excepted group life technical guide

ellipse

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 insurance to cover all or part of your promise to provide death in service benefits to the members of your excepted scheme.

Your commitment

- To pay the premiums when they are due.
- To comply with the policy terms and conditions.
- To establish a scheme.
- To tell us of any claims as soon as possible.
- To provide us, at the agreed intervals, with the information specified in the policy as needed to ensure effective and timely cover for the scheme members.
- To ensure that any information you supply is completed and accurate at the time when you provide it.
- To provide information about the policy and how it works to members.

Our commitment

- Once we accept a claim we will pay the benefit within five days providing we have valid payment details.
- We will pay promptly any premium refunds that may arise.
- We will request information about you or your scheme members only to the extent it is necessary to ensure the efficient running of your policy.
- We will copy in your adviser to any correspondence we send to you.
- We will not copy you or your adviser into any correspondence sent to members in connection with assessing their health (to protect their privacy), but we will ensure you and your adviser are aware of the progress and results of such assessments.

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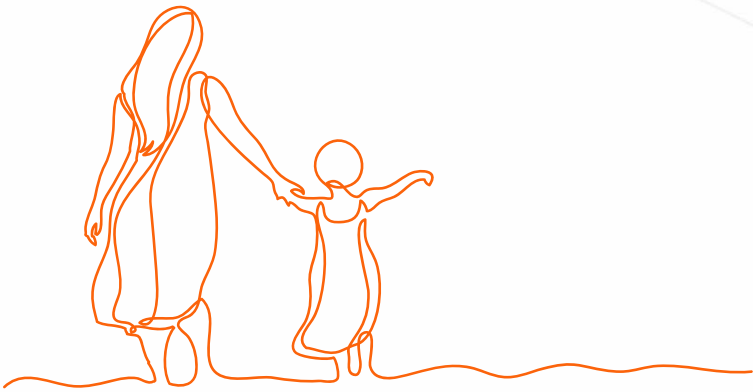

Risk factors

- If you do not 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 and not pay any new claims.
- We will cease the policy if it fails to meet the HM Revenue & Customs (HMRC) regulations applicable to an excepted group life policy.
- We may cease this policy if we cease to insure the benefits under any other policies that this policy is linked to.
- Any delay in providing the information we require may result in individual not being covered or having less than their full cover.
- If you do not fairly present the risk (e.g. the information we have 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 terms and conditions or cease the policy – see section 9.4 'What happens if you do not make a fair presentation of the risk'.
- There are maximum limits for claims arising from a single event. If the benefits insured are insufficient to cover the benefit promised on the death of a member, the responsibility for any shortfall lies with you.
- 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?'

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 members of your excepted scheme.
- The scheme must be established under a discretionary trust.
- You decide the eligibility and level of benefit that you would like us to cover, subject to the conditions set by HMRC for excepted schemes. The same level of cover must apply to all members covered under the policy. If you wish to provide different levels of cover for different members, separate policies must be set up.
- 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 are not 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 employees.
- We provide the cover whilst premiums are being paid and the policy remains in force no matter how many claims you make.
- The benefit to be paid in the event of claims will be as shown in the policy schedule. Limits to the total sums payable from this and any associated life assurance policy insured by us, may apply where claims arise from the same, or related, events.
- All members 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.
- You will be required to provide us with membership data within fourteen days of us

requesting it. We will confirm at the start of the policy how often you will provide updated membership data which needs to be complete and accurate. This should include details of new entrants, who have joined the scheme since the previous data refresh and who will normally be covered as soon as they fulfil the scheme's eligibility conditions. However, if

- a new entrant's benefit exceeds the automatic acceptance limit
- a new entrant is joining without fulfilling the normal eligibility conditions
- a new entrant is joining other than at their first opportunity
- an individual requires cover beyond the age cover ceases

we should be informed immediately rather than at the next data refresh because we will need to individually assess them to establish the terms, if any, on which cover can be offered.

