

Terms & Conditions

Level Term Assurance & Mortgage Protection



Your Protection Plan

Including:
Life Insurance
Critical Illness Insurance
Income Protection Insurance

Introduction

These Terms and Conditions set out the roles of the various parties in providing the benefits under Synergy Protect. You are advised to read them carefully in conjunction with the Key Features document.

These Terms and Conditions set out the agreement between Synergy Financial Products Ltd (SFP), Prudential Assurance Company Limited (Prudential) and you the Plan holder. Where Applications are submitted online, the Plan holder will be required to confirm the details SFP holds are accurate and complete. The agreements will start when SFP accept an Application from the Plan holder and the first premium is paid.

What SFP does

SFP administers and manages the Plan, which means SFP:

1. Arranges for the Insurance cover provided by the Plan with the Insurers.
2. Arranges for the administration of new Applications including:
 - Processing new Applications;
 - Underwriting the Application in accordance with the Insurers guidelines and policy;
 - Issuing Acceptance Terms (or a Declinature Notice if terms cannot be offered);
 - Calculating and collecting premiums, redirecting them to the relevant Insurers;
 - Paying commission to authorised intermediaries.
3. Arranges for the administration of in-force Plans including:
 - Alterations;
 - Calculating and collecting premiums;
 - Issuing the Annual Renewal Notice.
4. Provides administration support for claims which means SFP:
 - Receives notification of new claims;
 - Issues the Claim Form;
 - Refers the claim to the relevant Insurers;
 - Communicates Prudential's decision to the Plan holder;
 - Administers claims for Income Protection on an ongoing basis.
5. Is responsible for all Plan holder communications relating to the administration and management of the Plan including any variation to the Plan Terms and Conditions.
6. Will only accept Applications from authorised intermediaries (Adviser) who are acting as their client's agent. Correspondence will normally be issued to the Plan holder via their Adviser although there are some situations when we are required to communicate direct with the Plan holder and/or Insured if different e.g. the Cancellation Notice, confirmation of Direct Debit collections, confidential underwriting information.
7. Will deal with complaints regarding the administration and management of the Plan. If the complaint relates to an aspect of the Plan for which another organisation is responsible e.g. an Insurer, SFP will forward the complaint and inform the Plan holder.
8. Receives fees from the Insurers for administering the Plan. In addition, SFP reserves the right to receive commission from and enter into profit sharing arrangements with the Insurers.
9. SFP does not provide advice in relation to the Plan.

What Prudential Assurance does

Prudential is an Insurer in the Plan, which means Prudential:

1. Provides the following Insurances under the Plan:
 - a. Life Insurance (including Terminal Illness cover);
 - b. Life Insurance with Critical Illness Insurance;
 - c. Critical Illness Insurance (Stand Alone);
 - d. Income Protection Insurance.
2. Assesses claims in respect of the Insurances they provide in accordance with the Plan Terms and Conditions and authorises payment of valid claims or a declinature to SFP. Prudential may also obtain additional information upon receipt of a claim from SFP.
3. Forwards payment on valid claims to the Plan holder or their estate.
4. Will deal with complaints regarding the Insurances they provide and any disputes regarding their assessment of claims in respect of these.

What Insurances are available in the Plan

You can apply to include any of the following Insurances in your Plan:

- Life Insurance (including Terminal Illness cover);
- Life Insurance with Critical Illness Insurance;
- Critical Illness Insurance (Stand Alone);
- Income Protection Insurance;

Details of what Insurances are included in your Plan will be confirmed in your Certificate of Insurance.

Full details of the Insurance covers (including any specific definitions used, exclusions, claims processes etc) are contained in this document:

General definitions

The following definitions apply throughout:

Acceptance Date: the date your Application Form is accepted by SFP and the Insurers.

Acceptance Terms: confirmation of the cover the Insurers are prepared to offer.

Annual Renewal Notice: the document issued prior to your Plan Anniversary confirming your premiums for the following 12 months.

Application Form: the document completed and signed by the Insured, and Plan holder if different, applying for insurance provided in connection with Synergy Protect.

Certificate of Insurance: the Certificate confirming the Insurance cover provided by the Plan.

Client Account: an account or accounts at a bank selected by SFP which holds the Plan premiums for onward transmission to the Insurers.

Declinature Notice: confirmation the Insurers are unable to offer cover.

Employed: the Insured is working for remuneration under a contract of employment and assessable to Class 1 National Insurance contributions.

FSA: the Financial Services Authority.

Full Time: continuous Employment or Self-Employment for 16 hours or more per week.

Insurance or Insurances: the types of covers available in the Plan.

Insured: the person covered by the Plan.

Insurer or Insurers: the Insurance Companies appointed by SFP to provide the Insurance cover included in the Plan.

Level Term Assurance: Insurance where the Sum Insured stays level throughout the Plan Term.

Mortgage Protection (Decreasing) Cover: Insurance where the Sum Insured decreases each year such that the amount payable is equal to the amount outstanding on a hypothetical repayment mortgage at a variable interest rate that fluctuates from time to time and which is equal to the Halifax Variable Rate 1 plus 0.5%, (subject to a maximum amount of 12% a year).

In the event that the Halifax Variable Rate 1 exceeds the Bank of England Base Rate by more than 2% SFP reserves the right to substitute either of the following instead:

- A similar mortgage lending rate from another mortgage lender where that rate does not exceed the Bank of England Base Rate by more than 2%; or
- The Bank of England Base Rate plus 2%.

Non-Smoker: a person who has not used any tobacco products for the last 12 months.

