

Decreasing Mortgage Cover Plan - Guaranteed Payments

Terms and Conditions

Contents

1. Who can have the plan?	3
2. The aim of the plan	4
3. The cover and benefits in more detail	5
Life cover only	5
Life or earlier critical illness cover	6
Life or earlier critical illness cover with extra life cover	7
Total permanent disability – unable before age 60 to do your own occupation ever again benefit	9
Payment protection benefit	10
Waiver of payment benefit	14
4. How long the plan can last	15
5. Making payments	15
6. How flexible is it?	16
Guaranteed insurability option	16
Reducing your cover	18
Separation option	18
7. Making a claim	18
8. Changes we can make to the plan	20
9. General terms	20
10. Law	20
11. Other information	20
Critical illnesses and operations	22
How to contact us	33
Appendix A - Data protection	34

Large print,
audio and
Braille.

Please let us know if you would like a copy of this in large print, braille, audiotape or CD.

If you are a textphone user, we can answer any questions you have through a Typetalk Operator. Call us on 18001 01793 514514. Or, if you'd prefer, we can introduce your adviser to a sign language interpreter.



Terms and conditions – your contract with us

These terms and conditions and your plan schedule set out the terms and conditions of the Decreasing Mortgage Cover Plan – Guaranteed Payments.

Changes or additions to the terms and conditions can only be made by us and we will confirm them in writing from our head office.

If you've purchased your plan having had advice from an adviser, we do not authorise your adviser to agree to any changes or additions to these terms and conditions.

The plan is provided by Zurich Assurance Ltd so where we refer to 'we', 'our', 'us' or 'Zurich' we mean Zurich Assurance Ltd. Where we refer to 'you' or 'your' we mean the life or lives assured. Where the plan has been taken out on another person's life 'you' and 'your' may also mean the plan owner, where applicable.

In these terms and conditions, where we can use our discretion, make a decision, require information or evidence or use our judgment, then we will do so acting reasonably, proportionately, fairly and in accordance with the law and regulations.

You are responsible for the following:

- a) Giving us accurate information when we reasonably ask for it. If you ask us to make a change to your plan, or to the amount of your payment, and we need to ask you some questions to help us consider whether we can agree to your request, you should take reasonable care to answer the questions we ask you honestly and to the best of your knowledge.
- b) Letting us know if your name, address or contact details change. Please do this as soon as possible, because otherwise we may send confidential information about you and your plan to your old address.
- c) Keeping any passwords secret and the documents relating to this plan safe. You must also let us know straightaway if you know about or suspect identity theft.
- d) Regularly reviewing your plan and its benefits. You may need to get advice from a financial adviser.
- e) If you decide to move to another country outside of the UK, you need to tell us about any change in your residency before the change happens. For more information, please see 'Moving abroad' in section 11.

Please keep this booklet in a safe place with your key features and plan schedule.

We've tried to use plain language in this booklet but avoiding all technical terms is difficult.

For more explanation of some of the terms we use you should read 'Your guide to your cover'. This is available on our website. Alternatively, please contact us and we will send you a copy.

1. Who can have the plan?

You can take out the plan for yourself or for two people jointly.

You must be at least 16 when the plan starts (if the plan covers two people, you must both be at least 16). If your plan is for life cover only the maximum age you can be when it starts is 79. If the plan is for two people, the maximum age the older person can be is 79.

If your plan includes critical illness cover the maximum age you can be when it starts is 69. If the plan is for two people, the maximum age the older person can be is 69.

If you want to include the payment protection benefit, the maximum age you can be when the plan starts is 59.

The plan can be taken out on someone else's life as long as they agree and the plan owner can show they would suffer financially if the life assured died or suffered a critical illness.

You must be resident in the United Kingdom to take out a Decreasing Mortgage Cover Plan – Guaranteed Payments. If the plan covers two people jointly this applies to each plan owner.

2. The aim of the plan

The plan is designed to protect your repayment mortgage or commercial loan. It can provide either:

- **Life cover only**

We'll pay the life cover cash sum if you die during the plan's term.

Or:

- **Life or earlier critical illness cover**

We'll pay the cash sum if, during the plan's term you die or are diagnosed with a critical illness that meets our plan definition*.

The plan will then end – it only pays out the full sum assured once.

If your plan is for life or earlier critical illness cover you can include extra life cover. If you include extra life cover and we pay a full critical illness cover claim, your life cover will continue but we will reduce it by the amount of critical illness cover we've paid.

* We include 32 critical illness conditions where we will make an additional critical illness cover cash payment only. If we make an additional critical illness cover cash payment this will not reduce the amount of cover provided by your plan.

The complete list of medical conditions and operations we cover is shown on pages 22 and 23.

You agree the term at the start of the plan, matching it with how long you will take to pay off your repayment mortgage or commercial loan (if applicable). At the end of the term your cover will stop. The plan doesn't have a cash-in value. This means that you will not receive any payment if you cancel the plan after the time limit set out in your key features document (the 'cancellation period').

Additional critical illness cover cash payments

These are payments for the conditions listed as additional critical illness cover cash payment conditions in the operations and conditions covered section of these Terms and Conditions starting on page 22. When making these payments we will pay out £15,000 or 20% of the full critical illness cover sum assured at the time you claim, whichever is the lower. More information on these conditions is on page 5.

Optional benefits

There are some optional benefits you can choose to include in your plan for an extra cost:

- **Total permanent disability – unable before age 60 to do your own occupation ever again benefit**
You may be able to include this if the plan includes critical illness cover. This pays the full critical illness cover cash sum if you are totally permanently disabled from performing all the tasks of your own occupation due to illness or injury and meet our definition in section 3. Your own occupation is the one you were performing immediately before the start of the disability. If you were not working immediately before the start of the disability, 'own occupation' is the occupation you specified in your application. Please note, where we refer to 'Total permanent disability – own occupation benefit' in other literature, we mean 'Total permanent disability – unable before age 60 to do your own occupation ever again benefit'.
- **Payment protection benefit**
This pays a monthly amount if you are incapacitated within the meaning set out in section 3 and as a result can't perform your own occupation because of the illness or injury. Your own occupation is your occupation at the time of the illness or injury. We will also make your payments to the plan if you are claiming this benefit.
- **Waiver of payment benefit**
This means we will make your payments to the plan for you if you are incapacitated within the meaning set out in section 3 and as a result you can't perform your own occupation because of the illness or injury. Your own occupation is your occupation at the time of the illness or injury.

For more information on all these benefits, please read section 3.

Depending on the cover you have chosen, the life cover or life or earlier critical illness cover decrease each month and are designed to reach zero by the end of the term. If you make a claim on your life cover or life or earlier critical illness cover and we agree to pay it, your plan will pay off your outstanding mortgage or commercial loan, provided that:

- the initial amount of cover (or where both life cover and critical illness cover are included and are for different amounts, the lowest level of cover) matches your outstanding mortgage or commercial loan
- you keep your mortgage or commercial loan payments up to date
- your mortgage or commercial loan interest rate stays at 10% or less.
- the claim is not for a condition where we will pay an additional critical illness cover cash payment only – see section 3.

Your plan schedule shows the initial amount of cover you have, any optional benefits that are included and any specific exclusions we have applied to your plan. These exclusions are in addition to the general exclusions set out in other parts of this booklet. If you are not happy with your plan, you can cancel it within the cancellation period set out in your key features document and we'll refund any payments you have made. So, if you do not agree to the specific exclusions we have applied, you can cancel your plan. Please see your key features document for information about cancelling your plan.

Exclusions

An exclusion removes our obligation to pay the cover or the benefits (or both) where the claim results from you taking part in certain specified occupations, pursuits or activities, or where you suffer from certain specified illnesses, disabilities or medical conditions. We'll include any specific exclusions on your plan schedule.

3. The cover and benefits in more detail

Life cover only

When we'll pay the life cover

We'll pay the cash sum if you die during the plan's term. We'll pay the cash sum early if you are diagnosed with a terminal illness.

Terminal illness

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

- the illness either has no known cure or has progressed to the point where it cannot be cured; and
- in the opinion of the attending consultant, the illness is expected to lead to death within the earlier of 12 months and the remaining term of the cover.

If the plan covers two people, we'll pay when the first person dies or is diagnosed with a terminal illness.

How much we'll pay

Your plan schedule shows the initial amount of life cover we'll pay. This amount decreases each month. We'll send you a statement each year showing the level of cover you have.

If you want to know your current level of cover, at any other time, please ask us.

When the plan stops

The plan will stop at the end of the term or when we pay the life cover cash sum, whichever happens first. If the plan covers two people, the plan will stop when the first person dies or is diagnosed with a terminal illness. The cover on the second person will then stop.

When we won't pay

We won't pay a life cover claim if:

- you haven't made all payments that were due
- you commit suicide within 12 months of the date the plan started or is reinstated. Instead, we'll refund the payments you've made since the plan started or was reinstated
- the cause of the claim arises from the circumstances stated in any specific exclusions on your plan schedule.

If you have used the guaranteed insurability option (see section 6) to increase your cover and you commit suicide within 12 months of the increase, we'll pay the amount of life cover before the increase and refund the payments you've made to pay for the increased cover.

Life or earlier critical illness cover

When we'll pay the life or earlier critical illness cover

We'll pay the life cover cash sum if you die during the plan's term. If you are diagnosed with a critical illness that meets our plan definition, the amount we'll pay will depend on the condition you are diagnosed with.

The majority of the conditions and operations we cover will result in the payment of the full critical illness cover sum assured. However, some of the conditions we cover will result in a payment of £15,000 or 20% of the full critical illness cover sum assured provided by the plan at the time you claim, whichever is the lower. In these terms and conditions, we refer to these as 'additional critical illness cover cash payments'. For these conditions we'll pay a maximum of one claim per condition per life assured. So, if the plan covers two people, we'll pay a maximum of one claim per condition for each life assured. If we make an additional critical illness cover cash payment, this will not reduce the amount of cover provided by your plan.

If the life cover or full critical illness cover cash sum is paid the plan will end - it only pays the full sum assured once.

Example 1 of how additional critical illness cover cash payments work

Your plan provides £100,000 of life and critical illness cover. You are diagnosed with significant visual loss which is permanent and irreversible. You make a claim and we will pay you £15,000.

You are later diagnosed with a cerebral or spinal aneurysm resulting in surgery or radiotherapy. You make another claim and we will pay you a further £15,000. The full critical illness cover provided by your plan is not reduced as a result of either of these claim payments. If the plan covers two people this applies to each of you.

Example 2 of how additional critical illness cover cash payments work

Your plan provides £100,000 of life and critical illness cover. You are diagnosed with a cancer in situ of the colon and rectum resulting in intestinal resection. You make a claim and we will pay you £15,000. You are later diagnosed with cancer in situ of the stomach resulting in removal of the tumour. You make another claim and we will pay you a further £15,000. The full critical illness cover provided by your plan is not reduced as a result of either of these claim payments. If the plan covers two people this applies to each of you.

