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Income Protection policy

User guide - including general terms

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Income Protection policy
User guide

This document:

- Explains the main features of our Income Protection (IP) product
- Includes the general terms which contain the detail of the insurance contract between the policyholder and Unum. The general terms and the policy document including the policy coverage document should be read as if they were one document. If parts of the user guide are referred to in the general terms or the policy coverage document, those parts also become part of the policy. If there is any difference between them or any ambiguity, the terms in the policy coverage document will apply
- Is designed for use by commercial customers

The policy:

- Meets the demands and needs of an employer who wishes to provide a monthly benefit if a member is unable to work because of illness or injury for an agreed length of time
- Includes the option to provide:
  - Additional benefits covering associated business expenses and ongoing employment costs
  - Additional lump sum benefits to be used at your discretion

Unless specified, any references to employees include the equity partners of a partnership or members of a limited liability partnership or barristers.

Any reference to employer is also intended to refer to the equity partners of a partnership, members of a limited liability partnership, or barristers.

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Your commitment

By taking out a policy with us, you agree to:

- Pay premiums on time
- Give us accurate and complete information when we ask for it
- Identify any discretionary entrants
- Notify us if there are significant changes to your business
- Notify us of claims within the time limits set out in this document
- Tell us of any change in the employment status of any claimants
- Facilitate and support actions to help employees stay in or return to work. This includes making reasonable adjustments to working conditions

Risk factors

You should be aware of the following risks:

- The rates used to calculate the premiums and the terms of this policy are usually guaranteed for 2 years and are then reviewed. However, we can amend the terms if there is a significant change to your business. Please see section 8 for more information
- Cover will end if you do not comply with the policy terms or if premiums are not paid
- If you do not notify us of a claim within the specified time limits, benefit payments may be delayed or deferred. We can refuse liability if you do not notify us of a claim within 90 days of the end of the deferred period
- The way that HMRC tax benefits may change in the future. The eligibility rules for and amount of state benefits available from the Department of Work and Pensions may also change. If state benefits mentioned in this guide are withdrawn, we will advise you how we will treat the replacement benefits

How your policy works

1. Who can be covered?

We will agree this with you at the start of the policy:

- We can cover all your employees or a clearly defined group of employees
- You can choose different eligibility conditions for different groups of employees
- We can provide cover up to an employee's 70th birthday

You can choose:

- The categories of employee you want to be covered
- Minimum and maximum ages for joining the policy
- Whether cover starts immediately or after an employee has been employed for a certain amount of time

In practice

You can set up the policy to cover members of your pension scheme. If you want to do this, you will need to provide us with the eligibility conditions for the pension scheme.

You also decide when new members join the policy and increases in benefit take place. This is usually on a daily basis but there are monthly, quarterly, half-yearly or yearly options.

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General terms

Membership

The eligibility conditions and the dates that employees can join the policy are shown in the policy coverage document.

An employee can include:

- Permanent and fixed term employees, including directors, employed by you or another employer included in this policy
- An equity partner. A partner is defined as a person entitled to a share in the profits of the business
- A member of a Limited Liability Partnership who is working in the business
- A barrister who is a member of the set of chambers which arranges the policy

If your policy has been set up to provide cover for members of your pension scheme, an employee who joins the pension scheme:

- Within 12 months of their first opportunity, or
- Through auto enrolment

will be regarded as joining when they first became eligible.

Eligible employees will be covered from the policy start date or when they are actively at work, if later.

Employees who become eligible later will be covered from the joining date shown in the policy coverage document or when they are actively at work, if later.

You must:

- Include all employees in the policy when they first become eligible
- At the start of the policy and at each policy anniversary provide us with details of all employees who meet the eligibility conditions

If we do not receive the necessary information about an eligible employee, they will not become a member until the information is received and we have confirmed cover.

Actively at work

We will only cover an employee who is actively at work on the day before their cover is due to start.

In practice

At the start of the cover, we will regard an employee as being actively at work if they meet the requirement on the day it applies but they are:

- On a period of leave that was agreed in advance by you, or
- Not contracted to work

Cover for an employee who is not actively at work will start once they return to work and meet the requirement.

General terms

Actively at work

Actively at work means that an employee:

- Is actively following their normal occupation, and
- Is working the normal number of hours required by their contract of employment, and
- Is working at their normal business or at another business location, and
- Has not received medical advice to reduce or stop their work activity

Increases in cover

- A member must be actively at work on the day before any increase in benefit is due to take place
- Increases in benefit for a member who is not actively at work will come into effect once they return to work and meet the requirement
- The insured benefit cannot be increased during a period of temporary absence

Discretionary entrants

You must tell us if you want to include an employee who is a discretionary entrant under your policy.

You can ask us to include a discretionary entrant at any time. We will let you know:

- The information we need to assess if cover can be provided, and
- The date that cover will start

In practice

A discretionary entrant may be:

- An early entrant (an employee you wish to include before they have completed a required period of employment). Early entrants will become eligible employees once they have been employed for the required period of time
- A late entrant (an employee who was not included when first eligible)

General terms

Discretionary entrants

A discretionary entrant is an employee you want us to cover:

- Who was not included for cover as soon as they met the eligibility conditions, or
- Who does not satisfy the eligibility conditions

We will provide a period of temporary cover while we assess if we can provide full cover. Please see section 6 for more information about temporary cover.

Extended cover

If you have chosen a cover cease age which is below 70 but want to provide cover for an employee who works beyond the cover cease age, we can provide cover up to their 70th birthday.

In practice

We will set up a separate category for those being provided with extended cover.

So there is no break in cover, you must provide us with details of an employee to be included in this category before they reach the cover cease age.

Existing members who are actively at work on the day they reach the cover cease age will transfer to the extended cover category at that point.

Extended cover

Cover cannot be provided beyond the member's 70th birthday.

The non-medical limit will apply to the extended cover category as long as:

- There are at least 3 members in the category, and
- You include all eligible employees working beyond the cover cease age

When a member transfers to the extended cover category, benefit in excess of the non-medical limit, or the whole benefit if the non-medical limit does not apply will be underwritten. We provide temporary cover on the benefit that is being underwritten. Please see section 6 for more information about temporary cover.

Cover during temporary absence

We can provide cover for up to 3 years for those on unpaid leave - eg. reservists or those on sabbaticals.

Cover during statutory leave

Cover for a member can continue during any period of statutory leave as long as they remain employed by you. Cover will be provided in exactly the same way as if the member was still actively following their occupation.

General terms

Cover during temporary absence

Cover for a member can continue during a period of agreed absence such as:

- A sabbatical or compassionate leave, or
- If they are serving as a regular or volunteer reservist

Cover is provided as long as:

- The member remains employed by you
- The period of absence is determined at the start and is less than 3 years
- You have given written consent, including the date of return, within one month of the absence starting

During a period of temporary absence:

- The insured benefit cannot be increased
- Benefit will become payable on the later of:
    - The end of the deferred period; and
    - The day the member was due to return to work

Cover for a member on a fixed-term contract of employment will end if their contract of employment expires during a period of temporary absence.

Can cover be provided for someone who is based outside the UK?

We can usually offer cover for an employee who is based overseas but you will need to provide some additional information.

In practice

You must tell us about an employee who is based outside the UK, including their nationality and countries they work in.

If a member is not paid in sterling we will convert their salary to sterling to calculate the premium.

Can cover be provided for someone who is on a zero-hours contract?

We may be able to do this. You must tell us if you want to include an employee on a zero-hours contract so that we can agree the terms on which we can provide cover.

In practice

We can usually provide cover if:

- The definition of earnings takes account of the variation in earnings, and
- In the event of a claim, it will be possible for us to establish the duties required to perform the insured occupation. We call these the material and substantial duties

General terms

Overseas cover

An employee who is based overseas must have a contract of employment with a UK resident employer.