Plan Anniversary: the renewal date for your Plan.

Part Time: continuous Employment or Self-Employment for less than 16 hours per week.

Plan Charge: the charge made for administering your Plan. This is automatically included in your Premium calculation and is detailed in your Personal Illustration together with the details we send you when your Plan starts.

Plan holder: the person who owns the Plan.

Plan Term: the period between when the Insurance cover starts and ends.

Self Employed: the Insured is actively working alone; in partnership; or as a member of a limited liability partnership; being assessable to Class 2 National Insurance contributions and to Income Tax under Schedule D Case I or II.

Sum Insured: the amount of benefit payable.

Waiver of Premium: if this benefit is selected, we will pay an amount equal to the premiums, subject to any maximums in force.

You or Your: the Plan holder.

Premiums

We only accept premiums via monthly Direct Debit. We will confirm details of the amounts and dates of your premiums before they are collected at the start of your Plan, prior to the Plan Anniversary and if you alter your Plan at any time. Your first premium may include a proportionate amount in respect of the initial period of cover.

Your premiums will be reviewed annually. When you start your Plan, we will confirm details of your premiums for the first year. These premiums are guaranteed provided you do not alter your Plan during this period. We will also provide an indication of the premiums for future years. The premiums in future years will depend on mortality and morbidity rates on this business (both historical and predicted), forecasts of costs to us of settling future claims, any changes in taxation and inflation. We will not seek to recover, in future years, the cost of any claims already paid out. Changes in your premium will not depend on your individual circumstances, for example, your health. The level of future premiums for any particular benefit looks at the premium being charged for everyone insured under that type of cover, and not you personally.

At least 30 days before each Plan Anniversary, we will advise you in writing of your premiums for the following 12 month period and again these will be guaranteed provided you do not alter your Plan. We will continue to do this until your Plan cover ends.

All premiums are held in a segregated SFP Client Account before being redirected to the appropriate Insurers. No interest is payable to Plan holders in respect of these accounts.

You can stop paying Premiums for any type of benefit at any time without penalty by notifying SFP in writing. If you do this the insurance cover for that benefit will stop and you will not be covered. If all benefits are cancelled the Plan will terminate.

SFPL will treat unclaimed premiums as client money in accordance with the FSA handbook, for a period of 6 years (interest will not be paid on such funds). The investor consents to any money held in the client account for more than 6 years being released.

If a premium is not paid on the date it is due we will write and bring this to your attention. You will be given 30 days grace to pay the outstanding premium. If it is not paid within this period, we will cancel your Plan and all cover will cease. Where this occurs, we will write to you confirming this.

If we cancel your Plan because you did not pay your Premium, you can ask us to restart it within 3 months of the date of cancellation. This will be subject to the agreement of the relevant Insurers and provided all of the unpaid premiums during this period are paid. We will confirm the Insurers requirements for reinstating the Plan at that time.

SFP may give the Plan holder 90 day's written notice to cease to operate the Plan, if it becomes impossible, impractical, or unreasonable for it to continue to do so.

Your Plan has no cash or surrender value at any time.

Loyalty Discount

Your Plan includes a valuable Loyalty Discount benefit, which is designed to minimise future premium increases. This is applied in the form of a discount on the rates used once the Plan has been in force for at least 1 year. The amount of Loyalty Discount will vary by Plan and by the types of Insurance you include in your Plan.

The Loyalty Discount does not apply to the Plan Charge, the Cover Increase Option or the Waiver of Premium benefit if included.

Where benefits are added or increased a Loyalty Discount will apply separately to the new part of the Plan based on whole years as if the addition or increase started from the Plan Anniversary following the change. The combined effect of any Loyalty Discount applicable to the following year will be shown on the Annual Renewal Notice.

If an intermediary sacrifices some or all of the commission payable it is reflected as a reduction in the premium payable and achieved by increasing the Loyalty Discount and in some cases allocating a Loyalty Discount in the first 12 months.

The amount of Loyalty Discount that applies to your Plan will be indicated in your Personal Illustration and confirmed in the Certificate of Insurance we issue when your Plan cover starts and in your Annual Renewal Notice.

Who we will pay the benefits to

We will pay the benefits to the person legally entitled to receive them. This will depend on the nature of the claim, your circumstances at the time and whether the Plan has been assigned or put under trust.

In the event of a claim on the Insured, we will pay the benefits to the Plan holder or their personal representatives, if the Plan holder has died. Personal representatives must send us an original Grant of Representation or Grant of Confirmation before we will pay any benefits to them.

If the Plan has been assigned we will pay the benefits to the assignee. Assignees must send us the original deed of assignment before we will pay any benefits to them.

If the Plan is under Trust, we will pay the benefit to the Trustees. The Trustees must then follow the terms of the Trust to distribute the money to the chosen beneficiaries. Trustees must send us the original Trust Deed and any deeds altering the Trust before we pay any benefit to them.

If you have a Claim

If you believe that you have a valid claim you should:

- Phone Client Services on: 01727 797 800;
- Fill out the claim form that we will send you and send this back to us with any other documents we request in respect of the Insurances provided by the Prudential;
- Continue to pay your premiums (except in the case of death claims).

Depending on the nature of the claim, we may need one or more of the following:

- The birth, marriage or death certificate of the person covered;
- Any other evidence of a change of name;
- Medical evidence to support the claim;
- Evidence of income;
- Evidence of the amount and status of the Insured's mortgage.

We will tell the Insured which of these we need, and if we need anything else in support of your claim. If we require you to go for a medical or other specialist reports this will be paid for by the Insurers.