Example 3 of how additional critical illness cover cash payments work

Each life assured can only claim for each listed additional critical illness cash payment once, for example:

Your plan provides £100,000 of life and critical illness cover. You are diagnosed with a cancer in situ of the breast resulting in surgical removal of the tumour. You make a claim and we will pay you £15,000. The full critical illness cover provided by your plan is not reduced as a result of this claim payment. If you are diagnosed with another cancer in situ of the breast resulting in surgical removal of the tumour at a later date no further payment will be made to you.

We only cover the critical illnesses we set out in this plan and no others.

Critical illness

The list of critical illnesses is on pages 24 and 25 and you will also need to refer to pages 25-37 for the full medical definitions. All diagnoses and medical opinions must be given by a medical specialist who:

- is a consultant at a hospital in the UK
- is acceptable to our Chief Medical Officer; and
- is a specialist in an area of medicine appropriate to the cause of the claim.

If the plan covers two people, unless the claim is for an additional critical illness cover cash payment, we'll pay the life or full critical illness cover cash sum when the first person suffers the critical illness that meets our plan definition or dies. The cover on the second person will then stop.

How much we'll pay

Your plan schedule shows the initial amount we'll pay. This amount decreases each month. We'll send you a statement each year showing the level of cover you have. If you want to know your current level of cover, at any other time, please ask us.

When the plan stops

The plan will stop at the end of the term or when we pay the life cover cash sum or the full critical illness cover cash sum, whichever happens first.

When we won't pay

We won't pay a life cover claim if:

- you haven't made all payments that were due
- you commit suicide within 12 months of the date the plan started or is reinstated. Instead, we'll refund the payments you've made since the plan started or was reinstated
- the cause of the claim arises from the circumstances stated in any specific exclusions on your plan schedule.

If you have used the guaranteed insurability option (see section 6) to increase the cover and you commit suicide within 12 months of the increase, we'll pay the amount of life cover before the increase and refund the payments you've made to pay for the increased cover.

We won't pay a critical illness cover claim if:

- you haven't made all payments that were due
- the illness suffered is not included in these terms and conditions
- the illness suffered does not exactly meet the plan definitions
- you don't tell us about the claim within six months of diagnosis or operation
- the general exclusion detailed on page 9 applies; or
- the cause of the claim arises from the circumstances detailed in any specific exclusions included on your plan schedule.

We won't pay an additional critical illness cover cash payment if:

- your claim for an additional critical illness cover cash payment also meets a definition for a critical illness as defined in the critical illnesses and operations section.

If you've already received payment protection benefit and you later make a critical illness cover claim for the same condition, we'll deduct the amount of payment protection benefit payments that we've already made from the critical illness cover cash sum we pay you.

If you use the guaranteed insurability option (GIO) – explained in section 6 – to increase your cover, we will not pay out the GIO increase if, at the time of using the option you:

- had been diagnosed with one of the illnesses defined in your plan
- have had, or are due to have one of the operations defined in your plan
- were undergoing medical investigations by either your own GP or a hospital consultant.

At the time that you want to use the GIO you will be asked for written confirmation that none of the above apply.

Life or earlier critical illness cover with extra life cover

If your plan is for life or earlier critical illness cover you can choose to have a higher level of life cover than critical illness cover. We'll pay the life cover cash sum if you die during the plan's term. If you are diagnosed with a critical illness that meets our plan definition, the amount we'll pay will depend on the condition you are diagnosed with.

The majority of the conditions and operations we cover will result in the payment of the full critical illness cover sum assured. However, some of the conditions we cover will result in a payment of £15,000 or 20% of the full critical illness cover sum assured provided by the plan at the time you claim, whichever is the lower. In these terms and conditions, we refer to these as 'additional critical illness cover cash payments'. For these conditions, we'll pay a maximum of one claim per condition per life assured. So, if the plan covers two people, we'll pay a maximum of one claim per condition for each life assured.

If your claim was for the full critical illness cover cash sum, your life cover will continue but we'll reduce the life cover cash sum by the amount of critical illness cover we've paid. We'll also set a new lower payment amount based on the reduced cover and your age when the plan started.

If your claim was for an additional critical illness cover cash payment we won't reduce the amount of cover provided by your plan.

You will not be able to make any claims for an additional critical illness cover cash payment after the full critical illness cover sum assured has been paid.

We'll pay the life cover (including any extra life cover) cash sum early if you are diagnosed with a terminal illness. The plan will then end.

Terminal illness

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

- the illness either has no known cure or has progressed to the point where it cannot be cured; and
- in the opinion of the attending consultant, the illness is expected to lead to death within the earlier of 12 months and the remaining term of the cover.

Where extra life cover is included in your plan, the extra life cover amount will only be paid if you die during the remaining term of the plan.

The life cover and critical illness cover are explained in more detail above.

Children's critical illness benefit

If your plan includes critical illness cover, it will automatically include children's critical illness benefit. If your plan doesn't include critical illness cover, children's critical illness benefit is not included.

A child means your natural or legally adopted child. In either case, the child must be financially dependent on you.

Your children are covered for the conditions listed on pages 24 and 25 at no extra cost. Children's critical illness benefit applies from the date each child turns three months and lasts until they reach age 18, as long as the plan is in force.

When we'll pay the children's critical illness benefit

We'll pay a critical illness cash sum if your child is diagnosed with a critical illness that meets our plan definition during the plan's term and survives for 14 days from the day of diagnosis.

How much children's critical illness benefit we'll pay

For the majority of the conditions and operations we cover on the plan we will pay £25,000 or 50% of the full critical illness cover sum assured provided by the plan at the time you claim, whichever is the lower. We'll only pay one claim for each child but there is no limit to the number of children covered.

However, for some of the conditions we cover we'll pay £15,000 or 20% of the full critical illness cover sum assured provided by the plan at the time you claim, whichever is the lower. These conditions are marked with a ⁽¹⁾ in the list of critical illnesses and operations we cover on pages 24 and 25. For these conditions only, we'll pay a maximum of one claim per condition for each child.

If you claim for your child, this will not reduce the amount of cover provided by your plan.

If you have any other Zurich plans that pay children's critical illness benefit we'll deduct the amount we pay under the other plans from the amount we pay under this plan.

When the children's critical illness benefit stops

The children's critical illness benefit stops on the earlier of these events:

- the child reaches age 18
- you die
- we have paid the full critical illness cover cash sum; or
- the end of the plan's term.

When we won't pay the children's critical illness benefit

We won't pay a children's critical illness benefit claim if:

- you haven't made all payments that were due
- the illness suffered is not included in these terms and conditions
- the illness suffered does not exactly meet the plan definitions
- the claim is for a medical condition from which the child was already suffering before the start of the cover (whether or not there were any symptoms)
- the claim is for a legally adopted child who was already suffering from the medical condition at the date of the adoption (whether or not there were any symptoms)
- you don't tell us about the claim within six months of the diagnosis or operation
- the child doesn't survive 14 days from the diagnosis or operation; or
- the general exclusion detailed on the next page applies.

General exclusion applying to critical illness cover, children's critical illness benefit, total permanent disability – unable before age 60 to do your own occupation ever again benefit and payment protection benefit

Living abroad

The medical condition arises while you are living abroad and you don't return to the United Kingdom or one of the other countries we specify. These are countries where, from our experience we know we can manage the claims process effectively. Our current list of countries is Australia, Austria, Belgium, Bulgaria, Canada, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, Republic of Ireland, Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Republic of Macedonia, Malta, Monaco, the Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, and United States of America.

We can add and remove countries on the list if the cost or the availability of medical or other evidence changes, or for any of the reasons set out in section 8.

If you are thinking of moving abroad, it is important that you contact us for an up-to-date list. We will act reasonably when considering whether we can continue to cover you in that country.

Total permanent disability – unable before age 60 to do your own occupation ever again benefit

If the plan includes critical illness cover, you may be able to include this benefit as an extra optional benefit when your plan starts. If you have this benefit it will be shown in your plan schedule. This means we'll pay the full critical illness cover if you are totally permanently disabled before age 60 from doing your own occupation ever again. For these purposes, your 'own occupation' is the one you were performing immediately before the start of the disability. If you were not working immediately before the start of the disability 'own occupation' is the occupation you specified in your application.

To make a claim you must be totally permanently unable to carry out all the tasks of your own occupation. You must, if you can, take action to lessen the effect of a disability, or change the way you do your own occupation to enable you to carry out all the tasks. If you don't do so we won't pay.

You can only choose this benefit when the plan starts. If you decide you no longer want to include this benefit, please write and tell us and we'll remove it as long as the new payment amount does not go below the minimum payment amount. The minimum payment amount as at May 2015 is £5 for monthly payments and £50 for yearly payments. Please ask if you want to know what it is currently. If you make your payments yearly, your payments will reduce from the next plan anniversary. If you make your payments monthly, your payments will reduce on the next monthly payment. If we remove this benefit you won't be able to include it again in the future.

If the plan covers two people, you can choose whether you want to include this benefit on one person or both of them. You can't include the benefit if you are 55 or older when the plan starts. The benefit stops and your payments will reduce on the plan anniversary after your 60th birthday.

Total permanent disability – unable before age 60 to do your own occupation ever again benefit

Loss of the physical or mental ability through an illness or injury before age 60 to the extent that the insured person is unable to do the material and substantial duties of their own occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of the person's own occupation that cannot reasonably be omitted or modified. Own occupation means your trade, profession or type of work you do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

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

What will stop us paying the total permanent disability – unable before age 60 to do your own occupation ever again benefit?

We won't pay a claim for total permanent disability – unable before age 60 to do your own occupation ever again benefit if:

- you haven't made all payments that were due
- you had more than one job and you can still do some of the tasks involved in any of them
- the cause of the claim is due to infection with Human Immunodeficiency Virus (HIV) or conditions due to any Acquired Immune Deficiency Syndrome (AIDS) (unless caught in the UK from a blood transfusion, a physical assault or at work in an eligible occupation). The eligible occupations for HIV caught at work are:
 - any occupation which provides accident and emergency, medical, laboratory, phlebotomy, dental or nursing services
 - the police force
 - the prison service
- the general exclusion detailed on page 9 applies.

Payment protection benefit

If this benefit is shown on your plan schedule, we'll pay you an income every month if you can't perform your own occupation because you're incapacitated due to illness or injury. The incapacity must have started after the plan began and you must be incapacitated from doing the main duties of the job or jobs you were doing immediately before the start of the incapacity.

