AIG

Group Protection

Single Relevant Life Insurance

Technical Guide

Contents

Welcome to AIG

AIG Life Limited ('AIG') is a life insurance organisation which operates in the UK. We provide financial and practical support for individuals, families, employees and businesses when illness or injury threatens their life, lifestyle or livelihood.

Information about our business, performance and financial position, and details on how we control our business and manage risks can be found in our Solvency and Financial Condition Report available on our website www.aiglife.co.uk.

Contact us

Group Protection Client Service
AIG Life Limited
PO Box 12010
Harlow
CM20 9LG

Call us on:

0330 303 9972

Calls are charged at standard rates from a BT landline but may cost more via mobiles and other networks.

Email: groupclientservice@aiglife.co.uk

We're open Monday to Friday, 9am to 5.30pm except bank holidays. Please note these opening hours are UK local time.

We may record or monitor calls to make sure we have an accurate record of the instructions we are given, for training purposes, to improve the quality of our service and to prevent and detect fraud.

This document is available in other formats. If you would like a Braille, large print or audio version, please contact us.

This Single Relevant Life insurance is designed to pay a lump sum benefit if the member dies.

It's available to UK registered organisations (either with Companies House or similar) and isn't available to UK branches of overseas organisations.

This Technical Guide has been produced based on the standard format recommended by the Group Risk Development Group and the Association of British Insurers.

This document is aimed at the employer and describes the main features and benefits of the product. It should be read alongside the quote issued. It doesn't form part of the policy contract – the Policy Terms and Conditions can be found on our website.

Any reference in this Technical Guide to employer can include the principal employer and participating employers and is also intended to refer to the trustees of the Excepted Group Life Scheme written on behalf of the employer.

Policy aims

- To provide cover for a single member who can't be provided cover under an Excepted Group Life Policy
- To provide insurance to cover a lump sum benefit payable on the death of the member covered by this Single Relevant Life Policy

Your commitment

- To pay the premiums when they are due
- To comply with the Policy Terms and Conditions
- To establish a scheme, using an appropriate discretionary trust
- To tell us of any claims as soon as possible
- To provide us, at the agreed intervals, with the information specified in the Policy Terms and Conditions as needed to ensure cover for the member
- To ensure that any information you supply is complete and accurate when you provide it
- To provide information about the policy and how it works to the member

Our commitment

- We'll deal with claims promptly and fairly and will provide information on the progress of the claim. Once we've determined that the claim is valid, we'll pay the benefit in accordance with the trustees' instructions
- We'll promptly pay any premium refunds that may arise
- We'll request information about you or the member only to the extent it is necessary to ensure the efficient running of your policy
- We'll copy in your adviser to any correspondence we send to you
- We won't copy you or your adviser into any correspondence sent to the member in connection with assessing their health (to protect their privacy), but we'll ensure you and your adviser are aware of the progress and results of such assessments

Risk factors

- If you don't pay premiums on time, provide data when requested or you fail to comply with any of the Policy Terms and Conditions we reserve the right to cease the policy
- We'll cease the policy if it fails to meet the HM Revenue & Customs (HMRC) regulations
- We'll cease the policy if we become aware that there isn't a discrentionary trust in place for the purpose of holding the policy and governing the scheme
- We may cease this policy if we cease to insure the benefits under any other policies that this policy is linked to
- This policy runs alongside a Group Life Insurance policy for other employees
- Any delay in providing the information we require may result in the member not being fully covered
- If you don't fairly present the risk (i.e. the information we've requested is not provided, is incomplete or is inaccurate) then we have the right to adjust the premiums we charge for the cover and/or the Policy Terms and Conditions or cease the policy – see section 9.4 'What happens if you don't make a fair presentation of the risk'
- There are maximum limits for claims arising from a single event or where members travel together on business – see section 6 'What isn't covered'. If the benefit insured is insufficient to cover the benefit promised on the death of the member, the responsibility for any shortfall lies with you. You should take this into account when describing this benefit to the member
- The premiums may be reviewed and varied, even within a rate guarantee period, in the circumstances described in the next section 'How does the policy work?'
- There could be legislative, regulatory or other HMRC changes that could affect this policy

Your questions answered

How does the policy work?

