Employers

Group Life Insurance Policy T&Cs

INTERNATIONAL CITIZENS INSURANCE

William Russell

Platinum Trusted Service Award 2025

feefo

3 YEARS RUNNING

Group life insurance policy

Your group life insurance policy is a contract for commercial organisations.

The William Russell Association for Health, Financial Protection and Well-being

By taking out a group life insurance policy from William Russell you have become a member of the William Russell Association for Health, Financial Protection and Well-being (WRA), and your employees are eligible for cover under WRA's contract of insurance with AWP Health & Life SA.

William Russell Europe SRL

William Russell Europe SRL is the administrator of the policy. William Russell Europe is registered in Belgium with the Financial Services and Markets Authority (FSMA), as mandated underwriter acting on behalf of AWP Health & Life SA.

AWP Health & Life SA

AWP Health & Life SA is the insurer of the policy. AWP is part of the Allianz group of companies. AWP Health & Life SA is regulated by the French Prudential Supervisory Authority "Authorite de Controle Prudentiel et de Resolution" (ACPR), located at Eurosquate 2, 7 rue Dora Maar, 93400 Saint-Ouen, France. It is authorised to carry out insurance activities in accordance with the provision of the Insurance Code in France.

Contents

Definitions

Certain terms in this policy have a special meaning. These terms are in bold type, and each one is defined below, or in the policy.

Actively at work

Means that an full-time employee:

- is actively fulfilling their normal occupational duties, and
- is working the normal number of hours required by their contract of employment, and
- is working at their normal place of business or at another business location, and
- has not received medical advice to reduce or refrain from their normal work activity.

on their entry date to the policy

If an actively at work requirement is applied on a day that isn't a working day, we'll treat an employee as actively at work unless their medical record shows that they were suffering from a medical condition that would reasonably have been expected to prevent them from working normally.

Annual renewal date

Means the date on which the policy falls due for renewal.

Automatic acceptance limit

Means that maximum level of cover that is automatically given to members, without medical underwriting. If your policy has an automatic acceptance limit, it will be stated on your certificate of insurance.

Certificate of insurance

Means the document we issue which sets out the terms, conditions and special terms that apply to your policy. It also describes the eligibility conditions for each member category, and the way we calculate the member benefit for each category.

Eligible employee

Means a person who meets the eligibility conditions for a member category shown on your certificate of insurance.

Entry date

Means the date when an eligible employee is included in the policy.

Fully underwritten

Means that all employees must go through underwriting before their cover can start.

Individually costed

Means that premium rates are calculated according to each member's age at the policy start date, or the last policy renewal date, whichever is the later date.

Member

Means a person who is covered by the policy.

Member benefit

Means the sum payable in the event of the member suffering an event covered by the policy.

Membership declaration

Means the information we need you to give us about your company and about your policy membership.

Membership review date

Means the date(s) by which you must make a full declaration of your policy membership. These dates will be stated on your certificate of insurance.

Policy

Means this document, its appendices and the web-pages to which it links, which all together with your certificate of insurance and other information you provide us with regarding the risk you are asking us to take, makes up your contract of insurance with us.

Policy start date

Means the date on which the policy first starts.

Policy year

Means your annual period of cover from the policy start date, and then from subsequent annual renewal dates when your policy is renewed.

Salary

Means the basic annual salary (including contractual bonuses paid as part of their employment contract) a member is earning before the deduction of income tax.

It does not include dividends, over-time, non-contractual discretionary bonuses or benefits in kind such as, (but not limited to) a car, or housing allowance. If a member's earning are based directly on sales performance, we will take into account 50% of their commission earnings over the 12 month period leading up to their entry date. If a member's commission earnings fluctuate, we will take an average of their commission earning during the 36 month period prior to their entry date.

Single event

Means one originating cause, event or occurrence or a series of origination causes, events or occurrences, resulting in a claim from more than one member.

Special terms

Mean exclusions or conditions and/or additional premium that we may apply to a member's cover.

Unit rate

Means a policy which is costed using a single rate that will apply to each member, regardless of their age.

We/our/us

Means William Russell Europe SRL on behalf of AWP Health & Life SA.

Membership

Eligibility conditions

A minimum of 3 employees are required to form a group policy, and your employees must be covered on a compulsory basis. Cover must be for all employees, or all employees of a certain category (e.g., directors, managers, expatriate employees. Your company must pay for your group protection insurance policy.

If you have a fully underwritten policy, all eligible employees must apply for cover and will be subject to underwriting before their cover will start.

If you have an individually costed or unit rate policy, the eligibility conditions are as follows:

An eligible employee must be included in the policy automatically as a member from:

- The policy start date, if they meet the eligibility conditions on that date, or
- Their entry date, if they meet the eligibility conditions after the policy start date,

provided that the eligible employee is actively at work on the date on which they become eligible to be included in the policy.

Members not actively at work on the day they become eligible for cover

If a member is not actively at work on the day they become eligible for cover, they will not be covered until they have returned to work and been actively at work for 40 consecutive working days.

Members who are absent from work due to a pre-arranged absence

We will treat members who are absent from work due to paid maternity or paternity leave or paid holiday, as being actively at work provided they are on pre-arranged absence of up to one year unless their medical record shows they were suffering from a medical condition that would reasonably have been expected to prevent them working normally.

Members who do not join the policy at the time they become eligible

If you do not include an eligible employee from the date upon which they become eligible for cover, their inclusion in the policy will be subject to underwriting.

Cover for members within the automatic acceptance limit

If your policy has an automatic acceptance limit, provided the member is actively at work on the date on which they first become a member, and they are included in your policy at the time they become eligible to join, the member will be covered for their full member benefit, or the automatic acceptance limit, whichever is the LOWER amount.

You must tell us if the cover you need for a member is above the automatic acceptance limit. Underwriting will be required in respect of cover in excess of the limit.

Underwriting

To enable us to underwrite, the information we need will include:

- An application for cover form completed by the eligible employee which will ask questions about their health and activities.
- Evidence of the eligible employee's health, such as a medical examination, and/or additional tests, and details of their medical history from a doctor who has attended them in the past.
- Any other evidence we require to assess whether there is an increased risk that the eligible employee may die or suffer an illness or injury likely to give rise to a claim under this policy.

We may impose special terms if our underwriting finds that the eligible employee:

- has a medical condition or an increased risk of developing a condition, and/or
- is involved in hazardous activities, and/or
- is engaged in an occupation that poses a greater risk than a desk based occupation.

This may result in an additional premium or restricted cover for that eligible employee. We will tell you in writing the terms that apply.

We also reserve the right to refuse to cover an eligible employee, or to limit their cover to the automatic acceptance limit if we consider that their health, activities and/or occupation pose too great a risk of a claim.

Future increases in cover resulting from an increase in salary

Once we've completed our underwriting and agreed the terms of cover for a member, we'll apply these terms to future increases in cover of up to 15% of the member's benefit, or US$50,000 or £40,000 or €45,000, whichever is the lower amount.

Provided the member is actively at work on the date on which their salary increases, and provided the benefit increase is still below the automatic acceptance limit, (or within the permitted 15% or US$50,000 or £40,000 or €45,000 limit), the benefit increase will apply from the date of the new salary starting.

