Employer guide to Group Income Protection

What it is and how it works

Please note: this guide provides brief summaries of the cover and options available. **It doesn't form part of the contract.** For full details you must read the Policy Wording.

AVIVA

Contents

How this brochure can help you

Please note, whenever we use ‘we’ or ‘our’ in this document, we’re referring to Aviva. The use of ‘member’ refers to an employee or equity partner.

Part of Aviva’s Group Protection Portfolio, Group Income Protection can be a valuable asset for employers looking to provide a competitive benefits package.

In a nutshell, our Group Income Protection policy provides cover for a proportion of regular income promised in a contract of employment or agreed in a partnership deed. The cover applies when a member is unable to work due to sickness or illness and suffers a loss of earnings. This financial support can take away some of the added pressure they may be feeling, allowing them to focus on getting well.

Unfortunately, when people are off work for long periods, due to illness or injury, the effects can be far reaching for their workplace as well as themselves. Group Income Protection can help with this, too. In addition to providing financial support for your members, it can provide practical rehabilitation services or sign-posting support, should they be absent or struggling in the workplace.

How Group Income Protection cover makes a difference

A period of absence from work can be highly charged with emotion, often with unexpected considerations for everyone involved. With Group Income Protection cover from Aviva, those affected can receive financial and emotional support at a time when it’s needed most. After all, your employees and equity partners are your most valuable assets.

Within this brochure, we’ve provided information to help you understand the benefits of Group Income Protection and how it works. This document doesn’t contain the full terms and conditions of the policy. These can be found in the appropriate Policy Wording.

As you may be aware, we’re unable to give you any advice, but can take you through your options to help you make an informed decision. You’re responsible for deciding what may be best for your specific needs. We recommend you speak to an independent Financial Adviser. If you don’t have a Financial Adviser, you can find one at **www.unbiased.co.uk**.

It’s important to review and update your Group Income Protection cover regularly, to ensure that it remains appropriate for your needs.

What is Group Income Protection?

Employees or equity partners don't want to worry about their finances when recovering from an illness or injury. Yet there remains a need to make sure an employer's business is running smoothly and costs aren't increasing through the need to pay an absentee as well as their replacement. Fortunately, Group Income Protection can help overcome both of these problems.

As an employer, you can insure a percentage of a member's monthly taxable earnings and, for employee cover, you have options to insure pension fund contributions and National Insurance contributions or Social Security contributions. There's also an option for employee cover to insure a lump sum payment which can, for example, be used to help fund their early retirement. The process is straightforward: in the event of a valid claim, and after a waiting period of your own selection, these benefits are paid directly to you, to be passed on through your normal pay-roll processes. You also select the time period during which a claim can be paid.

With a Group Income Protection policy in place, you and your members are also able to reach out to us for rehabilitation support. You, like us, want to help them get back to work as quickly as possible – so we'll look to help where we can. Of course, it may not always be possible to help, and no two claims are exactly the same, but rest assured that our dedicated case managers will always be on hand to take your call, and will be pleased to guide you and your members through the process of any claim which may be needed.

What are the benefits of Group Income Protection?

To the employer...

- Helps to enhance the overall benefits package which will assist in attracting and retaining the right people.
- Provides your valued members with a proportion of their income while they recover.
- Premiums will normally qualify as an allowable business expense and therefore qualify for corporation tax relief. This is based on our current understanding of tax rules and legislation.

To the member...

- Gives some peace of mind knowing that they may be entitled to a proportion of their taxable earnings during a period of absence.
- Gives access to a range of wellbeing services, designed to help provide emotional and practical support.
- Provides access to experienced case managers who can support members during their absence.

How does a Group Income Protection policy work?

A brief summary:

- You can choose whether to insure all of your members or just a specified selection such as directors or managers. You'll also need to choose the age at which members will cease to be provided with cover. It's also down to you to fix the level of income replacement benefits you want to provide (different categories of membership can have different levels of cover).
- For employees, you can also decide if you wish to insure employer and employee pension contributions and/or National Insurance contributions or Social Security contributions.
- You choose the length of the waiting period (known as a deferred period) before any claim payments are made.
- You also need to decide how long payments will be made in the event of a claim. For example, you can insure until State Pension age or choose a benefit payment term of two, three, four of five years.
- Choose a definition of incapacity under which your members will be insured.
- You provide us with the member information we require each year to calculate accurate premiums and to assess any claims.
- Employers normally pay all of the premium, with the cost usually treated as an allowable business expense for tax purposes.
- We pay all valid claims payments directly to you, to be passed on to affected employees through your normal pay-roll processes. Alternatively, if insured, we'll pay directly to the equity partner.
- You can access expert rehabilitation support, if required, as well as taking advantage of any additional wellbeing services.

If you need more detail on how it all works...

We appreciate you're likely to have questions concerning how the policy operates, and there may also be details which you might not even have considered. With this in mind, we hope to have addressed many of these points below:

Who can be covered under a Group Income Protection policy?

Employees – a person employed by you with a current UK, Channel Islands or Isle of Man contract of employment can join, provided they meet the eligibility criteria decided by you. Some examples of these criteria would be factors such as minimum and maximum entry ages, entry dates and waiting periods. We're also able to insure fixed term contractors.

Equity partners – an equity partner (or fixed share partner) in your business, evidenced as such by a partnership deed or contract. They need to be a part-owner of the assets of the business and;

- participate jointly and severally in the risks and rewards of the business; and
- are treated by HM Revenue & Customs (HMRC) as a self-employed partner for tax purposes.

We offer slightly different levels of cover for equity partners. The following sections set out what cover is available for each insured member type.

Can cover be provided for members who aren't in the UK, Channel Islands or Isle of Man?

Yes, provided they maintain a UK, Channel Islands or Isle of Man registered contract of employment and they're working in one of our listed standard territories or any additional locations that we may agree. We'll need to be advised of any members who are working overseas in case we need to apply any special terms and conditions.

Is there a minimum number of lives needed in a scheme?

