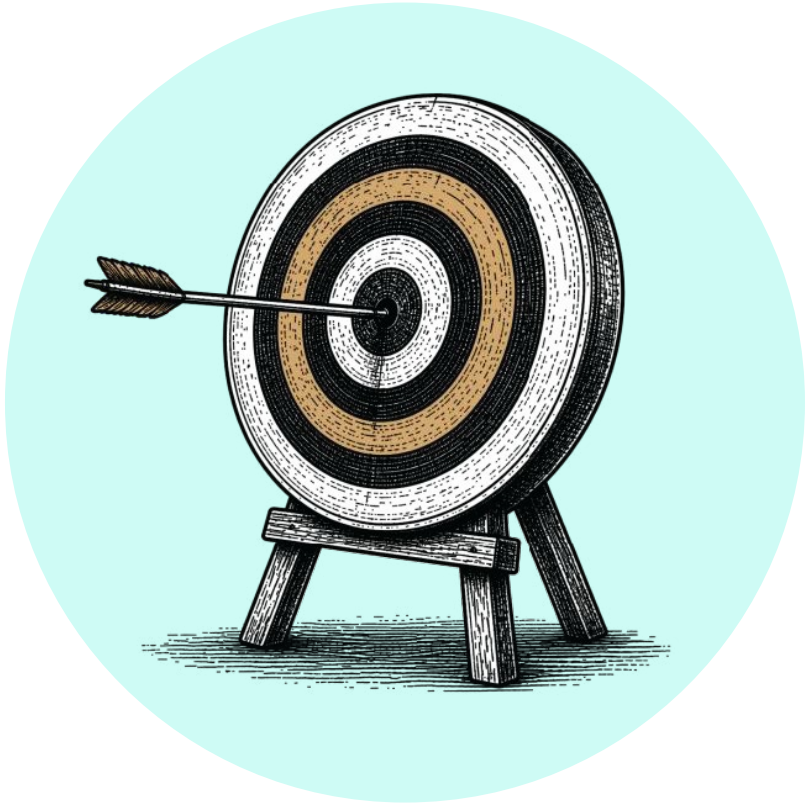
2025 claims report

ILLUSTRATING THE VALUE OF PROTECTION

GUARDIAN 1821

LIFE. MADE BETTER.

ACCURACY MATTERS



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"Claims are where our brand is put to the test. That's why we publish our claims statistics every year.

We're delighted to have paid 297 claims totalling almost £31.7 million in 2025, a 48% increase on the amount paid to customers and their families in 2024.

This report shares our claims performance for 2025 and shows the value protection delivers. This year, we've also included a snapshot of our performance since launch. We're still only 8 years old, but we believe consistency over time is the true measure of a protection provider. And I'm proud of that consistency.

In 2025, 24 claims were declined due to misrepresentation. And that's 24 claims too many. Misrepresentation isn't just a Guardian challenge; it's an industry challenge. Providers, advisers and customers all have a role to play by making sure every application is completed honestly, accurately and in full. Because we genuinely want to be able to pay every single claim.

I'm proud of the support we've provided to customers in 2025 and grateful to the advisers who continue to place their trust in Guardian."

Carlton Hood
Chief Executive Officer

THE IMPORTANCE OF BALANCE

In 2025, we paid 297 claims in total. 209 relating to adult and children's critical illness and 88 to life and terminal illness cover. The figures highlight the growing importance of getting the balance right between life and illness cover.

TOTAL AMOUNT PAID:

£31,671,373

This is a **48%** increase on 2024

TOTAL NUMBER OF CLAIMS PAID:

297

Plus, a further **293** Premium Waiver claims

% OF ALL CLAIMS PAID:

91%

"In 2025, we paid almost £31.7 million in claims, up 48% on the amount paid to families in 2024.

£14.8 million supported adults and children facing critical illness, and we paid 100% of children's critical illness claims.

It highlights a simple truth: illness is one of the greatest financial risks families face, and can leave clients exposed."