- The policy terms and conditions and the underlying premium rate table are normally guaranteed for two years and will not be reviewed during that time unless one of the following occurs across the aggregate of this policy and any associated life assurance policy insured with us:
  - a greater than 50% variation in the number of members or their total salaries
  - the number of members drops below two
  - the new inclusion of an 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 an 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 is no longer an adviser acting for you in connection with this policy
  - there is a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
  - if you do not give us complete and accurate information
  - we cease to insure the benefits under any other associated life assurance policy.

  These matters define the risk as a whole.
- When we have accepted a claim we will pay the lump sum benefit in accordance with the trustees' instructions (subject to the HMRC rules for excepted policies) . Lump sum benefit will be subject to the normal inheritance tax rules applicable to discretionary trusts.

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

Within the restrictions for excepted schemes 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 included in the policy. Workers engaged through zero hour contracts will not ordinarily be covered by our policy. If you want to cover workers engaged through zero hour contracts they must be in a separate policy with suitable eligibility and salary definitions. An individual will be covered once they fulfil the eligibility conditions.

Cover can be provided for equity partners, providing all equity partners are included.

1.2 Eligibility conditions

The eligibility conditions must be clearly defined and agreed with us before the policy starts.

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 (for example, you might specify that individuals must have completed three months' service)
- the date on which new entrants will be included, (for example, on the day they satisfy the eligibility conditions or on the first of the following month)
- full details of the pension scheme eligibility conditions where eligibility is linked to membership of a workplace pension scheme
- the date on which benefit increases are applied, which can be daily, monthly or annually.

1.2.1 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 individuals who satisfy the eligibility conditions and must not be discretionary.

We consider an individual joining the pension scheme within twelve months of first becoming eligible as joining at their first opportunity.

Individuals who meet the eligibility conditions are usually covered automatically for their benefit up to the policy's automatic acceptance limit. If this is not the case (or the policy's automatic acceptance limit is zero) the individuals will be individually assessed before we will consider providing cover.

1.3 When will cover cease?

1.3.1 Under normal circumstances

A member will cease to be covered if they:

- **a)** reach the age at which their cover would cease according to the terms of the policy, unless we have agreed with you that their cover can be continued
- **b)** cease being employed by the employer or otherwise become ineligible for membership
- **c)** retire (unless the policy specifically provides cover during early retirement)
- **d)** are a worker engaged through a zero hour contract who has not received earnings from the employer for a period of six consecutive months unless they are unavailable for work due to ill health
- **e)** are absent from work due to ill health 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?'
- **f)** die.

Under no circumstances can cover continue beyond a member's 75th birthday.

Cover will also cease if it is not allowed under the HMRC regulations applicable to an excepted group life policy.

1.3.2 Cancelling the cover

The policy does not have a termination date. You can cancel the policy at any time providing you notify us in writing. Cancellation cannot be backdated and we will charge for the time on risk.

We reserve the right to cancel the policy if:

- **a)** you do not pay premiums when they are due
- **b)** you do not comply with the policy terms and conditions
- **c)** you do not provide information we have requested within 90 days
- **d)** we become aware that the scheme no longer meets the requirements of an excepted scheme
- **e)** there is a change in legislation, regulation, HMRC practice or taxation which affects this policy
- **f)** an employer covered under the policy ceases to carry on business, or if any order is made or resolution passed for the winding up of that employer
- **g)** you fail to fairly present the risk prior to setting up the policy, or at a rate review, or when you request a change to the policy
- **h)** we cease to insure the benefits under any other life assurance policies that the policy is linked to.

1.4 What types of cover are available?

1.4.1 Lump sum benefit

The lump sum benefit payable on death can be a fixed amount or a multiple of salary. For workers engaged through zero hour contracts the maximum fixed amount we will normally offer is £50,000. The same formula for calculating the levels of cover must apply to all members covered under the policy. If you wish to provide different levels of cover for different members, separate policies must be set up.

Benefit in excess of £10 million for a single 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 (bonuses, commission etc.) 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 we will average them over the 18 month period).

