

# Registered Group Life Policy

Technical guide



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We've based this technical guide on the 'best practice' format recommended by the Group Risk Development group (GRiD) and The Association of British Insurers (ABI). The technical guide is an important document that explains the features of our Registered Group Life Policy.

The guide should be read together with your quotation setting out the cost and other details specific to the cover you requested. This will include any modifications to our standard terms and conditions and any additional requirements we may need.

The full terms and conditions of the product are contained in your policy. It consists of our standard terms and conditions and the policy schedule, which shows details specific to your cover, including any modifications to the standard terms and conditions which are set out in the quotation.

We will issue the policy when all the details of your cover have been finalised, any requirements set out in the quotation have been met and we have agreed to enter into a contract with you.

**If you'd like to see a copy of the standard terms and conditions earlier, please ask.**

Our Registered Group Life Policy should only be used by commercial customers who are taking out the policy in the ordinary course of their trade, business or profession.

The legal and tax information contained in this guide summarises Zurich's understanding of the law and of HM Revenue & Customs (HMRC) practice at the date of publication.

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Throughout this technical guide where we refer to '**we**', '**us**' or '**our**' we mean Zurich Assurance Ltd. Where we refer to '**you**' or '**your**' we mean the trustee(s) of the scheme. Where we refer to '**member**' we mean a person who is included in the policy.

#### **Its aims**

- To provide insurance to cover lump sum life assurance benefits payable on the death of a member.
- To provide insurance to cover an additional lump sum life assurance benefit which will be used by the scheme's trustee(s) to purchase a dependant's pension in the insurance market.
- To offer a flexible range of choices in relation to these benefits and additional options available under the policy.
- To offer a range of options tailored to budget and employment philosophy.

#### **Your commitment**

- To give us the complete and accurate information we've asked for within the times we've specified.
- To tell us if information that affects the premium changes (**see section 3**).
- To pay all the premiums we ask for, when they are due.
- To tell us about any claims as soon as possible, but in any event within the timescales set out in **section 5.2**.
- To tell us in advance of changes to participating companies including their activities, location and the relationship between them.
- To tell us as soon as possible of any 'discretionary entrants'. These are people who don't meet the eligibility conditions for the scheme but whom you want to be covered.
- To abide by the terms and conditions of the policy.

#### **Risk factors**

- If you don't meet your commitments, we may not pay your claims and may cancel the policy.
- If you delay giving us requested information or letting us know of changes to participating companies and discretionary entrants, this could lead to:
  - a premium increase;
  - members not being covered under the policy or not being covered for full benefits;
  - delays in processing claims.
- We may exclude certain causes of claim for some members (**see section 6**).

### Risk factors *continued*

- We may revise the terms and conditions or rates where:
  - the taxation of policy benefits and premiums changes;
  - you request we change the basis for calculating the policy benefits;
  - you request we change the eligibility conditions, including admitting or removing groups of employees or participating employers;
  - the number of employees included in the policy, or their total salaries, vary by more than 25% since the beginning of the rate guarantee period;
  - the employer's location or nature of business changes.
- We may cancel the policy if the 'registered' status of the policy is withdrawn or has not been obtained.
- We'll restrict the total amount of benefits payable in respect of multiple claims resulting from a catastrophe, or where members of the scheme travel on business together (**see section 6**).
- Any claims received later than two years from the date of the member's death will not be accepted (**see section 5.2**).
- You should seek legal and tax advice to ensure you understand any potential taxation issues for you and your employees, and any conflicts with your employees' contracts of employment.
- Lump sum benefits payable under a registered group life policy may impact on an individual member's Lifetime Allowance, and any enhanced protection that they may have. Employees should seek advice on how membership of a registered group life scheme may affect their personal circumstances.

### How does the policy work?

We have designed this policy to finance death in service benefits. The benefits must be provided under a discretionary trust established on or before the policy start date. The policy will cover lump sum benefits payable on death and can include an additional lump sum. The Trustee(s) can use any additional lump sum to purchase dependants' pension in the insurance market.