The following additional requirements apply if the employee is seconded abroad:

- The UK employer must retain control of where and for who the employee works
- The employee and their UK employer must have a written agreement that the employee will return to work with the UK employer when the secondment ends

For the purposes of this policy the UK means England, Northern Ireland, Scotland, Wales, the Channel Islands and the Isle of Man.

Zero-hours contracts

Employees on zero-hours contracts:

- Must be available to work for the employer on the day that cover is due to start, and
- Will not be considered to be actively at work if their medical records show that on the day cover starts, they were suffering from a medical condition which would have prevented them from working

2. When will cover for a member end?

Cover for a member will end in the circumstances shown in the general terms.

In practice

Limited benefit payment period policies:

- Once the end of the benefit payment period has been reached, the claim and cover for that member will end
- If the employee later returns to work, they will be eligible for cover once they have been actively at work for at least 4 weeks. If that member becomes incapacitated again any benefit would become payable after the end of the deferred period

Limited benefit payment period policies with final lump sum:

- There is no option for the employee to be covered under the policy once the lump sum benefit has been paid

General terms

Cover for a member ending

Cover for a member will end when they:

- Reach the cover cease age
- No longer meet the eligibility conditions
- Are no longer employed by you or an employer covered by the policy
- Die
- Do not return to active employment following a period of temporary absence
- Carry out any work without your prior agreement while they are incapacitated
- Reach the end of a limited benefit payment period if the policy had been set up on this basis

Cover for a member will also end when the policy ends.

3. What types of cover are available?

When setting up the policy, you will be able to make a number of decisions about the type and level of cover to be provided.

The choices you make will affect the premiums we charge and there may be occasions when some options are not available.

Decision 1 - who to cover

When deciding the categories of employee to be covered under your policy, you can choose to provide:

- The same benefit basis for all members covered by the policy, or
- Different benefit levels for different categories

The benefit basis must be the same for all members within a category.

Decision 2 - how long to provide cover for

You can choose the age at which cover for a member will stop. We call this the cover cease age. This is usually the State Pension Age (SPA) but can be any age up to a member's 70th birthday.

General terms

Coverage choices

The policy coverage document will contain the choices of cover you have made for each category including:

- The eligibility conditions
- The cover cease age
- The definition of insured salary
- The basic benefit
- The deferred period
- The benefit payment period
- The definition of incapacity
- Any additional benefits to be provided
- The rate of escalation

The details shown in the policy coverage document will apply to your policy.

Decision 3 - the salary to be used to calculate benefits

Benefits are usually expressed as a percentage of salary. This means we will need to agree the definition of salary to be used when calculating benefits. We call this the insured salary.

Examples include:

- Basic annual salary
- Basic annual salary plus variable payments averaged over the last 12 months or 3 years
- Total earnings averaged over the last 12 months or 3 years
- P60 earnings

If you operate a salary sacrifice arrangement, we use the pre-sacrifice salary.

In practice

Where earnings are averaged over a period of time:

- Variable payments can be:
  - Averaged over 12 months, capped at 20% of basic salary, or
  - Averaged over 3 years
- If a member has been employed for less than that period of time, we will average earnings over the time they've been employed
- If a member has been on pre-arranged temporary absence during that period of time, we will average earnings over the time they were working

For partners and barristers, the normal definition is the average of the last 3 years' earnings after partnership/chambers expenses have been deducted.

General terms

Insured salary

The benefit will be calculated based on the member's insured salary at the date incapacity started.

Decision 4 - the level of basic benefit you want to provide

You can provide a percentage of insured salary or a fixed amount of benefit for all members of a category.

We can provide a basic benefit up to 80% of insured salary for employees or up to 50% for partners and barristers. There is an overall maximum basic benefit limit of £350,000 per year for each member.

Decision 5 - when you want benefit payments to start

Benefit payments start after a member has been unable to work for a period of time because of illness or injury. We call this the deferred period.

The options are 8, 13, 26, 28 or 52 weeks.

Decision 6 - how long benefits will be paid for

When setting up the policy you can choose from the following options:

- Benefit paid up to the cover cease age you have chosen
- Benefit to be paid for a limited period of 2, 3, 4, or 5 years. Benefit payments will stop earlier if the member reaches the cover cease age during the payment period. We call this a limited benefit payment period

In practice

The options for linking the cover cease age to SPA are:

- Benefit is paid up to the SPA that applied to the member at the start of their incapacity; or
- Benefit is paid until the member reaches their SPA even if that changes after they become incapacitated. This is subject to a maximum SPA of 70. We call this dynamic SPA

The option you have selected will be shown in the policy coverage document

General terms

Basic benefit

The annual basic benefit will be shown in the policy coverage document.

The maximum basic benefit limit is:

- 80% of insured salary for employees
- 50% of insured earnings for partners or barristers

This is subject to an overall limit of £350,000 per year for each member.

If the basic benefit is calculated as a percentage of insured salary less an offset, the following will apply in the event of a claim:

- We will always deduct the offset when calculating the basic benefit. This is reflected in the premium charged
- If the offset refers to Employment and Support Allowance (ESA), we will deduct the offset regardless of whether the member receives ESA
- The offset will be the amount used to calculate the premium at the policy anniversary immediately before the member first became incapacitated

For fully integrated and net pay policies, we will deduct ESA at the rate that would be paid to the member. This means we will always deduct the ESA basic allowance (BA) during the 13-week assessment phase. We will then deduct ESA on the following basis:

- For those placed in the work related activity group, we will deduct ESA for up to 39 weeks. No deduction will be made thereafter
- For those placed in the support group, we will deduct BA plus the support component for the duration of the claim
- For those who apply but do not qualify for ESA, we will make no deduction
- For those who do not apply for ESA, we will deduct BA plus the support component for the duration of the claim

For fully integrated policies we will deduct the gross amount of ESA.

For net pay policies, the total of the benefit we provide and any ESA which the member is entitled to will give a net income which is equal to the percentage of net salary shown in the policy coverage document.

Decision 7 - how incapacity is to be defined

For benefit to be paid, the member must be unable to work because of illness or injury. We call this the definition of incapacity.

You will be able to choose from 3 definitions of incapacity which offer benefit payment at different levels of incapacity.

We are providing simplified wordings in this section.

Insured occupation cover

A member is incapacitated if they are unable to perform the material and substantial duties of their insured occupation because of illness of injury.

However, if a member is required to hold a licence or certificate which is issued only when the member meets required medical standards, the member is incapacitated if they are unable to perform the material and substantial duties of any gainful occupation because of illness or injury.

The term "licence" does not include a licence to drive ordinary cars, vans or motorcycles.

Gainful occupation cover

A member is incapacitated if they are unable to perform the material and substantial duties of any gainful occupation because of illness or injury.

Combined cover

Insured occupation cover applies for the deferred period and the first 2 years following the deferred period. After this, gainful occupation cover applies.

General terms

Incapacity

The definitions of incapacity in section 10 of the user guide are incorporated into the policy terms.

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Decision 8 - the optional additional benefits you want to provide

You can choose one or more of the following additional benefit options:

Employer's National Insurance Contributions (NICs)

This provides cover for your liability to pay NICs on a member's basic benefit.

Long-term supplementary benefit for your business

This is a benefit to cover employment costs that may continue when a member is on long-term sick leave - eg. your contributions to a pension scheme, holiday pay, group life premium, company car allowance.

Equity partners can use the benefit to cover their share of the partnership's normal costs of running the business.

Short-term supplementary benefit for your business

This is a benefit to help cover the extra costs to a business that can arise when an employee is absent from work - eg. the costs of recruiting temporary or replacement staff. You can choose a benefit payment period of up to 6 or 12 months.

General terms

Optional additional benefits

The policy coverage document will detail any additional benefits covered under this policy.

