Group Protection

Sick Pay

TECHNICAL GUIDE

WELCOME TO AIG

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

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

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

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 tell us when a member is absent from work due to ill health by the end of the fifth week of absence;
- To tell us of any changes to the employment status (including whether they have returned to work) of a member for whom a claim has been submitted or is being paid;
- To fully participate in any vocational rehabilitation programme or 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 ensure that any information you supply is complete and accurate at the time when you provide it;
- To provide information about the policy and how it works to members.

Our commitment

- We'll make our decision about the eligibility of a claim as quickly as possible;
- We'll pay promptly any premium refunds that may arise;
- We'll 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'll copy in your adviser to any correspondence we send to you;
- We won't copy you or your adviser into any correspondence sent to 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 assessments.

Risk factors

- If you don't 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 individuals not being covered or having less than their full cover;
- If you don't 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 9.4 '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 5.7 'Does other income the member receives affect the benefit from this insurance?';
- Receipt of benefits may disqualify the member from receiving some State benefits;
- The tax treatment of any lump sum claim payment to the employer (if this benefit structure is selected) may vary depending on how, when and in what circumstances the payment is used;
- 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. You should take into account your organisation's absence policy when deciding on the cover to be provided;
- In order to ensure that you comply with relevant employment and taxation legislation you should obtain appropriate legal and tax advice;
- 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 a member 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 member 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 and fulfill the actively at work requirements. 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 14 days of us requesting it. We'll confirm at the start of the policy how often you will provide updated membership data which needs to be complete and accurate. This should include details of new entrants, who have joined the scheme since the previous data refresh and who will normally be covered as soon as they fulfil the scheme's eligibility conditions and the actively at work requirements. However, if:
  - a new entrant's annual benefit exceeds the automatic acceptance limit;
  - a new entrant is joining without fulfilling the normal eligibility conditions;
  - a new entrant is joining other than at their first opportunity;
  - an existing member's annual benefit increases to exceed the automatic acceptance limit;
  - an individual requires cover beyond the age that cover ceases;

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

- The policy terms and conditions and the underlying premium rate 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 salary changes by more than 30%;
  - the number of members drops below two;
  - the new inclusion of a participating employer or a TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006) transfer;
  - the disposal of a participating employer or closure of a part of 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 30% 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;
  - you do not give us complete and accurate information.
- Where an absence could be shortened or otherwise mitigated, our Vocational Rehabilitation Specialist 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 member's work environment that would allow a return to work, amongst many others. For more information go to our website.
- 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 member through your normal payroll system. We will continue to review the member'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. When deciding on your insurance needs you should take into account your organisation's absence policy.

1.1 Who can be covered?

Full time, part time and fixed term contract workers can be included in the policy. An individual 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 individuals must have completed three months' service);
- the date on which new entrants will be included, (for example, on the day they satisfy the eligibility conditions or on the first of the following month);
- full details of the pension scheme eligibility conditions where eligibility is linked to membership of a workplace pension scheme;
- the date on which salary increases are applied, which can be daily, monthly or annually.

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

We consider an individual joining the pension scheme within 12 months of first becoming eligible as joining at their first opportunity providing they are actively at work when they join the pension scheme.

Individuals 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 individual will need to 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 their 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. If a new entrant is not actively at work on the required date they will be covered from the next day on which they are actively at work. Similarly, if an existing member is not actively at work on the day their cover is due to increase they will receive the increase in cover on the next day they are 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 and we have not agreed with you that their cover can be extended;

b) cease being employed by the employer or otherwise become ineligible for membership;

c) permanently take up residence outside the UK, Channel Islands or Isle of Man;

d) reach the end of their fixed term contract;

e) reach the end of their temporary absence cover period as detailed in section 1.10 'Does a member continue to be covered if they are absent from work';

f) a lump sum benefit is paid in respect of them following a limited term claim;

g) die.

Under no circumstances can cover continue beyond a member's 70th birthday.

