Group Income Protection Policies

Technical Guide (inc. Flexible Benefit Policies)

GENERALI

Generali Group Income Protection

This Policy meets the demands and needs of those who need insurance for loss of earnings suffered by an employee in the event that they are incapacitated from working by reason of illness or injury.

We keep this Policy under review to check it continues to meets the demands and needs of policyholders.

The Policy is designed for commercial customers only, as categorised by the Financial Conduct Authority's Insurance Conduct of Business Rules.

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

Within this guide Generali is referred to as 'we' or 'us' and the policyholder is referred to as 'you'.

1 Its aims

To provide you with insurance for loss of earnings suffered by an Employee in the event that they are Incapacitated from working by reason of illness or injury.

1.1 How does the Policy work? (for Flexible Benefit policies see Section 6)

- we will agree with you at the outset:
  - which Employees can be covered under the Policy;
  - the level of cover; and
  - any additional options that you wish to insure.
- you will be responsible for paying all the Premiums that fall due. Premiums are usually treated for tax purposes as a business expense. Premiums are not usually taxed as a benefit in kind for Members;
- you will notify us when illness or injury prevents a Member from working after 4 weeks but no later than 6 weeks before the end of the Deferred Period;
- we will pay Benefit due under the Policy to you monthly in arrears from the end of the Deferred Period (see section 2.6) for as long as the claim remains valid;
- you will be responsible for paying the appropriate amount of Benefit to the Incapacitated Member, after deduction of income tax and national insurance, through your payroll system;
- we will continue to consider and pay claims where Incapacity occurred before cover was discontinued provided you have paid Premiums due and complied with the terms and conditions of the Policy.

1.2 Your commitment

- you agree to promptly provide all the information we ask for when applying for a Policy, at Annual Revision Dates, monthly in respect of Flexible Benefit (if applicable) and in support of a claim;
- you agree to obtain and maintain all necessary permissions to share personal data with us in connection with this Policy;
- you agree to advise us of any errors in the information provided;
- you agree to notify us of any potential claims within the stated time limits;
- you agree to notify us of any change to the employment status, medical condition or residence of any Member for whom a claim has been submitted;
- you agree to pay all Premiums due under the Policy;
- you agree to adhere to the Policy terms and conditions.

1.3 Risk factors

- we may terminate, restrict or suspend cover under the Policy, if you fail to comply with the Policy terms and conditions;
- if you delay in providing information that we request, this may result in:
  - a change in Premium;
  - Members not being covered for their full entitlement; or
  - claims not being paid;
  - the Policy being terminated.
- the Premium Rates and Policy terms and conditions are usually guaranteed for two years
- the above guarantee will not apply if:
  - there is a greater than 25% variation in the number of lives or total Insured Salary of the membership, since the last accepted quotation;
  - a change is agreed to the basis to be used for calculating cover;
  - a change is agreed in the Policy Eligibility Conditions;
  - we agree to include an additional Employer;
  - we agree to include one or more Employees following the acquisition of a business or undertaking by an Employer;
  - an alteration to the Policy terms and conditions in relation to an Associated Policy is required; or
  - if any legislation (or change in legislation) comes into force that affects the Policy;
- Benefits paid under the Policy may be reduced if the Member is receiving other regular income as a result of Incapacity (see section 7.5);
- receipt of Benefits may disqualify Members from entitlement to some State Benefits.

2 What factors should be considered in deciding what Annual Benefits to provide?

A group income protection Policy offers an extensive menu of options permitting Employers to design cover to meet their organisation's objectives.

2.1 Who can be covered?

An Employee will become a Member when they satisfy the Policy Eligibility Conditions and Actively at Work requirements.

These requirements also apply to increases in cover for existing Members of the Policy.

2.1.1 Eligibility Conditions

You will provide us with details of the eligibility conditions in respect of each category of membership, which will include:
- the minimum and maximum entry ages;
- any service qualifications; and
- the relevant benefit basis.

Where cover is dependent on membership of a pension scheme, the above eligibility conditions must include the pension scheme's current eligibility terms.

2.1.2 Actively at Work

The Actively at Work condition will apply:
a) to all Employees at the Commencement Date;
b) when a new Employee joins after the Commencement Date;
c) where a Member is eligible to switch to a different category of benefit; and
d) when Members are affected by an alteration of the benefit basis under the Policy.

Cover (or the increase in cover) will be restricted to Temporary Cover until the Employee/Member has returned to work and met the Actively at Work requirements detailed in the quotation.

2.1.3 Actively at Work when changing insurer

Where your Policy is currently insured elsewhere, Members who are Actively at Work on the last working day prior to commencing cover with us, will usually be covered on terms which are 'no worse' than the existing insured arrangement.