The limits for these additional benefits are:

Employer's NICs

The benefit will be the employers NICs payable on the basic benefit at the start of the claim.

Long-term supplementary benefit

The maximum benefit is the lower of 60% of insured salary or £10,000 per month.

Short-term supplementary benefit

The maximum benefit is the lower of 60% of monthly insured salary or £10,000 per month.

Combined total for long-term supplementary benefit and short-term supplementary benefit

The total of long-term supplementary benefit and short-term supplementary benefit cannot be more than the lower of 90% of insured salary or £15,000 per month.

Final lump sum benefit

If you've selected a limited benefit payment period, you can opt to cover a final lump sum benefit. This benefit can be a multiple of insured salary or annual basic benefit or can be tailored to approximately match future pension contributions.

Where the lump sum is a multiple of basic benefit, it will be the basic benefit in payment at the end of the limited benefit period. Where it is linked to the insured salary, the insured salary will be increased in line with any increases in the basic benefit throughout the payment period.

The lump sum benefit is payable if the member satisfies the chosen definition of incapacity at that point.

The definitions of incapacity that can be used for the lump sum are insured occupation cover or gainful occupation cover, or serious illness definition (where the member must meet the definition of one of the listed qualifying conditions). The full conditions can be found in section 10 of this document.

The final lump sum can be paid only once per member.

Initial lump sum benefit

A lump sum benefit payable if a member is absent from work for at least 14 days as a result of a diagnosis of one of the following conditions:

- Cancer
- Heart attack
- Stroke

For benefit to be paid, the diagnosis must meet the definition in section 10 of this document.

Employee pension contributions

You can also cover the contributions employees make to your pension scheme.

Please note that the only additional benefits available to partners and barristers are employer's long-term supplementary benefit and initial lump sum benefit.

General terms

Final lump sum benefit

The maximum final lump sum benefit is the lower of:

- 9 x annual basic benefit; or
- £1 million

The final lump sum is restricted to an amount equal to:

- Monthly basic benefit multiplied by the number of whole months between the end of the limited benefit payment period and the cover cease age

Initial lump sum benefit

The maximum initial lump sum benefit is £10,000 per member.

This benefit:

- Can be paid at any time while the employee is a member of the policy
- Is paid only once per member

A pre-existing condition exclusion applies to this benefit and full details are in section 10 of this document.

Employee pension contributions

The total of basic benefit and employee pension contributions cannot be more than 80% of insured salary. This is subject to an overall limit of £350,000 per year for each member

Maximum benefits

The maximum benefit limits apply at the start of the claim. Benefits in payment may increase above these limits if you have selected an escalation option.

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Decision 9 - whether benefits will increase during payment

You can choose whether benefits in payment stay at the same level or increase each year. We call this the escalation rate.

The escalation rates available are:

- Nil
- A fixed rate of 3% or 5% per year
- In line with Retail Prices Index (RPI) capped at 2.5% or 5%
- In line with Consumer Prices Index (CPI) capped at 2.5% or 5%

In practice

Benefit increases take place on the first of the month. This can be:

- The anniversary of benefit payments starting for the member, or
- A set month for all claims chosen by you when the policy was set up

General terms

Increase in benefit during payment

The policy coverage document will show:

- If you have chosen to insure an increase in benefits; and
- The rate of increase that applies

If you've chosen an index-linked rate, we will:

- Use the annual increase in RPI and CPI rates as at the date 3 months before the date the benefit is increased
- Not reduce our benefit if RPI or CPI falls below 0% per annum

4. What special policy types are available?

Flex

Includes a core benefit funded by you, and gives your employees the option to increase their cover.

Simplicity Income Protection

An income protection policy with simplified options and administration.

Pay direct policy

A policy which gives you the option to instruct us to continue to pay basic benefit to a former employee after they have left service.

The following pages describe each special policy type.

General terms

Special policy types

The general terms for each of the policy types apply in addition to or, where stated, replace the general terms for our standard Income Protection policy.

Flex

This Income Protection policy can be included in a flexible benefit package.

When the policy is set up you can choose:

- The level of cover you wish to provide (we call this the core benefit)
- The options to be offered to your employees to increase their benefit (we call these flex steps)
- Which lifestyle events apply (from the list in the general terms on the opposite side of this page)
- Whether there is a default benefit for new joiners

Minimum number of members	250
Minimum core benefit	35% of salary
Maximum benefit level (core benefit + flex)	80% of salary (including employee pension contributions) up to £350,000
Flex step options	Any percentage of salary between 5% and 30%

Flex selection options	Employees joining at their first opportunity can choose any level of cover.
	Employees joining at any other time can only select the lowest level of cover.
	Employees can then:
	• Flex up (increase their benefit) one step at a time up to twice a year. The options to change the benefit selection are:
	  • Once on a set day each year (this is usually the policy anniversary)
	  • Once a year if their circumstances change - eg. if they marry, divorce or have children – we call these lifestyle events. Any benefit changes must be made within two months of the lifestyle event
	• Flex down (decrease their benefit) by any number of steps at a time
	Employees cannot reduce their benefit below the core benefit. The actively at work requirement applies to increases in benefit as a result of benefit selections either at a lifestyle event or annual enrolment window.

General terms

The policy coverage document will show if the policy is a flex policy.

Lifestyle events

A member will be able to increase their benefit by one flex step in the event of one of the lifestyle events shown in your policy coverage document, chosen from the following:

- The birth of a child of the member
- The member or their spouse/civil partner becoming pregnant
- The member starting or returning to work after maternity, paternity or parental leave
- The adoption of a child by the member
- The member starting or returning to work after adoption leave
- The death of an adult or child dependant of the member
- The marriage of a member or the member entering a civil partnership, or the member being in a relationship with a partner for 6 months
- Divorce of a member, dissolution of the member's civil partnership or the member separating from a spouse, civil partner or partner of 6 months or more
- The member being seconded to work overseas or returning to work after the completion of an agreed secondment
- An increase in the member's contractual working hours of at least 20%
- A decrease in the member's salary of at least 5%, as long as the decrease is not due to illness or injury
- An increase in the member's salary of at least 5% or the member being promoted
- The member moving to a new permanent home
- The members spouse, civil partner or partner being made redundant

Increases in benefit resulting from a lifestyle event are restricted to one per policy year. The increase in benefit must take place within 2 months of the lifestyle event.

Flex steps will be shown in the policy coverage document.

The choices you make will affect the premiums we charge and there may be occasions when some options are not available.

In practice

For flex policies, our quote will be guaranteed for 3 months:

- The quote can be accepted at any time during the 3 month guarantee period
- We will then confirm that the flex step option rates are guaranteed for up to 3 more months until the start date

Please note that the flexible benefit option is not available for equity partners, LLP members or barristers.

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General terms

Flex

You must give us:

- Membership data at the start of the policy and each month after that
- Premiums based on the membership and the rates we have provided to you

For flex policies, we will need medical evidence for employees when their total benefit (core plus flex) goes over the non-medical limit.

For flex policies, once and done and forward underwriting do not apply.

For flex policies our quote will show the rates offered, agreed flex steps and lifestyle events. We will quote a unit rate to calculate the premium for the core benefit and a table of age-related rates for the flex step options.

Simplicity

Income Protection from Unum

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We offer an IP policy with simplified options and administration. This policy provides:

Basic benefit	£12,000 a year (or 100% of earnings if lower) per member
Cover cease age	State Pension Age (SPA)
Definition of incapacity	Insured occupation cover
Premiums	Payable monthly by direct debit
Eligibility	All pension scheme members or all employees
Deferred period	26 weeks
Benefit payment period	2, 3, 4 or 5 years, or to cover cease age
Benefit increase rates	Nil, 3%, 5% or RPI or CPI capped at 2.5% or 5%
Long-term supplementary benefit	£1,800 a year per member (optional)

Simplified administration means:

- No medical underwriting needed
- We will not take account of income from other sources at the claim stage
- A membership list is only needed once a year
- Occupational details are not needed

Simplicity IP is not available on policies with fewer than 20 members or for partners or barristers.

