interact technical guide

ellipse

Any reference in this technical guide to employer can include the principal employer and participating employers.

Policy aims

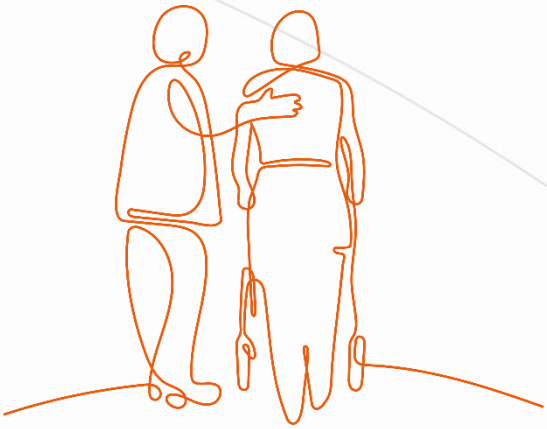
- To provide insurance to cover your promise to pay a proportion of a member's income in the event that they are unable to work (and suffer a loss of earnings) due to ill health.
- To provide a reduced payment in the event that the member's ill health allows them to work in a reduced capacity or for a reduced number of hours.

Your commitment

- To pay the premiums when they are due.
- To comply with the policy terms and conditions.
- To notify us when a member is absent from work due to ill health that seems likely to last for more than four weeks, and in any event of all member absences that have lasted four weeks and not previously been notified to us.
- To notify us of any changes to the employment status (including whether they have returned to work) in respect of a member for whom a claim has been submitted or is being paid.
- To fully participate in any return to work initiative in respect of absent members.
- To pass the appropriate benefits paid under the policy to the member.
- To provide us at the agreed intervals with the information specified in the policy as needed to ensure effective and timely cover for scheme members.
- To have obtained all necessary consents from the members to enable us to process their information.
- To ensure that any information you supply is accurate and complete at the time when you provide it.

Our commitment

- We will make our decision about the eligibility of a claim as quickly as possible.
- 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 and the services provided as part 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 outcome of such assessment



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Risk factors

- If you do not pay premiums on time, provide data when requested or you fail to comply with the policy terms and conditions we reserve the right to cease the policy and not pay any new claims.
- Any delay in providing the information we require may result in members not being fully covered.
- 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 cover and/or the terms and conditions or cease the policy – see Section 9.5 'What happens if you do not make a fair presentation of the risk'.
- Certain types of claims may be excluded – see section 6 'What is not covered'.
- Benefit payments under the policy may be reduced if the member is receiving other income as a result of incapacity - see section 5.5 'Does other income the claimant receives affect the benefit from this insurance?'.
- Receipt of benefits may disqualify the member from receiving some State benefits.
- 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 HM Revenue & Customs (HMRC) changes that could affect this policy.

Your questions answered

How does the policy work?

- You decide the eligibility and the cover you wish to provide, including the amount of benefit, how soon benefit payments start, how long they are paid for, the definition of incapacity and whether the benefit increases each year in payment. You can choose different eligibility and bases of cover for different categories of employees.
- 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 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.
- We provide the cover whilst premiums are being paid and the policy remains in force no matter how many claims you make.
- You provide us with any information we require in order to assess and monitor an individual who is absent from work due to ill health. Where appropriate we will work with you, the member and the appropriate experts to help them return to work.
- We pay income benefit to you monthly in arrears on the first day of each month, from the end of the deferred period – see section 1.7 'When will benefit payments start', and you pass on the benefit to the claimant after the appropriate deductions for tax and National Insurance Contributions are made. For equity partners, benefit payments are made to the partnership.

- All members will be covered for benefits 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 also needs to be accurate and complete. 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

  we should be informed immediately rather than at the next data refresh because we will 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 tables are normally guaranteed for two years and will not be reviewed during that time unless one of the following occurs:
    - the total number of members or the total scheme salary changes by more than 25%
    - the number of members drops below two
    - the new inclusion of an associated employer or a TUPE transfer
    - the disposal of a participating employer or closure of a part of an employer's business
    - the inclusion of a new member category
    - 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 an employer's business
    - more than 25% of the total number of members or total salary changes location
    - 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.