1.4.2 Cancelling the cover

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

We reserve the right to cancel the policy if:

a) you don't comply with the policy terms and conditions;

b) you don't provide information we have requested within 90 days;

c) you don't pay premiums when they are due;

d) 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;

e) 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;

f) there is a change to, or new, legislation, regulation, HMRC practise or taxation which affects the treatment of this 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 pre-incapacity earnings. You can choose a percentage up to a maximum of 80% (inclusive of any employee pension scheme contributions insured). You can also choose to apply a deduction from the benefit. This deduction can be:

a) a fixed deduction equivalent to the Employment and Support Allowance (ESA) (whether or not this is actually paid);

b) for schemes currently insured on this basis, a fixed deduction equivalent to the ESA and (if required) the notional value of the Work Related Activity Component (WRAC) – whether or not the ESA is actually paid.

Examples of gross pay bases are '75% of salary less an amount equal to the ESA' or '50% of salary'.

Alternatively, for schemes currently insured on this basis, you can choose that the deduction in respect of ESA is applied only if the member qualifies for ESA. This is known as partial integration.

The maximum percentage of income for equity or limited liability 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 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. Any variable pay must be averaged over three years (or shorter period if applicable, e.g. if bonuses have only been paid for 18 months we will average them over the 18 month period). Dividends can be included in the salary definition and they must be averaged over three years in the same way as other variable pay. If, in the event of a claim, dividend payments don't 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 or limited liability 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).

If a salary sacrifice arrangement is being operated which will reduce a member's contractual basic salary and you want to base the benefits on the pre-sacrifice salary level you must agree the basis with us.

1.5.2 Employer's lump sum benefit

For schemes of more than 20 members which are insured on a limited payment basis it is possible to include a lump sum payment if the member meets the definition of incapacity at the end of the limited payment period. This option must be selected when the policy is set up.

The value of the lump sum payment can be a multiple of between one and five times a member's initial basic benefit subject to a maximum of £1m and the multiple must be agreed when the policy is set up and cannot be greater than the number of years of the limited payment term (e.g. for a three year limited payment period policy the maximum value of the lump sum multiple is three). In addition, the lump sum benefit will be restricted so that it doesn't exceed the monthly basic benefit multiplied by the number of months from the end of the limited payment period until the member's cover cease age. For example, if the lump sum multiple for a scheme is four and the member is 63.5 years at the end of the limited payment period and the cover cease age is 65 the lump sum for that member will be restricted to 1.5 x basic benefit.

Only one employer's lump sum can be paid per member.

Please note that where a member has been individually assessed for their annual benefit and had part of their cover declined, postponed or had an exclusion applied to it we will apply these same terms to the pro-rated value of the lump sum benefit.

The employer lump sum benefit is not available to members in extended cover or where the regular payments under the policy are paid directly to the member.

1.5.3 Optional additional protection

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

- pension scheme contributions;
- employer National Insurance Contributions.

Pension scheme contributions

Employer and employee pension scheme contributions to workplace pension schemes can be insured. The maximum pension scheme contribution that can be covered is 35% of pre-incapacity earnings of which the maximum employee pension scheme contribution is normally 10%. 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.

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 is 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 is not following or engaged in any other gainful occupation whether as an employee or otherwise.

Own occupation switching to Suited occupation after two years:

A member is considered to be incapacitated, measured by their inability to perform, during the first 24 months of any claim, as a result of illness or injury, the material and substantial duties of their usual occupation and is not following or engaged in any other gainful occupation whether as an employee or otherwise. If the member's absence continues after this, the measure of incapacity will be that the member must be unable, as a result of illness or injury, to perform the material and substantial duties of their usual occupation and any other reasonable alternative occupation to which they are suited and is 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 ill health 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 causes 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 which they could do for profit or pay taking into account their employment history, knowledge, transferable skills, training, education and experience;
- 'Usual occupation' means the occupation for which the member was employed or engaged to do immediately before their incapacity started.

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 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 three weeks on four occasions within a 52 week period, they will have served 12 weeks of their 26 week deferred period.

