GROUP CRITICAL ILLNESS

How it Works
Product Guide
Claims

Critical Illness Claims Guide

Introduction

We aim to make the claims process as straightforward as possible. This guide will help you through the process and answers some of the frequently asked questions.

If you have any further questions please contact us.

Your claim

We will advise you of any further information required to process the claim, within five working days.

Support services

Personal Nurse Service and Second Medical Opinion services are available to anyone who makes a claim.

PERSONAL NURSE SERVICE

Click here for full details

SECOND MEDICAL OPINION

Click here for full details

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GROUP CRITICAL ILLNESS

Initial Considerations

Does the policy cover the illness diagnosed or surgical procedure undertaken?

Not every serious illness or surgical procedure is covered by our Group Critical Illness policy. Claims can only be considered for illnesses or procedures that are specifically covered by the employer's policy.

We offer different levels of cover so it is important to check what level of cover has been selected. Our **Webguide** shows the range of illnesses that are covered by each level. Cover for the Additional Illnesses and Total Permanent Disability is optional and may not have been chosen.

The illness diagnosed or surgical procedure undertaken must be one of those covered by the policy for a claim to be considered. Claims cannot be considered for illnesses not specifically insured.

Has the policy definition of the illness or condition diagnosed been satisfied?

Each insured illness is clearly defined and where applicable specifies the level of severity required in line with the guidelines as published by Association of British Insurers (ABI).

To be considered a valid claim the diagnosis must fully satisfy the definition.

Have the exclusions imposed on the illness diagnosed or surgical procedure undertaken been considered?

Our Group Critical Illness policies have a number of exclusions including a pre-existing conditions and related conditions exclusion. Claims will be declined if any of these exclusions apply.

Important information regarding our policy terms and critical illness definitions

We have a number of documents available via **'How it Works'** or in the **Document Library** of our website which provide information about the illnesses which may be insured, the definitions which must be satisfied for a claim to be considered and the exclusions which are imposed:

- **Policy Conditions**
- **Webguide**
- **Product information document Exclusions – Pre-existing and Related Conditions**

Please **contact us** if you have any questions on the terms and conditions insured or if a copy of the applicable policy is required.

Important information

Please note that the documents on our website only provide information on our current terms and conditions. Claims are assessed in line with the **actual** Policy Conditions applicable at the date an insured illness is diagnosed or insured surgical procedure takes place. These may not be the same as our current terms and conditions.

What we need

What we need

For all claims we require as a minimum:

- a fully completed Claim Form
- a fully completed Personal Statement
- medical evidence to validate the claim

Additional information will be required if the claim is in respect of a spouse, civil partner, partner or child. These are detailed on the next page.

Claim Form

This should be completed and signed by someone who is authorised to act on behalf of the Policyholder i.e. the principle employer insured under the policy.

Claim Form

Personal Statement

This should be completed by the person who has been diagnosed with one of the insured illnesses or undergoes the insured surgical procedure.

This form requests comprehensive information regarding the illness or surgical procedure for which the claim is being made.

It also provides us with the required authority to obtain appropriate medical evidence to validate the claim.

Which Personal Statement should be completed?

We have a number of different versions of the Personal Statement available.

For the majority of claims our standard **Personal Statement**

Please **contact us** so that we can send you the correct Personal Statement if a claim is to be submitted in respect of one of the insured illness as detailed below:

- Loss of independent existence
- total permanent disability – Unable to look after yourself ever again
- total permanent disability – Activities of daily living

Notes

If the person who has been diagnosed with or suffered from the critical illness is not physically or mentally able to complete the Personal Statement, it can be completed on their behalf by their spouse, civil partner or partner.

What we need if submitting a claim for a spouse, civil partner or partner

For all claims we require as a minimum:

- a fully completed Claim Form
- a fully completed Personal Statement
- medical evidence to validate the claim
- for a spouse or civil partner, sight of the original marriage or civil partnership certificate to validate the relationship
- for a partner, appropriate proof of cohabitation and financial dependency/ interdependency

The Personal Statement should be completed and signed by the spouse, civil partner or partner who has been diagnosed with one of the insured illnesses or undergoes the insured surgical procedure.

If they are not physically or mentally able to complete the Personal Statement, it can be completed on their behalf by their spouse, civil partner or partner.

'What we need'
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What we need
(continued)

What we need if submitting a claim for a child

For all claims we require as a minimum:

- a fully completed Claim Form
- a fully completed Personal Statement
- medical evidence to validate the claim
- sight of the child's original birth certificate
- sight of the child's original adoption certificate

The Personal Statement must be completed and signed by a parent or guardian of the child.