  These matters define the risk as a whole.
- Where an absence could be shortened or otherwise mitigated, our Case Manager will recommend the appropriate interventions to achieve this. The nature of the interventions will vary according to the specifics of each case but could include organising referrals to specialists, setting up treatment plans and identifying modifications to the employee's work environment that would allow a return to work, amongst many others.
- When we have accepted a claim, the benefit is paid to you monthly in arrears. You pay the same amount (less any tax, National Insurance Contributions and pension scheme contributions etc.) to the claimant through your normal payroll system. We will continue to review the claimant's health on a regular basis to check that the claim is still valid and assess if there are any measures that can be taken to facilitate a return to work.

Contents

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

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. An employee will be covered once they fulfil the eligibility conditions and satisfy any actively at work requirement we apply. Workers engaged through zero hour contracts cannot be included in the policy.

Cover can be provided for equity partners, providing all equity partners engaged in the business of the employer are included.

1.2 Eligibility conditions

The eligibility conditions must be clearly defined and agreed with us before the policy starts. Different eligibility conditions can be applied to different categories of membership.

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 employees must have completed three months' service before they can join your scheme)
- 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 pension scheme membership
- the date on which salary 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 employees who satisfy the eligibility conditions.

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

Employees who meet the eligibility conditions and satisfy the actively at work requirements are usually covered up to the policy's automatic acceptance limit. If this is not the case (or the policy's automatic acceptance limit is zero) the employees will be individually assessed before we will consider providing cover.

1.3 'Actively at work' requirements

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 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 the job:

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

For newly insured schemes, individuals will be covered providing they are actively at work on the policy start date. For previously insured schemes individuals must be actively at work on the last working day prior to the policy start date in order to be covered.

Once a policy is in force, new entrants must be actively at work before their cover can begin and increases in cover for existing members will also be subject to them being actively at work.

1.4 When will cover cease?

1.4.1 Under normal circumstances

A member will cease to be covered if they

a) reach the age at which their cover ceases according to the terms of the policy,
b) cease being employed by the employer or otherwise become ineligible for membership,
c) die,
d) permanently take up residence abroad.

1.4.2 Cancelling the cover

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 comply with the policy terms and conditions
b) you do not provide data we have requested within 90 days, or such extended time as we may, at our discretion, agree in writing
c) you do not provide information we have requested within 90 days, or such extended time as we may, at our discretion, agree in writing
d) you do not pay premiums when they are due
e) 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
f) 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.

1.5 What types of cover are available?

1.5.1 Basic benefit

You can choose what level of basic benefit you wish to provide and the level can be different for different categories of members.

Benefits are expressed as a percentage of the pre-incapacity earnings. You can choose a percentage up to a maximum of 75%. You can also choose to apply a fixed deduction from the benefit in respect of the basic Employment and Support Allowance (ESA) (whether or not these are actually paid). Examples of gross pay bases are '75% of salary less an amount equal to the ESA' or '50% of salary'.

The maximum percentage of income for equity partners will be 50%.

Whatever benefit formula is selected, the maximum basic benefit we will provide is £350,000 per annum.

What are pre-incapacity earnings?

The definition of salary used to calculate the member's benefits 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 paid for 18 months we will average them over the 18 month period). If, in the event of a claim, dividend payments do not stop the benefit payable will be reduced by the amount of dividends paid. We will not accept a salary definition which is based on dividends only.

The salary definition available for equity partners is either

- the taxable earnings after 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 incapacity, averaged over the preceding three years (or shorter period if applicable).

