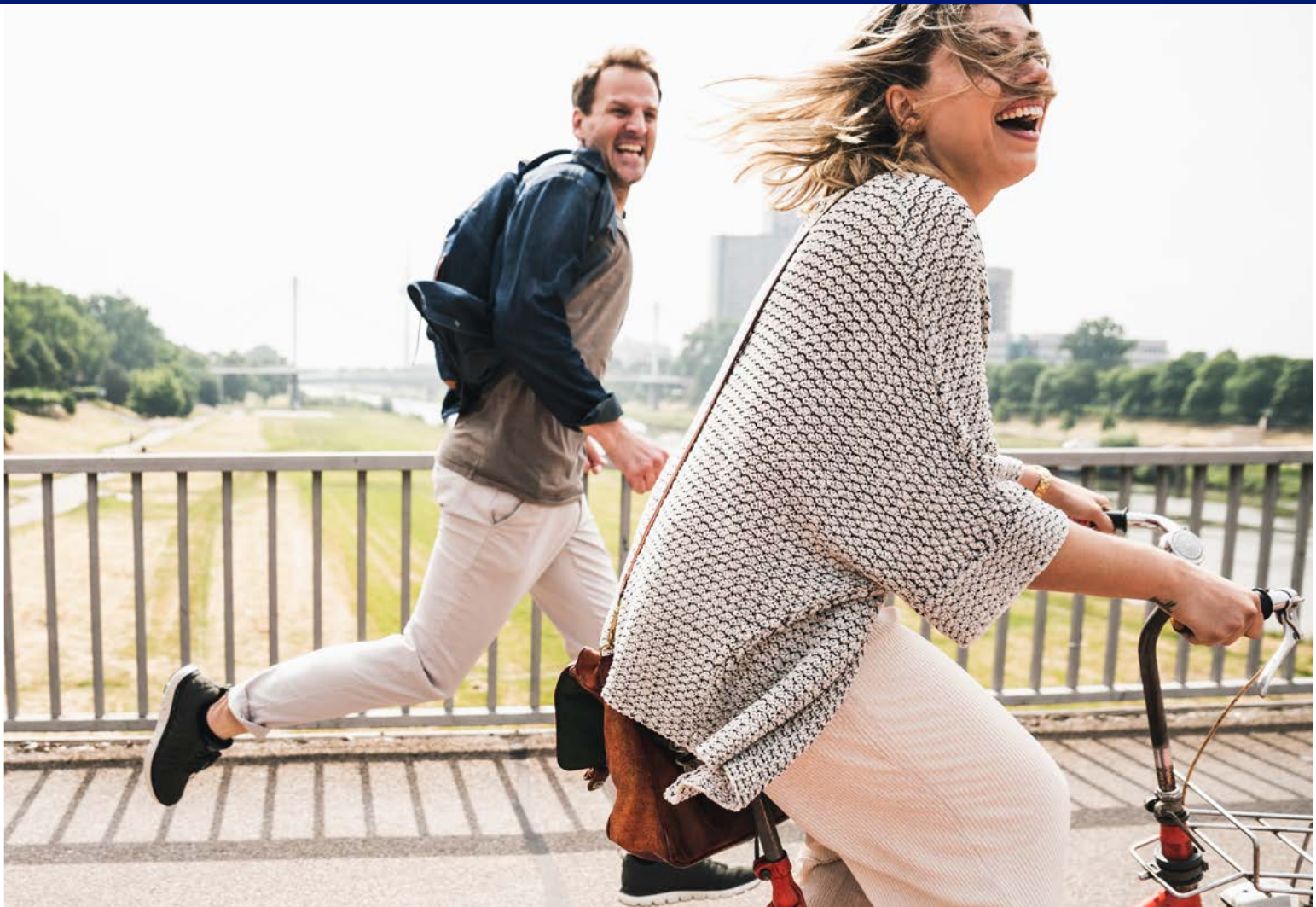




Group Protection

Registered Group Life Insurance

Technical Guide



Contents

Welcome to AIG

Policy aims	4
Your commitment	4
Our commitment	4
Risk factors	4
Your questions answered	5

Section 1

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

1.1 Who can be covered?	6
1.2 Eligibility conditions	6
1.3 When will cover end?	6
1.4 What types of cover are available?	7
1.5 When are pension payments due?	8
1.6 For how long will pensions be paid?	8
1.7 Can pension benefit be inflation protected?	8
1.8 Does a members continue to be covered if they're absent from work?	8
1.9 Are any additional options available under the policy?	9
1.10 Flexible benefits	9

Section 2

Setting up the policy

2.1 What are the requirements for setting up the policy?	10
2.2 Does any evidence of health have to be provided before members are covered?	11
2.3 What happens if a claim arises before an underwriting decision has been made?	13

Section 3

What premiums will be charged for the policy?

3.1 How will premiums be calculated?	14
3.2 Will there be any extra premium?	14
3.3 Is there a discount for a good claims history?	15
3.4 What commission is included within the premium?	15

Section 4

How does the policy accounting work?

4.1 What information is required for accounting purposes?	16
4.2 How are accounts adjusted for members who join, leave or have benefit changes during the year?	16
4.3 If the policy is cancelled mid-year, will premiums paid in advance be lost?	16

Section 5

Claiming a benefit

5.1 How are claims made?	17
--------------------------	----

Section 6

What isn't covered?

6.1 Event limit	18
6.2 Group travel limit	18

Section 7

Can cover be provided for a member who isn't based in the UK?

7.1 Members who travel outside the UK	19
7.2 Members seconded outside the UK	19
7.3 Members permanently based outside the UK	19

Section 8

Taxation of policies

8.1 Payment of premiums	20
8.2 Payment of benefits	20

Section 9

Your duty of fair presentation of the risk

9.1 What you know or ought to know	21
9.2 Material facts	21
9.3 Paying claims in full means that we're contracting out of this part of the Insurance Act 2015	21
9.4 What happens if you don't make a fair presentation of the risk	21
9.5 Fraudulent claims	22

Section 10

Further information

10.1 Complaints	23
10.2 Compensation	23
10.3 Data protection	23
10.4 Law	23

Section 11

Glossary

24

Welcome to AIG

American International Group, Inc. (AIG, Inc.) is a leading international insurance organisation serving customers in more than 80 countries and jurisdictions. AIG is the marketing name for the worldwide property-casualty, life and retirement, and general insurance operations of AIG, Inc.

