GROUP INCOME PROTECTION

eProduct Technical Guide

Introduced from 26 September 2018.

class™

Canada Life
Group Insurance

About us

We provide support when it's needed most

We are Canada Life Group Insurance, the UK's largest provider of group insurance. We have over 45 years' experience covering thousands of businesses throughout the UK.

Our mission is to help people when they need it most, so we specialise in three products that help employers do exactly that – **Life Assurance**, **Income Protection** and **Critical Illness** cover.

We've grown considerably since we first arrived in the UK in 1903. We now support over 24,000 employers, covering 2.8 million employees for over £260 billion of benefits. This makes us the largest provider of group insurance in the UK.

Find out more

We are dedicated to helping more employers support their employees when they need it most. Use our **website** to find out more about our products or feel free to contact us on **0345 223 8000**.

Support Services

At Canada Life, we believe insurance is about much more than just a financial benefit. When employers choose our Group Income Protection policy, they also get access to five FREE[1] Support Services. Supporting employees back to work following absence and helping them stay healthy at every stage of their life.

EmployeeCare

EmployeeCare provides confidential telephone and face-to-face counselling, as well as support with everyday matters such as finding childcare or eldercare, legal issues and debt management.

Early Intervention Service

Early Intervention Service offers day-one absence management support. If an employee is absent, employers can call our helpline for immediate support and guidance.

Second Medical Opinion

The Second Medical Opinion service provides access to over 53,000 leading consultants worldwide. They offer second opinions on diagnoses and treatments for almost any condition.

Treatment Sourcing

The Treatment Sourcing service makes it easier for employees and their families to access convenient private healthcare at competitive prices.[2]

BusinessCare

BusinessCare gives employers the tools they need to comply with employment law, follow best HR practice and trade safely to protect their businesses.

[1] Free for all service users as the Support Service costs are absorbed with the Group Income Protection Insurance premium.
[2] The cost of any treatment will be met by the service user. Medical Care Direct may charge an administration fee when treatment is sourced.

The Early Intervention Service is provided by Canada Life Ltd, all other Support Services are provided by Canada Life's service company CLFIS (U.K.) Ltd (CLFIS), through its service providers Best Doctors® Inc, Medical Care Direct, LifeWorks and Epoq Legal Ltd. These services are non-contractual benefits which are available if you have a Group Income Protection policy with us. The provision of these services does not form part of your insurance contract with us and we provide access to these services as a value-added extra. These are complimentary services and can be altered or withdrawn at any time.

To find out more about our Support Services please visit
www.canadalife.co.uk/group

An excellent choice

Canada Life Limited aims to satisfy your specific requirements for Group Income Protection cover.

You will directly benefit from the full support of a dedicated team of specialist underwriters, administrators, account managers, claims assessors and rehabilitation consultants.

This eProduct is only available through Canada Life's web portal CLASS (Canada Life Automated Self Service). CLASS is provided to authorised and registered intermediaries. It aims to streamline processes and offer a more cost effective way to quote, place, administer and renew group protection business.

As an additional option, CLFIS provides access to Canada Life's AbsenceFirst programme under a separate contract and on a case by case basis, provided by Health Assured.

Your quotation gives you an illustration of the first year costs you may incur and the technical guide outlines the main features of this product. You should be comfortable that you understand its features before you ask us to provide you with cover. If there is anything you are not sure about, you can ask us or your intermediary.

This document should be read in conjunction with the quotation. This document does not override the Policy, which contains full details.

Visit our website to download all our forms and materials.

Follow us on Twitter and receive our news as it happens.

Subscribe to our YouTube Channel to be notified of our latest webcasts.

Current **Policy** Conditions, claims guides and forms can be found in our Document Library section **click here.**

You can also request copies of any items or contact us at the following address:

CLASS User Support Team
Canada Life Group Insurance
3 Rivergate
Temple Quay
Bristol BS1 6ER

Or e-mail: **class@canadalife.co.uk**
or ring **0345 223 7137.**

Lines are open Monday to Friday, 9am to 5pm.

This contract is designed to be used by companies, partnerships and other organisations.

This technical guide has been produced based on the 'best practice' format recommended by the Group Risk Development group (GRiD) and The Association of British Insurers (ABI).

Best Doctors and EmployeeCare are inclusive benefits for all employees, and Best Doctors is also available for eligible dependants. Access to these services is not dependent on a claim being made.

The BusinessCare service is automatically available to you and provides information and advice on employment/HR issues, health & safety, legal, tax & VAT, and employee health management and wellbeing.

You should take appropriate legal and tax advice. This is so that you understand whether there are any taxation issues for you or your employees or any conflicts with your employees' contracts of employment.

Terms and expressions we use

In this guide when we refer to 'we', 'us' or 'our' we mean Canada Life Limited. When we refer to 'you' or 'your', we mean the existing or prospective **Policyholder.** Some terms have specific meanings. These are listed below in alphabetical order together with their meanings. If a particular term cannot be identified you may need to combine more than one of the definitions listed below.

'Actively at work':
means that a person:

- is present at their place of work; and
- has not received medical advice to refrain from work; and
- is mentally and physically capable of performing fully the normal regular duties associated with the job they are engaged to do; and
- is working their normal contracted number of hours, either at their normal place of business or
- at a place that the business requires.

'Annual revision date':
the date in each calendar year when the premiums are calculated.

'Basic benefit':
The amount of benefit for which cover is required (excluding any **supplementary benefits).**

'Cease age':
the age agreed between us as being the age at which cover and benefit payments for a **member** cease.

The age selected will be:

- 65, or
- 65 or state pension age if higher, or
- 70.

'Claim benefit':
the amount of **insured benefit** that we have agreed to pay following a **member's incapacity.**

'Commencement date':
the date that the **Policy** starts.

'Decision Letter':
written confirmation issued by us following our assessment of medical and other evidence obtained for a **member**.

For the purpose of this definition this will include:

- acceptance of benefits,
- declinature of benefits,
- postponement of a decision,
- restriction of benefits.

'Deferred period':
the period of time you have agreed with us which starts after the **commencement date**, and throughout which a **member** suffers an **incapacity** and is unable to work due to that **incapacity**.

The period starts on the first day that the member is unable to work due to that **incapacity**.

- If the **member** is on **statutory leave** the deferred period will start from the date of **incapacity**, and benefit payments will start from either the end of the **deferred period** or the agreed return to work date, whichever is later.
- If the **member** has been granted a temporary leave of absence, the **deferred period** starts on the first day on which the agreed leave of absence ends.

Terms and expressions we use

Claim benefit will not be payable for the period from the date of incapacity to the end of the deferred period. The **deferred period** is shown in your quotation.

'Discretionary benefit':
a benefit you want us to provide for a **member** that is larger or smaller than the **total benefit** for which the **member** would be eligible.

'Discretionary entrant':
someone:

- who is not an **eligible employee** but who you wish to include in the **Policy**, or
- who is an **eligible employee** but who you want covered from a different date to their **normal inclusion date,** or
- who is a late entrant.

'Eligible employee':
someone who meets the eligibility requirements for inclusion in the **Policy**.

'Employer':
any company, partnership or organisation that we have agreed to include in the **Policy.**

'ESA':
the Employment and Support Allowance (ESA) is a State benefit paid to those who are unable to work due to illness or incapacity. The ESA, work related activity component, support component and assessment phase are described in Chapter 5, Part 1 of the Welfare Reform Act 2007.