Incapacity

Incapacity means an injury or illness that reasonably causes you to be unable to do the main duties of your usual paid job. We'll interpret 'incapacitated' and also 'disabled' and 'disability' in the same way. We'll look at the duties of your job and your ability to do them. For example, you might be a personal assistant whose main duties include writing and typing letters and using the telephone to organise meetings and diaries. We would still pay the payment protection benefit if you could no longer write and type letters and organise meetings and diaries, even if you were still able to use the telephone.

Paid job does not include doing domestic tasks, for example as a housewife or househusband, in your own home. If you are looking after someone else's house and being paid to do so, this does count as a paid job.

We'll always act reasonably in considering your claim to be incapacitated.

You choose how soon after being incapacitated you want the payment protection benefit to start. This is called the deferred period. Your plan schedule shows the deferred period you've chosen.

Deferred period

The deferred period starts when you can't work and lasts until the time you decide you want the payment protection benefit to start.

You can choose a deferred period of three months, six months or 12 months. If the plan covers two people, you can choose a different deferred period for each person. No payment protection benefit is payable during the deferred period.

You can only choose this benefit when the plan starts; you can't add it later. It must end on or before the plan anniversary after your 65th birthday. Your plan schedule shows if the benefit will end before the plan anniversary after your 65th birthday. Your payments will reduce when the benefit ends.

If the plan covers two people, you can choose whether the payment protection benefit covers one person or both of them. You cannot include payment protection benefit for anyone who has waiver of payment benefit under the plan.

If you decide you no longer want to include the payment protection benefit, please write and tell us. We'll remove it as long as the new payment amount does not go below the minimum payment amount. The minimum payment amount as at May 2015 is £5 for monthly payments and £50 for yearly payments. Please ask if you want to know what it is currently. If we remove the benefit, you won't be able to include it again in the future.

When we'll pay the payment protection benefit

We'll pay the payment protection benefit if you are incapacitated from doing the main duties of the job you were doing at the start of the incapacity. Your plan schedule says whether we have applied a special definition of disability. If you have more than one job at this time we won't regard you as incapacitated if you are able to perform the main duties of any of your jobs.

Special definition of disability

Some occupations need a high degree of medical fitness, a licence to perform the occupation or total dependence on the use of your hands or voice. In these cases, we'll apply the special definition of disability. This means that if you are still claiming payment protection benefit 12 months from the end of the deferred period, we will stop paying the payment protection benefit at any time after the 12-month period when you could return to work in a new occupation to which you are suited because of your education, training, retraining or experience. Your plan schedule says whether this applies to you.

Once a claim begins we'll pay you on the first day of each month. If the first day falls on a weekend or public holiday, we'll pay you on the next working day. So payment would start on the first of the month after the end of the deferred period you've chosen, provided we are in a position to pay the claim, with subsequent payments being made monthly in arrears. If we are not in a position to pay the claim at the end of the deferred period, we'll let you know, and when we do start to pay you we'll backdate the payments to the end of the deferred period. You must carry on making payments to the plan during the deferred period or until we agree your claim, if later. We'll refund any payments you make between the end of the deferred period and when we accept your claim.

The first payment may only be for part of a month's benefit if it covers the period from the end of the deferred period to the end of the month.

Example of how the deferred period works

You're incapacitated as defined in this plan and unable to work from 12 November.

- If the deferred period is six months, it will end on 11 May.
- We'll make the first payment on 1 June; this payment will cover the period from 12 May to the end of May.
- We'll make the first full payment on 1 July.

If you return to work part way through a month, the final payment we make will be the proportionate part of a month's benefit.

You don't need to make any payments to the plan while we're paying you the payment protection benefit.

Payment protection benefit limits

The minimum benefit you can choose is a monthly payment of £100 a month. The maximum benefit you can choose is a monthly payment of 1% of the life cover or critical illness cover at the start of the plan, whichever is the higher amount. This is subject to a limit of £4,000 a month or 50% of your earnings at the point of claim, whichever is the lower amount.

Example of how the payment protection benefit limits work

Your plan provides £50,000 of life or earlier critical illness cover plus extra life cover of £25,000.

At the start of the plan you earn £1,500 a month.

Your payment protection benefit is £750 a month (that is 1% of £75,000 – the total life cover amount – and 50% of the amount you earned at the start of the plan).

When you make a claim your earnings have reduced to £1,200 a month. We will pay a maximum payment protection benefit of £600 a month (that is 50% of £1,200).

If the plan covers two people and the payment protection benefit is on both, the total combined benefit must not be more than 1% of the life cover or critical illness cover, whichever is the higher amount.

This is subject to a limit of £4,000 a month, shared between you, or 50% of your earnings at the point of claim, whichever is the lower amount. When calculating your payment protection benefit entitlement we will use the earnings of the person making the claim.

Where we refer to earnings we mean your 'pre-incapacity earnings'. When calculating your payment protection benefit entitlement we will use your earnings from the 12 months immediately before the date of your incapacity. If you (or we) reasonably consider this does not fairly reflect your normal level of earnings then you should (or we can ask you to) send us other evidence of earnings. We'll tell you what this other evidence should be. We calculate the maximum amount of payment protection benefit at the end of the deferred period.

The amount of payment protection benefit we pay you is subject to an overall limit of 50% of your earnings at the time of claim less any deductions described here on page 11. The earnings we'll take into account are set out below.

Pre-incapacity earnings

If you are employed the earnings we'll use are:

- basic salary
- overtime payments
- benefits in kind as defined and valued by HM Revenue and Customs (HMRC)
- bonuses
- commission payments.

If you are a director of a private limited company, and you were working for that company immediately before your period of incapacity, we will also include your share of the pre-tax profits of that company.

If you are self-employed the earnings we'll use are your net relevant earnings. This means your share of pre-tax profits after the deduction of trading expenses.

What will reduce the payment protection benefit we pay?

We'll reduce the payment protection benefit by the amount you receive (or are entitled to receive) from any of the following if they take you over 50% of your pre-incapacity earnings. This means that after any payments you receive, or are entitled to receive, from any of the following have been taken into account, your income including the amount of any payment protection benefit we pay you will not be more than 50% of your pre-incapacity earnings.

If you are employed:

- continuing salary
- continuing benefits in kind (as defined and valued by HMRC)
- continuing bonuses
- continuing commission
- other insurances and pensions that start to be paid after your incapacity. This includes regular payments made directly to you or payments made on your behalf, such as to pay your mortgage, credit card or loans.

If you are self-employed:

- continuing net relevant earnings
- other insurances and pensions that start to be paid after your incapacity. This includes regular payments made directly to you or payments made on your behalf, such as to pay your mortgage, credit card or loans.

If you are a controlling director of a limited company, we'll deduct your share of the pre-tax profits if these continue during the life of your claim.

If we reduce the payment protection benefit because your earnings have fallen, or because of any other benefits you receive, and the payment protection benefit you chose is higher than the maximum we'll pay we won't refund any of your payments.

If the plan includes extra life cover and we pay a full critical illness cover claim, your life cover will continue but it will be reduced by the amount of critical illness cover we've paid. Your payment protection benefit will also reduce by the same proportion.

Example 1 of payment protection benefit being reduced

We pay £200,000 due to a critical illness claim. At the time the plan provides life or earlier critical illness cover of £200,000, extra life cover of £100,000 (i.e. a total of £300,000 of life cover) and payment protection benefit of £1,500 a month. The plan will continue to provide life cover of £100,000 (i.e. a reduction of two thirds) until the end of the term and the payment protection benefit will reduce by the same proportion. This means it will reduce to £500 a month.

What won't reduce the payment protection benefit we pay?

We won't reduce your payment protection benefit for any amounts you receive (or are entitled to receive) from:

- income support or any other means-tested State benefits
- income from savings and investments; or
- the taxable value of any royalties from any patent or copyright or profits from selling shares or securities.

Returning to work

If you return to another less well paid job, the payment protection benefit will stop but you may be entitled to receive a reduced benefit called 'proportionate benefit'. This won't apply if you have a special definition of disability because of your occupation. If you go back to the same job on a part-time basis, you may be entitled to receive 'rehabilitation benefit'.

You don't need to make any payments to the plan while we're paying you any proportionate benefit or rehabilitation benefit.

We work out how much proportionate benefit or rehabilitation benefit we'll pay you when you return to work and review it regularly. When we review the payments we are making to you, we'll take into account your health and occupational duties together with your earnings and other benefits. We calculate the proportionate or rehabilitation benefit by reducing the payment protection benefit by the same proportion as the reduction in your pre-incapacity earnings.

Example 2 of payment protection benefit being reduced

Your pre-incapacity earnings were £20,000 a year and the payment protection benefit was £4,000 a year. If you return to another less well paid job, of say £10,000 a year, the payment protection benefit will reduce by the same proportion to £2,000 a year.

Proportionate benefit

We'll pay this benefit if your incapacity means that you can't carry on the job you were doing before you were incapacitated. You must have started one of the following that pays you less than you earned before you were incapacitated:

- a new job with a new employer
- a different role with the same employer
- a new business that is significantly different from your business before you were incapacitated.

You must have been receiving the payment protection benefit immediately before your claim for proportionate benefit. We won't pay this benefit if a special definition of disability has been applied to your plan.

Rehabilitation benefit

We'll pay this benefit if your incapacity means that you return to your usual job but you can't carry out your usual job to the same extent you were doing before you were incapacitated and so you earn less than you earned before you became incapacitated. This may be because you are working part-time. You can claim rehabilitation benefit for a maximum of 12 months from the time you return to work. You must have been receiving the payment protection benefit immediately before your claim for rehabilitation benefit.

When the payment protection benefit, proportionate benefit or rehabilitation benefit stop

We'll continue to pay you the payment protection benefit, proportionate benefit or rehabilitation benefit under the terms of your plan (and as explained above) until the first of the following:

- you no longer meet our definition of incapacity
- you continue to meet the definition of incapacity but you start working in a new job as an unpaid volunteer, unless you are working as an unpaid volunteer for a registered charity.
- you no longer have any loss of earnings
- you reach the age when this benefit on the plan stops
- the plan anniversary after your 65th birthday
- the end of the plan's term
- the plan ends following payment of a full critical illness claim, a terminal illness or death claim; or
- for rehabilitation benefit claims:
 - 12 months after you return to work; or
 - you are able to work in your pre-disability occupation on a full-time basis and without any restrictions in your duties.

If we have applied a special definition of disability to your plan and you are still claiming payment protection benefit 12 months from the end of the deferred period, we'll stop paying payment protection benefit at any time after the 12-month period when you could return to work in a new occupation to which you are suited because of your education, training, retraining or experience.

If there is less than a full month between the end of the deferred period and the time when you're no longer incapacitated, then we'll pay you a proportion of the payment protection benefit. The amount we'll pay would be what we'd pay you over a year, divided by 365, for each of the days you're incapacitated.