If, as a result of ill health, a member is unable to work their normal contracted number of hours or has to significantly reduce their workload, we may (at our discretion) consider the deferred period as starting from the time their working hours or workload reduced.

1.8 For how long will benefit be paid?

You can choose how long you want the benefit to be paid for. The options available are until the State Pension Age or age 70, 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 or related illness for which they are paid benefit, 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 (or, where applicable, the end of the limited payment period if earlier);

d) Where the cover cease age is State Pension Age it will the date they reach their State Pension Age, up to a maximum age of 70 (i.e. if their State Pension Age increases whilst they are a claim their age cover ceases will be the new State Pension Age applicable to them).

1.9 Can income benefit be inflation protected?

Yes, when you set up the policy you can choose if you would like benefit 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. Where appropriate we will restrict the escalation applied to the benefit a member is receiving whilst being a claim so that it doesn't exceed the maximum benefit.

1.10 Does a member continue to be covered if they are absent from work?

If a member is temporarily absent from work for any reason other than ill health we will continue to provide cover:

a) for as long as the member remains employed by the employer whilst a member is on maternity, paternity or adoption leave; or

b) for up to one year providing the member remains employed by the employer and has the right to return to the same job when the absence ends.

You must continue to pay premiums in respect of such members.

If a member being covered during temporary absence becomes ill or is injured during this time the deferred period will start from the day they become incapacitated. The benefit payments will become payable on the later of:

a) the end of the deferred period;

b) the day the temporary absence ends.

We will base the member's cover on their salary on the day before the temporary absence started unless statutory increases apply.

1.11 Are any additional options available under the policy?

1.11.1 Extended cover

Cover for members working beyond the age cover ceases is considered discretionary and will be subject to individual assessment. These members will be in a separate category with an age cover ceases of 70.

Under no circumstances can cover continue beyond a member's 70th birthday.

1.12 Flexible benefits

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

1.13 **Additional services provided as part of your product**

1.13.1 Support Matters

Managers and employees will have access to an employee assistance programme called Support Matters which has been designed to provide everyday support services offering help on a wide range of topics including:

- structured clinical counselling for a range of life events, either face to face or via telephone;
- manager support;
- everyday work-life enquires;
- help with dependent care;
- legal information and support;
- financial support;
- debt management counselling;
- career coaching;
- retail shopping discounts.

The Support Matters website acts as the information and access hub for all of these services and is provided in addition to the core telephone service which is available 24 hours a day, all year round.

Support Matters is provided by Workplace Options. More information about Support Matters can be found in section 10 'Support Matters'.

Once we have confirmed that cover is in place we will provide you with details on how your employees can access Support Matters. Support Matters is a non-contractual service and we reserve the right to withdraw it at any time.

2 Setting up the policy

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 '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, 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 then send you an email with details of how to register to access the site. Once you have registered and downloaded the form, you must:

a) review the application form to ensure that the information it contains is complete and accurate. Please pay particular attention to the section on the application form headed 'Information you provided on which we produced our quotation'. It is essential that you tell us if this information is incomplete or inaccurate;

b) answer all our questions clearly and completely and provide any further material information requested or tell us if you do not have the information we requested;

c) insert any information that is shown as required (for example, we will need the scheme name and cover start date. We will also need the total number of employees – not just those included in a Sick Pay category – in the company so that we can set up the Support Matters service);

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).

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 or who has had a medical exclusion applied to their benefit that you have previously told us about. It will also ask you to add the same details in respect of any other member who has had an exclusion applied or benefit declined or postponed.

If any of the information used to pre-populate the application form is incorrect or information you subsequently add affects the risk presented (for example, if details of members who have been declined cover are declared who we had not been previously aware of), it may mean the terms of our quotation, including the premium, are invalidated and may have to be reviewed, or even that we have to withdraw our quotation entirely.

Once we have confirmed cover can start, we need details of the terms of acceptance for members who have been individually assessed (underwritten) by the previous insurer to be sent to us within 14 days.