If the member is not actively at work on the date that the increase occurs, the increase won't apply until the member is next actively at work.

Increases in cover that exceed 15% or US$50,000 or £40,000 or €45,000, whichever is the lower amount, will be subject to further underwriting.

If a member has never been through underwriting, all increases in benefit that exceed the automatic acceptance limit will be subject to underwriting.

When you must tell us about new employees

If you have a fully underwritten policy, you must tell us about new employees immediately. They will have to complete an application form and there will be no cover for these employees until we have completed underwriting and agreed to cover them.

Otherwise, you must tell us about new members no later than the next membership review date. However, if a new member needs to apply for cover in excess of the automatic acceptance limit, you must tell us as soon as they join, so that we can underwrite.

When you must tell us about members eligible for an increase in benefit

If you have a fully underwritten policy, you must tell us every time a member becomes eligible for an increase in benefit.

Otherwise, you must tell us if an existing member's cover entitlement increases above the automatic acceptance limit. Until we have completed our underwriting, cover for the member will be restricted to the automatic acceptance limit, or, if we have underwritten the member previously, to within 15% of the benefit we previously agreed, (subject to the increase in benefit being no more than US$50,000 or £40,000 or €45,000).

When you must tell us about members who leave the policy

If you have a fully underwritten policy you must tell us about members who leave the policy within 30 days of their leaving.

Otherwise, you must tell us about members who have left on your next membership declaration.

When you must provide us with a membership declaration

You must provide a full membership declaration at each of the membership review date(s) stated on your certificate of insurance. Your membership declaration must include:

- A list of all members at the membership review date with the following information in respect of each member:
  - Member's full name
  - Date on which the member became eligible for cover (entry date)
  - Date of birth
  - Gender
  - Occupation
  - Location
  - Nationality
  - Salary
  - Date of salary increase (in respect of member's whose salary has increased since the last membership review date)
- A list of members who left the policy since the last membership review date, and the date on which they left.
- A list of members who are on temporary absence.

Cover during periods of temporary absence

Provided a member continues to be employed by you, and provided you continue to pay their premiums, we will maintain cover for a member in the following circumstances:

- If a member is away from work on a paid pre-arranged period of temporary absence, we will maintain cover for up to 12 months.
- If a member becomes absent due to illness or injury, we will maintain their cover up to age 65.

During a period of temporary absence, we will maintain cover at the benefit the member was insured for by us at the time they start their period of temporary absence.

You must tell us about members who are on a period of temporary absence.

When Membership ends

Membership and cover will end on the earliest date on which any of the following events occur:

- the member reaches the maximum age limit unless we agree in writing to extend cover for a member beyond the maximum age limit, or
- the member dies, or
- the member no longer meets the eligibility conditions shown in the certificate of insurance, or
- the member is no longer employed by you, or
- the member ceases, for any reason, to be a member of the policy, or
- the member reaches the end of the agreed temporary absence period, or
- the member is paid from the terminal illness benefit, or
- the member takes up residence in any of the Excluded countries, as outlined in "EXCLUDED COUNTRIES & REGIONS" section, or
- the policy is cancelled or not renewed.

Cover under the following optional benefits will end when any of the following events occur:

Critical Illness benefit

Cover under this benefit will terminate from the date on which we pay the claim.

Critical Illness benefit for dependent children

Cover under this benefit will terminate from the date on which we pay the claim.

Cover will continue for the member's other benefits, for as long as the member remains eligible for cover, and you continue to pay their premiums.

Policy benefits

We provide cover for each member in accordance with the member benefit stated on your certificate of insurance, subject to the maximum cover limits stated in the policy.

Your certificate of insurance states how the benefit payable is calculated for each category of member.

The basis of calculating the member's benefit can vary between different categories of membership, but must be the same basis for all members within a specified category.

Life insurance benefit

If a member dies during the policy year, we will pay the member's benefit to the member's nominated beneficiary, unless the member is diagnosed with a terminal illness in which case the benefit will be paid to the member.

Early payment of the life insurance benefit upon a terminal illness diagnosis

When a member is diagnosed with a terminal illness for the first time, whilst they are covered by the policy, we'll pay out their life insurance benefit to them before their death, provided that our Chief Medical Officer agrees that the member's terminal illness will lead to their death within 12 months of the date of diagnosis. In the event of a disagreement between the member's medical consultant(s) and our Chief Medical Officer, the decision of our Chief Medical Officer is final.

If the terminal illness benefit is paid, no further payment will be due when the member dies.

Optional additional benefits

Your certificate of insurance will show if your policy includes any of the following additional benefits:

Accidental death & permanent disablement benefit

If this applies, this optional benefit provides two types of cover:

Accidental death benefit

When a member dies as a result of an accidental injury that happens whilst they are covered by the policy, we'll pay out their accidental death benefit, provided their death happens within one year of the date on which the accidental injury occurred, and provided they are still a member of the policy at the time of their death.

Accidental permanent disablement benefit

When a member suffers an accidental injury that happens whilst they are covered by the policy, and results in one or more of the permanent disablements specified in Appendix 1, we'll pay out the specified percentage of their accidental death benefit.

If a member suffers several disablements due to the same accident, we calculate the total benefit by adding together each disability payment.

A list of the disablements covered are set out in the Compensation schedule in Appendix 1.

Critical illness benefit

The critical illness benefit pays out a lump sum to a member if they are diagnosed with an illness specified in Appendix 2, after the expiration of the applicable waiting period.

The waiting period is the period from the member's entry date, and is either a three month or a seven month period.

No benefit is paid in respect of an illness diagnosed prior to or during the applicable waiting period.

The list of specified illnesses and their applicable waiting periods are as set out in Appendix 2.

Optional additional benefits (continued)

Critical illness benefit for dependent children

Child critical illness benefit pays out a lump sum of US$5,000 or £5,000 or €5,000 to a member if their child is diagnosed with an illness specified in Appendix 3, after the expiration of the applicable waiting period.

The waiting period is the period from the member's entry date, and is either a three month or a seven month period.

No benefit is paid in respect of an illness diagnosed prior to or during the applicable waiting period.

The list of specified illnesses and their applicable waiting periods are as set out in Appendix 3.

A dependent child is defined as a biological or legally adopted, or step child of the member, who is under the age of 18 at the time of the diagnosis.

Funeral expenses benefit

We will pay a lump sum of US$5,000 or £5,000 or €5,000 when a member dies as the result of an event covered by the policy. This benefit is payable in addition to the life insurance benefit.

Maximum cover limits

Maximum limits payable for each benefit

In the event of a valid claim we will pay the member's benefit entitlement, subject always to the following maximum amounts and limitations:

Life insurance benefit

The life insurance benefit we pay under this policy cannot exceed ten times the member's salary, and is also subject to a maximum life insurance benefit of US$2,000,000 per member. For sterling policies the maximum life insurance benefit is £1,600,000. For Euro policies, the maximum life insurance benefit is €1,800,000.

