Zurich Corporate Risk

Group Income Protection Policy

Technical guide

Group Income Protection Policy

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 Group Income Protection Policy.

The guide should be read together with your quote 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 quote.

We'll issue the policy when all the details of your cover have been finalised, any requirements set out in the quote have been met and we've 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 Group Income Protection Policy is a 'non-consumer' contract and 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.

Contents

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 policyholder. Where we refer to '**member**' we mean a person who is included in the policy.

Where equity partners of a partnership or members of a limited liability partnership (partnership members) are included in this arrangement, references to:

- 'employee' or 'employees' should be interpreted to include partnership members
- 'normal occupation', 'employment' and 'employed' should be interpreted as actively working in the business of the partnership or limited liability partnership as appropriate
- 'contract' or 'contracts of employment' should be interpreted to include the partnership members' partnership agreement.

However, membership must be compulsory for all partnership members and not be voluntary or linked to membership of a pension scheme.

Optional additional protection is not available to partnership members.

Its aims

- To provide insurance that helps you pay your employees a regular monthly income if illness or injury stops them working and earning.
- To provide you with the option to cover associated expenses such as pension scheme contributions and employer's National Insurance contributions.
- To provide a reduced replacement income in proportion to an employee's loss of earnings if illness or injury forces them to take a part-time or lower-paid job.
- To offer you a range of options to tailor the cover to your budget and employment philosophy.

Your commitment

- To provide a fair presentation of the risk.
- 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're due.
- To tell us about any claims as soon as possible, but in any event within the timescales set out in **section 5.3**.
- 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 policy but whom you want to be covered.
- To let us know if a member's benefit should end.
- 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 reduce the benefits we pay if a member receives other income arising from their incapacity (**see section 5.5**)
- Receiving benefits may disqualify members from receiving some state benefits which are means tested and other state benefits payable as a result of incapacity that they might otherwise be entitled to.
- We may exclude certain causes of claim for some members (**see section 6**).
- We may revise the policy terms and conditions or rates where:
  - the number of employees included in the policy exceeds 9 or falls below 10
  - you fail to provide a fair presentation of the risk
  - the taxation of policy benefits, premiums and ancillary services 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. This does not apply to individual costing policies
  - you change your location or the nature of your business
  - the state changes the basis of calculation, terms and conditions for payment or taxation of state benefits
  - an employee resident overseas changes location.
- 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.

How does the policy work?

- We agree between us the terms before cover starts, this includes:
  - the policy's eligibility conditions
  - the type and amount of benefits
  - how soon we'll start, and for how long we'll pay, the benefit
  - the definition of incapacity you require; and
  - whether the benefit payments will increase each year.
- We'll confirm in writing the amount of cover we'll provide. This cover will apply provided you continue paying premiums when they're due, no matter how many times you claim. We'll continue accepting claims where incapacity arose before cover was discontinued. You provide us with the information we need to manage a claim.
- We pay benefits monthly in arrears from the end of the 'deferred period' for as long as claims are valid.

Your questions answered

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

We offer you a wide choice of cover to meet your organisation's objectives. Before the policy starts, or changes in any way, we must agree with you the formula for calculating any member's benefit and the circumstances in which a claim will arise.

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 at least 2 members when the policy starts, and an aggregate of 3 members under this and any linked policy.

Where partnership members (equity partners of a partnership or members of a Limited Liability Partnership) are to be included, membership must be compulsory and not be voluntary or linked to membership of a pension scheme.

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 69 can be included as members, the maximum entry age for integrated policies is 64 (**see section 1.3.1.2**)
- 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 (e.g. 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 the 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 12 months of their first opportunity will be regarded as having been included within the Group Income Protection Policy on the date they joined the pension policy. 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 quote assumes a satisfactory number of people will join. We call this the 'take up' rate. Your quote shows our assumptions on such factors as the required minimum take up rate.

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

- of the membership take up rate
- that all new entrants have joined the pension scheme within 12 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 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 records show 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 quote.

When a scheme is insured for the first time

Employees must be actively at work on the day cover starts. Those not actively at work on the day cover starts will only be covered when they meet the following requirements:

- for policies with less than 20 members, they must return to work and have been Actively At Work for 5 consecutive working days.
- for policies with 20 or more members, they must return to work and have been Actively At Work.

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 policy at their first opportunity. We normally express this limit as a salary level and you should make sure we always know the current salary of members who earn more than the limit in order to ensure that they receive the cover to which they're entitled.