'Evidence of insurability':
any documentary or medical evidence that we may reasonably require to include someone for **total benefits** in the **Policy.**

'Free cover limit':
the total amount of a normal entrant's **total benefit** that we will cover on standard terms without the need for evidence of insurability. This will be shown in your quotation.

'Gainful occupation':
any activity that the **member** undertakes that has the potential to provide the **member** with some form of tangible gain, directly or indirectly, either immediately or in the future. This gain could include (but is not limited to) salary, fees, benefits in kind and profit or earnings from self-employment.

'HMRC':
HM Revenue & Customs.

'Illness':
Clinical ill-health causing a material deterioration in physical or mental health.

'Incapacity':
illness or injury meeting the definition of incapacity chosen by you (see Section 1.4 of this guide) and set out in your quotation.

'Injury':
A trauma to the body resulting in a clinical deterioration or loss of physical health.

Terms and expressions we use

'Insured benefit':
the **basic benefit** and **supplementary benefit** for which the **member** has been accepted under the Policy.

'Late entrant':
a person who joins an **employer's** pension arrangement after the date on which they first became eligible to join that arrangement where entry and/or the benefit entitlement under the **Policy** is dependent upon membership of that arrangement.

'Limited period':
a period of time consisting of 2, 3 or 5 years, which starts the day after the end of the **deferred period.**

'Material and substantial duties':
the duties that a **member** is normally required to do to perform their **normal occupation** and which cannot reasonably be omitted or modified by you or the **member**. The duties refer to the tasks the **member** is required to perform, and whether those tasks could be carried out for you or any other employer. In addition, a journey to and from the **member's** normal residence to the normal place of work is not regarded as part of the **normal occupation**.

'Member':
an **eligible employee** included in the Policy.

'Member's Earnings':
For an employee the greater of:

- their **scheme salary**, or
- the total earned income from all sources received by the **member** in the last 12 months. This includes any commission, bonuses, overtime, directors' fees and other variable income.

  But, where a **member's** basic annual rate of salary or wages from their **employer** at the end of that period is three-quarters or less of their total earned income, we will limit earnings to:

  – the **member's** basic annual rate of salary or wages, plus

  – the annual average of all other earnings they have received during the last 3 years or since joining their current **employer** if this is less than 3 years.

'National Insurance contributions':
an amount equal to the annual amount of the **employer's** National Insurance contributions which would be payable for the **member** if the total annual rate of the **member's** earnings from the **employer** was equal to that part of the **basic benefit** for which they have been included in the **Policy.** The basis is shown in your quotation.

'Normal inclusion date':
the first day that an **eligible employee** qualifies for inclusion in the **Policy.**

Terms and expressions we use

'Normal occupation':
the occupation for which the **member** was employed or engaged to do immediately before their **incapacity** started.

'Other benefits':
any payments that a **member** receives due to their **incapacity** from any of the following:

- a group or individual insurance policy giving rise to benefits as a result of illness, injury or disablement,
- a mortgage protection policy,
- a loan or credit protection arrangement (including credit and store cards), or
- an insurance premium waiver.

'Other income':
any payments that a **member** receives from:

- any employer (whether included in the **Policy** or not) in salary or other payments (but not any payments for statutory minimum holidays accrued during a period of incapacity),
- self-employment, or
- a pension including:
  - a scheme pension (but not a scheme pension before and continuing after the **member's deferred period** starts),
  - an annuity (but not an annuity in payment before and continuing after the **member's deferred period** starts),
  - drawdown,
  - withdrawal of uncrystallised funds pension lump sums (but only that portion treated as income for tax purposes.

'Pension scheme contributions':
the contributions that you have agreed with us in respect of a **member's** membership of an **employer's** pension arrangements. The basis is shown in your quotation.

'Periodic review date':
the date when your premium rates, **Policy** Conditions and **policy fee** are reviewed.

'Policy':
this is comprised of:

- these **Policy** Conditions and any subsequent updates and/or replacements,
- the information provided in the Proposal Form,
- your **Policy Particulars** and any subsequent updates and/or replacements,
- the information provided prior to the **commencement date,** or in relation to any alteration to the cover provided under the **Policy,**
- any questionnaire or written statement relating to a member, including but not limited to, a Health Declaration Form,
- any **decision letter** issued in writing by us in respect of any **member**, and
- any special terms, exclusions or limitations issued by us in writing.

'Policy fee':
an annual charge for each **Policy** towards our costs.

'Policy year':
any 12 month period from an **annual revision date** during which the **Policy** is in force.

Terms and expressions we use

'Reduced capacity':
the ability to perform some work related activity which could include fewer hours or undertaking less onerous duties.

'Relevant date':
the **commencement date** or such other date specified by us.

'Return to work plan':
a return to work and reintegration plan designed to enable a **member** suffering from an **incapacity** to return to work that we recommend for a **member** and, if appropriate, agree with that **member's** General Practitioner, attending physician, consultant or other suitably qualified person treating the **member's** illness or injury. There must be a reasonable expectation that the **member** will recover from their incapacity and return to their **normal occupation.**

'RPI':
the Retail Prices Index, published by the Office for National Statistics.

'Scheduled territories':
the United Kingdom, all European Union (EU) countries, Andorra, Australia, Canada, the Channel Islands, Gibraltar, Hong Kong, Iceland, the Isle of Man, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA and the Vatican City.

'Scheme benefit':
the benefit or benefits set out in your quotation.

'Secondment':
a period of time when an employee is sent to work somewhere other than their normal place of work by an employer on a temporary basis with an expectation of return to their original job, or to their original employer in their original location.

'State pension age':
the age at which the **member** is first entitled to receive the basic state pension or any benefit that may replace it.

'Statutory leave':
any statutory leave taken from employment due to an entitlement to:

- maternity leave,
- paternity leave,
- adoption leave, or
- shared parental leave.

'Supplementary benefit':
National Insurance contributions and/or pension contributions.

'Total benefit':
the sum of a **member's basic benefit** and **supplementary benefit.**

'TUPE':
Transfer of Undertakings (Protection of Employment) Regulations.

'Underwriting':
the process whereby evidence of insurability is obtained and assessed.

Contents

The aim of the Policy

The aim of the Policy is to meet your need for insurance to help you pay benefits for a member who is unable to work due to incapacity.

As part of this insurance, we will assess claims on your behalf and help you manage them through return to work plans. These plans can help minimise the costs of incapacity and maximise the value that incapacitated people can bring to an organisation.

Your commitment

You must:

- ensure that any intermediary you appoint to act for you is authorised and registered to use the CLASS web portal,
- give us your current Companies House registration number,
- ensure that your intermediary deals immediately with any data or information provided to them in connection with your Policy using the CLASS web portal,
- give us accurate and complete information and data at all times and tell us immediately, whenever this changes,
- pay us all of the premiums we ask for, when they are due, in UK currency,
- abide by the terms and conditions of the Policy,
- tell us when a member suffers incapacity in accordance with Section 5.1 of this guide and submit a claim form in respect of the benefit being claimed within 6 months of the end of the deferred period,
- submit any claims in line with the process described in Section 5 of this guide,
- comply with the Equality Act 2010 and consider, and where appropriate make, reasonable workplace adjustments in order to comply with that Act,
- facilitate and support a return to work plan for a member,
- pass on the appropriate benefits paid under the Policy to the member, and
- tell us when a member returns to work.

