited to the **amount of cover** on your original **policy** at the time you wish to use the option.	Not applicable	No age limit

If you change the **amount of your cover** using one of these options, the **premium** you need to pay will also change to reflect this. The **premium** will be based on your age and smoker status at the time of the change. If you had to pay any extra **premiums** on your original **policy**, because of your health or leisure activities, then this extra **premium** may also be applied to the increased **amount of cover**.

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

- Your original marriage certificate or civil partnership registration certificate,

  or
- the original birth certificate or adoption certificate,

  or
- a copy of your mortgage offer,

  or
- your original decree absolute, dissolution certificate, or confirmation signed by a solicitor that you are no longer living together and have separated,

  or
- evidence that your basic salary has increased such as three months payslips confirming the increase.

We'll let you know exactly what evidence we need at the time you wish to use one of these options.

B2 – Other ways to change the amount of your cover

You can change the **amount of cover**, or the term of your **policy** at any time. If you want to do this (other than using the Guaranteed Increase Options in Section B1, or inflation-linking, which is explained in Section A2(b)) we'll work out the new **premium** depending on your age, health and medical history, leisure activities, whether you smoke and the premium rates available at the time.

We'll confirm the new **amount of cover** and **premium** before we make the changes. Unfortunately, we can't guarantee that we'll be able to offer you an increase in the future, as it will depend on your age, health and medical history, leisure activities and whether we are offering the same type of insurance at that time.

Section C – 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**.

C1 – Paying your premiums

You are responsible for paying **premiums** on the date shown in your Policy Schedule (these are known as **premium** due dates). You must pay your **premiums** by Direct Debit through a bank or building society. Your premiums are guaranteed not to increase unless you have chosen inflation-linked cover (which we explain in Section A1(b)).

C2 – Stopping your premiums

We give you 60 days from the due date for you to pay a **premium**. If we haven't received a **premium** from you, we will send you a reminder to let you know.

If you fail to pay any **premium** within this 60 day period, then your **policy** stops immediately, and we will cancel it. We will not pay anything to you if this happens. If we cancel your **policy**, we'll let you know.

C3 – Re-starting your premiums

If your **policy** has stopped because you didn't pay a **premium**, you can ask us to start it again. You can do this within six months of the first unpaid **premium**. So that we can restart your **policy**, we will need you to pay all of the **premiums** that you haven't paid. You will also need to complete some health questions.

Unfortunately, it is possible that we may not be able to restart your **policy**, or if we can it may be on different terms to those originally offered, for example if your health has got worse since your **policy** started. If this happens, we will explain our decision to you and the reasons for it. Please note as the **policy** has actually ended we are not obliged to restart it for you.

C4 – Can you change the amount of my premium?

We have designed your **policy** with the aim that the amount of your **premium** won't change other than changes for inflation-linked cover, or if you change your **policy** yourself.

We work out the **premium** for your **policy** based on our current understanding of:

- the way your **policy** is taxed

  and

- the factors that we're legally able to take into account.

We could only change the **premium** after the **start date** of your **policy** for the following reasons:

- Changes to legislation that changes the way its taxed
- Changes to legislation that changes the factors we can legally use
- A decision by a UK court or the European Court of Justice that changes the factors that we can take account of

These are the only times when we can change the **premiums** for your **policy**.

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.

If we advise you of an increase to your **premium**, you can choose to continue paying the previous amount instead. If you choose this your **amount of cover** will then be reduced; to the amount that we work out your existing **premium** will pay for.

You must tell us, if you decide to do this, at least 30 days before the change is due to be made.

You can also choose to cancel your **policy**, although you should think about it carefully before doing so. If you decide to do this, you will lose all of the cover under your **policy** and you won't get anything back.

C5 – Proof of your age and name

The **premium** you pay for your **amount of cover** is based on your age as shown in your Policy Schedule.

Before we can pay a claim on your **policy** we'll need to confirm your date of birth. For a death claim we'll take this information from your death certificate. If you've been diagnosed with a **critical illness** we'll get this information from your medical records. In some cases we may also ask to see your original birth certificate or passport (not photocopies) to help confirm your age.