Pay direct policy

We offer a pay direct policy. If you select this policy, you will have the option to instruct us to continue to pay basic benefit directly to a former employee after they have left service.

In practice

When benefit is paid direct:

- We will continue to assess the claim against the definition of incapacity that would have applied to the member if they were still employed by you
- We will pay basic benefit only. Optional additional benefits will stop being paid
- We will deduct basic rate tax from the benefit payments

General terms

Pay direct policy

The policy coverage document will show if the policy is a pay direct policy.

For us to pay basic benefit directly to your former employee, the following terms apply:

- The employee must have remained employed by you for the whole of the deferred period
- We must have started to make benefit payments to you
- Your request to pay direct must be made at least 14 days before the employee leaves your service
- We will pay basic benefit only. Optional additional benefits will stop being paid
- Cover for your former employee will end when entitlement to benefit ends and no new claims will be considered
- The agreement to pay direct will be between you (as the policyholder) and us. No contractual rights are given to your former employee

5. Putting cover in place and policy servicing

So we know who you want us to cover under the policy, you must send us an up-to-date membership list:

- When we prepare a quote
- At the policy start date
- At the start and end of each policy year so we can prepare an account

For policies with fewer than 10 members, you should tell us about any new members joining the policy during the year.

You must also tell us as soon as:

- A member's cover goes over the non-medical limit during the policy year
- You want us to cover any discretionary entrants

In practice

The membership list should give the following information for each employee to be covered:

- Full name
- Date of birth
- Gender
- Membership category
- Date of joining or date of leaving if applicable
- Benefit/insured salary
- Occupation
- Work location postcode

General terms

Information to be provided

You must provide us with the information we need to calculate premiums, administer the policy and assess and pay claims.

All information must be provided in the form and timescales we specify. We are not responsible for any errors or omissions in any information provided to us.

The information we need and the time that it is needed are more fully described in the user guide. That information is part of the policy terms.

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Quote

Your broker will ask us for a quote. The request should include:

- Your company details including industry and locations
- An up-to-date membership list
- Details of the cover required
- Scheme history for the last 6 years (if previously insured) – the total number of members, total insured salary, or total insured benefit and a list of the claims you have made

If your policy has fewer than 100 members, your broker will be able to get a quote for a range of cover options online.

Our quote will show the premium and total benefits. Quotes are usually guaranteed for 3 months.

The quote will also tell you if there is anything else we need to know. It includes any assumptions we have made and any special terms.

The premium shown in our quote includes the commission payable to your broker.

Starting the cover

Your broker will need to email us to confirm the quote you are accepting and the date you want cover to start. We cannot backdate cover.

We will provide cover for up to 30 days from the policy start date - called a conditional cover period - while the following information is provided:

- An up-to-date membership list
- Deposit premium or direct debit mandate
- Evidence that a customer verification has been completed

For online quotes, your broker will be able to start cover online.

General terms

Start of cover

The policy start date will be shown in the policy coverage document.

Cover will not begin until we receive confirmation of our quote from you or your broker, and will cease if the information and documents detailed in the user guide on the opposite side of this page are not provided on time.

Our quote will have been based on the information you provided at that time. You will need to let us know if there are any significant changes to that information between the time we quoted and the date you want the policy to start.

Premiums and policy accounting

We will calculate the premium for each policy accounting period based on:

- The total insured salary or total insured benefit
- The premium rates or unit rate applying
- Any underwriting loadings

Premiums are payable yearly or monthly in advance by Direct Debit. Please note, we add a loading for non-annual premiums.

We will send you an account detailing the premium due at the start of the policy and at each policy anniversary.

The way we calculate premiums depends on the number of members at the start of the policy year.

Policies with up to 9 members	Policies with 10 or more members
At the start of the policy year we calculate a premium	
We use a rate table to calculate the premium for each member and then add them together. The premium rate for a member will depend on their age at the start of the policy year.	We work out a rate that applies for all benefits – we call this a unit rate. The premium is calculated by multiplying the total insured salary (or sometimes total benefit) by the unit rate.
At the end of the policy year, we calculate an adjustment to allow for new members, leavers and changes in benefit during the year	
The adjustment takes account of the amount of benefit and period we have provided cover for each member.	The adjustment assumes that any changes took place halfway through the accounting period.

In practice

We don't charge premiums for a member who is receiving benefit.

General terms

Premiums

Premiums must be paid from a UK bank account in pounds sterling on receipt of our invoice.

If you do not pay premiums when they are due, we may:

- Charge interest for late payment and/or
- Cancel the policy

We will give you at least 30 days' notice before we do this.

We have the right not to pay claims if the incapacity started in a period for which premiums have not been paid.

Calculating premiums

At the start of the policy and at each policy anniversary, you must provide us with the information we need to calculate the premium.

If we do not have all the information we need to work out the premium, we will calculate:

- A deposit premium based on the details we have at that time
- The actual premium when we have full information. Any refund or outstanding premium will then become payable

If we do not receive the information we need to calculate the premium within 2 months of the policy anniversary, we can vary the terms of, or cancel, the policy. We will give you at least 30 days' notice before we do this.

At the end of a policy accounting period, we will work out an adjustment to allow for changes during the period including:

- New members
- Leavers
- Changes in benefit

Any refund or outstanding premium will then become payable.

Will there be any unexpected extra premium?

The premium will be affected if any members are medically underwritten and cannot be accepted on standard premium rates.

In practice

If a loading applies to a member, the extra premium will be:

- Charged from the date we write to let you know a loading applies
- Included in our next account

Premium rate tables, unit rates and the policy terms are usually guaranteed for 2 or 3 years from the start of the policy, or the last review of premium rates. We call this the review date.

They will then be reviewed and may change at that time.

We can also change the rates and terms if:

- You do not provide the information we request within 2 months
- There is a change in legislation or taxation which affects the cost of cover
- There is a significant change to your business as described in section 8

If you cancel the policy mid-year, will premiums paid in advance be lost?

No. We will produce a final account for the cover provided up to the date the policy is cancelled. We will either pay a refund or request any outstanding premiums.

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General terms

Changing premium rates

We can change the terms and conditions of the policy and the rates or unit rate at any review date. Any change will apply with effect from the review date.

We can also change the rates and policy terms as described in the user guide on the opposite side of this page. These terms are incorporated into the policy.

We will give you at least 30 days' notice before any such change to the terms and conditions of the policy and the premium rates or unit rate comes into effect. The change in terms will have effect from the date of the change in legislation or taxation, or the change in your business.

6. Medical underwriting

The quote and policy coverage document will show the maximum amount of benefit we can provide for a member without information about the member's health and lifestyle. We call this the non-medical limit. If you've had a policy for a while, you may have seen this referred to as a free cover limit.

The non-medical limit does not apply to discretionary entrants or to categories with fewer than 3 members.

In practice

We will underwrite a member for the first time:

- When their benefit goes over the non-medical limit, or
- At their date of joining if their benefit is over the non-medical limit or the non-medical limit does not apply to them

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General terms

Medical underwriting

If the non-medical limit applies to a member, you must let us know as soon as their benefit exceeds that level. We will underwrite the benefit above the non-medical limit.

If an employee does not benefit from the non-medical limit, you must let us know as soon as you want the cover to start. We will underwrite the whole benefit.

You must take reasonable steps to ensure that we are provided with any information we request as part of the medical underwriting process.

We will provide temporary cover on the benefit being underwritten, subject to the terms described in the user guide.

What information is required for employees who are being underwritten?