Optional additional benefits

Accidental Death & Permanent Disablement benefit

The Accidental Death & Permanent Disablement benefit cannot exceed the member's Life insurance benefit, and is subject to an aggregate maximum limit of US$1,000,000. Benefit(s) payable under the Permanent Disablement benefit are subject to a sub limit of US$500,000. For sterling policies, the maximum benefit limits are £800,000 with a sub limit of £400,000 for the Permanent Disablement Benefit, and for Euro policies the maximum benefit limits are €900,000 with a sub limit of €450,000 for the Permanent Disablement Benefit.

Critical illness benefit

The critical illness benefit cannot exceed the member's life insurance benefit and is subject to a maximum benefit of US$100,000. For sterling policies this limit is £80,000, and for Euro policies the limit is €90,000.

Critical illness benefit for dependent children

US$5,000 For sterling policies this limit is £5,000, and for Euro policies the limit is €5,000.

Funeral expenses

US$5,000 For sterling policies this limit is £5,000, and for Euro policies the limit is €5,000.

Single event limit

There is a limit to how much we'll pay if death, illness or injury occurs, directly or indirectly, as a result of a single event.

The total aggregate of the insured member benefits payable under the policy (and any Associated Policies if more than one is insured with us) will be limited to a maximum of US$6,000,000 for claims arising from a single event. For sterling policies this limit is £4,900,000, and for Euro policies the limit is €5,400,000.

If the total amount of benefit due in respect of such an event exceeds the single event limit, the benefit payable in respect of each member will be reduced proportionately. If the total member benefit is twice the single event limit, the benefit payable in respect of each member will be reduced by half.

Group travel limit

The total aggregate amount payable under this policy and any other policies to which this policy is linked (if more than one is insured with us) in respect of members who die as a result of an incident that occurred whilst travelling (by any means) together will be limited to US$6,000,000. This limit will apply from the time the members depart to the time they arrive at their destination. For sterling policies this limit is £4,900,000, and for Euro policies the limit is €5,400,000.

Age limits

Cover will automatically terminate on the renewal date after the member attains the following ages:

Life insurance benefit

Minimum Age: 18

Maximum Age: 70

Optional additional benefits

Accidental death & permanent disablement benefit

Minimum Age: 18

Maximum Age: 70

Adult critical illness benefit

Minimum Age: 18

Maximum Age: 65

Child critical illness benefit

Minimum Age: 0

Maximum Age: 18

Funeral expenses

Minimum Age: 18

Maximum Age: 70

Unless we have specifically agreed in writing to grant cover beyond the ages stated above.

Excluded countries & regions

There are certain countries and regions where we are unable to provide cover due to political, and/or regulatory reasons, or because sanctions prevent us from doing so.

Countries where we cannot provide cover

If an insured event that gives rise to a claim occurs whilst a member is in an excluded country, we will not pay that claim. For a full list of the countries where we do not provide cover, please follow this link.

Please note that the list of excluded countries does change from time to time as new countries are added to the sanctions list, and new political situations arise.

Countries or regions where the UK Foreign, Commonwealth & Development Offi e has advised its citizens to leave

Excluded countries and regions also include countries or regions where the UK Foreign, Commonwealth & Development Office has advised its citizens to leave. You can check the current advice offered by the FCDO about a particular country or region at www.gov.uk/foreign-travel-advice.

Countries where Sanctions apply

We won't provide you or a member with any services or benefits if in doing so we violate, or may risk violating, any applicable (including UK, EU and USA (Office of Foreign Asset Control)) sanctions, laws or regulations.

This could result in us having to amend or terminate your policy with us.

Policy exclusions

No benefit will be paid if a claim under this policy relates to or arises directly or indirectly from any of the following causes:

General exclusions relating to all benefits

The following exclusions apply to all members in respect of all benefits:

A pre-existing medical condition

Pre-existing medical conditions are conditions a member had before their entry date. When a member's cover is subject to underwriting, that member will not be insured for pre-existing conditions unless they have disclosed them on their application form for cover, and we have agreed to cover them, or we have agreed to cover them with special terms.

Pre-existing medical conditions also include conditions that we believe a member may have known about before their entry date, even if they hadn't yet sought medical help.

Members who have cover below the automatic acceptance limit where it is not required for any medical information to be disclosed will not be subject to this exclusion, provided the member has satisfied the actively at work conditions.

Participating in an illegal activity

We will not pay a claim which happens when a member is committing, attempting, or participating in an activity that is illegal in the country where it takes place.

Active participation in war, warlike activities or terrorist activities

We will not pay a claim when the member is an active participant in war, warlike activities, military action, civil-war, rebellion, revolution, insurrection, mutiny, riot, strike, and/or any act of terrorism.

Suicide, or the consequences of attempted suicide or intentionally self-inflicted injuries or illnesses.

We exclude all claims where the cause is suicide, or attempted suicide, or intentionally self-inflicted injuries or illnesses, whether the member was sane, or insane.

In the case of a claim under the life insurance benefit, this exclusion only applies during a member's first 12 months of cover, and to any subsequent increases in cover for a period of 12 months from the date of the increase.

This exclusion applies permanently in respect of all other benefits.

Flying

When the member is in any kind of aircraft unless they are travelling as a fare paying passenger in a commercial aircraft.

Professional sport and professional racing

Participation in any form of racing as an amateur or professional, or in in any kind of professional sport, including training or practicing of any kind.

Hazardous sports and activities

All claims arising from participation in any hazardous sports and activities. For examples of sports and activities we deem to be hazardous, please refer to our website.

Nuclear Reaction

The consequences of a claim resulting from a nuclear reaction.

Additional exclusions relating to the Accidental death and permanent disablement benefit

No benefit will be paid if death or accidental bodily injury is caused by any of the following events or causes:

War, warlike activities and terrorism – even as an innocent bystander

This includes war, warlike activities, military action, acts of foreign hostilities, (whether or not war is declared), civil-war, rebellion, revolution, insurrection, usurped power, mutiny, riot, strike, martial law, state of siege, attempted overthrow of government, and any act of terrorism.

A violent act – even as an innocent bystander

This includes murder, attempted murder, kidnap, (including attempted kidnap or attempted rescue from kidnapping), or assault of any kind, anywhere in the world.

Gross negligence and deliberate exposure to exceptional danger

When a member negligently or deliberately exposes themselves to exceptional danger except when they are attempting to save a human life.

Whilst under the influence of alcohol or drugs

Whilst being under the influence of alcohol or drugs, or the misuse of prescribed medication.

Any illness or disease

Food poisoning or bacterial infections

Except infection which occurs through accidental cut or wound.

Intentional inhalation of gas, or intentional ingestion of poisons or drugs

Intentionally contracted infection by bacteria or virus

Radioactivity or any nuclear material contamination, including the combustion of nuclear fuel

Additional exclusions relating to the Critical Illness benefit

The full list of exclusions for each critical illness is outlined in Appendix 2 and 3.

Alcohol and drug abuse

Illness that is caused as a result of the abuse and/or misuse of alcohol, drugs, and/or prescribed medication.

Cancer arising from HIV/ AIDS

Cancer that, in our reasonable opinion, is caused directly or indirectly by Acquired Immune Deficiency Syndrome (AIDS) or by any Human Immunodeficiency Virus (HIV) infection, as defined by the World Health Organisation.