When a scheme changes insurer

If you're continuing cover from a group arrangement previously insured with another insurer, we'll only cover any employee who is absent from work through illness or injury on the day before cover transfers to us, from the day they return to active employment. An employee not actively at work will be covered for benefits up to the automatic acceptance limit, or for benefits we've accepted following underwriting by a previous insurer, when they're next actively at work.

When the automatic acceptance limit or terminating age increase or the cover increases due to a change in the benefit calculation basis when a scheme transfers from another insurer

If the automatic acceptance limit or terminating age increase or the cover increases as a result of a change to the basis of calculation of benefits from that applicable under the previously insured policy, individuals who are not actively at work on the day before cover transfers to us will not be covered for the increase in benefit basis until they've returned to work and been actively at work for five consecutive days.

If the Member isn't Actively At Work on the day they are eligible to join, they will not be covered until they have met the Actively At Work requirements that would be applicable to a new policy with the same number of members.

Increases in benefit at any time

For benefit increases resulting from an increase in salary not requiring underwriting (see also **section 2.2** for benefit increases above the automatic acceptance limit) members must be actively at work on the effective date of the increase in their cover. Those who do not qualify will become entitled to their increased cover when they're next actively at work.

1.2 When will cover end?

1.2.1 Under normal circumstances

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

- they reach the terminating age set out in the policy (the earlier of the age set by the employer or age 70)
- they no longer meet the eligibility conditions in the policy
- they're no longer employed by you (except where we've agreed to provide cover in the circumstances described in **section 5.2.3**)
- they're no longer employed in the UK except where we've agreed to provide cover in the circumstances described in **section 7**
- they reach the end of the temporary absence period agreed.

Cover is not available for people aged 70 or older – or state pensionable age or older where the State Employment and Support Allowance received is to be offset (**see section 1.3.1.2**).

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 cancel the policy if the aggregate membership under this and any linked policy falls below 3 lives or 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's 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 continue any claims already in payment and consider any valid claim where incapacity occurred before the date cover was cancelled.

We'll refund any overpaid premiums. We'll not pay claims or refund premium where to do so would be in breach of law or regulation or would violate, or may risk violating, any financial sanctions, laws or regulations.

1.2.3 Temporary absence

If a member is away from work for reasons other than illness or injury and is still receiving pay they'll be covered for up to 12 months 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 regular reservist, a volunteer reservist or seconded to work that we agree is of national importance, we'll do this for an indefinite period.

If the member is away for reasons other than illness or injury and is not receiving pay the member can be covered for up to 12 months at the level in force on the day before the absence began provided that:

- There is an agreed date of return in writing, between the employer and employee.
- The employee remains an employee and has a right to return to work to the same occupation.
- The absent member continues to be included in the data and premiums are paid in respect of the member.

Where cover is continued during unpaid temporary absence the Income Benefit will be paid one month in arrears from the later of:

- The Deferred Period or
- The agreed date of return

1.3 What types of cover are available?

The section below describes the different types of cover available and the maximum amount we'll pay.

The maximum amount we'll pay in the event of a claim relates directly to the member's salary immediately before they become incapacitated. We'll limit the maximum yearly amount of income benefit we pay for each member to the amount stated in your quote. The maximum amount includes any employee pension contributions and applies irrespective of the type of cover or chosen benefit formula.

1.3.1 Income protection benefit

There are two types of cover available.

1.3.1.1 Gross pay policies

You choose the level of income benefit, it can either be a fixed amount or percentage of the member's gross pay. This can be up to 80% of policy salary, inclusive of the member's pension contributions and with no deduction where the members benefit would be subject to PAYE. Where the member's benefit would be tax exempt, for example, equity partners, the maximum level of benefit we'll cover is 50%. If you choose to have the benefit based on a percentage of gross pay, you can decide whether you want to deduct any amounts. The deductions available to offset against the basic benefit are:

- the basic level of Employment and Support Allowance (ESA)
- the basic level of Employment and Support Allowance plus the Support component (ESA+SC)
- a fixed amount specified by you.

The deduction is always made irrespective of whether any benefits are received or applied for.

In the event that the Department for Work and Pensions ceases to publish a figure for any state incapacity benefit, we'll continue to apply the last published amount increasing the amount annually by the same percentage that the retail prices index increased over the preceding 12 months.