We will gather information about the member's health and lifestyle. This is most effectively done over the phone but there is an option to fill in a form and return it to us.

There may be cases where we need to ask for more medical evidence - eg. a GP report, medical examination or blood or other tests. This will be because of the information provided by the member and not because their benefit has exceeded the non-medical limit by a certain amount.

We will pay for any medical information we request up to the rates charged in the UK. We will not pay any travel or other expenses incurred by the employee in connection with these reports.

We will assess the information and let you know the terms on which we can provide cover.

Where basic benefit is restricted to less than the full potential benefit, any lump sum benefits will be restricted by the same percentage.

You should ensure that your employee is aware that some medical information related to underwriting decisions and non-medical information about them which is necessary to enter into an insurance contract will be shared with you as the policyholder. This could include policy exclusions relating to a specific medical condition.

General terms

Underwriting outcomes

We will let you know if the benefit being underwritten can be accepted on standard terms or special terms and/or restrictions apply. In some cases we will be unable to provide cover.

If within a reasonable period we do not receive all the information we request to medically underwrite an employee we can:

- Refuse to cover the employee (if the non-medical limit does not apply to them)
- Refuse to cover an increase in benefit for the member
- Attach conditions to the benefit

Full cover will not be in place until we have confirmed our terms in writing.

In practice

Once and done

If we have underwritten a member and cover is in place, future increases in benefit can be provided on the same terms and without medical underwriting as long as:

- The benefit for the member has not been restricted to the non-medical limit
- The policy has 20 or more members, and
- The increase in benefit results solely from an increase in salary

Forward underwriting

In other cases where we have underwritten a member and cover is in place we will only underwrite again if the increase in benefit for the member is more than 10% per annum. We call this the forward underwriting bar.

Changes to the non-medical limit

If the non-medical limit is reduced or withdrawn, we will continue to cover members for the benefit that applied to them on the day before the non-medical limit was changed.

An increase in the non-medical limit will apply to all members if:

- The previous non-medical limit applied to them, and
- They are actively at work on the day of the increase. If they are not actively at work on that day, the increased non-medical limit will apply from the day they are next actively at work

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General terms

Once and done

The once and done terms in the box opposite are incorporated into policy terms.

Changes to the non-medical limit

We will let you know:

- The non-medical limit at the start of the policy, and if
- The non-medical limit changes. This will usually only happen at a policy anniversary or review date

We can withdraw the non-medical limit if you do not follow the eligibility conditions or if the number of members falls below 3.

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Temporary cover during underwriting

We will provide temporary cover for the amount of benefit that is being underwritten as long as:

- The member meets the actively at work requirement on the day cover is due to start, and
- The amount of the member's benefit has not been restricted by us

In practice

- Our account will show the members who need to be underwritten because their benefit is over the non-medical limit.
- If, within 90 days of the account being issued, the member makes an appointment for a telephone call to provide us with the health and lifestyle information we need (or returns a completed form to us), we will provide temporary cover until we have underwritten the member and written to you with our terms. If we don't receive all the information we require, we may stop temporary cover. We will advise you in writing if this happens.
- If, after 90 days of the account being issued, the member has not engaged in the underwriting process, we will stop temporary cover.

General terms

Temporary cover

If temporary cover applies, we will provide cover for the amount of benefit that is being underwritten.

However, we will not pay benefit for absences caused by a medical condition for which the member:

- Received treatment, care or services (including diagnostic measures) or
- Took prescribed drugs or medicines

in the 12 months before temporary cover started.

The temporary cover terms in the box opposite are incorporated into the general policy terms.

Temporary cover starts on:

- The policy anniversary, or
- The joining date for new members

Policies switching to us from another insurer

If the policy is moved to us from another insurer we will need to know the non-medical limit offered by the previous insurer and the underwriting terms for each member whose benefit exceeds our non-medical limit.

In practice

A copy of the previous insurer's underwriting decision letter will provide us with the information we need about a member.

We will match the underwriting terms applied by the previous insurer on benefit exceeding our non-medical limit.

The extra premium we charge may be different from that charged by the previous insurer because the underlying rates may be different.

7. Making a claim

What specialist support can we provide to help get a member back to work?

We have a team of specialists who will work with you to help the member achieve a safe and sustainable return to work. Rehabilitation and reintegration programmes are an integral part of the claims management process and the support we provide.

From the first week of an employee's absence, you can contact us to ask for general guidance.

- Contact the Rehab Helpline on **01306 646 001**
- Email us at RHM.Enquiries@unum.co.uk

Once a claim has been submitted and a consent form completed, our team can make contact and begin to work with you and your employee.

- Each case is managed individually to take account of the particular circumstances
- The focus is on getting your employee back to work at the earliest appropriate time and we expect this will reduce absence costs for your business

When to tell us about a claim

You can submit a claim as soon as you anticipate a problem. The earlier we are told about an absence, the earlier we can identify any support we can provide. It will also ensure we are ready to pay benefit at the end of the deferred period.

Late notification

If we are notified of a claim after the end of the deferred period, our ability to manage the absence and assess the claim may be affected.

General terms

Reasonable adjustment

Your obligation, which we can ask you to evidence, is to:

- Investigate and implement any reasonable adjustments to the working conditions, the physical features and any other arrangements relating to a member's occupation which would enable them to continue working for you, and
- Investigate and make reasonable efforts to implement any rehabilitation and reintegration programmes designed to enable the member to return to work

Claim notification

You must provide us with a completed employer claim form and a completed employee claim form before a member has been incapacitated for:

- 10 weeks for deferred periods of 26 weeks or more
- 6 weeks for shorter deferred periods

Late notification

If we are notified of a claim after the end of the deferred period (but less than 90 days later) we have the right to pay benefit from the date we receive the notice.

If we are notified of a claim later we have the right not to pay benefit.

How to tell us about a claim

You will need to send us:

- A completed employer claim form, and
- The member's absence records, and
- A job description for the member's occupation

We will also need the following information from the member:

- A completed employee claim form
- A signed consent form which gives us authority to ask their doctors for further information

The member will need to give their doctor:

- A second copy of the signed consent form
- A request for copies of medical records

This will allow their doctor to provide us with the medical records.

In practice

You can get our claim forms by:

Website: Download the forms at unum.co.uk/claims/group-income-protection

Phone: Call our Customer Care Department on **01306 873243**

Email: Contact us at customercareclaims@unum.co.uk

You can return completed claim forms to us by post or email.

Post: Claims Department, Unum, Milton Court, Dorking, Surrey, RH4 3LZ.

Email: DorkingClaimsAdmin@unum.co.uk

How are claims assessed?

We will assess if the member satisfies the definition of incapacity. We will need:

- Evidence of their medical condition
- Evidence they are receiving appropriate medical advice and treatment
- Information about their job role

We may ask the member to attend an independent medical examination with a medical practitioner or consultant chosen by us.

We may also need to visit you or the member. If this happens we will always make an appointment in advance.

In practice

To enable us to assess and manage a claim, you must ensure that we are provided with:

- A completed employer claim form
- A completed employee claim form
- A signed employee consent form
- Information we request to assess the claim
- Notification of any change in the member's condition or circumstances which might affect our liability to pay benefit. For example, a change in their condition, their contract of employment, their income or if the member performs any work whether paid or unpaid

The information we request may include, but is not limited to, medical evidence, proof of membership, details of the insured occupation, personnel, medical and occupational health records held by you, proof of earnings before and during incapacity, a birth certificate, information relevant to the claim from any person the member has consulted in connection with their incapacity, and the member attending a medical examination when requested to do so.

We will pay for any medical evidence we request in the UK.

General terms

Claims assessment

The policy terms in force at the date a member becomes incapacitated will apply for the duration of the claim.

You must provide (and ensure that the member provides) the evidence, information and access to information we need to assess and review the claim.