AIG Life Limited is the life insurance arm of AIG, Inc. in the UK. We provide financial and practical support for individuals, families and businesses when illness or injury threatens their life, lifestyle or livelihood. 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 available on our website www.aiglife.co.uk.



Contact us

Group Protection Client Service
AIG Life Limited
The AIG Building
PO Box 12010
Harlow
CM20 9LG

Call us on:

 0330 303 9972

Calls are charged at standard rates from a BT landline but may cost more via mobiles and other networks.

Email: groupclientservice@aiglife.co.uk

We're 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.

This document is available in other formats. If you would like a Braille, large print or audio version, please contact us.

This Registered Group Life insurance is designed to pay a benefit if a member dies.

It is available to UK registered organisations (either with Companies House or similar) and is not available to UK branches of overseas organisations.

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

This document is aimed at the employers and describes the main features and benefits of the product. It should be read alongside the quote issued. It doesn't form part of the policy contract – the Policy Terms and Conditions can be found on our website.

Any reference in this Technical Guide to employer can include the principal employer and participating employers and is also intended to refer to the trustees of the Registered Group Life Scheme written on behalf of the employer.

Policy aims

- To provide insurance to cover all or part of your promise to provide death in service benefits to the members of your Registered Group Life scheme
- The cover provided can be for a lump sum benefit and/or a death in service pension

Your commitment

- To pay the premiums when they are due
- To comply with the Policy Terms and Conditions
- To establish a scheme by setting up a discretionary trust (or have already done so) or by joining The AIG Life Group Life Master Trust. If you don't want to participate in The AIG Life Group Life Master Trust the scheme must be registered with HM Revenue & Customs (HMRC) and you'll need to provide us with the Pension Scheme Tax Reference (PSTR) you receive from the HMRC
- To tell us of any claims as soon as possible
- To provide us, at the agreed intervals, with the information specified in the Policy Terms and Conditions as needed to ensure cover for the scheme members
- To ensure that any information you supply is complete and accurate when you provide it
- To provide information about the policy and how it works to members

Our commitment

- We'll deal with claims promptly and fairly and will provide information on the progress of the claim. Once we've determined that the claim is valid, we'll pay the lump sum benefit in accordance with the trustees' instructions
- We'll promptly pay 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
- 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'll ensure you and your adviser are aware of the progress and results of such assessments

Risk factors

- If you don't pay premiums on time, provide data when requested or you fail to comply with any of the Policy Terms and Conditions, we reserve the right to cease the policy and not pay any new claims
- We'll cease the policy if your scheme's registration is withdrawn by HMRC
- We may cease this policy if we cease to insure the benefits under any other policies that this policy is linked to
- Any delay in providing the information we require may result in individuals not being covered or having less than their full cover
- If you don't fairly present the risk (i.e. the information we've requested is not provided, is incomplete or is inaccurate) then we have the right to adjust the premiums we charge for the cover and/or the Policy Terms and Conditions or cease the policy – see section 9.4 'What happens if you don't make a fair presentation of the risk'
- There are maximum limits for claims arising from a single event or where members travel together on business – see section 6 'What isn't covered'. If the benefit insured is insufficient to cover the benefit promised on the death of a member, the responsibility for any shortfall lies with you. You should take this into account when describing this benefit to members
- 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 HMRC changes that could affect this policy

Your questions answered

How does the policy work?

- The policy insures all or part of your promise to provide death in service benefit to the members of your Registered Group Life scheme
- The scheme must be established under a discretionary trust. A scheme administrator must be appointed who registers the scheme with HMRC and obtains the PSTR. If your scheme participates in The AIG Life Group Life Master Trust this will be done by Zedra Governance Ltd (Zedra)
- You decide the eligibility conditions and level of benefits that you would like us to cover, subject to the conditions set by HMRC for Registered schemes. You can choose different eligibility and bases of cover for different categories of members
- In order to ensure that you comply with relevant employment and taxation legislation you should obtain appropriate legal and tax advice
- You pay premiums when they are due. Premiums are normally treated as a business expense for tax purposes and aren't treated as a benefit in kind, however you should confirm this with your tax advisers
- We provide the cover whilst premiums are being paid and the policy remains in force no matter how many claims you make
- The benefit to be paid in the event of claims will be as detailed in the Policy Schedule. Limits to the total sums payable from this and any associated life insurance policy insured by us, may apply where claims arise from the same, or related, events or whilst members are travelling together on business – see section 6 'What isn't covered'
- All members will be covered for a benefit up to an automatic acceptance limit specific to your policy, providing they join the scheme at their first opportunity within the eligibility conditions. Any benefit that exceeds the automatic acceptance limit will be subject to individual assessment – see section 2.2 'Does evidence of health have to be provided before members are covered?'
- You must provide us with membership data within 14 days of us requesting it. We'll confirm at the start of the policy how often you'll provide updated membership data (known as the data refresh) which needs to be complete and accurate. This should include details of new entrants, who've joined the policy since the previous data refresh and who'll normally be covered as soon as they fulfil the policy's eligibility conditions. However, if:
 - a new entrant's benefit exceeds the automatic acceptance limit
 - a new entrant is joining without fulfilling the normal eligibility conditions
 - a new entrant is joining other than at their first opportunity
 - an existing member's benefit increases to exceed the automatic acceptance limit, or
 - an individual requires cover beyond the age cover ceases we should be told immediately rather than at the next data refresh because we'll individually assess them to establish the terms, if any, on which cover can be offered.
- The Policy Terms and Conditions and rate(s) are normally guaranteed for two years and won't be reviewed during that time unless one of the following occurs across the aggregate of this policy and any associated life insurance policies insured with us:
 - a greater than:
 - 50% variation in the number of members or their total salaries for schemes that are costed on an age related rate table basis (see section 3.1 'How are premiums calculated'), or
 - 30% variation in the number of members or their total salaries for schemes costed on an unit rate basis (see section 3.1 'How are premiums calculated')
 - the number of members drops below three
 - 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 a participating employer's business
 - the inclusion of a new 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 a participating employer's business
 - the total benefit insured at any one location (including a new location) changes by more than £5 million
 - there's no longer an adviser acting for you in connection with this policy
 - there's a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
 - you don't give us complete and accurate information, or
 - we cease to insure the benefits under any associated life insurance policy
- Once we've determined that a claim is valid, we'll pay the lump sum benefit in accordance with the trustees' instructions. Under the terms of how Registered schemes are established, the trustees must have the discretion to decide who receives the benefit. Since the lump sum is paid under a discretionary trust it doesn't form part of the member's estate and isn't subject to Inheritance Tax. However the beneficiaries may be liable for a tax charge if the member's Lump Sum and Death Benefit Allowance is breached. Death in service pensions will be paid in accordance with the trustees instructions. Pension benefit is treated as earned income by HMRC and therefore is subject to income tax.