The scheme administrator will need to register the scheme with HM Revenue & Customs (HMRC). You will need to provide confirmation of registration to us no later than 30 days after the policy start date.

We agree between us the terms before cover starts, this includes:

- the scheme's eligibility conditions;
- the type and amount of benefits.

We'll confirm in writing the amount of cover we'll provide. This cover will apply provided you continue paying premiums when they are due, no matter how many times you claim. If the policy is cancelled we'll continue accepting claims where they arose before cover was discontinued. You must provide us with the information we need to assess a claim.

## How does the policy work? *continued*

If you want to make a claim for a member who has died, you must tell us no later than two years after that member's death. If we can admit your claim, we'll pay the lump sum and any additional lump sum (if applicable) to you to pay out in accordance with your discretionary powers. The lump sum payment is free of all taxes up to the Lifetime Allowance.

The lump sum benefits paid to you do not form part of the deceased member's estate. Therefore it can be paid immediately without having to wait for probate to be granted.

## Your questions answered

### 1. What factors should be considered in deciding what benefits to provide?

The Registered Group Life Policy offers employers a flexible approach to meeting the death in service benefits promised to their employees. The policy enables an employer or trustee(s) to insure fully or partially any lump sum benefits, including any additional lump sum that may be used by the trustee(s) to purchase a dependant's pension in the insurance market.

If you have members with lump sum benefits above the Lifetime Allowance, you can consider providing cover under an Excepted Group Life Policy (EGLP), or equivalent single life policy. These are separate policies that can be used to provide benefits above the Lifetime Allowance without the tax charge. If you require further information on providing cover in this way please contact us for details.

#### 1.1 Who can be covered?

As soon as an employee satisfies the 'eligibility' and 'actively at work' conditions below they must be included in the policy.

There must be a minimum of five members when the policy starts.

#### 1.1.2 Eligibility conditions

The 'eligibility' conditions will need to be agreed between us before the cover starts and may include factors such as:

- the categories of employees to be covered;
- the minimum and maximum entry ages. Only people aged from 16 to 74 can be included as members;
- service qualifications.

### **Categories of employees**

You can choose to define eligible membership categories in a number of ways, for example by job grade, salary bands or job type (for example directors, clerical workers, manual workers). Membership must be compulsory for all employees within the defined category or categories. Eligibility conditions covering entry age, entry dates and service qualifications must be the same for each member within a defined category.

Both full and part time employees (that is those on a permanent contract working a reduced number of hours) must be eligible.

You should take account of any laws relating to discrimination or unfair treatment, such as those relating to age or sex discrimination and the treatment of part-time, fixed term or disabled employees.

### **Eligibility linked to pension scheme membership**

Eligibility is often defined as 'all members of the pension scheme' and pension scheme membership cannot be compulsory. Pension scheme members who elect to join the pension scheme within six months of their first opportunity will be regarded as having been included within the group life scheme on the date they joined the pension scheme. However, we won't consider a definition of eligibility where the 'first opportunity' would be at the invitation of the employer.

If cover is dependent upon membership of a pension scheme, then the pension scheme's current eligibility conditions must also be specified.

Where eligibility is linked to pension scheme membership our quotation assumes a satisfactory number of people will join. We call this the 'take up' rate. Your quotation shows our assumptions on such factors as the required minimum take up rate.

At the cover start date, and at each subsequent review date, we must have written notification:

- of the membership take up rate;
- that all new entrants have joined the pension scheme within six months of their first opportunity.

#### **1.1.3 'Actively at work' requirements**

**Actively at work** means that an employee has not received medical advice to refrain from work, is not absent from work or restricted from working due to illness or injury and is actively following their normal occupation. This means working at their normal capacity for the normal number of hours required by their contract, either at their normal place of business or at a location at which the business requires them to work.

Where the requirement to be actively at work refers to a particular day, which is not a working day, employees will be considered to be actively at work unless their medical record shows that they were suffering from a medical condition which would reasonably have been expected to prevent them from working normally.