2.1.4 No worse terms

Where a Policy that is currently insured is switched to us the following shall apply:

- cover at or below the Free Cover Limit (as explained in section 3.2) shall be accepted by us on standard terms unless the Member was a discretionary entrant under the existing arrangement and was not accepted at ordinary rates;
- cover in excess of the Free Cover Limit may be offered on the same underwriting terms as those in force with the previous insurer. This may apply both when a Member has been accepted at ordinary rates, or where they are subject to an increased Premium expressed as a multiple or additional percentage of ordinary rates. Specific limits apply in this respect and will be detailed in your quote. These terms will then be applied to our Premium Rates so the actual monetary amount may differ. Where an underwriting decision falls outside our prescribed limits we are unable to guarantee that no worse terms will apply.

In order to confirm what terms will apply we will require the following information in relation to the existing insured arrangements:

- the name of the existing insurer;
- the existing insurer's Free Cover Limit;
- full details of any discretionary entrants or Members who exceed the existing insurer's Free Cover Limit including name, gender, date of birth and level of cover applicable on the day prior to the commencement of the Policy; and
- copies of the existing insurer's acceptance terms for these Employees detailing the effective date of their underwriting decision and details of the level of cover to which their terms relate, or a declaration confirming these details from the previous insurer.

No worse terms only automatically apply when the Policy is switched on an identical basis. Where this is not the case, Members may need to be individually underwritten.

Details of the specific no worse terms limits will be detailed in your quotation.

2.2 When will cover commence?

Cover commences immediately for Annual Benefit up to the Free Cover Limit (as explained in section 3.3) when an Employee is:

- joining the Policy within the predefined eligibility conditions;
- joining within 12 months of their first opportunity to do so; and
- Actively at Work.

For Employees who do not satisfy the above, please see section 3.3.

2.3 When will cover cease?

Member's cover ceases on the earliest to occur of the following:
- the date they cease to be an Employee;
- the date their current contract of employment expires;
- the date they cease to satisfy the eligibility conditions;
- the date they retire;
- the date they reach the specified Termination Age;
- in the case of an Incapacitated Member on a fixed term contract, the date the contract of employment applicable at the date of Incapacity expires;
- the date they die;
- the date you receive written notice from the Member that they no longer wish to be covered under the Policy
- the date on which the Policy terminates;
- upon payment of a capital sum under the terms of the Policy; or
- the date an Incapacitated Member undertakes any gainful Work without your and our consent.

The Policy will remain in force until:
- the date we receive written confirmation from you to cease risk; or
- you fail to pay Premiums due or fail to comply with the Policy terms and conditions and we have notified you in writing that cover has ceased.

2.4 What types of cover are provided?

You can select from the following types of cover:

Non-integrated benefits
Benefits are specified as a percentage (up to a maximum of 80%) of a Member's gross annual pre-Incapacity earnings.

Integrated benefits
Benefits are specified as a percentage (up to a maximum of 80%) of a Member's gross annual pre-Incapacity earnings, less a deduction equivalent to the level of state benefit applicable for Incapacitated Members at that time.

State benefits are then deducted by way of:

- 'standard basis' whereby a specified standard level of state benefit is deducted, whether payable or not; or
- 'fully integrated basis' whereby all state benefits to which a Member is entitled to as a result of sickness/Incapacity are deducted.

2.4.1 What are pre-Incapacity earnings?

This normally means the Member's Insured Salary.

Any fluctuating emoluments to be included within the definition of Insured or Pensionable Salary will be averaged over the previous complete three years.

2.4.2 Is there any limitation to Annual Benefit?

Basic benefit will be restricted to 80% of pre-Incapacity earnings up to a maximum monetary amount of £350,000.

2.4.3 Optional additional protection

The following additional benefits may be insured at an additional cost:

Pension scheme contributions

Pension scheme contributions can be insured to a maximum of 35% of the Member's Pensionable Salary inclusive of Employer and Employee's contributions.

The maximum level of Employee contributions is 10%.

The maximum monetary amount that can be insured in respect of pension scheme contributions is £75,000 per annum.

Contributions that differ from Member to Member within a defined category, or fluctuate, cannot be covered.

National Insurance contributions

Your (i.e. Employer) National Insurance contributions may also be insured.

Employee National Insurance contributions cannot be insured under the Policy.

Capital Sum

A Capital Sum can be insured. Payment would be subject to the Member continuing to meet the Definition of Incapacity at the date that the limited payment term ends.

The Capital Sum payable will never exceed the amount a Member may have been paid under a Policy payable to Termination Age.

No Capital Sum will be paid where the Limited Term period exceeds the Member's Termination Age.

No Capital Sum will be paid in respect of Members whose cover is extended beyond the normal Termination Age.

2.5 How is Incapacity defined?

You may select from the following definitions of Incapacity:

Own occupation definition

As a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, and they are not carrying out any other Work or occupation.

Suited occupation definition

as a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, or any occupation to which they are suited by education, training or experience, and they are not carrying out any other Work or occupation.

Switch definition

During the first two years of Incapacity; as a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, and they are not carrying out any other Work or occupation. Thereafter the definition changes to; as a result of illness or injury, the Member is incapable of performing the Material and Substantial duties of their occupation, or any occupation to which they are suited by education, training or experience, and they are not carrying out any other Work or occupation.