Nischal Singh
Chief Financial Officer

LIFE

% of claims paid:
87%

Total amount:
£9,217,344

Number of claims paid:
53

TERMINAL ILLNESS

% of claims paid:
92%

Total amount:
£7,660,194

Number of claims paid:
35

CRITICAL ILLNESS

% of claims paid:
90%

Total amount:
£13,986,218

Number of claims paid:
169

CHILDREN'S CRITICAL ILLNESS

% of claims paid:
100%

Total amount:
£807,617

Number of claims paid:
40

This report includes the following covers: Life Protection launched in August 2018, Critical Illness Protection launched in August 2018, Combined Life and Critical Illness Protection launched in October 2019, and Children's Critical Illness Protection launched in August 2018. All claims with a decision made from 1 January to 31 December 2025.

This report doesn't include: Income Protection launched in April 2023, Life Essentials launched in January 2024, Critical Illness Essentials or Combined Life and Critical Illness Essentials launched in June 2026 or Fracture Plus Protection that closed to new business in October 2019.

THE FRAGILITY OF LIFE

These figures show that life cover claims can happen much earlier than many people expect. With the youngest claimant just 31 and the average age only 52, they highlight how important it is for people to have financial protection in place during their working lives, when families and financial commitments are often at their highest.

% OF LIFE CLAIMS PAID:

87%

TOTAL AMOUNT PAID:

£9,217,344

Highest amount paid:
£963,827

Average amount paid:
£173,912

Lowest amount paid:
£1,951

Total number of claims paid:
53

Total number of claims not paid:
8

Claims not paid due to misrepresentation:
13%

See page 16 for details of some of the claims we couldn't pay.

Youngest age of claimant:
31

Average age of claimant:
52

Oldest age of claimant:
67

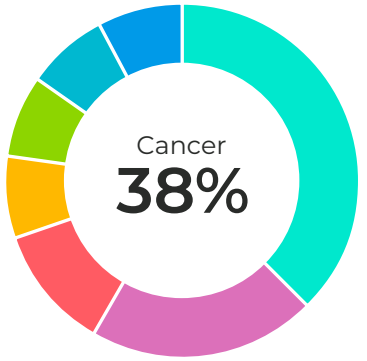
% male:
62%

% female:
38%

Our 2025 life claims shown above are for Life Protection only. Life Essentials launched in January 2024, and we've only had a very small number of claims so far. It's standard industry practice to share claims information after 5 years.

One of the claims paid was for a reduced payment due to misrepresentation of medical history on the application.

THE CAUSES OF LIFE CLAIMS	No. of claims	% of claims
Cancer	20	38%
Cardiovascular*	11	21%
Accident	6	11%
Neurological	4	7.5%
Respiratory	4	7.5%
Suicide	4	7.5%
Other natural causes	4	7.5%



KEY POINT

*We paid one for cardiovascular claim before the policy had gone in force under our Immediate Cover.

Immediate Cover is temporary cover that starts as soon as we receive a completed application form.

A BUILT-IN WAY TO MAKE SURE THE MONEY GETS TO THE RIGHT PEOPLE FASTER

HELPING AVOID PROBATE DELAYS

Payout Planner allows clients to nominate beneficiaries during their application. When they die, the payout can go directly to their nominated beneficiaries without waiting for probate or other legal proceses to be completed.

This can help provide financial support more quickly at what is often a difficult time for families.

HELPING PROVIDE GREATER CERTAINTY

Payout Planner can also help make sure the policyholder's wishes are clear. This is particularly important for unmarried couples, who aren't automatically recognised under intestacy rules. By allowing beneficiaries to be nominated in advance, Payout Planner can help reduce uncertainty and make the claims process smoother for loved ones.

In short, Payout Planner helps make sure the payout reaches the intended beneficiaries faster and with fewer complications.

PAYOUT PLANNER IN ACTION

A policyholder took out their cover in June 2021 and, sadly, died from stomach cancer in October 2025.

We were notified of the claim on a Wednesday. We spoke with the policyholder's family the following day, completed our assessment and paid the claim the same day, after we spoke with the policyholder's family.

Because the policyholder had Payout Planner in place and had named his wife as the beneficiary, we were able to pay the money directly to her. This meant she received the money quickly, without having to wait for probate or other legal processes to be completed.

71%

of all our life policies that went in force in 2025 used Payout Planner.

70%

of life claims paid in 2025 were paid using Payout Planner.

21

days were saved at claim on average using Payout Planner in 2025.

4%

of life claims paid in 2025 were paid into a trust.

Only

21%*

of life policies are written in trust across the industry.

* Swiss Re, Life claims: What Matters Most? November 2025.