We'll consider those employees on pre-arranged absence, for example statutory leave (maternity or paternity leave etc.) or holiday to be actively at work. This will not apply if their medical record shows that on the day when cover starts under the policy they were suffering from a medical condition which would reasonably have been expected to prevent them from working normally.

The requirements vary in different circumstances. If the 'actively at work' requirements are modified, specific terms will be set out in your quotation.

### **When a scheme is insured for the first time**

#### **Basis A – For new policies with fewer than 20 members**

Employees must be actively at work on the day cover starts. Those not actively at work must either provide such evidence as we require or be actively at work for five consecutive days before they are covered.

#### **Basis B – For new policies with 20 to 99 members**

Employees must be actively at work on the day cover starts. Those not actively at work on the day cover starts will be covered on the day they are next actively at work.

#### **Basis C – For new policies with 100 or more members**

The actively at work requirement will be waived for benefits below the automatic acceptance limit on schemes with 100 or more members.

**Automatic acceptance limit** (sometimes known in the group insurance market as the free cover limit) is the maximum level of cover that is automatically given (without medical underwriting) to employees who join the scheme at their first opportunity and satisfy the actively at work requirement. We express this limit as a level of benefit that would be paid on the death of a member. You should make sure we always know the current entitlement for members who qualify for a higher level of benefit in order to ensure that they receive the cover to which they are entitled.

### **When a scheme changes insurer**

If you're continuing cover for a previously insured group scheme, the actively at work requirement is waived for all existing insured benefits.

If any individual is not actively at work on the date cover switches to us, but is within the temporary absence period agreed with the previous insurer, we'll continue to provide cover to the end of that temporary absence period.

### **New members of an existing scheme at any time**

New members must be actively at work on the day they are eligible to join. We'll cover those not actively at work on the day cover starts, for their benefits, up to the automatic acceptance limit when they're next actively at work.

This requirement will be waived for new members of an existing scheme with more than 100 members.

### **Increases in benefit**

For benefit increases below the automatic acceptance limit the actively at work requirements will not apply (also see 2.2 for benefit increases above the automatic acceptance limit).

## **1.2 When will cover end?**

### **1.2.1 Under normal circumstances**

Members will not normally be covered under the policy when any of the following happens:

- they reach the terminating age set out in the policy (the earlier of the normal retirement age set by the employer or age 75);
- they no longer meet the eligibility conditions in the policy;
- they are no longer employed by an employer included in the policy;
- they are no longer employed in the UK except where we have agreed to provide cover in the circumstances described in **section 7**;

Cover is not available for people aged 75 or older.

### **1.2.2 Cancelling the cover**

You may cancel the policy at any time provided you do so in writing. The policy will continue until you cancel it provided you comply with its terms and conditions.

We can only cancel the policy for a material breach of its terms and conditions (such as a failure to provide essential information we've asked for to assess the risk or administer the policy or a failure to pay a premium within 30 days of the date when it is due). If we cancel the policy in these circumstances cover will end on the date the material breach occurred.

We won't backdate any cancellation and we'll charge premiums for the time the policy was running.

All cover will end when the policy is cancelled. However, we'll consider any valid claim that happened before the date cover was cancelled.

We'll refund any overpaid premiums.

### **1.2.3 Temporary absence**

If a member is away from work due to illness or injury and you still regard them as your employee, cover can be provided up to the policy terminating age.

If a member is away from work for reasons other than illness or injury and you still regard them as your employee, we will maintain cover for them for up to 12 months (or for up to 36 months with our prior agreement) at the level in force on the day before the absence began.

We may agree to extend cover for longer periods in some circumstances. For example if the member is called up as a reservist, or seconded to work that we agree is of national

importance, we'll do this for an indefinite period. You must tell us before if you need cover for any employee (whether you are continuing to pay them or not) so that we can agree the terms with you, and members can be informed of our agreement.

### **1.3 What types of cover are available?**

The following types of cover are available and can be either a fixed amount or a multiple of salary.