We reserve the right to stop paying a claim, or not to pay it, if you do not provide any evidence we ask for or the information that is provided is inaccurate or incomplete.

SFP or the Insurers have the power to cancel these Insurances if the Plan holder or the Insured makes an untrue statement, acts fraudulently, or fails to disclose a material fact in connection with the issue or amendment of the Plan or any claim made. Where this occurs, all premiums paid will be forfeited to the Insurer.

Your Cancellation Rights

When your Plan starts we will send you information about your right to change your mind and cancel your Plan. You have 30 days from the date you receive this to cancel your Plan. If you cancel your Plan in this time we will refund any premiums you have paid.

You may cancel your Plan at any other time by giving not less than 30 days' written notice to us. If you cancel, your Plan will end on the day your next payment to us is due, and we will not refund any payments you have made to us.

Tax

If there is any change in any tax and other laws affecting the Insurers or us, the Insurance cover set out in your Plan documents may be subject to change.

Law

English Law applies to this Plan.

If you have a Complaint

We hope that you will never have reason to complain about the administration of your Plan, but if you do, you should write to us at:

Synergy Financial Products Limited,
PO Box 1010, St Albans, Herts, AL1 9NB.
Telephone: 01727 797 800

We will always try to resolve complaints as quickly as possible. If we are unable to deal with a complaint within 5 working days of your complaint being received by us, we will send you a letter to acknowledge your complaint and provide you with regular updates until your complaint is resolved. We can provide you with more information about our complaint handling procedures on request. We are committed to resolving complaints whenever possible through our complaints procedures.

Where the complaint relates to an aspect of the Plan for which another organisation is responsible, for example an Insurer, we will forward the complaint to the appropriate organisation and inform you of this.

If a matter cannot be resolved satisfactorily you may be able to refer your complaint to the Financial Ombudsman Service at:

South Quay Plaza, 183 Marsh Wall, London E14 9SR;
Telephone: 0845 080 1800
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

The Financial Ombudsman Service has been set up by law to help settle individual disputes between consumers and financial firms. They can decide if we or any of the Insurers have acted wrongly and if you have lost out as a result. If this is the case they will tell us or the Insurers how to put things right and whether this involves compensation. Their service is independent and free of charge. There may be some instances in which this body does not have the jurisdiction to consider complaints.

We will send you a leaflet explaining the Financial Ombudsman Service if you make a complaint and the leaflet is also available on request. Alternatively you can contact the Ombudsman direct at the address above.

If you make a complaint, it will not affect your right to take legal proceedings.

Variations

1. The Plan holder may request an alteration to their Plan at any time and this will be subject to the agreement of the relevant Insurers and payment of the premium quoted at that time.
2. SFP may vary these terms (except for the Critical Illness definitions) in the event of changes to applicable law, taxation, or levies, and by giving no less than 30 days written notice to the Plan holder.

The premium rates used and/or the Plan Charge may be varied at any time subject to the provision of 30 days written notice to the Plan holder. The change in rates will not affect the premiums payable until the next Plan Anniversary after the expiry of the 30 days notice period.

In providing services under these Terms, SFP will act in good faith and with due diligence. SFP accepts responsibility for loss to the Plan holder to the extent that such loss is due to a breach of duty or breach of these Terms, or negligence, wilful default or fraud or any breach by SFP of The Financial Services and Markets Act 2000 or FSA rules provided that SFP is not liable for the acts, omissions or defaults of agents or custodians or their employees, nor for strikes, interruption of power supplies, machinery failure or causes beyond SFP's control.

If at any time any provision or part of the Insurances included in the Plan, these Terms and Conditions or any Certificates of Insurance issued becomes invalid, illegal or unenforceable, the remaining parts or provisions shall continue in full force and effect.

What Insurance

This applies to the following Insurances:

- Life Insurance (including Terminal Illness cover);
- Life Insurance with Critical Illness Insurance;
- Critical Illness Insurance (Stand Alone);
- Income Protection Insurance;
- Cover Increase Option.

Cover can be provided on a Level (Level Term Assurance) or Decreasing (Mortgage Protection) basis.

Your Certificate of Insurance will confirm which Insurances are included in your Plan and on what basis.

Who provides this Insurance

The Prudential Assurance Company Limited, registered in England and Wales at Laurence Pountney Hill, London EC4R 0HH.

Definitions that apply

Civil Partnership: the registration of a relationship between the Insured and another person of the same sex, as a Civil Partnership under the Civil Partnership Act 2004. It excludes any such registration which is a second or subsequent registration of the same two partners under that Act.

Deferred Period: the period during which the Insured must be ill or disabled before we will pay any benefit.

Earnings (Insured is Employed): total pre-tax Earnings for PAYE assessment purposes (excluding benefits in kind). This may include:

- Regular bonuses and commission received by the Insured;
- Dividends received by the Insured from a private limited company in which they and no more than 3 other shareholders are Employed as Full-Time working directors;
- The dividend amount must represent their share in the net trading profit of that company from its normal regular business; be consistent with the trading position of the company; and stop being paid as a result of their Incapacity.

Earnings (Insured is Self-Employed): total share of pre-tax profit from their trade, profession, or vocation for the purposes of Schedule D Case I and II of the Income and Corporation Taxes Act 1988.

Eligible Child: any child between the ages of 30 days and 18 years who:

- a) is a natural child of the Insured; or
- b) is legally adopted by the Insured; or
- c) resides with and is financially dependent on the Insured.