The minimum number of people who can be insured under your policy is five. However, if you wish to insure a lump sum, the minimum number of lives rises to 20.

All members must be actively at work to be covered when the policy commences.

Must all members have the same level of benefit?

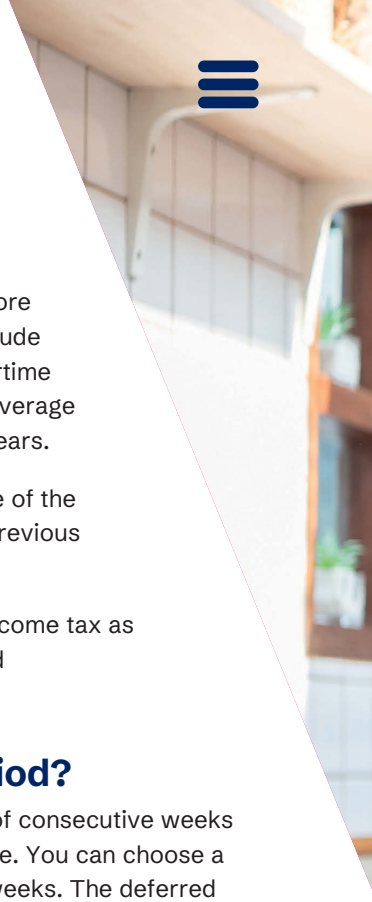
No. You have a great deal of flexibility and can choose different levels of benefits for different insured members. If you wish, members can be grouped according to categories of employment, with different levels of benefit applying to each. For example, directors may have a higher benefit than other staff. It's very important that we know which members fall into each category, so that we can correctly calculate your premiums and ensure that the correct benefits are paid in the event of a claim.

What levels of cover can Aviva provide?

You choose the income benefits as a percentage of the member's before tax earnings. You select the benefit level depending on your budget, as a percentage of the member's earnings. The maximum benefit you can choose is:

- 80% of before tax earnings for employees; or
- 50% of equity partner earnings.

Cover can be arranged to provide a maximum income benefit of up to £425,000 per year.



What additional benefit types of cover are available for employees?

As well as insuring income benefits, you can also cover:

- your continuing liability to pay pension contributions to an occupational pension scheme;
- some of the employees' own pension contributions; and
- your liability to pay National Insurance contributions or Social Security contributions on the insured benefit amount.

Employee's pension scheme contributions:

Employee's pension contributions can be either covered at a fixed amount, or as a percentage of pensionable salary. This choice is up to you, depending on the way you pay your employees. Where you insure these benefits, they contribute to the overall maximum cover allowed – 80% of earnings and a maximum of £425,000 per year.

Employer's pension scheme contributions:

We can cover employer's pension contributions at a fixed amount or a percentage of pensionable salary. The maximum amount you can insure is £75,000 per year. This doesn't contribute to the overall maximum benefit of £425,000 per year.

Employer's National Insurance contributions or Social Security contributions:

Your National Insurance contributions or Social Security contributions can also be insured. The amount insured will be the employer's National Insurance contribution or the Social Security contribution payable on the income benefit amount.

Lump sum payment:

If you've chosen a limited payment term, you can opt to cover a lump sum of up to five times the employee's salary, or up to nine times the annual income benefit.

The maximum amount you can insure is £1.6 million. Please note, it isn't possible to provide lump sum cover for employees on a fixed term contract.

What additional benefit types of cover are available for equity partners?

We're only able to provide cover for income benefit for an equity partner. We can't offer them cover for pension contributions, National Insurance contributions or Social Security contributions.

Please note, we're also unable to provide lump sum payment cover for an equity partner.

What can be included in the definition of earnings?

For an employee – their annual before tax salary or wage. We can also include other income such as bonuses, overtime or commission. If we do this, we'll average these amounts over the last three years.

For an equity partner – the average of the equity partner's earnings over the previous three years, less:

- any amount allowable against income tax as expenses, where applicable; and
- before the deduction of tax.

What is a Deferred Period?

A deferred period is a waiting time of consecutive weeks before any claim payments are made. You can choose a deferred period of 13, 26, 28 or 52 weeks. The deferred period starts on the first day of absence from work, with no payments being made until it's completed.

Normally, the deferred period is tied in with your contractual sick pay agreements. For example, if you're contracted to pay income due to sickness or absence for 26 weeks, you should consider a deferred period of 26 weeks. You should not select a deferred period less than your contractual agreements, as a claim won't be paid until the claimant's income from you ceases.

What are the policy & category cease age options?

You choose when you'd like the cover and benefit payments to stop under the policy. This is called the policy cease age and can be:

- any fixed age from 50 to 70; or
- State Pension Age up to a maximum of 70; or
- Dynamic State Pension Age up to a maximum of 70.

If you've chosen a cease age of State Pension Age, be aware that in the event of incapacity, benefit is paid until the member's State Pension Age that applied at the start of their incapacity.

If the policy cease age is below the member's State Pension Age or is State Pension Age and their State Pension Age changes after the start of their incapacity, you may still be liable to continue to pay benefits after a benefit ceases under the policy, until their actual State Pension Age.

If you've chosen a cease age of Dynamic State Pension Age in the event of incapacity, benefit is paid until the member reaches their State Pension Age even if that changes after their first date of incapacity. This means that if there are future changes to the member's State Pension Age because of Government policy, then the cease age of any valid claim will be adjusted.

As mentioned previously, we're unable to give you any advice, but can take you through your options to help you make an informed decision. You're responsible for deciding what may be best for your specific needs. We recommend you speak to a Financial Adviser if you feel you need advice.

When will cover stop for a member?

Cover will stop when a member:

- is no longer eligible for the policy, or
- is no longer employed by the employer or if an equity partner, leaves the partnership, or
- when a member moves overseas to a location not listed in our standard territories, or
- reaches the cease age, or
- receives a lump sum benefit (if covered) at the end of a limited payment term, or
- dies.

Cover will stop for all members when the policy is cancelled.

What is a Limited Payment Term?