#### **a) Lump Sum Benefits**

Lump sum benefits can be either a fixed amount or a multiple of salary. The benefits can vary between different categories of membership, but must be the same basis for all members within a specified category.

#### **b) Additional lump sum to purchase a dependant's pension**

An additional lump sum can be insured and used by the trustee(s) to purchase a pension in the insurance market in the event of the death of a member. The additional lump sum must be on the same basis as the main benefit.

### **1.3.1 What is scheme salary?**

We must agree between us the definition of salary to be used. This normally means the employee's basic yearly salary. However, other definitions of salary can be used. For example, total pre-tax earnings from this employer for PAYE assessment over a 12 month period.

Any variable components of pay, such as bonus, commission, overtime and incentive payments, can be included and averaged where that is considered appropriate.

### **1.3.2 Optional additional protection**

The Registered Group Life Policy offers a range of additional options which are available at an additional cost.

#### **a) Ill health early retirement**

Members who retire early due to ill health can continue to be covered for a lump sum. The benefit amount cannot exceed the amount of benefit the member was entitled to immediately prior to leaving service.

#### **b) Early retirement**

Lump sum cover can be provided in respect of members who take early retirement, and for whom continued life cover is permissible under HMRC regulations. The benefit amount cannot exceed the amount of benefit the member was entitled to immediately before leaving service.

Additional lump sum benefits used to purchase pension benefits cannot be covered. This cover can only be provided up to the earlier of the policy terminating age or attainment of age 65.

### c) **Continuing or extended cover after the terminating age**

We are able to provide cover for members who wish to continue in active employment beyond the relevant policy terminating age. This is the age you normally expect your staff to retire, and is the one you will specify when the policy is prepared.

Any lump sum benefit can continue to be provided up until attainment of age 75. If you have selected a policy terminating age of less than 75, lump sum cover can be continued for all members who wish to continue in active employment beyond your selected policy terminating age.

We must agree in advance to what age you want to continue cover. This cover is available up to and including age of 74.

- **For all employees** – You can choose to continue cover for all employees who wish to work beyond their normal policy terminating age. A change to the terminating age will have to be agreed between us.
- **Selected employees only** – Where cover is required beyond the policy terminating age for a selected employee, such cover will be provided subject to medical evidence in each case and the terms will need to be agreed between us.

### d) **Redundancy Cover**

A member who has been made redundant can be covered for a defined period of up to two years. Individuals must be actively at work on their last working day immediately prior to redundancy.

This cover ends on the earliest of:

- the member finding alternative employment either on a part-time, full time or self-employed basis;
- the member reaching the terminating age of the policy;
- the end of the redundancy period is reached for the member.

## **1.4 Will increased earnings be covered?**

Cover will increase when the scheme salary increases provided it does not exceed the automatic acceptance limit. Increases that exceed the automatic acceptance limit will require underwriting (**see section 2.2**). Scheme salary can be updated annually, monthly or whenever an increase occurs but this must be agreed between us before the policy is set up.

## **2 Setting up the policy**

### **2.1 What are the requirements for setting up the policy?**

You must contact us to agree terms before the cover starts. We need a completed 'on risk instruction form' including any information requested in your quotation. We'll also need confirmation that a discretionary trust for the purpose of holding and distributing policy benefits is in place.

Within 30 days from the date the cover starts, we'll also require,

- a completed proposal form;
- a deposit premium or a completed direct debit mandate;
- membership data as at the cover start date, including details of previous underwriting decisions.
- details of long term absentees (i.e. those who have been absent from work for 90 days or more);
- Pensions Scheme Tax Reference (PSTR) number;
- full business address and postcode information for all scheme members to be covered.

We must be able to calculate the sum insured at each postcode.

If the risk differs from the quotation, we'll let you know what else we require and whether we need to change the premium. We allow a 15% variation in the number of members or their total salaries between quotation and on risk data but the quotation basis will be applied to the up-to-date information you provide.

If we don't receive any one of the requirements we ask for when they are due, we may cancel the policy.