1.5.2 Optional additional protection

In addition to the basic benefit, you can choose to insure:

- pension scheme contributions, and/or
- employer National Insurance Contributions

Pension scheme contributions

Employer and employee pension scheme contributions to workplace pension schemes can be insured. The maximum employer pension scheme contribution that can be covered is 30% of pre-incapacity earnings and the maximum employee pension scheme contribution is 5%. Cover for employee pension scheme contributions can only be provided if the employer pension scheme contributions

are also insured. The overall maximum amount of pension scheme contribution that can be insured is £75,000 per annum.

Employer's National Insurance Contributions
You can choose to insure the employer National Insurance Contributions payable on the member's benefit and they can be covered on either a contracted in or contracted out basis.

1.6 How is incapacity defined?

You can choose one of four definitions of incapacity to apply to your scheme or to a category of members within your scheme.

The full definition of incapacity applicable to your policy will be detailed in your policy document and we will assess any claims against this definition.

The definitions of incapacity available are:

Own occupation:

A member is considered to be incapacitated, measured by their inability to perform, as a result of illness or injury, the material and substantial duties of their usual occupation and not following or engaged in any other gainful occupation whether as an employee or otherwise.

Suited occupation:

A member is considered to be incapacitated, measured by their inability to perform, as a result of illness or injury, the material and substantial duties of their usual occupation and any other reasonable alternative occupation to which they are suited and not following or engaged in any other gainful occupation whether as an employee or otherwise.

Own occupation switching to Suited occupation after 2 years:

A member is considered to be incapacitated, measured by their inability to perform, as a result of illness or injury, the material and substantial duties of their usual occupation. This measure of incapacity will be during the first 24 months of claim payments. If the member's absence continues after this, the measure of incapacity will be that the member must be unable to perform the material and substantial duties of their usual occupation and any other reasonable alternative occupation to which they are suited and not following or engaged in any other gainful occupation whether as an employee or otherwise.

Activities of daily working:

A member is considered to be incapacitated, measured by their loss of the physical ability through an illness or injury to do at least 3 of the 6 work tasks listed below without the help or supervision of another person:

Walking – the ability to walk more than 200 metres on a level surface.

Climbing – the ability to climb up a flight of 12 stairs and down again, using the handrail if needed.

Lifting – the ability to pick up an object weighing 2kg at table height and hold for 60

seconds before replacing the object on the table.

Bending – the ability to bend or kneel to touch the floor and straighten up again.

Getting in and out of a car – the ability to get into a standard saloon car, and out again.

Writing – the manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

Or in the event of mental incapacity, they have a mental incapacity which has failed to respond to optimal treatment and requires the need for continuous psychotropic medication and is supported by evidence of progressive loss of ability to remember, reason, perceive, understand, express and give effect to ideas, and cause a significant reduction in mental and social functioning, requiring the continuous supervision of the person covered.

The insured person must be unable to perform the task, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

Please note:

- Where a member's occupation requires a licence (other than a standard UK driving licence), or the member's main role is to buy or sell securities, options or futures, or instruments creating or acknowledging indebtedness or contracts of difference (known as a dealer, trader, sales, front office, broker, analyst or similar), the 'Own occupation' definition of incapacity will not be available. The loss of a licence will not, of itself, be sufficient to make a valid claim.
- 'Material and substantial' means duties that are normally required for and form a significant and integral part of the performance of the member's own occupation and which cannot be reasonably omitted or modified by the member or the employer.
- 'Reasonable alternative' means an occupation for which they are suited by virtue of their transferrable skills (education, training or experience) and one that provides a reasonable, but not necessarily comparable, salary and status in relation to their usual occupation.
- 'Usual occupation' means the occupation they performed at the time of claiming.

1.7 When will benefit payments start?

Benefit payments will be payable at the end of the deferred period and will be paid monthly in arrears on the first day of each month. Payments in respect of incomplete months will be paid on a proportionate basis.

The deferred period is the period of time from the date first absent during which no benefit is payable and you can choose from 4, 8, 13, 26, 28, 41 or 52 weeks. Longer deferred periods cost less than shorter ones.