How often you can claim

There is no limit to the number of times you can claim the payment protection benefit and any subsequent proportionate or rehabilitation benefit. If you have received the benefit and you claim again from the same cause within six months of returning to work, there won't be another deferred period before we start paying you again. To keep your cover going, you must start making payments to your plan when you return to work and we stop paying you any benefit under your plan. We'll write to tell you when you need to start making payments.

When we won't pay the payment protection benefit, proportionate benefit or rehabilitation benefit

We won't pay any payment protection benefit, proportionate benefit or rehabilitation benefit if:

- you haven't made all payments that were due
- you weren't in a paid job when you became incapacitated
- the plan will end before the expiry of your chosen deferred period
- the benefit will end before the expiry of your chosen deferred period
- you have more than one job and you can still do the main duties of any of them
- you are not continuously disabled throughout the deferred period
- the cause of the claim is due to infection with Human Immunodeficiency Virus (HIV) or conditions due to any Acquired Immune Deficiency Syndrome (AIDS) (unless caught in the UK from a blood transfusion, a physical assault or at work in an eligible occupation). The eligible occupations for HIV caught at work are:
 - any occupation which provides accident and emergency, medical, laboratory, phlebotomy, dental or nursing services
 - the police force
 - the prison service
- the cause of the claim is due to any act of terrorism, war, invasion, hostilities (whether war is declared or not) civil war, rebellion, revolution or taking part in a riot or civil commotion
- the general exclusion detailed on page 9 applies; or
- the cause of the claim arises from the circumstances detailed in any specific exclusions included on your plan schedule.

We won't pay the proportionate benefit if we have applied a special definition of disability to your plan.

If you have any other Zurich plans that pay a similar benefit, we'll deduct the amount we pay you under the other plan(s) from the amount we pay you under this plan.

Waiver of payment benefit

If this benefit is shown on your plan schedule, we'll make your payments to the plan if you are incapacitated and can't perform your own occupation because of illness or injury for longer than six months (the deferred period). The illness or injury must have started after the plan began and you must be incapacitated from doing the main duties of the job or jobs you were doing at the time of the injury or start of the illness.

Incapacity

Incapacity means an injury or illness that causes you to be unable to do the main duties of your usual paid job. We'll interpret 'incapacitated' and also 'disabled' and 'disability' in the same way. We'll look at the duties of your job and your ability to do them. For example, you might be a personal assistant whose main duties include writing and typing letters and using the telephone to organise meetings and diaries. We would still pay waiver of payment benefit if you could no longer write and type letters and organise meetings and diaries, even if you were still able to use the telephone.

Paid job does not include undertaking domestic tasks, for example as a housewife or househusband, in your own home. If you are looking after someone else's house and being paid to do so, this does count as a paid job.

We'll always act reasonably in considering your claim to be incapacitated.

Deferred period

The deferred period is the period of time that starts when you can't work and lasts until we start to pay the benefit. The deferred period for this benefit is six months. We won't make your payments to the plan during the deferred period.

You must carry on making payments to the plan during the deferred period or until we agree your claim if later. We'll refund any payments you make between the end of the deferred period and when we accept your claim. You can only choose this benefit when the plan starts; you can't add it later. If you decide you no longer want to include this benefit, please write and tell us and we'll remove it as long as the new payment amount does not go below the minimum payment amount.

The minimum payment amount as at May 2015 is £5 for monthly payments and £50 for yearly payments. Please ask if you want to know what it is currently. If we remove this benefit you won't be able to include it again in the future. If you make your payments yearly your payments will reduce from the next plan anniversary. If you make your payments monthly your payments will reduce on the next monthly payment.

If the plan covers two people, you can choose whether you want to include this benefit for one person or for both. You cannot include the waiver of payment benefit for any person who has payment protection benefit under your plan. Waiver of payment benefit cannot be included if you are age 55 or older when the plan starts.

We'll remove this benefit from your plan and your payments will reduce on the plan anniversary after your 65th birthday.

When we'll pay the waiver of payment benefit

We'll make your payments to the plan if you are incapacitated from doing the main duties of the paid job you were doing at the time of the injury or start of the illness. If you have more than one job at this time we will not regard you as incapacitated if you are able to perform the main duties of any of your jobs.

When we won't pay a waiver of payment benefit claim

We won't make your payments to the plan if:

- you haven't made all payments that were due
- you had the illness or injury that caused the incapacity before the plan started
- the plan has less than six months to run
- the benefit has less than six months to run
- you weren't in a paid job when you became incapacitated
- you have more than one job and you can still do the main duties of any of them
- you are not continuously disabled throughout the deferred period
- the cause of the claim is due to infection with Human Immunodeficiency Virus (HIV) or conditions due to any Acquired Immune Deficiency Syndrome (AIDS) (unless caught in the UK from a blood transfusion, a physical assault or at work in an eligible occupation). The eligible occupations for HIV caught at work are:
 - any occupation which provides accident and emergency, medical, laboratory, phlebotomy, dental or nursing services
 - the police force
 - the prison service

- the cause of the claim is due to any act of terrorism, war, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion
- the cause of the claim arises from the circumstances detailed in any specific exclusions included on your plan schedule.

When we'll stop paying the benefit

The benefit stops on the earlier of the following events:

- you no longer meet our definition of incapacity
- you return to paid employment
- the end of the plan's term
- the plan anniversary after your 65th birthday
- the plan ends following payment of a full critical illness claim, a terminal illness or death claim.

4. How long the plan can last

You agree the term (how long the plan will run) at the start of the plan. If the plan includes:

- Life cover only – the term of the plan must be at least five years and the longest it can run is 50 years. The plan must end before your 85th birthday.
- Critical illness cover – the term of the plan must be at least five years and the longest it can run is 40 years. The plan must end before your 75th birthday.
- Payment protection benefit – the term of the plan must be at least five years. The longest this benefit can run is 49 years and it will end on or before the plan anniversary after your 65th birthday.

5. Making payments

You must make all the payments that are due over the plan's term. Your plan schedule says how much you need to pay, how often your payments are due and how long the plan will run. Your payments are guaranteed, which means that the factors we have used to work out the payments for the relevant cover will not change during the plan's term. Your payments will change if you change the amount of your cover or benefits (or both).

We work out your payments based on the type and amount of cover you've chosen, any extra benefits that are included, the term of your plan, your age, and whether you smoke.

Your health, activities, or both, may mean you have to make an extra payment for your cover. If this applies to you we'll include it on your plan schedule.

The first payment is due from the date the plan starts. If this payment is not made, the plan will not provide any cover.

You can make payments monthly or yearly by direct debit. You can also make yearly payments by cheque. If you pay by direct debit, we collect your payments on the first day of the month. If this falls on a weekend or public holiday we'll collect your payment on the following working day. If payments are made monthly, they are due on the first day of every month. If they are made yearly, they are due every year on the anniversary of the day the plan started.

Your payments to us will stop on the earliest of the following events:

- you die
- we pay a terminal illness claim
- we have paid out the full critical illness cover sum assured unless the plan includes extra life cover
- the plan's term ends.

You don't need to make any payments to the plan if we're making your payments under the waiver of payment benefit or if we're paying you the payment protection benefit, proportionate benefit or rehabilitation benefit.

If you don't make a payment when it is due, the plan will continue providing cover for 30 days. At the end of the 30-day period the plan will end and you won't get any of your payments back. If we accept a claim during this 30-day period under the terms of the plan, we'll deduct any due payment from the amount we pay.

Although your plan will have formally ended and you will therefore have no rights under the plan you can ask us to reinstate your cover up to 60 days after your plan ended. To help us consider your request, we'll ask you for details about your health and activities. If we agree to reinstate your plan, you will need to send us a cheque for the payments you have missed. We do not have to reinstate your plan. If you use the guaranteed insurability option (explained in section 6) to increase your cover, your payments will increase.

If you pay monthly, your cover and payments will increase from the first of the month.

If you pay yearly, your cover and payments will increase from the next plan anniversary. However, you can ask us to increase your cover before the next plan anniversary. If you do so we'll ask you to pay for the increased benefits for the rest of the year until the next plan anniversary. Your cover will increase from the date you make the increased payment.

If you reduce your cover, your payments will reduce. There is no limit to the new level of cover as long as the payment for that level of cover does not go below the minimum payment amount. The minimum payment amount as at May 2015 is £5 for monthly payments and £50 for yearly payments. Please ask if you want to know what it is currently.

6. How flexible is it?

The plan includes some options that enable you to change your cover if your circumstances change.

Guaranteed insurability option

The plan may include a guaranteed insurability option that enables you to increase your cover, if you increase your mortgage or commercial loan, without giving us any more details about your health or activities as long as you're 54 or younger. If the plan includes critical illness cover, we will ask you to confirm that you haven't been diagnosed with one of the specified illnesses and you haven't had, or are due to have, one of the specified operations and that you are not currently undergoing medical investigations by your own GP or a hospital consultant.

However, your health or activities or both may mean that we can't include this option in your plan. We'll tell you on your plan schedule if the guaranteed insurability option does not apply to you.

If the plan covers two people, the older person must be 54 or younger at the time the option is used and both have to agree in writing before the option can be used. The term of the plan will stay the same.

Guaranteed insurability events

- Increasing your mortgage to buy or improve your main home.
- Entering into a new commercial loan or increasing an existing one.

These events are explained in more detail below.

How much your cover can increase in total

You can use the guaranteed insurability option on this plan more than once, but the total increase to your cover is limited to:

- mortgage increases – £150,000 or the amount of critical illness cover (or if the plan includes life cover only, the amount of life cover) at the start of the plan, whichever is the lower amount; or
- commercial loan increases – £250,000 or half the amount of critical illness cover (or if the plan includes life cover only, half this amount) at the start of the plan, whichever is the lower amount.

We may increase these limits in the future. You can find out the current limits by asking us.

Example of increasing cover under the guaranteed insurability option (GIO)

Original cover – £600,000.

Your mortgage has increased by £140,000 so you apply to increase your cover by that amount.

After that £140,000 increase, the maximum remaining increase available under the GIO would be:

- £10,000 for any future mortgage increase – in other words, up to the £150,000 limit stated above; or
- £110,000 for any commercial loan increases – in other words, up to the £250,000 limit stated above.

Where applicable we'll apply any increase equally to both the life cover amount and the critical illness cover amount.

If you increase your cover and the plan includes payment protection benefit, you can also increase the payment protection benefit by the same proportion as the increase in cover. The increase is subject to the limits explained in section 3.

Example of increasing the payment protection benefit following a guaranteed insurability option increase

Your plan provides life or earlier critical illness cover of £100,000 and payment protection benefit of £500 a month.

If you use the guaranteed insurability option to increase your life or earlier critical illness cover to £150,000, you can also increase your payment protection benefit by 50% or £250 a month, bringing it up to £750 a month (subject to the limits explained in section 3).

The increase in cover will take effect from the date you make the increased payment.