We will also request membership data (including employee National Insurance numbers or unique identifier) as at the policy start date, and require that to be supplied within 14 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 14 days of our request we'll request payment based on the estimated annual premium in the quotation.

For annual paying policies which pay premiums by bank transfer we'll issue an invoice for the estimated annual premium and payment must be made within 14 days.

For quarterly paying policies which pay premiums by direct debit we will request a payment for 25% of the estimated annual premium. For quarterly payment polices

who are temporarily paying premiums by bank transfer we'll issue an invoice for 25% of the estimated annual premium and payment must be made within 14 days.

For monthly payment policies which pay premiums by direct debit we will request a payment for 1/12th of the estimated annual premium. For monthly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 1/12th of the estimated annual premium and payment must be made within 14 days.

If, once the data is received, there is a greater than 30% 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, there is a material change in the risk, it may mean we have to withdraw our offer or review our pricing and/or terms and conditions. We would withdraw our offer if the change in the risk is such that if we had known about it when we were asked to quote we would have declined to quote, for example, all of the 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'll notify you that we have ceased the policy and charge you for the cover provided between the policy start date and the date we ceased the policy.

2.2 Does any evidence of health have to be provided before members are covered?

One of the advantages of a group policy is that it is normally possible to provide cover for all eligible 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.

If a member has a salary increase and as a result there is to be an increase to their benefit, this increase will only apply if the member is actively at work on the date the increase applies. Once the member returns to being actively at work they qualify for the full increase to their benefit as a result of the salary increase, unless their benefit exceeds the automatic acceptance limit in which case they will need to be individually assessed and accepted by us before the cover in excess of the automation acceptance limit can be provided.

The automatic acceptance limit is reviewed at the end of every rate guarantee period (usually two years) and is dependent on the number of members and benefits insured.

Any individual whose benefit has 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 benefit 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 three 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 benefit in excess of the automatic acceptance limit (benefit below the limit is still covered);

b) an individual is offered cover by the employer without satisfying the usual eligibility conditions or is being offered a different basis of cover from 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 did not join the pension scheme within 12 months of first becoming eligible but then joins the scheme subsequently or who joins the pension scheme within 12 months of first becoming eligible but who was not actively at work when they joined the pension scheme (a 'late entrant');

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

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

If you wish to make a change to the policy design (such as an amendment to the benefit level, the age cover ceases or the eligibility conditions), you must put the request in writing. We'll 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 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 have had a medical exclusion applied to their benefit. In addition you must tell us of any employees who travel on business to or are seconded to 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.

2.2.2 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'll advise both the individual and you of our decision. If there is a premium loading we'll assume that it is acceptable and adjust future premium collections accordingly, unless you write to tell us otherwise. If this is the case, we'll remove the loading and restrict the member's benefit accordingly.

Wherever possible, we aim to limit the number of times any individual needs to be assessed. Therefore, if we 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 the benefit basis, or their cover cease age increases, or the deferred period changes, or there is an increase in salary of more than 20% in a 12 month period.

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

Where a scheme transfers its insurance on the same basis to us from another insurer (with the exception of a Lloyd's syndicate insurer), we'll normally take over the benefit accepted by the previous insurer on the same terms, provided we get details of the previous insurer's terms of acceptance. The transfer of an individual's cover from a Lloyd's syndicate insurer will be subject to individual consideration.

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

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

Temporary cover starts from the date we are advised of the level of benefit required. It is subject to the following condition:

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 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 benefit has been postponed (either by us or another insurer);
- has previously failed to provide medical evidence that has been requested;

- is joining outside of the eligibility conditions or is being offered a different basis of cover to the majority of the rest of the scheme membership;
- is requesting cover beyond the age cover ceases;
- is a late entrant.

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 AIG, we will require documentary proof of the previous acceptance terms.