The amount will not be reduced in a deflationary period where there is an annual decrease in the retail prices index.

The maximum amount we'll pay in the event of a claim will be limited so as to help to ensure there is a financial incentive to return to work.

- If the benefit from a gross pay policy would be taxable, (for example, because the member is subject to PAYE), the maximum level of benefit we'll cover is 80% of policy salary (**see section 1.3.2**). Inclusive of the employee's pension contributions and with no deduction.
- If the benefit from a gross pay policy would be tax exempt, (for example, for equity partners), the maximum level of benefit we'll cover is 50% of policy salary.

1.3.1.2 Integrated policies

We expect the member to apply for Employment and Support Allowance. If the member doesn't qualify for this benefit we'll pay the full benefit without deduction.

The maximum benefit we'll pay under an integrated policy is 80% of policy salary, including member's pension contributions. We'll deduct the Employment and Support Allowance the member receives from this and pay the balance.

Integrated policies are not available for:

- members with a terminating age beyond their state pension age
- equity partners
- instances when the deferred period is less than 28 weeks.

If a member doesn't apply for Employment and Support Allowance we'll calculate their benefits as if they had applied successfully for the allowance and qualified for the basic allowance.

1.3.2 What is policy salary?

We must agree a salary definition with you. This is normally the employee's basic yearly salary. However, we can use other definitions, such as, total pre-tax earnings from the employer for PAYE assessment over a 12 month period or other forms of taxable earned income that would stop in the event of incapacity.

We recognise that dividends often form a part of a company director's earnings. So, for directors of small limited companies, we're prepared to regard their earnings as gross salary plus their share of the company's pre-tax profit. Their percentage shareholding during the accounting period will determine the relevant share. We'll also need to see the latest company accounts, noting the salary and profit share taken for the accounting period. However, we won't use a salary from a different period to that covered by the last accounts. If the company will continue trading during the claim period, the claimant must agree on us considering any ongoing salary or profit share as continuing income (**see section 5.5** for details of the treatment of continuing income from an employer).

Any variable pay components, such as bonus, commission, overtime and incentive payments can be included. However, if they represent more than 20% of policy salary or change by more than 10% a year, we must average them over a three year period or any shorter period that the member received them.

Policy salary for equity partners will be the member's share of pre-tax profit after deducting trading expenses. This follows the assessment for Income Tax agreed by HMRC. We normally expect this to be averaged over three years or a shorter period that the member received it. However, our scheme underwriters can decide to waive this limitation if the income is stable. We can't consider drawings as income.

1.3.3 Optional additional protection (not available to equity partners)

- **Employer's pension scheme contributions**
  You may insure a yearly amount to maintain your ordinary yearly contributions to a pension scheme. We can cover most types of occupational and group personal pension schemes. The total of your pension scheme contribution insured as additional protection for a member must not exceed 35% of policy salary or £75,000 a year – whichever is lower.
- **Employer's national insurance contributions**
  You can insure an amount to cover the employer's national insurance liability on the member's income benefit. We'll adjust your cover for any changes in the level of national insurance contribution rates. However, any such changes won't affect the amount we'll pay for members already claiming.
- **Employee's pension scheme contributions**
  You can insure a yearly amount to maintain your employees' normal contributions to a pension scheme provided this, when added to their income protection benefit, does not take their insured benefit above 80% of their policy salary.

We don't cover employer and employee pension contributions that change between members or vary over time. For example, we don't cover arrangements where no standard contribution rate exists and members can decide to vary contributions, such as individual personal pensions and additional voluntary contribution policies. If contribution rates vary by age, we'll base the benefit on the contribution rate when incapacity started.

1.3.4 Lump sum option

To qualify for the lump sum benefit, the member must meet the suited definition of incapacity at the end of the specified limited term of Income Benefit payment, (that is two, three, four or five years' of benefit payment), you can ask us to pay a lump sum of up to four times their yearly salary provided that the lump sum is not more than £1,600,000.

Where a member is within five years of the policy's terminating age when a lump sum becomes payable, their benefit will be restricted by multiplying it by the number of complete months remaining to the terminating age divided by 60.

Cover for a member under the policy will end following a lump sum payment.

1.4 How is incapacity defined?

You can choose the definition of incapacity from the list of options below. We'll specify in your quote the definition of incapacity that applies.

We've a 'standard' definition that normally applies to most members.