The salary definition available for equity or limited liability partners is either:

- the taxable earnings after the deduction of business expenses, derived by the member from the partnership, averaged over the preceding three years (or shorter period if applicable), or
- the taxable earnings received by the member as detailed in the partnership accounts for the partnership year ending immediately prior to the member's date of death.

The salary definition available for workers engaged through zero hour contracts is either:

- 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 will use the total earnings in the twelve months up to the date of death), or
- total earnings in the twelve months up to the date of death.

Please note we will not pro rata earnings for workers engaged through zero hour contracts who have worked for less than twelve months – their cover will be based on their earnings for the period of time worked.

1.5 Do members continue to be covered if they are absent from work?

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

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

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

1.5.3 If they are 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 will not continue beyond the end of the contract in force at the date the member was first absent.

1.5.5 For members who are workers engaged through zero hour contracts cover during periods of temporary absence due to ill health will cease on the earlier of

- **a)** the end of the zero hour contract in force when the member was first absent
- **b)** when that zero hour contract is terminated
- **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 'extended cover' section below) 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.

Members who are being covered during periods of temporary absence must be included in the data.

Whilst any member is absent and where the basis of cover is based on their salary, cover will 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).

1.6 Are any additional options available under the policy?

We offer the following options at additional cost:

1.6.1 Extended cover

Cover for members working beyond the age cover ceases is considered discretionary and will be subject to individual assessment.

Under no circumstances can cover continue beyond a member's 75th birthday.

1.6.2 Early retirement

Where eligibility is linked to membership of a workplace pension scheme for members who leave active service and are granted an immediate early retirement from the workplace pension scheme. This benefit will be fixed at the date of the early retirement and cover will cease on the member's State Pension Age.

1.6.3 Cover during redundancy

Cover for lump sum benefit can be provided for a period of up to two years for members who have been made redundant, although cover will automatically cease upon commencement of alternative employment or the member reaching the age cover ceases under the policy.

Premiums in respect of members covered under the above options must continue to be paid and these individuals must be identified on the data supplied to us.

1.7 Flexible benefits

We can provide cover under a flexible benefits scheme, whereby members can decide the level of cover that is most appropriate for their lifestyle. Increases in cover can be selected at policy anniversary date and following a 'lifestyle event', such as marriage or the birth of a child. Additional terms and conditions, including actively at work conditions, will apply to flexible benefit schemes and these will be set out in our quotation.
A separate policy will be required for each basis of cover.

2. Setting up the policy

A scheme should 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 quotation is detailed at the beginning of section 3 'What premiums will be charged for the cover?' We will prepare a quotation based on the information you provide and it is normally valid for three months. If you want us to assume risk, you or your adviser will need to confirm this, and supply any outstanding information that is shown in the quotation as subject to our review and approval before cover can be provided.

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

If your adviser has provided your email address, we will send you an email with details of how to register to access the site. Once you have 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 is 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 do not have the information we requested.

c) insert any information that is shown as required (for example, we need the scheme name and cover start date).

d) sign the form and the direct debit mandate (if you are paying by direct debit) and return it to us by email before the policy start date (cover cannot be backdated).

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

If your adviser has not provided your email address, the application form will be sent to the adviser, who will contact you about completion.

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

The application form will also show the details of the individuals we have been advised of who are absent due to ill health and have been:

- in schemes with up to 50 members, for one week or longer
- in schemes with between 51 and 500 members, for four weeks or longer
- in schemes with 501 or more members, for twelve weeks or longer.

The application form will ask you to tell us about any members you have not already disclosed who are currently absent due to ill health and

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

For each absent individual, we will need their gender, 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 have been absent from work due to ill health are declared who we had not previously been aware of), it may mean the terms of our quotation, including the premium, are invalidated and may have to be reviewed, or that we have to withdraw our quotation entirely.

Once we have confirmed cover can start, we need details of the terms of acceptance for members who have been individually assessed (underwritten) by the previous insurer to be sent to us within fourteen days.