- The policy insures all or part of your promise to provide death in service benefit to the member covered by this policy
- The scheme must be established under a discretionary trust
- You decide the eligibility conditions and level of benefit that you would like us to cover, subject to the conditions set by HMRC
- In order to ensure that you comply with relevant employment and taxation legislation you should obtain appropriate legal and tax advice
- You pay premiums when they are due. Premiums in respect of employees are normally treated as a business expense for tax purposes and aren't treated as a benefit in kind, however you should confirm this with your tax advisers. Premiums paid via salary sacrifice may be treated as a benefit in kind for the member
- We provide the cover whilst premiums are being paid and the policy remains in force
- The benefit to be paid in the event of a claim will be as detailed in the Policy Schedule. Limits to the total sums payable, from this and any associated life insurance policy insured by us, may apply where claims from this and any associated group life insurance policy arise from the same, or related, events or whilst members are travelling together on business – see section 6 'What isn't covered'
- The member will be covered for benefit up to an automatic acceptance limit specific to your policy, providing they join the scheme at their first opportunity within the eligibility conditions. Any benefit that exceeds the automatic acceptance limit will be subject to individual assessment – see section 2.2 'Does evidence of health have to be provided before members are covered?
- You must provide us with membership data within 14 days of us requesting it. We'll confirm at the start of the policy how often you'll provide updated membership data (known as the data refresh) which needs to be complete and accurate. However if the member's benefit increases to exceed the automatic acceptance limit we should be told immediately rather than at the next data refresh because we'll need to individually assess them to establish the terms, if any, on which cover can be offered
- The Policy Terms and Conditions and the rate(s) are normally guaranteed for two years and won't be reviewed during that time unless one of the following occurs across the aggregate of this policy and any associated group life insurance policy:
  - a greater than:
    - 50% variation in the number of members or their total salaries for schemes that are costed on an age related rate table basis (see section 3.1 'How are premiums calculated'), or
    - 30% variation in the number of members or their total salaries for schemes costed on an unit rate basis (see section 3.1 'How are premiums calculated')
  - the new inclusion of a participating employer or a TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006) transfer
  - the disposal of a participating employer or closure of a part of a participating employer's business
  - a change in policy design such as an amendment to the benefit level, the age cover ceases or eligibility conditions
  - a change in the nature of a participating employer's business
  - the total benefit insured at any one location (including a new location) changes by more than £5 million
  - there's no longer an adviser acting for you in connection with this policy
  - there's a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
  - you don't give us complete and accurate information, or
  - we cease to insure the benefits under any other associated life insurance policy
- Once we determine a claim is valid, we'll pay the benefit in accordance with the trustees' instructions. We expect the trustees to confirm that benefit will only be paid to an individual or charity.

Section 1

What factors should be considered in deciding what benefit to provide?

Within the rules set by HMRC, we can provide a wide range of options to match your budget and needs.

1.1 Who can be covered?

Full time, part time and fixed term contract workers can be covered by the policy. The policy will start and the individual will be covered once they fulfil the eligibility conditions and we have accepted them.

Workers engaged through zero hours contracts won't automatically be covered by the policy. They can be covered under a Single Relevant Life policy subject to our agreement.

Equity partners or partners of a limited liability partnership can't be covered under a Single Relevant Life policy.

1.2 Eligibility conditions

The eligibility conditions must be clearly defined and agreed with us before the policy starts. They should be consistent with the Excepted Scheme trust deed and rules.

All eligibility conditions must take account of any relevant employment or discrimination legislation and will include:

- the minimum and maximum entry ages
- any service qualification (e.g. you might specify that the individual must have completed three months' service)
- full details of the pension scheme eligibility conditions where eligibility is linked to membership of a workplace pension scheme, and
- the date on which benefit increases are applied, which can be daily, monthly or annually.

Eligibility can be linked to membership of a workplace pension scheme. Where this is the case, membership of the pension scheme must be open to all employees who satisfy the eligibility conditions and must not be discretionary.

We consider a late entrant to be an individual who:

a) joins the workplace pension scheme 12 months or more after first being eligible and whose benefit is above £250,000
b) was absent due to ill health on the date they joined the workplace pension scheme for
   - one week or longer in schemes with up to 50 members
   - four consecutive weeks or longer in schemes with between 51 and 500 members, or
   - 12 consecutive weeks or longer in schemes with 501 or more members, or
c) changes their employee pension scheme contribution 12 months or more after first being able to do so and as a result has an increase in benefit and whose benefit is above £250,000.

Cover for late entrants is subject to individual assessment before we will consider providing cover.

If the individual meets the eligibility conditions and joins at their first opportunity they're usually covered automatically for their benefit up to the policy's automatic acceptance limit. If this isn't the case (or the policy's automatic acceptance limit is zero) the individual will be individually assessed before we'll consider providing cover.

1.3 When will cover end?

1.3.1 Under normal circumstances

Cover for the member will end, and the policy will cease, if they:

a) reach the age at which their cover would cease according to the terms of the policy, unless we've agreed with you that their cover can be continued
b) are no longer being employed by a participating employer or otherwise become ineligible for membership
c) are a worker engaged through a zero hours contract who hasn't received earnings from the employer for a period of six consecutive months unless they're unavailable for work due to ill health
d) are absent from work and reach the end of the period of cover we provide during temporary absence as detailed in section 1.5 'Does a member continue to be covered if they are absent from work', or
e) die.

Cover can't continue beyond the member's 75th birthday.

Cover will also end if it isn't allowed under the HMRC regulations.

1.3.2 Cancelling the cover

The policy doesn't have a termination date. You can cancel the policy at any time providing you notify us in writing. Cancellation can't be backdated and we'll charge for the time on risk.

We reserve the right to cancel the policy if:

a) you don't pay premiums when they are due
b) you don't comply with the Policy Terms and Conditions
c) you don't provide information we've requested within 90 days
d) we become aware that the scheme no longer meets HMRC requirements
e) we became aware that there isn't a discretionary trust in place for the purpose of holding the policy and governing the scheme
f) there's a change in legislation, regulation, HMRC practice or taxation which affects the policy
g) an employer covered under this policy or any associated group life insurance policy ceases to carry on business, or if any order is made or resolution passed for the winding up of that employer
h) you fail to fairly present the risk when setting up the policy, or at a rate review, or when you request a change to the policy, or
i) we cease to insure the benefits under any other associated life insurance policy.

1.4 What types of cover are available?

The basis of cover should reflect the scheme rules. The employer will be responsible for any shortfall between the benefit promised under the scheme and the cover provided under your policy with us.

1.4.1 Lump sum benefit

The benefit payable on death can be a fixed amount or a multiple of salary. For workers engaged through zero hours contracts the maximum fixed amount we'll normally offer is £50,000.