In the event of a claim, instead of providing claim payments until the policy cease age you chose, you can elect to cap the amount of time that a valid claim is paid for. This is known as a limited payment term and you can choose for benefit payments to be limited to a period of 2, 3, 4 or 5 years.

What is a definition of incapacity?

You can choose from three different definitions of incapacity. The options are designed to give you flexibility on how you insure your members, as well as offering different pricing options according to your budget. The three options available to you are:

Own Occupation: the member's inability to perform, on a full and part time basis, the duties of their job role, as a result of their illness or injury.

Suited Occupation: the member's inability to perform, on a full and part time basis, the duties of their job role, and other occupations for which they're suited by reason of education, training or experience, as a result of their illness or injury.

Switched: for the first 24 months after the deferred period has been completed, the member's inability to perform the Own Occupation definition applies. After this period a switch is made to the Suited Occupation definition.

There are many factors which can influence your overall price – but, typically, Own Occupation is the most expensive option, followed by Switched and then Suited.

A more detailed explanation of how we assess the three options at claim stage can be found in the 'Claims: what you need to know' section of this brochure.

Will evidence of health need to be provided by members?

One of the benefits of a Group Income Protection policy is that we normally offer what we call a free cover limit (FCL). The FCL is the limit under which medical information isn't needed. This means that:

- if an eligible member's total benefit remains below the FCL, we won't need to ask for any medical information.
- if the member's total benefit is above the FCL, we'll need to request medical information, so our underwriters can determine whether we can cover the amount which exceeds the FCL. The proportion of benefit which falls below the FCL will normally continue to be covered regardless of the underwriter's decision.

The FCL amount will vary depending on the size of the scheme, with a maximum allowed benefit of £150,000 per year.

Can benefit payments be inflation protected?

Yes. You can choose a 'claims escalator', which means that when a claim is in payment the benefit will increase. You can choose either:

- a fixed increase of 3% or 5%; or
- in line with the Retail Prices Index (RPI) with increases capped at either 2.5%, 3% or 5% or;
- in line with Consumer Price Index (CPI) with increases capped at either 2.5%, 3% or 5%.

The benefits will increase by the chosen level after they've been paid for 12 consecutive months.

We won't reduce the benefit if RPI or CPI falls below 0% per year.

What premiums will be charged for the cover?

The premium calculated depends on several factors which include, but aren't limited to:

- the level and type of benefits insured
- the cease age
- eligibility and entry conditions
- annual increase in benefit payments (if any)
- deferred period the age of members
- gender
- occupations of the members
- locations of the workforce; and
- claim history if the policy has been insured before.

A minimum premium of £600 applies and will be shown on the illustration. All premium payments are to be made in pounds sterling.

How are premiums calculated?

Premiums are calculated for each member using our current premium rates. These underlying rates are usually guaranteed for two years. We'll calculate premiums each year, with rates dependent upon the age and gender of the members at the anniversary date. Premium rates generally increase with age.

We have two different methods of calculating a premium, depending on how many members there are in the scheme:

For policies with fewer than 20 lives:

an individual premium will be calculated for each member, using our current premium rates. The rate is determined by the member's age and gender, with the rate applied to the member's benefit to arrive at a premium.

Premiums are recalculated at the beginning of each policy year and rates generally increase with age. To do this, we'll need to know the amount of benefit needed for each member at the anniversary date.

For policies with 20 or more lives:

a single premium will be calculated for the scheme as a whole, using what's known as a 'unit rate'.

The premium is calculated based upon the total benefits for members at the beginning of each policy year.

We'll maintain the accuracy of the premium each year by incorporating revised member data, which we'll ask for in advance of the policy anniversary date.

How and when are premiums collected?

The premiums are always paid in advance by the employer and can be paid monthly, quarterly, half yearly by Direct Debit – or yearly, by this method or by electronic funds transfer.

Is there a penalty for cancelling the policy?

There's no cooling off period, however there isn't a penalty for cancelling the policy. It can be cancelled by you at any time in accordance with the policy terms (although we'll only cancel from the date we're advised) and we'll only charge a premium for the time we're 'on-risk'. For example, if a full 12 months premium was paid on 1 April and we received notification that the policy is no longer required from 1 October, then we'll calculate the premium due from 1 April to 1 October and refund the remainder (in this case, six months' premium). If a claim was received during the period 1 April to 1 October, then this would have no impact on the refund due. However, in this instance we wouldn't pay claims for members' absence after 1 October, as cover would no longer be in place.

When can Aviva cancel the policy?

We can cancel the policy if you don't pay the premium within 30 days of the due date. We also reserve the right to cancel the policy if you don't give us the information and documentation we need to administer the policy, or the membership drops below our minimum of five lives.

If we cancel the policy we'll give you at least 30 days' notice.

What happens if there's a claim or I need rehabilitation support?

Our aim is to make the process as easy and straightforward as possible. You'll have dedicated contacts throughout any rehabilitation or claims journey. This assistance is provided to help you and support your members at what would inevitably be a difficult time for them. Each case will, of course, be different and we can talk through the best and most appropriate course of action.

The sections later in this brochure explain in detail what you need to do, and how we'll handle rehabilitation support or claim assessment.

Getting a quote for a Group Income Protection policy...

Once you've assessed all the information available to you, and you feel that Group Income Protection could form a key component of your company benefit package, you'll want to know how you can obtain a quote.

You should start by contacting our Sales team on 0800 145 5684* or at **GroupProtectionSalesSupport@aviva.com**. They'll explain the quotation process and go through the information that they'll need to prepare your quote. This includes the following details about your members:

- Gender
- Dates of birth
- Salaries, taxable earnings from a partnership
- Benefit basis/level
- Occupations
- Work locations
- Countries of residence (if outside the UK, Channel Islands or Isle of Man)
- Details of any members who aren't actively at work (see Questions & Answers section of this brochure for more details).

If you've had a similar scheme with another insurer, we'll also need to see details of the scheme and any claims history.

There may be other information that you're required to provide, if this is the case, our Sales team will let you know.