2.6 When will Benefits start?

Benefit payments will commence from the end of the Deferred Period. Benefit payments are made monthly in arrears at the end of each calendar month, provided that the Member continues to be Incapacitated, we have accepted the claim, and all the Policy terms and conditions have been met.

The Deferred Period is the period of time during which no Benefit is payable following the Member's first day of absence from work due to illness or injury.

The minimum Deferred Period is 13 weeks.

2.7 For how long will Benefits be paid?

You can select the maximum period for which Benefit will be paid. This will normally be up to a pre-defined Termination Age up to a maximum age of 70.

You can also select a Limited Term for Benefit payment of 2, 3, 4 or 5 years, with or without a Capital Sum paid at the end. The selected period will be the maximum duration for which Benefit can be paid in respect of any individual Member for each unrelated cause or medical condition. The Limited Term must be agreed prior to the outset of the Policy and will be detailed in the quotation. Payment of Benefit is always conditional upon the Policy terms and conditions being satisfied.

2.8 Can Benefits in payment be inflation protected?

Yes, Benefits in payment can increase at an interest rate agreed at the outset of the Policy. The increase will take effect on the anniversary of first day of the month in which Benefit became payable, and on the same day at each subsequent anniversary.

The maximum Escalation Rate available is 5% per annum.

2.9 Who will benefits be paid to

Benefits will usually be paid gross to the Policyholder, save where we have agreed with the Policyholder for a pay direct feature to be included in the Policy, The terms of the pay direct feature will be set out in the Policy Schedule.

3 Setting up a Policy

3.1 Requirements to set up a Policy

Unless specified otherwise, the terms offered in our quotation are guaranteed for three months. The terms will be based on the Policy specific information you have provided with any assumptions we have made clearly indicated in the quotation. Should any of the information or assumptions be incorrect, you must not accept the terms and must inform us in order that our quotation can be revised. If the information given causes us to withdraw or amend our offer we will endeavour to notify you immediately.

Should you wish to accept the terms offered in this quotation or in a revised quotation, we must receive the following details in writing by 2pm on the day prior to the date you wish us to commence cover:

- on risk form;
- your confirmation of any assumptions that were detailed in our quotation; and
- confirmation of any Members that fall outside of our no worse terms conditions.

Upon receipt of the above, we will provide written confirmation of our acceptance of risk on an interim basis. Cover will be provided during the interim period on the basis detailed in the accepted quotation and on risk form. Reference will be made to the Policy specific information provided during the quotation process.

Once we have accepted the risk on an interim basis, we will issue you with our on risk requirements which will include a completed application form, inception data, deposit premium, confirmation of Member acceptance terms and any further information that we may require. The information and documentation must be returned to us within 30 days or cover may lapse. Until you have received written acknowledgment you should not assume that cover is in place.

A policy document and initial accounts will be provided once we have received the relevant on risk information. Should it transpire that any of the details provided to us are incorrect or that there is a greater than 25% variation in the number of lives or total Insured Salary, we reserve the right to review the terms offered or terminate cover.

3.2 Associated Policies

Unless indicated otherwise in the quotation, we assume that there will be one Policy, one set of accounts with one attaching invoice, and one point if contact. There will be cost implications if this is assumption is incorrect.

In certain circumstances Policies may be linked together and their terms be dependent on each other. Where this is the case the Policies will be deemed as Associated.

In order to be deemed Associated the additional Policy should be issued by us either to you, or a company or organisation associated with you, which provides Benefits on the Incapacity of an individual.

3.3 Evidence of health to be provided before Employees /Members are covered

The Free Cover Limit is the amount of cover a Member may be provided with under the Policy without the need to provide evidence of health or activities.

Cover commences immediately for Annual Benefit up to the Free Cover Limit when an Employee is:
- joining the Policy within the predefined eligibility conditions;
- joining within 12 months of their first opportunity to join the Policy; and
- Actively at Work.

Employees who do not satisfy the above requirements will be asked to provide satisfactory evidence of health and details of hazardous pastimes before they are accepted for cover. They will initially be asked to complete a 'personal declaration of health form'. We may also require additional medical information such as reports from the individual's GP and medical examinations.

You will be told if, as a result of the medical underwriting, an Employee has been accepted for cover and on what terms. You will be advised when the next evidence of insurability will be required.

Where there are 20 or more Members we will not normally need more information about a Member's health or activities as once only underwriting will usually apply.

3.4 What happens if a claim arises before a decision has been made?

Where we require Employees/Members to provide satisfactory evidence of health as part of the medical underwriting process, we allow a maximum of 90 days in order to complete the underwriting process. During this period the Employee/Member will be provided with Temporary Cover in relation to the amount of cover being medically underwritten.

Temporary Cover specifically excludes any claim resulting either directly or indirectly from any disease, illness or injury that the Member has experienced symptoms of, received treatment for, had routine monitoring of, or has undergone investigations for, in the 5 years immediately before the date they qualify for inclusion within the Policy (or date of increase in benefits).