Benefit in excess of £10 million for the member will only be provided subject to our express agreement.

The definition of salary used to calculate the member's benefit will be agreed at outset. It can be the member's basic annual salary or additional variable pay (such as bonuses and commission) can be taken into account. Where dividends form part of the salary definition they must be averaged over the preceding three years (or shorter period if applicable e.g. if dividends have only been payable for 18 months they must be averaged over the 18 month period).

The salary definition available for a worker engaged through a zero hours contracts is either:

- total earnings in the 12 months up to the date of death, or
- P60 earnings in the tax year immediately preceding or coinciding with the date of death (if there are no P60 earnings for that tax year we'll use the total earnings in the 12 months up to the date of death).

Please note that we won't annualise earnings for workers engaged through zero hours contracts who have worked for less than 12 months – their cover will be based on their earnings for the period of time worked.

1.5 Does the member continue to be covered if they're absent from work?

In many circumstances, cover continues while the member is absent from work.

1.5.1 In the event of the member being absent from work due to ill health they'll continue to be covered until they reach the age at which cover ceases.

1.5.2 If the member is absent due to maternity, paternity or adoption leave cover will continue whilst they're still considered an employee.

1.5.3 If the member is absent from work for any other reason cover will cease after three years.

1.5.4 If a member is on a fixed term contract, then regardless of the reason for absence, cover during periods of temporary absence won't continue beyond the end of the contract in force at the date the member was first absent.

1.5.5 If the member is a worker engaged through zero hours contract cover during periods of temporary absence due to ill health will cease on the earlier of:

a) the end of the zero hours contract in force when the member was first absent
b) when that zero hours contract is terminated, or
c) three years from the start of the ill health.

1.5.6 If a member is beyond the age cover ceases and still being covered (see section 1.6.1 'Extended cover') their cover during periods of temporary absence can be until age 75 if due to ill health and for up to 12 months if absence is due to any other reason.

Whilst the member is absent and where the basis of cover is based on their salary, cover will be based on their salary at their last working day before they became absent. However, cover can increase in line with average company pay awards up to a maximum of 5% per annum (the 5% maximum will be waived where the member's entitlement to a higher increase is enshrined in law, e.g. an increase in the National Minimum Wage).

1.6 Are any additional options available under the policy?

We offer the following option at additional cost:

1.6.1 Extended cover

If you wish to provide cover for the member if they're working beyond the age cover ceases, this is considered discretionary and will be subject to individual assessment.

Cover can't continue beyond the member's 75th birthday.

Section 2

Setting up the policy

A scheme must be set up by an appropriate trust document.

2.1 What are the requirements for setting up the policy?

The information we require to prepare a quote is detailed at the beginning of section 3. 'What premiums will be charged for the cover?' We'll prepare a quote based on the information you provide and it's normally valid for three months. If you want us to start cover, your adviser will need to ask us to do so, and supply any outstanding information that is requested in the quote.

We'll create an application form which has been partially completed with the information you've provided, then post it on our secure website.

If your adviser has provided your email address, we'll send you an email with details of how to register to access the site. Once you've registered and downloaded the form, you must:

a) review the application form to ensure that the information it contains is complete and accurate. Please pay particular attention to the section on the application form headed 'Information you provided on which we produced our quotation'. It's essential that you tell us if this information is incomplete or inaccurate
b) answer all our questions clearly and completely and provide any further material information requested or tell us if you don't have the information we requested
c) insert any information that is shown as required (e.g. we'll need the scheme name and cover start date), and
d) sign the form and the direct debit mandate and return it to us by email before the policy start date (cover can't be backdated).

The information detailed on the application form in the section headed 'Information you provided on which our quotation was produced' is in respect of members covered under this policy and any associated group life insurance polices to be insured by us.

If your adviser hasn't provided your email address, the application form will be sent to the adviser, who'll contact you about completion.

The application form will show the details of any member who has had benefit declined or postponed you've previously told us about, and will ask you to add the same details of any other member who has had benefit declined or postponed.

The application form will also show the details of the individuals we've been advised of who are absent due to ill health and have been in the case of this policy and any associated group life insurance policy, that have a total of:

- up to 50 members, for one week or longer
- between 51 and 500 members, for four consecutive weeks or longer, or
- 501 or more members, for 12 consecutive weeks or longer.

The application form will ask you to tell us about any members you haven't already disclosed who are currently absent due to ill health and, in the case of this policy and any associated group life insurance policy, that have a total of:

- up to 50 members, have been absent from work due to ill health for one week or longer, or
- between 51 and 500 members have been absent from work due to ill health for four consecutive weeks or longer and whose total benefit exceeds the annual premium quoted.

For each absent individual, we'll need their sex, age, date of absence, benefit level, the category the member is covered under and the medical reason for their absence.

If any of the information used to prepopulate the application form is incomplete or incorrect or information you subsequently add affects the risk presented (e.g. if details of members who've been absent from work due to ill health are declared who we hadn't previously been aware of), it may mean the terms of our quote, including the premium, are no longer valid and may have to be reviewed, or that we have to withdraw our quote entirely.

Prior to the policy start date, we need details in writing of the terms of acceptance for any members who've been individually assessed (underwritten) by the previous insurer. Please send this to us alongside the completed application form. We'll need copies of the original decision letters for these members within 14 days of us confirming cover.

Once we've confirmed cover can start, we'll request membership data (including employee National Insurance numbers or unique identifiers) as at the policy start date, and this must be supplied within 14 days of our request.