Once all the information is received, our underwriters will prepare a quote outlining what the annual and monthly premiums will be. This will usually be issued to you within 10 days of the request being received, and will include links to useful information.

How long is the quote valid for?

The quote will normally be valid for a period of three months. We may need to issue a re-quote if your proposed scheme membership increases or decreases by 25%, or if the benefit basis changes within that three-month period.

To get started, call our Sales team on 0800 145 5684* or at GroupProtectionSalesSupport@aviva.com

*Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

Setting up a Group Income Protection Policy

If you're happy with the premium quoted and wish to proceed with the insurance, you'll need to follow the five straightforward steps detailed below to fully set up the policy and activate your cover:

Step 1

Contact our Sales Team to confirm that you're happy with the quote and want to proceed.

Step 2

We'll email you with details of further specific information required to help set up the policy, together with any forms that need to be completed.

Step 3

Once we've received the information requested in Step 2, our underwriters will email confirmation that your policy is 'on-risk', together with your policy number and an invoice for the deposit premium. This means that all members of your scheme will be covered for the benefits detailed in the quote. The date we go on-risk will be the date we receive all the requested information – it can't be backdated.

Step 4

So we can complete your scheme's set-up, you'll need to send us:

- A completed application form
- A completed Direct Debit form, or payment of the deposit premium
- A completed list of all members of the scheme
- Individual details of any members who are above the free cover level
- For existing policies, details from your previous insurer of any medical underwriting decisions.

Step 5

Once we've received the information detailed in Step 4, we'll, issue your initial account pack together with the Policy Schedule and Policy Wording.

The process is slightly different for members whose insurance needs to be medically underwritten, because they're over the Free Cover Limit. Cover for these members will be requested and processed as part of our general scheme administration. If there are no medical underwriting requirements, then we won't usually need any more information until six weeks before the anniversary date of your policy (information required for any mid-year changes is detailed in the Questions & Answers section of this brochure). When this time arrives, we'll we issue a reminder for you to supply details of the current membership, so we can calculate an accurate premium for the next policy year.

Rehabilitation and claims service built around your needs

Our aim is to start actively working with you and your members after four weeks' absence. This is because our experience has shown that working at an early stage of absence is more likely to result in a successful return to work.

Once a member of staff has been absent from work for four weeks or more, we'd encourage you to contact us as soon as possible. You can call the claims team on **0800 1422377**, email them at **groupipclaims@aviva.com** or complete our online **claim form**

When you contact us at this point, we'll assign a dedicated case manager who will guide you (and the employee, with your consent) by assessing the case and helping you decide the best way forward. This will include the support we can offer, or if appropriate we may agree a future date to review the potential claim. This discussion won't have any bearing on the deferred period applicable on the policy, because there are often instances when providing support at this point can prevent a significant claim.

Extra condition specific support

Mental health
- Flexibility on communication to meet the sensitive needs of individuals.
- Tailored mental health treatment, from counselling to private treatment.
- Support for a wide range of conditions including depression, anxiety and stress.

Cancer
- We don't need medical evidence to confirm if the claim is supported.
- Specialist rehabilitation partners to help support an employee's recovery and return to work.
- Dedicated Cancer Work Support Service.

Covid-19
- Dedicated Covid-19 Work Support service.
- Support for mild or severe symptoms, including long-covid and those struggling as an indirect result of the pandemic.

Musculoskeletal
- Face to face and virtual physiotherapy.
- Help for acute pain and recovery from musculoskeletal surgery.

Neurodiversity
- Clinical screening to help identify employee strengths and challenges.
- Workplace adjustments.
- Employer coaching and training to better understand and support employees.

Cardiac
- Specialist support to help achieve the best outcome for individuals diagnosed with a cardiac condition or following a cardiac event.
- Lifestyle and risk factor management.
- Return to work advice, guidance and support.

Neurological
- Neurological rehabilitation for conditions affecting the brain and spinal cord.
- Specialist neurological occupational therapy.
- Neuro and vocational rehabilitation interventions.

How the process works

We'll consider rehabilitation on every case and if it's appropriate, we'll ask for consent to speak to your member of staff to gain further information. We'll provide support through our comprehensive clinical pathways.

The case manager will draw on support from our in-house clinical team and rehabilitation partners. They may also seek approval from their General Practitioner (GP) of any treatment plan where appropriate.

The case manager will provide support throughout the process and will be your main point of contact.

If the member of staff is fit to return to work, the case manager will work with all parties to put together a return-to-work plan. This could include a gradual phasing of duties, changes to hours or responsibilities, or even retraining requirements.

If the member of staff isn't ready to return to work by the end of the deferred period, we'll work seamlessly through the claim process with all parties and calculate the benefit payments due. Further information on the claims process can be found in the following section 'Claims: what you need to know'.

Claims: what you need to know

When do I need to tell you someone is absent from work?

You must tell us about a potential claim as soon as you can, preferably no later than when they've been absent for two months or, in the case of a 13-week deferred period, one month.

Benefits that were due before we were told about the absence can't be backdated to the end of the deferred period. If, due to the delay in telling us, we can't confirm incapacity – or if our ability to intervene has been compromised – payment of benefit may be affected.

If you don't tell us about a claim within six months of the end of the deferred period, we may not accept the claim.

How do I notify you that I have a member absent from work?

If you need to submit a claim, please contact us:

Telephone: **0800 142 2377**
Email: **groupipclaims@aviva.com**, or
Completing our **online claim form**.

We will then advise you what will happen next and what information we require.

Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

What happens when someone makes a claim?

Our aim is to make the claims process as easy and straightforward as possible. You'll have dedicated contacts throughout the claims journey to help you and support your members at what will inevitably be a difficult time for them. Each case will, of course, be different and we'll always be on hand to talk through the best and most appropriate course of action.

When you contact us to make a claim, our aim is to make things as easy as possible. All the information we need will be taken over the phone, almost like a conversation. This means we fill the forms in over the phone, rather than you having to fill them in afterwards. We also make use of electronic signatures, which makes the consent process a lot easier, and reduces potential further delays in waiting for handwritten ones to be received.