We can decline or stop paying a claim or adjust the benefit payable for a member if we do not receive the information that is described or listed in the user guide.

When will we pay benefit?

Monthly benefits

Monthly benefits are paid in arrears 3 working days before the end of the month.

In practice

The deferred period can be:

- Continuous absence
- Separate periods of absence (of at least 2 weeks) from the same or related causes. The deferred period must be completed within a time span of twice the deferred period - e.g. a member would complete a 26 week deferred period if they had 26 weeks of absence within 52 weeks
- Periods where because of illness or injury a member works part time or on restricted duties or in a lower-paid role

Initial lump sum benefit

If you have selected this option, we will pay benefit if a member is diagnosed with one of the specified conditions and as a result, is absent from work for at least 14 days.

Final lump sum benefit

If you selected this option, the lump sum benefit will become payable when the member has completed the limited benefit payment period.

How will the benefit be paid?

We will pay benefits to you in sterling by direct credit. However, for partners or barristers basic benefit will be paid to the member.

General terms

When benefit payments are made

Monthly paid benefits

Monthly benefit payments become payable when a member's incapacity continues past the end of the deferred period. Your choice of deferred period will be shown in the policy coverage document.

Monthly benefits are payable from:

- The day after the end of the deferred period, or
- If later, the day the member was due to return to work following a period of unpaid leave

Initial lump sum

The policy coverage document will show if you have selected this benefit. The initial lump sum benefit will become payable if:

- The member is diagnosed with cancer, heart attack or stroke, and
- The diagnosis meets the definition in section 10, and
- The member is absent from work for at least 14 days due to suffering from the specified condition

A pre-existing conditions exclusion applies to the initial lump sum benefit. Details of this exclusion can be found in section 10.

Initial lump sum benefit can only be paid once for a member.

Final lump sum

The policy coverage document will show if you have selected this benefit. The final lump sum benefit will become payable if:

- Monthly benefit has been paid in respect of a member for the whole of the limited benefit payment period, and
- On the last day of the limited benefit payment period the member satisfies the definition of incapacity used to assess entitlement to this lump sum benefit

Final lump sum benefit can only be paid once for a member.

How long do we pay benefits for?

Monthly benefits

We regularly review claims and will request any information we need to do this. Benefit payments will continue as long as the medical and other relevant evidence supports a claim.

In practice

Leaving service

When a member leaves service because of long-term illness, if you have not selected a pay direct policy, we may still agree to a request by you to pay basic benefit to your former employee.

If we agree to pay benefit direct, the general terms will be the same as those for a pay direct policy but the definition of incapacity will change to "gainful occupation" from the earliest of:

- 52 weeks after we pay benefit direct, or
- The date the gainful occupation definition would have applied if the member had remained in employment

We will pay basic benefit only. Optional additional benefits will stop being paid.

We will deduct basic rate tax from the benefit payments.

TUPE transfers

If an incapacitated member is transferred to another employer under the terms of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) – which is generally known as a TUPE transfer, we can pay basic benefit and optional additional benefits to the new employer.

General terms

When benefit payments end

We will stop paying benefits for a member on the earliest of:

- The date they return to work
- They no longer meet the definition of incapacity
- The date the limited benefit payment period ends
- The date they reach the cover cease age
- The expiry of a fixed-term contract of employment in force at the date incapacity began
- The date they die
- They leave your service

Payment of additional benefits will end if we agree to pay benefits directly to an incapacitated member.

TUPE transfers

If an incapacitated member (including a member within the deferred period) is transferred to another employer under a TUPE transfer, we will agree to a request from you and the new employer for payment of basic benefit and any optional additional benefits to be made to the new employer. For the purposes of the claim:

- Benefit will be paid without any change to the terms and conditions; and
- The new employer will be treated as the policyholder and will be bound by the terms of the policy in respect of the transferring employee

If the new employer does not agree to be bound by the policy terms we can stop benefit payments. We will give the new employer and the member at least 30 days' notice before we do this.

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What happens if a member can return to work on a reduced basis?

If an illness or injury prevents a member from working in their own role for the normal number of hours but they work part time or on restricted duties or in a lower-paid role, we will pay benefit at a reduced rate. We call this proportionate benefit.

In practice

- We will calculate the new salary as a proportion of the pre-incapacity salary. Benefit is then reduced by that proportion. For example, if a claimant receives 40% of their previous salary, we will reduce the benefit by 40%
- So that the member is not penalised when we calculate proportionate benefit, we will increase their pre-incapacity salary in line with inflation
- Where the basic benefit is a percentage of salary less a deductible, we will recalculate the basic benefit without the deduction when we calculate the proportionate benefit
- We will use an assumed new salary if the member does not receive the market rate of pay
- Proportionate benefit can be paid from the end of the deferred period

General terms

Proportionate benefit

If a member is incapacitated but:

- Is working in their normal occupation on a reduced basis, or
- Is working in a different occupation, and
- Suffers a loss of earnings

we will pay a proportionate benefit.

We will recalculate proportionate benefit each time the member's new salary changes.

Proportionate benefit can never be more than the full benefit that would be payable to the member.

Any final lump sum benefit will be reduced in the same proportion as the basic benefit.

Can benefit payments restart if an employee becomes incapacitated again?

Yes. We will treat the absence as an extension of the original claim if benefit payments end because the member is no longer incapacitated but

- Becomes ill again within a year, and
- Meets the definition of incapacity

We call this a linked claim.

In practice

Under linked claims:

- Monthly benefits become payable immediately
- We will link the claim if the second period of incapacity is from the same or a different cause
- Benefit payments will restart at the level of the previous claim
- A deferred period will apply to any increase in benefit resulting from a salary increase or a benefit basis change while the member was actively at work

Linked claims under limited payment period policies:

- If the member returned to work for less than 4 weeks, the claim will continue for the remainder of the limited benefit payment period
- If the member returned to work for 4 weeks or more, a new benefit payment period will start immediately

Can a further claim be submitted if a member does not return to work?

Yes. You can submit a further claim within a year from our decision if:

- We decline or stop paying a claim because the member does not meet the definition of incapacity, and
- The member does not return to work

In practice

The date of our decision is:

- The day after the end of the deferred period for claims which are declined
- The date we stop paying a claim because the member no longer meets the definition of incapacity

General terms

Further claims if the member does not return to work

If we decline or stop paying a claim because the member does not meet the definition of incapacity, but the member does not return to work, you can submit a new claim if their condition worsens, or they suffer a new condition within a year from our decision.

What happens to claims if the policy is cancelled?

We will continue to pay any claims that are already in payment for as long as they remain valid.

We will continue to assess claims where incapacity started before the cover ended, but we haven't yet started to pay benefit e.g. if the end of the deferred period has not been reached.

In practice

If it isn't possible to pay benefit to the employer - e.g. if they have stopped trading, we will pay basic benefit to the member and optional additional benefits will stop.

If the policy is moved to another insurer and the employee returns to work before they have completed the deferred period but is then absent again, we will:

- Add the separate periods of absence together as long as they are from the same or related cause and our deferred period is completed within a time span of twice the deferred period, and
- Pay any benefit during the new insurer's deferred period

If the policy is moved to another insurer, any new claims will be the responsibility of the new insurer. However, if we have been paying benefit for a member, our linked claim approach will mean that:

- If the member returns to work before or after the policy has switched to the new insurer, and
- Meets the actively at work requirement of the new insurer, and
- Within a year of returning to work the member again meets the definition of incapacity

We will pay benefit during the new insurer's deferred period

General terms

Your business ceases trading

If your business ceases trading:

- This policy will end immediately
- We will pay basic benefit directly to the incapacitated member for as long as the claim remains valid under the policy terms in force at the date they became incapacitated
- Additional benefits will not be payable

Linked claims

The linked claim terms in the user guide on the opposite side of this page are incorporated into policy terms.