Circumstances when the guaranteed insurability option may be restricted or will not apply

The guaranteed insurability option will not apply if:

- we've told you on your plan schedule that the guaranteed insurability option does not apply to you; or
- you have any other Zurich plans that also include an option to increase your cover (without having to give us any more details about your health or activities) and you've already used up all the increase amounts that are available to you by using the options on the other plans.

The guaranteed insurability option may be restricted if:

- you have any other Zurich plans that also include an option to increase your cover (without having to give us any more details of your health or activities) and you've already used part of the amount of the increase that is available to you by using the options on the other plans. For example, if you have already increased another plan by £100,000, then the maximum increase available on this plan would be £150,000 for commercial loan increases or £50,000 for a mortgage increase.

Circumstances when you can't use the guaranteed insurability option

You can't use the insurability option if:

- you haven't made all payments that were due
- your plan includes payment protection benefit or waiver of payment benefit and you are incapacitated within the meaning of this plan
- you've been diagnosed with one of the specified illnesses or had, or are due to have, one of the specified operations
- you're currently undergoing medical investigations by either your own GP or a hospital consultant
- you've been diagnosed with a terminal illness
- the plan has less than 12 months to run; or
- you are aged 55 or over or if the plan covers two people, either of you is 55 or over.

The guaranteed insurability events in more detail

Mortgage increase

The maximum amount by which you can increase your cover is the amount of critical illness cover (or if your plan is for life cover only, the amount of life cover) you had at the start of the plan or £150,000, whichever is the lower amount. However, you won't be able to increase your cover to more than the total outstanding mortgage. Please write and tell us if you want to increase your cover and include a copy of the lender's offer letter. We need this no more than 30 days before the mortgage is due to be released to you or within 90 days after the mortgage has been released to you.

Commercial loan

Your commercial loan protection needs may change if you, the company or the partnership, enter into a new commercial loan or increase an existing commercial loan. The maximum amount by which you can increase your cover is half the amount of critical illness cover (or if the plan is for life cover only, half this amount) at the start of the plan or £250,000, whichever is the lower. At the time you want to use this option, you must be an employee or shareholding director in a private limited company, an equity member of a partnership or a sole trader. We need documentary evidence of the loan, or increased loan, from the lender. You cannot increase your cover if the loan does not proceed.

How we work out your new payment

If you increase your cover, we work out your new payment based on the rates at the time for your age, whether or not you smoked when the plan started and the number of years left until the end of the plan's term.

Reducing your cover

You can reduce your cover. There's no limit on the new level of cover as long as the new payment for that level of cover does not go below the minimum payment amount. The minimum payment amount as at May 2015 is £5 for monthly payments and £50 for yearly payments. Please ask if you want to know what it is currently.

If you reduce your cover, your new payment will be based on the new level of cover.

Separation option

This option is available on joint life plans where two people are using the plan to protect a mortgage. It enables each person to continue their cover using separate plans without giving us any more details about their health or activities. The option is available to either person, but both have to agree in writing before this plan can be stopped and the option used.

The option must be used at least five years before the end of the term.

You both have the option of starting a new plan in your sole name if:

- the mortgage on your existing property is rearranged and it is in the name of either one of you only; or
- either of you take out a new mortgage on a new property.

The new plan must start within 30 days of the date the mortgage is rearranged or the new mortgage started. We'll need a copy of the lender's offer letter. We need this no more than 30 days before the mortgage is due to be released or up to 30 days after it has been released.

The terms and conditions of the new plan will be those that apply to that plan at the time. The new plan will include the same, or a similar, type of cover, extra payments and exclusions as the original plan. The amount of cover available for each new plan will be the amount of cover provided by the original plan at that time. The payments will be based on the cost of providing cover at the time.

The term of the new plans should be the same as the term left to run on the original plan. However, as the terms of the new plans must run for complete years they may continue up to 11 months beyond the end of the term of the original plan.

This option will only be available if we are offering the same or a similar type of plan at the time you want to use the option.

You can use the option if we are paying the waiver of payment benefit or payment protection benefit.

7. Making a claim

If you need to make a claim, you, or the person dealing with your affairs, should contact us on the telephone number below.

We'll provide any claim form we require and it must be completed in full and signed before we can proceed with the claim.

We'll confirm what information we'll need from your doctor, consultant or any other third party. We always try to pay all valid claims as soon as possible and we'll keep you, or the person dealing with your affairs, informed of how the claim is progressing.

To make a claim please call us on 0370 243 0827.

Our opening hours are 9am to 5pm Monday to Friday.

Claiming for the life cover

The person dealing with the claim will need to complete a form we provide. We may need the death certificate, proof of identity and, where applicable, reasonable evidence that the person dealing with the claim is entitled to claim (for example, a grant of probate showing that he or she is the executor of your estate). They must pay any costs incurred in providing these. Where it is reasonable to do so, we can also ask for medical evidence and information regarding the cause and/or circumstances of death. We'll tell the person dealing with your affairs what we need when they make a claim.

Claiming for a terminal illness

You will need to complete a form we provide. When we receive your completed form, we'll tell you what medical evidence we'll be obtaining and any documents you need to send to us before we can pay the claim.

Claiming for critical illness cover and children's critical illness benefit

You must tell us within six months of you or your child being diagnosed with the critical illness or having the operation.

At the point of claim we'll usually carry out a telephoned based interview unless this is not possible at the time, when we will instead send you a claim form. If we have carried out a telephone interview, we'll send you a summary of our conversation for you to check, sign and return. Once we have received your signed confirmation or your signed claim form, we'll tell you what medical evidence we'll be obtaining and any documents you need to send to us before we can pay the claim. You will need to carry on making payments to the plan until we agree to pay the claim.

For an additional critical illness cover cash payment claim and for a children's critical illness benefit claim, you will need to continue making payments to the plan until we agree to pay the claim and after we agree to do so as payment of this type of claim does not end the plan.

Claiming for the payment protection benefit

You must tell us at least four weeks before the end of the deferred period if you want to claim this benefit. If you tell us after the end of the deferred period, we need not backdate your payments to before the date when we were told. However, we will backdate your payments if you give us a satisfactory explanation for the late notification and medical evidence confirms that you have been continuously incapacitated since the date when you first had to stop work.

At the point of claim we'll usually carry out a telephone based interview unless this is not possible at the time, when we will instead send you a claim form. If we have carried out a telephone interview, we'll send you a summary of our conversation for you to check, sign and return. Once we have received your signed confirmation or your signed claim form, we'll tell you what medical evidence we'll be obtaining and any documents you need to send to us before we can pay the claim. You will need to carry on making payments to the plan until we agree to pay the claim.

Where it is reasonable to do so, based on the medical evidence, we can require you to have further medical examinations or tests, which will be carried out by a medical practitioner we provide. If so, we'll aim to make these as convenient as possible for you and we'll pay the costs of any extra medical examinations. You can claim, within reason, for any expenses you incur as a result of having these extra tests.

You must be able to prove that you are incapacitated. We will ask for any further reasonable evidence.

We'll also tell you what evidence we need about your earnings at the time you claim and for any period before then. The evidence will depend on the type of earnings you have and we may ask for independent proof of them.

You must be receiving regular medical care and supervision for your condition and we can ask you or your doctor for medical evidence at regular intervals throughout your claim.

Claiming for the waiver of payment benefit

You must tell us if you have become incapacitated within six months of this happening. If you don't tell us within this time, we need not backdate your payments to before the date when we were told. However we will backdate your payments if you give us a satisfactory explanation for the late notification and medical evidence confirms that you have been continuously incapacitated since the date when you first had to stop work.

When we receive your completed claim form, we'll tell you what medical evidence we'll be obtaining and any documents you need to send us before we can pay the claim.

You will need to continue making payments to the plan until we agree to pay the claim. Where it is reasonable to do so, based on the medical evidence, we can require you to have further medical examinations or tests, which will be carried out by a medical practitioner we provide. If so, we'll aim to make these as convenient as possible for you and pay the costs. You can claim, within reason, for any expenses you incur as a result of having these extra tests.

We can ask for independent confirmation that any medical treatment is necessary and appropriate. You must be receiving regular medical care and supervision for your condition and we can ask you or your doctor for medical evidence at regular intervals throughout your claim.

8. Changes we can make to the plan

To the extent that any change is proportionate and reasonably required, we may alter the terms and conditions of your plan, including your payments and benefits, for any of the following reasons:

- a) so we can look after your plan more efficiently or effectively, or to reflect changes in technology or insurance industry practice
- b) to take account of a decision by a court, governmental body, ombudsman, regulator, industry body, or similar body anywhere in the world where the decision impacts on us with regard to your plan. Or, where we need to comply with changes to the law, taxation, official guidance, relevant codes of practice, or how we are regulated, including the amount of capital we must hold
- c) if in our reasonable opinion we are at material risk of becoming insolvent and this may be avoided by changing the terms and conditions of your plan and those of other plan owners with similar plans and the changes are in the interests of our plan owners as a whole.

We'll write and tell you of any changes to these terms and conditions 30 days before the change where this is reasonably possible. Otherwise we'll let you know as soon as we reasonably can.

9. General terms

If the ownership of this plan is transferred to someone else, we need to be informed by a 'notice of assignment' at our address on page 33. This protects the legal position of the person to whom it is transferred. Notices of assignment must give the date and details of the assignment, including the full name of the person to whom the plan ownership is being transferred.

If the currency of the United Kingdom is replaced by the Euro, we'll change the payments, charges and benefits to Euros.

If any of the details you have provided are wrong, we can change the terms of your plan to reflect the correct details.

If you want to make any changes to your plan please make your request in writing. We also recommend that you confirm with us in writing any issues you discuss with us that are not covered in these terms and conditions or your other plan documents.

Only you (or if you die, the person managing your affairs or the person who is entitled to benefit from the plan) can enforce the terms of your plan. We exclude the rights of any other persons under the Contracts (Rights of Third Parties) Act 1999.

10. Law

The plan is governed by the law of England. We will not provide you with any services or benefits if in doing so we violate any applicable (including UK, EU and USA (Office of Foreign Asset Control)) financial sanctions, laws or regulations. This could result in us having to terminate your plan with us.

This version of the booklet applies from January 2018.

11. Other information

How to complain

If you need to complain, please see the 'How to contact us' section.

You can ask us for details of our complaint handling process. If you are not satisfied with our response to your complaint, you can complain to:

Financial Ombudsman Service
Exchange Tower
Harbour Exchange Square
London
E14 9SR

Telephone: 0800 023 4567 or 0300 123 9123

Or visit the website www.financial-ombudsman.org.uk

This service is free to you and you can find out more at any time by contacting the Financial Ombudsman Service. You do not have to accept the decision of the Financial Ombudsman Service and you are free to go to court instead if you wish.