What information will be needed to assess a claim?

Every person is unique, and no two absences are exactly alike. We treat all cases individually and judge them on their own merit.

We'll need information from you about the member, their job role and income. We're also very likely to need medical information, which will be expertly assessed by your designated Case Manager in liaison with our clinical team. They'll gain a clear understanding of any rehabilitation in place, ensuring that the claims decision supports any return-to-work plan.

If additional evidence is required to support the claim, such as medical reports or independent assessments, these will be requested. We'll keep everyone informed of progress throughout and will meet the costs of gathering any medical reports which we may require.

How will a claim be medically assessed?

The medical assessment will vary depending on the type of cover that you chose – more on this later. You'll appreciate that we can't be specific as to when a claim will and won't be paid, as each individual and their circumstances can be very different. As part of the assessment process, we'll take care to understand the job they performed before they became absent and the duties within that role. If applicable, we'll also gather information on the member's past work experience, skills and training.

As well as consulting with yourself and the member to find out this information, we'll also ask for relevant medical details from the member's own clinicians, possibly also asking for an independent assessment to be carried out. The medical information required will include details of the severity of the condition, how long it has existed and how it affects them. We also need to know that they're continuing to receive medical advice and treatment where appropriate.

All the medical information that we gather is expertly assessed by the Case Manager and our clinical experts to form a claim decision.

Assessing the three types of cover

As you may recall, the three types of cover offered are Own Occupation, Suited Occupation or Switched. These are assessed as follows:

Own Occupation

This definition refers to a cover type where we assess the member's inability to perform their job role on a full and part-time basis. The member needs to be unable to perform the duties of their job role and not performing any other job. The job role is the one they were performing at the time they became absent.

We'll assess the medical information we've obtained in line with the material and substantial duties normally required to perform the member's job role. These duties are the significant and integral parts of the job which can't be reasonably omitted or modified. If there are some aspects of the job that can't be performed but could be classed as minor, this wouldn't necessarily mean that a claim would be valid.

Suited Occupation

As well as everything under the Own Occupation assessment, this stricter definition also allows us to consider the member's ability to perform occupations **for which they're suited**, by reason of education, training or past experience.

This assessment extends to occupations that they can perform outside of your organisation with a different employer as well as within. It's important to understand that we're assessing capacity to work, and not whether the occupation is available or not.

As part of the claim process, we'll gather details of the member's past experience and training to enable us to make an informed decision. When considering which occupations the member is suited to, we'll consider jobs that they could reasonably perform considering their current job role and past experience.

Switched Occupation

Own occupation cover applies for the deferred period and the two years following it. After this, Suited Occupation cover applies. Both definitions are described above.

Absence caused by workplace matters, such as a relationship breakdown, workplace demands or failure to make reasonable adjustments aren't covered under any of the three definitions.

Absence caused by a lifestyle choice or family requirement, such as the need to care for a dependant, are also not covered.

Duties don't include the journey as part of a regular commute to and from a normal place of work.

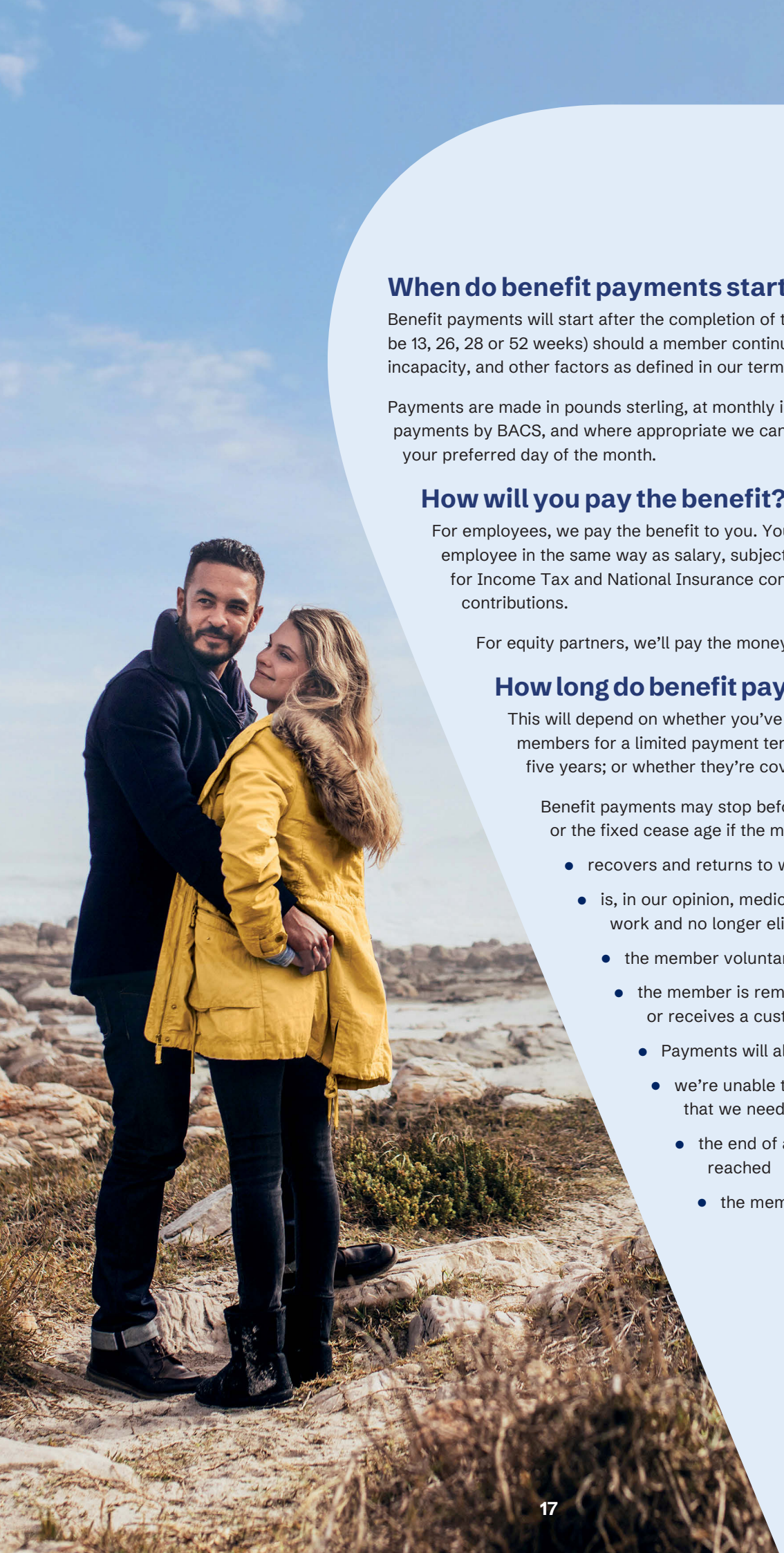
How will you communicate with my members?