Incapacity or Incapacitated: shall be such that as a result of an illness or accident the Insured meets the following definitions:

If the Insured is in Full Time employment immediately prior to the commencement of Incapacity:

- For **Occupation Classes 1 and 2**, the Insured is totally unable to carry out the material and substantial duties of their usual Occupation; and is not following any other Occupation for profit or reward;
- For **Occupation Classes 2 Suited and 3**, the Insured is totally unable to carry out the material and substantial duties of their usual Occupation and to carry out any Occupation for which they are reasonably suited by training, education or experience and is not following any other Occupation for profit or reward;
- For **Occupation Class 4**, the Insured is totally unable to perform 3 out of the 6 Working Tasks.

If the Insured is not in Full Time Employment immediately prior to the commencement of Incapacity:

- The Insured is totally unable to perform 3 out of the 6 Living Tasks.

The Occupation class will be shown on the Certificate of Insurance.

Usual Occupation means the Occupation followed at the time Incapacity commenced and is not restricted to any one place of work

Irreversible: 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 the claim.

Living Tasks: the 6 Living Tasks are as follows:

- **Washing:** the ability to wash in the bath or shower (including getting into and out of the bath and shower) such that an adequate level of personal hygiene can be maintained;
- **Dressing:** the ability to put on, take off, secure and unfasten all necessary garments and any medically necessary braces, artificial limbs or other surgical appliances;
- **Transferring:** the ability to move from a bed to an upright chair or wheelchair, and vice versa;
- **Mobility:** the ability to move from one room to another in the Insured life's normal place of residence on the same floor, using any walking stick or frame, if required;
- **Continence:** the ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained; and
- **Feeding:** the ability to feed oneself once food and drink have been prepared and made available.

Mental failure (for Income Protection Insurance): mental Incapacity which has failed to respond to optimal treatment and requires the need for continuous psychotropic medication or is due to an organic brain disease or brain injury supported by evidence of progressive loss of ability to:

- remember;
- reason; and
- Perceive, understand, express and give effect to ideas;

and causes a significant reduction in mental and social functioning, requiring the continuous supervision of the person covered.

Mental failure (for Total Permanent Disability and loss of Independent Existence): Irreversible mental incapacity due to an organic brain disease or brain injury supported by evidence of progressive loss of the ability to:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas;

and causes a significant reduction in mental and social functioning, requiring the continuous supervision of the person covered.

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.

Payment Period: the maximum period shown in the Certificate of Insurance for which Income Protection Insurance will be payable in respect of any one cause or series of linked causes.

Permanent: Expected to last throughout the Insured person's life, irrespective of when the cover ends or the Insured person retires.

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 coordination, tremor, seizures, lethargy, 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.

Pre-Existing Condition: any medical condition including congenital defects, which existed prior to the latest of the following:

- The date your Critical Illness Insurance cover starts;
- 30 days after the child's birth;
- The legal adoption of the child.

Pre-Incapacity Earnings: The average gross monthly earnings in the 12 months before the Insured became Incapacitated.

If the Earnings of the Insured vary significantly from one year to another, for example because they are made up mainly of commission or bonuses, we will use their average gross monthly Earnings over the last 3 years before the claim. Income received from savings and investments will not be included.

Working Tasks: the 6 Working Tasks are as follows:

- **Walking:** the ability to walk 200 metres on a level surface with a stick or other aid without stopping or severe discomfort;
- **Lifting:** the ability to pick up 1kg from table height with either hand and carry it for 5 metres;
- **Using a pen/pencil/keyboard:** the ability to use a pen, pencil or keyboard with either hand using any reasonable aids;
- **Hearing:** the ability to hear well enough, with hearing aids, to understand someone speaking a common language in a normal voice in a quiet room;
- **Speech:** the ability to be understood in a common language in a quiet room;
- **Vision:** the ability to see well enough to read 16-point print using spectacles or other reasonable aids.

Life Insurance (including Terminal Illness cover)

This Insurance automatically includes Terminal Illness cover.

If your Certificate of Insurance specifies this Insurance is included, we will pay a valid claim if during the Plan Term the Insured:

- Dies; or
- Is diagnosed with a Terminal Illness where the expectation of life has been confirmed to be less than 12 months.

The Plan will end following payment of a valid death claim and thereafter no more premiums are payable.

We will not pay a claim if:

- The claim is the result of an Exclusion shown in your Certificate of Insurance;
- The claim is the result of a standard Exclusion shown in these Terms and Conditions;
- The Insured fails to provide the Insurers with satisfactory evidence to support their claim.

Life Insurance with Critical Illness Insurance

If your Certificate of Insurance specifies this Insurance is included, we will pay a valid claim upon the first occurrence, if during the Plan Term the Insured:

- Dies; or
- Is diagnosed with a Terminal Illness where the expectation of life has been confirmed to be less than 12 months; or
- Is diagnosed with any of the critical illnesses listed in these Terms and Conditions and survives for at least 14 days after diagnosis.

Cover under this section ends following the payment of a valid claim. The premiums in respect of any other insurance included in the Plan are still payable to maintain that cover.

We will not pay a claim if:

- The claim is the result of an Exclusion shown in your Certificate of Insurance;
- The claim is the result of a standard Exclusion shown in these Terms and Conditions;
- The Insured fails to provide the Insurers with satisfactory evidence to support their claim.

Critical Illness Insurance (Stand Alone)

If your Certificate of Insurance specifies this Insurance is included, we will pay a valid claim if during the Plan Term the Insured:

- Is diagnosed with any of the Critical Illnesses listed in these Terms and Conditions and survives for at least 14 days after diagnosis.