Compensation

We are covered by the Financial Services Compensation Scheme (FSCS). If we cannot meet our obligations, you may be entitled to compensation under the scheme.

Any compensation you receive under the scheme will be based on the FSCS's rules. For this type of plan, the scheme covers 100% of the claim. Please note that for life assurance products the FSCS's first responsibility is to ensure the cover continues rather than pay compensation.

If you need more information, you can contact the FSCS helpline on 0800 678 110 or 020 7741 4100, write to the address below or visit the website www.fscs.org.uk.

Financial Services Compensation Scheme
10th Floor
Beaufort House
15 St Botolph Street
London
EC3A 7QU

Data Protection

Zurich Assurance Ltd is your Data Controller under data protection legislation and is committed to ensuring the way we collect, hold, use and share personal information about you complies fully with the legislation.

This is explained in our data protection statement – see Appendix A.

Moving abroad

This plan is designed for customers who are resident in the United Kingdom.

- We do not provide any tax advice. If you decide to live outside of the United Kingdom after this plan has been issued, we recommend that you obtain independent advice in relation to this plan on the tax consequences of changing your country of residency. We are not responsible for any adverse tax consequences that may arise in respect of your plan and/or any payments made under your plan as a result of you changing your country of residency.
- If you move to another country outside the UK, your plan may no longer be suitable for your individual needs. UK laws or the local laws and regulations of the jurisdiction to which you move may impact our ability to continue to operate your plan in line with these terms and conditions. You must tell us of any planned change in your residency while you have a plan prior to such change becoming effective, if you do not do so this will be a material breach of these terms and conditions and we may terminate the plan as a result.

Conflicts of interest

We make every effort to identify conflicts of interest. A conflict of interest is where the interests of our business conflict with those of a customer, or if there is a conflict between customers of the business. Once identified, we aim to either prevent the conflict or put steps in place to manage it so that it is no longer potentially detrimental to our customers.

We have processes in place to ensure we conduct our business lawfully, with integrity, and in line with current legislation. We operate in line with our conflicts of interest policy, available on request or on our website, which details the types of conflicts of interest that affect our business and how we aim to prevent or manage these. Where we cannot prevent or manage a conflict which may be detrimental to you, we will fully disclose it to you in line with our policy.

Critical illnesses and operations

This section lists the conditions and operations covered by your plan.

We've tried to put the definitions in plain English, but it is difficult to completely avoid the use of medical terms. For more explanation of some of the terms we use you should read 'Your guide to your cover'. This is available on our website. Alternatively, please contact us and we will send you a copy.

The Life Assurance Industry through the Association of British Insurers (the ABI) has agreed standard definitions for a number of operations and conditions. For those operations and conditions, the definitions used match the ABI standard.

There are certain key definitions you should be aware of:

Diagnosis

Diagnosis means unequivocal diagnosis of the relevant condition.

All diagnoses and medical opinions must be given by a medical specialist who:

- is a consultant at a hospital in the UK
- is acceptable to our Chief Medical Officer; and
- is a specialist in an area of medicine appropriate to the cause of the claim.

Irreversible

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

Major UK hospital

Major UK hospital means any National Health Service hospital and any other hospital that Zurich reasonably agrees is a major UK hospital.

Occupation

A trade, profession or type of work undertaken for profit or pay. It is not a specific job with any particular employer and is independent of location and availability.

Permanent

Permanent means expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

Permanent neurological deficit with persisting clinical symptoms

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

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

The following are not covered:

- an abnormality seen on brain or other scans without definite related clinical symptoms
- neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- symptoms of psychological or psychiatric origin.

Operations and conditions covered

The complete list of conditions we cover is set out below. These headings are only a guide to what is covered. The full definitions of the conditions covered and the circumstances in which you can claim start on page 23. These typically use medical terms to describe the illnesses but in some cases the cover may be limited.

Where cover is limited for a condition the criteria for the limitation is shown in the definition for that condition.

For children's critical illness cover, the same conditions are covered as listed below. Please see the children's critical illness benefit section on page 32 for any exceptions.

Where possible, we have grouped conditions which may be similar together to make them easier to understand.

Definitions qualifying for full critical illness payments

- Aorta graft surgery - for disease and trauma
- Aplastic anaemia – of specified severity
- Bacterial meningitis – resulting in permanent symptoms
- Benign brain tumour – resulting in permanent symptoms or specified treatment
- Benign spinal cord tumour – resulting in permanent symptoms or specified treatment
- Blindness – permanent and irreversible
- Cancer – excluding less advanced cases
- Cardiac arrest – with insertion of a defibrillator
- Cardiomyopathy – of specified severity
- Coma – with associated permanent symptoms
- Coronary artery bypass grafts – (a payment is available to pay for surgery after being placed on an NHS waiting list)
- Creutzfeldt-Jakob disease (CJD) – requiring continuous assistance
- Deafness – permanent and irreversible
- Dementia including Alzheimer's disease – resulting in permanent symptoms
- Encephalitis
- Heart attack – of specified severity
- Heart surgery – with thoracotomy
- Heart valve replacement or repair
- HIV – caught from a blood transfusion, by physical assault or at work¹
- Kidney failure – requiring permanent dialysis
- Liver failure – end stage
- Loss of hand or foot – permanent physical severance
- Loss of independence – of specified severity
- Loss of speech – total permanent and irreversible
- Major organ transplant – from another donor
- Motor neurone disease and specified diseases of the motor neurones – resulting in permanent symptoms
- Multiple sclerosis – of specified severity
- Neuromyelitis optica (Devic's disease) – with persisting clinical symptoms
- Paralysis of limb – total and irreversible
- Parkinson's disease – resulting in permanent symptoms
- Parkinson's plus syndromes – resulting in permanent symptoms
- Pneumonectomy – for disease or trauma
- Primary pulmonary arterial hypertension – resulting in permanent symptoms
- Pulmonary artery replacement – with surgery
- Removal of an eyeball as a result of injury or disease – permanent physical severance
- Severe lung disease/respiratory failure – of specified severity
- Spinal stroke – resulting in permanent symptoms
- Stroke – resulting in specified symptoms
- Systemic lupus erythematosus – of specified severity
- Terminal illness – where death is expected within 12 months
- Third-degree burns – covering 20% of the body's surface area or 50% of the face's surface area
- Total permanent disability – unable before age 65 to look after yourself ever again
- Traumatic brain injury – resulting in permanent symptoms

¹The incident causing the infection must have occurred in a country that is listed on page 27 (the eligible countries).

The medical conditions and operations qualifying for additional critical illness cover cash payments

- Bladder removal
- Brain abscess drained via craniotomy
- Cerebral or spinal aneurysm – with surgery or radiotherapy
- Cerebral or spinal arteriovenous malformation – with surgery or radiotherapy
- Less advanced cancer of the Anus
- Less advanced cancer of the Bile Ducts
- Less advanced cancer of the Breast
- Less advanced cancer of the Cervix
- Less advanced cancer of the Colon and Rectum
- Less advanced cancer of the Gallbladder
- Less advanced cancer of the Larynx
- Less advanced cancer of the Lung and Bronchus
- Less advanced cancer of the Oesophagus
- Less advanced cancer of the Oral cavity or Oropharynx
- Less advanced cancer of the Ovary
- Less advanced cancer of the Pancreas
- Less advanced cancer of the Prostate
- Less advanced cancer of the Renal Pelvis
- Less advanced cancer of the Stomach
- Less advanced cancer of the Testicle
- Less advanced cancer of the Urinary Bladder
- Less advanced cancer of the Uterus
- Less advanced cancer of the Vagina
- Less advanced cancer of the Vulva
- Other less advanced cancers in situ
- Liver resection
- Non-malignant pituitary adenoma – with specified treatment
- Significant visual loss – permanent and irreversible
- Single lobectomy – the removal of a complete lobe of a lung
- Syringomelia or Syringobulbia – treated by surgery
- Skin cancer (not including melanoma) – advanced stage as specified

- Third-degree burns – less extensive – covering 5% of the body's surface area or 19% of the face's surface area

Definitions

The medical conditions and operations qualifying for full critical illness payments

Aorta graft surgery – for disease and trauma

The undergoing of surgery to the aorta with excision and surgical replacement of a portion of the affected aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

The following are not covered:

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

Aplastic anaemia – of specified severity

A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be complete bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia that has been treated with at least one of the following:

- blood transfusion
- bone-marrow transplantation
- immunosuppressive agents
- marrow stimulating agents.

For the above definition, the following are not covered:

- other forms of anaemia.

Bacterial meningitis – resulting in permanent symptoms

A definite diagnosis of bacterial meningitis by a consultant neurologist. There must be inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms.

The following are not covered:

- all other forms of meningitis, not mentioned above, including viral meningitis.

Benign brain tumour – resulting in permanent symptoms or specified treatment

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- surgical removal of part or all of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

The following are not covered:

- tumours in the pituitary gland
- tumours originating from bone tissue
- angiomas and cholesteatoma.

Benign spinal cord tumour – resulting in permanent symptoms or specified treatment

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

- permanent neurological deficit with persisting clinical symptoms; or
- surgical removal of part or all of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

The following are not covered:

- angiomas.

Blindness – Permanent and irreversible

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

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
- Lymphoma (except cutaneous lymphoma - lymphoma confined to the skin).

The following are not covered:

- all cancers which are histologically classified as any of the following:
 - pre-malignant
 - non-invasive
 - cancer in situ
 - having borderline malignancy; or
 - having low malignant potential
- 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
- all Tumours of the prostate unless histologically classified as having a Gleason score of 7 or above, or having progressed to at least TNM classification T2bNOM0.

Cardiac arrest – with insertion of a defibrillator

Confirmation by a consultant medical specialist of a definite diagnosis of cardiac arrest with the permanent insertion of an implantable cardiac defibrillator.

Cardiomyopathy – of specified severity

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

For the above definition, the following are not covered:

- all other forms of heart disease, heart enlargement and myocarditis.

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.

For the above definition, the following is not covered:

- medically induced coma.

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 bypass grafts.

If you are placed on the NHS waiting list for coronary artery bypass surgery, up to 20% of the critical illness cover amount can be accelerated to enable the surgery to be performed privately.

Creutzfeldt-Jakob disease – requiring continuous assistance

The unequivocal diagnosis of Creutzfeldt-Jakob disease, made by a consultant neurologist, evidenced by a significant reduction in mental and social functioning such that continuous supervision or assistance by a third party is required.

Deafness – permanent and irreversible

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

Dementia including Alzheimer's disease – resulting in permanent symptoms

A definite diagnosis of dementia, including Alzheimer's disease, by a consultant neurologist, psychiatrist or geriatrician.

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.

Encephalitis

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

For the above definition, the following are not covered:

- Chronic fatigue syndrome and myalgic encephalomyelitis.