Section 1

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

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

1.1 Who can be covered?

Full time, part time and fixed term contract workers can be included in the policy. Workers engaged through zero hours contracts won't automatically be covered by the policy. If you want to cover workers engaged through zero hours contracts they must be in a separate category with suitable eligibility and salary definitions.

Cover can be provided for equity partners and/or limited liability partners, providing all partners are included.

1.2 Eligibility conditions

The eligibility conditions must be clearly defined and agreed with us before the policy starts. They should be consistent with the Registered scheme trust deed and rules.

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 (e.g. you might specify that individuals must have completed three months' service)
- the date on which new entrants will be included (e.g. 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, and
- the date on which benefit 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 individuals who satisfy the eligibility conditions and must not be discretionary.

We consider a late entrant to be an individual who:

- a) joins the workplace pension scheme 12 months or more after first being eligible and whose total benefit (lump sum benefit plus capitalised death in service pension benefit using the capitalisation factor used to assess if the automatic acceptance limit has been exceeded) is above £250,000
- b) was absent due to ill health on the date they joined the workplace pension scheme for
 - one week or longer in schemes with up to 50 members
 - four consecutive weeks or longer in schemes with between 51 and 500 members, or
 - 12 consecutive weeks or longer in schemes with 501 or more members, or
- c) changes their employee pension scheme contribution 12 months or more after first being able to do so and as a result has an increase in benefit and whose total benefit is above £250,000.

Cover for late entrants is subject to individual assessment before we will consider providing cover.

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

1.3 When will cover end?

1.3.1 Under normal circumstances

Cover for a member will end if they:

- a) reach the age at which their cover would cease according to the terms of the policy, unless we've agreed with you that their cover can be continued
- b) are no longer being employed by a participating employer or otherwise become ineligible for membership
- c) retire (unless the policy specifically provides cover during early retirement)
- d) are a worker engaged through a zero hours contract who hasn't received earnings from their employer for a period of six consecutive months unless they're unavailable for work due to ill health

- e) are absent from work and reach the end of the period of cover we provide during temporary absence as detailed in section 1.8 'Does a member continue to be covered if they are absent from work', or
- f) die.

Cover can't continue beyond a member's 75th birthday.

1.3.2 Cancelling the cover

The policy doesn't have a termination date. You can cancel the policy at any time providing you notify us in writing. Cancellation can't be backdated and we'll charge for the time on risk.

We reserve the right to cancel the policy if:

- a) you don't pay premiums when they are due
- b) you don't comply with the Policy Terms and Conditions
- c) you don't provide information we've requested within 90 days
- d) your scheme's registered status is withdrawn by HMRC
- e) there's a change in legislation, regulation or HMRC practice or taxation which affects the policy
- f) an employer covered under the policy ceases to carry on business, or if any order is made or resolution passed for the winding up of that employer
- g) you fail to fairly present the risk when setting up the policy, or at a rate review, or when you request a change to the policy, or
- h) we cease to insure the benefits under any other life insurance policies that the policy is linked to.

1.4 What types of cover are available?

The basis of cover should reflect the scheme rules. The employer will be responsible for any shortfall between the benefit promised under the scheme and the cover provided under your policy with us.

1.4.1 Lump sum benefit

The lump sum benefit payable on death can be a fixed amount or a multiple of salary and must apply to all members within a category. For workers engaged through zero hours contracts the maximum fixed amount we'll normally offer is £50,000.

1.4.2 Death in service pension benefit

A pension can be provided for a member's dependants and can be based on a percentage of either the member's salary or prospective pension. As with the lump sum benefit, you can vary the basis between categories but it must be the same for all members in the same category.

You can choose whether the pension is payable to a spouse/civil partner only, or define dependant in any way that complies with the Finance Act 2004 definition of dependant. If a dependant's pension is payable to more than one person it will be allocated as directed by the scheme trustees. If the adult dependant is more than ten years younger than the member, the pension will be reduced by 2.5% for every complete year in excess of ten years.

In the event of the death of the spouse, civil partner or adult dependant, the pension benefit can continue to any surviving eligible children. If there isn't a spouse, civil partner or adult dependant, the pension benefit may be payable to any surviving eligible children, if the trust deed and rules allow. In addition you can provide a separate children's pension.

Pensions payable in respect of children can be paid for any natural, adopted or other child who in the opinion of the trustees was financially dependent on the member at their date of death.

Benefit in excess of £10 million (including the capitalised value of any death in service pension – which is calculated by multiplying the annual pension benefit by the capitalisation factor used to assess if the event limit has been exceeded) for a single member will only be provided subject to our express agreement.

Salary definition

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 (such as bonuses and commission) can be taken into account. Where dividends form part of the salary definition they must be averaged over the preceding three years (or shorter period if applicable e.g. if dividends have only been payable for 18 months they must be averaged over the 18 month period).