If we haven't already been in contact with them to offer our rehabilitation services, we will – with your consent – contact them by phone to start the claims process. We won't do this until you've informed them that we'll be in touch.

If, however, you feel they may be too ill to talk to us on the phone, we can send paperwork directly to them.

How will I know what stage the claim is at?

We'll ensure that you're kept informed at all times, including notification as soon as a decision is made and a future review plan, where appropriate, has been completed. If you have any queries about a claim, we're only a phone call away.



When do benefit payments start?

Benefit payments will start after the completion of the deferred period (which can be 13, 26, 28 or 52 weeks) should a member continue to satisfy the definition of incapacity, and other factors as defined in our terms and conditions.

Payments are made in pounds sterling, at monthly intervals in arrears. We make payments by BACS, and where appropriate we can bulk payments together on your preferred day of the month.

How will you pay the benefit?

For employees, we pay the benefit to you. You then pass this money to the employee in the same way as salary, subject to the normal deductions for Income Tax and National Insurance contributions or Social Security contributions.

For equity partners, we'll pay the money directly to them.

How long do benefit payments last?

This will depend on whether you've selected to cover your members for a limited payment term of two, three, four or five years; or whether they're covered until a fixed cease age.

Benefit payments may stop before the end of a limited term or the fixed cease age if the member:

- recovers and returns to work
- is, in our opinion, medically fit to return to work and no longer eligible
- the member voluntarily resigns
- the member is remanded in custody or receives a custodial sentence.
- Payments will also stop if:
- we're unable to obtain medical evidence that we need to support a continued claim
- the end of a fixed term contract is reached
- the member dies.

What happens if a member receives income from other sources?

If the member is in receipt of any other regular income, we may need to consider this when calculating the amount of benefit we pay. Examples of other sources of income that may affect the benefit are continuing salary or profit share from you and regular payments from other insurance policies. If the payment period of the other insurance policies is less than two years, we'll ignore it.

You should also be aware that payments from Group Income Protection may also affect a member's entitlement to means-tested state benefits.

What if a member can only return to work part-time, or in an alternative lower paid job role?

We may still be able to pay some benefit under what we call 'Proportionate Benefit'. This is a benefit that is paid in proportion to the reduction in their earnings, with an allowance for inflation. For example, if a member returns to work and the revised earnings you pay them are half of their original earnings, we'll pay half of their benefit to top up.

If there's no reduction in earnings, then the claim will simply cease.

What happens if a member's incapacity returns and they're unable to work again?

If, within 12 months of the last monthly benefit payment, incapacity is caused once again for the same reason, we'll consider the further claim without imposing the deferred period again. This is known as a linked claim. We'll also link claims for different causes, provided that the new reason for absence has lasted 30 days or more.

What happens if a member makes more than one claim?

A member can make more than one claim as long as they haven't exhausted any limited payment term period or, if insured, received a lump sum payment. No further payments will be made until a further deferred period has been satisfied, unless it's a linked claim as above.

Any limited payment term applies to incapacity from one illness or injury. So, where incapacity is from the same cause, we'll combine the periods and the total will be limited to the payment term insured.

What happens to members who have fixed term contracts?

Any member who is receiving benefit and has a fixed term contract will only be eligible for benefit for the remainder of the contract in place as at the date of first absence, whether this is extended or not.

What happens if a member receiving benefit is dismissed?

If you remove a member from your payroll, any benefit they're receiving from us will normally cease at the same time, ending the claim. This is why you must tell us immediately if this happens.

We'll consider, at our reasonable discretion, continuing paying benefit to a member in this position if:

- you've requested us to do so; and
- you've been eligible to receive benefit for that person under this policy for a continuous period of more than six months.

Any pension, supplementary and National Insurance benefits or Social Security contributions will stop. Where we pay the benefit to a member directly, and the definition of incapacity is Own Occupation, this will change to the Suited Occupation. Please refer to the Claims FAQ of 'How will a claim be medically assessed?' for further information on what this means.

If insured, we won't pay a lump sum at the end of the limited payment term where we've been paying the benefit directly to a member.

What else is included?

We're dedicated to helping people live their best lives.

With Group Income Protection, your employees get access to expert clinical help when they need it. Alongside that and the financial support it offers, your employees get a suite of wellbeing services to help them make informed, balanced and positive lifestyle choices. And if the going gets tough, we also have support services to help them cope, with stress and grief.

Aviva DigiCare+ Workplace

We can help support your insured employees with the Aviva DigiCare+ Workplace app, provided by Square Health. It gives them the guidance they need to help detect, manage and prevent physical and mental health problems. It helps your employees stay on top of their health. From an Annual Health Check to clinical help and opinions to consultations with experts, it offers the peace of mind they need to live their best lives. Terms apply.

Employee Assistance Programme (EAP)

Designed to help your employees to stay happy and healthy, the Employee Assistance Programme can offer valuable support in all areas of their lives, such as coping with pressures at work, relationship breakdowns, or money worries. Provided by Care first, the service is open to all employees, even if they aren't covered by your Group Income Protection policy.