Cover under this section ends following the payment of a valid claim. The premiums in respect of any other insurance included in the Plan are still payable to maintain that cover.

We will not pay a claim if:

- The claim is the result of an Exclusion shown in your Certificate of Insurance;
- The claim is the result of a standard Exclusion shown in of these Terms and Conditions;
- The Insured fails to provide the Insurers with satisfactory evidence to support their claim.

Critical Illness Conditions

Critical Illness will mean one or more of the conditions listed and defined below. Any diagnosis must be by a medical practitioner registered in the United Kingdom whose specialism is appropriate to the cause of the claim and confirmed by the Insurer's Chief Medical Officer.

(*) An asterisk denotes the condition is covered for children.

Alzheimer's disease - resulting in permanent symptoms:

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

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Other types of dementia.

Aorta graft surgery - for disease: (*)

The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft.

The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair.
- Surgery following traumatic injury to the aorta.

Aplastic anaemia - permanent and irreversible: (*)

Permanent and irreversible bone marrow failure, which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

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

Bacterial meningitis - resulting in permanent symptoms: (*)

Confirmation by a Consultant Physician of a definite diagnosis of bacterial meningitis resulting in permanent neurological or physical damage. All other forms of meningitis including viral are not covered.

Benign brain tumour - resulting in permanent symptoms: (*)

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

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

Blindness - permanent and irreversible:

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

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, lymphoma and sarcoma.

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
 - pre-malignant;
 - non-invasive;
 - cancer in situ;
 - having either borderline malignancy; or
 - having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

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's classifications of functional capacity.*

For the above definition, the following are not covered:

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

* New York Heart Association Class 3: Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain.

Coma – resulting in permanent symptoms:

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- requires the use of life support systems for a continuous period of at least 96 hours; and
- results in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug abuse.

Coronary artery by-pass grafts – with surgery to divide the breastbone: (*)

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

Creutzfeldt Jacob disease (CJD) – resulting in permanent symptoms: (*)

Diagnosis (before age 65), by a Consultant Neurologist at a major UK hospital, of Creutzfeldt Jacob disease. The diagnosis must, at the time it is made be supported by evidence of progressive deterioration of memory and the ability, to reason and perceive, understand, express and give effect to ideas.

Deafness – permanent and irreversible:

Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

Dementia – resulting in permanent symptoms: (*)

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. The diagnosis must be supported by evidence of progressive loss of ability to do all of the following:

- remember;
- to reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Dementia secondary to alcohol or drug abuse.

Encephalitis – resulting in permanent symptoms: (*)

A definite diagnosis of encephalitis by a Consultant Neurologist resulting in 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 coordination, tremor, seizures, lethargy, dementia, delirium and coma.

End stage liver failure – of advanced stage: (*)

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

- Permanent jaundice
- Ascites
- Hepatic encephalopathy

For the above definition, the following are not covered:

- Liver disease secondary to alcohol or drug abuse.

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:

- Typical clinical symptoms (for example, characteristic chest pain).
- New characteristic electrocardiographic changes.

- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
 - Troponin T > 1.0 ng/ml
 - AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

Heart valve replacement or repair – with surgery to divide the breastbone: (*)

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

HIV infection – caught in the UK from a blood transfusion, a physical assault or at work in an eligible occupation:

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 start of the plan and satisfying all of the following:
 - the incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
 - where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
 - there must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.
 - the incident causing infection must have occurred in the UK.

The eligible occupations covered by this benefit are as follows:

Ambulance Workers; Chiropractors; Dental Nurses; Dental Surgeons; District Nurses; Fire Brigade Firefighters; General Practitioners; Hospital Caterers; Hospital Cleaners; Hospital Doctors, Surgeons and Consultants; Hospital Laboratory Technicians; Hospital Laundry Workers; Hospital Nurses; Hospital Porters; Midwives; Nurses Employed by General Practitioners; Occupational Therapists; Paramedics; Physiotherapists; Podiatrists; Policemen and Policewomen; Prison Officers; Radiologists; Refuse Collectors; Social Workers.

For the above definition, the following is not covered:

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

Kidney failure - requiring dialysis: (*)

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

Loss of hands or feet - permanent physical severance:

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

Loss of independent existence - after age 60:

The insured, in the insurer's opinion, is, as a result of a medical condition either:

- permanently unable to perform all of the tasks contained in three out of six living tasks without the assistance of another person, but with the use of appropriate devices; or
- suffering from mental incapacity or brain injury which has affected the insured's ability to reason and understand and the insured has deteriorated to an extent that the insured can no longer look after themselves and require the continual supervision and assistance of another person.

Loss of speech - permanent and irreversible: (*)

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

Major organ transplant: (*)

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

For the above definition, the following is not covered:

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

Motor neurone disease - resulting in permanent symptoms: (*)
A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

Multiple sclerosis – with persisting symptoms: (*)
A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Paralysis of limbs – total and irreversible:
Total and irreversible loss of muscle function to the whole of any 2 limbs.

Parkinson's disease before age 65 - resulting in permanent symptoms:
A definite diagnosis of Parkinson's disease before age 65 by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability.

For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse.

Primary pulmonary hypertension – of specified severity: (*)
A definite diagnosis of primary pulmonary hypertension. 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's classifications of functional capacity, confirmed by a specialist whose speciality is in respiratory medicine or who is a Consultant Cardiologist.*

For the above definition, the following are not covered:

- Pulmonary hypertension secondary to any other known cause (i.e. not primary).