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

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

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

- total earnings in the 12 months up to the date of death, or
- P60 earnings in the tax year immediately preceding or coinciding with the date of death (if there are no P60 earnings for that tax year we'll use the total earnings in the 12 months up to the date of death).

Please note that we won't annualise earnings for workers engaged through zero hours contracts who have worked for less than 12 months; their cover will be based on their earnings for the period of time worked.

1.5 When are pension payments due?

We'll pay pension payments monthly in advance on the first day of each month. The first payment will include a pro-rata amount for the period from the member's death.

1.6 For how long will pensions be paid?

Pension benefit will be paid to a spouse, civil partner or adult dependant until they die. Pension benefit in respect of children will be payable until a maximum age of 18 or 23 if the child is in full time education, or as detailed in the policy schedule or scheme rules (if different). Pension payments to a child can't continue beyond their 23rd birthday unless the child is dependant on the member because of physical or mental impairment, in which case they can be paid until the child dies.

1.7 Can pension benefit be inflation protected?

Yes, we can provide increases on pension benefit in payment; this is known as escalation and can apply to the whole pension or part of it. We offer the following levels of escalation:

- a) 3% per annum
- b) 5% per annum
- c) in line with the annual Consumer Prices Index (CPI) to a maximum of either 2.5% or 5%
- d) in line with the annual Retail Prices Index (RPI) to a maximum of 2.5% or 5%, or
- e) any combination of the above.

Escalation applies on the anniversary of the date of death, 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. In no circumstances will the death in service pension benefit be reduced in the event that the basis of escalation results in a rate of escalation below 0% per annum.

1.8 Does a member continue to be covered if they're absent from work?

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

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

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

1.8.3 If they're absent from work for any other reason cover will end after three years.

1.8.4 If a member is on a fixed term contract, then regardless of the reason for absence, cover during periods of temporary absence won't continue beyond the end of the contract in force at the date the member was first absent.

1.8.5 For members who are workers engaged through zero hours contracts, cover during periods of temporary absence due to ill health will end on the earlier of:

- a) the end of the zero hours contract in force when the member was first absent
- b) when that zero hours contract is terminated, or
- c) three years from the start of the ill health.

1.8.6 If a member is beyond the age cover ceases and still being covered (see section 1.9.1 'Extended cover') their cover during periods of temporary absence can be until age 75 if due to ill health and for up to 12 months if absence is due to any other reason.

Whilst any member is absent and where the basis of cover is based on their salary, cover will be based on their salary at their last working day before they became absent. However, cover can increase in line with average company pay awards up to a maximum of 5% per annum (the 5% maximum will be waived where the member's entitlement to a higher increase is enshrined in law, e.g. an increase in the National Minimum Wage).

Members who are being covered during periods of temporary absence must be included in the data and on the correct amount of salary and/or benefit.

1.9 Are any additional options available under the policy?

We offer the following options at additional cost:

1.9.1 Extended cover

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

Cover can't continue beyond a member's 75th birthday.

1.9.2 Early retirement

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

1.9.3 Cover during redundancy

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

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

1.10 Flexible benefits

We can provide cover under a flexible benefits scheme, where members can decide the level of cover that's 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 actively at work conditions, will apply to flexible benefit schemes and these will be set out in our quote.

Section 2

Setting up the policy

The policy has been designed to insure benefits provided under workplace Registered Group Life schemes that have been established under discretionary trust. If you don't participate in The AIG Life Group Life Master Trust a scheme administrator must have been appointed who has registered the scheme with HMRC and obtained the PSTR before the scheme can be insured.

2.1 What are the requirements for setting up the policy?

The information we require to prepare a quote is detailed at the beginning of section 3 'What premiums will be charged for the cover?' We'll prepare a quote based on the information you provide and it's normally valid for three months. If you want us to start cover, your adviser will need to ask us to do so, and supply any outstanding information that is requested in the quote.

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

If your adviser has provided your email address, we'll send you an email with details of how to register to access the site. Once you've 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's 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 don't have the information we requested
- c) insert any information that is shown as required (e.g. we'll need the scheme name and cover start date), and
- d) sign the form and the direct debit mandate and return it to us by email before the policy start date (cover can't be backdated).

The information detailed on the application form in the section

'Information you provided on which our quotation was produced' is in respect of members covered under this policy and any associated life insurance policies to be insured by us.

If your adviser hasn't provided your email address, the application form will be sent to the adviser, who'll contact you about completion.

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

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

- in schemes with up to 50 members, for one week or longer
- in schemes with between 51 and 500 members, for four consecutive weeks or longer, or
- in schemes with 501 or more members, for 12 consecutive weeks or longer.

The application form will ask you to tell us about any members you haven't already disclosed who are currently absent due to ill health and:

- in schemes with up to 50 members, have been absent from work due to ill health for one week or longer, or
- in schemes with between 51 and 500 members have been absent from work due to ill health for four consecutive weeks or longer and whose total benefit (including where appropriate the capitalised value of any death in service pension payable under the policy) exceeds the annual premium quoted.

For each absent individual, we'll need their sex, age, date of absence, benefit level (details of the sum insured and pension insured, as appropriate), the category the member is covered under and the medical reason for their absence.

Note that where the cover being sought is for death in service pension, the benefit level is the value of the member's annual pension benefit multiplied by the capitalisation factor used to calculate if event limits are exceeded (which will be shown in the quote). Where the cover being sought is for both lump sum and death in service pension, the benefit level is the capitalised value of the pension benefit plus the lump sum benefit.

If any of the information used to prepopulate the application form is incomplete or incorrect or information you subsequently add affects the risk presented (e.g. if details of members who've been absent from work due to ill health are declared who we hadn't previously been aware of), it may mean the terms of our quote, including the premium, are no longer valid and may have to be reviewed, or that we have to withdraw our quote entirely.

Prior to the policy start date, we need details in writing of the terms of acceptance for any members who've been individually assessed (underwritten) by the previous insurer. Please send this to us alongside the completed application form. We'll need copies of the original decision letters for these members within 14 days of us confirming cover.