For this reason, if a cancer is diagnosed, we may ask the member to undergo a blood test for HIV, before we can confirm if they are covered. If the blood test results indicate the presence of any Human Immunodeficiency Virus (HIV) or antibodies such as a virus, we will consider that there is an AIDS or HIV infection, and therefore, the member will not be covered.

Premiums

You can pay an annual premium, or you can pay monthly, quarterly or half-yearly premiums with an additional cost. Your certificate of insurance shows the premium frequency you've chosen.

If you pay an annual premium, the premium is due at the policy start date and on each subsequent annual renewal date. If you pay monthly, quarterly or half-yearly premiums, the premium is due at the start of each payment interval.

Premiums must be paid in advance of the date on which they fall due.

Currency

You must pay all premiums in the currency in which your policy is denominated. The certificate of insurance shows the currency of your policy.

How we calculate premiums

The method of premium calculation that applies depends on the type of policy you have.

If you have a fully underwritten policy, or an individually costed policy we calculate the premium according to the age of each member.

If you have a unit rate policy, we will take into account all of the relevant risk factors and calculate one single rate that will apply to all members.

How we calculate premiums for mid-year changes

Premium adjustments in respect of new members, members who leave the policy, and members who have an increase in benefit during your policy year, will be debited or credited on a pro-rata basis from the date of the change unless your policy has an annual membership review date.

If your policy has an annual membership review date we will apply a simplified method of calculating premiums for mid-year changes. At the start of each policy year, we will calculate a provisional premium, based on your membership at that time. At the end of the policy year, if the provisional premium is lower than the actual premium, you must pay the shortfall to us. If it's higher than the actual premium, we will refund the difference to you.

The premiums we charge

Premiums are calculated using the premium rate(s) applicable to your policy, unless there are material changes to the risk you are asking us to take. The circumstances under which we can change the premium rates mid policy year are stated below.

We may charge extra premiums for members who've been through underwriting.

Insurance premium tax

Insurance premium tax will be added to your premium in countries where insurance premium tax is applicable by law.

Non-payment of premiums

If you don't pay a premium within 30 days of when it's due, cover will be suspended, and we may cancel the policy.

When we can review premiums

Premiums are reviewed at each annual renewal date.

We can review and if we deem it necessary change the premium rate(s) at any time if one or more of the following situations arises:

- the number of members falls below three;
- the number of members at any time increases or decreases by 20% or more;
- you want to add or remove a new group of employees to or from the policy;
- you want to change rules that affect someone's inclusion as a member or affect the member benefits;
- the nature of your business or location changes;
- there is a change in the occupations of the members or where they work.

Renewing the policy

Information we need in advance of the annual renewal date

We will let you know what information we need at least 60 days before each annual renewal date. You must provide the information we ask for as soon as possible to ensure we have enough time to tell you the new premium in advance of the annual renewal date.

Cancelling the policy

When you can cancel the policy

You can cancel the policy at any time, provided you give us advance notice in writing.

When we can cancel the policy

We can cancel the policy, cover or benefits or change the terms of the policy, cover or benefits where:

- You don't pay a premium within 30 days of the date it is due;
- You don't provide the information we ask for to enable us to administer the policy;
- You cease to carry on business, or an order is made or a resolution passed for you to be wound up;
- The number of members insured under the policy falls below three;
- You, or anyone acting on your behalf makes a claim which is in any way fraudulent;
- We are not able to provide cover under the policy for legal or regulatory reasons, including without limitation where offering cover will violate, or may risk violating, any sanctions, laws or regulations.

If the policy is cancelled by either party we will pay any claims we have already agreed, and we will consider any valid claim if the death or disablement happened prior to the date of cancellation, and the member remains incapacitated, except where to do so would be in breach of law or regulation or would violate, or may risk violating, any sanctions, laws or regulations.

If the policy is cancelled at any time during the policy year, we will refund any overpayments to you or ask you to pay any premiums due. We will send you a final statement showing the cover we provided and the premiums you paid.

Making a fair presentation of the risk

The information you give us must make a fair presentation of the risk, to enable us to completely understand, assess and rate the risk you are asking us to take. This includes both whether the information disclosed by the member was either intentionally or carelessly misrepresented.

If you fail to comply with this condition, the policy may be affected in one or more of the following ways depending on what we would have done if a fair presentation had been made.

If we would not have provided you with any cover we will have the option to:

- void the policy, which means that we will treat it as if it had never existed and repay the premium paid; and
- recover from you any amount we have already paid for any claims.

If we would have applied different terms to the cover (other than in relation to premium) we will have the option to treat this policy as if those different terms apply.

If we would have charged you a higher premium for providing the cover, we will proportionately reduce any claim by reference to the same ratio that the premium actually charged bears to the premium that would have been charged. For example if we would have doubled the premium, we will only pay half of any claim.

If a member fails to make a fair presentation of the risk, for example when we underwrite them, we will apply the above terms to the member, as if a separate insurance contract had been issued to them, leaving the remainder of the policy unaffected.

Making a claim

If you need to make a claim, please contact us as soon as possible by phone or by email.

The information we will need

You must provide us with all the information we request to assess the claim properly. If we don't have all the information we need, we may not pay a claim.

For a life claim, or a claim for funeral expenses, we will need the member's original death certificate.

For an accident claim, we may require additional reports such as police and ambulance reports, when relevant.

For all claims we will need detailed medical reports to establish the cause of the illness or injury that causes the claim.

We will also need evidence of the member's salary.

We will let you know what other documentation we'll need.

Once we have all the evidence we need, we will tell you whether we've accepted the claim.

Time limitation on claims

We won't accept any claims we receive more than two years after the event that gives rise to a claim.

How we assess a claim

When you tell us about a claim, our claims team will ask you for the member's name, date of birth, and details about the cause of the claim. We will then allocate a case manager who will decide on the next steps.

Claims if the policy ends

If the policy ends and you've paid all premiums due up to the date it ends, we'll consider any valid claims that happened before the date the policy ended.

Payment of claims

Claims are paid in the currency of the policy to the member, or, if the member is deceased to the member's nominated beneficiary(ies).

If a member has not appointed a beneficiary or beneficiaries, the beneficiary of their benefit shall be their spouse*, failing them, their legally declared child(ren) in equal shares, failing them, their estate.

* Please note that a partner may not have the same rights as those attributed to a legal spouse.

Fraudulent Claims

If you or anyone acting on your behalf makes a claim which is in any way fraudulent, we will be entitled to refuse to pay the whole of the claim and recover any sums that we have already paid in respect of the claim.

We may also notify you that we will be treating the policy as having terminated with effect from the date of the fraudulent claim.

If we terminate the policy under this condition you'll have no cover under the policy from the date of termination and you won't be entitled to any refund of premium.

If any fraud is perpetrated by or on behalf of a member and not on behalf of you we will apply this condition to the member and not to the policy as a whole.

General conditions that apply to the policy

Your contract with us

The contract between you and us comprises:

- your application form and all information you have told us about the risk you are asking us to cover.
- the certificate of insurance
- this policy and its appendices
- any documents enclosed with it when issued
- any endorsements or amendments to it.