Does other income the member receives affect the benefit?

If the member receives other income it may affect the amount of benefit we pay.

Other income includes:

- Benefit from any other accident, sickness or Income Protection policies where the benefit payment period is more than 2 years
- Early retirement pensions
- Income from you
- Any other income

In practice

We will not reduce our benefit if the member is totally and permanently incapacitated or take account of:

- Contractual occupational sick pay during the first 12 months of incapacity
- Income the member was receiving before they became incapacitated
- Pensions taken by anyone over age 55
- Income from other sources if you have selected a Simplicity IP policy

Claims for employees based outside the UK

All benefits will be paid in sterling to a UK bank account of the UK employer.

In practice

- Foreign earnings will be converted to sterling using the exchange rate we used when we calculated the premium

General terms

Income from other sources

We will limit the basic benefit payable for a member so that the total of

- The basic benefit, and
- Any other income payable to the member

does not exceed 80% of earnings, or 50% of earnings for partners and barristers.

In these circumstances, the basic benefit will be reduced by the amount of the excess.

Other income which is not taxable will be increased to make it comparable with taxed income (and vice versa for partners and barristers).

Incapacitated members based overseas

The following additional policy conditions apply for incapacitated members who are based overseas:

- You will be responsible for paying for any medical examinations or tests which are undertaken outside the UK. However, we will contribute an amount towards the cost, equal to the amount we would expect to pay in the UK for similar evidence
- Medical evidence should be provided in the original language it was written and we will arrange for any translation into English. You will be liable for the cost of the translation

All information must be provided in a form which is acceptable to us.

8. Amendment and cancellation

General terms

Amendment and cancellation by us

We can withhold or restrict cover for an employee who is not included in the data or the information is inaccurate or incomplete.

We can amend the policy terms:

- At any time the premium rate is reviewed
- If there is any change in the legislation (including the introduction of new legislation) which affects the premium rate or the payment of benefit under this policy
- If there is any change in the taxation system which affects this policy
- If there is any change in the state welfare system (including the criteria for receiving state benefit) which affects this policy
- If there is a significant change to your business

You must tell us immediately if there is a significant change to your business including:

- A merger or acquisition
- The sale of part of your business
- A change to your normal business locations or overseas travel patterns
- Changes to the occupations of the members

We have the right to change the terms or premium rate to reflect any additional risk.

We will give you at least 30 days' notice before we make any changes to the policy terms.

We can cancel the policy or amend the policy terms if:

- You do not provide us with the information we request
- You do not pay the premiums when they are due
- Your business stops trading
- The number of members falls below 3

We will give you at least 30 days' notice before we cancel the policy. We will charge a premium for the cover we have provided up to the cancellation date.

Amendment or cancellation by you

You can ask us to consider a change to the policy at any time. Changes cannot be backdated. The following changes will have an impact on the terms of the policy and/or the premiums payable:

- A change to the benefit basis, cover cease age or eligibility conditions
- If you wish to remove an existing employer from cover under the policy or add a new employer for cover under the policy

You can cancel the policy at any time by letting us know in writing. Cancellation cannot be backdated and we will charge a premium for the cover we have provided up to the cancellation date.

Trade sanctions

We can also cancel the policy immediately and stop payment of benefits if:

- You or an employer or the beneficial owner of either becomes a restricted person
- We believe that you may expose us to the risk of being or becoming subject to any sanction, prohibition or adverse action by the government of the United Kingdom, the United States of America, the United Nations, European Commission or Council of the European Union

We can deny or permanently stop payment of benefit in respect of an incapacitated member who is a restricted person.

9. Taxation

This section is based on our understanding of the tax rules applying to Income Protection policies and is not intended to give definitive advice. You should take advice from an independent financial adviser to ensure you understand the impact of tax on your policy and the benefits it provides.

Premiums

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

For tax purposes, premiums paid by you to cover your employees are treated as a business expense and are not treated as a P11D expense for employees.

HMRC do not normally grant tax relief on premiums paid for any employees with a proprietorial interest in the company. HMRC may agree to grant relief if a substantial number of other employees are provided with similar benefits. In these circumstances you should ask your local Inspector of Taxes or your broker for clarification.

For equity partners and barristers, each member pays for their own cover. There is no tax relief on the premium paid.

Monthly benefit

The benefit paid to you will be treated as a trading receipt. The benefit you pass on to your employee is treated as a trading expense. The result is a neutral tax position.

The benefit paid by you to your employee will be subject to tax and National Insurance under the PAYE system.

For equity partners and barristers, the benefit paid directly to the member is tax free.

Lump sum benefits

The lump sum benefit will be paid to you.

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

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10. Definitions of incapacity

General terms

Insured occupation cover

A member is incapacitated if we are satisfied that they are:

- Unable, by reason of their illness or injury, to perform the material and substantial duties of the insured occupation, and are
- Not performing any occupation

If the member is required by the terms governing the employment relationship to hold a licence or certificate which is issued only when the member meets required medical standards, we must also be satisfied that they are unable, by reason of their illness or injury, to perform the material and substantial duties of any gainful occupation with any employer for which they are reasonably fitted by reason of training, education or experience.

The term “licence” does not include a licence to drive ordinary cars, vans or motorcycles.

Gainful occupation cover

A member is incapacitated if we are satisfied that they are unable, by reason of their illness or injury, to perform the material and substantial duties of:

- The insured occupation, and of
- Any gainful occupation with any employer for which they are reasonably fitted by reason of training, education or experience, and
- They are not performing any occupation

Combined cover

- For the deferred period and the first 2 years following the completion of the deferred period the insured occupation cover definition applies
- Beginning immediately after the first 2 years following the completion of the deferred period the gainful occupation cover definition applies

Definitions

Insured occupation means the trade, profession or general role that the member was actively undertaking for you immediately prior to incapacity.

If a member has returned to work for you after a period of incapacity and payment of benefit has stopped for a period of 52 weeks, insured occupation means the occupation the member was following immediately prior to any further period of incapacity.

Where the insured occupation includes working in excess of 48 hours per week, an incapacitated member will be considered able to perform that requirement if they are working, or have the capacity to work, 48 hours per week.

For the insured occupation cover definition of incapacity, material and substantial duties means the duties that are normally required for the performance of the member’s insured occupation and which cannot be reasonably omitted or modified. It is those duties required for the performance of the occupation at their, or any other employer. The insured occupation does not include:

- Work activities, contractual or not, which the member undertook for, or at, the employer prior to incapacity which are not a common feature of the member’s trade, profession or general role
- The specific manner in which the member was expected to complete work tasks for a specific employer or at a specific location
- Any trade, profession or general role undertaken by the member other than for the employer
- The journey between the member’s normal residence and the member’s normal place of work

Gainful occupation means an occupation that is providing, or can be expected to provide, the member with an income within 12 months of their return to work:

- Which exceeds 2/3rds of their gross earnings from the employment relationship immediately prior to incapacity, increased in line with any percentage increase in the RPI since the date of incapacity, and
- For working the same number of hours the member worked in the course of the employment relationship immediately prior to the incapacity

For the gainful occupation cover definition of incapacity material and substantial duties are the duties that are normally required for the performance of the gainful occupation as it is performed for, or at, their, or any other employer and which cannot reasonably be omitted or modified.

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General terms

Serious illness definition qualifying conditions

Arthritis

Active and progressive forms of inflammatory polyarthritis including widespread joint destruction with major clinical deformity of three or more joint areas.

Blindness

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

Burns

Physical, thermal or radiation injuries and scarring causing severe and multiple deformities or structural abnormalities, or

Third Degree Burns - Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

Cancer

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue, and there is evidence of continuing progression of the disease.

Dementia/brain injury/stroke

Organic brain disorders due to physical damage or degenerative brain disease including all dementias and causing persisting neurological deficit.