Once we've confirmed cover can start, we'll request membership data (including employee National Insurance numbers or unique identifiers) as at the policy start date, and this must be supplied within 14 days of our request.

The premium payment options available are as follows:

Payment frequency	Payment method	
	Schemes with up to 199 members	Schemes with 200 or more members
Monthly	Direct debit	Direct debit
Quarterly	Direct debit	Direct debit
Annual	Direct debit	Bank transfer

If we don't receive complete data within 14 days of our request, we'll request payment based on the estimated annual premium in the quote.

For annual payment policies that pay premiums by bank transfer, we'll issue an invoice for the estimated annual premium and payment must be made within 14 days. For annual payment policies that pay premiums by direct debit, we'll request a payment for the estimated annual premium.

For quarterly payment policies, we'll request a payment for 25% of the estimated annual premium.

For monthly payment policies, we'll request a payment for 1/12th of the estimated annual premium.

If, once the data is received, there's a greater than:

- 50% variation in the number of members or their total salaries for schemes that are costed on an age related rate table basis (see section 3.1 'How are premiums calculated'), or
- 30% variation in the number of members or their total salaries for schemes costed on an unit rate basis (see section 3.1 'How are premiums calculated')

compared to the data used for the quote, we reserve the right to review our pricing and/or Policy Terms and Conditions.

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

If any of these requirements aren't provided when they're due, we reserve the right to withdraw cover. We'll notify you that we've 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's normally possible to provide cover for all eligible members up to a certain limit without the need to individually assess them. This limit is known as the automatic acceptance limit. Any member who has joined the scheme at their first opportunity, within the eligibility conditions, will usually be covered automatically for benefit up to the automatic acceptance limit.

For the purposes of identifying members with benefit in excess of the automatic acceptance limit, the member's benefit is calculated as follows:

- if only lump sum cover is being provided, benefit is the member's sum insured
- if only death in service pension cover is being provided, benefit is the value of the member's pension benefit multiplied by the capitalisation factor used to assess if the automatic acceptance limit has been exceeded (detailed in the appropriate category), or
- if both lump sum and death in service pension cover is being provided, benefit is the combined value of the member's sum insured added to the member's pension benefit multiplied by the capitalisation factor used to assess if the automatic acceptance limit has been exceeded (detailed in the appropriate category).

If benefit is based on salary and a member has a salary increase and as a result there's 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. If a member isn't actively at work, then once they return to being actively at work they qualify for the full increase to their benefit as a result of the salary increase. However, if the salary increase results in the member's benefit exceeding the automatic acceptance limit they'll need to be individually assessed and accepted by us before the cover in excess of the automatic 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 insured. If a member is included in more than one policy insured by us, the member's aggregate benefit (including the capitalised value of any death in service pension) will be used to assess whether the automatic acceptance limit is exceeded.

Any individual whose benefit has been restricted, declined, postponed or accepted on non-standard terms won't benefit from any increase in the automatic acceptance limit. For example, if the original limit is £800,000 and a member has a total benefit of £900,000; of which £100,000 is subject to a premium loading, an increase in the limit to £1 million won't mean that the loading is removed.

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

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

- a) an individual has benefit in excess of the automatic acceptance limit (benefit below the limit is still covered automatically)
- b) an individual is offered cover by the employer without satisfying the usual eligibility conditions, or is being offered a different basis of cover to the majority of the rest of the scheme membership (a 'discretionary entrant')
- c) eligibility for cover is linked to pension scheme membership and an individual:
 - i. joins the workplace pension scheme 12 months or more after first being eligible and whose total benefit (lump sum plus capitalised death in service pension using the capitalisation factor used to assess if the automatic acceptance limit has been exceeded) is above £250,000
 - ii. was absent due to ill health on the date they joined the workplace pension scheme for
 - one week or longer in schemes with up to 50 members
 - four consecutive weeks or longer in schemes with between 51 and 500 members, or
 - 12 consecutive weeks or longer in schemes with 501 or more members, or
 - iii. changes their employee pension scheme contribution 12 months or more after first being able to do so and as a result has an increase in benefit and whose total benefit is above £250,000, or
- 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), we'll normally be able to accommodate this, but it may mean we have to individually assess some members before we can confirm their full benefit. We'll need details of members who are absent due to ill health and have been:

- in schemes with up to 50 members, for one week or longer
- in schemes with between 51 and 500 members, for four consecutive weeks or longer, or
- in schemes with 501 or more members, for 12 consecutive weeks or longer.

The details we'll require are the sex, age, date of absence, level of cover (sum insured and/or pension insured), the category the member is covered under and the medical reason for their absence. We'll review this information and advise you whether these individuals will need to be individually assessed before they can benefit from the change in policy design.

The same requirements apply if you wish to include a group of employees as a result of a TUPE. You must also provide details of the number of TUPE employees and their total benefit (sum insured and pension insured), the current automatic acceptance limit and full details of any employee who has had benefit declined or postponed. In addition you must tell us of any employees who travel on business to, 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](#). We'll then assess the potential impact that including these individuals has on the existing policy and advise if we're 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?

Any individual whose promised benefit exceeds the automatic acceptance limit will need to be individually assessed for their excess benefit. We must be told about these individuals immediately as their level of cover can't be confirmed until the individual assessment has been completed.

Individuals who need to be assessed will be sent an email containing a link to our secure online questionnaire. During this questionnaire they'll be asked questions about their health and lifestyle and they'll 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 or an independent

medical examination) before a final decision can be made. If further tests or examinations are required, the individual will be sent instructions as to how to make an appointment with one of our medical test providers in order for the tests to be carried out. On rare occasions we may need to get further information from the individual's GP and/or other medical professionals who have attended them. The individual continues to have a duty to take reasonable care not to make a misrepresentation during this process.