Law & Arbitration

All disputes arising out of or in connection with the policy shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce of Paris by one or more arbitrators appointed in accordance with the said rules, and shall take place in Paris. The arbitration shall be conducted in English, and French law will apply. A sole arbitrator shall be appointed by the International Chamber of Commerce of Paris unless the parties to the dispute both agree otherwise.

Time limits for legal actions

In accordance with Articles L.114-1 to L.114-3 of the French Insurance code, the following rules apply to the time limits for bringing legal actions related to this insurance policy.

Under Article L.114-1 actions arising from an insurance contract must be initiated within two years of the event that gave rise to them. In the event of concealment, omission, false or inaccurate declaration of the risk involved, this time period runs from the day on which the insurer became aware of it. In the event of a claim of damages this time period runs from the day on which the interested parties become aware, providing they can prove they were unaware until then. When the action of the Insured Party against the Insurer is due to the action of a third party, the time period runs from the day on which the third party initiated legal proceedings against the Insured Party or was compensated by him.

The time period is extended to ten years in life insurance contracts when the beneficiary is a person distinct from the policyholder and, in accident insurance contracts affecting people, when the beneficiaries are the beneficiaries of the deceased insured party.

For life insurance contracts, notwithstanding the provisions for claims of damages, the actions of beneficiaries are limited to thirty years after the death of the Insured Party.

Under Article L.114-2 the time periods for action detailed above are interrupted by one of the ordinary causes of interruption as provided for by law, by the appointment of experts following an incident or by the sending of a registered letter with return receipt requested sent by the Insurer to the Insured Party regarding the action for the payment of the premium and by the Insured Party to the Insurer for the payment of the compensation.

Under Article L.114-3 the time periods above may not be modified, even by mutual agreement, and the grounds for suspension or interruption may not be added to.

Confidentiality

We'll treat the information provided to us in connection with this policy as confidential except where it:

- was legitimately in our possession before you gave it to us;
- was or is already generally available to the public;
- is trivial or obvious; or
- is required to be disclosed to fulfil an obligation under the policy.

We won't disclose confidential information to any person other than our insurers, reinsurers, professional advisers and auditors, employees and employees of other companies in our group, or where we are required to disclose to a legal or regulatory authority.

Data Protection

How we process your information

Your policy is underwritten by AWP Health & Life SA and administered by William Russell Europe SRL. This is a summary of our respective Privacy Policies. You can find full copies here:

William Russell	william-russell.com/privacy
AWP	allianzcare.com/en/privacy

The following statements refer to the personal information of your employees.

The information we collect

We collect information about your employees from you, your employees, your broker (if you have one), your employee's healthcare providers and other third parties involved in the arranging and administering of your policy. We collect information as part of your application, and in correspondence by phone, email, post or other means of communication. This information may include sensitive personal information such as your employees' physical or mental health.

Failing to provide the personal information we require in order to underwrite and administer your policy, or to process your employees' claims, could result in your employees' claims being rejected or not being fully paid, or your policy being cancelled.

How we use personal information

We will only collect information that is necessary to provide you and your employees with the products and services we offer. These include underwriting and administering your policy, processing your claims, our legitimate business interests, compliance with legal and regulatory obligations, research or statistical analysis to help us improve our services and communicating with you.

We will only use your employees' information in ways that we are permitted to do so by law. Where the use of your employee's personal information relies on their consent, your employee's will be able to withdraw their consent at any time, but if they do so we may not be able to process claims or manage the policy properly.

Who we may share information with

We may disclose your employees' personal information to selected third parties for the purposes detailed above, including to our providers of payment services, organisations (such as regulatory authorities) where we have a duty to disclose or share personal information to comply with legal obligations, providers of research, marketing, and analysis services, the insurers or reinsurers of your policy, your insurance adviser (if you have one).

Your employees' personal information may be disclosed to other parties (such as other insurance companies) with a view to preventing fraudulent or improper claims.

We never sell personal information to third parties.

Processing claims

In the event of a claim we may have to give some information to those involved in your employees' treatment or care. This will be done confidentially.

How we keep, store and dispose of personal information

We hold your employees' information in various forms, including electronic databases, computerised files and paper files. Information may be held for a period after your policy ends with a view to preventing or detecting fraud, or as we are required to under Belgian, French or UK law. When we dispose of personal information, we will do so securely. We may continue to keep non-personally identifiable information for the purposes of research and statistical analysis to improve the services we offer.

Where we store personal information

The personal information we collect may be transferred and stored at a destination outside the European Economic Area (EEA). It may also be processed by staff o erating outside of the EEA who work for us or one of our suppliers. We will take all steps necessary to ensure that your employees' personal information is treated securely and in accordance with this data protection notice.

Obtaining a copy of the information we hold

Your employees' have the right to request a copy of the information we hold about them. They also have the right to restrict or object to how we use their information, or to request that any inaccurate information be corrected. To exercise these rights your employees may contact:

The Data Protection Officer
William Russell Europe SRL
Place Marcel Broodthaers, 8
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486455
Email contact@william-russell.com

If you or your employees believe we are not processing your personal data in accordance with the law, you can complain to:

The Data Protection authority
Rue de la Presse-Drukpersstraat, 35
1000 Brussels, Belgium

Complaints

We believe that you always have the right to professional customer service of the highest quality at all times. If you think we have fallen short of this standard, please follow the procedures outlined below.

If you are not happy with the service you have received, you may write to us at any time at the following address:

William Russell Europe SRL
Place Marcel Broodthaers, 8
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486 455
Email contact@william-russell.com

We will acknowledge receipt of your complaint within 2 working days. We will investigate your complaint and send a response to you within 4 weeks of the receipt of your complaint. If we are unable to provide you with a final response within this time period, we will write to you advising you of when we will be able to respond. We will endeavour to send a final response to you within 8 weeks of the receipt of your complaint. If we are unable to provide you with a final response within this time period, we will write to you again explaining why and advising you of when you may expect a final response.

William Russell acts as mandated underwriter on behalf of the insurer of your policy in respect of policy administration and claims handling. If your complaint relates to a decision we have made on behalf of our insurers (e.g., a decision regarding a claim you have made), you can write to the insurers at any stage in the process.

AWP Health & Life SA
Customer Relationships
Eurosquare, 2
7 rue Dora Maar
93400 Saint Ouen
France

Email client.care@allianzworldwidecare.com

AWP Health & Life SA is a signatory to the French Insurance Mediation charter. In the event of a persistent and definitive disagreement, the policyholder has the option, after the exhaustion of all domestic remedies referred to above, to call for the French Insurance Mediator without prejudice to possibilities of legal action.

La Médiation de l'assurance
TSA 50 110
75441 Paris Cedex 09
France

Web mediation-assurance.org
Email contact@federalombudsman.be
Web federaalombudsman.be

How to contact us

If you need to contact us you can write, phone or email:

If you have an enquiry about your policy or insurance

Available from 9:00am to 5:00pm (UK time), Monday to Friday

Phone: +44 1276 486 455
Email: contact@william-russell.com

If you need to make a claim

Available from 6:00am to 6:00pm (UK time), Monday to Friday

Phone: +44 1276 486 460
Email: claims@william-russell.com

If you'd like to write to us

William Russell Europe SRL
Place Marcel Broodthaers, 8
1060 Saint-Giles
Brussels, Belgium

Appendix 1

Compensation Schedule for the Accidental Permanent Disablement Benefit

Permanent disablements not specified in the below Compensation Schedule will be compensated according to their severity compared to similar disablements specified in the compensation schedule.