3 What premiums will be charged for the cover?

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

- the amount of cover provided;
- the eligibility and entry conditions;
- the age cover ceases;
- the age and gender of individuals to be covered;
- if the benefit increases in payment, the level of the increase;
- 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 or are seconded to countries that we regard as high risk – an up to date list of these countries can be found on our website here;
- details of any members who have been individual assessed and had an exclusion applied, had cover postponed or had cover declined;
- the claims experience;
- the level of commission (if any) you have agreed with your adviser.

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 30%;

b) the number of members drops below two;

c) the new inclusion of a participating employer, or a TUPE transfer;

d) the disposal of an employer or closure of a part of an 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 30% 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'll 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 12 months. For policies that use our Livewire™ automated data link data can be updated monthly. After each data refresh, the cost of providing the cover will be recalculated to reflect the actual cover being provided.

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

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

4.1 What information is required for accounting purposes?

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

- National Insurance number or unique identifier (whichever you have chosen to use);
- name;
- gender;
- date of birth;
- salary (based on the policy salary definition);
- 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 is to be refunded, based on the actual cover provided since the previous anniversary date.

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

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

5 Claiming benefit

We know how important it is to handle claims quickly and efficiently. In this section we have set out how we handle claims made in respect of members. Our claims guide provides more detailed guidance.

5.1 When do we need to know about a member who is absent from work due to ill health?

If you think a member's absence due to ill health will last beyond the end of the deferred period you should tell us as soon as possible. However, you must tell us when a member is absent from work due to illness or injury by the end of the fifth week of absence by calling our claims team on 0330 303 9973 and providing information about the member and their absence.

If we are not notified of the claim before the end of the deferred period, we reserve the right not to backdate claim payments to the end of the deferred period.

5.2 How early intervention can help

At AIG Life Limited we have professional Vocational Rehabilitation Specialists who can help employers and employees deal with the impact of ill health.

Where we are notified of an absence that will last for more than four weeks we will assign a Rehabilitation Specialist who will contact you and the member to identify the steps, if any, that may help the member's recovery and subsequent return to work. This might include a consultation with the member by a qualified professional to obtain full information about the member's condition.

Where the Rehabilitation Specialist believes that member would benefit from additional help or support, for example counselling or physiotherapy, they will work with you, the member and the member's medical advisers to identify and source the most appropriate treatments. The Rehabilitation Specialist will oversee the delivery of the services, keeping all involved up to date with progress.

When the time is right our Rehabilitation Specialist will work with you and the member to draw up a return to work plan which is agreed by all parties including the member's medical advisers. The Rehabilitation Specialist will continue to act as the main contact point for all and will regularly review the progress of the member's return to work.

More information about our vocational rehabilitation process can be found on our website.

5.3 How are claims made?

Where an absence looks as if it might extend beyond the deferred period that applies to your policy, we will send you a claim form to complete and return to us. To protect the member's confidential medical information, the form will not contain any information about the member's condition.

A separate form called a member's statement – will be sent for the member to complete and return to us.

In addition to these completed forms we will need from the employer and/or the member

- 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);
- proof of membership and earnings;
- a copy of their job description detailing their regular duties;
- details of other income to be taken into account for the calculation of the maximum benefit;
- contact details of their GP or treating doctor;
- absence records.

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

If we don't receive a completed claim form and member statement within 90 days of the end of the deferred period we will not accept the claim.

5.3.1 How will claims be assessed?

When assessing the claim we will look at the evidence relating to the medical condition, its severity, how long it has existed and how it affects the member's ability to work.

In determining whether a member's level of incapacity meets the definition chosen, we will assess the claim based

on the medical evidence provided in conjunction with the definition of incapacity chosen. Any diagnosis or medical opinion 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 and a fit note will not in of itself be satisfactory proof of incapacity. For the avoidance of doubt our assessment will not be based purely on the medical opinions provided. The payment of any State incapacity benefits does not automatically qualify the individual for benefit under this policy and vice versa.

If we accept a claim we'll pay the benefit to your UK bank account. You should pass this on to the member through your payroll system to deduct tax, National Insurance Contributions etc.

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

We'll 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.