Using the results of the online questionnaire and any other information gathered, we advise if the individual can be accepted at standard rates or if we need to apply special terms, decline or postpone our decision. (We may postpone it, for example, if the individual is about to undergo an operation which could radically affect their state of health once completed.) Special terms will normally take the form of a premium loading, but in some circumstances an exclusion may be applied (e.g. if the individual takes part in a hazardous sport or activity). We'll advise both the individual and you of our decision. If there's a premium loading we'll assume that it's 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're able to offer terms, they'll normally not need to be assessed again if their total benefit (sum insured plus pension benefit multiplied by the capitalisation factor used to assess if the automatic acceptance limit has been exceeded) doesn't exceed £5 million. However, we reserve the right to individually assess members again if their benefit increases as a result of a change in benefit basis or an increase in salary of more than 20% in a 12 month period.

2.2.3 How does a member's cover transfer from the previous insurer?

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 up to a maximum benefit of £5 million (sum insured plus pension benefit multiplied by the capitalisation factor used to assess if the automatic acceptance limit has been exceeded) for any one member, on the same terms, provided we get sight of the previous insurer's terms of acceptance. Cover for benefit in excess of £5 million will be subject to individual assessment.

Where the previous insurer was a Lloyd's syndicate insurer the maximum cover we'll transfer is £1 million.

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

Whilst we're assessing an individual we'll provide them with temporary cover for a maximum period of 90 days or until the date we finalise our assessment, if earlier.

Temporary cover starts from the date we're advised of the level of benefit required. It's subject to the following conditions:

- a) if a claim arises directly or indirectly as a result of any medical condition which the individual:
 - has received treatment for
 - has suffered symptoms of
 - has sought advice on, or
 - was diagnosed with

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

- b) the amount of temporary cover is limited so that, when added to any existing benefit the member may receive, their total benefit entitlement during the period that temporary cover operates shall not exceed £5million. Members whose benefit exceeds £5million are therefore not offered temporary cover in excess of £5 million.

Temporary cover won't be given to any individual who:

- has previously been declined, offered cover on nonstandard terms or where a decision on their benefit has been postponed (either by AIG 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, or
- is being individually assessed because, on the date the policy change was requested, they had been absent due to ill health:
 - in schemes with up to 50 members, for one week or longer
 - in schemes with between 51 and 500 members, for four consecutive weeks or longer, or
 - in schemes with 501 or more members, for 12 consecutive weeks or longer.

If we're unable to complete our assessment before the temporary cover expires, the individual's cover will be restricted to their previous accepted level of cover. If the previous accepted level of cover was based on underwriting carried out by an insurer other than AIG, we'll require documentary proof of the previous acceptance terms.

Section 3

What premiums will be charged for the policy

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
- if, where provided, death in service pension benefits increase once in payment, the level of the increase
- the age and sex of members to be covered
- the nature of the industry you're in and your principal activity
- the salaries of the members
- the location of the workforce (postcode if in the UK or country if outside the UK)
- details of any members who travel on business to 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](#)
- if there are any members who are currently absent due to ill health and have been:
 - in schemes with up to 50 members, for one week or longer
 - in schemes with between 51 and 500 members, for four consecutive weeks or longer, or
 - in schemes with 501 or more members, for 12 consecutive weeks or longer
- details of such members
- the claims experience
- the level of commission (if any) you've agreed with your adviser.

3.1 How will premiums be calculated?

The costing basis will depend on how many members there are in the scheme when the policy is set up and when the policy is reviewed.

3.1.1 Age specific rate table

This basis normally applies to schemes of up to 999 members. Premiums are calculated for the cover provided to each member based on age-related premium rates which we apply to the amount of their benefit.

3.1.2 Unit rate

This basis normally applies to schemes of 1,000 or more members. A weighted average rate is calculated based on the factors detailed in the beginning of this section and this is applied to the amount of members' 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 Conditions and rate(s) for two years until the second policy anniversary date. They'll be reviewed at the end of the guarantee period and a new guarantee period will be set. However, we may review them part way through a guarantee period if any one of the following occurs across the aggregate of this policy and any associated life insurance policies insured with us:

- a) a greater than:
 - 50% variation in the number of members or their total salaries for schemes that are costed on an age related rate table basis, or
 - 30% variation in the number of members or their total salaries for schemes costed on a unit rate basis
- b) the number of members drops below three
- c) the new inclusion of a new participating employer or a TUPE transfer
- d) the disposal of a participating employer or closure of a part of a participating employer's business
- e) 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 eligibility conditions
- g) a change in the nature of a participating employer's business

- h) the total benefit insured at any one location (including a new location) changes by more than £5 million
- i) there's no longer an adviser acting for you in connection with this policy
- j) there's a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
- k) you haven't given us complete and accurate information, or
- l) we cease to insure the benefits under any other associated life insurance policy.

3.3 Is there a discount for a good claims history?

Claims experience, both good and bad, can have an impact when calculating the premiums for policies.

Generally, the larger the policy the greater the significance that will be attached to claims experience.

3.4 What commission is included within the premium?

You and your adviser are responsible for deciding the level of commission, if any, to be paid by us to your adviser. The premium charged will include the level of commission payable. We'll confirm the rate of commission payable to your adviser in your quote and at regular intervals during the life of the policy.

Section 4

How does the policy accounting work?

During the year, you'll send us updated membership data at a frequency agreed when the policy starts. For schemes with up to 199 members, data can be provided quarterly or annually. For schemes with 200 or more members, data can only be provided annually. The data will be used to calculate the premium.

The quote 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 benefit – change), or
- 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've chosen to use)
- name
- sex
- date of birth
- salary (based on the policy salary definition)
- benefit category
- location (postcode if in UK or country if outside the UK), and
- date of joining/leaving (if applicable).

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 and we'll agree with you before the policy starts which of the following bases will be used:

4.2.1 Exact cover cost

This basis applies as standard for all schemes with up to 999 members. Premiums will be calculated based on the amount of cover and time on cover for each member i.e. member's join dates and leave dates will be taken into account.