The Compensation Schedule assumes that the member's right hand is dominant. If their left hand is dominant, the percentages stated for the left and right upper limbs will be transposed.

The Compensation Schedule

	Benefit	Overall (or either)	Left Non-dominant	Right Dominant
Full coverage	Total and irrecoverable loss of sight in both eyes	100%		
	Loss of, or loss of use of, both arms or both hands	100%		
	Complete and permanent deafness of both ears	100%		
	Removal of lower jaw bone	100%		
	Permanent loss of speech	100%		
	Loss of, or loss of use of, one arm and one leg	100%		
	Loss of, or loss of use of, one arm and one foot	100%		
	Loss of, or loss of use of, one hand and one leg	100%		
	Loss of, or loss of use of, one hand and one foot	100%		
	Loss of, or loss of use of, both legs	100%		
	Loss of, or loss of use of, both feet	100%		
Head	Loss of osseous substance of the skull in all its thickness:			
	surface of at least5 sq. cm	40%		
	surface of 3 to 5 sq. cm	20%		
	Partial removal of the lower jaw, rising section in its entirety or half of the maxillary bone	40%		
	Total and irrecoverable loss of sight in one eye	40%		
	Complete and permanent deafness in one ear	30%		
Upper Limbs	Loss of, or loss of use of, one arm or one hand		50%	60%
	Permanent loss of one bone in the arm		40%	50%
	Total paralysis of the upper limb (incurable lesion of the nerves)		55%	65%
	Total paralysis of the circumflex nerve		15%	20%
	Shoulder ankylosis		30%	40%
	Elbow ankylosis:			
	in a favourable position (15 degrees round the right angle)		20%	25%
	In an unfavourable position		30%	40%
	Permanent loss of two bones in the forearm		30%	40%
	Total paralysis of the median nerve		35%	45%
	Total paralysis of the radian nerve at the torsion cradle		35%	40%

The Compensation Schedule (contunued)

	Benefit	Overall (or either)	Left Non-dominant	Right Dominant
Upper Limbs Continued	Total paralysis of the forearm radian nerve		25%	30%
	Total paralysis of the hand radial nerve		15%	20%
	Total paralysis of the cubital nerve		25%	30%
	Ankylosis of the wrist in favourable position (straight and pronation)		15%	20%
	Ankylosis of the wrist in unfavourable position (flexion or strained extension of supine position)		25%	30%
	Total loss of thumb		15%	20%
	Simultaneous amputation of thumb and forefinger		25%	35%
	Amputation of thumb and finger other than forefinger		20%	25%
	Amputation of three fingers other than thumb and forefinger		15%	20%
	Amputation of four fingers including thumb		40%	45%
	Amputation of four fingers excluding thumb		35%	40%
Lower Limbs	Amputation at the thigh (upper half)	60%		
	Amputation at the thigh (lower half and leg)	50%		
	Total loss of foot (tiblo-tarsal disarticulation)	45%		
	Partial loss of a foot (tiblo-tarsal disarticulation)	45%		
	Partial loss of foot (sub ankle bone disarticulation)	40%		
	Partial loss of foot (medio-tarsal disarticulation)	35%		
	Partial loss of foot (tarso-metatarsal disarticulation)	30%		
	Total paralysis of lower limb (incurable nerve lesion)	60%		
	Complete paralysis of the external poplitic sciatic nerve	30%		
	Complete paralysis of the internal poplitic sciatic nerve	20%		
	Complete paralysis of two nerves (poplitic sciatic external and internal)	40%		
	Ankylosis of the hip	40%		
	Ankylosis of the knee	20%		
	Loss of osseous substance from the thigh or bones of the leg (incurable condition)	60%		
	Loss of osseous of the knee-pan with considerable separation of the fragments and considerable difficulty of movements in stretching the leg	40%		
	Loss of osseous substance of the knee-pan while the movements are preserved	20%		
	Shortening of the lower limb:			
	by at least 5 cm	30%		
	by 3-5 cm	20%		
	Total amputation of all toes on one foot	25%		
	Amputation of four toes (including the big toe)	20%		

Appendix 2

Adult Critical Illness benefit

We will pay out a lump sum to the member if they are diagnosed with an illness specified below, after the expiration of the applicable waiting period.

Specified Illnesses with a 3-month waiting period

Illness	What is covered	What is not covered
Arteriovenous malformation of the brain (requiring surgical treatment)	The benefit is payable if surgical intervention is required following Arteriovenous malformation (AVM) of the brain that required craniotomy, endovascular repair or radiosurgery	
Benign Brain Tumour (requiring surgical treatment)	The benefit is payable if surgical intervention has been required due to a non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.	- Tumours in the pituitary gland - Tumours originating from bone tissue - Angioma and cholesteatoma
Benign Tumour Spinal Cord Tumour (requiring surgical treatment)	The benefit is payable if surgical intervention has been required due to a non-malignant tumour within the spinal canal and originating in or arising from the meninges or spinal cord. The tumour must be interfering with the function of the spinal cord which results in permanent neurological deficit with persisting clinical symptoms and for which surgery has been required.	- Cysts - Granulomas - Malformations in arteries and/or veins of spinal cord - Hematomas and/or abscesses - Disc protrusions and/or osteophytes
Bone Marrow Transplant	The benefit is payable following surgery as a recipient of a bone marrow transplant (allogenic) when required for the following conditions - Leukemia - Myelodysplastic syndrome - Lymphomas - Neuroblastoma - Ewing sarcoma - Aplastic anemia - Paroxysmal nocturnal hemoglobinuria	- Bone marrow transplant for any condition not listed on the left - Any transplant needed as a consequence of alcohol or misuse of drugs that have not been prescribed - Any transplant made possible through the purchase of the required bone marrow from a donor.
Brain aneurysms (requiring surgical treatment)	The benefit is payable if surgical intervention has been required due to a brain or cerebral aneurysm that required treatment with craniotomy, endovascular repair or radiosurgery	
Cancer (excluding less advanced cases)	Any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).	- 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;

Specified Illnesses with a 3-month waiting period (continued)

Illness	What is covered	What is not covered
Cancer (excluding less advanced cases) Continued		- 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 T2bN0M0. - Chronic lymphocytic leukaemia. - Any skin cancer other than malignant melanoma or squamous cell carcinoma - Malignant melanoma or squamous cell carcinomas of the skin that are confined to the epidermis (outer layer of skin) - All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0 - All cancer arising from cervical dysplasia - Neuroendocrine tumours without lymph node involvement or distant metastases unless classified as WHO Grade 2 or above. - Gastrointestinal stromal tumours without lymph node involvement or distant metastases unless classified by either AFIP/Miettinen and Lasota as having a moderate or high risk of progression, or as UICC/TNM8 stage II or above. - All malignancies that arise directly or indirectly from a pre-existing condition or previous cancer (this means that you already had this type of cancer in the past, even if it was before the start of your policy). - Cancer arising directly or indirectly from AIDS/HIV
Less advanced cancer/carcinomas In-situ – with surgery	For the covered conditions below we will pay 50% of your insured benefit A benefit is payable if surgical intervention has been required due to a diagnosis of a less advanced cancer or carcinoma in-situ of a named site and of specified severity that required surgical treatment. Confirmation of tumour histology and treatment by surgery to remove the tumour will be required. - Gastrointestinal stromal tumour (GIST) or neuroendocrine tumour (NET) of low malignant potential by histological confirmation, that has been treated by surgery to remove the tumour - Ovarian tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary	- Any other carcinomas in-situ or less advanced cancer not specified above - Any tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment(other than prostate cancer) - All malignancies that arise directly or indirectly from a pre-existing condition or previous cancer (this means that you already had this type of cancer in the past, even if it was before the start of your policy). - Cancer arising directly or indirectly from AIDS/HIV