Heart attack – of specified severity

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

- the characteristic rise of cardiac enzymes or Troponins
- new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests.

The evidence must show a definite acute myocardial infarction.

The following are not covered:

- other acute coronary syndromes
- angina without myocardial infarction.

Heart surgery – with thoracotomy

The undergoing of heart surgery requiring thoracotomy on the advice of a consultant cardiologist to correct a structural abnormality of the heart.

For the above definition, the following is not covered:

- any percutaneous, transluminal or investigative procedure.

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.

HIV caught from a blood transfusion, a physical assault or at work

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment
- a physical assault; or
- an incident occurring during the course of performing normal duties of employment.

After the plan starts 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 five 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 an eligible country*, see next page.

For the above definition, HIV infection resulting from any other means, including sexual activity, is not covered:

* The eligible countries are: Australia, Austria, Belgium, Bulgaria, Canada, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, Republic of Ireland, Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Republic of Macedonia, Malta, Monaco, the Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, and United States of America.

Kidney failure – requiring permanent dialysis

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

Liver failure – end stage

End stage liver failure due to cirrhosis and resulting in all of the following:

- Permanent jaundice
- Ascites
- Encephalopathy.

Loss of hand or foot – permanent physical severance

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

Loss of independence – of specified severity

Confirmation by a consultant physician of the permanent loss of the ability to live independently which meets the following criteria:

Either:

- mental health condition. The diagnosis by a consultant neurologist or psychiatrist, of an irreversible and permanent mental impairment due to an organic brain disease or brain injury supported by evidence of the loss of ability to:
- remember;
 - reason; and
 - perceive, understand and give effect to ideas which causes a significant reduction in mental and social functioning, requiring continuous supervision

Or:

- the life assured is unable to perform two out of the following five activities without the help of another person, even with the use of appropriate assistive aids.

Activity definitions:

- Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower).
- Dressing – The ability to put on and take off, secure and unfasten all garments.
- Getting between rooms – The ability to get from room to room on a level floor.
- Feeding yourself – The ability to feed yourself when food and drink has been prepared.
- Maintaining personal hygiene – The ability to maintain a satisfactory level by using the toilet or otherwise managing bowel and bladder functions.

Loss of speech – total permanent and irreversible

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

Major organ transplant – from another donor

The undergoing as a recipient of a transplant from either a human donor, animal or insertion of an artificial device, or inclusion on an official UK waiting list for any of the following:

- transplant of bone marrow
- transplant of a complete heart, kidney, liver, lung or pancreas
- transplant of a lobe of liver; or
- transplant of a lobe of lung.

For the above definition, the following are not covered:

- transplant of any other organs, parts of organs, tissues or cells.

Motor neurone disease and specified diseases of the motor neurones – resulting in permanent symptoms

A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Kennedy's disease, also known as spinal and bulbar muscular atrophy (SBMA)
- Spinal muscular atrophy (SMA).

There must also be permanent clinical impairment of motor function.

Multiple sclerosis – of specified severity

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).

All of the evidence must be consistent with multiple sclerosis.

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

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

The following is not covered:

- Neuromyelitis optica spectrum disorder.

Paralysis of limb – total and irreversible

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

Parkinson's disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a consultant neurologist.

There must be permanent clinical impairment of motor function with associated tremor or muscle rigidity.

The following are not covered:

- Parkinsonian syndromes/Parkinsonism

Parkinson's plus syndromes – resulting in permanent symptoms

A definite diagnosis by a consultant neurologist or geriatrician of one of the following Parkinson plus syndromes:

- Corticobasal ganglionic degeneration
- Diffuse Lewy body disease
- Multiple system atrophy
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Progressive supranuclear palsy.

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

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

Pneumectomy – for disease or trauma

The undergoing of surgery on the advice of a consultant physician to remove an entire lung due to disease or trauma.

For the above definition the following are not covered:

- removal of a lobe of the lungs (lobectomy)
- lung resection or incision.

Primary pulmonary arterial hypertension – resulting in permanent symptoms

Primary pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in permanent irreversible physical impairment to the degree of at least Class III of the New York Heart Association Classification of cardiac impairment.

For the purposes of this condition, NYHA Stage III (as classified) means:

- a marked limitation of physical activity of the person covered due to symptoms of less than ordinary activity causing fatigue, palpitations, dyspnoea or anginal pain. The person covered is only comfortable at rest.

Pulmonary artery replacement – with surgery

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

Removal of an eyeball as a result of injury or disease – permanent physical severance

Permanent surgical removal of an eyeball as a result of injury or disease.

Severe lung disease/respiratory failure – of specified severity

Confirmation by a consultant physician of severe lung disease which is evidenced by all of the following:

- the need for continuous daily oxygen therapy on a permanent basis
- evidence that oxygen therapy has been required for a minimum period of six months
- FEV1 being less than 40 percent of normal
- vital capacity less than 50 percent of normal.

Spinal stroke – resulting in permanent symptoms

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

Stroke – resulting in specified symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either:

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

The following are not covered:

- transient ischaemic attack
- death of tissue of the optic nerve or retina/eye stroke.

Systemic lupus erythematosus – of specified severity

A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- permanent impairment of kidney function with Glomerular Filtration Rate (GFR) below 30 ml/min.

Terminal illness – where death is expected within 12 months

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

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

Third-degree burns – covering 20% of the body's surface area or 50% of the face's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or covering 50% of the face's surface area.

Total permanent disability – unable before age 65 to look after yourself ever again

Loss of the physical ability through an illness or injury before age 65 to do at least three of the six tasks listed below ever again.

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

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 prescribed medication.

The tasks are:

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

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

Traumatic brain injury – resulting in permanent symptoms

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

The medical conditions and operations qualifying for additional critical illness cover cash payments

Bladder removal

Complete surgical removal of the urinary bladder (total cystectomy).

For the above definition the following are not covered:

- Urinary bladder biopsy
- removal of a portion of the urinary bladder.

Brain abscess drained via craniotomy

Surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a consultant neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

Cerebral or spinal aneurysm – with surgery or radiotherapy

The undergoing of craniotomy, endovascular repair or stereotactic radiotherapy to treat a cerebral or spinal aneurysm.

Cerebral or spinal arteriovenous malformation – with surgery or radiotherapy

The undergoing of craniotomy, endovascular repair or stereotactic radiotherapy to treat a cerebral or spinal arteriovenous fistula or malformation.

Less advanced cancers of named sites and specified severity

An additional critical illness cover cash payment applies to each form of less advanced cancer. Please see section 3 for more information. A definite diagnosis with less advanced cancer of named sites and of severity requiring treatments.

- **Anus** - Cancer in situ of the anus with surgery to remove the tumour.
The following is not covered:
 - anal intraepithelial neoplasia (AIN) grade 1 or 2.
- **Bile Ducts** – Cancer in situ of the extra-hepatic bile ducts with surgery to remove the tumour.
- **Breast** – Cancer in situ of the breast with surgery to remove the tumour.
- **Cervix** – Cancer in situ of the cervix uteri resulting in trachelectomy (removal of the cervix) or hysterectomy.
The following are not covered:
 - loop excision, laser surgery, conisation and cryosurgery
 - cervical Intra-epithelial neoplasia (CIN) grade 1 or 2.

- **Colon and Rectum** – Cancer in situ of the colon or rectum resulting in intestinal resection.
The following are not covered:
 - local excision and polypectomy.
- **Gallbladder** – Cancer in situ of the gallbladder with surgery to remove the tumour.
- **Larynx** – Cancer in situ of the larynx treated with surgery, laser or radiotherapy.
- **Lung and Bronchus** – Cancer in situ of the lung or bronchus resulting in wedge resection or lobectomy.
- **Oesophagus** – Cancer in situ of the oesophagus with surgery to remove the tumour.
- **Oral cavity or Oropharynx** – Cancer in situ of the oral cavity or oropharynx with surgery to remove the tumour.

* Note: includes lip, inside of cheek, floor of the mouth, tongue, gums, hard palate, soft palate and tonsils.

- **Ovary** – Ovarian tumour of borderline malignancy/low malignant potential and has resulted in surgical removal of an ovary.
The following is not covered:
 - removal of an ovary due to a cyst.
- **Pancreas** – Cancer in situ of the pancreas with surgery to remove the tumour.
- **Prostate** - Cancer of the prostate histologically classified as having either a Gleason score between 2 and 6, or having a TNM classification between T1N0M0 and T2aN0M0, with prostatectomy (complete surgical removal of the prostate) or treatment with brachytherapy/radiotherapy.
The following are not covered:
 - treatment with transurethral resection (TUR) of the prostate, hormone therapy or cryotherapy.
- **Renal Pelvis (of the kidney) or Ureter** - Cancer in situ of the renal pelvis or ureter.
The following are not covered:
 - non-invasive papillary carcinoma and tumours of TNM classification stage Ta.
- **Stomach** - Cancer in situ of the stomach with surgery to remove the tumour.

- **Testicle**

Benign testicular tumour or Intra-tubular germ cell neoplasia unclassified (ITGCNU) resulting in orchidectomy (removal of a testicle).

- **Urinary bladder**

Cancer in situ of the Urinary bladder.

The following are not covered:

- non-invasive papillary carcinoma and TNM classification stage Ta bladder cancer.

- **Uterus**

Cancer in situ of the lining of the uterus (endothelium) resulting in hysterectomy.

- **Vagina**

Cancer in situ of the vagina resulting in surgery to remove the tumour.

The following are not covered:

- laser surgery and diathermy
- vaginal intra-epithelial neoplasia (VAIN) grade 1 or 2.

- **Vulva**

Cancer in situ of the vulva resulting in surgery to remove the tumour.

The following are not covered:

- laser surgery and diathermy
- vulval intra-epithelial neoplasia (VIN) grade 1 or 2.

- **Other cancer in situ**

Cancer in situ diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of organs and that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

- any skin cancer (including melanoma); and
- tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment.

Liver Resection

The undergoing of a partial hepatectomy (liver resection) on the advice of a specialist surgeon in gastroenterology and hepatology.

For this definition the following are not covered:

- surgery relating to liver disease resulting from alcohol or drug abuse
- surgery for liver donation (as a donor)
- liver biopsy.

Non-malignant pituitary adenoma – with specified treatment

Diagnosis of a non-malignant pituitary tumour requiring radiotherapy or surgical removal.

For the above definition, the following are not covered:

- non-malignant tumours of the pituitary gland treated by other methods.

Significant visual loss – permanent and irreversible

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/24 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 45 degrees or less of an arc, as certified by an ophthalmologist.

Single Lobectomy – the removal of a complete lobe of a lung

The undergoing of medically essential surgery to remove a complete lobe of a lung for disease or traumatic injury.

For the above definition, the following are not covered:

- partial removal of a lobe of the lungs (segmental or wedge resection)
- any other form of lung surgery.