Where a Member has previously been medically underwritten and cover accepted at ordinary rates, the Temporary Cover will be the difference between the Member's existing level of cover and the proposed increased level of cover.

4 What Premiums will be charged for the cover?

We will calculate the rates applicable to the Policy based on various factors. These factors will include the amount of cover to be provided, details of the Employees occupations and locations and the Policy's past claims experience.

A minimum Premium of £2,500 p.a. per Policy applies, however, there is no minimum Premium per Member.

All Premium payments are to be paid in pounds sterling.

No Premiums will be charged in respect of an Incapacitated Member from the Annual Revision Date following commencement of Benefit payments.

4.1 How will Premiums be calculated?

The Premium will be calculated and charged based on a Premium Rate, which is expressed per £100 of Insured Salary. The Premium is calculated based upon the total Insured Salary for all Members at the Commencement Date and subsequent Annual Revision Dates.

4.2 Will there be any unexpected extra Premiums?

This will depend on whether the composition of the Policy has changed.

Premium loadings may be imposed in respect of Members who have been subject to medical underwriting. Any loading will reflect their medical condition or hazardous pursuits they may undertake. Such loadings will be payable at the next Annual Revision Date.

We usually guarantee the rates for a period up to two years. New rates may apply at the end of the two year period. We will confirm any changes to the Premium Rates in writing.

4.3 Is there a discount for good claims experience?

Past claims experience is a factor in assessing the rate applicable to a Policy and therefore good claims history will usually be reflected in the rates applied.

4.4 What commission is included within the Premium?

The commission rate (if any) will be shown in the quotation.

5 How does the Policy accounting work? (For Flexible Benefit Policies see Section 6)

Policies will usually operate on an annual accounting period under what is known as simplified administration. This means we will review the cost of your Policy at each Annual Revision Date to determine the Premium payable for the following year and any adjustments required in respect of the previous year.

This calculation is made by comparing the total cover in respect of all Employees at the start and end of the accounting period and averaging any changes by assuming that they all occurred at the mid-year point.

Operating a Policy under simplified administration means that you do not have to inform us of starters or leavers unless a new joiner has an Insured Salary above the Free Cover Limit or is joining outside of the usual Policy Eligibility Conditions.

5.1 What information is required for accounting purposes?

At each Annual Revision Date you will need to provide us with details of all Members. Data should also be provided as at the day before the revision date in order to accurately calculate the mid term adjustments. This information should be provided as a secure Excel file, and include the following information:

- name;
- sex;
- date of birth;
- Insured Salary and Pensionable Salary (where applicable);
- category of membership;
- date of joining;
- date of leaving if appropriate; and
- details of Members located overseas for more than 12 months.

Additional information including occupations, postcode information and long term sick information will be requested prior to the end of the Premium Rate expiry in order for new terms to be provided. You must have all necessary permissions to share the personal data set out in this paragraph 5.1 with Generali.

5.2 When are Premiums due?

Unless otherwise agreed, deposit Premiums are payable annually within 30 days of the Annual Revision Date. However, subject to our prior written agreement, Premiums can be paid monthly, quarterly or half yearly subject to the appropriate loading shown in the quotation.

Any additional Premium due, as detailed in the Annual Revision accounts, is payable within 30 days of the date we notify you of the amount. If a refund is due we will offset this against the following year's Premium unless the Policy has been cancelled in which case we will refund the appropriate amount to you within 30 days.

5.3 If the Policy is discontinued mid-year will Premiums paid in advance be lost?

No, the final invoice issued will take into account the cover that has been provided up to the date the Policy was cancelled.

Termination of the Policy will be effective from the date we receive written confirmation from you to cease risk or an agreed date if later.

In order to produce the termination accounts we will require data as listed above as at the date of termination. We will then issue the appropriate refund or invoice if monies are owed to us.

6 Flexible Benefits

6.1 How does the Policy work?

- we will agree with you prior to assuming risk:
  - which Employees can be covered under the Policy;
  - the level of cover; and
  - any additional options you wish to insure.
- you will choose the level of Core Benefit applicable to your Policy. The Core Benefit is the minimum level of cover in respect of a Member;
- you will then set out the additional level of cover a Member may select. These Benefits will be referred to as the Member's Flexible Benefit.

6.2 When can Members increase or decrease their level of Flexible Benefit?

When a Member first becomes eligible for Flexible Benefit they may choose any level of Annual Benefit subject to the Policy maximum.

Members can then increase or decrease their level of Flexible Benefit at Qualifying Lifestyle Events, which include the Annual Revision Date of the Policy.

In some circumstances pre-defined lifestyle events will only allow either an increase or decrease in Annual Benefits.

A Member can only increase or decrease their level of Flexible Benefit on a maximum of two Qualifying Lifestyle Events in any one year.

Members have 31 days from the date of the Qualifying Lifestyle Event to request a change in their level of Flexible Benefit.

If the Qualifying Lifestyle Event in question is the Annual Revision Date then Members must make their Flexible Benefit choices in advance.