AN EXCEPTIONAL TERMINAL ILLNESS DEFINITION

Uniquely, our Life Protection terminal illness definition pays out not only when death is expected within 12 months, but also on diagnosis of incurable stage 4 cancer, motor neurone disease, Parkinson Plus syndromes or Creutzfeldt-Jakob disease (CJD), regardless of life expectancy.

% OF TERMINAL ILLNESS CLAIMS PAID:

92%

TOTAL AMOUNT PAID:

£7,660,194

VALUE OF OUR TERMINAL ILLNESS DEFINITION:

34%

of the claims we paid wouldn't have met the industry standard definition.

Highest amount paid:
£1,402,566

Average amount paid:
£218,863

Lowest amount paid:
£30,000

Total number of claims paid:
35

Total number of claims not paid:
3

Claims not paid due to misrepresentation:
8%

See page 16 for details of some of the claims we couldn't pay.

Youngest age of claimant:
32

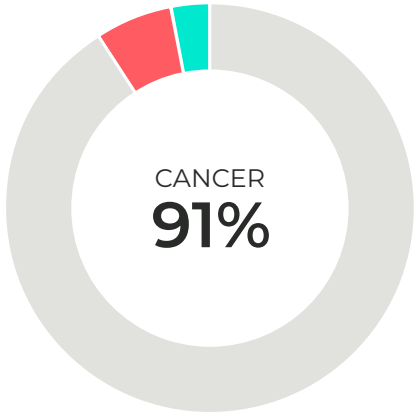
Average age of claimant:
53

Oldest age of claimant:
69

% male:
57%

% female:
43%

THE CAUSES OF TERMINAL ILLNESS CLAIMS	No. of claims	% of claims
Cancer	32	91%
Parkinson Plus syndrome	2	6%
Motor neurone disease	1	3%



KEY POINT

The life expectancy of the policyholders of 9 of the cancer claims, the 2 Parkinson Plus syndrome claims, and the motor neurone disease claim all exceeded 12 months, and were paid under our enhanced terminal illness definition, which pays regardless of life expectancy.

2 of the claims paid were a reduced payment due to misrepresentation of medical history on the application.

CLARITY HAS REAL VALUE

With our signature Critical Illness Protection, we focus on providing clear, simple and comprehensive definitions for the illnesses people are most likely to claim for.

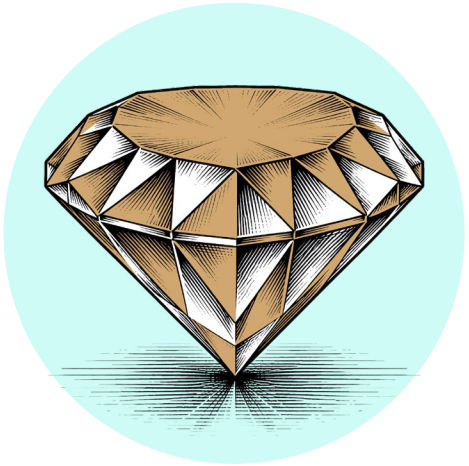
That's why for many illnesses including the big 4 (cancer, heart attack, stroke and multiple sclerosis), confirmation from UK consultant is all we need to pay a claim.

% OF CLAIMS PAID:

90%

TOTAL AMOUNT PAID:

£13,986,218



TOTAL PAYOUTS

Total number of claims paid:
169

Total number of claims not paid:
18

Misrepresentation:
7% (13 claims)

Not meeting the definition:
3% (5 claims)

See page 16 for details of some of the claims we couldn't pay.

FULL PAYOUTS

Highest amount paid:
£1,000,000

Average amount paid:
£87,555

Lowest amount paid:
£7,341

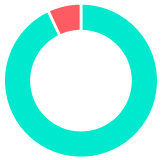
ADDITIONAL PAYOUTS

Highest amount paid:
£39,698

Average amount paid:
£13,873

Lowest amount paid:
£2,041

Full payout
93%



Additional payout
7%

Youngest age of claimant:
23

Average age of claimant:
49

Oldest age of claimant:
68

% male:
43%

% female:
57%

79%

of our critical illness claims paid were for the big 4 conditions:

CANCER

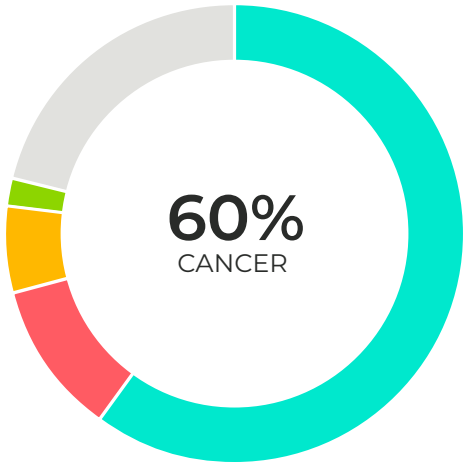
HEART ATTACK

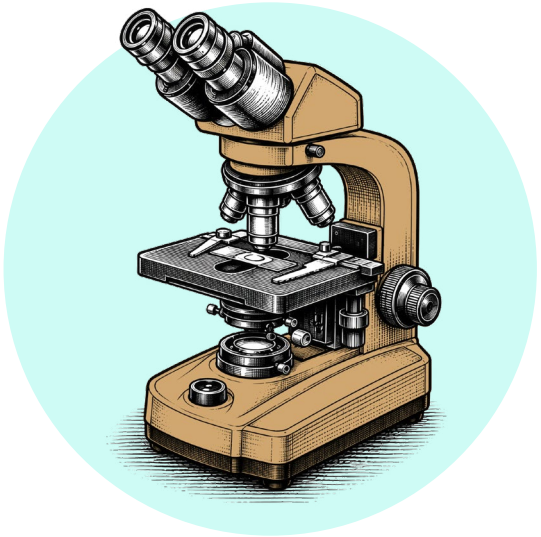
STROKE

MULTIPLE SCLEROSIS

8 of the claims paid were for a reduced payment due to misrepresentation of medical history on the application.

Condition	Male	Female	Total	%
Cancer	**37**	**65**	**102**	**60**
Stroke	**6**	**12**	**18**	**11**
Heart attack	**8**	**2**	**10**	**6**
Multiple sclerosis	**1**	**3**	**4**	**2**
Angioplasty	3		3	2
Heart valve replacement or repair	2	1	3	2
Non-melanoma skin cancer	2	2	4	2
Traumatic brain injury	3		3	2
Benign brain tumour		2	2	1
Benign spinal cord tumour	1		1	1
Blindness	1		1	1
Carcinoma in situ of the breast		2	2	1
Cardiac arrest	1		1	1
Cardiomyopathy	2		2	1
Coma	1		1	1
Crohn's disease	1	1	2	1
Intensive care benefit		1	1	1
Interstitial lung disease	1		1	1
Motor neurone disease	1		1	1
Neuroendocrine tumours		2	2	1
Ovarian tumour		2	2	1
Parkinson's disease	2		2	1
Total permanent disability		1	1	1





Cancer Stroke Heart attack Multiple sclerosis Other

Using customer-supplied evidence to pay claims quickly

A policyholder contacted us to tell us they'd had a heart attack earlier that month.

We spoke to them the next day, and they shared the medical evidence they had. We then confirmed the diagnosis with their Consultant.

After reviewing the information, we accepted the claim and arranged payment just 6 working days after being notified. This meant the customer received their critical illness payout quickly, providing valuable financial support when they needed it most.

Percentages don't add up to 100% due to rounding.

GREATER FLEXIBILITY FOR KIDS

Our Children's Critical Illness Protection is an optional extra that can be added to any adult cover at any time.

This allows clients to choose higher cover amounts from £10,000 up to £100,000 (limited to the parent's cover amount). If a covered child dies, we'll also pay £10,000 towards funeral costs.