Specified Illnesses with a 3-month waiting period (continued)

Illness	What is covered	What is not covered
Less advanced cancer/carcinomas In-situ – with surgery Continued	- Prostate cancer classified as having a Gleason score of 6 and treatment includes the complete removal of the prostate gland or external beam or interstitial implant radiotherapy, or High Intensity Focused Ultrasound, or Hormone therapy or Cryotherapy - Other carcinomas in-situ of the following specified sites and severity. • Bile duct: benefit payable if surgery required to remove the tumour, • Breast (ductal or lobular carcinoma in-situ): benefit payable if surgery required to remove the tumour, • Colon or rectum: benefit payable if surgery required to remove the tumour, • Gallbladder: benefit payable if surgery required to remove the tumour, • Larynx, Lung (or bronchus) : benefit payable if surgery required to remove the tumour including laser or radiotherapy treatment, • Oesophagus: benefit payable if surgery required to remove the tumour, • Oral cavity (Oropharynx) (including lip, inside of cheek, floor of mouth, tongue, gums, hard palate, soft palate and tonsils): benefit payable if surgery required to remove the tumour, • Renal pelvis or ureter: benefit payable if surgery required to remove the tumour, • Stomach: benefit payable if surgery required to remove the tumour, • Testicular: benefit payable if surgery required to remove the tumour, • Urinary bladder: benefit payable if surgery required to remove the tumour	- Any other carcinomas in-situ or less advanced cancer not specified above - Any tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment(other than prostate cancer) - All malignancies that arise directly or indirectly from a pre-existing condition or previous cancer (this means that you already had this type of cancer in the past, even if it was before the start of your policy). - Cancer arising directly or indirectly from AIDS/HIV • Treatments including local excision or simple polypectomy for removing part of the colon or rectum • Treatments other than surgery for Oesophagus. Treatment for Barrett's Oesophagus • For Renal pelvis or ureter, non-invasive papillary carcinoma and tumours of TNM classification stage Ta • For urinary bladder, non-invasive papillary carcinoma, stage Ta bladder carcinoma and all other forms of non-invasive carcinomas are not covered
Major organ transplant As recipient	- The benefit is payable following surgery as a recipient of a transplant from another person of a complete heart, kidney, liver, lung, or pancreas, or a whole lobe of the lung or liver.	- Transplant of any other organs, tissues or cells. - Any transplant needed as a consequence of alcohol or misuse of drugs that have not been prescribed - Any transplant made possible through the purchase of the required organs from a donor.
Severe epilepsy Severe epilepsy here refers to refractory/ drug-resistant epilepsy – it is a form of epilepsy that does not respond to at least two anti-seizure medications.	The benefit is payable if the following surgical interventions are required to remove the brain tissue in the area where the seizures originate has been required: - Resective surgery - Laser interstitial thermal therapy - Deep brain stimulation - Corpus callosotomy - Hemispherectomy - Functional hemispherectomy - Surgery for sequelae from encephalitis	

Specified Illnesses with a 7-month waiting period

Illness	What is covered	What is not covered
Heart valve replacement or repair	The benefit is payable if surgical intervention has been required, on the advice of a consultant cardiologist, to replace or repair one or more heart valves for any of the following conditions: - Aortic valve stenosis or insufficiency - Mitral valve stenosis or insufficiency - Tricuspid valve stenosis or insufficiency - Pulmonary valve stenosis or insufficiency	- Any valvular disorder associated with connective tissue disease - Any valvular disorder associated with congenital heart disease or congenital malformation.
Coronary artery angioplasty/ stenting	The benefit is payable following surgery for any of the following procedures to treat a narrowing or blockage in two or more of the main coronary arteries: Balloon angioplasty - Atherectomy - Rotablation - Laser treatment - Insertion of stents For the purpose of this definition main coronary arteries are described as one or more of the following: - Right coronary artery - Left main stem - Left anterior descending - Circumflex This procedure must have been carried out on the advice on a consultant cardiologist to treat severe coronary artery disease in two or more main coronary arteries at the same time, or if the procedure is only performed on one main coronary artery there must be at least 70% diameter narrowing in another main coronary artery.	- Procedures to any branches of any of the main coronary arteries - Any other procedures to treat narrowing or blockage of coronary arteries
Coronary bypass surgery	The benefit is payable following surgery to divide the breastbone (median sternotomy) or thoracotomy to correct narrowing or blockage of one or more coronary arteries with by-pass grafts when recommended by a Consultant Cardiologist and one of the following situations apply: - There is a left main coronary artery stenosis of over 50%. - There is a diameter reduction of over 70% in the left anterior descending artery. - There is three-vessel disease	- Any other surgical procedure or treatment to divide the breastbone or thoracotomy to correct narrowing or blockage of one or more coronary arteries

Specified Illnesses with a 7-month waiting period (continued)

Illness	What is covered	What is not covered
Heart attack Of specified severity	The benefit is payable if death of heart muscle, due to inadequate blood supply, has resulted in all of the following evidence of acute myocardial infarction: - Typical clinical symptoms (for example, characteristic chest pain). - New characteristic electrocardiographic changes. - The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher: - Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L) - Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L) The evidence must show a definite acute myocardial infarction.	- Other acute coronary syndromes. - Angina without myocardial infarction.
Aorta graft surgery For disease only	Benefit is payable following surgery to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft.	- Procedures to any branches of the thoracic and abdominal aorta - Any other surgical procedure, for example the insertion of stents or endovascular repair
Severe peripheral vascular disease Bypass surgery	Benefit is payable following bypass graft surgery to the arteries of the legs following a definite diagnosis by a Consultant Cardiologist or Vascular Surgeon of peripheral vascular disease with objective evidence from imaging of obstruction in the arteries.	- Any other surgical procedure, for example the insertion of stents or endovascular repair
Pulmonary artery surgery For disease only	Benefit is payable following surgery completed on the advice of a consultant cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft	
Aortic aneurysm With endovascular repair	Benefit is payable following surgery completed by endovascular repair on an aneurysm of the thoracic or abdominal aorta with a graft.	- Procedures to any branches of the thoracic and abdominal aorta
Carotid artery stenosis Treated by endarterectomy or angioplasty	Benefit is payable following surgery completed on the advice of a consultant cardiologist by endarterectomy or therapeutic angioplasty to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery	
Stroke Resulting in permanent symptoms	Benefit payable following the death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in the following evidence of stroke: - Neurological deficit with persistent clinical symptoms lasting at least 7 days; and - Definite evidence of death of tissue or haemorrhage on a brain scan.	- Transient ischemic attack - Traumatic injury to brain tissue or blood vessels - Death of tissue of the optic nerve or retina / eye stroke

Appendix 3

The Child Critical Illness Benefit

We will pay out a lump sum to the member if their dependent child is diagnosed with an illness specified below, after the expiration of the applicable waiting period.