For Members to be able to increase their level of Flexible Benefit they must meet the anti-selection requirement. This can range from an Actively at Work declaration to full medical underwriting. The terms applied will be clearly detailed in your quotation. In all cases Annual Benefits in excess of the Free Cover Limit will be underwritten.

A change in Flexible Benefit will usually take effect from the first of the month following the Member's request to change their level of Flexible Benefit subject to any anti-selection requirements being met and the level of cover being less than the Free Cover Limit.

If the above does not apply, the increase will take effect following completion of satisfactory medical underwriting (see section 3.3" Evidence of health to be provided before Employee/Members are covered").

If a Member fails to confirm their options within 31 days of the lifestyle event, they will be required to wait until the next Qualifying Lifestyle Event to effect any such change.

Members can increase their level of Flexible Benefit by one pre-defined tranche at each Qualifying Lifestyle Event.

Members can decrease their level of Flexible Benefit by any number of tranches at each Qualifying Lifestyle Event. They are not allowed to decrease their level of Flexible Benefit below the Core Benefit.

6.3 What are Qualifying Lifestyle Events?

The Qualifying Lifestyle Events need to be defined prior to the Commencement Date of the Policy. The rules regarding the increasing and decreasing of Flexible Benefit must also be pre-defined.
The Annual Revision Date of the Policy will always be a Qualifying Lifestyle Event.

Qualifying Lifestyle Events can include:
- marriage;
- civil partnership;
- divorce; and
- the birth of a child.

Details of the Qualifying Lifestyle Events will be specified in the quotation. Should additional events be required, our prior agreement must be sought and this may result in an increase in the Premium payable.

6.4 How does Policy accounting work

6.4.1 How are accounts adjusted for Employees/Members who join, leave or have increases in cover during the year?

Core Benefits will operate on an annual accounting period under simplified administration. Flexible Benefits are then accounted for on a monthly basis upon receipt of accurate data in respect of these benefits.

What information is required for accounting purposes?

You will need to provide us with details of all Members on an annual basis in respect of the Core Benefits and on a monthly basis in respect of the Flexible Benefits. Core Benefit data should also be provided as at the day before the Annual Revision Date in order to accurately calculate the mid term adjustments. This information should be provided as a secure Excel file, and include the following information:

- name;
- sex;
- date of birth;
- Insured Salary and Pensionable Salary (where applicable);
- category of membership;
- date of joining;
- date of leaving if appropriate; and
- details of Members located overseas for more than 12 months (required annually only with provision of Core Benefit data).

Additional information including occupations, postcode information and long term sick information will be requested prior to the end of the Premium Rate expiry in order for new terms to be provided.

6.4.2 When are Premiums due?

Unless otherwise agreed, deposit Premiums are payable annually within 30 days of the Annual Revision Date. However, subject to our prior written agreement, Premiums can be paid monthly, quarterly or half yearly subject to the appropriate loading shown in the quotation.

Any additional Premium due, as detailed in the Annual Revision accounts, is payable within 30 days of the date we notify you of the amount. If a refund is due we will offset this against the following year's Premium unless the Policy has been cancelled in which case we will refund the appropriate amount to you within 30 days.

7 When can claims be made?

This section deals with common questions, which arise when a Member becomes Incapacitated.

7.1 How are claims made?

Claims are made by you completing and submitting a claim form.

7.1.1 Under what circumstances?

We will pay a claim when a Member satisfies the Definition of Incapacity and when their Incapacity continues beyond the end of the Deferred Period.

7.1.2 How Incapacitated must the Member be?

The Member's illness or injury must be sufficiently severe that their condition satisfies the Definition of Incapacity that you have chosen.

7.1.3 How will this be assessed?

We will take into account the nature of the Member's Incapacity, and seek to determine whether or not they satisfy the Definition of Incapacity you have chosen.

As part of our assessment we will consider any reasonable adaptations you may be obliged to make, as required under the Equality Act 2007, which would assist the Member to return to work.

When assessing a claim, we will take into account the Member's medical condition, its severity, how long it has existed and how it affects them.

The evidence required to assess a claim will include:

- evidence of membership and earnings;
- the Member's job description;
- a claim form completed by you;
- a claim form completed by the Member;
- a consent form signed by the Member that provides us with the authority to obtain further information from their doctors as required under the Access to Medical Reports Act, and to process their personal data under applicable data protection legislation;
- proof of age;
- details of any pension or other income which is to be taken into account for the purpose of ascertaining the maximum Benefit in respect of the Member;
- satisfactory medical evidence including details of the Member's medical history and treatment for the present Incapacity;
- such independent medical examinations and/or functional assessments as we may require; and
- such visits to the Member and/or the Employer as we may require.

We will advise you of our requirements in advance and you must ensure that the Member attends all medical examinations, co-operates with reasonable requests for claim visits and provides the information requested for consideration of a claim within 30 days. Failure to do so may result in a claim being declined or Benefit payments being discontinued.