The premium payment options available are as follows:

Payment frequency	Payment method	
	Where the total number of members in this policy and all associated polices is up to 199	Where the total number of members in this policy and all associated policy is 200 or more
Monthly	Direct debit	Direct debit
Quarterly	Direct debit	Direct debit
Annual	Direct debit	Bank transfer

If we don't receive complete data within 14 days of our request we'll request payment based on the estimated annual premium in the quote.

For annual payment policies that pay premiums by bank transfer we'll issue an invoice for the estimated annual premium and payment must be made within 14 days. For annual payment policies that pay premiums by direct debit, we'll request a payment for the estimated annual premium.

For quarterly payment policies we'll request a payment for 25% of the estimated annual premium.

For monthly payment policies we'll request a payment for 1/12th of the estimated annual premium.

If, once the data is received for this policy and any associated group life insurance policy, there's a greater than:

- 50% variation in the number of members or their total salaries for schemes that are costed on an age related rate table basis (see section 3.1 'How are premiums calculated'), or
- 30% variation in the number of members or their total salaries for schemes costed on an unit rate basis (see section 3.1 'How are premiums calculated')

compared to the data used for the quote we reserve the right to review our pricing and/or Policy Terms and Conditions.

If, once the data is received for this policy and any associated group life insurance policy, there's a material change in the risk, it may mean we have to withdraw our offer or review our pricing and/or Policy Terms and Conditions. We would withdraw our offer if the change in risk is such that if we'd known about it when we were asked to quote we'd have declined to quote, for example, all members being based outside the UK.

If any of these requirements aren't provided when they're due, we reserve the right to withdraw cover. We'll notify you that we've ceased the policy and charge you for the cover provided between the policy start date and the date we ceased the policy.

2.2 Does any evidence of health have to be provided before the member is covered?

One of the advantages of the policy is that it's normally possible to provide cover for an eligible member up to a certain limit without the need to individually assess them. This limit is known as the automatic acceptance limit. If the member has joined the scheme at their first opportunity, within the eligibility conditions they'll usually be covered automatically for benefit up to the automatic acceptance limit.

If benefit is based on salary and the member has a salary increase and as a result there's to be an increase to their benefit, this increase will only apply if the member is actively at work on the date the increase applies. If the member isn't actively at work then once they return to being actively at work they qualify for the full increase to their benefit as a result of the salary increase. However, if the salary increase results in the member's benefit exceeding the automatic acceptance limit they'll need to be individually assessed and accepted by us before the cover in excess of the automatic acceptance limit can be provided.

The automatic acceptance limit is reviewed at the end of every rate guarantee period (usually two years) and is dependent on the number of members in this policy and any associated group life insurance policy. If a member is included in more than one policy insured by us, the member's aggregate benefit will be used to assess whether the automatic acceptance limit is exceeded.

Any individual whose benefit has been restricted, declined, postponed or accepted on non-standard terms won't benefit from any increase in the automatic acceptance limit. For example, if the original limit is £800,000 and the member has a total benefit of £900,000; of which £100,000 is subject to a premium loading, an increase in the limit to £1 million won't mean that the loading is removed.

Where there are fewer than three members in this policy and any associated group life insurance policy, no automatic acceptance limit will be given.

There will be some instances where individuals will be subject to individual assessment to establish the terms, if any, on which cover can be offered. These arise where:

a) an individual has benefit in excess of the automatic acceptance limit (benefit below the limit is still covered automatically)
b) an individual is offered cover by the employer without satisfying the usual eligibility conditions or who is being offered a different basis of cover to the majority of the rest of the scheme membership (a 'discretionary entrant')
c) eligibility for cover is linked to pension scheme membership and an individual:

i. joins the workplace pension scheme 12 months or more after first being eligible whose benefit is above £250,000

ii. was absent due to ill health on the date they joined the workplace pension scheme for:
- one week or longer in schemes with up to 50 members
- four consecutive weeks or longer in schemes with between 51 and 500 members, or
- 12 consecutive weeks or longer in schemes with 501 or more members

iii. changes their employee pension scheme contribution 12 months or more after first being able to do so and as a result has an increase in benefit and whose benefit is above £250,000, or

d) the member is working beyond the date cover ceases and you are seeking cover for them.

2.2.1 What happens if you want to make a change to the scheme?

If you wish to make a change to the policy design (such as an amendment to the benefit level, the age cover ceases or the eligibility conditions), we'll normally be able to accommodate this, but it may mean we have to individually assess some members before we can confirm their full benefit. We'll need details of members who are absent due to ill health and have been, in the case of this policy and all associated life insurance policies, that have a total of:

- up to 50 members, for one week or longer
- between 51 and 500 members, for four consecutive weeks or longer, or
- 501 or more members, for 12 consecutive weeks or longer.

The details we'll require are the sex, age, date of absence, level of cover, the category the member is covered under and the medical reason for their absence. We'll review this information and advise you whether these individuals will need to be individually assessed before they can benefit from the change in policy design.

The same requirements apply if you wish to include a group of employees as a result of a TUPE and this results in the need for a Single Relevant Life policy. You must also provide details of the number of TUPE employees and their total benefit, the current automatic acceptance limit and full details of any employee who has had benefit declined or postponed. In addition you must tell us of any employees who travel on business to or are seconded to countries that we regard as high risk. An up to date list of these countries can be found on our website here. We'll then assess the potential impact that including these individuals has on the existing policy and advise if we're willing to provide cover for them or if we need further information before we can make a decision.