You must also tell us immediately, whenever:

- there is any change to the companies or groups of people included in the Policy, or
- there is any change to the structure or legal status of any of the employers, or
- you wish to change the cover or the way in which benefits are calculated, or
- you wish to include (or remove) any special cover, or
- there are changes to the work locations or business travel destinations of any members, or
- there are any changes in the nature of an employer's business which makes the occupations of the members more hazardous, or
- changes are made to an employer's pension scheme, to which the membership or levels of benefit insured under the Policy are linked, or
- a member's total benefit exceeds the free cover limit, or
- you want to include someone who is a discretionary entrant or a late entrant, or
- you want to include someone for a discretionary benefit, or
- you change or dismiss your intermediary, or
- you want to cancel cover completely.

Risk factors

- It is important that you fulfill your commitments under the Policy. A breach of certain commitments within the Policy will result in us rejecting your claims, stopping benefit payments for claims that we have previously accepted, or withdrawing cover.
- We will only continue your cover if you keep your premium payments up to date and give us the information and data we need.
- Any delay paying your premiums or giving us the information or data we need, may result in unexpected premium arrears or someone not being fully covered.
- In order for us to pay any insured benefits, or any additional amounts of insured benefits, we must be provided with a completed claim form, in respect of the benefit being claimed, not later than 6 months after the end of the deferred period.
- If a member receives other income or other benefits during incapacity, the member's total benefit payable under the Policy may be reduced.
- Exclusions may apply for certain activities (see Section 6 of this guide).
- In order for us to pay any insured benefit under the Policy you must comply with the Equality Act 2010. We may refuse to pay or continue to pay all or part of the benefit or benefits payable if you, or any other employer fails to comply with the Equality Act 2010, where appropriate (see Section 1.6 of this guide).
- We may alter the premium rates, Policy Conditions and Policy fee at the periodic review date or at any other time if a change that affects any of them, occurs.
- There may be changes to legislation, regulation, the state pension age, HMRC practice or tax rules affecting the Policy, the Policy benefits, premiums or ancillary services.
- In the event of a claim, where the cease age is linked to state pension age, the member's state pension age will be the one that applies at the beginning of the deferred period and will not change if state pension age subsequently changes.

How does the Policy work?

You contact your intermediary before you want cover to start, or change. Together with your intermediary you decide the basis of the eligibility conditions and the benefits you would like us to cover.

Your intermediary obtains a quotation for this cover using the CLASS web portal.

If you agree the quotation provided, your intermediary will arrange cover with us online.

If you want to make any changes to benefit categories or levels after the Policy has started you can, but you must agree any changes with us before they can take effect.

If you provide us with all the information we require and pay the premiums we ask for, we will provide cover on the basis we have agreed with you.

You must give us the information we need to assess and monitor the validity of claims.

If a member suffers incapacity and we can settle your claim, we will pay the claim benefit to you, monthly in arrears, from the end of the deferred period.

This product does not acquire a surrender value.

Your questions answered

Section 1.0

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

You will need to consider:

- what benefit promises you have made.
- the importance of group income protection benefits as a part of your overall benefits package.
- what salary basis you wish to use for benefit purposes, for example basic salary only, fixed at a specific date.
- whether you wish to limit the member's salary for benefit purposes, for example by applying a notional earnings cap. The maximum basic benefit for a member is limited to £350,000 pa (see Section 6 – Policy limits or restrictions of the Policy Conditions).
- whether you wish to insure supplementary benefits, for example pension scheme contributions.
- whether you want to give the same level of benefit to all members.
- any legislation relating to sex discrimination, age regulations or discrimination against part time, fixed term and disabled employees.

Our Group Income Protection eProduct offers you simplified options to enable the business to be processed online.

1.1 Who can be covered?

We can cover all employees or defined groups of employees.

We can cover up to 8 categories of membership. If there is more than one category, there must be at least 2 members in each category.

Only employees who are employed and resident in the UK can be covered, other than as shown in Section 7 of this guide.

Everyone who satisfies the agreed eligibility and actively at work requirements must be automatically included in the Policy.

These requirements will also apply to increases in the basis of cover for existing members. We can cover different categories of membership for different levels of benefit.

1.1.1 Eligibility requirements

The eligibility conditions will normally include:

- the minimum and maximum entry ages and any service qualifications,
- the age at which cover ceases. This can be 65, or 65 or state pension age, if higher, or 70. Where the cease age is linked to state pension age, see Section 1.2.1 of this guide, which shows what happens to the cease age if state pension age changes.
- the eligible categories, normally by occupation or job title that you want us to cover,
- when new entrants can be included in the Policy, and
- when members may have increases in their total benefits.

There must be at least 2 members when your Policy starts.

Inclusion in the Policy must be available to all individuals who meet the eligibility conditions and not solely at your invitation.

If either the eligibility conditions or the benefit categories depend on inclusion in a scheme for pension retirement benefits, you must tell us what the eligibility conditions are for those benefits. A minimum take-up rate of 80% is required.

If someone does not join the scheme when they are first eligible, we will have further requirements.

1.1.2 Actively at work requirements

There are no actively at work requirements for eligible employees who, after the commencement date, join the scheme for the normal agreed benefits basis when they first satisfy the agreed eligibility conditions.

However, there are other circumstances where we will apply our actively at work requirements.

If a person:

- is already a claimant under a previous group scheme with another insurer, and
- is receiving income protection benefit payments immediately prior to the commencement date of this Policy,

we will not include them in the Policy until those payments have stopped and they have completed our actively at work requirements.

What we need if our actively at work requirement is not met

If someone does not meet our actively at work requirements, we will not provide cover (or any increase in benefit) until they have returned to work.

There is an extra requirement where there are under 20 members to be included in the Policy at the relevant date. Any member who has been absent from work on account of ill health or incapacity for more than 5 consecutive working days during the 6 months before that date, will not be included in the Policy (or be covered for any increase in benefit) until they have returned to work and have continuously been actively at work for at least 2 months.

Benefits are to be insured for the first time, including when benefits have been previously self-insured

Our actively at work requirement will be applied to all employees who are to be insured on the commencement date.

Benefits are already insured but you wish to switch the cover to Canada Life

Our actively at work requirement will be applied to all employees who are to be insured on the commencement date.

Changes to the eligibility conditions or increases in benefits on the date the cover switches to Canada Life

In addition to any requirement detailed above, our actively at work requirement will also be applied to all members who are affected by, or whose benefits increase as a result of, the switch on the commencement date.

Changes to the eligibility conditions or increases in benefits after the commencement date

Our actively at work requirement will be applied to all members who are affected by the change, or whose benefits increase, on the date we agree to make the changes to the Policy.

Inclusion of a new group of people including a company or organisation (including new categories, new companies or transfers to new contracts of employment)

Our actively at work requirement will be applied to all members who are included as a result of the new group being added on the date we agree to make the changes to the Policy.

Note:

Please note that there will be circumstances where we will require other forms of evidence of insurability (including underwriting requirements) in order to provide cover. These are as follows:

- benefits that have not been accepted by a previous insurer, or
- total benefits that are above the free cover limit, or
- benefits that were subject to special terms or were declined by a previous insurer, or
- changes to the eligibility conditions or increases in benefits which affect less than 2 members.