Once a claim has been accepted, we will regularly review and monitor the Member's progress and the on-going validity of the claim.

7.1.4 Can rehabilitation help?

You can minimise the costs of Incapacity and maximise the value that Incapacitated Members bring to your organisation by ensuring that rehabilitation and reintegration programmes are investigated and implemented wherever appropriate. Working conditions, physical features and other arrangements can often be adjusted quite reasonably so that an Incapacitated Member can continue to work.

It is a requirement of the Equality Act 2007 (EA) that Employers make adjustments to working conditions where it is reasonable to do so.

We require you to make all reasonable adjustments to facilitate your Employee's return to work, whether or not the disability falls within the scope of the EA.

Our claims management team works with you and your medical advisers to ensure the claims process runs as smoothly as possible. We can help you to meet the requirements of the EA and your other responsibilities to disabled Employees where appropriate.

7.2 For how long will the Benefit be paid?

7.2.1 The Benefit will be paid until the earliest of the following:

- the date the Member no longer satisfies the Definition of Incapacity;
- the date the Member is no longer suffering loss of earnings;
- the date the Member ceases to be an Employee of the Employer (unless a pre-agreed pay direct feature is being exercised);
- the date the Member ceases to satisfy the Policy Eligibility Conditions;
- the date the Member leaves service;
- the date the Member retires;
- the date the Member dies;
- the date the Member reaches the specified Termination Age;
- in respect of a Member on a fixed term contract, the date the contract of employment applicable at the date of Incapacity expires;
- the date the Limited Term expires, where applicable;
- the date the Member undertakes any gainful employment without our knowledge and consent; or
- the date the Member, Employer or policyholder commits any fraudulent act or deception.

We reserve the right to terminate, restrict or suspend paying Benefits if you or the Member fail to supply information requested or evidence of continued Incapacity within 30 days of our request.

Payment of Benefit is conditional upon Members taking all reasonable steps to aid their own recovery and not unreasonably refusing to follow any medical advice or rehabilitation plan.

7.2.2 What happens if the Employee's illness or injury means that they can work part-time or in a reduced capacity?

We may pay a partial benefit, at our discretion, where an Incapacitated Member has completed the Deferred Period and either:

- returns to work with you but performs another less well paid occupation; or
- returns to their pre Incapacity occupation with you but on a reduced basis for a reduced level of earnings.

It is not necessary for a full claim to have been paid before we will consider a claim for partial benefit but the Deferred Period will apply.

7.3 When do we need to advise you of a Member's absence from Work due to illness or injury?

As soon as possible but in any case when a Member has been absent from work, or working on a reduced basis, due to illness or injury for a period of one month.

In the first instance, a notice of absence form should be completed and returned to us by the Employer.

We will review the Member's progress with you and, if it appears that the Member's absence from Work will extend beyond the Deferred Period, full claim forms should be completed by the Employer and the Member and returned to us no later than six weeks before the Deferred Period is due to expire.

It is important that the claim forms are sent to us promptly so that we can consider the claim before the Deferred Period has expired.

If you fail to comply with the timescales detailed above, we reserve the right to decline the relevant claim.

7.4 Who pays for medical evidence?

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

If we request medical evidence in relation to a Member located overseas we will pay for it provided that the cost is no greater than it would have been in the UK. Any excess will be the responsibility of the Member or policyholder, unless we agree to make payment in advance.

7.5 Does other income affect the Benefit from this insurance?

Any retirement pension or other income payable as a result of Incapacity will be taken into account. This could include:

- income from any other accident, sickness, or long term Incapacity insurance policy covering illness or injury;
- any loss of earnings element in respect of a personal injury award;
- any uninsured sickness payments or benefits received by the Incapacitated Member from you; and
- any state benefit payable as a result of sickness/ Incapacity. The level of this deduction will depend on the basis of cover you have selected (see section 2.4).

7.6 After a Member, in respect of whom a claim has been made, returns to work, can another claim be made for that Member?

7.6.1 If Incapacity is from the same or a different cause or medical condition:

Where Benefit has been paid and Incapacity occurs again from the same or a different cause or medical condition lasting at least 14 consecutive days within 52 weeks of that individual returning to work, the Deferred Period will not apply and Benefit payments will recommence subject to receipt of satisfactory supporting medical evidence. The level of Benefit will be the same as that paid before the Member's return to work. This is referred to as a 'linked claim'.

If the Policy has a Limited Term for which claims will be paid then all periods of Incapacity will be added together to calculate the maximum duration of payment.

7.7 What happens to claims if the Policy is discontinued?

If a Policy ceases to be insured with us, provided all Premiums due are paid, we will:

- continue to pay claims that were accepted before the Policy ceased, whilst they remain valid; and
- consider claims where Incapacity occurred before the Policy ceased.

If a claimant in respect of whom we are paying Benefit returns to work after cover is switched all future claims will be the responsibility of the new insurer except where we subsequently accept that a 'linked claim' has occurred in which case the following will apply:

- if the claimant meets the Actively at Work criteria of the new insurer we will reinstate Benefit payments for a maximum period equivalent to new insurer's Deferred Period; or
- if the claimant fails to satisfy the new insurer's Actively at Work condition, we will remain liable for future Benefit payments until such time as the new insurer's Actively at Work condition is satisfied.