% OF CLAIMS PAID:
100%

TOTAL AMOUNT PAID:
£807,617

% OF CLAIMS ATTACHED TO ADULT LIFE COVER:
53%

% OF CLAIMS FOR FUNERAL COVER:
23%

Total number of claims paid:
40

Total number of claims not paid:
0

FULL PAYOUTS

Highest amount paid:
£114,639

Average amount paid:
£30,394

Lowest amount paid:
£10,888

ADDITIONAL PAYOUTS

Highest amount paid:
£32,565

Average amount paid:
£9,977

Lowest amount paid:
£6,250

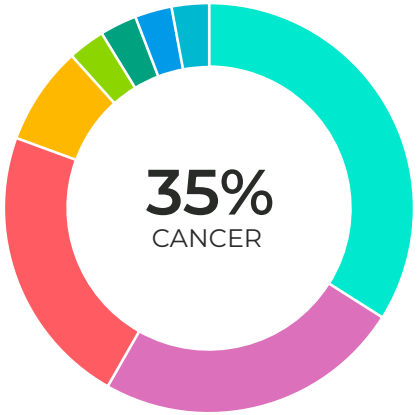
Full payout:
50%

Additional payout:
27%

Funeral cover:
23%

CLAIMS IN CONDITION	No. of claims	% of claims
Cancer	14	35%
Type 1 insulin-dependent diabetes mellitus	10	25%
Funeral cover	9	23%
Open-heart or structural heart surgery	3	8%
Bacterial meningitis	1	3%
Cerebral palsy	1	3%
Intensive care benefit	1	3%
Pituitary tumour	1	3%

Percentages don't add up to 100% due to rounding.



Amounts may exceed the original cover level where Increasing Cover was selected.

A PROMISE THAT MAKES A BIG DIFFERENCE

Our cover upgrade promise is included in the critical illness covers in our Protection range. It means that if we improve our Critical Illness Protection definitions for new policyholders after their cover has started, we'll give those improved definitions to them as an existing policyholder.

2 CLAIMANTS BENEFITED FROM OUR COVER UPGRADE PROMISE IN 2025:

ADULT CRITICAL ILLNESS CLAIM

Greg took out £40,000 of Combined Life and Critical Illness Protection with us in 2020.

In 2025, after an artery blockage was identified, he was placed on the waiting list for angioplasty surgery and contacted us to make a claim.

Because of a cover upgrade we made in June 2025, he was eligible for additional payment as soon as he was added to the NHS waiting list for his surgery, rather than having to wait until after the surgery had taken place. This meant we paid £10,000, 25% of his cover amount, under our upgraded angioplasty definition, while he was waiting for his treatment.

Under the definition in Greg's original policy terms and conditions, we wouldn't have paid his claim until after his surgery.

CHILDREN'S CRITICAL ILLNESS CLAIM

Paul took out Life Protection in 2022 and added optional Children's Critical Illness Protection.

In 2025, Paul's son Mikey was born. Shortly after his birth, the doctors detected a heart murmur. Further investigations revealed that Mikey had 2 holes in the heart and would need surgery to correct the condition.

Under the original definition, we'd have paid this claim after the surgery. However, following an enhancement made through our cover upgrade promise in April 2025, claims could be paid once Mikey was added to the NHS waiting list.

After Mikey was placed on the waiting list in September 2025, we assessed the claim immediately and paid it in October 2025, before his surgery took place.

This meant we were able to pay the claim before the surgery, giving the family financial support when they needed it most.

THE BOTTOM LINE.

Our cover upgrade promise means that improvements to the definitions in the critical illness covers in our Protection range strengthen cover for both new and existing customers.

These stories are real, but we've changed the names for confidentiality.

PREMIUM WAIVER BUILT-IN

We include Premium Waiver as standard because we believe it's invaluable.

It means if your client becomes too ill to work and their income reduces, we'll pay their premiums until they're well enough to return to work. And, depending on what type of cover they choose, we may also pay their premiums for up to 6 months if they're made redundant or take maternity or paternity leave, as long as their policy has been in force for a year at the time of claim.

% OF PREMIUM WAIVER CLAIMS PAID:

99%

Total number of claims paid:
293

Total number of claims not paid:
3

Highest monthly amount paid:
£357.47

Average monthly amount waived:
£50.19

Lowest monthly amount waived:
£5.23

REASONS FOR PAYMENTS

27%

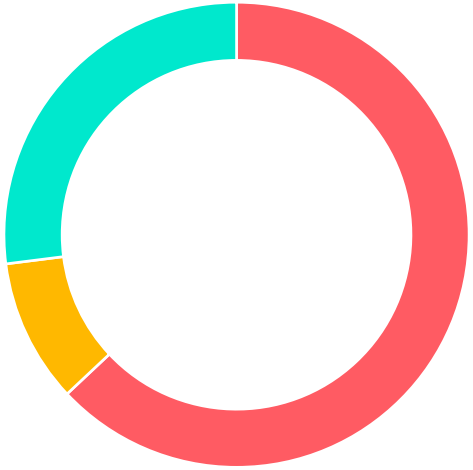
Illness / Injury (79 claims)

The average medical waiver claim payment duration in 2025 was 15 months.