1.2 When will cover cease?

1.2.1 Under normal circumstances

Cover will cease for a member on whichever of the following events is first to occur:

- on reaching the cease age agreed with us, or
- on ceasing to satisfy the agreed eligibility conditions for inclusion in the Policy, or
- on ceasing to be actively employed by the employer for any reason other than during a period of temporary leave of absence, or
- on reaching the end of the period allowed under the Policy for a temporary leave of absence and having not returned to active employment, or
- on reaching the end of their employment contract, or
- on ceasing to work in the UK, Channel Islands or Isle of Man, other than as shown in Section 7 of this guide, or
- on reaching the end of the limited period chosen, if the member has been incapacitated throughout the whole of that limited period.

Where the cease age is linked to state pension age and the state pension age changes, the cease age will be based on the member's new state pension age.

However, in the event of a claim, the member's state pension age will be the one that applies at the beginning of the deferred period and will not change if state pension age subsequently changes.

Cover may continue for a member during a period of temporary leave of absence from work.

If you continue to pay premiums, we will continue to cover a member:

- during any period of illness, disablement or statutory leave, or
- for up to 1 year if absent for any other reason, provided the member has a right at the end of the agreed temporary leave of absence to return to the occupation for which they were employed or engaged immediately before the leave of temporary absence commenced.

Any benefit increases during a period of temporary leave of absence will be restricted as shown in Section 1 of our Policy Conditions – Who is covered.

1.2.2 Cancelling the cover

1.2.2.1 When you can cancel the cover

If you want to cancel the Policy you must ask your intermediary to tell us using the termination facility within eAdmin in CLASS. The Policy will continue until we receive your instructions.

We will not backdate cancellation of cover and will charge for the time we have been providing cover.

1.2.2.2 When we can cancel the cover

We reserve the right to cancel cover if:

- you do not pay the premiums requested within 30 days of the date they were due, or
- new leigislation or regulations are introduced, or changes are made to existing legislation which affect income protection policies or the Policy.

1.3 What types of cover are available?

You can decide the type and level of basic benefit and the salary basis you would like us to cover. You can also decide what State benefit deduction (if any) you want us to use. As well as basic benefit, you can also insure your liability for supplementary benefits.

1.3.1 Basic benefit

Maximum benefit

The maximum benefit available is 75% of the member's salary.

Fixed deduction for State benefits

In this case the basic benefit is up to a maximum of 75% of a member's salary less a State benefits deduction.

We will apply the deduction whether or not the member receives State benefits. We will use the annual equivalent amount of the State benefits and these will normally be fixed at the start of the member's incapacity.

You can choose the deduction you want us to use for each category from the following alternatives:

- the gross ESA exclusive of any work related activity component, support component and any extra premium (the 'basic ESA'),
- the basic ESA plus the work related activity component.

The basic ESA, work related activity and support components will be based on the amounts that would be due for a successful applicant at the end of the assessment phase. The assessment phase is usually the 13 week period starting when someone would normally be entitled to an employment and support allowance.

1.3.1.1 What happens if the amount of State benefit a member is receiving changes?

The amount of claim benefit payable will not change if the amount of State benefits the member receives changes following our final claim benefit calculation.

1.3.2 How salary is defined

So that we both know what is covered, we need to agree how to define salary. You must also agree with us when salary changes become effective, and therefore alter a member's benefit. Some examples of acceptable salary bases are:

- basic salary only,
- basic salary plus agreed other variable earnings from the employer (for example, overtime, bonus, commission or directors' fees) averaged over a given 3 year period,
- P60 earnings in the preceding tax year, or
- pre salary sacrifice.

Where

- salary includes other variable earnings in addition to basic salary, and
- the member's basic salary is less than 75% of the amount of total earnings advised to us,

we will restrict the amount of salary used to calculate the member's benefit to their basic salary plus the average of those other variable earnings over the previous 3 years.

Salary cannot include dividends from the employer.

If a salary sacrifice arrangement is being operated which will reduce a member's contractual basic salary and you want to base the benefits on the pre-sacrificed salary level, you must agree the basis with us.

You must give us data that is consistent with the salary basis you have agreed with us. We will use the agreed salary basis to determine the amount payable for any claims you make, not the data provided.

1.3.3 Is there any limitation to these benefits?

We will restrict the basic benefit, where necessary, so that it does not exceed £350,000 per annum.

We will also restrict the basic benefit payable for a member, where necessary, so that the aggregate total of that benefit and:

- any other amounts due to the member from other schemes or policies, or
- any other continued earnings from any employment or any other income

will not exceed 75% of that member's earnings.

We will not apply this restriction to the aggregate total of benefit for a member who is taking part in a return to work plan agreed with us (see Section 5.3 of this guide).

When we calculate the aggregate total we will exclude any supplementary benefits (see Section 1.3.4 of this guide).

We will normally ignore other benefits (but not salary or other payments from an employer) if the benefit payment period under the policy, arrangement or waiver agreement that the income arises from, is less than 2 years. But these other benefits will not be ignored if:

- the period is limited only because the member is less than 2 years from their state pension age, or
- the total of other income, other benefits and the scheme benefit would exceed the member's earnings before their incapacity starts.

Example showing the impact of other income on benefit calculations

- **Basic Salary**
  £30,000 per annum
- **Basic Benefit**
  75% of Basic Salary with no state benefits deduction £30,000 x 75% = £22,500 pa
  Total earned income (including overtime and bonus) in previous 12 months £38,000 pa
- **Other Income**
  Accident and Sickness Benefit £5,500 pa plus Waiver of Premium Benefit £1,500 pa (£5,500 + £1,500 = £7,000)
  Maximum permitted income in accordance with limitation £38,000 x 75% = £28,500 pa Less £7,000
- **Total Income Protection Benefit Payable**
  £21,500 pa

1.3.4 Optional additional protection

For additional cost, we can provide the following benefits to complement the basic benefits.

1.3.4.1 Pension scheme contributions

We can provide cover for contributions payable by the member and/or you to your pension scheme. We will normally cover a contribution rate that is a percentage of the member's salary.

This is limited to a maximum member's pension contribution rate of 7.5% of their salary each year. The maximum combined total of your and the member's pension scheme contributions that we will cover must not be more than 35% of the member's salary or, if less, £75,000 each year.

We will not cover contribution rates that vary at the member's discretion, for example contributions to individual personal pension arrangements or additional voluntary contribution arrangements.

If contribution rates vary by age, we will base the amount of pension scheme contribution on the contribution rate applicable at the beginning of the deferred period in the event of a claim, subject to a maximum of the rate agreed by us.

However, if the contributions to an appropriate pension scheme reduce or cease, cover for the contributions will also cease or reduce.

If a member chooses to make a pension scheme contribution through a salary sacrifice arrangement, and the insured benefit is based on their scheme salary before the sacrifice took place, the member's pension scheme contributions cannot be insured as an optional additional benefit.

1.3.4.2 Employer's National Insurance contributions

We can provide cover for an employer's liability to pay National Insurance contributions on the member's basic benefit. Contribution rates of employer's National Insurance contributions will be fixed at the date the deferred period ends, even if they subsequently change.

However, if your liability for these National Insurance contributions ceases, this supplementary benefit will not be payable or will cease if a claim benefit is in payment.

1.4 How is incapacity defined?

You can choose from all of the following incapacity definitions for total benefits.