We recognise that these are valuable documents that other people may need at the same time. We will look after the documents carefully, and return them to you quickly.

It is really important that you check your Policy Schedule has the correct date of birth on it, as it affects the amount we can pay out for a claim. If your actual date of birth differs from that shown on your Policy Schedule, we will change your **amount of cover** to the amount that would have been available, based on the your actual age and the **premiums** you have paid.

If when a claim is made your name is different from the name on your Policy Schedule and birth certificate we will also need evidence of this change (for example a marriage certificate). We may need to ask for additional evidence, but we won't ask for anything unreasonable. We will tell you what evidence we need, and why we need it.

C6 – When you can cancel your policy

You can cancel your **policy** at any time by contacting us, although if you do you will lose all your cover under the **policy** and you won't get anything back.

If you cancel your **policy** within 30 days of it starting we'll refund the **premiums** you've paid, however if you cancel after 30 days you won't receive a refund.

C7 – When we can cancel your policy

Once your **policy** starts we'll only cancel it if you've died as a result of taking your own life within 12 months of the **start date** of your **policy**, or if you haven't paid all of the **premiums** that are due. We've explained what happens if you stop paying **premiums** in Section C2.

Please understand that whilst the vast majority of our customers are honest, we do have to protect ourselves (and customers) against the effects of fraudulent claims so the following exclusions apply:

We can cancel your **policy**, or not pay your full **amount of cover** if either you or anyone you are insuring acts 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 C3).

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 all of the questions we asked you honestly and in full, it would have led us to a different decision about the **amount of cover**. For example:

- A higher **premium** would have applied for the **amount of cover**,
  or
- the **amount of cover** would have been lower for the same **premium**,
  or
- we would have restricted the **critical illnesses** covered under your **policy**,
  or
- the term of your **policy** would have been restricted,
  or
- your application would have been deferred, for example, pending the outcome of a medical investigation,
  or
- 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.

C8 – When your policy ends

On the **end date** shown in your Policy Schedule, your **policy** will stop and no further **premiums** will be due. You won't receive anything back when it ends.

Also once we have paid a claim on your **policy** (unless the claim is for children's cover – see Section A3 or for an **additional payment condition** – see Section A9), it automatically ends, and we are not liable for any further claims.

If we pay a critical illness claim for a **full payment condition** the **policy** will end unless the Policy Schedule shows that you have an 'amount of extra life cover' (See Section A8).

C9 – Arranging for the amount of cover to be paid to a specific person

You might want to arrange for the **amount of cover** to be paid to another person, or company when you claim, such as your mortgage lender.

You can do this by transferring ('assigning') your **policy** to another person (or people) or a company. But remember, you will still be the person insured.

If you do this, you need to send us the relevant documents so that we can update our records. If you don't, we may not pay the right person, people or company when a claim is made.

You are responsible for making sure that the **policy** has been assigned, or placed in trust in a way which is valid and effective. You may want to talk to a solicitor before doing this.

C10 – The law that applies to your policy

Combined Life & Critical Illness Guaranteed 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.

C11 – 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 www.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 – The list of critical illnesses

In this Appendix we have provided detailed definitions of the **critical illnesses** that are covered by this **policy**.

We have split this into **full payment conditions** – where we would pay the full **amount of cover**, and **additional payment conditions**, where we would pay a proportion of your **amount of cover**. For **additional payment conditions** we will only make one payment for each condition. You can't make multiple claims for one single **additional payment condition**.

Your Policy Schedule explains which of these **critical illnesses** you're covered for. This depends on whether you chose to be covered for all of the **critical illnesses**, or all of the **critical illnesses** except total permanent disability (condition no. 44). The choices you have are explained in Section A1.

Also in some cases due to your health, occupation or leisure activities we may not be able to cover all of these **critical illnesses**. If this is the case, it will be noted on your Policy Schedule under the heading of Special Provisions.

Full payment conditions

A **full payment condition** is a condition where we pay your full **amount of cover**. If we pay a claim under one of these conditions then your **policy** will normally end. The only exception to this is if we pay a claim under children's cover, or where you have chosen more life cover than critical illness cover. If this is the case then after we've paid a critical illness claim, your **policy** will continue for the extra amount of life cover that you chose.