We will also request membership data (including employee National Insurance numbers or unique identifier) as at the policy start date, and require that to be supplied within fourteen days of our request.

Premiums payable on an annual basis will be paid by bank transfer. Premiums payable quarterly or monthly will be paid by direct debit.

If we do not receive complete data within fourteen days of our request we will request payment based on the estimated annual premium in the quotation.

For annual payment policies which pay premiums by bank transfer we will issue an invoice for the estimated annual premium and payment must be made within fourteen days.

For quarterly payment policies which pay premiums by direct debit we will request a payment for 25% of the estimated annual premium. For quarterly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 25% of the estimated annual premium and payment must be made within fourteen days.

For monthly payment policies which pay premiums by direct debit we will request a payment for 1/12th of the estimated annual premium. For monthly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 1/12th of the estimated annual premium and payment must be made within fourteen days.

If, once the data is received, there is a greater than 50% variation in the number of members or total salary for the insured members compared to the data used for the quotation we reserve the right to review our pricing and/or terms and conditions.

If, once the data is received, there is a material change in the risk, it may mean we have to withdraw our offer or review our pricing and/or terms and conditions. We would withdraw our offer if the change in the risk is such that if we had known about it when we were asked to quote we would have declined to quote, for example, all the members being based outside the UK.

If any of these requirements are not provided when they are due, we reserve the right to withdraw cover. We will notify you that we have 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 members are covered?

One of the advantages of a group policy is that it is normally possible to provide cover for all eligible members up to a certain limit without the need to individually assess them. This limit is known as the automatic acceptance limit. Any member who has joined the scheme at their first opportunity, within the eligibility conditions will usually be covered automatically for benefit up to the automatic acceptance limit.
The automatic acceptance limit is reviewed at the end of every rate guarantee period and is dependent on the number of members and benefits insured. 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 will not benefit from any increase in the automatic acceptance limit. For example, if the original limit is £800,000 and a 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 will not mean that the loading is removed.

Where there are fewer than three members in a 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 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 does not join the pension scheme as soon as they satisfy the eligibility conditions, (a 'late entrant')

d) you are seeking cover for a member working beyond the date cover ceases.

Where individuals are auto-enrolled into the employer's workplace pension scheme, either at a staging date or at a re-enrolment date, if an individual is absent due to ill health and has been:

- in schemes with up to 50 members, for one week or longer
- in schemes with between 51 and 500 members, for four weeks or longer
- in schemes with 501 or more members, for twelve weeks or longer

we may require them to be individually assessed to establish the terms, if any, on which they can be covered. You must tell us the gender, age, date of absence, level of cover and the medical reason for their absence. We will review this information and advise you if the individual can be included without any further requirements or if they need to be individually assessed.

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 will 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 will need details of members who are absent due to ill health and have been:

- in schemes with up to 50 members, for one week or longer
- in schemes with between 51 and 500 members, for four weeks or longer
- in schemes with 501 or more members, for twelve weeks or longer.

The details we will require are the gender, age, date of absence, level of cover, the category the member is covered under and the medical reason for their absence. We will 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. 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 benefits declined or postponed. In addition you must tell us of any employees who travel on business to, are seconded to, or are resident in countries that we regard as high risk. An up to date list of these countries can be found on our website here. We will then assess the potential impact that including these individuals has on the existing policy and advise if we are 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 does not apply?

Individuals who need to be assessed will be sent an email containing a link to our secure online questionnaire. During this questionnaire they will be asked questions about their health and lifestyle and they will 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, independent medical examination, etc., 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 will advise both the individual and you of our decision. If there is a premium loading we will assume that it is acceptable and adjust future premium collections accordingly, unless you write to tell us otherwise. If this is the case, we will 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 are able to offer terms, individuals will normally not need to be assessed again if their total benefit does not exceed £5 million. We reserve the right to individually assess members again if their benefit increases as a result of a change in benefit basis or an increase in salary of more than twenty percent in a twelve month period.