In addition, please refer to the notes at the end of these definitions.

- The **'Standard'** definition.
  We will treat a member as suffering incapacity if, throughout the deferred period and beyond, the member's illness or injury prevents them from, and makes them incapable of, performing the material and substantial duties of their normal occupation.
- The **'Suited Occupation'** definition.
  We will treat a member as suffering incapacity if, throughout the deferred period and beyond, the member's illness or injury prevents them from, and makes them incapable of:
  - performing the material and substantial duties of their normal occupation, and
  - any other occupation for which they are reasonably suited due to their education, training or experience.
- The **'Standard switching to Suited Occupation after 2 years'** definition.
  We will treat a member as suffering incapacity if, throughout the deferred period and beyond, the member's illness or injury prevents them from, and makes them incapable of, performing the material and substantial duties of their normal occupation.

  Once the member has suffered incapacity for a period of 2 years from the end of the deferred period (whether continuous or not), this definition changes. Thereafter, we will only continue to treat a member as suffering incapacity if their illness or injury also prevents them from, and makes them incapable of, performing any other occupation for which they are reasonably suited because of their education, training or experience.

Example (for illustrative purposes only)
A Sales Representative whose normal job duties involve the need to drive extensively throughout the UK and who has a musculoskeletal condition (confirmed by objective clinical findings) that prevents prolonged sitting and driving could be regarded as valid on an 'own occupation' basis.

At the 2 year point, the definition would be extended to the 'suited occupation' definition. The assessment will then investigate what else this member could reasonably do as a result of training, education or experience.

With evidence indicating the member has a considerable history of working in the sales industry, including telesales, the member could be regarded as capable of performing a similar sales role that did not require any need to travel. Assuming this member can get around freely in an office or home environment, the 'suited occupation' definition would not be satisfied.

Notes:

- If a member takes up any gainful occupation, we reserve the right to adjust the amount of, or stop, claim benefit payments. If you are aware that this is the case you should advise us immediately.
- We will apply the 'suited occupation' definition of incapacity where a member has to hold a licence or certificate that is dependent on them being certified as medically, physically or mentally fit to be able to perform their normal occupation. Examples of these occupations include LGV drivers, PSV drivers and Aircraft Pilots.
- We will also apply the 'suited occupation' definition for some special occupations. Examples of these special occupations include, but are not limited to, Merchant Navy personnel, aircrew and dealers. (For this purpose, a dealer is someone whose main role is to place orders to buy or sell securities, options or futures, or instruments creating or acknowledging indebtedness or contracts of difference.)
- You cannot change the definition of incapacity that applies to a member's benefits if their deferred period has already started.
- In certain instances though, we can pay a reduced amount of benefit when a member is working in a reduced capacity. This is known as proportionate benefit. It is directly related to the reduction in salary that the member suffers as a result of working fewer hours or undertaking lower paid duties.
- We will not pay proportionate benefit if the 'suited occupation' definition applies, or continue to pay any proportionate benefit previously being paid under the 'standard' definition, when a switch to 'suited occupation' occurs.

1.5 When will claim benefit payments start?

We will pay the claim benefits for members who are suffering incapacity by monthly instalments in arrears, starting one month after the end of a member's deferred period. However, any salary increase that occurs during the course of a member's deferred period, will not be covered.

You can choose either 13, 26, 28 or 52 weeks for the deferred period where no deduction, or a fixed deduction for State benefits, applies to the basic benefit. We will show the deferred period you have requested for each category in your quotation.

Note:
You can add together separate periods of incapacity, suffered by a member to decide when the deferred period is complete, if:

- the periods are all due to the same cause, and
- if the total period of time since the beginning of the period of incapacity is no more than twice the length of the deferred period.

You cannot add together separate periods of incapacity which occur prior to the commencement date of the Policy. Also, you cannot change the deferred period for a member who is already suffering incapacity.

1.6 For how long will claim benefits be paid?

We will pay claim benefits for members suffering incapacity until they reach the cease age you have agreed with us (for example their state pension age) unless they return to work.

In the event of a claim, where the cease age is linked to state pension age, the member's state pension age will be the one that applies at the beginning of the deferred period and will not change if state pension age subsequently changes.

You can choose a limited period which allows payment for a specific period of 2, 3 or 5 years. But if you choose the 'standard switching to suited occupation' definition of incapacity (see Section 1.4 of this guide), the only limited period available is 5 years.

If you choose a limited period, we will stop paying claim benefits for a member suffering from incapacity at the end of the limited period.

Choosing a limited period reduces the cost of the insurance.

We will pay the claim benefit until the member either:

- stops suffering incapacity, or
- no longer suffers loss of earnings, or
- leaves the service of an employer, or dies, or
- reaches the cease age you have agreed with us, or
- reaches the end of their contract of employment, or
- the member reaches the end of the limited period chosen, or
- remains outside any of the scheduled territories for more than 6 months, or
- ceases to satisfy the eligibility conditions agreed with us.

If the claim benefit payments for a member include an amount for:

- pension scheme contributions, that part of the payments will stop being paid or will reduce if the employer's pension arrangements for that member end or the contribution rate to that arrangement reduces,
- National Insurance contributions, that part of the payments will stop being paid or will reduce if National Insurance contributions for that member are no longer payable or reduce.

We will also stop making monthly claim benefit payments if:

- the member is dismissed from the service of their employer,
- the member does not follow medical advice,
- you do not facilitate, or the member does not agree to participate in, a reasonable and medically endorsed return to work plan,
- the member does not co-operate fully during a reasonable and medically endorsed return to work plan,
- we do not get the evidence of the member's continuing incapacity or reduced earnings that we have asked for.

If a member takes up any gainful occupation we reserve the right to adjust the amount of, or stop, claim benefit payments.

You must comply with the Equality Act 2010. If you fail to comply with that Act without being able to say:

- that the failure is justified, and/or
- the member unreasonably fails to co-operate with those adjustments,

we will:

- reserve the right to refuse to pay part or all of the claim benefit, or
- refuse to continue to pay part or all of the claim benefit

when such unjustified failure or lack of co-operation prevents that member from working.

1.7 Can claim benefits increase during payment?

You can choose to have the benefits increasing annually during payment. You should agree with us the annual rate of increase in the benefits you want, from the following standard options:

- 0%,
- 3%,
- 5%, or
- RPI up to either 2.5% or 5%.

Increases will be on the anniversary of the date on which the first monthly claim benefit payment was due.

1.8 Will members need to provide evidence of insurability every year?

If we are able to accept a member's total benefit, terms will be issued specifying when further evidence of insurability will be required for any increase.

Section 2.0

2.0 Setting up the Policy

2.1 Requirements to set up the Policy

Before the quotation expires (usually 1 month) your intermediary must instruct us to assume risk by completing the CLASS online process.

If the basis of risk differs from the quotation, your intermediary will need to obtain a new quotation.

You can accept the quotation up to 30 days before the commencement date. Cover cannot start on the same day that you accept the quotation. Cover will start at 00.01 on the selected commencement date. Cover cannot be backdated.

We will require full details of the basis, including eligibility conditions, benefit structure, employers included and any specific requirements set out by us in the quotation, before we can provide cover.

In order to complete the CLASS process, whereby we assume risk, your intermediary will need:

- the employer's company name, address and Companies House registration number,
- full details of the eligibility conditions and benefit structure.