4.2.2 Simplified administration

This basis is only available to schemes over 200 lives with annual data refreshes. It's standard for all schemes with over 1,000 members where premiums are calculated on a unit rate basis. The premium for the first accounting period will be based on the membership data as at the inception date. For subsequent accounts, a premium adjustment is calculated to allow for changes during the policy year such as joiners, leavers and any changes in benefit. It is payable at the end of the policy year. As a result join/leave dates don't need to be provided and data should only include members covered as at the data refresh date.

Where premiums are collected by direct debit, the amount collected will be adjusted from the next due date. Where premiums are paid by bank transfer we'll request any additional premium due or refund premium if there has been an overpayment.

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.

Section 5

Claiming a benefit

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

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

Claims won't be paid while premiums are overdue.

Upon receipt of a claim, we'll deal with it promptly and fairly and will provide appropriate information on the progress of the claim.

Both lump sum payments and death in service pensions will be paid in accordance with the trustees' instructions.

There must be an appropriate UK bank account into which payments can be made.

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

5.5.1 Can a claim decision be appealed?

If a claim is declined and you disagree with our decision you, the beneficiary or the beneficiary's personal representative can appeal our decision.

An email should be sent to 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 wasn't involved in the original claim decision.

5.1 How are claims made?

To ensure a claim is processed quickly, you must advise us as soon as possible of a member's death by completing and sending us a claim form which can be downloaded from our website. If you have any questions, you can call our claims team on 0330 303 9973.

In most cases we won't need to see the death certificate as we'll check the online register of deaths, but we will if the death occurred outside the UK or is the subject of a coroner's inquest which is still open (in the latter case, if the coroner issues an interim certificate this is an acceptable alternative to a death certificate).

We'll need a completed claim form. If the claimed benefit includes a death in service pension, we'll also need:

- where they are to be paid to an spouse or civil partner, original copies of a marriage or civil partnership certificate
- where they are to be paid to other adult dependants, appropriate evidence of dependence (such as details of how the trustees determined that there was dependency and joint mortgage statements or rent books and a utility bill) plus birth certificate(s), and
- where they are to be paid to children, original copies of birth or adoption certificates.

Section 6

What isn't covered?

There are no standard exclusions under the policy. However, where benefit for particular members is subject to individual assessment (see section 2.2 'Does any evidence of health have to be provided before members are covered?'), exclusions may apply for claims arising from certain specified medical conditions or in specified circumstances.

6.1 Event limit

An event limit is applied to each location and to the policy as a whole. This will define the maximum paid out in the event of one or more deaths occurring as a result of a single event.

A single event is defined as one originating cause, event or occurrence or a series of related originating causes, events or occurrences, resulting in the death of more than one member, irrespective of the period of time or area over which such originating causes, events or occurrences take place and irrespective of the period of time over which such deaths occur. Originating causes, events and occurrences include, but won't be limited to:

- War (whether declared or not)
- Terrorist activities
- Earthquakes
- Windstorm
- Flood
- Sudden release of atomic energy or nuclear radiation
- Radioactive contamination (whether controlled or uncontrolled)
- Biological or chemical substances
- Pandemic illnesses.

In respect of terrorist activities, a series of events will be considered to be related where, on the balance of probability, they result from persons acting in concert or in accordance with a plan or design. We shall be the sole judge as to what constitutes an event.

If event limits apply to specific locations, these will be detailed in the quote, application form and policy schedule, along with the limit applying to the scheme as a whole. For locations that aren't listed, or if none are listed, a maximum location event limit of £5 million will apply to that location.

Where we issue separate policies to a number of entities that form all or part of the same group for corporation tax purposes or where a number of trusts comprise a scheme, our maximum liability across all policies will be shown in each policy schedule.

Where employees of the same group of companies are covered under different policies with us, the benefits (including the capitalised value of any death in service pensions) under all such policies will be aggregated when applying the event limit.

If claims are made as a result of a single event we'll use the order in which they were received by us to determine when the event limit is reached. Once the event limit is reached (or exceeded) we'll pay an amount equivalent to the event limit to the scheme trustees.

Where the benefit includes a death in service pension or the deaths occur (or are identified) in a period of time of more than one week, we'll come to an agreement with the scheme trustees on the most appropriate way in which we calculate and pay the benefit.

6.2 Group travel limit

In the event that two or more members travel together on business, the maximum amount payable from claims arising from the same or related causes whilst they're together will be limited to £40 million. This applies both while they're travelling and for up to seven days at the location where they're engaged in the employer's business. If a lower event limit applies in the location where they're temporarily on business, claims involving these members will be subject to the travel limit of £40 million, not the location limit. If a higher event limit applies to the location where they're temporarily on business then the higher limit applies.

Where members have been at a location for more than seven days, the event limit for that location will apply to them and not the travel limit.

Where employees of the same group of companies are covered under different policies with us, the benefit (including the capitalised value of any death in service pensions) under all such policies will be aggregated when applying the group travel limit.

Section 7

Can cover be provided for a member who isn't based in the UK?

We're unable to provide cover for individuals who are permanently based outside the UK.

7.1 Members who travel outside the UK

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

7.2 Members seconded outside the UK

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

- they satisfy the eligibility conditions of the scheme
- the member has a UK contract of employment or for services with a participating employer
- there's the intention to return to the UK, and
- the country of secondment is declared for each member at the start of the policy and at each data refresh.

Where members are temporarily working outside the UK, the amount of salary and/or benefit advised at each data refresh must be expressed in pounds sterling. The exchange rate will be based on the Bank of England exchange rate and will be fixed at each data refresh. Therefore, in the event of a claim for a member who isn't 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 death.

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

We'll reimburse the member for the tests we've requested, up to a maximum of the amount we'd pay for the same test in the UK. Reimbursement will be in pounds sterling to a UK bank account and the exchange rate used for reimbursement will be our bankers' rate of exchange on the date of reimbursement.

All results and/or reports must be provided in English.

7.3 Members permanently based outside the UK

We're unable to provide cover for individuals who are permanently based outside the UK.

Section 8

Taxation of policies

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

8.1 Payment of premiums

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

For tax purposes, premiums are treated as a business expense and aren't treated as a P11D benefit for employees resident in the UK.

