ZURICH

Registered Group Life Policy – Master Trust

Technical guide

Registered Group Life Policy – Master Trust

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 – Master Trust.

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 Registered Group Life Policy – Master Trust 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.

Its aims

- To provide insurance to cover lump sum life assurance benefits payable on the death of a member.
- 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 provide a fair presentation of the risk.
- To complete a proposal form and a notice of participation to the Zurich Registered Group Life Policy – Master Trust.
- 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 5.2**.
- 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 policy but whom you want to be covered.
- To abide by the terms and conditions of the policy.

Risk factors

- If we've agreed in writing to provide you cover but you don't provide the completed and executed proposal form and notice of participation within 30 days of the specified date you'll be deemed never to have been admitted to participate in the Zurich Registered Group Life Policy - Master Trust and any claim won't be enforceable under the scheme.
- Any claim made under the policy for benefits under the Zurich Registered Group Life Master Trust arising during this period prior to our receipt of the required documentation will be payable at our sole discretion and we shall not be liable for any tax which may arise in the event you're deemed not to have participated in the Zurich Registered Group Life Master Trust.
- If you don't meet your commitments, we may not pay your claims and may cancel the policy.
- If you delay giving us or the trustees 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**).
- We may revise the terms and conditions or rates where:
  - you fail to provide a fair presentation of the risk
  - the taxation of policy benefits or premiums change
  - you request we change the basis for calculating the policy benefits
  - the number of employees included in the policy exceeds 9 or falls below 10
  - 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
  - the number of employees at a location varies by more than 25% since the beginning of the rate guarantee period and their total benefits exceed £5,000,000. This does not apply to individual costing policies
  - the employer's location or nature of business changes.
- We may cancel the policy if the 'registered' status of the scheme is withdrawn or you cease to be a party of the scheme.
- We may cancel the policy if you or any participating employer ceases to be a UK registered company or a UK limited liability partnership.
- We'll restrict the total amount of benefits payable in respect of multiple claims resulting from a catastrophe or where members within the policy 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 the members, 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 Lump Sum and Death Benefits Allowance. Employees should seek advice on how membership of a Registered Group Life scheme may affect their personal circumstances.

How does the policy work?

We've designed this policy to finance death in service benefits for UK employees of a UK registered employer, paid through PAYE. The benefits must be provided under the Zurich Registered Group Life Master Trust. The policy will cover a lump sum benefit payable on death.

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

- the policy's eligibility conditions
- the 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're 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.

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 to the scheme trustee(s) to pay out in accordance with their discretionary powers.

The lump sum payment is free of all taxes up to the Lump Sum and Death Benefits Allowance.The lump sum benefits paid to the scheme trustee(s) 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 – Master Trust offers employers a flexible approach to meeting the death in service benefits promised to their employees. The policy enables an employer to insure fully any lump sum benefits.

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

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 (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 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 12 months of their first opportunity or as part of an auto enrolment exercise will be regarded as having been included within the group life policy 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 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 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 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 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 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 to 99 members, they must return to work and have been Actively At Work
- for new policies with 100 or more members, the actively at work requirement will be waived for benefits below the automatic acceptance limit

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 arrangement 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're entitled.

When a scheme changes insurer

If you're continuing cover for a previously insured group arrangement, cover will commence immediately for all existing insured benefits that we're notified of and agree to cover.

If any individual is not actively at work on the day before cover transfers 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.

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 benefit 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 met the actively at work requirements that would be applicable to 'When a scheme is insured for the first time' with the same number of members.

New members of an existing policy

If the Member isn't Actively At Work on the day they're eligible to join, they'll not be covered until they've 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 below the automatic acceptance limit if the member isn't actively at work on the date that the increase occurs the increase will not apply until the member is next actively at work.

If the member is not actively at work the increases in cover during a period of temporary absence will be limited in line with **section 1.2.3**.

If an increase means that the total cover you require for a member is above the automatic acceptance limit the benefits above the automatic acceptance limit will be subject to underwriting (**see section 2.2**).

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 age set by you or age 75)
- they no longer meet the eligibility conditions in the policy
- they're no longer employed by an employer included in the policy
- 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 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 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) or, for example, the Scheme ceases to be a Registered Pension Scheme. 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. 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 and you still regard them as an employee of an employer included in the policy and continue to pay premiums in respect of them, we will maintain cover where the absence is a result of illness or injury up to the terminating age or where the absence is for any other reason for 36 months. On your request the period that cover continues during absence:

- as a result of illness and injury can be reduced
- for any other reasons can be reduced to 12 months.

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.

During a period of temporary absence, cover can increase in line with the lesser of the general level of standard company pay increases for all members or 6%. Cover can increase above this amount if the increase is as a direct result of a change in the legal minimum wage.

1.3 What types of cover are available?

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.