2.2.2 What happens if the automatic acceptance limit is exceeded or doesn't apply?

If the individual's promised benefit exceeds the automatic acceptance limit, they'll need to be individually assessed for their excess benefit. We must be told about this immediately as their level of cover can't be confirmed until the individual assessment has been completed.

If the member needs to be assessed we'll send them an email containing a link to our secure online questionnaire. During this questionnaire they'll be asked questions about their health and lifestyle and they'll be expected to take reasonable care not to make a misrepresentation. In many cases a decision as to what cover can be provided and on what terms, is given at the end of the assessment. In some cases further medical information is needed, (e.g. blood tests or an independent medical examination), before a final decision can be made. If further tests or examinations are required, the individual will be sent instructions as to how to make an appointment with one of our medical test providers in order for the tests to be carried out. On rare occasions we may need to get further information from the individual's GP and/or other medical professionals who have attended them. The individual continues to have a duty to take reasonable care not to make a misrepresentation during this process.

Using the results of the online questionnaire and any other information gathered, we advise if the individual can be accepted at standard rates or if we need to apply special terms, decline or postpone our decision. (We may postpone it, for example, if the individual is about to undergo an operation which could radically affect their state of health once completed.) Special terms will normally take the form of a premium loading, but in some circumstances an exclusion may be applied (e.g. if the individual takes part in a hazardous sport or activity). We'll advise both the individual and you of our decision. If there's a premium loading we'll assume that it's acceptable and adjust future premium collections accordingly, unless you write to tell us otherwise. If this is the case, we'll remove the loading and restrict the member's benefit accordingly.

Wherever possible, we aim to limit the number of times any individual needs to be assessed. Therefore, if we're able to offer terms, the member will normally not need to be assessed again if their total benefit does not exceed £5 million. However, we reserve the right to individually assess the member again if their benefit increases as a result of a change in the benefit basis or an increase in salary of more than 20% in a 12 month period.

2.2.3 How does a member's cover transfer from the previous insurer?

Where a scheme transfers its insurance on the same basis to us from an insurer (with the exception of a Lloyd's syndicate insurer), we'll normally take over the benefit accepted by the previous insurer up to a maximum benefit of £5 million for the member, on the same terms, provided we get sight of the previous insurer's terms of acceptance. Cover for benefit in excess of £5 million will be subject to individual assessment.

Where the previous insurer was a Lloyd's syndicate insurer the maximum cover we'll transfer is £1 million.

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

Whilst we're assessing the individual we'll provide them with temporary cover for a maximum period of 90 days or until the date we finalise our assessment, if earlier.

Temporary cover starts from the date we're advised of the level of benefit required. It is subject to the following conditions:

a) if a claim arises directly or indirectly as a result of any medical condition which the individual:
   - has received treatment for
   - has suffered symptoms of
   - has sought advice on, or
   - was diagnosed with

   within the last two years immediately prior to the temporary cover starting, the temporary cover won't apply (i.e. any benefit paid will be limited to the member's previously accepted level of cover).

b) The amount of temporary cover is limited so that, when added to any existing benefit the member may receive, their total benefit entitlement during the period that temporary cover operates shall not exceed £5 million. Members whose benefit exceeds £5 million are therefore not offered temporary cover in excess of £5 million.

Temporary cover won't be given to any individual who:

- has previously been declined, offered cover on non-standard terms or where a decision on their benefit has been postponed (either by AIG or another insurer)
- has previously failed to provide medical evidence that has been requested
- is joining outside of the eligibility conditions or is being offered a different basis of cover to the majority of the rest of the scheme membership
- is requesting cover beyond the age cover ceases
- is a late entrant, or
- is being individually assessed because, on the date the policy change was requested, they had been absent due to ill health:
  - in schemes with up to 50 members, for one week or longer
  - in schemes with between 51 and 500 members, for four consecutive weeks or longer, or
  - in schemes with 501 or more members, for 12 consecutive weeks or longer.

If we're unable to complete our assessment before the temporary cover expires, the individual's cover will be restricted to their previous accepted level of cover. If the previous accepted level of cover was based on underwriting carried out by an insurer other than AIG, we'll require documentary proof of the previous acceptance terms.

Section 3

What premiums will be charged for the cover?

The premium we charge depends on a number of factors in respect of this policy and any associated group life insurance policy including:

- the amount of cover provided
- the eligibility and entry conditions
- the age cover ceases
- the age and sex of individuals to be covered
- the nature of the industry you are in and your principal activity
- the salaries of the members
- the location of the workforce (postcode if in the UK or country if outside the UK)
- details of any members who travel on business to or are seconded to countries that we regard as high risk – an up to date list of these countries can be found on our website here
- if there are any members who are currently absent due to ill health and have been in the case of all life insurance policies issued by AIG that have a total of:
  - up to 50 members, for one week or longer
  - between 51 and 500 members, for four consecutive weeks or longer, or
  - 501 or more members, for 12 consecutive weeks or longer

  details of such members
- the claims experience
- the level of commission (if any) you've agreed with your adviser.

3.1 How will premiums be calculated?

The premium for the policy will be calculated in the same way as for the associated group life insurance policies.

3.1.1 Age specific rate table

This basis normally applies to schemes of up to 199 members. Premiums are calculated for the cover provided to each member based on age-related premium rates which we apply to the amount of their benefit.

3.1.2 Unit rate

This basis normally applies to schemes of 200 or more members. A weighted average rate is calculated based on the factors detailed in the beginning of this section and this is applied to the amount of member's benefit.