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

Premiums for partnership partners won't normally be allowed as a business expense.

8.2 Payment of benefits

Lump sum benefit counts towards a member's lump sum and death benefit allowance. It's normally paid tax-free, unless the member's Lump Sum and Death Benefit Allowance is exceeded, but death in service pensions are treated as earned income for the purposes of tax.

Section 9

Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact that you know or ought to know of. If you don't 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 don't 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's common knowledge), or
- we specifically say we don't 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're 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 haven't been deliberate or reckless in doing so) we can proportionately reduce the claim. We believe it's 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 don't make a fair presentation of the risk

9.4.1 Deliberate or reckless misrepresentation of the risk

If you deliberately or recklessly don't make a fair presentation when setting up the policy we may void 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 don't make a fair presentation but you haven't been deliberate or reckless the outcome depends upon what we would have done if we'd known the material facts:

- if we wouldn't have entered into the policy we may void 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), or
- if we would have applied different terms and/or an additional premium, we'll 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's a fraudulent claim. If there's a fraudulent misrepresentation by a member which affects our acceptance of a claim made in respect of that member we won't pay the claim in respect of that member. If there's a fraudulent claim made by you we won't pay the claim and we reserve the right to terminate the policy.

Section 10

Further information

Cover is provided by AIG. AIG provides information about the insurance contracts we offer but doesn't provide a personal recommendation about the insurance products we offer. Employees of AIG 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's 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.

10.1 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 Protection Complaints Team at:

Group Protection Complaints Team
AIG Life Limited
PO Box 12010
Harlow
CM20 9LG

by email to groupcomplaints@aiglife.co.uk

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

If you're 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**

10.2 Compensation

If we're 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**

10.3 Data protection

We're 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 the USA, China, Mexico, Malaysia, Philippines and Bermuda). Full details can be found in our Privacy policy <https://www.aiglife.co.uk/privacy-policy>

10.4 Law

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

Our Group Policy Terms and Conditions 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've contracted out as described in section 9.3.

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

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

The policy has no surrender value and can't be assigned without our prior written permission.

This document should be read in conjunction with the quote. This document doesn't override the Policy Terms and Conditions. If there's a difference between the Policy Terms and Conditions and the Technical Guide, the Policy Terms and Conditions takes precedence.

Section 11

Glossary

AIG

AIG Life Limited.

Absentee

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

- in schemes with up to 50 members, one week or longer
- in schemes with between 51 and 500 members, four consecutive weeks or longer, or
- in schemes with 501 or more members, 12 consecutive weeks or longer.

Actively at work

Describes an individual who is:

- a) either actively performing their normal occupation or is taking leave (other than sick leave) that has been authorised by their employer
- b) working the normal number of hours required by their contract with their employer, either at their normal place of employment, at a location as agreed with their employer, or at a location to which they are required to travel for business, and
- c) mentally and physically capable of performing all the duties normally associated with their job

and isn't acting against medical advice in meeting any requirement of a) to c).

Associated group life insurance policy

Policies which we've agreed to link together for the purposes or rate(s), event limits and/or automatic acceptance limits.

Automatic acceptance limit

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

Benefit

The total financial value of amounts paid in the event of a member's death. For the purposes of identifying members with benefit in excess of the automatic acceptance limit, the member's benefit is calculated as follows:

- if only lump sum cover is being provided, benefit is the member's sum insured
- if only death in service pension cover is being provided, benefit is the value of the member's pension benefit multiplied by the capitalisation factor used to assess if the automatic acceptance limit has been exceeded (detailed in the appropriate category), or
- if both lump sum and death in service pension cover is being provided, benefit is the combined value of the member's sum insured added to the member's pension benefit multiplied by the capitalisation factor used to assess if the automatic acceptance limit has been exceeded (detailed in the appropriate category).

Note: Since the most frequent need for the calculation of benefit is to see if the automatic acceptance limit is exceeded or to identify a late entrant, the above definition refers to the capitalisation factor used to assess if the automatic acceptance limit has been exceeded. However for all other calculations of benefit, e.g. to calculate the total benefit for event limit purposes, the capitalisation factor that must be used is the one used to assess if events limits are exceeded and not the one to assess if the automatic acceptance limit has been exceeded.

Discretionary entrant

An individual to whom scheme membership is offered without their having fulfilled the eligibility conditions or who is being offered a different basis of cover to the majority of the rest of the scheme membership.

Eligibility conditions

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

Late entrant

We consider a late entrant to be an individual who:

- a) joins the workplace pension scheme 12 months or more after first being eligible and whose total benefit (lump sum benefit plus capitalised death in service pension benefit using the capitalisation factor used to assess if the automatic acceptance limit has been exceeded) is above £250,000
- b) was absent due to ill health on the date they joined the workplace pension scheme for
 - one week or longer in schemes with up to 50 members
 - four consecutive weeks or longer in schemes with between 51 and 500 members, or
 - 12 consecutive weeks or longer in schemes with 501 or more members, or
- c) changes their employee pension scheme contribution 12 months or more after first being able to do so and as a result has an increase in benefit and whose total benefit is above £250,000.

Cover for late entrants is subject to individual assessment before we will consider providing cover.

Lump Sum and Death Benefit Allowance

This is the financial limit on the amount that can be drawn from pension schemes (a Registered Group Life scheme is a pension scheme for the purposes of the Lump Sum and Death Benefit Allowance) without triggering an extra tax charge.

Member

An employee, equity partner, limited liability partner and, if we've agreed to cover them, workers engaged through zero hours contracts.

Registered

The scheme must be registered with the HM Revenue & Customs to obtain the Pension Scheme Tax Reference.

UK

The United Kingdom consisting of England, Wales, Scotland and Northern Ireland.



www.aiglife.co.uk

AIG Life Limited. Telephone 0345 600 6820. If calling from outside the UK, please call +44 1737 441 820. Registered in England and Wales. Number 6367921. Registered address: The AIG Building, 58 Fenchurch Street, London EC3M 4AB. AIG Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. The registration number is 473752.