For previously insured policies we'll normally accept the underwriting terms offered by the previous insurer up to the level of benefits they provided when the cover transferred to us. Special agreement will be needed in respect of benefits over £3,000,000. We'll need details of those members who have been medically underwritten, including those who have been subject to special terms.

### **2.2 Does any evidence of health have to be provided before members are covered?**

Group cover is intended to be provided on a non-discretionary basis where the 'eligibility' and the 'actively at work' conditions apply.

To reduce the need to medically underwrite all the members of a scheme, we'll set a limit called the automatic acceptance limit, below which, evidence of health will not be required. The automatic acceptance limit will be specified in your quotation and may be revised from time to time, for example, when the rate guarantee period expires.

For benefit amounts above the automatic acceptance limit, or for those members not eligible for the limit, our underwriters will ask for evidence of health. Therefore, you must let us know straightaway if the cover you need for a new member exceeds the automatic acceptance limit, or if an existing member's cover increases above this limit. We will need details of the members health and activities and an authority to contact the member's doctor for additional information. The member may complete a form in full or use our telephone data gathering process. Under the telephone data gathering process a qualified nurse will contact the member, at an agreed time, to conduct a telephone interview.

If our medical underwriting identifies that a member has a medical condition or risk or involvement in hazardous pursuits, we may impose special terms. This may result in an additional premium or cover restriction.

We'll also require health and activities information before we can consider cover for a discretionary entrant. We may agree to waive this requirement for a discretionary entrant who is to join before the date they are first eligible where it can be shown that they are newly recruited and the cover is required to replace cover with their immediate former employer.

### **2.2.1 Forward Underwriting**

Once we have agreed the terms of cover for a member these will apply to future increases and within the limits described below. We won't normally need further evidence of health for increases. There may be circumstances when our underwriters decline or limit forward underwriting for individual members.

- For policies of 50 lives or more we'll not normally need further evidence of health until a member's benefits reach £3,000,000 provided the member is actively at work.
- For policies of under 50 lives and provided the member is actively at work we'll not normally need further evidence of health for five years unless either the amount of total benefit increases by more than 15% per annum compound or a member's benefits reach £3,000,000.

If a member is not actively at work any increases will be restricted to the general rate of pay increases awarded by their employer, if they would have received a higher rate of increase it will be applied when they are next actively at work.

If you transfer a policy to us, for those members who have been medically underwritten and granted forward underwriting terms by the previous insurer, subject to you providing evidence that is acceptable to us, we will usually agree to honour those terms.

If we are unable to accept the previous insurer's forward underwriting terms then, irrespective of the size of scheme, we'll apply our forward underwriting basis used for policies of under 50 lives to the level of benefits and on the underwriting terms provided by that insurer at the time of the switch, for the balance of five years since they were last underwritten. Alternatively, you'll have the option of allowing us to fully underwrite any member with benefits above our automatic acceptance limit, should you wish to take advantage of our forward underwriting limits.

We'll tell you in writing the forward underwriting terms that apply.

Future increases that take a member's total cover above £3,000,000 will be subject to underwriting.

### **2.3 What happens if a claim arises before an underwriting decision has been made?**

We'll provide temporary cover while underwriting a member's benefits which exceed the automatic acceptance limit. This temporary cover will end when we offer underwriting terms or after 90 days from the date you notify us of the member's benefit amount, whichever happens first.

We'll backdate temporary cover to the date the member became entitled to the benefit if you tell us within 30 days of the member first becoming entitled to that benefit level.

Temporary cover doesn't apply:

- to discretionary entrants;
- to members for whom we or a previous insurer either refused cover or offered cover on non-standard terms;
- to members who have previously not provided medical evidence or any other requirements;
- to any part of the member's benefit that brings their total benefit to more than £3,000,000;
- if a member's death arises from a medical condition which happened, or for which they had treatment, routine monitoring, or underwent investigation during the 24 months immediately before their entry date (or date of an increase in benefits).

## **3. What premiums will be charged for the cover?**

We charge a minimum premium of £750 a year.