* New York Heart Association Class 3: Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain.

Progressive supranuclear palsy – resulting in permanent symptoms: (*)
A definite diagnosis of progressive supranuclear palsy by a Consultant Neurologist. There must be clinical impairment of eye movements and motor function.

Respiratory failure – of advanced stage: (*)
Advanced stage emphysema or other chronic lung disease, resulting in all the following:

- The need for regular oxygen treatment on a permanent basis.
- The permanent impairment of lung function tests as follows; Forced Vital Capacity (FVC) and Forced Expiratory Volume at 1 second (FEV1) being less than 50% of normal.

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

For the above definition, the following are not covered:

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

Systemic lupus erythematosus – with severe complications: (*)
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
- The permanent impairment of kidney function tests as follows; Glomerular Filtration Rate (GFR) below 30 ml/min

Terminal illness: (*)
Advanced or rapidly progressing incurable illness where, in the opinions of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months.

Third degree burns – covering 20% of the body'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.

Traumatic head injury – resulting in permanent symptoms: (*)
Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

Total Permanent Disability before age 60:
Total, permanent and irreversible disability as a result of accident or illness such that:

- for insureds engaged in a full time remunerative occupation immediately prior to the commencement of disability the insured is totally unable:
 - for class 1 and 2 occupations, to carry out the material and substantial duties of their usual occupation and will never again be able to perform their own occupation;
 - for class 2 suited and class 3 occupations, to carry out the material and substantial duties of their usual occupation and to carry out any occupation for which they are reasonably suited by training, education or experience and will never again be able to perform any such occupation;
 - for class 4 Occupations to perform three out of the six working tasks. Confirmation that the insured is permanently unable to perform three out of the six working tasks is required from the insurer's Chief Medical Officer.
- for insureds not engaged in a full time remunerative occupation immediately prior to the commencement of disability the insured is unable to perform three out of the six living tasks. Confirmation that the insured is permanently unable to perform three out of the six living tasks is required from the insurer's Chief Medical Officer.

The occupation class will be shown on the Certificate of insurance.

Usual occupation means the occupation followed at the time disability commenced and is not restricted to any one place of work.

You do not need to notify the insurer of any change in the insured's occupation after the plan has started.

Children's Critical Illness Insurance

This benefit is automatically provided if the Plan includes Life Insurance with Critical Illness Insurance or Critical Illness Insurance (Stand Alone).

If your Certificate of Insurance specifies Critical Illness Insurance is included, we will pay a valid claim if during the Plan Term an Eligible Child:

- Is diagnosed with any of the Critical Illness Conditions indicated above by an asterisk and survives for at least 14 days after diagnosis.

If the Insured's Critical Illness Insurance is cancelled or comes to the end of the Plan Term, Children's Critical Illness Insurance will no longer apply.

Payment of Children's Critical Illness benefit does not affect the amount of any main cover and will be paid to the Child's parent, grandparent, or legal guardian.

The benefit is payable on each Eligible Child and will be calculated as the lower of:

- 50% of the Critical Illness Insurance benefit shown on your Certificate of Insurance or £25,000.

The above limits apply across all such Plans, and we will only make one payment for any Eligible Child.

Income Protection Insurance

If your Certificate of Insurance specifies Income Protection Insurance and/or the Waiver of Premium Benefit is included, we will pay a valid claim if during the Plan Term the Insured:

- Is diagnosed as being Incapacitated for a continuous period longer than the Deferred Period shown in your Certificate of Insurance. The Deferred Period begins on the day you become Incapacitated.

The amount payable for Income Protection Insurance will be the specific amount shown on your Certificate of Insurance. For Waiver of Premium Benefit it is an amount equivalent to the Premium due under the Plan.

We will continue to pay the benefits until the earliest of the following events happens:

- The Insured no longer satisfies the definition of Incapacity;
- The Insured returns to work;
- The selected Payment Period ends;
- The Insured's 65th birthday;
- The end of the Plan Term;
- The Insured dies.

We will not pay a claim if:

- The claim is the result of an Exclusion shown in your Certificate of Insurance;
- The claim is the result of a standard Exclusion shown in these Terms and Conditions;
- The Insured fails to provide the Insurers with satisfactory evidence to support their claim.

Maximum Benefits:

The maximum monthly payment is 55% of the Insured's Gross Pre-Incapacity Earnings (including the Waiver of Premium Benefit if selected) less:

- a) Any benefits due under other insurances against incapacity by illness or accident which involve a regular payment to the Insured, or on behalf of the Insured, or as waiver of a regular payment due from the insured. This includes:
 - any payment from other income protection policies, or any policy that replaces all or part of the Pre-Incapacity Earnings
 - any policy that makes payments to any mortgage, loan, finance or credit agreement, or credit card, on behalf of the Insured
 - any policy that makes contributions to any pension arrangement on behalf of the Insured."
- b. Any Earnings the Insured continues to receive from any form of Employment or Self Employment;
- c. Any payments from any pension arrangement.

The maximum monthly payment under any circumstances is £5,000. All payments are monthly in arrears.

Where the Insured is not Employed at the start of Incapacity and was not during the 12-month period prior to this, the maximum monthly payment is £1,000 (including the Waiver of Premium benefit if selected).