5.3.2 When does a claim become payable?

We'll pay claims where the member satisfies the definition of incapacity and the incapacity continues beyond the end of the deferred period and the member suffers from a loss of earnings. Claims will not be paid while premiums are overdue.

5.3.3 Can a claim decision be appealed?

If a claim is declined and you disagree with our decision you or the member can appeal our decision.

An email should be sent to groupclaims@aiglife.co.uk outlining the reason for the appeal and attaching any additional information. The claim will be reviewed by an appropriately qualified and experienced assessor who 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.

5.4 When will benefit cease?

We'll pay the 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 employment 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 vocational rehabilitation programme or the member does not follow medical advice.

Where the cover cease age is State Pension Age it will the date the member reaches their State Pension Age up to a maximum age of 70 (i.e. if their State Pension Age increases whilst they are a claim their age cover ceases will be the new State Pension Age applicable to them).

5.4.1 What happens if a member receiving benefit is dismissed

If you remove a member receiving benefit from your payroll, we'll consider at our discretion, paying the benefit directly to the member. You must ask us in advance of the member leaving service. We'll make 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 by us;
- benefits will cease if the former employee takes up residence outside the UK, Channel Islands or Isle of Man;
- benefit payments will cease as described in section 5.4 'When will benefit cease?'.

5.5 What happens if an incapacitated member's contract of employment is transferred to another employer under a TUPE arrangement?

If a member for whom we are paying benefit (or who is currently in their deferred period) transfers to a different employer under TUPE we will continue to pay any benefit to the new employer under the same terms and conditions, treating the claim as if there had been no break in employment, provided that the new employer takes responsibility for the member's potential return to work

plan, including any ongoing rehabilitation. We'll require a written statement from the new employer to this effect.

5.6 Who pays for medical evidence?

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

5.7 Does other income the member receives affect the benefit from this insurance?

The scheme is designed to ensure that a member receives a lower income when they are receiving benefit 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'll restrict the benefit we pay in respect of an employee so that when it is added to other income it doesn't exceed 75% of the member's pre-incapacity earnings from their employer. Similarly, we'll restrict the benefit we pay in respect of an equity or limited liability partner so that when it is added to other income it doesn't exceed 50% of the member's pre-incapacity remuneration from the partnership.

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'll ignore insurance policies which pay benefit 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'll reduce the benefit by the amount of dividends paid.

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

5.8.1 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.

5.8.2 If incapacity is from the same cause

Yes, and if incapacity occurs within 12 months of the member returning to work, the deferred period does not need to be completed. This is known as a 'linked claim'. The benefit will be payable once the member is absent for at least one week and 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.

5.9 What happens to claims if the policy is discontinued?

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'll consider all claims where incapacity arose before the policy ceased.

5.9.1 If a scheme transfers to another insurer

In general any future claims will be the responsibility of the new insurer. However, if a member 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 12 months, we will pay benefit 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'll remain liable for any future benefit payments until the new insurer's actively at work requirements are satisfied.

5.9.2 What happens if the business goes into liquidation?

We'll 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. We will make 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;
- benefit will cease if the former employee takes up residence outside the UK, Channel Islands or Isle of Man;
- benefit payments will cease as described in section 5.4 'When will benefit cease?.

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 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 or for leisure outside the UK.

7.2 Members seconded outside the UK

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

a) they satisfy the eligibility conditions of the scheme;

b) they have a contract of employment or for services with a participating employer;

c) the country of secondment is declared for each member at policy start and at each data refresh.

Where members are temporarily seconded outside the UK the amount of their salary and/or benefit advised at each data refresh must be expressed in pounds sterling using the Bank of England exchange rate applicable. The exchange rate will be fixed at each data refresh. Therefore in the event of a claim for a member who is not paid in pounds sterling the benefit will be calculated based on the exchange rate agreed at the most recent data refresh before the date of incapacity.

Where a member remains outside the UK we will pay a claim for a maximum period of six months unless they are 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 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 AIG Life Limited, 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'll 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 won't provide cover for individuals permanently based outside the UK.