The premium we charge for a policy will depend on the cover you need and factors such as:

- the level of benefits;
- the eligibility and entry conditions;
- the age when cover ends;
- ages;
- genders;
- occupations;
- locations of the workforce;
- claims history.

After reaching an underwriting decision for a member we'll put into effect immediately the cover we can provide. For members who are medically loaded, you must tell us within 14 days of our notification of the underwriting decision if you are not happy to pay the loaded premium (**see section 3.2**)

### **3.1 How will we work out the premiums?**

#### **3.1.1 Individual costing basis**

We work out premiums using this method for policies with 5 to 19 members or, with our agreement, for policies with more members. The yearly cost of the policy will be the premium we need to cover the members for that year only. If the number of members increases to 20 or more, we may calculate premiums using the unit rate basis.

### **3.1.2 Unit rate basis**

We work out premiums using this method for policies with 20 or more members. To minimise administration, at the start of the rate guarantee period, we calculate a yearly rate that applies to all members. At the beginning of each year, we'll calculate a provisional premium, basing it on the policy unit rate and the total benefit in force on that date. If the number of members falls below 20 we will calculate from the anniversary date the premium using the individual costing basis.

### **3.2 Will there be any unexpected extra premiums?**

We usually guarantee unit rates and the rate tables underlying individually costed policies for two years. We'll review them when the rate guarantee expires and we set a new guarantee expiry date. The review will consider any changes in the details of insured people and other factors mentioned earlier in the section. It will also reflect any change in the claims we expect from policies of this type; interest rates; and the cost of administrating and distributing such policies.

We'll remove the guarantee and recalculate the premium if the number of members under the policy or total benefit provided under the policy or both change by 25% or more.

We may charge extra premiums for members who have undergone medical underwriting. Any extra premiums will only relate to the benefit we underwrite. The extra premiums will normally be worked out using the method for calculating the normal policy premiums and applying any additional loading to that part of the premium that relates to the underwritten benefit. Once we reach an underwriting decision we'll put into effect immediately the cover we can provide and will write to tell you. If you do not wish to pay the extra premiums you should tell us within 14 days of our written confirmation.

### **3.3 What commission is included within the premium?**

The standard rate of commission is 4%. However commission levels may be varied at the intermediary's request.

Your quotation reflects the commission rate that we have included.

### **3.4 Is there a discount for good claims history?**

There may be, as we consider past claims when working out premiums.

## **4. How does the accounting work?**

The policy operates on one-year accounting periods. Unless you agree an alternative with us, you will pay premiums in advance every year by direct debit. However, you can also pay monthly, quarterly or half-yearly or by other payment methods at an additional cost.

While we're waiting for accurate information from you, we'll charge you a provisional premium.

However, when we've calculated the accurate premium, you must pay any shortfall between this and the provisional premiums. If you've paid too much, we'll refund the difference to you.

### **4.1 What information is required for accounting purposes?**

We'll let you know what information we need at least 90 days before each yearly revision date.

#### **4.1.1 Individual costed policies**

We'll need a list of all members at each yearly revision date showing their:

- name;
- occupation;
- gender;
- date of birth;
- scheme salary or benefit;
- scheme benefit category;
- address and post code of work place;
- the date they joined or left.

You should also list members who are temporarily absent from work.

#### **4.1.2 Unit rated policies**

At each yearly revision date, we need information on:

- the total number of members per category;
- the total salary roll or benefit amount per category;
- each member whose benefits exceed the automatic acceptance limit; to whom we've applied special terms; who has extended cover; and who is temporarily absent from work.

We'll ask for more detailed information when the rate guarantee expires or when we need to recalculate the unit rate. The information needed at that time will be the same as is needed for individually costed policies.

## **4.2 How are accounts adjusted for members who join, leave or have benefit changes during the year?**

### **4.2.1 Individual costed policies**

For a policy where premiums are paid either monthly, quarterly or half yearly, the next premium will reflect the adjustment. However, any over or under-payment will be processed separately and you will be notified of the change.