Whilst we would normally expect the deferred period to be one continuous period of time, we will link periods of absence of at least two weeks for the same incapacity together in determining when the deferred period has been completed. These periods of absence must occur over a period of time not more than twice the deferred period for the scheme. For example, if the deferred period is 26 weeks and an individual is absent for 3 weeks on 4 occasions within a 52 week period, they will have served 12 weeks of their 26 week deferred period.

1.8 For how long will benefit be paid?

You can choose how long you want benefits to be paid for. The options available are until a fixed age such as 65, 70 or, the greater of 65 or the State Pension Age, or for a limited payment period of 2, 3, 4 or 5 years per claim.

Please note:

a) For some occupations such as pilots we may apply a lower cover cease age.
b) If a claimant under a limited payment period scheme has a number of absences for the same illness for which they are paid benefits, these periods of absence will be added together in determining when the limited payment period has been reached.
c) Benefit payments in respect of fixed term contract workers will cease at the end of the contract that was in force at the beginning of the deferred period.

1.9 Can income benefits be inflation protected?

Yes, when you set up the policy you can choose if you would like benefits in payment to increase each year or to remain level. Increases (known as escalation) can be 3%, 5%, linked to the Retail Price Index (RPI) up to a maximum of either 2.5% or 5%, or linked to the Consumer Price Index (CPI) up to a maximum of either 2.5% or 5%. If escalation is linked to CPI or RPI and either falls below 0% per annum we will not reduce the benefit in payment.

Escalation applies on the anniversary of the end of the deferred period and where escalation is linked to an Index the value of the Index used in the calculation of the escalation rate will be the latest value available to us.

2. Administrating the policy

2.1 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 employees 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 and who satisfies our actively at work requirements will usually be covered for benefit up to the automatic acceptance limit.

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 and benefits insured.

Any individual whose benefits have been restricted or accepted on non-standard terms will not benefit from any increase in the automatic acceptance limit. For example, if the original automatic acceptance limit is £100,000 p.a. and a member has total benefits of £125,000 p.a., of which £25,000 p.a. is subject to a premium loading, an increase in the automatic acceptance limit to £125,000 p.a. will not mean the loading is removed.

Where there are fewer than five members in a scheme, no automatic acceptance limit will be given.

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

a) an individual has benefits in excess of the automatic acceptance limit (benefit below the limit is still covered)
b) an individual is offered cover by the employer without the member satisfying the usual eligibility conditions (a 'discretionary entrant')
c) eligibility for cover is linked to pension scheme membership, an individual did not join the pension scheme within twelve months of first becoming eligible but then joins the scheme subsequently (a 'late entrant')

2.1.1 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), you must put the request in writing. We will consider the request and advise if the change can be made and details of any requirements we may have (including our actively at work requirements).

If you wish to include a group of employees as a result of a TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006), you must provide details of the individuals to be covered under the TUPE including their occupations and details of the claims experience and scheme history. You must also tell us if any of them have had benefit declined or postponed or who have had a medical exclusion applied to their benefit. In addition you must tell us of any employees who travel to on business, are seconded to, or are resident in countries that we consider high risk. An up to date list of these countries can be found on our website here. We

will then assess the impact that including these individuals would have 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.

2.1.2 What happens if the automatic acceptance limit is exceeded or doesn't 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 professional who has 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 take the form of a premium loading or an exclusion for a specific condition. 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 benefits accordingly.

Wherever possible, we aim to limit the number of times any individual needs to be assessed. Therefore, if we are willing to offer terms, individuals will normally not need to be assessed again. We reserve the right to individually assess members again if their benefit increases as a result of a change in benefit basis, or their cover cease age increases, or the deferred period changes, or there is an increase in salary of more than twenty percent in a twelve month period.

2.1.3 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 on the same basis 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 £350,000 per annum for any one member on the same terms, provided we get details of the previous insurer's terms of acceptance. Cover for benefit in excess of £350,000 per annum will be subject to individual assessment. The transfer of an individual's cover

from a Lloyd's syndicate insurer will be subject to individual consideration.