2.2.3 If members have been assessed by a previous insurer, do they need to be re-assessed when we commence cover?

Where a scheme transfers its insurance to us from another insurer (with the exception of a Lloyd's syndicate insurer), we will normally take over the benefits accepted by the previous insurer up to a maximum benefit of £5 million for any one 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 will transfer is £1 million.

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

Whilst we are assessing an individual we will provide them with temporary cover for a maximum period of 30 days or until the date we finalise our assessment, if earlier.

Temporary cover starts from the date we are 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
- was diagnosed with

within the last two years immediately prior to the temporary cover starting, the temporary cover will not apply (benefit paid will be limited to the amount the member was previously entitled to).

b) temporary cover is limited to a maximum of £5 million if the member for whom it is provided has no existing cover under the aggregate of this policy and any associated life policies insured by us. If the member has got existing cover, temporary cover is limited to that amount which, when added to the level of existing cover, would take the member's

total cover – existing and temporary – to a maximum of £5 million.

Temporary cover will not be given to any individual who:

- has previously been declined, offered cover on nonstandard terms or where a decision on their benefit has been postponed (either by Ellipse 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 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 weeks or longer
    - in schemes with 501 or more members, for twelve weeks or longer
- is a late entrant.

If we are 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 Ellipse, we will require documentary proof of the previous acceptance terms.

3. What premiums will be charged for the cover?

The premium we charge depends on a number of factors including:

- the amount of cover provided
- the eligibility and entry conditions
- the age cover ceases
- the age and genders of members 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, are seconded to, or are resident in 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 schemes with up to 50 members, for one week or longer
    - in schemes with between 51 and 500 members, for four weeks or longer
    - in schemes with 501 or more members, for twelve weeks or longer

  details of such members
- the claims experience.

3.1 How will premiums be calculated?

Premiums are calculated for the cover provided to each member based on age-related premium rates which we apply to the amount of their insured benefit.

3.2 Will there be any extra premium?

Premium loadings may be imposed on members' 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 membership and benefits provided during each accounting period.

We normally guarantee the policy terms and underlying rate tables for two years until the second policy anniversary date. They will 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 across the aggregate of this policy and any associated life assurance policy insured with us:

a) the total number of members or the total salary changes by more than 50%
b) the number of members drops below two
c) the new inclusion of a participating employer or a TUPE transfer
d) the disposal of a participating employer or closure of a part of a participating employer's business
e) a change in policy design such as an amendment to the benefit level, the age cover ceases

or eligibility conditions

f) a change in the nature of a participating employer's business
g) the total benefit insured at any one location (including a new location) changes by more than £5 million
h) there is no longer an adviser acting for you in connection with this policy
i) there is a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
j) you have not given us complete and accurate information
k) we cease to insure the benefits under any other associated life assurance 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 will confirm the rate of commission payable to your adviser in your quotation and at regular intervals during the life of the policy.

4. How does the policy accounting work?

During the year, you will send us updated membership data at a frequency agreed when the policy starts. The frequency can be quarterly or every twelve months. For policies that use our Livewire™ automated data link, data can be updated monthly. After each data refresh, the cost of providing the cover will be recalculated to reflect the actual cover being provided.

The quotation will show the estimated first year cost assuming that all members are accepted at standard terms for their full benefit entitlement, based on the data supplied. The actual premium payable will vary from this:

- if the membership data changes (which will happen as people join or leave the company, or the amount of their salaries – and therefore benefits – change)
- if any of the circumstances set out in section 3.2 'Will there be any extra premium?' arise.

4.1 What information is required for accounting purposes?

When each data refresh is due, you must provide complete and accurate details of all current members including their:

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

For the avoidance of doubt, fair presentation of the risk at a data refresh is providing the information we ask for completely and accurately.

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

Premiums will be adjusted according to the latest data received, allowing for joiners, leavers and benefit changes. Where premiums are collected monthly or quarterly, the amount collected will be adjusted from the next due date. Where premiums are paid annually, at each policy anniversary date we will calculate if any premium is due or is to be refunded, based on the actual cover provided since the previous anniversary date.