Syringomelia or Syringobulbia – treated by surgery

A definite diagnosis of Syringomelia or Syringobulbia by a consultant neurologist, which has been surgically treated. This includes surgical insertion of a permanent drainage shunt.

Skin cancer (not including melanoma) – advanced stage as specified

Non-melanoma skin cancer diagnosed with histological confirmation that the tumour is larger than 2 centimetres across and has at least one of the following features:

- tumour thickness of at least 4 millimetres (mm)
- invasion into subcutaneous tissue (Clark level V)
- invasion into nerves in the skin (perineural invasion)
- poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope); or
- has recurred despite previous treatments.

Third-degree burns – less extensive – covering 5% of the body's surface area or 19% of the face's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area or 19% loss of the surface area of the face which for the purposes of this definition includes the forehead and ears.

No claim will be payable in respect of this benefit where a claim for Third-degree burns – covering 20% of the body's surface area or 50% of the face's surface area, is submitted at the same time as or within 30 days of the diagnosis of Third-degree burns – covering 20% of the body's surface area or 50% of the face's surface area.

Children's critical illness benefit

The definitions covered under children's critical illness benefit are the same operations and conditions covered as listed above, with the following differences:

- for children's critical illness benefit 'total permanent disability' means an irreversible level of disability which, in Zurich's reasonable opinion, means the child would be disabled from performing any occupation whatsoever if he or she were an adult
- intentional harm inflicted on a child by a plan owner is not covered.

Please note that if your plan doesn't include critical illness cover, then the children's critical illness benefit is not included.

The children's critical illness benefit is only payable if the child suffers from the relevant condition or undergoes the relevant operation and survives for 14 days. The benefit is included, for the conditions and operations outlined above, from the date each child turns three months until their 18th birthday. If your child is under the age of three months at the start of your plan, they will be included on reaching the age of three months.

For the majority of the conditions and operations we cover on the plan we will pay the lower of £25,000 or 50% of the full critical illness cover sum assured provided by the plan at the time you claim. We'll only pay one claim for each child but there is no limit to the number of children covered.

However, for the additional critical illness cover cash payment definitions we cover we'll pay the lower of £15,000 or 20% of the full critical illness cover sum assured provided by the plan at the time you claim. For these definitions only, we'll pay a maximum of one claim per definition for each child.

If you make a claim for your child, this will not reduce the amount of cover provided by your plan.

We do not ask for any medical details on children before they are included on your plan. So you should be aware that you would not be able to claim if your child had previously suffered, or was suffering, from one of the above conditions, or had previously had or was about to undergo one of the operations, before they were included on your plan.

For further details on the conditions and operations included for this benefit, please see the relevant pages in this booklet. For further details of when we won't pay the benefit please see page 8.

How to contact us



Call us on

01793 514514

Monday to Friday 8am – 6.30pm and
Saturdays 9.30am – 12.30pm
(excluding bank holidays). We may
record or monitor calls to improve our
service.



Write to us at

Zurich Assurance Ltd
Tricentre One
New Bridge Square
Swindon
SN1 1HN

Keep in touch

It's important that we keep in touch so if you change your address or any of your contact details, please let us know.

We want everyone to find it easy to deal with us. If you need information about our plans and services in a different format, just let us know and we'll provide it.

Appendix A – Data protection

Who controls my personal information?

This notice tells you how Zurich Assurance Ltd ('Zurich'), as data controller, will deal with your personal information. Where Zurich introduces you to a company outside the group, that company will tell you how your personal information will be used.

You can ask for further information about our use of your personal information or complain about its use in the first instance, by contacting our Data Protection Officer at: Zurich Insurance Group, Tri-centre 1, Newbridge Square, Swindon, SN1 1HN or by emailing the Data Protection Officer at GBZ.General.Data.Protection@uk.zurich.com.

If you have any concerns regarding our processing of your personal information, or are not satisfied with our handling of any request by you in relation to your rights, you also have the right to make a complaint to the Information Commissioner's Office. Their address is: First Contact Team, Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, SK9 5AF.

What personal information will you collect about me?

We will collect and process the personal information that you give us by phone, email, filling in forms, including on our website, and when you report a problem with our website. We also collect personal information from your appointed agent such as your trustee, broker, intermediary or financial adviser, including staff in your adviser's firm, in order to provide you with the services you have requested and from other sources, such as credit reference agencies and other insurance companies, for verification purposes. We will also collect information you have volunteered to be in the public domain and other industry-wide sources.

We will only collect personal information that we require to fulfil our contractual or legal requirements unless you consent to provide additional information. The type of personal information we will collect includes; basic personal information (i.e. name, address and date of birth), occupation and financial details, health and family information, claims and convictions information and where you have requested other individuals be included in the arrangement, personal information about those individuals.

If you give us personal information on other individuals, this will be used to provide you with a quotation and/or contract of insurance and/or provision of financial services. You agree you have their permission to do so. Except where you are managing the contract on another's behalf, please ensure that the individual knows how their personal information will be used by Zurich. More information about this can be found in the 'How do you use my personal information' section.

How do you use my personal information?

We and our selected third parties will only collect and use your personal information (i) where the processing is necessary in connection with providing you with a quotation and/or contract of insurance and/or provision of financial services that you have requested; (ii) to meet our legal or regulatory obligations, or for the establishment, exercise or defence of legal claims; (iii) for our "legitimate interests". It is in our legitimate interests to collect your personal information as it provides us with the information that we need to provide our services to you more effectively including providing you with information about our products and services. We will always ensure that we keep the amount of information collected and the extent of any processing to the absolute minimum to meet this legitimate interest. Examples of the purposes for which we will collect and use your personal information are:

- to provide you with a quotation and/or contract of insurance
- to identify you when you contact us
- to deal with administration and assess claims
- to make and receive payments
- to obtain feedback on the service we provide to you
- to administer our site and for internal operations including troubleshooting, data analysis, testing, research, statistical and survey purposes
- for fraud prevention and detection purposes.

We use automated decision making to decide if we can provide insurance to you and the price, product and terms we can offer. We do this by taking the personal information you provide us (including age, smoker status and medical information) and using rules to calculate the cost of the cover that you have requested in your application. You have the right to ask for a person to review an automated decision. If you wish to exercise this right please contact us at applicationsupport@uk.zurich.com.

We will use your health information and information about any convictions for the purposes of providing insurance, and this includes arranging, underwriting, advising on or administering an insurance contract between you and us.

We will contact you to obtain consent prior to processing your personal information for any other purpose, including for the purposes of targeted marketing unless we already have consent to do so.

Who do you share my personal information with?

Where necessary, we will share the personal information you gave us for the purposes of providing you with the goods and services you requested with the types of organisations described below:

- associated companies including reinsurers, suppliers and service providers
- brokers, introducers and professional advisers;
- survey and research organisations
- credit reference agencies
- healthcare professionals, social and welfare organisations
- other insurance companies
- comparison websites and similar companies that offer ways to research and apply for financial services products
- fraud prevention and detection agencies.

Or, in order to meet our legal or regulatory requirements, with the types of organisations described below:

- regulatory and legal bodies
- central government or local councils
- law enforcement bodies, including investigators
- credit reference agencies
- other insurance companies.

We may also share the following data with the types of organisations outlined above, for the purpose of statistical analysis, research and improving services:

- anonymised data - data encrypted to make it anonymous, which protects an individual's privacy by removing personally identifiable information
- pseudonymised data - personally identifiable information replaced with a pseudonym to make the data less identifiable, such as replacing a name with a unique number
- aggregated data - similar groups of data, such as age, profession or income which are expressed as a summary for statistical analysis.

How do you use my personal information for websites and email communications?

When you visit one of our websites we may collect information from you such as your email address or IP address. This helps us to track unique visits and monitor patterns of customer website traffic, such as who visits and why they visit.

We use cookies and/or pixel tags on some pages of our website. A cookie is a small text file sent to your computer. A pixel tag is an invisible tag placed on certain pages of our website but not on your computer. Pixel tags usually work together with cookies to assist us to provide you with a more tailored service. This allows us to monitor and improve our email communications and website. Useful information about cookies, including how to remove them, can be found on our websites.

How do you transfer my personal information to other countries?

Where we transfer your personal information to countries that are outside of the UK and the European Union (EU) we will ensure that it is protected and that the transfer is lawful. We will do this by ensuring that the personal information is given adequate safeguards by using 'standard contractual clauses' which have been adopted or approved by the UK and the EU, or other solutions that are in line with the requirements of European data protection laws.

A copy of our security measures for personal information transfers can be obtained from our Data Protection Officer at: Zurich Insurance Group, Tri-centre 1, Newbridge Square, Swindon, SN1 1HN, or by emailing the Data Protection Officer at GBZ.General.Data.Protection@uk.zurich.com.

How long do you retain my personal information for?

We will keep and process your personal information for as long as necessary to meet the purposes for which it was originally collected.

There are a number of factors influencing how long we will keep your personal information, and these are shown below:

- to comply with applicable laws and regulations or set out in codes issued by regulatory authorities or professional bodies;
- our business processes, associated with the type of product or service that we have provided to you;
- the type of data that we hold about you;
- if your data relates to any ongoing, pending, threatened, imminent or likely dispute, litigation or investigation;
- to enable us to respond to any questions, complaints, claims or potential claims;
- if you or a regulatory authority require us to keep your data for a legitimate purpose.

What are my data protection rights?

We will, for the purposes of providing you with a contract of insurance, processing claims, reinsurance and targeted marketing, process your personal information by means of automated decision making and profiling where we have a legitimate interest and/or you have consented to this. You have a number of rights under the data protection laws, namely:

- to access your data (by way of a subject access request)
- to have your data rectified if it is inaccurate or incomplete
- in certain circumstances, to have your data deleted or removed
- in certain circumstances, to restrict the processing of your data
- a right of data portability, namely to obtain and reuse your data for your own purposes across different services
- to object to direct marketing
- not to be subject to automated decision making (including profiling), where it produces a legal effect or a similarly significant effect on you
- to claim compensation for damages caused by a breach of the data protection legislation
- if we are processing your personal information with your consent, you have the right to withdraw your consent at any time.

You can exercise your rights by contacting our Data Protection Officer at: Zurich Insurance Group, Tri-centre 1, Newbridge Square, Swindon, SN1 1HN or by emailing the Data Protection Officer at GBZ.General.Data.Protection@uk.zurich.com.

What happens if I fail to provide my personal information to you?

If you do not provide us with your personal information, we will not be able to provide you with a contract or assess future claims for the service you have requested.

Zurich Assurance Ltd, authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.
Registered in England and Wales under company number 02456671.
Registered Office: Unity Place, 1 Carfax Close, Swindon, SN1 1AP.
Telephone: 01793 514514.
We may record or monitor calls to improve our service.

NP122265A57 (7063-2) (10/21)