3.2 Will there be any extra premium?

Premium loadings may be imposed on the member's cover as a result of them being individually assessed. Any loading will reflect their medical condition or hazardous pursuit and will apply only to the benefit that has been individually assessed.

The actual premium payable will depend on the benefit provided during each accounting period.

We normally guarantee the Policy Terms and Conditions and the rate(s) for two years until the second policy anniversary date. They'll be reviewed at the end of the guarantee period and a new guarantee period will be set. However, we may review them part way through a guarantee period if any one of the following occurs to the aggregate of this policy and any associated group life insurance policy:

a) a greater than:
   - 50% variation in the number of members or their total salaries for schemes that are costed on an age related rate table basis, or
   - 30% variation in the number of members or their total salaries for schemes costed on a unit rate basis

b) the new inclusion of a new participating employer or a TUPE transfer

c) the disposal of a participating employer or closure of a part of a participating employer's business

d) a change in policy design such as an amendment to the benefit level, the age cover ceases or eligibility conditions

e) a change in the nature of a participating employer's business

f) the total benefit insured at any one location (including a new location) changes by more than £5 million

g) there's no longer an adviser acting for you in connection with this policy
h) there's a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
i) you haven't given us complete and accurate information, or
j) we cease to insure the benefits under any other associated life insurance policy.

3.3 Is there a discount for a good claims history?

Claims experience, both good and bad, can have an impact when calculating the premiums for policies. Generally, the larger the policy the greater the significance that will be attached to claims experience.

3.4 What commission is included within the premium?

You and your adviser are responsible for deciding the level of commission, if any, to be paid by us to your adviser. The premium charged will include the level of commission payable. We'll confirm the rate of commission payable to your adviser in your quote and at regular intervals during the life of the policy.

Section 4

How does the policy accounting work?

During the year, you'll send us updated membership data at a frequency agreed when the policy starts. The frequency for this policy will be the same as for the associated group life insurance policies. The data will be used to calculate the premium.

4.1 What information is required for accounting purposes?

When each data refresh is due, you must provide complete and accurate details of the member's:

- National Insurance number or unique identifier (whichever you've chosen to use)
- name
- sex
- date of birth
- salary (based on the policy salary definition)
- location (postcode if in UK or country if outside the UK), and
- date of joining/leaving (if applicable).

4.2 How are accounts adjusted if the member has a benefit change during the year?

Premiums will be adjusted according to the latest data received, allowing for benefit changes.

Where premiums are collected by direct debit, the amount collected will be adjusted from the next due date. Where premiums are paid by bank transfer we'll request any additional premium due or refund premium if there has been an overpayment.

4.3 If the policy is cancelled mid-year, will premiums paid in advance be lost?

No, a final account will be produced based on the cover we provided up until the date you cancelled the policy.

Section 5

Claiming a benefit

We know the importance of handling claims quickly and efficiently. In this section, we've set out how we handle claims following the death of the member.

5.1 How are claims made?

To ensure a claim is processed quickly, you must advise us as soon as possible of the member's death by completing and sending us a claim form, which can be downloaded from our website. If you have any questions you can call our claims team on 0330 303 9973.

In most cases we won't need to see the death certificate as we'll check the online register of deaths, but we will if the death occurred outside the UK or is the subject of a coroner's inquest which is still open (in the latter case, if the coroner issues an interim certificate this is an acceptable alternative to a death certificate).

We'll need a completed claim form.

Claims won't be paid while premiums are overdue.

Upon receipt of a claim, we'll deal with it promptly and fairly and will provide appropriate information on the progress of the claim.

Payment will be made at the direction of the trustees who must ensure they comply with the rules laid down by HMRC in respect of Excepted Group Life Insurance policies. There must be an appropriate UK bank account into which benefit payments can be made.

If we decline a claim we'll write to you providing an explanation of the decision.

5.5.1 Can a claim decision be appealed?

If a claim is declined and you disagree with our decision you, the beneficiary or the beneficiary's personal representative can appeal our decision.

An email should be sent to groupclaims@aiglife.co.uk outlining the reason for the appeal and attaching any additional information. The claim will be reviewed by an appropriately qualified and experienced assessor who wasn't involved in the original claim decision.

Section 6

What is not covered?

There are no standard exclusions under the policy. However, if the benefit for the member is subject to individual assessment (see section 2.2 'Does any evidence of health have to be provided before the member is covered?'), exclusions may apply for a claim arising from certain specified medical conditions or in specified circumstances.

6.1 Event limit

An event limit is applied to each location and to the policy as a whole. This will define the maximum paid out in the event of one or more deaths occurring as a result of a single event.

A single event 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. Originating causes, events and occurrences include, but won't be limited to:

- War (whether declared or not)
- Terrorist activities
- Earthquakes
- Windstorm
- Flood
- Sudden release of atomic energy or nuclear radiation
- Radioactive contamination (whether controlled or uncontrolled)
- Biological or chemical substances
- Pandemic illnesses.

In respect of terrorist activities, a series of events will be considered to be related where, on the balance of probability, they result from persons acting in concert or in accordance with a plan or design. We shall be the sole judge as to what constitutes an event.

If event limits apply to specific locations, these will be detailed in the quote, application form and policy schedule, along with the limit applying to the scheme as a whole. For locations that aren't listed, or if none are listed, a maximum location event limit of £5 million will apply to that location.

Where we issue separate policies to a number of entities that form all or part of the same group for corporation tax purposes or where a number of trusts comprise a Scheme, our maximum liability across all policies will be shown in each policy schedule.