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.

5. Claiming benefit

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

5.1 How are claims made?

To ensure a claim is processed quickly, you must advise us as soon as possible of a member's death. A claim form can be downloaded from our website at:
http://www.ellipse.co.uk/request_a_claim_form

Alternatively, you can call our claims team on 020 3003 6161.

In most cases we will not need to see the death certificate, 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 will need a completed claim form.

Claims will not be paid while premiums are overdue.

Upon receipt of a claim, we will deal with it promptly and fairly and will provide appropriate information on the progress of the claim. Once we accept a claim we will pay the benefit within five days providing we have valid payment details.

Lump sum payments 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 assurance policies. There must be an appropriate bank account into which benefit payments can be made. We will only make payments to UK bank accounts.

If we decline a claim we will 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 claims@ellipse.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 was not involved in the original claim decision.

If the appeal process upholds the original decision contact details of the Financial Ombudsman Service will be provided.

6. What is not covered?

There are no standard exclusions under the policy. However, where benefit for particular members are subject to individual assessment (see section 2.2 'Does any evidence of health have to be provided before members are covered?'), exclusions may apply for claims 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 will not 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 quotation, application form and policy schedule, along with the limit applying to the scheme as a whole. For locations that are not 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 compromise 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 will 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 will pay an amount equivalent to the event limit to the scheme trustees. The

scheme trustees are then responsible for distributing benefits to members' beneficiaries as they see fit.

Where the deaths occur (or are identified) in a period of time of more than one week we will come to an agreement with the scheme trustees on the most appropriate way in which we calculate and pay the benefits.

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 are together will be limited to £40 million. This applies both while they are travelling and for up to seven days at the location where they are engaged in the employer's business. If a lower event limit applies in the location where they are 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 are 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.

The £40 million travel limit will not always apply where the scheme includes members who are employed as professional sports people. In these cases, the travel limit to apply will be as detailed on the quotation, application form and in the 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 group travel limit.

7. Can cover be provided for a member who is not based in the UK?

7.1 Members who travel outside the UK

We will provide cover for members based in the UK who travel on business or leisure outside the UK.

7.2 Members seconded outside the UK

We will usually provide cover for members who are temporarily seconded outside the UK providing:

a) they satisfy the eligibility conditions of the scheme
b) the member has a contract of employment or for services with a participating employer
c) the country of secondment is declared for each member at the start of the policy and at each data refresh.

7.3 Members permanently based outside the UK

We will provide cover for members who are permanently working outside the UK in any of the following locations; European Union, Andorra, Australia, Canada, Channel Islands, Hong Kong, Iceland, Isle of Man, Gibraltar, Liechtenstein, Monaco, New Zealand, Norway, San Marino, South Africa, Singapore, Switzerland or the USA, providing:

a) they satisfy the eligibility conditions of the scheme
b) the member has a contract of employment or for services with a participating employer
c) the country of residence is declared for each member at the start of the policy and at each data refresh
d) the scheme rules allow members who are resident outside the UK to be included.

Where employees are 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 for a member who is not paid in pounds sterling benefit will be calculated based on the exchange rate agreed at the most recent data refresh before the date of death.

Where a scheme includes members who are resident outside the UK, the company must satisfy itself regarding any taxation consequences.

Where members are outside the UK, and provision of their benefit is subject to individual assessment, they will 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 Ellipse otherwise we will not be liable for any costs and the member may also be required to undertake another set of tests with an approved centre/provider.

We will reimburse the member for the tests we have requested, up to a maximum of the amount we would 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.

8. Taxation of policies

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

8.1 Payment of premiums

You are responsible for remitting the premiums to us

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

Tax relief on premiums paid in respect of any employees who have a proprietorial interest in the company will not normally be available. HMRC may agree to allow such relief if similar benefits are provided for a substantial number of other employees. Clarification of the tax position in such cases should be sought from your tax advisers.

Premiums for partnership partners will not normally be allowed as a business expense.