Thrive Mental Wellbeing

Help all of your employees look after their wellbeing with Thrive Mental Wellbeing, a confidential mental healthcare support, when it's needed, where it's needed, for as long as it's needed. The app helps employees to prevent, detect and manage common mental health conditions and build resilience, using evidence-based tools and techniques. It also offers tailored goals and further support, all at the touch of a button. Available to all your employees regardless of whether they're insured on the policy or not. Terms apply.

Aviva Cancer Care

Everyone's cancer journey is unique, which can be challenging for you as an employer when it comes to supporting employees who are living with cancer.

To help you understand more about managing cancer in the workplace, we've worked with Macmillan Cancer Support to put together a guide that highlights different areas you need to think about.

It covers topics from understanding cancer to how it may affect someone at work, from talking about cancer in the workplace to supporting employees caring for others with cancer, and much more.

Aviva Line Manager Toolkit: Mental Health

Developed by mental health professionals, the Aviva Line Manager Toolkit: Mental Health offers video modules and downloadable materials aimed at helping line managers spot the warning signs of poor mental health. It also helps them identify reasonable adjustments and manage professional boundaries.

The toolkit gives your managers more confidence to have supportive conversations with team members, so they can address issues before they become more serious. Terms apply

Lifestyle discounts with Get Active

With Get Active, your insured employees can get discounts at over 3,000 health and fitness clubs, plus great at-home fitness offers and a range of savings on other products and services. It's all designed to help keep them and their families active, healthy and happy. Terms apply.

Wellbeing Training

The benefits of a healthy workforce can be far reaching. A well-implemented workplace wellbeing programme has the potential to make a real difference to your business. It can offer education, awareness and understanding of a number of issues, all helping to improve everyday life in the workplace.

Looking after the wellbeing of your employees can help them cope better with what life throws at them, whether that's illness, stress, physical issues or other difficulties. Knowing you care about them can also lead your employees to become more engaged with your business. As an employer, it helps you create a culture of openness, and a healthier, happier workforce.

Wellbeing Library

Stress and worry can take a toll on wellbeing, wherever it comes from. The Wellbeing Library is an online library of useful content, hints and tips - including guides and tools. In the Wellbeing Library, all of your employees will find sections offering helpful support on all kinds of situations, from family and relationships, money or work, mental or physical health conditions. Whatever's on their mind, they can find information to help them deal with it.

Working alongside Macmillan Cancer Support to help your employees

We're working with Macmillan to raise awareness of the support Macmillan can give employees affected by cancer, either with their own diagnosis or that of a friend or loved one. Whether they have questions about symptoms and treatment or they simply want to talk to someone who understands, Macmillan are always ready to talk to all employees.

Red Apple Law Legal Services

One of the things that can help improve employees' wellbeing and peace of mind is knowing that they have their affairs in order. With Red Apple Law, who form part of the Trust Inheritance Group, your employees can benefit from expert advice, useful legal tools and the ease of managing all their legal affairs in one central place.

Red Apple Law legal services are available to all of your employees and their spouse or partner through your Group Income Protection policy, whether they are insured or not. Terms apply.

With the exception of the Red Apple Law legal services, all services are available to employees who are permanent residents of Great Britain, Northern Ireland, the Channel Islands or the Isle of Man. Differing residency restrictions apply for each service available under Red Apple Law, for full details please check the **FAQ section of the Red Apple Law website**. You'll find this information under 'Jurisdictions and Coverage'.

Find out more

For more information about the wellbeing services available with Group Income Protection please visit our **Employer Wellbeing Hub**.

Questions and answers

What does actively at work actually mean?

To enable us to provide insurance cover, the members you wish to insure must be at work doing their full normal job role and working their normal hours at the time the policy starts. In addition, they must not be working against medical advice. Anyone who isn't meeting these conditions can't be insured until they make a full return.

What medical evidence will be needed for underwriting?

If a member wants cover above the free cover limit, they will need to provide us with information on their leisure activities, medical history and family history. We call the assessment of this information, medical underwriting.

We prefer to collect this information using our digital platform as it is faster, more convenient and avoids the need for the member to complete a long questionnaire. A paper form or telephone-interview is available on request.

Depending on the information a member gives us, we may need to ask for more evidence. This could include a medical examination and blood or other tests. We'll pay for the cost of the medical examination and tests if we ask for more evidence. We will only consider paying benefit for these members if we can obtain satisfactory medical evidence in English. If we need a member who is based overseas to attend a medical examination or test(s) in a foreign country, we will pay an amount towards the cost of the examination or test(s) up to the amount of an equivalent test in the UK.

If we have medically underwritten an employee or equity partner, when will they next need to give us medical information?

For most policies of 20 lives or over, we adopt a 'once only' approach to underwriting. This means that in the majority of cases future increases in benefit won't be subject to further underwriting. For policies under 20 lives, members could be given a 'bar', over which any future increases would need further underwriting.

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

While medical underwriting is taking place, we'll provide full cover for up to 180 days, excluding pre-existing conditions. If, after we medically underwrite a member, we think they represent an increased risk, we may charge an additional premium. This would be added on to the annual premium that is calculated for the scheme.

Rest assured that our expert medical underwriting team will support you and your members through the underwriting process should it be necessary.

What happens when someone leaves or someone new joins?

If you have a unit rated policy, insuring more than 20 lives, you'll normally only need to tell us about any new joiners or leavers at the policy anniversary date. If you have a single premium policy, less than 20 lives, you're required to inform us immediately about any new joiners or leavers.

We also require immediate details of any members whose benefits are above your Free Cover Limit; if the total membership changes by 25%; or if you have any members who don't meet your defined eligibility conditions.

Please see our Technical Guides for a detailed account of what information we need to know and when.

Questions and answers

What happens to claims if the policy is cancelled?

You may cancel the policy whenever you wish. All claims in payment at that time will continue in line with the terms and conditions of the policy. Also, new claims will still be considered if the absence started before the date the policy was cancelled, with all due premiums paid up to that date.