2.2 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 condition:

a) if a claim arises directly or indirectly as a result of any medical condition which the insured person:

- has received treatment for
- has suffered symptoms of
- has sought advice on
- was diagnosed with

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

Temporary cover will not be given to any individual who

- has previously been declined, offered cover on non-standard terms or where a decision on their benefits 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 benefit greater than the rules of the scheme provide for
- 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 an assessment 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
- eligibility and entry conditions
- the age cover ceases
- the age and gender of employees to be covered
- if the benefit increases in payment
- the deferred period
- the definition of incapacity
- the payment period
- the nature of the industry you are in and your principal activity
- occupations
- the salaries of the members
- the location of the workforce (postcode if in the UK or country if overseas)
- 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
- 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:

a) the total number of members or total salary changes by more than 25%
b) the number of members drops below two
c) the new inclusion of an associated employer, or a TUPE transfer
d) the disposal of a participating employer or closure of a part of the employer's business
e) the inclusion of a new member category
f) a change in policy design such as an amendment to the benefit level, the age cover ceases or the eligibility conditions
g) a change in the nature of an employer's business
h) more than 25% of the total number of members or total salary change location

i) there is no longer an adviser acting for you in connection with this policy
j) a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
k) you have not given us complete and accurate information.

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 any commission payable. We will confirm the rate of any 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
- name
- gender
- date of birth
- salary (based on the policy salary definition)
- benefit category
- 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 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 made in respect of members.

5.1 How are claims made?

Notification of long-term incapacity
If a member is off work due to ill health that seems likely to last for more than four weeks, and in any event where a member absence has lasted four weeks and not previously been notified to us, you should call our claims team on 020 3003 6161.

Where we identify an absence as having the potential to become long term, our Case Manager will conduct a review of the absence to identify the steps, if any, that might help the member return to work. These might include a consultation with the member by a qualified professional to obtain full information about the member's condition, followed by the development and implementation of a return to work plan where possible.

Can rehabilitation help?
You can minimise the costs of incapacity and increase the value the incapacitated member brings to your organisation by ensuring that rehabilitation programmes are implemented whenever appropriate. From the early stages of a claim we will appoint a Case Manager to advise, assist and support a member to help them cope with or overcome their incapacity.

It is a requirement of The Equality Act 2010 that you make any reasonable adjustment to a member's workplace that would assist them to continue to work and our policy terms and conditions take this into account.

Under what circumstances will income benefit be paid?
Where an absence looks as though it might extend beyond the deferred period that applies to your policy, we will use the information we hold to populate a claim form and send it to you to complete and return to us. To ensure no breach of the member's right to medical confidentiality, the form will not contain any information about the member's condition.

A separate form, also pre-populated with any information we already hold, will be sent to the member for them to complete.

We will pay claims where the member satisfies the definition of incapacity and incapacity continues beyond the end of the deferred period.

Payment of any State incapacity benefits does not automatically qualify the individual for benefit under this policy and vice versa.

Upon receipt of a claim, we will deal with it promptly and will provide appropriate information on the progress of the claim. Once all the information required has been received, we will start eligible claims payments promptly.

How incapacitated must the member be?
The member's ill health must be sufficiently severe that their condition satisfies the definition of incapacity that you have chosen.

The policy schedule will tell you which definition of incapacity is being used.

How will this be assessed?
We will make an objective assessment of the nature of incapacity and determine whether or not the member would be able to undertake the material and substantial tasks involved in their occupation.

When assessing the claim we will look for evidence of the medical condition, its severity, how long it has existed and how it affects their ability to work. As part of the assessment we will need the following:

- a completed claim form signed by the you
- proof of the member's age (for example the member's passport or birth certificate, or confirmation that you have seen one of these documents)
- an assessment form completed by the member – this will include their consent for us to seek further medical information as required by the Access to Medical Reports Act
- proof of membership and earnings
- details of other income to be taken into account for the calculation of the maximum benefit
- a copy of their job description detailing their regular duties
- details of their GP or treating doctor.