It's possible to arrange cover with combinations of definitions, for example, the 'standard' definition below applying for the first two years of benefit payment and then the 'suited' definition below replacing it.

To include some occupations we may need to use a 'suited' definition of incapacity.

We'll apply the 'suited' definition if a member's occupation requires them to hold a licence or certificate which depends on them being physically or mentally fit, for example, HGV drivers, PSV drivers or pilots. We may also apply it to other occupations.

For any of the following definitions of incapacity, we'll not consider the member to meet any definition of incapacity if the reason for the member being unable to perform the material and substantial duties is due to a breakdown in an employment relationship.

a) **Standard**
   We consider a member incapacitated if they're unable, because of illness or injury, to perform the material and substantial duties of their current employment and are not doing any paid work.

b) **Suited**
We consider a member incapacitated if they're unable, because of illness or injury, to perform the material and substantial duties of their current employment, or any other occupation to which they're suited by their transferable skills at that time and are not engaged in any paid work.

Any suited occupation should provide reasonable, though not necessarily comparable, salary and status to the current occupation.

When we assess transferable skills we'll consider training and experience.

c) **Benchmark**
We consider a member to be incapacitated if they're unable because of illness or injury, to perform the material and substantial duties of a benchmark occupation and of their employment and aren't engaged in any paid work. The benchmark occupation will be one you select and we agree when setting up the policy. It will relate to a specific category of members and be a representative substitute generic occupation.

'**Material and substantial duties**' are the essential activities for which a member is employed that take up a significant proportion of their time, which cannot be reasonably omitted or modified by them or their employer.
These activities don't include:

- travel from the member's residence to their place of work
- working in excess of 48 hours a week.

Where we asses the duties of a 'suited' or 'benchmark' occupation, they'll be those performed in the occupation generally.

1.5 When will benefit payments start?

Benefits become payable at the end of the 'deferred period' for valid claims (**see section 5**).

The '**deferred period**' is the period of time we don't pay benefits, following the member first being unable to work through illness or injury.

You can find your deferred period in your quote. The deferred period may be 8, 13, 26, 28, 41 or 52 weeks. However, for integrated policies the minimum deferred period is 28 weeks.

We'll pay the benefits monthly in arrears while the member is incapacitated.

We may add a member's periods of incapacity together to determine when the deferred period ends. We'll do this if:

- the member suffers separate periods of incapacity from the same cause lasting at least five days; and
- the total time that has elapsed since the first period started doesn't exceed twice the deferred period.

1.6 For how long do you want the benefits to be paid?

You can specify how long you want us to pay benefits. We'll usually pay benefits up to the terminating age for valid claims.

Alternatively, you can select a 'limited period' for us to pay benefits. This means we can agree to pay for a period up to two, three, four or five years only in respect of an incapacity connected directly or indirectly to the same cause.

1.7 Can benefit in payment be inflation protected?

We can agree to a yearly compound rate of increase to the benefits. Where you require this, we'll increase the benefits on the anniversary of the date they started. The rate of increase can be set to one of 2.5%, 3% or 5% and we'll limit the increase to the yearly change in the retail prices index, if less, if this is requested.

Benefits will not be reduced in a deflationary period where there is an annual decrease in the retail prices index.

1.8 Will increased earnings be covered?

We'll increase cover when the policy salary increases, provided it doesn't exceed the automatic acceptance limit. Increases exceeding this limit will require underwriting (**see section 2.2**). You can update the policy salary annually, monthly or whenever an increase occurs, however, you must agree this with us before we set up the policy.

1.9 Continuing cover after the terminating age

This cover is only available with no deduction or a fixed deduction for state benefits. It's not available if you selected integrated benefits (**see section 1.3.1.2**).

We're able to provide cover for members beyond their relevant terminating age, this is the age that you agree with us when the policy is prepared.

We must agree in advance to what age you want to continue cover. This cover is available up to and including the age 69.

Where you elect to continue cover, members will have to be actively at work when they reach their relevant policy terminating age and may be subject to underwriting. Where the member is not actively at work, for any reason, they'll not be covered until they've returned to work and been actively at work for five consecutive days.

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 our quote.

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 evidence of previous underwriting decisions.

If the risk differs from the quote, we'll let you know what else we require and whether we need to change the premium. We allow a variation in the number of members or their total salaries between quote and on risk data but the quote basis will be applied to the up-to-date information you provide. The variation allowed is as follows for the aggregate membership of the policy and any linked policies:

- for less than 10 members – the quote basis will apply unless the number of members exceeds 10 lives, if this occurs we may need to provide a new quote on a unit rated basis
- for 10 to 19 members – the allowable variation is 20%
- for 20 or more members – the allowable variation is 15%.