8 What is not covered?

There are no general exclusions applicable to the Policy. However, exclusions for claims arising from certain specified medical conditions or in specific circumstances may be imposed on medically underwritten benefits.

9 Can cover be provided for Members who are not in the UK?

We can usually provide cover for Members working outside of the United Kingdom as long as they remain eligible for membership of the Policy and they have UK contracts of employment.

Members working overseas for periods in excess of 12 months need to be notified to us at each Annual Revision Date and when undertaking a rate review.

If a claim is made in respect of a Member residing outside of the authorised countries Benefit will be paid for a maximum period of 6 months. This period may be extended if it is agreed that it is not medically advisable for the Member to travel in order to return to an Authorised Country.

10 Can benefit be paid direct to former Employees after they have left service?

Provided that:

(i) a direct pay feature has been agreed between us and the Policyholder, the terms of which will be set out in the Policy Schedule; and

(ii) the Employer has satisfied all of its obligations under the Equality Act 2010, then payment may be made directly to former Employees.

11 Taxation of Policies

The whole cost of the Policy will be borne by you. Premiums paid by you will normally be treated as a business expense and are not treated as a benefit in kind for the Members.

Benefits are taxed and subject to National Insurance contributions under the PAYE system prior to payment to the Member.

This information is based on our understanding of legislation and HM Revenue & Customs practice at the date of printing.

12 Continuation option

There is no continuation option allowing cover to continue for a Member leaving service.

13 Surrender value

The Policy has no surrender value.

14 Glossary

"Actively at Work"
means that an Employee:

- is not absent from work due to illness or Incapacity;
- has not received medical advice to refrain from work and is actively following their normal occupation; and
- is working the normal number of hours required by their contract of employment, either at their normal place of work or at a location to which they are required to travel for business.

An Employee will be regarded as being Actively at Work if they are fully capable of so doing were it not for:

- a leave of absence previously authorised by their Employer (including adoption, maternity and paternity leave); or
- the requirement for being Actively at Work falling on a day the individual is not contracted to work (such as a weekend or public holiday).

They will be regarded as being Actively at Work provided that they were capable of meeting the definition on the last day they were due to work.

"Annual Benefit"
means the basic benefit and, if applicable, additional benefit.

"Annual Revision Date"
means the date used for the annual provision of data and calculation of Premiums.

"Associated Policy"
means a Policy that is linked to another policy insured by Generali by way of Premium Rate or Free Cover Limit.

"Authorised Country"
means members of the European Union together with members of the European Free Trade Association plus Alderney, Australia, Bahamas, Canada, Cayman Islands, China, Guernsey, Gibraltar, Hong Kong, India, Isle of Man, Jersey, Malta, Mexico, New Zealand, Philippines, Sark, Serbia, Ukraine, and the United States of America, or such other countries as may be agreed by Generali.

"Benefit"
means any amount paid by Generali to the principal Employer by reason of the Incapacity of a Member including basic benefit, additional benefit and partial benefit.

"Capital Sum"
means a pre-defined lump sum amount that would be payable at the end of a specified Limited Term.

"Commencement Date"
means the inception date of cover placed with Generali.

"Consumer Price Index"
means the UK Consumer Price Index rate issued by the Office for National Statistics. Generali reserves the right to use another index if the Consumer Price Index is discontinued or if in Generali's opinion the way in which the rate is calculated changes to a material extent.

"Core Benefit"
means the minimum level of Annual Benefit available to Members, or groups of Members, under a Flexible Benefit Policy.

"Deferred Period"
means the period of Incapacity which must elapse before Benefit may become payable. If the Member is on statutory leave or granted leave of absence, the Deferred Period will start from the date of Incapacity and Benefit payments will start from either the end of the Deferred Period or the agreed return to work date whichever is the later. Generali will link periods of absence where the Member has been working at reduced capacity (in either their same or an alternative role), caused by the same illness or injury within any 12 month period.

"Definition of Incapacity"
means the 'test' against which the validity of any claim will be measured.

"Employee"
means an individual who is employed by one of the Employers.

"Employer"
means one of the Employers by which a Member is employed.

"Escalation Rate"
means the Escalation Rate by which a Member's Benefit would increase.

"Flexible Benefit"
means the level of Annual Benefit in excess of the Core Benefit that a Member can opt to increase or decrease.

"Free Cover Limit"
means the level of Insured Salary above which a Member is required to provide evidence of health.

"Incapacity" or "Incapacitated"
means, in the opinion of Generali, incapacity or incapacitated in accordance with the Definition of Incapacity.

"Insured Salary"
means the salary definition relating to the calculation of basic benefit.

"Limited Term"
means the maximum length of time for which Benefit is payable in respect of a Member.