For yearly paid policies the adjustment will only be collected or refunded immediately if it is more than £750. If it is still outstanding at the end of the policy year, it will be added to the next premium due, or collected as part of the policy termination process. This will reflect the amount and duration of cover we provided during the year. You must tell us of any changes within 30 days.

### **4.2.2 Unit rated policies**

We'll adjust your premium at the end of the policy year. This will reflect any salary increases or decreases, or membership changes within the scheme's defined benefit and eligibility conditions.

To remove the need for you to give us detailed records, we'll assume these changes occur halfway through the policy year. However for the members over the automatic acceptance limit a more accurate costing method is fairer and we'll charge for the time we are on risk for their benefits.

## **4.3 If the policy is cancelled mid-year will I lose any premiums I have paid in advance?**

No. We'll either refund overpayments to you or ask you to pay any outstanding premiums. We'll send you a final statement showing the cover we provided and the premiums you paid.

## **5. Claiming benefit**

This section deals with the common questions, which arise following a member's death.

### **5.1 How are claims made?**

If you wish to make a claim it is important you notify Zurich direct or via your Intermediary.

The death claim notification number is 0800 181 4004.

When you notify a claim, the claims team will ask you for details of the member's name, date of birth, cause and date of death if known. The more information that we can establish, the quicker we can assess the claim.

On receipt of a claim notification, the case will be allocated to a case manager who will be your main point of contact throughout the process. The case manager dealing with your claim will decide on the next steps having reviewed the initial notification details.

Our claims process involves no lengthy form filling. All claims are assessed over the telephone and are recorded. We'll inform you of the documentation we require to assess the claim.

We'll need an original of the member's death certificate.

We may need evidence of a member's earnings from you where individual data has not been received.

Please send originals of evidence requested. We do not accept photocopies of certificates. We'll send all original documentation back to you by recorded delivery. Once we have received our evidence requirements we'll then assess the claim.

If we can admit a claim, we'll make payment to you.

All payments will be in the currency of the UK even in respect of members based abroad and foreign nationals.

Please note that if the lump sum death benefit is more than 50% of the standard Lifetime Allowance, the scheme administrator will be required to report this to HMRC.

## **5.2 When do we need to know about a claim?**

Please notify us as soon as possible after a member's death. Any claims received later than two years from the date of the member's death will not be accepted.

## **6. What is not covered?**

All causes of death are covered, however, exclusions may apply as a result of underwriting for discretionary entrants or for members with benefits in excess of the automatic acceptance limit.

There are also limitations to the overall cover under the policy.

### **6.1 Catastrophe limit**

Unless otherwise agreed, the total benefit payable under the policy (or associated policies if more than one is insured with us) will be limited to a maximum of £100,000,000 where deaths occur directly or indirectly as a result of a catastrophe and may be reduced further for certain buildings or postcodes. Any catastrophe limits will be detailed in your quotation and policy schedule.

A **catastrophe** is defined as:

'One originating cause, event or occurrence or a series of related originating causes, events or occurrences, resulting in the death of more than one member, irrespective of the period of time or area over which such originating causes, events or occurrences take place and irrespective of the period of time over which such deaths occur.'

Or, in respect of terrorist activities, a catastrophe is defined as:

'One originating cause, event or occurrence or a series of originating causes, events or occurrences, resulting in the death of more than one member, which on the balance of probability results from persons acting in concert or in accordance with a plan or design, irrespective of the period of time or area over which such originating causes, events or occurrences take place and irrespective of the period of time over which such deaths occur.'

By 'associated policies', we mean any policy where we provide the benefits payable on the death of any individual in connection with their employment with an employer included in the policy. This also extends to any company, partnership or organisation, which together with the employer, form the same group or part of the same group.

## **6.2 Group travel limit**

The total amount payable under the policy (or associated policies if more than one is insured with us) in respect of members travelling together on business (by any means) will be £25,000,000. This limit will apply from the time the members depart to the time they arrive at their destination.