For some **full payment conditions** if you are diagnosed as having the condition and you are under 45 years of age we will pay 1 ½ times your **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**. We have explained this under the relevant conditions, so you'll know when this is available. This enhanced payment is not available for children's cover.

For some **full payment conditions** we will pay twice your **amount of cover** if the cause of your claim was as a direct result of an accident. We have explained this under the relevant conditions, so you'll know when this is available. These payments are also available for children's cover.

For the purposes of this an 'accident' means:

any violent, external and visible event that happens by chance, solely and independently of any other cause, which results in a bodily injury being sustained.

It doesn't include any event where the injury is caused by, or a contributing factor is:

- an intentional self-inflicted act
- an act deliberately inflicted by another person
- taking drugs
- drinking alcohol
- consuming poisonous substances (including inhaling gases or fumes)
- actively taking part in any criminal or fraudulent act
- actively taking part in any riot, civil commotion, uprising or war (whether declared or not), or any related act or incident
- taking part in any form of motor racing (including time trials)
- taking part in any form of aviation, including travelling in an aircraft (except as a fare paying passenger)
- natural causes, or an illness or disease of any kind

To help you understand when this applies we have highlighted the word 'accident' in bold text like this: **accident**.

1. Alzheimer's disease or other forms of dementia – resulting in permanent symptoms

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

- Remember
- Reason; and
- Perceive, understand, express and give effect to ideas.

If you're under 45 years of age, and your claim meets this definition we will pay 1 ½ times the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

2. Aorta graft surgery – for disease or traumatic injury

The undergoing of 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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 the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

If your claim doesn't meet this definition you may still be able to claim on our **additional payment condition** – partial loss of sight. Please see condition no. 58 in the additional payment conditions section of this Appendix.

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 tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0.
- Malignant melanoma 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 on one of our **additional payment conditions** if you have suffered from one of the following:

- Carcinoma in-situ of the cervix (condition no. 47)
- Carcinoma in-situ of the Urinary bladder (condition no. 48)
- Ductal or lobular Carcinoma in-situ of the breast (condition no. 54)
- Prostate cancer (condition no. 60)
- Testicular carcinoma in-situ (condition no. 64)

Please see the relevant numbered condition in the additional payment conditions section of this Appendix.

9. 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.

10. 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 our **additional payment condition** – Non-severe cardiomyopathy. Please see condition no. 55 in the additional payment conditions section of this Appendix.

11. 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.

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

12. Coronary artery bypass grafts

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

13. Creutzfeldt-Jakob disease

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

14. 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 the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

If your claim doesn't meet this definition you may still be able to claim on our **additional payment condition** – partial loss of hearing. Please see condition no.57 in the additional payment conditions section of this Appendix.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. Loss of hands or feet – permanent physical severance

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

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

23. 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.

The insured person 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 yourself – the ability to feed yourself when food has been prepared and made available.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

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

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

24. Loss of speech – permanent and irreversible

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

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

25. 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.

26. Motor neurone disease – resulting in permanent symptoms

A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function. All forms of motor neurone disease are covered including spinal muscular atrophy.

If you're under 45 years of age, and your claim meets this definition we will pay 1 ½ times the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

27. 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.

28. Multiple system atrophy – resulting in permanent symptoms

A definite diagnosis of multiple system atrophy by a Consultant Neurologist. There must be evidence of permanent clinical impairment of either:

- Motor function with associated rigidity of movement
- The ability to coordinate muscle movement
- Bladder control and postural hypotension.

If you're under 45 years of age, and your claim meets this definition we will pay 1 ½ times the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

29. 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.

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

The undergoing of 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.

31. Paralysis of a limb – total and irreversible

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

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

32. Parkinson's disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with either associated tremor or muscle rigidity.

For this definition the following are not covered:

- Parkinsonian syndromes/Parkinsonism.