If we don't receive any one of the requirements we ask for when they're due, the cover will end.

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. We'll need evidence of those members who've been medically underwritten, including those 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 policy, 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 quote 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'll need details of the member's health and activities and an authority to contact their doctor for additional information. The member may complete a form in full or use our telephone data gathering process. In 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 conditions 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're first eligible where it can be shown that they're newly recruited and the cover is required to replace cover with their immediate former employer.

2.2.1 Forward underwriting

Once we've 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 provided the member is actively at work. There may be circumstances when our underwriters decline or limit forward underwriting for individual members.

- For policies of 20 lives or more, we won't normally need further evidence of health.
- For policies of under 20 lives, we won't normally enquire again for five years or unless the total amount of benefit increases by more than 15% compound in any 12 month period.

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

If we're unable to accept the previous insurer's forward underwriting terms then, irrespective of the size of policy, we'll apply our forward underwriting basis used for policies of under 20 lives. We'll consider the level of benefits and the underwriting terms provided by the previous insurer at the time of the switch and where we agree they'll apply 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.

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

When a member's benefits require underwriting, we'll provide temporary cover for a maximum of 120 days for that benefit while we wait for the information and do the underwriting.

Temporary cover will commence from notification, however, 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 will end when we offer underwriting terms, or after 120 days, whichever happens first.

Temporary cover doesn't apply to:

- discretionary entrants
- members for whom we or a previous insurer refused cover or offered cover on non-standard terms
- members who've previously failed to provide us or a previous insurer with medical evidence or any other requirements asked for

- members' benefit (or any part of it) that brings their total income benefit to more than £300,000 a year; or
- members whose incapacity results from a medical condition that happened, or for which they had treatment, routine monitoring or underwent investigation during the 24 months immediately before the date they qualify for inclusion in the policy (or date of an increase in benefits).

3. What premiums will be charged for the cover?

We charge a minimum premium of £450 a year.

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

- the amount of income benefits and supplementary benefits (if any)
- the eligibility and entry conditions
- the deferred period
- your chosen incapacity definition
- your maximum income benefit payment period
- the age when cover ends
- the rate by which we increase income benefit payments (where this is included)
- ages
- genders
- job titles/occupations
- locations of the workforce
- claims history.

After reaching an underwriting decision for a member, we'll offer immediate cover. 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**).

We do not charge for members for whom we're paying benefits.

3.1 How will we work out the premiums?

Normally, for schemes with 10 or more lives, 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. We call this calculation method unit rated.

Normally, for schemes with fewer than 10 lives at the start of the rate guarantee period, we calculate a table of rates. At the beginning of each year, we'll calculate a provisional premium, basing it on the total benefit for each member and the individual rate that applies to them. We call this calculation method individual costing.

3.2 Will there be any unexpected extra premiums?

We usually guarantee unit rates 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 rate(s) and recalculate the premium when:

- the number of members exceeds 9
- the number of members under the policy or total benefit provided under the policy change by 25%. This does not apply to individual costing policies
- the number of members under the policy falls below 10.

3.3 What commission is included within the premium?

The standard rate of commission is 12%. However, commission levels may be varied at the intermediary's request.

Our quote reflects the commission rate which is shown as a percentage of the premium.

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'll 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.

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, when we need to recalculate the rate(s), for individual costing policies or when the number of members falls below 10.

The information needed at that time will include a list of all members showing their:

- name
- job titles/occupation
- gender
- date of birth
- policy salary or benefit
- benefit category
- workplace address and location, by reference to the geographical postcode of the building
- the date they joined or left.

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

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

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 policy's defined benefit and eligibility conditions.

For individual costing policies this will reflect the period for which the level of cover was provided in respect of each member.

For unit rated policies 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?

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 when a member becomes incapacitated.

5.1 When can claims be made?

You can claim at any time if the policy is in force or the member's incapacity began when the policy was in force (**see section 5.3**).

5.1.1 Under what circumstances?

We'll consider a claim when we're notified of a member's incapacity. The benefit will be paid at the end of the deferred period.

5.1.2 How ill or injured must the member be?

The member's illness or injury must satisfy the definition of incapacity shown in the policy schedule.