Proportionate Benefits:

If we have been paying a claim, and the Insured goes back to work in their own Occupation but on a Part-Time basis with reduced Earnings as a direct result of their illness or injury, we will pay a reduced amount of benefit. The following formula will apply;

$$\frac{(\text{Pre-Incapacity Earnings} - \text{reduced Earnings}) \times \text{normal cover}}{\text{Pre-Incapacity Earnings}}$$

In this formula 'normal cover' means the amount of cover we would pay if the Insured remained Incapacitated and was not working. Where the reduced Earnings vary the amount paid under this cover will also vary. We will need evidence of the reduced Earnings. We will pay this reduced amount provided the Insured:

- Goes back to work for less than 30 hours per week;
- Was working for more than 30 hours per week prior to Incapacity; and
- Has Earnings from Part-Time work, which are less than their Earnings when they became Incapacitated.

We will continue to pay this reduced amount of benefit until the earliest of the following events happens:

- The Insured returns to work Full-Time;
- The Earnings from Part-Time work of the Insured are more than their Pre-Incapacity Earnings;
- The end of the selected Payment Period shown in your Certificate of Insurance;
- The end of the Plan Term; or
- The Insured dies.

If the Insured goes back to work but in a different Occupation with lower Earnings, we will pay a reduced amount of benefit. The same formula stated above and definition of 'normal cover' will apply.

We will pay this benefit provided the Insured:

- Remains Incapacitated; and
- Has Earnings from the different Occupation, which are less than their Earnings when they became Incapacitated.

We will continue to pay this reduced amount of benefit until the earliest of the following happens:

- The Earnings from the different Occupation of the Insured are more than their Pre-Incapacity Earnings;
- The end of the cover Payment Period shown in your Certificate of Insurance;
- The end of the Plan Term; or
- The Insured dies.

We work out the amount of cover as at the date of diagnosis of Incapacity. We will not take into account any change to the amount of cover after this date.

Connected Claims:

More than one valid claim is permissible under Income Protection Insurance provided all the conditions are satisfied and the Insured meets the definition of Incapacity.

A connected claim happens if we start to pay a claim, and the Insured then goes back to work but has to stop work again within the next 26 weeks. Subject to satisfactory proof, we will treat the further period of Incapacity as a connected claim and start to pay the benefit straight away provided:

- The Insured did not go back to work against the advice of their doctor;
- The Insured is Incapacitated from the same cause as the original claim;
- The Insured is still working in the same Occupation at the time the further period of Incapacity starts;
- We are notified within 2 weeks of the date the Insured stops work again.

Where the Payment Period shown in the Certificate of Insurance states the benefit is payable for 2 years the following will apply:

- The number of monthly benefit payments will be a maximum of 24.
- If a further period of Incapacity caused by the same or any related condition should occur once the 2 year Payment Period has been completed, no further benefit would be payable in respect of that or any other related condition unless two years have elapsed between recovery and commencement of the Incapacity.
- In addition, during that two-year period, the Insured must have continuously been at work and must not have received any form of treatment for the condition or any other related condition. In these circumstances, a new Deferred Period will be applied.
- If an unrelated condition arises a new Deferred Period must start.

Change of Occupation:

Occupation means the Occupation followed at the time disability commenced and is not restricted to any one place of work. You do not need to notify the Insurer of any change in your Occupation.

Geographic Limitations for Claims (Income Protection and Waiver of Premium):

If the Insured is living, working or traveling outside any of the countries listed below, their eligibility to claim will cease 6 months after the end of the Deferred Period or after 6 months residence outside these countries if later. This means the Insured may have to return to one of the following countries:

Australia, Austria, Belgium, Canada, Channel Islands, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, Ireland, Isle of Man, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom, United States of America.

The Insured must provide evidence of Incapacity satisfactory to the Insurer. The Insurer will pay the fees for any medical examinations requested. The amount of such fees will be limited to an amount that would normally be expected to apply for carrying out the same examination in the United Kingdom. The Insurer will not pay for any costs or expenses incurred by the Insured for attending medical examination and supplying the Insurer with any other relevant evidence to support a claim.

The Insured must provide the Insurer with any financial or other evidence needed to assess the claim.

Cover Increase Option (CIO)

If you took out the Plan on your own life and your Certificate of Insurance specifies the Cover Increase Option is included, you can increase the level of cover provided in the Plan without any further medical underwriting on the following events:

- Increasing your mortgage; and
- Your marriage, or entering into a Civil Partnership or on the birth or adoption of a child.

This Option can be exercised subject to the following conditions:

- You are aged 50 attained or younger;
- The Plan was issued on our Standard Terms initially;
- The Option is exercised within 3 months of the occurrence of the event;
- The increase is based on the original amount of cover when the Plan was issued and not to any subsequent increases as a result of exercising this option;
- No claim has been made on the Plan (either completed or outstanding);
- All Premiums have been paid to date;
- You are not currently Incapacitated and have not suffered a Critical Illness;
- You are resident in the United Kingdom, Channel Islands or Isle of Man;
- All other alterations are subject to our standard underwriting requirements at that time.

You can increase cover on more than one occasion provided the total increase does not exceed the lesser of:

Mortgage related:

- 50% of the original amount of cover when the Plan was issued; and
- £150,000 for Life Insurance (including Terminal Illness cover), Life Insurance with Critical Illness Insurance and Critical Illness Insurance (Stand Alone); or
- £1,000 per month for Income Protection Insurance.

Marriage, Civil Partnership and Children related:

- 100% of the original amount of cover when the Plan was issued; and
- £150,000 for Life Insurance (including Terminal Illness cover), Life Insurance with Critical Illness Insurance and Critical Illness Insurance (Stand Alone); or
- £1,000 per month for Income Protection Insurance.

and that in respect of Marriage, Civil Partnership and Children, the maximum increase is 25% of the original amount of cover on any one occasion.