This list is not exhaustive and there may be times where more information is required.

We will consider any medical reports or additional information that you wish to provide.

In determining whether a claimant's level of incapacity meets the definition chosen, we will assess your claim based on the medical evidence provided in conjunction with the definition of incapacity as chosen. Any diagnosis or medical opinions must be given by a medical professional who is a specialist in the relevant area of medicine appropriate to the cause of the claim and is acceptable to our Chief Medical Officer. For the avoidance of doubt our assessment will not be based purely on the medical opinions provided.

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.

We will undertake regular reviews of the claim to ensure the member continues to satisfy the definition of incapacity. The frequency of these reviews will depend on the nature of incapacity.

Can a claim decision be appealed?
If a claim is declined and you disagree with our decision you or the claimant 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.

5.2 When will benefit cease?

We will pay benefit until the earliest of one of the following:

a) the member no longer satisfies the definition of incapacity
b) the member no longer suffers a loss of earnings
c) the member reaches the age cover ceases
d) the end of the limited payment period if this option has been selected
e) the member leaves service and there has been no agreement to continue the benefit
f) the contract of employment ends
g) the member dies
h) the member undertakes any form of employment without our agreement
i) the member or employer does not fully engage in an agreed rehabilitation programme or the member does not follow medical advice.

Where we may pay benefit direct to an individual
In the event EITHER that the claimant is removed from your payroll, and subject to agreement between us, the claimant and you, OR your business is wound up, we will continue to pay directly to the claimant subject to the following changes:

- If the definition of incapacity was 'own occupation' it will change to 'suited occupation'
- Any benefit in respect of National Insurance Contributions or pension scheme contributions will cease immediately
- Income tax will be deducted.

Where benefits are paid directly to an individual their entitlement to State benefits may be affected.

What happens if the member's illness or injury means that they can work on a part- time basis or in a reduced capacity?
In these circumstances, we may pay a proportionate benefit in respect of the member, e.g. if a member's earning are reduced by 20% due to incapacity we may pay 20% of their insured benefit.

It is not necessary for a full benefit to be paid before we will consider a claim for a proportionate benefit.

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

You should contact us when a member is off work due to ill health that seems likely to last for more than four weeks, and in any event where a member's absence has lasted four weeks and not previously been notified to us. This will enable us to complete the absence review and assess the claim.

5.4 Who pays for medical evidence?

If we ask for medical evidence we will pay for it.

5.5 Does other income the claimant receives affect the benefit from this insurance?

The scheme is designed to ensure that an individual receives a lower income when they are receiving benefits than when they are working, to ensure that they have a financial incentive to return to work. Therefore any other income which becomes payable as a result of their incapacity is likely to affect the benefit we pay.

We will restrict the benefit we pay so that when it is added to other income it doesn't exceed 75% of the member's total pre-incapacity income from their employer.

Examples of other income include:

- Occupational sick pay
- Ill health early retirement pensions
- Mortgage protection or loan or credit protection policies.

Any untaxed income will be adjusted so it can be comparable to taxed income and we will ignore insurance policies which pay benefits for up to two years duration unless they put the member's post-incapacity income in excess of their pre-incapacity income, in which case the member's benefit will be restricted so that it doesn't exceed their pre-incapacity income.

Where dividends form part of the salary definition, if they do not stop being paid in the event of a claim we will reduce the benefit by the amount of dividends paid.

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

If incapacity is from a different cause
Yes, this will be treated as a new claim and the member must satisfy the definition of incapacity and complete the deferred period.

If incapacity is from the same cause
Yes, and if incapacity occurs within twelve months of the claimant returning to work, the deferred period does not need to be completed. This is known as a 'linked claim'. The level of benefit paid will be the same as that being paid immediately before the member returned to work.