Specified Illnesses with a 3-month waiting period

Illness	What is covered	What is not covered
Bone Marrow Transplant	The benefit is payable following surgery as a recipient of a bone marrow transplant (allogenic) when required for the following conditions - Leukaemia - Myelodysplastic syndrome - Lymphomas - Neuroblastoma - Ewing sarcoma - Aplastic anemia - Paroxysmal nocturnal hemoglobinuria	- Bone marrow transplant for any condition not listed above - Any transplant needed as a consequence of alcohol or misuse of drugs that have not been prescribed - Any transplant made possible through the purchase of the required bone marrow from a donor.
Cancer (Excluding less advanced cases)	The benefit is payable following any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).	- 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; - 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 T2bN0M0. - Chronic lymphocytic leukaemia. - Any skin cancer other than malignant melanoma or squamous cell carcinoma - Malignant melanoma or squamous cell carcinomas of the skin that are confined to the epidermis (outer layer of skin) - All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0 - All cancer arising from cervical dysplasia - Neuroendocrine tumours without lymph node involvement or distant metastases unless classified as WHO Grade 2 or above. - Gastrointestinal stromal tumours without lymph node involvement or distant metastases unless classified by either AFIP/Miettinen and Lasota as having a moderate or high risk of progression, or as UICC/TNM8 stage II or above. - All malignancies that arise directly or indirectly from a pre-existing condition or previous cancer (this means that you already had this type of cancer in the past, even if it was before the start of your policy). - Cancer arising directly or indirectly from AIDS/HIV

Specified Illnesses with a 3-month waiting period (continued)

Illness	What is covered	What is not covered
Benign Brain Tumour (requiring surgical treatment)	The benefit is payable if surgical intervention has been required due to a non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.	- Tumours in the pituitary gland - Tumours originating from bone tissue - Angioma and cholesteatoma
Brain aneurysms (requiring surgical treatment)	The benefit is payable if surgical intervention has been required due to a brain or cerebral aneurysm that required treatment with craniotomy, endovascular repair or radiosurgery	
Arteriovenous malformation of the brain (requiring surgical treatment)	The benefit is payable if surgical intervention is required following Arteriovenous malformation (AVM) of the brain that required craniotomy, endovascular repair or radiosurgery	- Cysts - Granulomas - Malformations in arteries and/or veins of spinal cord - Hematomas and/or abscesses - Disc protrusions and/or osteophytes
Severe epilepsy Severe epilepsy here refers to refractory/ drug-resistant epilepsy – it is a form of epilepsy that does not respond to at least two anti-seizure medications.	The benefit is payable if the following surgical interventions are required to remove the brain tissue in the area where the seizures originate has been required: - Resective surgery - Laser interstitial thermal therapy - Deep brain stimulation - Corpus callosotomy - Hemispherectomy - Functional hemispherectomy - Surgery for sequelae from encephalitis	- Procedures to any branches of the thoracic and abdominal aorta
Trauma Requiring prosthesis	The benefit is payable if any of the following types of prosthesis are needed to replace the lost limb, or part of it due to trauma or an accident if the following types of prosthesis are needed: - Passive devices - Body-powered devices - Bionic devices	- The loss of a limb due to disease If an accident occurs during the waiting period requiring a prosthesis we will consider a claim on a case-by-case basis.
Kawasaki syndrome	The benefit is payable following a definite diagnosis of Kawasaki syndrome, that has caused cardiovascular sequelae, by a consultant cardiologist.	
Bacterial Meningitis	The benefit is payable following a definite diagnosis of bacterial meningitis by a consultant or medical doctor	- All other forms of meningitis other than those caused by bacterial infection.
Encephalitis	The benefit is payable following a definite diagnosis of encephalitis by a consultant neurologist	- Chronic fatigue syndrome and myalgic encephalitis
Less advanced cancer/carcinomas In-situ – with surgery	A benefit is payable if surgical intervention has been required due to a diagnosis of a less advanced cancer or carcinoma in-situ of a named site and of specified severity that required surgical treatment. Confirmation of tumour histology and treatment by surgery to remove the tumour will be required.	- Any other carcinomas in-situ or less advanced cancer not specified above - Any tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment(other than prostate cancer)

Specified Illnesses with a 3-month waiting period (continued)

Illness	What is covered	What is not covered
Less advanced cancer/carcinomas In-situ – with surgery Continued	- Gastrointestinal stromal tumour (GIST) or neuroendocrine tumour (NET) of low malignant potential by histological confirmation, that has been treated by surgery to remove the tumour - Ovarian tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary - Prostate cancer classified as having a Gleason score of 6 and treatment includes the complete removal of the prostate gland or external beam or interstitial implant radiotherapy, or High Intensity Focused Ultrasound, or Hormone therapy or Cryotherapy - Other carcinomas in-situ of the following specified sites and severity. • Bile duct: benefit payable if surgery required to remove the tumour, • breast (ductal or lobular carcinoma in-situ): benefit payable if surgery required to remove the tumour, • Colon or rectum: benefit payable if surgery required to remove the tumour, • Gallbladder: benefit payable if surgery required to remove the tumour, • Larynx, Lung (or bronchus), : benefit payable if surgery required to remove the tumour including laser or radiotherapy treatment, • Oesophagus: benefit payable if surgery required to remove the tumour, • Oral cavity (Oropharynx) (including lip, inside of cheek, floor of mouth, tongue, gums, hard palate, soft palate and tonsils): benefit payable if surgery required to remove the tumour, • Renal pelvis or ureter: benefit payable if surgery required to remove the tumour, • Stomach: benefit payable if surgery required to remove the tumour, • Testicular: benefit payable if surgery required to remove the tumour, • Urinary bladder: benefit payable if surgery required to remove the tumour	- All malignancies that arise directly or indirectly from a pre-existing condition or previous cancer (this means that you already had this type of cancer in the past, even if it was before the start of your policy). - Cancer arising directly or indirectly from AIDS/HIV • Treatments including local excision or simple polypectomy for removing part of the colon or rectum • Treatments other than surgery for Oesophagus. Treatment for Barrett's Oesophagus • For Renal pelvis or ureter, non-invasive papillary carcinoma and tumours of TNM classification stage Ta • For urinary bladder, non-invasive papillary carcinoma, stage Ta bladder carcinoma and all other forms of non-invasive carcinomas are not covered

Specified Illnesses with a 7-month waiting period

Illness	What is covered	What is not covered
Aortic heart valve replacement or repair As a result of rheumatic heart disease	The benefit is payable if, on the advice of a consultant cardiologist, surgery is required to replace or repair the aortic heart value as a result of rheumatic heart disease.	- Any other cause of valvular disorder or disease

Contact Us!

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