1.3.1 What is policy 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 – Master Trust 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**
Members who retire early can continue to be covered for a lump sum benefit up to age 65, their state pension age (if later) or such earlier age that was applicable when they began early retirement. The benefit amount cannot exceed the amount of benefit the member was entitled to immediately before leaving service.

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

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

We must agree in advance to what age you want to continue cover.

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.

For members where cover is continued beyond the policy terminating age and temporary absence applies, we'll maintain cover for no longer than 12 months.

d) **Redundancy cover**
A member who has been made redundant can continue to be covered for a defined period of up to two years. The benefit cannot exceed the amount of benefit the member was entitled to immediately before redundancy. 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 policy salary increases provided it does not exceed the automatic acceptance limit, subject to the limits detailed in **section 1.2.3**. Increases that exceed the automatic acceptance limit will require underwriting (**see section 2.2**). Policy 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 proposal form and notice of participation, including any information requested in your quote.

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

- a deposit premium or a completed direct debit mandate
- membership data as at the cover start date, including evidence of previous underwriting decisions
- details of long term absentees (i.e. those who've been absent from work for 90 days or more)
- full business address and location, by reference to the geographical postcode of the building, for all policy members to be covered. We must be able to calculate the sum insured at each postcode.

If the risk differs from the quote, we'll let you know what else we require and whether we need to change the premium or terms. 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, 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 £5,000,000. We'll need evidence of those members who've been medically underwritten, including those who've 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 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 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'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. There may be circumstances when our underwriters decline or limit forward underwriting for individual members.

- For policies of 20 lives or more, we'll not normally enquire again until a member's benefits reach £5,000,000 provided the member is actively at work.
- For policies of under 20 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% compound in any 12 month period or a member's benefits reach £5,000,000.

If the member is not actively at work the increases in cover during a period of temporary absence will be limited in line with **section 1.2.3**, if they'd have received a higher rate of increase it will be applied when they're next actively at work.

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

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 will 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.

Future increases that take a member's total cover above £5,000,000 will be subject to underwriting.

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 increased cover should have started or the policy start date if later, if you tell us within 30 days from that date.

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
- member's benefit (or any part of it) that brings their total benefit to more than £3,000,000
- members whose death 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 qualified 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 level of benefits
- the eligibility and entry conditions
- the age when cover ends
- ages
- genders
- job titles/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?

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?

Your policy schedule will show your rate guarantee expiry date. We'll review your rate(s) when the rate guarantee expires and we set a new rate 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 employees at a location varies by more than 25% and their total benefit exceeds £5,000,000
- 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 4%. However commission levels may be varied at the intermediary's request.

Your 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 continuing cover or 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 at each yearly revision date 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 following a member's death.

5.1 How are claims made?

If you wish to make a claim it's important you notice Zurich directly 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 can be notified 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've received our evidence requirements we'll then assess the claim. If we can admit a claim, we'll make payment to the trustee(s) of the scheme.

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

Please note that the scheme administrator will be required to ensure that they pass the appropriate information to the deceased member's legal personal representative.

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.

Claim payments may be withheld if:

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

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

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

6.1 Catastrophe limit

Unless otherwise agreed, the total aggregate benefit payable under the policy (and any associated policies if more than one is insured with us) will normally be limited to a maximum of £100,000,000 where deaths occur directly or indirectly as a result of a catastrophe.

Additionally, limits to the total aggregate of the insured member benefits payable at a certain location may apply where deaths occur directly or indirectly as a result of a catastrophe. Any additional limits will be specified in the quote special terms and conditions. The aggregation and application of these limits will be considered a part of the overall policy limit detailed above. We may agree to increase limits at locations providing you tell us if the total benefits you require for members at a location exceeds the specified limit.

For members where business locations have not been disclosed, the total aggregate benefit payable where deaths occur directly or indirectly as a result of a catastrophe will normally be £10,000,000 for each undisclosed location (£5,000,000 if that location is within the London postcode areas EC or E14). The aggregation and application of this limit will be considered a part of the overall policy limit detailed above.

Any non-standard catastrophe limits will be detailed in your quote 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 (and any associated policies if more than one is insured with us) in respect of members who die as a result of an incident that occurred whilst 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.

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

Members must be wholly employed in the UK by a UK registered company or a UK limited liability partnership. 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 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 employer covered by the policy
- their period overseas should not exceed three years unless they're 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 up to the Lump Sum and Death Benefit Allowance 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 Lump Sum and Death Benefits Allowance, the excess will be taxed at the highest rate at which the recipient pays income tax.

This information is based on our current understanding of current tax law legislation and HMRC practice. Employers and scheme trustee(s) 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 – Master Trust 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 insurance policy 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 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 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've 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.

PDF721655008 (10/25)

ZURICH