If we cancel the policy due to non-payment of premiums, new claims will only be considered up to the end of the period covered by the last premium paid. Claims in payment at that time will continue in line with the terms and conditions of the policy.

Will there be any unexpected extra premiums?

We usually guarantee the rate(s) for two years after the start date of the policy. A new rate may apply at the rate guarantee date.

Additional premiums may be payable for members who have been medically underwritten because of their health or any hazardous pastimes. Any additional premiums will apply immediately but will become payable at the next anniversary date.

What isn't covered?

There are no exclusions under this policy. However, exclusions may be applied to member's benefits that are above the Free Cover Limit.

One final point...

We recognise that making the decision to provide this benefit for your members should be considered carefully and that there's a lot of information to take in. We've tried to address many of the questions that have arisen in our experience of dealing with Group Income Protection, but you may still have queries of your own. For help with these, including full details of our terms and conditions, please contact our Sales Team on **0800 145 5684*** or at **GroupProtectionSalesSupport@aviva.com**.

*Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

It's important to understand that a decision to take out cover is your choice and responsibility. There's nothing in this document that can be considered as giving advice. If you feel that you need specific advice, we'd recommend that you speak to an Independent Financial Adviser. If you don't have a Financial Adviser, you can find one at **www.unbiased.co.uk**.

Further information

Third Party Rights

Only we and the employer taking out this policy will have any rights under this Policy. Any person or persons who aren't a party to these policies shall have no rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any terms under this policy. Reference to, or the consent of, any person who isn't a party to the policy isn't required for any changes to it or its rescission.

Compensation

The Financial Services Compensation Scheme (FSCS) may cover your policy. It will cover you if Aviva becomes insolvent and we're unable to meet our obligations under the policy. For this type of policy, the FSCS will cover you for 100% of the total amount of an existing claim. The FSCS will also provide a refund of 100% of the premiums that haven't been used to pay for cover whether you're making a claim under the policy or not.

For further information, see **www.fscs.org.uk** or telephone **0800 678 1100**.

Currency and jurisdiction

These policies are issued in England and subject to English Law. All payments made to or by us under this policy will be made in pounds sterling.

Insurer

The Group Income Protection policies are underwritten by Aviva Life & Pensions UK Limited. Aviva Life & Pensions UK Limited is a company in the United Kingdom.

The Head Office of Aviva Life & Pensions UK Limited is Aviva, Wellington Row, York, YO90 1WR, United Kingdom. Aviva Life & Pensions UK Limited is a wholly owned subsidiary of Aviva plc.

If you have any cause for complaint

Our aim is to provide a first-class standard of service to our customers, and to do everything we can to ensure you're satisfied. However, if you ever feel we've fallen short of this standard and you have cause to make a complaint, please let us know.

Our contact details are:

Group Protection Complaints
Aviva Life & Pensions UK Ltd
PO Box 540
Eastleigh
SO50 0ET

Telephone: **0800 158 2714**
E-mail: **gpcomplaints@aviva.com**

Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

We have every reason to believe that you'll be totally satisfied with your Aviva policy, and with our service. It's very rare that matters can't be resolved amicably. However, if you're still unhappy with the outcome after we've investigated it for you and you feel that there's additional information that should be considered, you should let us have that information as soon as possible so that we can review it. If you disagree with our response or if we haven't replied within eight weeks, you may be able to take your case to the Financial Ombudsman Service to investigate.

Their contact details are:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

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

Please note that the Financial Ombudsman Service will only consider your complaint if you've given us the opportunity to resolve the matter first. Making a complaint to the Ombudsman won't affect your legal rights.

Data Protection

Aviva Life and Pensions UK Limited is the data controller responsible for processing any personal information you provide us.

As the policyholder our understanding is that you aren't required to obtain individual consent from employees before providing us with any personal data we require to set up, administer and assess any claims under the policy. However, you'll need to ensure that you comply with data protection law and regulation and ensure that the appropriate information has been provided to data subjects to explain how the information will be processed and shared. If we need to obtain personal data from anyone covered under the policy, we'll contact them and if necessary obtain their consent before collecting and using their information.

We'll record and store any information provided to us accurately and securely.

Details of our full Privacy Policy is available at www. aviva.co.uk/Privacypolicy or you can request a copy by contacting us at Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester LE7 1PD. If you have any questions about how we use personal information, please contact our Data Protection Officer by writing to them at Data Protection Officer, Aviva, Level 4, Pitheavlis, Perth PH2 0NH.

Solvency and Financial Condition Report

Every year we publish a Solvency and Financial Condition report which provides information about our performance, governance, risk profile, solvency and capital management. This report is available for you to read on our website at **www.aviva.com/investors/regulatory-returns/**

If you need any help, contact either your Financial Adviser or our Sales team: **groupprotectionsalessupport@aviva.com**

Please note that our Sales team are unable to provide financial advice.

Aviva Life and Pensions UK Limited is the data controller responsible for processing any personal information you provide to us.

As the policyholder, you'll need to ensure that you comply with data protection law and regulation and ensure that the appropriate information has been provided to data subjects to explain how the information will be processed and shared.

Need this in a different format?

Please get in touch if you'd prefer this document (**GR02225 07/2024**) in large font, braille, or as audio.

How to contact us

0345 366 1644

contactus@aviva.com

aviva.co.uk

Our opening hours are Monday to Friday, between 9.00am and 5.00pm. For your protection and ours, calls to and from Aviva may be recorded and/or monitored. Calls to 0800 numbers from UK landlines and mobiles are free of charge. Calls from outside the UK may be charged at international rates.

Aviva Life & Pensions UK Limited.

Registered in England No. 3253947. Aviva, Wellington Row, York, YO90 1WR. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Firm Reference Number 185896. Member of the Association of British Insurers. Wellbeing services and Wellbeing Training are not insurance products and are not authorised or regulated by the Financial Conduct Authority or the Prudential Regulation Authority.

aviva.co.uk