Where employees of the same group of companies are covered under different policies with us, the benefits under all such policies will be aggregated when applying the event limit.

If claims are made as a result of a single event we'll use the order in which they were received by us to determine when the event limit is reached. Once the event limit is reached (or exceeded) we'll pay an amount equivalent to the event limit to the scheme trustees.

6.2 Group travel limit

In the event that two or more members travel together on business, the maximum amount payable from claims arising from the same or related causes whilst they're together will be limited to £40 million. This applies both while they're travelling and for up to seven days at the location where they're engaged in the employer's business. If a lower event limit applies in the location where they're temporarily on business, claims involving these members will be subject to the travel limit of £40 million, not the location limit. If a higher event limit applies to the location where they're temporarily on business then the higher limit applies.

Where members have been at a location for more than seven days, the event limit for that location will apply to them and not the travel limit.

Where employees of the same group of companies are covered under different policies with us, the benefit under all such policies will be aggregated when applying the group travel limit.

Section 7

Can cover be provided if the member isn't based in the UK?

We're unable to provide cover for individuals who are permanently based outside the UK.

7.1 If the member travels outside the UK

We'll provide cover if the member is based in the UK and travels on business or leisure outside the UK.

7.2 If the member is seconded outside the UK

We'll usually provide cover if the member is temporarily seconded outside the UK providing:

- they satisfy the eligibility conditions of the scheme
- the member has a UK contract of employment or for services with a participating employer
- there's the intention to return to the UK, and
- the country of secondment is declared at the start of the policy and at each data refresh.

If the member is temporarily working outside the UK the amount of salary and/or benefit advised at each data refresh must be expressed in pounds sterling. The exchange rate will be based on the Bank of England exchange rate and will be fixed at each data refresh. Therefore in the event of a claim where the member isn't paid in pounds sterling, the benefit will be calculated based on the exchange rate agreed at the most recent data refresh before the date of death.

If the member is outside the UK, and provision of their benefit is subject to individual assessment, they'll be invited to complete our online questionnaire as described in section 2.2.2 'What happens if the automatic acceptance limit is exceeded or doesn't apply?' If after this further medical information is required to enable us to complete our assessment, the member will be responsible for arranging and paying for the tests to be conducted. Examinations, tests or reports may only be arranged/conducted at a centre or provider with prior approval from AIG otherwise we won't be liable for any costs and the member may be required to undertake another set of tests with an approved centre/provider.

We'll reimburse the member for the tests we've requested, up to a maximum of the amount we'd pay for the same test in the UK. Reimbursement will be in pounds sterling to a UK bank account and the exchange rate used for reimbursement will be our bankers' rate of exchange on the date of reimbursement.

All results and/or reports must be provided in English.

7.3 If the member is permanently based outside the UK

We're unable to provide cover if the member is permanently working outside the UK.

Section 8

Taxation of policies

The following is our understanding of the current tax law and practises. You should get professional advice from your own tax advisers.

8.1 Payment of premiums

The whole cost of the policy will be met by you.

For tax purposes, premiums paid in respect of employees are treated as a business expense and aren't treated as a P11D benefit for employees resident in the UK. However if the premium has been paid via salary sacrifice there could be a P11D tax charge.

8.2 Payment of the benefit

The benefit doesn't count towards a member's lump sum and death benefit allowance under tax legislation and won't be subject to income tax. It will be subject to the normal inheritance tax rules applicable to discretionary trusts.

Section 9

Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact that you know or ought to know of. If you don't have complete information, you must tell us.

9.1 What you know or ought to know

You must conduct a reasonable search for, and tell us of, all material facts available to you, senior management of any employers covered under this policy, or anybody responsible for your insurance. This may include your adviser or your contractors.

You don't need to tell us about a material fact if:

- it diminishes the risk
- we know it
- we ought to know it
- we are presumed to know it (because it's common knowledge), or
- we specifically say we don't require the information.

9.2 Material facts

A material fact is something that would influence our decision whether or not to offer cover and, if so, on what terms.

9.3 Paying claims in full means that we're contracting out of this part of the Insurance Act 2015

Under the Insurance Act 2015 if you make a misrepresentation of the risk (but you haven't been deliberate or reckless in doing so) we can proportionately reduce the claim. We believe it's fairer to members to pay claims in full and charge you the correct higher premium. In order to do this we have to contract out of this part of the Act (i.e. Schedule 1 paragraphs 6 and 11 of the Insurance Act 2015). The remedies available for misrepresentation may be applied as outlined below.

9.4 What happens if you don't make a fair presentation of the risks

9.4.1 Deliberate or reckless misrepresentation of the risk

If you deliberately or recklessly don't make a fair presentation when setting up the policy we may void the policy from the beginning and recover claims paid. In the case of a deliberate or reckless failure to make a fair presentation of the risk at rate review or when you ask us to make a change to the policy, cancellation shall take effect from the rate review date or the date the change to the policy was made (as applicable).

9.4.2 Not deliberate or reckless misrepresentation of the risk

If you don't make a fair presentation but you haven't been deliberate or reckless the outcome depends upon what we would have done if we'd known the material facts:

- if we wouldn't have entered into the policy we may void the policy from the beginning and recover any claims paid. If the misrepresentation happened at the rate review or when you asked us to make a change to the policy, cancellation shall take effect from the rate review date or the date the change to the policy was made (as applicable), or
- if we would have applied different terms and/or an additional premium, we'll apply those different terms and/or premium from the beginning. If the misrepresentation happened at the rate review or when you asked us to make a change to the policy, the additional premium and/or different terms will apply from the rate review date or the date the change to the policy was made (as applicable).