If you're under 45 years of age, and your claim meets this definition we will pay 1 ½ times the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

33. Parkinson plus syndromes – resulting in permanent symptoms

A definite diagnosis by a Consultant Neurologist of one of the following Parkinson plus syndromes:

- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Corticobasal ganglionic degeneration
- Diffuse Lewy body disease.

There must be also permanent clinical impairment of at least one of the following:

- motor function; or
- eye movement disorder; or
- postural instability; or
- dementia.

If you're under 45 years of age, and your claim meets this definition we will pay 1 ½ times the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

34. Pneumonectomy – removal of an entire lung

The undergoing of 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 our **additional payment condition** – removal of one or more lobe(s) of the lung. Please see condition no. 61 in the additional payment conditions section of this Appendix.

35. 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.

If you're under 45 years of age, and your claim meets this definition we will pay 1 ½ times the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

36. 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.

37. 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.

38. 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.

39. 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.

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

40. 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.

41. 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.

42. 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 the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

If your claim doesn't meet this definition you may still be able to claim on our **additional payment condition** – partial third degree burns. Please see condition no. 59 in the additional payment conditions section of this Appendix.

43. Traumatic brain injury – resulting in permanent symptoms

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

If the cause of your claim was as a direct result of an **accident** then we will pay twice the **amount of cover**. This is subject to a maximum of £200,000 more than your **amount of cover**.

44. Total permanent disability – of specified severity

Your Policy Schedule states whether this is included and, if so, which of the following types of cover applies.
This condition is not covered under children's cover.

Although you don't need to tell us if you change your occupation after your **policy** starts, we will assess any claim based on the occupation that you were in when you became ill or had the accident which prevented you from working. We will use the type of cover shown on your Policy Schedule.

If you are not in paid or unpaid work at the time of the claim, then the work tasks definition will apply irrespective of the cover shown on your Policy Schedule.

- (a) Own occupation – unable to do your own occupation ever again.

  Loss of the physical or mental ability through an illness or injury to the extent that you're unable to do the essential duties of your own occupation ever again.

  The essential duties are those that are normally required for, and form a significant and integral part of, the performance of your own occupation that cannot reasonably be left out without affecting your ability to carry out your occupation.

  Own occupation means the trade, profession or type of work you do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when cover ends or you expect to retire.

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

- (b) Work tasks – unable to do 3 specified work tasks ever again

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

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

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

  The work tasks are:

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

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

It is important to understand that for us to pay a claim under either own occupation cover or work tasks cover, we need to be satisfied that your disability is expected to last for the remainder of your life, irrespective of when your policy ends, or when you retire.

This means we won't pay a claim if we determine you are only partially or temporarily disabled, or the medical evidence we have received in connection with your claim indicates that your disability is not expected to last for the remainder of your life.

We will pay a claim if the medical evidence we have received in connection with your claim shows that you have received all reasonable treatment options, these have been given a reasonable time to work, and have still failed to show any improvement in your symptoms.

More information on how to make a claim, and the types of evidence we need are explained in Section A5.

Additional payment conditions

An **additional payment condition** is a condition where we pay an amount equal to part of your **amount of cover**. If we pay a claim under one of these conditions, then your **policy** will still continue for your full **amount of cover**. We don't reduce your **amount of cover**. We explain how much we will pay under each condition listed. However we will only pay a claim once for each of these conditions.

If the claim you make meets the definition of one of the **full payment conditions** as well as one of the **additional payment conditions** we will only pay a claim for the **full payment condition**, and your **policy** will then end. The only exception to this is if we pay a claim under children's cover, or where you have more life cover than critical illness cover.

45. Accident hospitalisation cover

We will pay the lower of 25% of the **amount of cover** or £25,000 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.

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you undergo 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.

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you are 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.

48. Carcinoma in-situ of the urinary bladder

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you are 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.

49. Carotid artery stenosis – treated by endarterectomy or angioplasty

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you undergo endarterectomy or therapeutic angioplasty to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

50. Cerebral aneurysm – with surgery or radiotherapy

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you undergo 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.

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you suffer 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.