If the policy has a limited payment period, periods of absence from the same or related cause, for which benefit has been paid, will be added together when we calculate the duration of payment in order to assess if the limited payment period has been used up.

5.7 What happens to claims if the policy is discontinued?

If a scheme transfers to another insurer
In general any future claims will be the responsibility of the new insurer. However, if a claimant returns to work and satisfies the new insurer's actively at work requirements, and subsequently is absent from work as a result of the same illness or incapacity within twelve months, we will pay benefits for the duration of the new insurer's deferred period.

If the member does not satisfy the new insurer's actively at work requirements we will remain liable for any future benefit payments until the actively at work requirements are satisfied.

What happens if the business goes into liquidation?
We will continue to pay all claims that we have accepted whilst they remain valid and, provided all premiums are paid up to date, we will consider all claims where incapacity arose before the policy ceased. If the definition of incapacity is 'own occupation' it will be changed to 'suited occupation' – see section 1.6 'How is incapacity defined?' – and all supplementary benefits will cease and income tax will be deducted.

6. What is not covered?

There are no standard exclusions under the policy. However, where benefits for particular members are subject to individual assessment (see the earlier 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.

7. Can cover be provided for an employee 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 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) they have a contract of employment with a UK registered company
c) the country of secondment is declared for each employee at policy start and at each data refresh.

Where an employee remains outside of the UK we will pay a claim for a maximum period of six months unless they are resident in one of following: 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.

Where members are outside the UK, and provision of their benefits 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, to a maximum of the amount we would pay for the same tests 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 Members permanently based outside the UK

We will not provide cover for individuals permanently based outside the UK.

8. Taxation of policies

The following outlines our understanding of legislation and HMRC practice.

8.1 Payment of premiums

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

For tax purposes, premiums paid by you in respect of employees are treated as a business expense and are not treated as a P11D benefit for employees.

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.

Equity partners pay for their own premiums and there is no tax relief on these premiums.

8.2 Payment of benefits

The benefit is paid to you and should be treated as a business receipt. You pass it on to the employee as salary continuance through the PAYE system and it is treated as a business expense, resulting in a tax neutral position.

Benefits payable to equity partners are not subject to income tax.

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 When the duty of fair presentation applies

The duty of fair presentation applies to policies that start or have a rate review on or after 12 August 2016 as well as changes to existing policies which are agreed on or after 12 August 2016.

9.4 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 other remedies available for misrepresentation may be applied as outlined below.

9.5 What happens if you do not make a fair presentation of the risk

9.5.1 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).

9.5.2 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 this 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 this 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).

9.6 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

Actively at work:
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 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).

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

Discretionary entrant: An employee to whom scheme membership is offered without their having fulfilled the eligibility conditions.

Eligibility conditions: The conditions which must be met by the employees before they are included in the scheme.

Late entrant: Where membership is linked to a workplace pension scheme membership an individual who joins the pension scheme more than twelve months after first becoming eligible.

11. Further information

Ellipse is a trademark of the UK branch of ERGO Lebensversicherung Aktiengesellschaft. Cover is provided by ERGO Lebensversicherung, UK Branch.

ERGO Lebensversicherung Aktiengesellschaft is regulated by BaFin. The registration number is 1184.

ERGO Lebensversicherung, UK Branch is registered in England. The registration number is BR010594.

The registered office is 5th Floor, 15 Bermondsey Square London SE1 3UN

ERGO Lebensversicherung Aktiengesellschaft is a German insurance company with headquarters in Hamburg.

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 0203 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
1 Harbour Exchange Square
London E14 9SR

Tel 0800 023 4 567

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
10th Floor, Beaufort House
15 St Botolph Street London
EC3A 7QU

Tel: 0800 678 1100

Law

The policy is issued subject to the laws in England and Wales. Under the policy, members do not have any rights under the Contracts (Rights of Third Parties) Act 1999, except in respect of any complaint or dispute a member may have in respect of a claim for that member that has been submitted in accordance with our standard claims procedures.

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, excepted 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.

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.