"Material and Substantial"
means duties that are normally required for the performance of a Member's occupation and cannot reasonably be omitted or modified by their Employer.

"Member"
means an Employee included within the Policy.

"Pensionable Salary"
means the salary definition relating to the calculation of pension fund contributions.

"Policy"
means the contract of insurance between the principal Employer and Generali.

"Policy Eligibility Conditions"
means the defined eligibility conditions applicable to the entry of a Member to the Policy.

"Pre-existing Condition"
means any disease, illness or injury that the Member has experienced symptoms of, received treatment for, had routine monitoring of, or has undergone investigations for, in the 5 years immediately before the date they qualify for inclusion within the Policy (or date of increase in benefits).

"Premium"
means the sum(s) payable by the principal Employer to Generali as required under the Policy.

"Premium Rate"
means the Premium Rate(s) specified in the quotation.

"Qualifying Lifestyle Event"
means the event upon which a Member may choose to effect a change in their Flexible Benefit.

"Retail Prices Index"
means the UK Index of Retail Prices issued by the Office for National Statistics. Generali reserves the right to use another index if the Retail Prices Index is discontinued or if in Generali's opinion the way in which the UK Index of Retail Prices is calculated changes to a material extent.

"Temporary Cover"
means cover provided up to the full Annual Benefit level required for the period between the date that the principal Employer has been notified of the requirement for underwriting and the date an underwriting decision is issued. However no cover will be provided in respect of Pre-existing Conditions.

"Termination Age"
means the age cover would normally cease under the Policy.

"Work"
means on the part of a Member, any employment, self-employment or consultancy or engaging in any work or physical activity which gives rise, or is capable of giving rise, to any remuneration, income, fees, profits, capital or other gains, whether or not they are taxable and whether or not they are paid to, or to the order of, or enjoyed, whether directly or indirectly, by the Member or any person with whom he lives or to whom he is related or who is dependent on him.

15 Further information

15.1 Complaints

We aim to provide a helpful and efficient service, however if you have a complaint or concern about any aspect of the service you have received, please tell us by contacting:

Customer Relations Officer
Assicurazioni Generali S.p.A.
100 Leman Street
London, UK
E1 8AJ

Phone: 020 7265 6200

We will investigate your complaint and keep you informed as to progress whilst the investigation is ongoing. If you are unhappy with the outcome of our investigation, you may be able to refer your complaint to the Financial Ombudsman who will carry out an impartial review of your complaint and the way in which we have handled it.

The contact details for the Financial Ombudsman are as follows:

The Financial Ombudsman Service
Exchange Tower
Harbour Exchange Square
London, UK
E14 9SR

Phone: 0800 023 4567
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

15.2 Compensation

In certain circumstances, if we are unable to meet our liabilities, you may be able to claim compensation in respect of this Policy from the Financial Services Compensation Scheme (FSCS). The FSCS provides cover for 90% of the claim in respect of certain insurance contracts. Further information is available on request or directly from the Financial Conduct Authority or the FSCS.

15.3 Law

The Policy shall be subject to the laws of England and the exclusive jurisdiction of the Courts of England. Under the Policy, Members do not have any rights under the Contracts (Right of Third Parties) Act 1999. This document is a guide to the features of the Policy. Where there is any difference between this guide and the Policy, the Policy takes precedence.

15.4 Regulatory information

We are an Italian public company incorporated with limited liability. We were established in 1831 and have our Head Office in Trieste, Italy. We are registered on the Italian register of insurance and reinsurance companies in section 1 under number 1.00003 and we are authorised to transact insurance business by the Italian regulator, Istituto per la Vigilanza sulle Assicurazioni (IVASS). We have been operating in the UK since 1963 and our UK Branch is registered with Companies House under number BR1185.

15.5 How we use personal data

You and your members can see how Assicurazioni Generali S.p.A UK Branch uses personal data by visiting www.generali.co.uk/Info/Privacy-Information or contacting our Data Protection Officer by emailing privacy@generali.co.uk or writing to The Data Protection Officer, Assicurazioni Generali S.p.A UK Branch, 100 Leman Street, London E1 8AJ.

15.6 Packaged services

Your policy may include non-insurance services as part of a package which are made available to you free of charge. It is not possible to buy the different non-insurance components of your policy separately from us.

Generali Employee Benefits
100 Leman Street
London, E1 8AJ

Tel. +44 (0)20 7265 6200
Fax. +44 (0)20 7481 3481
www.generali.co.uk/eb

Assicurazioni Generali S.p.A. UK Branch 100 Leman Street London E1 8AJ

Company incorporated in Trieste in 1831. Share capital €1,565,165,364 fully paid-up. Registered office at Piazza Duca degli Abruzzi 2, Trieste, Italy.
Italian tax identification and companies registry number 00079760328. Authorised by Istituto per la Vigilanza sulle Assicurazioni (IVASS). Registered in the IVASS register of insurance and reinsurance companies under no. 1.00003.
Parent company of Generali Group and entered in the IVASS register of insurance groups under no. 026.
UK company registration no. BR1185.