Heart and lung disease

Progressive impairment of the cardio-respiratory function which severely and persistently limits effort tolerance to below 3 METs as measured by exercise testing.

HIV/AIDS

Severe and progressive immune deficiency states characterised by the occurrence of severe constitutional illness, of opportunistic infections, or tumour formation secondary to infection by HIV.

Injury to hands

Severe tissue damage and scarring of both hands which renders the hands functionless for all dextrous manipulation.

Kidney failure

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

Liver failure

Chronic and end stage liver failure.

Loss of ability to communicate

Severe hearing and speech impairment, causing the inability to communicate effectively beyond family and close friends.

Loss of independent existence

Severe mental or physical impairment such that throughout the day or night they require frequent or prolonged:

- Attention in connection with their bodily functions, or
- Supervision in order to avoid substantial danger to themselves or others

Loss of limbs

Amputation of:

- Both hands at or above the level of the carpo-metacarpal joints, or
- Both feet at or above the level of the tarso-metatarsal joints, or
- One hand and one foot at or above the level of the carpo-metacarpal and tarso-metatarsal joints.

Neurological disease

Severe and progressive neurological or muscle wasting diseases, including but not restricted to Multiple Sclerosis and Motor Neurone Disease, with objective clinical neurological findings and a confirmed medical diagnosis.

Paralysis

Tetraplegia - Paralysis of both arms and both legs.

Paraplegia - Paralysis of the lower limbs (including uncontrollable involuntary movements or ataxia which effectively renders the person functionally paraplegic).

Hemiplegia - Dense paralysis of the upper limb, trunk and lower limb on one side of the body.

Persistent vegetative state

A person in a vegetative state may seem to be awake and reflex responses may remain, but it is widely accepted that they have no awareness of their surroundings and that they are incapable of feeling mental distress or physical pain.

Psychosis

Schizophrenia, paranoid psychosis, or depression with psychotic features (but excluding alcohol or drug-induced psychosis) with objectively demonstrable mental impairment and incapacity.

Terminal illness

Advanced or rapidly progressing incurable illness where in the opinions of an attending consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months.

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General terms

Initial lump sum qualifying conditions

Cancer

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin)

For the above definition, the following are not covered:

- All cancers which are histologically classfield as any of the following:
  - Pre-malignant
  - Non-invasive
  - Cancer in situ
  - Having borderline malignancy, or
  - Having low malignant potential
- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A
- Any skin cancer (including cutaneous lymphoma) other than:
  - Malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin), or
  - Basal cell carcinoma or squamous cell carcinoma that has spread to lymph nodes or metastasized to distant organs

Heart attack

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- New characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests
- The characteristic rise of cardiac enzymes or Troponins

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes or
- Angina without myocardial infarction

Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that has resulted in all of the following evidence of stroke:

- Neurological deficit with persisting clinical symptoms lasting at least 24 hours, and
- Definite evidence of death of tissue or haemorrhage on a brain scan

For the above definition, the following are not covered:

- Transient ischaemic attack
- Traumatic injury to brain tissue or blood vessels
- Death of tissue of the optic nerve or retina / eye stroke

Pre-existing conditions exclusions

No initial lump sum benefit will be paid for cancer, heart attack or stroke if prior to the start of their cover a member:

- suffered that illness, or
- had been treated for or had been aware of a related condition

The related conditions are:

Cancer

Polyposis coli

Papilloma of the bladder

Any carcinoma-in-situ

Heart Attack and Stroke

Any disease or disorder of the heart

Any obstructive or occlusive arterial disease

Blood pressure treated at any time by prescribed medication

Diabetes mellitus

11. Further information

Complaints

If you are not completely happy with our service or a claims decision, you can make a complaint to our Customer Resolution team.

Phone: 01306 644761

Email: CustomerResolution@unum.co.uk

Letter: Customer Resolution Team
Unum
Milton Court, Dorking, Surrey
RH4 3LZ

Fax: 01306 873635

Please include your preferred contact details.

We will do our best to resolve your complaint, but if your complaint has not been resolved within 8 weeks, we will explain why it remains unresolved and inform you of your right to refer the matter to the Financial Ombudsman Service (FOS). Once we have finished investigating your complaint we will issue a Final Response Letter. If you remain dissatisfied you will have the right to refer the matter to the FOS. You must refer any complaint to the FOS within 6 months of the date of the Final Response letter. Please note that some cases may not be eligible for referral to the FOS.

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Consumer helpline: 0800 023 4567

For mobiles: 0300 123 9 123

Email: complaint.info@financial-ombudsman.org.uk

Web: www.financial-ombudsman.org.uk

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Law

The policy is subject to English Law, and by taking out the policy, you accept that any dispute shall be subject to the exclusive jurisdiction of the English Courts.

The policy is not assignable.

Employees do not have any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any terms of this policy. This means that there is no requirement to involve employees in day-to-day decisions on the administration and insurance of the policy. However, following a final decision by us concerning a claim, the employee may engage directly with us in order to ensure that the terms of the policy are met regarding the claim.

Financial Services Compensation Scheme

If we cannot meet our liabilities, you may be entitled to compensation under the Financial Services Compensation Scheme (FSCS)*.

* Please note that the FSCS does not cover firms based in the Channel Islands or the Isle of Man.

Data Protection

This section explains how we and you comply with Data Protection laws including the Data Protection Act 1998 and the General Data Protection Regulations (GDPR) in connection with the processing of members' personal data.

We are a Data Controller for insurance purposes.

We have the right to request the members' personal data we need to quote for and administer the policy.

We will:

- Record the data accurately
- Keep the data confidential and secure
- Use the data solely for the purpose of quoting for, providing and administering the policy and for marketing other Unum products to you
- Retain the data only for as long as is necessary
- Only process, transfer or permit access to any personal data outside of the European Economic Area in compliance with applicable data protection legislation

You are a Data Controller for employment purposes.

You must:

- Obtain the necessary consents from, and provide all relevant policy information to members before providing us with any personal data
- Ensure that the data is correct at the time it is provided to us and that alterations are notified to us in reasonable time

You and we will each provide reasonable assistance to the other as necessary to enable the other to comply with Data Protection laws including responding to Data Subject Requests, complaints or other queries received from members or other third parties in relation to members' personal data.

The legal definitions and data protection information contained in our data protection document at http://resources.unum.co.uk/downloads/data-protection-document-UP4031-052018.pdf are incorporated into general terms of this policy.

About Unum

Unum is a leading employee benefits provider offering financial protection through the workplace including: Income Protection, Life insurance, Critical Illness, and Dental cover.

Our Income Protection customers have access to medical and vocational rehabilitation expertise designed to help people stay in work and return to work following illness and injury. Unum LifeWorks, our Employee Assistance Programme, provides help and advice on a range of work/life issues.

Our Critical Illness customers can access our Cancer Support Service, providing personalised support for employees with a cancer diagnosis.

We are committed to workplace wellbeing for both employees and employers, and have a wide range of tools designed to help businesses create or enhance their employee wellbeing strategy.

At the end of 2017, Unum protected over 1.6 million people in the UK and paid claims of £306 million - representing in excess of £5.9 million a week in benefits to our customers - providing security and peace of mind to individuals and their families.

Unum Group has a financial strength rating of A (Excellent) from A.M Best with a stable outlook.

Our parent company, Unum Group, is a provider of employee benefits products and services in the United States, including group and individual disability insurance. Premium income for Unum Group and its subsidiaries totalled $8.6bn in the year ended 31 December 2017, with reported revenues for the group totalling $11.3bn and total assets of $64bn. For more information please visit www.unum.co.uk.

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We monitor telephone conversations and e-mail communications from time to time for the purposes of training and in the interests of continually improving the quality of service we provide.

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