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Life Limited.

single relevant 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 employee.

Policy aims

- To provide cover for a single member who cannot be provided cover under an excepted group life policy.
- To provide insurance to cover a lump sum benefit payable on the death of the member covered by this Single Relevant Life policy.

Your commitment

- To pay the premiums when they are due.
- To comply with the policy terms and conditions.
- To establish a scheme.
- To notify 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 member.
- To have obtained all necessary consents from the member 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

- Once we accept a claim we will pay the benefit within five days.
- We will pay promptly any premium refunds that may arise.
- We will request information about you or the member 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.

Document reference:

SRLP-TechGuide-Nov16-1

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.
- 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 the member 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 the 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'.
- 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 the member, the responsibility for any shortfall lies with you.
- The policy runs alongside a group life assurance policy for other employees.
- 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 member covered by this policy.
- 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.
- 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.
- We provide the cover whilst premiums are being paid and the policy remains in force.
- The benefit to be paid in the event of a claim will be as selected by you at the outset and shown in the policy schedule. Limits to the total sums payable may apply where claims from this and any associated group life policy arise from the same, or related, events.
- The member will be covered for benefit up to an automatic acceptance limit specific to your policy, providing they join the scheme at their first opportunity within the eligibility conditions. Any benefit that exceeds the automatic acceptance limit will be subject to individual assessment.

- 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.
- 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 group life assurance policy:
    - the total number of members or the total salary changes by more than 50%
    - 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
    - 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
    - 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.

  These matters define the risk as a whole.
- When we have accepted a claim we will pay the lump sum benefit to the trustees who are responsible for paying the member's dependants. You will need to have a trustee bank account into which these benefits can be paid. We will expect the trustees to confirm that the benefit will only be paid to an individual or charity.

Contents

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

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

1.1 Who can be covered?

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

Workers engaged through zero hour contracts will not ordinarily be covered by our policy. They can be covered under a Single Relevant Life policy subject to our agreement.

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

1.2 Eligibility conditions

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

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)
- 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 employees who satisfy the eligibility conditions.

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

If the employee meets the eligibility conditions they 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 employee will be individually assessed before we will consider providing cover.

1.3 When will cover cease?

1.3.1 Under normal circumstances

The member will cease to be covered, and the policy will cease, if they:

- **a)** reach the age at which their cover would cease according to the terms of the policy, unless we 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
- **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)** they 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 the member continue to be covered if they are absent from work'
- **f)** die.

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

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

Cover will also cease if it is not allowed under the HMRC regulations.

1.3.2 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)** we become aware that the scheme no longer meets HMRC requirements
- **e)** there is a change in legislation, regulation or HMRC practice or taxation which affects this policy
- **f)** you do not pay premiums when they are due
- **g)** an employer covered under this policy or any associated group life assurance policy ceases to carry on business, or if any order is made or resolution passed for the winding up of that employer
- **h)** you fail to fairly present the risk prior to setting up the policy, or at a rate review, or when you request a change to the policy.
- **i)** we cease to insure the benefits under any other associated life assurance policy.

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.

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 a worker engaged through zero hour contract 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 actual earnings in the twelve months up to the date of death.

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

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

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

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

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

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

1.5.5 If the 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.

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

a) the end of the zero hour contract
b) when the zero hour contract is terminated
c) three years from the start of the ill health.

Whilst the 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 larger increase is enshrined in law).

1.6 Are any additional options available under the policy?

We offer the following option:

1.6.1 Extended cover

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

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

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 accurate and complete. 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 headed 'Information you provided on which our quotation was produced' is in respect of members covered under this policy and any associated group life assurance policy.

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 member who might since have 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 the case of all group life assurance policies issued by Ellipse that have a total of:

- up to 50 members, for one week or longer
- between 51 and 500 members, for four weeks or longer
- 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 the case of all group life assurance policies issued by Ellipse that have a total of:

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

If such individuals are notified to us 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.

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.

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) 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 issue an invoice based on the estimated annual premium in the quotation.

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

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 quarterly paying policies which pay premiums by direct debit we will request a payment for 25% 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.

For monthly payment policies which pay premiums by direct debit we will request a payment for 1/12th of the estimated annual premium.

If, once the data is received for this policy and any associated group life assurance policy, there is a greater than 50% variation in the number of members or total salary 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 for this policy and any associated group life assurance policy, 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 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 employees 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 the member is 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. If the member has joined the scheme at their first opportunity, within the eligibility conditions they 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 in this policy and any associated group life assurance policy.

If a member is included in more than one policy insured by us, the member's aggregate benefit will be used to assess whether the automatic acceptance limit is exceeded.

Any individual whose benefit has been restricted, declined, postponed or accepted on non-standard terms will not benefit from any increase in the automatic acceptance limit. For example, if the original limit is £800,000 and the member has 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 five members in this policy and any associated group life assurance policy, 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 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 the member satisfying the usual eligibility conditions or who is being offered a different basis of cover to the majority of the rest of the scheme membership (a 'discretionary entrant')
- **c)** eligibility for cover is linked to pension scheme membership and an individual does not join the pension scheme as soon as they satisfy the eligibility conditions, (a 'late entrant')
- **d)** the member is working beyond the date cover ceases and you are seeking cover for them.