10%

Involuntarily losing job / being made redundant (28 claims)

Premiums were waived for up to 6 months.



63%

Maternity / paternity (186 claims)

Premiums were waived for 6 months.

31

The number of cases where both parents made a claim.

COVER THAT CONTINUES AFTER A CLAIM

Our dual life approach is designed to provide better cover for couples. Unlike traditional joint life cover, which typically ends after the first claim, our dual life approach treats each person separately, meaning each person has their own cover and their own potential claim.

This means that when one person claims, the other remains protected. The number of claims paid shows how our dual life approach can provide ongoing protection for couples and families.

51%

of all our 2025 life claims paid were under dual life

54%

of our 2025 terminal illness claims paid were under dual life

38%

of our 2025 adult critical illness claims paid were under dual life

As these policies were set-up using our dual life approach rather than traditional joint life, the claimants' partners could still have their own cover in place and the potential to claim in the future.

"Our dual life approach provides 2 potential payouts and continued protection for the claimant's partner, delivering greater long-term security than a traditional joint life policy."

Hilary Banks
Chief Commercial Officer

EXPERTLY TAILORED

Our claims support service, HALO, provides claimants and their immediate family members access to additional medical treatments, counselling, legal services, and financial support at no extra cost.

The help provided is at the discretion of our Claims Team, and to make sure we take the best care of policyholders, we've partnered with the best.

Here's a small selection of the partners that help us bring HALO to life:

RedArc
at your side, on your side

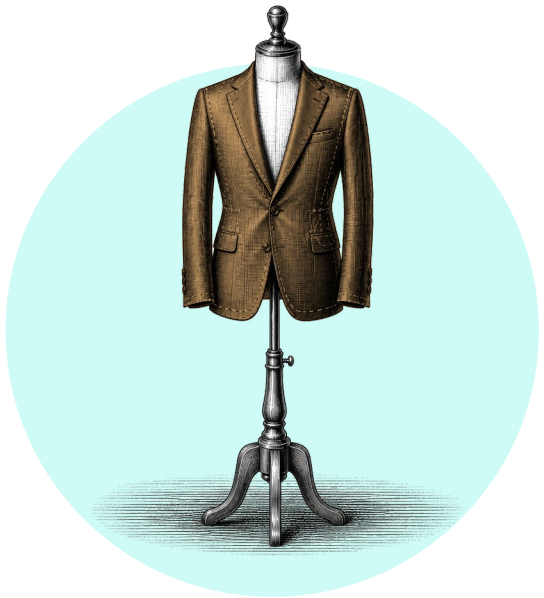
Provides specialist nurses who give claimants and their families practical advice and emotional support to help them cope with the impact of illness, disability, trauma and bereavement. The service also provides face-to-face second medical opinions and access to alternative therapies and counselling.

Krysalis
Neuro Occupational Therapy

Provides specialist therapy and support for claimants diagnosed with a neurological condition. This could include Parkinson's disease, motor neurone disease, a stroke, or an injury to the brain, spine or central nervous system.

LEGACARE

Provides personalised legal advice and continued support for claimants. They can advise on a range of complex issues faced by bereaved families and critically ill policyholders including care planning, estate and tax planning, powers of attorney, wills and financial matters.



HALO

The services made available to each claimant will depend on their situation. However, these examples show the breadth of support available.

- Second medical opinion from a UK Consultant
- Therapies to ease the consequences of treatments
- Finding a solicitor to handle probate
- Bereavement counselling
- Help to draw up a power of attorney
- Counselling to help families cope with serious illness
- Specialist therapy for neurological conditions
- Support with home, family and childcare issues
- Support and guidance to navigate the NHS
- Nursing support following diagnosis and treatment
- Estate planning following a terminal illness diagnosis
- Signposting to employer or state benefits

HALO doesn't form part of your client's contract with us, and we can change or remove the benefits included at any time.