Medical evidence

We will need medical confirmation of the diagnosis, surgical procedure and history of the critical illness for which the claim is being made.

Many patients are sent copies of clinical letters by their doctors or medical advisers and sight of these may help us to speed up our assessment.

If the individual making the claim has any of the following evidence available, it should be provided with the completed Personal Statement:

- A letter from their General Practitioner confirming the history, diagnosis and treatment
- Hospital admission and discharge letters
- Copies of letters from the treating doctor or specialist
- Biopsy and/or histology test results
- Reports/results of any scans

Further information on the processes involved in obtaining medical evidence can be found on **page 5.**

General notes

Proof of earnings is not normally required. If needed, we may request payslips, P60 or contracts of employment.

If the claim is for total permanent disability on either an Own or Suited occupation basis we will require a copy of the claimant's job description, including details of the duties undertaken.

Due to HMSO directives relating to copyright, we are unable to accept photocopies of UK certificates as proof.

All original certificates will be returned, by recorded delivery, within three working day of receipt.

Submitting a claim

When should we be notified of a claim?

We should be notified as soon as possible after an individual is diagnosed with one of the insured illnesses or undergoes the insured surgical procedure, provided the appropriate definition is fully satisfied.

How long do I have to submit a claim?

A Claim Form and Personal Statement must be submitted within two years of an individual being diagnosed with one of the insured illnesses or undergoing one of the insured surgical procedures.

Claims received after two years fall outside of the policy terms and will be declined.

What happens to the claims if the policy is discontinued?

If an individual is diagnosed with one of the insured illnesses or undergoes one of the insured surgical procedures before the policy ceased we will assess any submitted claim.

If an individual is diagnosed with one of the insured illnesses or undergoes one of the insured surgical procedures after the policy ceased we will not be liable for any claim.

What happens if the Policyholder is in administration, liquidation or receivership?

In these circumstances the administrator, liquidator or receiver may be able to act as the Policyholder.

A claim can still be submitted if an individual is diagnosed with an insured illness or undergoes one of the insured surgical procedures, provided:

- the administrator, receiver or liquidator has requested that the policy continues
- all premiums, membership data and other requirements for the cover to continue have been provided for the period when the individual is diagnosed with an insured illness or undergoes one of the insured surgical procedures.

If an individual is diagnosed with one of the insured illnesses or undergoes one of the insured surgical procedures after the policy ceased we will not be liable for any claim.

Our claims assessment process

Our claims assessment process

We examine six areas:

- we check that the policy is up to date
- we review and validate the information provided in the Claim Form
- we review and validate the information provided in the Personal Statement
- we assess any medical evidence submitted with the Personal Statement
- we request any further medical evidence deemed necessary to validate the information provided in or with the personal statement
- we review any certificates received for authenticity and make sure the personal information shown matches the Claim Form and membership data provided, if applicable

Is the policy up to date?

We review the policy to make sure that:

- all premiums requested have been paid
- membership data required to review rates and produce accounts has been received
- no other items required to maintain the policy are outstanding

Notes

Any outstanding premiums, membership data or other information could delay the assessment and payment of claims.

Validation of the Claim Form

We check that this has been fully completed and review the information provided to ensure:

- the organisation is covered by our policy
- the date of birth, occupation and location where the individual works match those previously advised
- the individual was and remains eligible for cover on the policy
- the individual joined the policy when first eligible, if applicable
- the individual employed by the Policyholder, or any other organisation that is covered, appears on membership data for the correct level of benefit
- the benefits being claimed, including any salary used in the calculation, match the policy
- the declaration has been signed by an appropriately authorised person
- the benefit being claimed has been accepted
- if flexible benefit are insured, any requirements have been satisfied for any increased benefit selection

Notes

Any questions regarding the information shown will be raised immediately.

If the claimant is a spouse, civil partner, partner or child, some of the above information will be validated against the employee insured under the policy.

Review of the information provided on the Personal Statement

We check that the correct form has been fully completed and review the information to assess whether:

- the critical illness or surgical procedure disclosed is one that is insured
- we need to obtain further medical evidence to validate whether the claimant's condition/diagnosis satisfies the illness definition as shown in the Policy Conditions
- details of the claimant's General Practitioner and other relevant medical advisers have been disclosed
- the employee's bank details have been provided
- the declaration and consent have been signed

Notes

Any questions regarding the information provided will be requested immediately.