Where individuals are auto-enrolled back 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 the case of all group life assurance policies issued by Ellipse that have a total of:

- up to 50 members, for one week or longer,
- between 51 and 500 members, for four weeks or longer
- 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 policy?

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 the case of all group life assurance policies issued by Ellipse that have a total of:

- up to 50 members, for one week or longer
- between 51 and 500 members, for four weeks or longer
- 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 provide cover for a group of employees as a result of a TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006) and this results in the need for a Single Relevant Life policy. You must also provide details of the number of TUPE employees and their total benefits, the current automatic acceptance limit and full details of any employee who has had benefit declined or postponed. In addition you must tell us of any employees who travel on business to, 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 policies 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?

If the member needs to be assessed we will send 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, the member will normally not need to be assessed again if their total benefit does not exceed £5million. We reserve the right to individually assess the member again if their benefit increases as a result of a change in the benefit basis or an increase in salary of more than twenty percent in a twelve month period.

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

Where a policy transfers its insurance to us from an insurer (with the exception of a Lloyd's syndicate insurer), we will normally take over the benefit accepted by the previous insurer up to a maximum benefit of £5 million for the member, on the same terms, provided we get sight of the previous insurer's terms of acceptance. Cover for benefit in excess of £5 million will be subject to individual assessment. Where the previous insurer was a Lloyd's syndicate insurer the maximum cover we will transfer is £1 million.

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

Whilst we are assessing the 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 scheme. 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 non-standard 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
- 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, 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
- 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 in respect of this policy and any associated group life assurance policy including:

- the amount of cover provided
- the eligibility and entry conditions
- the age cover ceases
- the age and genders of individuals to be covered
- the nature of the industry you are in and your principal activity
- the salaries of the members
- the location of 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 the case of all group life assurance policies issued by Ellipse that have a total of:
    - up to 50 members, for one week or longer
    - between 51 and 500 members, for four weeks or longer
    - 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 the 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 the member's cover as a result of them being individually assessed. Any loading will reflect their medical condition or hazardous pursuit and will apply only to the benefit that has been individually assessed.

The actual premium payable will depend on the 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 to the aggregate of this policy and any associated group life assurance policy:

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 an associated employer or a TUPE transfer
d) the disposal of a participating employer or closure of a part of an 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 an 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.

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. After each data refresh, the cost of providing the cover will be recalculated to reflect the actual cover being provided.

4.1 What information is required for accounting purposes?

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

- **a)** National Insurance number
- **b)** name
- **c)** gender
- **d)** date of birth
- **e)** salary (based on the policy salary definition)
- **f)** benefit category
- **g)** location (postcode if in UK or country if outside the UK)
- **h)** 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 if the member has a benefit change during the year?

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

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 the member.

5.1 How are claims made?

To ensure a claim is processed quickly, you must advise us as soon as possible of the member's death. 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.

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 to the trustees who are responsible for distributing the benefit and must 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.

5.1.1 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, if the benefit for the member is subject to individual assessment (see section 2.2 'Does any evidence of health have to be provided before the member is covered?'), exclusions may apply for a claim arising from certain specified medical conditions or in specified circumstances.

6.1 Event limit

An event limit will be 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, 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 limits.

6.2 Group travel limit

In the event that two or more people 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 that limit will apply.

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 if the member is not based in the UK?

7.1 If the member travels outside the UK

We will provide cover if the member is based in the UK and travels on business outside the UK.

7.2 If the member is seconded outside the UK

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

a) they satisfy the eligibility conditions of the scheme

b) the country of secondment is declared at the start of the policy and at each data refresh.

7.3 If the member is permanently based outside the UK

We will provide cover if the member is 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 country of residence is declared at the start of the policy and at each data refresh

c) the scheme rules allow employees who are resident outside the UK to be included.

If the member is working outside the UK the amount of salary and/or benefit advised at each data refresh must be expressed in pounds Sterling.

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

If the member is 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 practises. You should get professional advice from your own tax advisers.

8.1 Payment of premiums

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

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

8.2 Payment of benefit

Lump sum benefits do not count towards the 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:

a) it diminishes the risk
b) we know it
c) we ought to know it
d) we are presumed to know it (because it is common knowledge) or
e) 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 mis-representation of the risk (but you have not been deliberate or reckless in doing so) we can proportionally 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 mis-representation 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 mis-representation 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 mis-representation 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 mis-representation 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 mis-representation 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 mis-representation by the member which affects our acceptance of a claim made in respect of the member we will not pay the claim in respect of the 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 the case of all group life assurance policies issued by Ellipse that have a total of:

- up to 50 members, one week or longer
- between 51 and 500 members, four weeks or longer
- 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 the member's death.

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

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 subsequent re-enrolment date and who is, and has been, absent due to ill health, in the case of all group life assurance policies issued by Ellipse that have a total of:

- up to 50 members, for one week or longer
- between 51 and 500 members, for four weeks or longer
- 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 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 AG, 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 Hamburgh.

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
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. 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 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.