Once the Policy starts, and in order for cover to continue, you must also provide the following within 30 days of the date that your cover starts:

- a fully completed proposal form,
- a deposit premium or a completed Direct Debit mandate,
- completed 'actively at work' and/ or 'continuation of cover' declarations as appropriate, and
- any specific requirements set out in the letter confirming risk.

Failure to provide these items within 30 days means your cover will cease. We will treat the Policy as never having been on risk and any premiums paid will be refunded.

2.2 Evidence of insurability to be provided before members are covered

If you include members in the Policy as soon as they satisfy the agreed eligibility conditions and on the agreed benefit basis for that category of member, we can usually allow a free cover limit. The amount is shown on your quotation and may change at any annual revision date

If a member is included in more than one Group Income Protection Policy insured by our Group Insurance department, the member's total benefit will be used to assess whether the free cover limit is exceeded.

Benefits in excess of the free cover limit, discretionary benefits and benefits for discretionary entrants will normally require evidence of insurability.

We may impose additional premiums, special terms, postpone or decline cover as a result of evidence of insurability to reflect a member's medical condition, hazardous occupation, or any hazardous pursuits undertaken (see Section 3.2 of this guide).

You must tell us immediately if you require cover for anyone in the above situations so that we can tell you what evidence of insurability we will need before we can provide you with cover.

If a member's total benefit above the free cover limit has been declined, the member will not be entitled to any future increase in the free cover limit.

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

If evidence of insurability is needed by us before we can accept a member's total benefit, we will provide temporary cover for their total benefit.

This will apply for up to 120 days from the date:

- the person is first included in the Policy, or
- when an increase in a member's total benefit applies, or
- when we are notified of any discretionary entrant or late entrant, or
- when we are notified of any discretionary benefits

and will cease when we tell you what our decision is, if earlier.

However, temporary cover will not apply:

- if that person has previously had some or all of their total benefit declined or postponed, or
- if any additional premiums chargeable following the issue of our decision letter have not been accepted, or
- if a decision letter has not been issued where evidence of insurability or other requirements have been previously requested, or
- if a person suffers from an incapacity before a decision is made and their incapacity was due to a medical condition suffered from the 5 years prior to the date temporary cover commenced.

Section 3.0

3.0 What premiums will be charged for the cover?

The premiums we calculate depend on various factors including the:

- level of basic benefits and supplementary benefits (if any),
- eligibility and entry conditions,
- cease age,
- deferred period,
- chosen definition of incapacity,
- maximum payment period,
- rate at which the claim benefit increases in payment,
- company profile such as age, gender, occupation, and locations of the workforce,
- claims history,
- amount of the policy fee.

There is a minimum annual premium of £480.

3.1 How will premiums be calculated?

For policies with up to and including 9 members, we will use our single premium basis. Where there are 10 or more members, we will use our unit rate basis.

Full details of our standard terms that apply to each premium basis are set out in our Policy Conditions, see Section 7 – Premiums, and the circumstances when we may alter the rates to apply are set out in Section 8 – Alterations to the Policy cover.

3.2 Will there be any unexpected extra premiums?

If the information we need to calculate the premium is delayed or inaccurate, your premiums could change.

The premium rates, Policy Conditions and policy fee may change at the periodic review date. They may also change at any time that you make any changes that affect the factors we have used to calculate your premiums, as shown in our Policy Conditions, see Section 8 – Alterations to the Policy cover.

We may charge additional premiums for members' insured benefits that have special terms applied following the issue of our decision letter. Any additional premiums will only be charged for the amount of insured benefit to which those special terms apply and will reflect a member's medical condition, hazardous occupation or participation in any hazardous pursuits.

3.3 What commission is included within the premium?

The rate of commission payable to financial advisers is shown in the quotation. The premium shown includes the level of commission payable.

3.4 Is there a discount for good claims experience?

A poor claims experience may affect the availability of this eProduct.

Section 4.0

4.0 How does the Policy accounting work?

The Policy operates on one year accounting periods. You will normally pay your premiums annually in advance. If you choose to pay monthly by Direct Debit premiums increase by 2%.

While we are awaiting complete accurate information we will charge a deposit premium. A statement of account showing the accurate premiums due will be provided once the information has been received. The account will show any arrears which are due from you, or we will make a refund to you, if you have paid too much.

4.1 What information is required for accounting purposes?

We will normally advise you before each annual revision date what information we require. Full details of the information we need to calculate your premiums are set out in the Policy Conditions, see Section 7 – Premiums.

4.2 How are the accounts adjusted for members who join, leave or have benefit changes during the year?

Single premium schemes

At each annual revision date, we will calculate a premium adjustment for the amount and duration of the cover actually provided since the commencement date (or the last annual revision date if later).

Unit rated schemes

At each annual revision date, we will calculate a premium adjustment to allow for any increases or decreases in insured benefits or changes in membership since the commencement date, or last annual revision date if later.

We will assume that all changes occur half way through the policy year.

If there has been any change during the policy year to the following:

- basis of cover,
- eligibility,
- employers or groups of people included,
- legislation, or
- unit rate

we will calculate adjustments for the periods before and after that change took effect.

4.3 If the Policy is discontinued mid-year will premiums paid in advance be lost?

A final statement of account will be produced based on the cover actually provided and premiums paid up to the date when cover ceased. We will either send you a refund or request the balance of premiums you owe us.

Section 5.0

5.0 Claiming benefit

Our claims guides help you through the process and answer some of the questions we are frequently asked.

You can download our claims guides and claims forms from our website www.canadalife.co.uk/group or request them from the CLASS User Support Team, using the contact details given at the beginning of this guide, on page 3.

You and the member must provide all information and carry out all actions that are reasonably required by us:

- in order to assess a claim,
- in connection with the payment of claim benefits, and
- in connection with return to work plans.

5.1 When can claims be made?

If it appears that the member's illness or injury will extend beyond the deferred period and a claim is to be made we require a current claim form, fully completed by an official of the policyholder, and the member.

When a member has been suffering incapacity for:

- four weeks, if the deferred period is 13 weeks; or
- 10 weeks, for any longer deferred period.

We must receive a completed claim form not later than 6 months after the end of the deferred period.

We do not need to see a copy of the member's medical certificates as we do not accept these as proof of incapacity.

You should send completed forms and documentation to:

Claims Management Services
Canada Life Limited
Group Insurance
Temple Quay
Bristol BS1 6ER

Fax: **01707 671100**
E-mail: **ipclaims@canadalife.co.uk**

5.1.1 What happens if a member has had repeated absences as a result of the same incapacity?

If a member is absent from work for short periods of time, with the same incapacity, these may be added together to calculate the deferred period. These absences must occur within a period that is no more than twice the length of the deferred period. For example: if your deferred period is 26 weeks and there have been several periods of absence which total 26 weeks, within a maximum of 52 weeks, these may be added together to produce the deferred period.

5.1.2 What will happen next?

When we have received all of the initial forms and information, we aim to tell you within 5 working days what further information we need to determine whether your claim is eligible to be assessed.

If we cannot consider your claim, we will tell you why not.

The members section of the claim form includes a consent that provides us with the authority to obtain further information from any relevant medical professional that has attended the member, as required under the Access to Medical Reports Act.

If the claim is eligible to be assessed, we will ask the relevant medical professional for details of the member's medical history and the treatment being given for the incapacity.