5.1.3 How will this be assessed?

Experience shows that the longer someone is absent from work, the less likely it's that they'll return successfully to their job. There is a much greater chance that we'll be able to help someone to return to a full and active life, including resumed employment, if we can work with you and the member to establish the nature of the problem they face and which is preventing them from working, at an early stage. We ask that you notify us directly or via your financial adviser if it becomes clear that the member is incapacitated and unable to work. It will allow us the opportunity to identify the likelihood of long-term absence and advise you accordingly.

Please notify us by telephone on 0800 181 4004.

When you notify us of a claim, the claims team will ask you for such details as the member's name, date of birth, cause of incapacity, date of event and policy number. The more information you can provide the quicker we can assess the claim.

When we receive a claim, 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 usual claims process involves no lengthy form filling. We initially assess and record all claims over the telephone.

We'll call you to undertake an initial briefing interview. This will involve obtaining details about the circumstances of the claim. The case manager will ask for basic details, including the member's occupational duties, salary and reason for and duration of absence to date. The member doesn't need to be involved at this stage.

The call will be recorded and will form the basis of our assessment. If the details given in the call are incorrect or have changed, you'll need to tell us before you sign the employer declaration. A recording of the call is available upon request. If the member doesn't engage with the assessment we'll be unable to accept the claim.

As soon as we have your consent to do so (we can take this verbally), the claims manager will arrange a convenient date and time to undertake a full telephone interview with the member. This will involve discussing full details of the member's incapacity and occupation. The aim is to assess objectively the nature of the incapacity and determine whether or not the member could undertake the essential tasks involved in their occupation.

Under the Equality Act 2010 you've to make appropriate changes to working conditions for members who are disabled if this helps them continue in work, unless it's unreasonable to do so.

The call will be recorded and will form the basis of our assessment. If the details given in the call were incorrect or have changed the member will need to tell us before they sign the employee declaration and consent which also gives their consent for us to obtain any medical or other information we need to assess the claim. A recording of the call is available to the member upon request. If the member doesn't engage with the assessment we'll be unable to accept the claim.

We'll request medical information from the member's general practitioner plus any relevant hospital notes and reports. This will provide us with full details of the current medical condition and the history of symptoms. Where necessary, we'll also seek a report direct from any treating hospital specialist.

We may occasionally ask for an independent examination or a home visit to progress the claim. The purpose of a home visit is to gather information to aid our assessment, help the member's recovery and assist with the implications of long-term absence. We may also ask the claims visitor to meet you and, in certain circumstances, you and the member together. We'll arrange appointments in advance for these visits.

We promise to inform you of progress throughout our assessment.

Once we have all the evidence we need, we'll confirm whether we've accepted the claim, together with the benefit we'll pay. We'll also express an opinion regarding the expected duration of the claim and our proposed management plan.

To ensure ongoing validation of the claim, we'll perform periodic reviews. This will involve further telephone discussions with you and the member. We may also need to obtain further medical and other evidence.

5.1.4 Rehabilitation

Rehabilitation is the process of helping the member return to work safely at the earliest opportunity, thereby reducing the cost of long-term illness to you.

Active rehabilitation and return to work programmes are an integral part of our claims management process. They're designed to help members regain their health and return to work, wherever possible, maximising the member's contribution to your organisation.

We have the services and advice of independent experts who specialise in the various aspects of rehabilitation. Our rehabilitation partners provide a range of options covering a multitude of disabilities. They're able to work with you and the member and, where appropriate, implement a rehabilitation programme and timetable that helps the member in their attempts to reintegrate back into the workplace.

If a member is motivated to return to work but their condition prevents them returning to their own occupation, we have the facility to offer a vocational assessment that may be able to match the member's qualifications and experience with work opportunities within the organisation. A vocational assessment will take into account the member's functional limitations and take into consideration the retraining and other requirements necessary.

5.2 For how long will the benefit be paid?

We'll pay the benefit monthly in arrears, until the earliest of:

- the member returning to work or no longer satisfying the terms and conditions
- the member no longer satisfying the definition of incapacity
- the member reaching the terminating age specified in the policy
- the member retiring
- the member leaves service except where **section 5.2.2 or 5.2.3** apply
- the member undertaking any form of employment without our agreement
- the member fails to follow medical advice
- you, or the member fail to provide the evidence or consent to obtain the evidence required to assess and manage the claim
- you or their employer fail to facilitate or the member does not engage with a reasonable return to work plan
- the benefit period ending under a limited term policy
- the member dying.