9.5 Fraudulent claims

The Insurance Act 2015 also sets out remedies if there's a fraudulent claim. If there's a fraudulent misrepresentation by the member which affects our acceptance of a claim made in respect of the member we won't pay the claim in respect of the member. If there's fraudulent claim made by you we won't pay the claim and we reserve the right to terminate the policy.

Section 10

Further information

Cover is provided by AIG. AIG provides information about the insurance contracts we offer but doesn't provide a personal recommendation about the insurance products we offer. Employees of AIG are paid a basic salary and are also eligible for an annual performance bonus. On target bonus levels are dependent on grade. Each bonus is split so that there's a portion that relates to individual performance and a portion relating to company performance. Both elements are based on balanced objectives agreed at the start of each year which will include an element related to the overall volume of new premiums written and business retained during the year.

10.1 Complaints

If you have any queries, please contact your adviser in the first instance. If you wish to raise any queries with us, or make a complaint, please contact our Group Protection Complaints Team at:

Group Protection Complaints Team
AIG Life Limited
PO Box 12010
Harlow
CM20 9LG

by email to groupcomplaints@aiglife.co.uk

or by calling **0330 303 9974** (calls may be recorded for training and monitoring purposes.)

If you're still dissatisfied following a formal response to your complaint, you can approach the Financial Ombudsman Service at:

Financial Ombudsman Service Ltd
Exchange Tower
London
E14 9SR

Tel **0800 023 4567**

10.2 Compensation

If we're unable to meet our liabilities, you may be able to claim compensation from the Financial Services Compensation Scheme. Further information is available from the Financial Conduct Authority or the Financial Services Compensation Scheme.

Further information about compensation scheme arrangements is available from:

Financial Services Compensation Scheme
PO Box 300
Mitcheldean
GL17 1DY

Tel **0800 678 1100**

10.3 Data protection

We're the data controller in respect of personal data we receive from you in respect of the policy. We process personal data for the purposes of providing insured benefits on behalf of you for the benefit of your employees and their families. The information supplied by you may be transferred outside the UK (including the USA, Malaysia, and Philippines). Full details can be found in our privacy policy www.aiglife.co.uk/privacy-policy

10.4 Law

The policy is issued subject to the laws in England and Wales. The contract is with the named policyholder and members don't have any contractual rights under the policy under the Contracts (Rights of Third Parties) Act 1999.

Our Group Policy Terms and Conditions should be read and interpreted in the context of the Insurance Act 2015, and (where applicable) the Consumer Insurance (Disclosure and Representations) Act 2012, except where we've contracted out as described in section 9.3.

Any dispute in relation to the policy will be subject to the jurisdiction of the English and Welsh courts only.

AIG won't be responsible or liable to provide cover (including the payment of a claim) under the policy if we're prevented from doing so by any economic sanction which prohibits us or our parent company (or our parent company's ultimate controlling entity) from providing cover or dealing with you under the policy.

The policy has no surrender value and can't be assigned without our prior written permission.

This document should be read in conjunction with the quote. This document doesn't override the Policy Terms and Conditions. If there's a difference between the Policy Terms and Conditions and the Technical Guide, the Policy Terms and Conditions takes precedence.

Section 11

Glossary

AIG

AIG Life Limited.

Absentee

An individual who is, and has been, absent from work due to ill health for, in the case of all group life insurance policies issued by AIG that have a total of:

- up to 50 members, one week or longer
- between 51 and 500 members, four consecutive weeks or longer, or
- 501 or more members, 12 consecutive weeks or longer.

Actively at work

Describes an individual who is:

a) either actively performing their normal occupation or is taking leave (other than sick leave) that has been authorised by their employer
b) working the normal number of hours required by their contract with their employer, either at their normal place of employment, at a location as agreed with their employer, or at a location to which they are required to travel for business, and
c) mentally and physically capable of performing all the duties normally associated with their job

and isn't acting against medical advice in meeting any requirement of a) to c).

Associated group life insurance policy

Policies which we've agreed to link together for the purposes of rate(s) event limits or automatic acceptance limits.

Automatic acceptance limit

The maximum amount of benefit that can be provided for the member without the need for them to be individually assessed.

Benefit

The total financial value of amounts paid in the event of the member's death.

Discretionary entrant

An individual who is offered cover by the employer without satisfying the eligibility conditions or who is being offered a different basis of cover to the majority of the rest of the scheme membership.

Eligibility conditions

The conditions which must be met by the individual before they are included in the scheme.

Late entrant

We consider a late entrant to be an individual who:

a) joins the workplace pension scheme 12 months or more after first being eligible and whose benefit is above £250,000
b) was absent due to ill health on the date they joined the workplace pension scheme for
    - one week or longer in schemes with up to 50 members
    - four consecutive weeks or longer in schemes with between 51 and 500 members, or
    - 12 consecutive weeks or longer in schemes with 501 or more members, or
c) changes their employee pension scheme contribution 12 months or more after first being able to do so and as a result has an increase in benefit and whose benefit is above £250,000.

Cover for late entrants is subject to individual assessment before we will consider providing cover.

Member

An employee and, if we've agreed to cover them, workers engaged through zero hours contracts.

Scheme rules

The rules which apply to the scheme set up by the trustees – they will be found in the trust deed and rules document.

UK

The United Kingdom consisting of England, Wales, Scotland and Northern Ireland.

www.aiglife.co.uk

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