8 Taxation of policies

The following outlines our understanding of current legislation and HMRC practice. You should get professional adviser from your own advisers.

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 benefit

Monthly benefit

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

Benefit payable to equity partners is not subject to income tax.

Lump sum benefit (if selected)

The lump sum benefit will be paid to you.

The tax treatment will depend on how you choose to use the benefit. We cannot give specific advice on how the lump sum should be used or the tax position.

9 Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact which you know or ought to know of. If you do not have complete information, you must tell us.

9.1 What you know or ought to know

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

You do not need to tell us about a material fact if:

- it diminishes the risk;
- we know it;
- we ought to know it;
- we are presumed to know it (because it is common knowledge); or
- we specifically say we do not require the information.

9.2 Material facts

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

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

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

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

9.4.1 Deliberate or reckless misrepresentation of the risk

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

9.4.2 Not deliberate or reckless misrepresentation of the risk

If you do not make a fair presentation but you have not been deliberate or reckless the outcome depends upon what we would have done if we had known the material facts:

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

9.5 Fraudulent claims

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

10 Support Matters

Support Matters is an employee assistance programme that provides employee and manager support. It is designed to provide an engaging, useful, everyday support service for employees. Support Matters provides access to a wide range of help and information including:

- structured clinical counselling sessions for a range of life events, either face to face or via telephone;
- ManagerAssist™;
- everyday work-life enquires;
- help with dependent care;
- legal information and support;
- financial support;
- debt management counselling;
- career coaching;
- workplace crisis support;
- Computerised Cognitive Behavioural Therapy (CBT);
- retail shopping discounts from the Savings Centre.

The Support Matters website acts as the information and access hub for all of these services. This is in addition to the core telephone service which is available 24 hours a day all year round providing in-depth information and support on all of these topics. Employees can also contact the service by SMS text, email, and LiveChat via the Support Matters website. It can be used by all employees, even those not in a Sick Pay category.

10.1 What support and services does Support Matters provide?

Structured clinical counselling

Following the initial assessment, if structured counselling is appropriate to help the individual address the issue, up to four sessions will be provided face to face. A match will be made to a local clinician and the individual notified within two working days, with the first session held within five working days. Evening and weekend appointments are available. Alternatively if the individual would prefer, counselling can be conducted by telephone, where four sessions will be provided.

ManagerAssistTM

This provides advice for managers to help them deal with challenging workplace issues. This could include balancing the need for improved staff performance with personal problems, recognising employee absence issues and intervening early or helping employees who have been absent for some time return to work, amongst many others.

Everyday work-life enquires

The service is designed to support individuals with any issues that takes time out of their busy schedules. This could be any enquiry whether work or personal related. Specialists can help employees research and locate resources in several categories, including household tasks, garden/lawn services, relocation services, entertainment resources, restaurant options, and recreational activities.

Help with dependent care

The service supports individuals with all aspects of being a carer. Offering general counselling, educational support, and pre-screened, qualified referrals to resources to help the individual cope more effectively with the challenges of caring for others. The service is available for any kind of dependent: childcare; adultcare; and care for individuals with a special need/disability.

Legal information and support

Qualified legal professionals are available to provide information on a variety of legal matters such as neighbour disputes, consumer law, probate, road traffic incidents, matrimonial issues or contracts. There is no limit to the length of time spent consulting with the individual or to the number of issues supported.

Financial Support

Money advisers are available to support individuals facing financial challenges, including assisting with budgeting and planning, managing multiple debts and dealing with court action. Individuals will also have access to the Financial Centre, an online tool which will quickly and easily help them to manage their personal finances. They will also have access to a 45-minute preliminary telephone consultation with an Independent Financial Advisor (IFA) who can provide a basic overview of issues such as mortgages and pensions.

Debt management counselling

This is designed for individuals experiencing more serious financial problems. Qualified specialists will endeavour to negotiate directly with an individual's creditor(s) on their behalf to renegotiate repayments, freeze interest, or suspend court action. Specialists will also work with the individual to understand the behavioural issues that have led to the difficult position and to work with them to change their financial behaviours. There is no limit on the number of sessions provided to individuals.