5.2.1 What happens if the member's illness or injury means that they work on a part-time basis or in a reduced capacity?

We'll consider paying a benefit in proportion to the reduction in the member's earnings, with an allowance for inflation and for loss of state benefits.

We'll consider a claim for partial benefits even if a full claim has not been paid.

5.2.2 What happens if a member leaves service during the claim?

If this happens, you should consult us as soon as possible.

A member who is incapacitated and leaves service after the end of the deferred period will cease to be a member and benefits will not continue to be paid to them unless you tell us in advance and we consider the circumstances to be satisfactory. We'll decide whether we'll agree to pay the benefit direct to them after the deferred period and will consider factors including whether:

- the adjustments required under the Equality Act 2010 have been evaluated or implemented where the member is disabled
- we've agreed that the claim is, and is likely to remain, valid.

You should inform members that if we pay them benefit direct, this may reduce their entitlement to state incapacity benefits, for example Employment and Support Allowance. Fringe benefits arising from employment (e.g. Death in Service Benefits) will also usually stop. On termination of employment, payments from this policy in respect of any employer pension contributions or National Insurance Contributions will also stop.

Where benefit is paid direct, UK basic rate tax will be deducted from the payments we make, however the ex-member is responsible for declaring this income to their tax office.

If a member who is a partner in a firm where the firm is the policy owner, and the partnership agreement requires them to leave the partnership if they're incapacitated, we'll continue paying benefit direct to them.

5.2.3 What happens if an incapacitated member transfers to a new employer under TUPE?

If a member who is incapacitated transfers to a new employer under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) we may agree to pay the benefit to the new employer. You must submit a request in advance and all the required documentation must be completed satisfactorily by you, the new employer and the member.

Where we agree to continue cover for the member we'll pay benefits in the event of a valid claim to the new employer under the same terms and conditions.

If we agree to continue cover for a member, it will cease on the earliest of any of the events in **section 5.2** and the following:

- the member no longer being incapacitated unless a claim can be made under **section 5.6**.
- the member becoming eligible for cover under another Group Income Protection scheme.

5.3 When do we need to know about a member for whom you wish to claim?

You should tell us as soon as possible.

If your policy has a deferred period of 8 weeks, tell us as soon as the member's doctor has told them they're likely to be off work due to illness or injury for longer than eight weeks.

If your policy has a deferred period of 13, 26, 28, 41 or 52 weeks and the medical practitioner believes the member's illness or injury will last longer than the deferred period, you should tell us no later than four weeks after Incapacity. However, you must tell us at least eight weeks before the end of the deferred period.

We'll not be able to pay any benefit for any time before you notify us of a claim, unless we agree that the medical evidence supports a backdated claim.

Where you notify us of a claim but the member fails to provide the required declarations and consent to assess the claim within 30 days from us requesting it, we'll not backdate the claim

5.4 Who pays for medical evidence?

Where we ask for medical evidence we'll pay for it.

5.5 Does other income received by an incapacitated member affect the benefit from this insurance?

Other income received by the member will be deducted so that when added to the income benefit it does not exceed the relevant maxima.

If the member's income benefit is subject to PAYE the maximum will be the greater of 80% of:

- the member's pre incapacity earnings
- or the member's policy salary

If the member's income benefit is subject to Schedule D the maximum will be the greater of 50% of:

- the member's pre incapacity earnings
- or the member's policy salary.

Other income will include but is not limited to:

- payments from the employer unless they were being received before the start of incapacity.

Payments from a retirement pension unless:

- they were being received before the start of the incapacity
- they become automatically payable as a result of the member reaching the given age.

We'll not consider the following to be income:

- payments from the member's own income-protection policy
- income support or other means-tested state benefits
- income from savings and investments, or
- taxable value of any royalties from any patent or copyright, or profit from selling shares or securities
- income received in respect of holiday entitlement.

5.6. After an incapacitated member returns to work, can another claim be made for that member?

Yes. If benefit has been paid and incapacity occurs again from the same or related cause within 12 months of the member returning to work, the deferred period won't apply again.

If incapacity is from another cause, the member will have to serve another deferred period.

If the policy has a limitation on the time for which a claim will be paid then periods of incapacity attributable to the same cause will be added together to calculate the payment duration.