HALO

After being diagnosed with cervical cancer, we referred Julia to RedArc while she waited for her treatment plan. Understandably overwhelmed by the uncertainty ahead, the speed at which events were unfolding and concerns about her fertility, she received practical and emotional support from an experienced Registered Nurse. This included help preparing for appointments and access to trusted information and counselling services. The support helped Julia feel more informed, reassured and in control during a difficult time.

Following a horse-riding accident, Sarah had serious brain injuries, as well as multiple fractures, including injuries to her spine. She lost consciousness at the scene and was placed in a medically induced coma for 3 days.

We referred Sarah to Krysalis for an assessment. Over the following 6 months, Krysalis provided tailored rehabilitation to support Sarah's recovery, with a focus on improving physical function, confidence, and independence in everyday activities. Through consistent intervention, Sarah made steady progress, and achieved significant improvements, enabling her to move forward with greater independence and self-assurance.

When Fred's terminal illness claim progressed to a death claim, his family faced an additional challenge as there was no trust or Payout Planner in place, meaning a Grant of Probate was needed before we could pay the claim.

Initially unsure about applying, we referred his wife to Legacare for practical support and guidance. With their help, she secured the Grant of Probate, enabling us to pay the claim as quickly as possible.

There stories are real, but we've changed the names and images for confidentiality.

8 YEARS OF HIGH PERFORMANCE

A single year's claims statistics are important. But consistency is key.

Since 2018, we've helped hundreds of customers and their families when they needed us most. That's the track record advisers can recommend with confidence.

OUR PERFORMANCE SINCE 2018:

TOTAL AMOUNT PAID:

£84,857,747

TOTAL NUMBER OF CLAIMS PAID:

841

Plus, a further **893** Premium Waiver claims

% OF ALL CLAIMS PAID:

93%

LIFE COVER

% of claims paid:
93%

Number of claims paid:
172

Number of claims declined:
13

TERMINAL ILLNESS

% of claims paid:
95%

Number of claims paid:
94

Number of claims declined:
5

CRITICAL ILLNESS

% of claims paid:
91%

Number of claims paid:
467

Number of claims declined:
46

CHILDREN'S CRITICAL ILLNESS

% of claims paid:
98%

Number of claims paid:
108

Number of claims declined:
2

This report includes the following covers: Life Protection launched in August 2018, Critical Illness Protection launched in August 2018, Combined Life and Critical Illness Protection launched in October 2019, and Children's Critical Illness Protection launched in August 2018. All claims with a decision made from from our launch in 2018 to 31 December 2025.

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> Since Guardian re-entered the market 8 years ago, we've paid 841 life, critical illness and terminal illness claims, supporting customers and their families through some of life's most difficult moments. That's why we're here. And it's why consistency matters. Trust isn't earned in a year, it's built by being there, year after year, when it matters most.

Gower Wisdom
Chief Operating Officer

HELPING IMPROVE FUTURE CLAIMS OUTCOMES

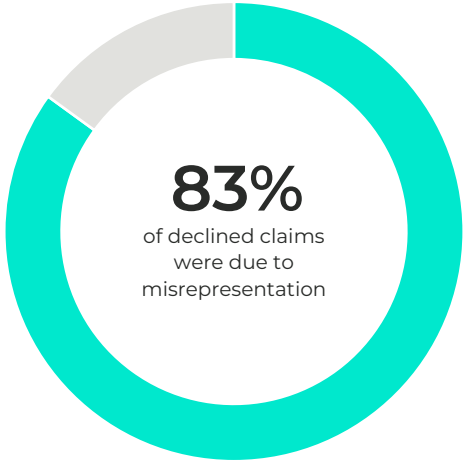
We want to pay every claim. So, to improve claims outcomes, it's important to understand why a small number of claims couldn't be paid.

In 2025, we declined 29 life, critical illness or terminal illness claims. The most common reason was misrepresentation, when inaccurate or incomplete information was provided during the application process.

29
Total number of adult claims declined.

5
Claims declined due to the definition not being met.

24
Claims declined due to misrepresentation.



There are no winners when we find ourselves unable to pay a claim due to inaccurate application information. That's why we ask advisers and customers to read our underwriting questions in full and answer them honestly and accurately.

STATEMENT OF FACTS

Please ask your clients to read the statement of facts within 30 days of the policy starting to check that all the answers are correct.

Policyholders will find this in their MyGuardian account when their policy starts.