52. Coronary artery angioplasty

We will pay the lower of 25% of the **amount of cover** or £25,000 if you undergo any of the following procedures to treat a narrowing or blockage in two or more of the main coronary arteries:

- Balloon angioplasty
- Atherectomy
- Rotablation
- Laser treatment
- Insertion of stents

This procedure must have been carried out on the advice on a Consultant Cardiologist to treat severe coronary artery disease in two or more main coronary arteries at the same time. The procedure must be to treat at least 70% diameter narrowing. If the procedure is only performed on one main coronary artery there must be at least 70% diameter narrowing in another main coronary artery.

For the purpose of this definition main coronary arteries are described as one or more of the following:

- Right coronary artery
- Left main stem
- Left anterior descending
- Circumflex

For this definition the following are not covered:

- Procedures to any branches of any of the main coronary arteries
- Any other procedures to treat narrowing or blockage of coronary arteries.

53. Diabetes mellitus type 1 – requiring permanent insulin injections

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you have a definite diagnosis of type 1 insulin dependent diabetes mellitus requiring the permanent use of insulin injections that have continued for a period of at least 12 months.

For this definition the following are not covered:

- Gestational diabetes
- Type 2 diabetes (including type 2 diabetes treated with insulin)
- Latent autoimmune diabetes of adulthood.

This condition is not covered under children's cover.

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

We will pay the lower of 25% of the **amount of cover** or £25,000 if you are diagnosed with ductal or lobular carcinoma in-situ of the breast, that is histologically confirmed, and results in you undergoing surgical removal on the advice of your hospital consultant.

55. Non-severe cardiomyopathy – definite diagnosis

We will pay the lower of 25% of the **amount of cover** or £25,000 if you are 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.

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you are 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.

57. Partial loss of hearing – of specified severity

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you suffer 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.

58. Partial loss of sight – permanent and irreversible

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you suffer 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.

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you suffer 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.

60. Prostate cancer

We will pay the lower of 25% of the **amount of cover** or £25,000 if you are diagnosed with a tumour of the prostate gland histologically classified as having a Gleason score between 2 and 6 inclusive provided:

- the tumour has progressed to at least clinical TNM classification T1N0M0; and
- treatment included the complete removal of the prostate gland or external beam or interstitial implant radiotherapy, or High Intensity Focused Ultrasound, or Hormone therapy, or Cryotherapy.

For this definition, the following are not covered:

- Experimental treatments, or
- Observation.

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you undergo 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.

62. Severe Crohn's disease – surgically treated

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you are 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.

We won't pay a claim under this condition if we have already paid a claim for severe ulcerative colitis (condition no. 63).

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you have been diagnosed with severe ulcerative colitis and have 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.

We won't pay a claim under this condition if we have already paid a claim for severe Crohn's disease (condition no. 62).

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

We will pay the lower of 12.5% of the **amount of cover** or £12,500 if you are diagnosed with, and have 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).

Definitions

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

'**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.

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

'**Critical illness**' and '**critical illnesses**' mean the illnesses, medical conditions or operations detailed in the Appendix. Your Policy Schedule explains which of these you are covered for.

'**Additional payment condition**' means a **critical illness** where you're covered for part of the **amount of cover**. The amount we would pay in the event of a claim is detailed under the relevant **critical illnesses** in the Appendix.

'**Amount of your cover**' and '**amount of cover**' mean the amount you are insured for (shown on your Policy Schedule). This includes any inflation-linked increases. If you have applied for a decreasing **amount of cover**, then your **amount of cover** goes down each month. This is explained in more detail in Section A2(c). You can choose different amounts of critical illness cover and life cover.

'**End date**' means the date when your **policy** ends. This date is shown in your Policy Schedule.

'**Full payment condition**' means a **critical illness** where you're covered for the full **amount of cover**.

'**Inflation**' means the rising cost of goods and services such as your weekly shopping, gas and electricity. We will measure this using the Retail Prices Index, unless this stops being published, in which case we would use another similar published index.

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

'**Plan anniversary**' means each 12 month anniversary from the date your **plan** originally started. This will be the same as the 12 month anniversary 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 and medical history, or your leisure activities. 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 your cover**.

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

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

Liverpool Victoria Friendly Society Limited: County Gates Bournemouth BH1 2NF.

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21205-2018 03/18