Where appropriate, and if able, we will usually contact the individual directly. We may make contact by phone or email if these details have been provided.

'Our claims assessment process' continues on the next page

Our claims assessment process
(continued)

Assessment of medical evidence provided with the personal statement

We assess the evidence in order to validate whether:

- the claimant's condition satisfies the critical illness definitions as shown in the Policy Conditions applicable at the date of diagnosis or surgical procedure
- any of the exclusions apply to the claim

If the evidence submitted is not sufficient to validate the claim we will request further medical evidence.

Process for requesting medical evidence

If we need to request further medical evidence to complete our claim assessment we will request this from the most appropriate source. This evidence could include:

- letters confirming the history, diagnosis and treatment(s)
- sight of the claimant's medical records
- hospital admission and discharge letters
- copies of letters from the treating doctor or medical adviser
- biopsy, histology or other test results
- reports/results of any scans

When a report is requested from any medical adviser we will write to the claimant, including parents or guardians in the case of a child, if they have indicated that they wish to see any reports before they are sent to us, to inform them of the information we have requested in line with the Access to Medical Records Act 1988.

Who pays for the medical evidence?

We will pay for any medical reports or tests that we ask for in the UK.

Support Services

Medical evidence obtained from outside the UK

If we agree to contribute towards the cost of obtaining the evidence it will be equivalent to the cost of obtaining similar evidence in the UK.

The medical evidence provided must be

- in English
- given by a medical adviser who is acceptable to our Medical Officer(s), and whose specialism is appropriate to the cause of the claim

Delays involved in the assessment process

Delays can be encountered after requesting reports from doctors, specialists or consultants.

Additional delays occur if evidence has to be obtained from outside the UK or if reports have to be translated into English.

Personal Nurse Service

Once a Claim form and Personal Statement have been received we will contact RedArc to confirm a claim is being processed by ourselves.

RedArc will then contact the individual who has suffered the critical illness directly to see if they can offer any practical help and or emotional support.

This is a no obligation service provided free of charge to the person who has suffered the critical illness and their immediate family.

Further information can be found on our website **https://www.canadalife.co.uk/group-insurance/group-critical-illness/personal-nurse-service**

Second Medical Opinion

A claim does not have to be made for the Best Doctors service to be used.

A second medical opinion service is provided to everyone insured under a Canada Life Group Critical Illness policy including immediate family living in the same household. Full details of the service can be found at **https://www.canadalife.co.uk/group-insurance/group-critical-illness/second-medical-opinion**

GROUP CRITICAL ILLNESS

Claim decisions

Claim decisions

Once we have received all the information required to assess the different elements of the claim we will either:

- confirm it is valid and arrange for appropriate payment(s) to be made
- decline payment

In all circumstances we will confirm our decision in writing along with the next course of action.

If a claim is declined we will, as a minimum, write to the Policyholder and the claimant's General Practitioner confirming, in as much detail as is allowed under the Data Protection Act, the reason for our decision. We will also confirm how an appeal can be made.

Claim payments

Claim payments

We will always make payment in UK currency via Bankers' Automated Clearing Services (BACS) to the employee insured under the policy, even if the claimant is their spouse, civil partner, partner or child.

Notes

Banks can take up to five days to complete the transfer.

Taxation of claim payments

The payment of benefits in the UK is not subject to taxation, provided P11D tax has been paid on the premiums paid to us.

If P11D tax has not been paid or the monies are being paid outside of the UK appropriate independent tax advice should be sought.

Appealing a declined decision

Appealing against a declined decision

Any appeal will require supporting evidence and should be submitted within three months of the date of declinature.

On receipt of an appeal, the claim will be reviewed by our Appeals Panel.

If the declinature is upheld, written correspondence upon conclusion will confirm that the Appeals Panel decision is the 'final decision on the case'.

Full Financial Ombudsman Service (FOS) details and supporting literature will be provided for eligible complainants.

Notes

We will not pay for any medical evidence provided for an appeal.

Full details of our Appeals Process are available at **http://documents.canadalife.co.uk/claim-appeal-process-group-critical-illness.pdf**

How to contact us

Contact us

Claims Management Services,
Canada Life Limited,
3 Rivergate,
Temple Quay,
Bristol BS1 6ER

Telephone
Monday to Friday 9am to 5pm
0117 916 4463

E-mail
ipclaims@canadalife.co.uk

Fax
01707 671100

Canada Life
Group Insurance

Our forms are available to download from our website: www.canadalife.co.uk/group

GRP1391 – 118R

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