We may also:

- contact you, or the member by telephone to obtain a fuller picture of their circumstances, and/or
- ask a specialist to conduct an independent medical examination, and/or
- ask one of our rehabilitation consultants (see below) to contact you or the member to discuss the claim by telephone or via a claims visit, and/or
- arrange for other investigations to be done, and/or
- ask for any employment records necessary, including recruitment records, job descriptions and/or evidence of earnings relating to the member, and/or
- ask for information about other income and/or other benefits.

Our rehabilitation consultants are experienced healthcare professionals who deal with all aspects of Income Protection. They will usually contact the member to arrange a visit and will carry proof of identity.

Whilst visits are arranged to help us assess your claim, the rehabilitation consultant is also trained to help you and the member by answering questions about Income Protection, State benefits and return to work plans.

5.1.3 How is a claim assessed?

We will make an objective assessment of the nature of a member's incapacity including the severity of any medical condition, how long it has existed and what affect it has on the member.

We will then seek to determine whether or not they would be able to undertake the tasks involved to satisfy the definition of incapacity, taking into account any adaptations which would assist them to work.

We will need evidence that the member is continuing to receive medical advice when appropriate and that treatment options have been investigated and explained to them.

We will also consider any medical reports or additional information that you or the member give us.

We will arrange periodic medical reviews to confirm that the member's illness or injury continues to meet the definition of incapacity you have agreed with us. The frequency of these medical reviews will depend on the member's medical condition.

5.1.4 Who pays for the medical evidence?

Canada Life will pay for any medical evidence obtained in the UK that we require. However, a cancellation fee may be incurred if the member does not attend an agreed medical examination.

5.1.5 How will the benefit be paid?

The claim benefits payable under the Policy will be paid by us to you in UK currency.

Any claim benefit will normally be paid by monthly instalments in arrears, benefit payments starting one month after the end of a member's deferred period.

Claim benefits will not be payable for the period from the date of incapacity to the end of the deferred period.

5.1.6 What happens if a member's incapacity occurs outside the UK, Channel Islands or the Isle of Man?

Where medical evidence in support of a claim is obtained outside the UK, Channel Islands or the Isle of Man, any evidence must be provided in English.

If we agree to contribute an amount towards the cost, this will be equivalent to obtaining similar evidence in the UK unless otherwise agreed.

For members who are suffering incapacity and who stay outside the scheduled territories, we only pay claim benefit for a maximum of six months, unless we agree that it is not medically advisable for them to return to a scheduled territory. We will only make further payments once a member has returned to a scheduled territory and provides fresh medical evidence. If a member who has returned to a scheduled territory subsequently leaves the scheduled territories during a period of incapacity, claim benefit payments will stop immediately.

5.2 For how long will the claim benefit be paid?

We will continue to pay the claim benefit as set out in Section 1.6 of this guide.

5.3 Can benefit payments restart if a member's incapacity recurs?

5.3.1 Linked claims:

Where incapacity is due to the same cause and lasts for 30 consecutive days or more, we will treat the claim as a 'linked claim' and if that incapacity recurs less than one year after the member's claim benefit payments stopped, we will not apply a further deferred period.

We will pay the claim benefit at the level that would have applied if the member had not returned to work.

Where a limited period has been chosen, we will aggregate that period so that the length of the limited period will not exceed the total length of the limited period applied to the original claim. The end date will be adjusted to take into account any period during which the member was not incapacitated.

5.3.2 Making another claim for a member for a further incapacity due to the same cause

Where incapacity is due to the same cause but recurs more than one year after the member's claim benefit payments stopped, the member must complete a new deferred period before any claim benefit can be paid under the Policy. This will not be treated as a linked claim.

Any benefit payable for a claim for a further incapacity due to the same cause, which is not being treated as a linked claim, can be paid for the whole of the chosen limited period. This does not apply where the member has been incapacitated throughout the whole of the limited period chosen.

Where the member has been incapacitated for the whole of the chosen limited period, no further claim benefit will become payable should that member return to work and again suffer a period of incapacity.

5.3.3 Can another claim be made for a member for a different cause of incapacity?

A claim can be made for a member who suffers a different incapacity after the claim benefit payments for a previous incapacity suffered by that member have stopped, providing that:

- the member has been actively at work in the intervening period, and
- the different incapacity is not being treated as a linked claim, and
- the member has not already been incapacitated throughout the whole of any limited period.

The member must complete a new deferred period before any claim benefit can be paid under the Policy.

Where a limited period has been chosen, we will treat a further claim for an individual member as a new claim. Any benefits payable under this new claim can be paid for the whole of the chosen limited period.

Simultaneous claims for different incapacities suffered by the same member cannot be made.

Examples showing the treatment of deferred period and maximum payment period for a further or different period of incapacity where a limited period applies.

These examples are based on a Policy with a deferred period of 26 weeks and limited period of 3 years.

First payment period	Return to work period	Nature of incapacity	New deferred period	Maximum payment period for further or different incapacity
1 year	6 months	Same cause	Nil	2 years
1 year	6 months	Different cause	26 weeks	3 years
1 year	2 years	Same cause	26 weeks	3 years
1 year	2 years	Different cause	26 weeks	3 years
3 years	No further income benefit is payable			

5.4 What happens if a member suffering incapacity leaves the service of an employer during a claim period?

We have no further liability to pay the claim benefits when:

- a member leaves an employer's service, or
- your business stops trading, is liquidated or sold.

If we are asked in advance of the member leaving the employer's service we may, at our discretion, agree to continue the claim and pay claim benefit (other than supplementary benefits) directly to the member while they are still suffering incapacity, but not where the member leaves service at the end of a fixed term contract of employment.

If we agree to continue the claim benefits and the member agrees, we will pay the claim benefits under a continuation of benefit arrangement, providing that:

- any supplementary benefits, even if insured, will stop being paid, and
- we will change the definition of incapacity to the 'suited occupation' definition (if this is not already the definition which applies to the member), and
- we will not agree to continue payments to members who are not resident in or take up residence outside the UK, Channel Islands or the Isle of Man.

Any such claim benefits will stop at the same time that they would have stopped under the Group Income Protection policy.

5.5 What happens if an incapacitated member's contract of employment is transferred to a different employer under a TUPE arrangement?

When an incapacitated member (including an incapacitated member within a deferred period) transfers to a different employer under TUPE regulations, we will continue to pay any claim benefit to the new employer, treating that claim as if there had been no break in employment provided that:

- the new employer takes responsibility for the member's potential return to work plan as if it were the policyholder, and
- the new employer complies with the Equality Act 2010, and
- a transfer deed is completed by you, us and the new employer.

5.6 Does other income affect the member's benefit from this insurance?

Any other income that the member receives is likely to affect the amount of claim benefit we will pay. The cover is designed to provide an income which is lower than they would receive if working, so that a member will have an incentive to return to work. For example, if a member continues to receive their full salary during a period of incapacity, we will not pay any benefit during that period.

We will offset other income and other benefits against the member's claim benefits if the member's total income will exceed the maximum permitted basic benefit for the type of cover (see Section 1.3 of this guide). We will adjust untaxed income (for example the benefits from an individual income protection policy) so that it compares to taxed income.

We will normally ignore other benefits other than in the circumstances outlined in Section 1.3.3 of this guide.

Payments from the Group Income Protection Policy may affect a member's entitlement to means tested State benefits. However, claims paid through your payroll system will not be offset against the ESA.