If you have more than one Plan with us these limits apply across all Plans where the option is included.

Free Life Insurance during Underwriting

If an Application is in connection with a Mortgage and subject to the agreement of the Insurers, free cover may be provided subject to the following conditions:

- The Application Form confirms the Plan is being effected in connection with a Mortgage;
- The Insured has answered 'No' to all of the questions asked in the following sections of the Application Form:
 - Personal Details;
 - Occupation Details;
 - Health Questions.

Where the Insurers agree, Life Insurance payable on the death of the Insured will be granted free of charge subject to a maximum of £150,000 or the Sum Insured if less, from the date of receipt of the Application Form until the earlier of the following:

- A Declinature Notice is issued; or
- The mortgage completes; or
- The expiration of 90 days.

If the Insured dies during the period of free Life Insurance, the Insurer reserves the right to obtain whatever evidence it considers necessary to establish the validity of a claim.

Free cover between Acceptance and Completion

There may also be free Life and Terminal Illness Insurance and Critical Illness Insurance (if applicable). If the Application is in connection with a Mortgage and accepted on Standard Terms, the Insurance will become effective from the later of:

- The Acceptance Date; or
- The date of Exchange of Contracts.

Cover will continue until the date of Completion of the Mortgage subject to a maximum period of 31 days.

If the Insured dies or makes a claim for Terminal Illness or Critical Illness during the period of free cover, the Insurer reserves the right to obtain whatever evidence it considers necessary to establish the validity of a claim. The benefit payable will be the Sum Insured shown in the Acceptance Letter and subject to a maximum of £150,000 or the Sum Insured if less.

Claims

All benefits payable are subject to satisfactory proof of claim, age and title as required by the Insurers.

If the date of birth of the Insured is wrong, we will recalculate the level of benefit that should have been provided based on the correct date of birth and the actual premium paid.

Written notice of a claim in respect of any benefit must be provided to SFP as soon as is reasonably practicable after the occurrence of the event upon which the claim is based.

- Critical Illness Insurance - written notice of the claim must be provided within 30 days of the initial occurrence and evidence satisfactory to the Insurer of the condition must be provided.
- Income Protection Insurance - written notice of a potential claim must be provided within 2 weeks, 4 weeks or 6 weeks of the first day off work in respect of Deferred Periods 4 weeks, 13 weeks and 26 weeks respectively. If notification of a claim is not received before the end of the Deferred Period, the Insurer may at their discretion backdate payment to the end of the Deferred Period if the claim can be medically proven to have started then.

During a claim for Income Protection, the Insurer reserves the right to request the Insured to attend for a medical examination by a Doctor chosen by the Insurer at any time or to request any other information (including financial information) that may be necessary. The benefit may cease if the Insurer is not satisfied that the condition continues to qualify for benefit.

Once entitlement and value are determined we will pay benefits monthly. The first payment will be due on the first day of the month after the end of the Deferred Period. If benefits do not terminate for any other reason the final payment will be due on the first day of the month following the expiry of the Income Protection Insurance.

The first and last payments will be fractions of the monthly amount. The first payment will be calculated as follows. We will:

- Calculate the number of days between the end of the Deferred Period and the date of the first payment, then
- multiply this number by 12 and divide by 365, then
- multiply the resulting figure by the amount of the monthly benefit payment.

We will calculate the last payment in the same way except that we will use the number of days between the second last payment and the expiry date of this benefit. If the end of the Deferred Period and the expiry date of this benefit are within the same month we will make only one payment, calculated as above, using the number of days between the end of the Deferred Period and the expiry date of this benefit.

Exclusions

We will not pay a claim if it is caused directly or indirectly from any of the following:

Alcohol or drug abuse (Critical Illness and Income Protection): Inappropriate use of alcohol or drugs, including but not limited to the following:

- Consuming too much alcohol.
- Taking an overdose of drugs, whether lawfully prescribed or otherwise.
- Taking Controlled Drugs (as defined by the Misuse of Drugs Act 1971) otherwise than in accordance with a lawful prescription.

Criminal acts (Critical Illness and Income Protection): Taking part in a criminal act.

HIV/AIDS (Income Protection):

Infection with Human Immunodeficiency Virus (HIV) or conditions due to any Acquired Immune Deficiency Syndrome (AIDS).

Pre-Existing Conditions (Childrens Critical Illness):

Conditions arising directly or indirectly from a Pre-Existing Condition.

Self-inflicted injury (Critical Illness and Income Protection): Intentional self-inflicted injury.

Suicide (Life and Terminal Illness):

If the death or Terminal Illness of an Insured shall occur within one year of cover starting as a result of self-inflicted causes, the Insurer shall not be liable to pay any benefits in respect of that death or Terminal Illness. This will not affect the rights of any mortgage lender who can prove they have an interest in the benefit. All premiums paid may be forfeited to the Insurer.

Unreasonable failure to follow medical advice (Critical Illness and Income Protection):

Unreasonable failure to seek or follow medical advice.

War and civil commotion (Critical Illness and Income Protection):

War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.



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Synergy Financial Products Limited
PO Box 1010
St Albans
AL1 9NB

Adviser Support / Client Services / New Business
Phone: 01727 797 800
Fax: 01727 797 801

website: www.sfpl.co.uk
email: support@sfpl.co.uk

Registered and incorporated in England, Number: 1792304
39 Alma Road, St Albans AL1 3AT.