PRE-EXISTING HEALTH CONDITIONS

Clients must tell us about any diagnosed conditions we ask them about, and any related treatment and ongoing symptoms.

UNDIAGNOSED HEALTH CONDITIONS

Please ask your clients to disclose any symptoms that they're waiting to see a specialist or undergoing or awaiting any medical tests for.

ALCOHOL CONSUMPTION

Please make sure your clients disclose their alcohol consumption accurately, and they tell us if they've ever been advised by a medical professional to reduce their alcohol consumption.

HEIGHT AND WEIGHT

Please ask your clients to measure their height and weight rather than disclosing guestimates.

This enables us to determine their accurate Body Mass Index, a few kilograms can make a big difference.

SMOKING AND VAPING

Please tell your clients they must disclose even the occasional cigarette, cigar or vape.

If they're an ex-smoker, they must provide us with an accurate date when they stopped.

MISREPRESENTATION CLAIMS IN DETAIL

In the interest of transparency, we're shining the spotlight on some of the claims we couldn't pay in 2025 due to misrepresentation.

Type of claim	Length of time cover had been in force before claimable event	Cause of claim	Reason for decline
Life	24 months	Chronic obstructive pulmonary disease (COPD)	The application described COPD as causing only a slight cough but didn't include that the customer had been on home oxygen for many years, had recently been in hospital, and was being considered for a lung transplant before applying for cover. Had this been disclosed, we wouldn't have offered cover.
Life	29 months	Cardiovascular	The application didn't include the customer's long-standing heart condition or that they had undergone major heart surgery. Had this been disclosed, we wouldn't have offered cover.
Life	26 months	Multi organ failure and alcohol liver disease	The application didn't include the details of the customer's excessive alcohol use, a referral for alcohol support, abnormal liver test results, or mental health issues. Had this been disclosed, we wouldn't have offered cover.
Terminal illness	54 months	Prostate cancer	Medical evidence we received during the claim showed the customer had been under a urologist's care and undergoing investigations in the year before applying for cover. Had this been disclosed, we wouldn't have offered cover.
Terminal illness	5 months	Cancer	The application didn't include details of a referral for assessment of skin lesions 3 months before applying for cover. Had this been disclosed, we wouldn't have offered cover.
Terminal illness	6 months	Motor neurone disease	The application didn't include details of symptoms including reduced mobility, which led to a neurology referral and further investigations before applying. Had this been disclosed, we wouldn't have offered cover.
Critical illness	7 months	Non-melanoma skin cancer	The application didn't include details that the customers was being investigated for suspected skin cancer before applying for cover. Had this been disclosed, we would have applied a skin cancer exclusion. We declined the claim but kept the policy in force with the exclusion added.
Critical illness	8 months	Heart attack	Before applying for cover, the customer had been told they were pre-diabetic, had abnormal blood test results and were under medical monitoring. Had this been disclosed, we wouldn't have offered cover.
Critical illness	3 months	Cancer	We were told that the customer's symptoms started after they applied for cover. However, medical evidence showed they had experienced symptoms and were undergoing investigations for more than a year before applying. Had this been disclosed, we wouldn't have offered cover.

START A CLAIM WITH A CONVERSATION

When your clients are living through a traumatic experience, making a claim can be overwhelming.

At Guardian, we guide claimants through the process personally.

Guardian's claims process is approved by the PDG Claims Charter.

1. CALL AND REGISTER

If your client needs to make a claim, please call:

0808 173 1821

Calls to this number are free.

2. WE TAKE THE DETAILS OVER THE PHONE

A member of our Claims Team will take all the details from your client over the phone.

3. WE EMAIL YOU CONFIRMATION

We'll then email the claim details to your client to make sure the information is right. If needed, we'll also send your client any appropriate forms to be signed.

4. WE KEEP YOU UPDATED

If you'd like, we'll keep you and your client updated throughout the claims journey.

5. WE INTRODUCE HALO

The Claims Specialist will discuss the additional support we can offer them and their family at this difficult time.

"When a customer makes a claim, they need clarity, compassion and answers. Nothing delivers that better than a conversation.

That's why every claimant is personally supported by a dedicated claims specialist.

It's the fastest and most effective way to get claims paid."

Helen Morris
Head of Claims

LIFE. MADE BETTER.

Find out more at: **adviser.guardian1821.co.uk**

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