5.7 Can the member's claim benefit increase in payment?

We will increase the member's claim benefit annually, on the anniversary of the date on which the first monthly payment was due, by the escalation rate, if any, that you have agreed with us. The rate will be shown in your quotation.

5.8 Can a proportionate claim benefit be paid?

Where the 'standard' definition of incapacity applies and if a member's illness or injury means that they can work on a part-time basis or in a reduced capacity, we will pay a claim benefit that is in proportion to the reduction in a member's earnings that occurs as a result of the reduced capacity, with an allowance for inflation. The reduction in a member's earnings must result solely from illness or injury.

This will not apply for any period where a 'suited occupation' definition of incapacity is applicable.

5.9 Return to work plans

Return to work plans can help minimise the costs of incapacity and maximise the value that incapacitated people bring to an organisation.

When an absent member is deemed able to return to work in some capacity, our rehabilitation consultants draw up a reasonable return to work plan, which is agreed by all parties before being implemented. This may include, if appropriate, agreeing the return to work plan with the member's General Practitioner, attending physician, consultant or other suitably qualified person who is treating their illness or injury. Thereafter it is regularly reviewed.

If a member participates in a return to work plan, we will maintain that member's claim benefit under the Policy unless they are also receiving:

- benefit from any other schemes or polices and/or
- payments from an employer,

which, together with the claim benefit we provide, exceeds the member's earnings applicable to the member immediately before the start of their incapacity.

Return to work plans are for a maximum of 12 months and are reviewed regularly. Members must participate and co-operate with them, to the best of their ability. Similarly, employers must facilitate and support a plan that is agreed for an incapacitated member.

You must comply with The Equality Act 2010 which requires employers to make adjustments to an employee's working conditions where it is reasonable to do so. Working conditions, physical features and other arrangements can often be adjusted so that an incapacitated person can continue to work.

If you, or any other employer fails to comply with that Act without being able to say that the failure is justified, and/or the member unreasonably fails to co-operate with those adjustments, we will:

- reserve the right to refuse to pay part or all of the claim benefit, or
- refuse to continue to pay part or all of the claim benefit

when such unjustified failure or lack of co-operation prevents that member from working.

5.10 What happens to claims if the Policy is discontinued?

If the Policy is discontinued, provided all of the premiums we have asked for have been paid, we will:

- pay the claims that we accepted before the date cover ended, while each claim remains valid and
- consider claims where incapacity started before the date cover ended, but that we had not accepted before that date. For example when the deferred period ends after that date.

If you arrange cover without any break, with another insurer and for the same benefit and eligibility bases that were insured by us immediately before the date cover under the Policy ended, we will apply the following to linked claims:

- If the member satisfies the new insurer's actively at work requirements, we will pay the claim benefit for a linked claim during a period of incapacity, but payments will stop no later than the end of the deferred period under the new insurer's policy. The new insurer will be responsible for the claim and any payment of benefits from the end of the deferred period.
- If the member does not satisfy the new insurer's actively at work requirements, we will pay the claim benefit and continue to be responsible for the claim until such time as the claim ceases under the terms of the Policy or the member is included in the new insurer's policy, if earlier.

Section 6.0

6.0 What is not covered?

We will not cover any incapacity that is directly or indirectly due a member engaging in the activities of any organisation formed for military or terrorist purposes, (but not including the Armed Forces of the Crown or an organisation concerned with National Service work).

Section 7.0

7.0 Can cover be provided for someone who is outside the UK, Channel Islands or the Isle of Man?

Cover will be maintained for members whilst they are outside the UK, Channel Islands or the Isle of Man on holiday or travelling in connection with their business, other than on secondment.

We may agree to cover members who are working outside the UK on secondment to a country within the scheduled territories subject to further information.

For members working outside the UK, premiums must be paid in UK currency, and all claim benefits will be paid in UK currency. The salary for a member not paid in UK currency will be converted to UK currency based on the exchange rate at the previous annual revision date.

If we require medical evidence for evidence of insurability or in support of a claim and it is obtained outside the UK, then any medical evidence must be provided in English.

If we agree to contribute an amount towards the cost, this will be equivalent to the cost of obtaining similar evidence in the UK, unless otherwise agreed.

Section 8.0

8.0 Taxation of schemes

According to our understanding of legislation and HMRC practice on 1st September 2014, the following applies in respect of group income protection.

- Premiums paid by you are usually treated as a business expense. However, tax relief on premiums paid by you in respect of any employees who have a proprietorial interest in the company will not normally be available. HMRC may agree to allow such relief if similar benefits are provided for a substantial number of other employees. Clarification of the tax position in such cases should be sought from your local Inspector of Taxes.
- Premiums paid by you are not treated as a P11D benefit for employees.
- Policy benefits received by you should be treated as a business receipt, and when passed on to the member as salary, the payment should be treated as a business expense resulting in a neutral tax situation.
- Benefits paid to the member as salary are subject to income tax.

Section 9.0

9.0 Further information

9.1.1 The Company

This Group Insurance is issued by Canada Life Limited, an incorporated company limited by shares, whose head office is in the United Kingdom. Its address is:

Canada Life Limited
Canada Life Place
Potters Bar
Hertfordshire EN6 5BA

9.1.2 What we do

Canada Life Limited is a company carrying out insurance business (also referred to as an insurance undertaking). We do not provide advice on whether the product meets your particular requirements.

9.1.3 Remuneration

Canada Life may pay some of our staff bonus payments which are linked to the number and/or value of the policies which we sell.

9.1.4 Financial strength

If you want to find out about our financial strength, including our solvency margin, you can view our Solvency and Financial Condition Report (SFCR) at www.canadalife.co.uk/adviser/about-us/solvency-2

9.2 Queries and complaints

For further information, or if you wish to complain about any aspect of the service you have received, please contact:

Customer Services
Canada Life
Group Insurance
3 Rivergate
Temple Quay
Bristol BS1 6ER

You can also e-mail:
groupcsc@canadalife.co.uk
or ring **0345 223 8000**.
Lines are open Monday to Friday, 9am to 5pm (Thursday, 9.30am to 5pm).

Complaints which we cannot settle can be referred to the Financial Ombudsman Service:

Financial Ombudsman Service
Exchange Tower
London E14 9SR

Telephone: **0800 0234 567 or, for mobile phone users: 0300 123 9123**
E-mail:
complaint.info@financial-ombudsman.org.uk
Website: **www.financial-ombudsman.org.uk**

Making a complaint will not prejudice your right to take legal proceedings.

9.3 Compensation

If we are unable to meet our liabilities, you may be able to claim compensation from the Financial Services Compensation Scheme. Further information is available from the Financial Conduct Authority and the Financial Services Compensation Scheme.

9.4 Law

The construction, validity and performance of the Policy will be governed by English law. If there is any dispute between the parties about anything to do with the Policy, the English Courts are the only courts which may make a judgement about the dispute.

Any person or company who is not a party to this Policy does not and shall not have or acquire any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Policy. But after a claim has been made by the Policyholder for a member, that member can pursue that claim as if they were the Policyholder.

Our forms are available to download from our website: www.canadalife.co.uk/group
Canada Life Limited, 3 Rivergate, Temple Quay, Bristol BS1 6ER. Telephone 0345 223 8000

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Canada Life
Group Insurance