8.2 Payment of benefits

Lump sum benefits do not count towards a member's Lifetime Allowance and will not be subject to income tax. They will be subject to the normal inheritance tax rules applicable to discretionary trusts.

9. Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact which you know or ought to know of. If you do not 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 do not 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 is common knowledge) or
- we specifically say we do not 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 are 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 have not been deliberate or reckless in doing so) we can proportionately reduce the claim. We believe it is 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 do not make a fair presentation of the risk

9.4.1 Deliberate or reckless misrepresentation of the risk

If you deliberately or recklessly do not make a fair presentation when setting up the policy we may avoid 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 do not make a fair presentation but you have not been deliberate or reckless the outcome depends upon what we would have done if we had known the material facts:

- if we would not have entered into the policy we may avoid 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).

- if we would have applied different terms and/or an additional premium we will 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 is a fraudulent claim. If there is a fraudulent misrepresentation by a member which affects our acceptance of a claim made in respect of that member we will not pay the claim in respect of that member. If there is fraudulent claim made by you we will not pay the claim and we reserve the right to terminate the policy.

10. Glossary of terms used

Absentee: An individual who is, and has been, absent from work due to ill health for:

- in schemes with up to 50 members, one week or longer
- in schemes with between 51 and 500 members, four weeks or longer
- in schemes with 501 or more members, twelve 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

c) mentally and physically capable of performing all the duties normally associated with their job

and is not acting against medical advice in meeting any requirement of a) to c).

Associated group life assurance policy: Policies which we have agreed to link together for the purposes or rate tables, event limits or automatic acceptance limits.

Automatic acceptance limit: The maximum amount of benefit that can be provided for any member without the need for them to be individually assessed.

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

Discretionary entrant: An individual to whom scheme membership is offered without their having fulfilled 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 employee before they are included in the scheme.

Late entrant: Where membership is linked to membership of a workplace pension an individual who:

a) joins the pension scheme more than twelve months after first becoming eligible

or

b) is enrolled into the scheme more than twelve months after they first meet the eligibility conditions at the staging date or a re-enrolment date and who is, and has 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 weeks or longer
- in schemes with 501 or more members, for twelve weeks or longer.

Re-enrolment date: The third year anniversary of the employer's staging date (or previous re-enrolment date) at which time all eligible employees have to be re-enrolled into a workplace pension scheme.

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.

Staging date: The date on which the employer must start automatically enrolling employees into a workplace pension scheme.

11. Further information

Ellipse is the trading style of AIG Life Limited. Cover is provided by AIG Life Limited.

Ellipse is a trading style of AIG Life Limited. Registered in England and Wales. Number 6367921. Registered address: The AIG Building, 58 Fenchurch Street, London EC3M 4AB. AIG Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. The registration number is 473752. AIG Life Limited's SFCR (Solvency and Financial Condition Report) is available on request.

AIG Life Limited provides information about the insurance contracts we offer but does not provide a personal recommendation about the insurance products we offer. Employees of AIG Life Limited 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 is 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.

11.1 Questions and 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 Chief Executive Officer at:

5th Floor
15 Bermondsey Square
London
SE1 3UN

or by email to puttingitright@ellipse.co.uk
or by calling 020 3003 6160 (Calls may be recorded for training and monitoring purposes.)

If you are 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 4 567

11.2 Compensation

If we are 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

11.3 Data Protection

We are 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 for the benefit of your employees and their families. The information supplied by you may be transferred outside the UK including to countries outside the European Economic Area (including the USA, China, Mexico, Malaysia, Philippines and Bermuda). Full details can be found in our Privacy Notice https://ellipse.co.uk/data-protection/

11.4 Law

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

Our Group policy 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 have contracted out as described in section 9.4.

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

Ellipse shall not be responsible or liable to provide cover (including the payment of a claim) under the policy if we are 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 cannot be assigned without our prior written permission.

This document should be read in conjunction with the quotation. This document does not override the policy. If there is a difference between the policy and the technical guide, the policy takes precedence.