Claim payments may be withheld if:

- material information relating to the policy or a claim that we have asked for, is outstanding; or
- the premiums we have asked for have not been paid.

We may also restrict cover for employees based in certain overseas locations.

## **7. Can cover be provided for an employee who is not based in the UK?**

Most of the scheme's members must be wholly employed in the UK. UK based members travelling abroad on business will not normally be subject to special terms.

You must tell us about members not based in the UK.

### **7.1 Members seconded abroad**

We may agree to cover any member working outside the UK but please note all premiums and benefits will be paid in the currency of the UK.

If we agree to cover members working outside the UK we may apply special terms and conditions if we consider this to be appropriate following our risk assessment.

We'll specify in your quotation the terms that apply to any members seconded abroad.

Members on secondment must meet the following conditions for cover under the policy:

- they must have a contract of employment with a UK employer covered by the policy;
- their period overseas should not exceed three years unless they are sent to a company within the same group of companies when the period abroad may be longer.

## **8. Taxation of policies**

We've based the information in this section on our understanding of current legislation and HMRC practice. Future changes in law and tax practice could affect how much tax is payable.

Our understanding of the tax rules are as follows:

### **Premiums**

Premiums are usually tax deductible and they can be offset against your profits for tax purposes and are not treated as a benefit in kind for employees.

### **Benefits**

Lump sum benefits paid from the policy are not subject to income tax and if set up under a discretionary trust, are not subject to inheritance tax. However, if the lump sum benefit paid to a beneficiary takes the member's benefits from all registered schemes above the Lifetime Allowance, then a tax charge of 55% will be due on any benefits above the Lifetime Allowance.

Dependant's death in service pensions do not count towards the deceased member's Lifetime Allowance and will be treated as earned income in the hands of the recipient.

This information is based on our current understanding of current tax law legislation and HMRC practice. Employers should refer to their advisers for specific advice on the tax position for their company. The tax treatment detailed above may not apply to overseas members of the policy.

## **9. Continuation option**

This policy doesn't provide an employee leaving the company with the option to buy a personal policy to replace the cover they lose.

## **10 Further information**

### **The Company**

This Registered Group Life Policy is issued by Zurich Assurance Ltd, whose head office is in the United Kingdom. Its address is:

Zurich Assurance Ltd,  
UK Life Centre,  
Station Road,  
Swindon,  
SN1 1EL,  
UK

### **Surrender value**

This group insurance doesn't acquire a surrender value.

### **Queries and complaints**

For further information, or if you ever need to complain, contact us at:

Zurich Corporate Risk,  
PO BOX 3512,  
Swindon,  
SN3 9AH  
UK  
Telephone: 0800 141 2002

You can get details of our complaints-handling process on request. If you're not satisfied with our response you can complain to:

Financial Ombudsman Service,  
South Quay Plaza,  
183 Marsh Wall,  
London,  
E14 9SR  
Telephone: 0845 080 1800

Email: [complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)

Website [www.financial-ombudsman.org.uk](http://www.financial-ombudsman.org.uk)

This service is free and using it won't affect your legal rights.

**Compensation**

If we're unable to meet our financial obligations in full you may be entitled to help from the Financial Services Compensation Scheme (FSCS). The compensation you'll receive will be based on their rules.

If you need more information you can contact the FSCS helpline on 0207 7892 7300, write to the address below or visit the website at [www.fscs.org.uk](http://www.fscs.org.uk).

Financial Services Compensation Scheme,  
7th Floor,  
Lloyds Chambers,  
1 Portsoken Street  
London,  
E1 8BN

**Law**

The policy is issued subject to the law of England.

You may enforce the benefits and rights granted to you under the policy. Nothing in the policy shall confer or is intended to confer rights on any third party or parties including the members.

Please read this document with the quotation. This document doesn't override the Terms and Conditions, which contain full details of the policy.

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

Zurich is creating a great reputation for service innovation, exceptional people and service delivery in the Corporate Risk market.  
**Zurich Corporate Risk – Always working for your business**