When the policy ends and the scheme moves to a new insurer then, if a member for whom you're claiming meets the 'actively at work' requirements of the new insurer but subsequently relapses from the same cause as the previous claim within the linked claims period, we'll pay benefit up to the end of the new insurer's deferred period. However, this is subject to the terms of our policy.

5.7 What happens to claims if the policy is discontinued?

If the policy is stopped, current claims remain payable and, if all premiums due have been paid, new claims will be considered if the incapacity began before the policy was stopped.

6. What is not covered?

There are no general policy exclusions, but exclusions may apply as a result of underwriting for discretionary entrants or members with benefits in excess of the automatic acceptance limit.

We'll not make claim payments if:

- information relating to the policy or a claim that we've asked for is outstanding
- you haven't paid the premiums we asked for.

We may also restrict cover for employees based in certain countries.

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

Most members must be wholly employed in the UK. UK, based members travelling abroad on business won't normally be subject to special terms.

You should 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 quote 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 company covered by the policy
- their period overseas shouldn't exceed three years, unless they're sent to a company within the same group of companies when the period abroad may be longer.

7.2 Claim payments

If a member stays outside the United Kingdom, Channel Islands, Isle of Man, Australia, Austria, Belgium, Canada, Cyprus, Denmark, Eire, Finland, France, Germany, Gibraltar, Greece, Iceland, Italy, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland or the USA, we'll normally pay benefits for no more than six consecutive months unless we agree it's not medically advisable for the member to return to one of these countries.

To continue payments, the member must return to one of the above countries and send us fresh medical evidence.

If we require a member located overseas to undergo a medical assessment, we'll contribute an amount towards the cost of the examination in that foreign country equivalent to the cost of similar assessment in the UK.

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.

8.1 Policies for employees

HMRC usually consider premiums for income protection benefits as a business expense and not as a P11D benefit.

There will normally be tax relief on premiums you pay. HMRC doesn't normally grant tax relief on premiums paid for any members with a proprietary interest in the company. However, HMRC may agree to allow tax relief if you provide similar benefits to many employees. For advice on this, please speak to your local Inspector of Taxes.

You should treat income benefits we pay you as a business receipt. When passing it on to the member as salary, you should treat the payment as a business expense. Doing this will result in a neutral position as far as Corporation Tax is concerned.

You pay the incapacitated member the appropriate amount through your payroll system after deducting income tax and National Insurance contributions.

8.2 Lump sum benefits

The lump sum that is payable to you'll be regarded as a business receipt. The tax treatment of the payments you make will vary widely according to individual circumstances. We recommend that you consult your Local Inspector of Taxes and Accountant or Tax Adviser.

8.3 Policies for equity partners

Under current HMRC practice, benefit payable to equity partners is not subject to Income Tax if premiums were paid from their taxed income. Premiums for equity partners aren't business expenses. If a claim occurs, the partnership must nominate a representative to whom benefits are payable. We'll usually pay benefits to the partnership on trust so that they'll pay the incapacitated equity partner.

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.

Further information

The Company

This Group Income Protection Policy is issued by Zurich Assurance Ltd, an insurance company whose head office is in the United Kingdom. Its address is:

Zurich Assurance Ltd
Unity Place
1 Carfax Close
Swindon
SN1 1AP
UK

Zurich has not made a personal recommendation in respect of the suitability of this product for the customer.

Surrender value

This Group Income Protection 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

Monday to Friday 9.00am – 5.00pm.

We may record or monitor calls to improve our service.

Email: zcrservicing@uk.zurich.com

Website: zurich.co.uk/corporate-risk

You can get details of our complaints handling process on request.

If you're not satisfied with our response, you can complain to:

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

Telephone: 0800 023 4567

Email: complaint.info@financial-ombudsman.org.uk

Website: www.financial-ombudsman.org.uk

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

Financial Strength

If you'd like to know more about our financial strength, including our Solvency and Financial Condition Report (SFCR) when available, please visit our website at www.zurich.co.uk/SFCR.

Compensation

If we're unable to meet our financial obligations in full you may be entitled to help from 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 0800 678 1100 or 020 7741 4100, write to the address below or visit the website www.fscs.org.uk.

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

Law

The policy is issued subject to the law of England.

You may enforce the benefits and rights granted to it 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 quote. This document doesn't override the Terms and Conditions, which contain full details of the policy.

Conflicts of interest

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

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

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

NP128000058 (06/22) CMS

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