Career Coaching

One telephone session of career coaching is available to help employees achieve their professional goals, whether that be enhancing work performance, seeking assistance with a possible promotion, or adapting to a role change.

Workplace crisis support

This is a post incident service designed to help an organisation deal with a crisis. Whether it's a widespread natural disaster, corporate restructuring, or death of an employee, there is a need for effective crisis response options to assist employees and reduce the impact of the trauma. The ultimate objective of the post-incident service is to assist employers with decreasing the number of psychological casualties among employees and to facilitate a return to regular business functions as quickly as possible.

Within 30 minutes of the notification of an incident, an incident manager will engage with the employer contact in a management consultation. There is no set formula for responding to a critical incident, so based on the consultation the incident manager will draw up a customised response.

Computerised Cognitive Behavioural Therapy (CBT)

This is available to complement the telephone and face-to-face counselling services, where it is appropriate for the individual and their needs.

Following a clinical assessment, the self-paced programme encourages participants to interact with the application on a weekly basis and to monitor their own perception of how they are functioning in terms of personal well- being, close family relationships, work, and social roles. Seven online CBT sessions are delivered over the course of seven weeks, with weekly e-mail and/or telephone support from qualified counsellors.

Savings Centre

This is a shopping discount website which is available to all employees and their friends and family. Once signed up to the site, users can get up to 25% discounts on branded products as well as collecting reward points which can be used to lower the cost of future purchases.

10.2 How do individuals get access to Support Matters?

The application form we send you will ask for the total number of all employees including those not included in a Sick Pay category and will ask if you want us to send employer communications on a regular basis. It will also contain details of how the Support Matters service can be accessed. Once we have confirmed that cover has started the employer contact will receive a welcome email from the Support Matters service. The access information should be shared with all employees.

Ongoing communications

If you have selected to receive employer communications when you completed the application form, Support Matters will send quarterly email newsletters which will include resources to help you promote the service to employees. You can opt out of the emails at any time.

Data confidentiality

Support Matters is completely confidential. You will not receive reports about who has used the service or for what purpose. This ensures that anything an employee or manager discusses with the Support Matters service is kept completely confidential and will not be disclosed under any circumstances.

10.3 Who provides Support Matters?

Support Matters is provided by a specialist provider of employee and workplace assistance services called Workplace Options. They provide these services to more than 46 million employees around the world, currently serving 3,200 companies within the UK and Ireland. While they have international reach, all Support Matters services are provided by their centre in Ealing, with 1,100 affiliate counsellors based around the UK. All call handlers have been trained extensively and are monitored via regular case reviews, close supervision, outcome measurements and call auditing, to ensure the highest standard of care is provided. Workplace Options also hold ISO 9001:2008 certification for quality management.

10.4 If I cancel the policy can my employees still use Support Matters?

No, access to Support Matters will stop once the policy ceases.

11 Further information

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

11.1 Complaints

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

AIG Life Limited
The AIG Building
58 Fenchurch Street
London
EC3M 4AB

by email to groupcomplaints@aiglife.co.uk

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

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

Financial Ombudsman Service Ltd
Exchange Tower
London
E14 9SR

Tel 0800 023 4567

11.2 Compensation

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

Further information about compensation scheme arrangements is available from:

Financial Services Compensation Scheme
PO Box 300
Mitcheldean
GL17 1DY

Tel: 0800 678 1100

11.3 Data Protection

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

11.4 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, except where we have contracted out as described in section 9.3.

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

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.

12 **Definitions**

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 or who is being offered a different basis of cover to the majority of the rest of the scheme membership.

Eligibility conditions

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

Late entrant

Where membership is linked to a workplace pension scheme membership an individual who joins the pension scheme more than 12 months after first becoming eligible or who joins the pension scheme within 12 months of first becoming eligible but was not actively at work when they joined the pension scheme.

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