TECHNICAL GUIDE

Pay Direct
Group Income Protection

Because everyone
needs a back-up plan

unum

This guide explains the main features of our Pay Direct Group Income Protection (PDGIP) product. Please note that PDGIP is only available through authorised intermediaries.

PDGIP:

- provides a replacement income in respect of employees unable to work because of long-term illness or injury
- allows you to choose what proportion of an employee's earnings to insure, how soon it is paid and for how long
- gives you the option to continue the income protection benefit after an incapacitated member is no longer an employee, with payments made direct to that member
- gives you the option to cover your associated expenses
- helps replace lost income if an employee has to take a part-time or lower-paid job because of long-term illness or injury
- the policy does not have a surrender value

For information on our other GIP products, click the following links:

GIP Classic Policies

GIP Dual Benefit Policies

Flexible Benefit Policies (including GIP)

Executive Income Protection

Contents

Section A - Your commitment as the policyholder

By taking out a Unum policy you are agreeing to;

- pay premiums on time
- choose the conditions of eligibility for members' entry at the start of the policy and to abide by those conditions
- To notify us in writing if you:
  - want to amend the eligibility criteria - eg. by changing the eligibility from management only to all staff
  - acquire another company and wish to include their employees to the policy
  - dispose of a company which results in the removal of members from the existing policy
  - want to change the policy design – eg. benefit level or Terminal Age
- identify any discretionary entrants (employees who do not fulfil the standard conditions for entry).
- notify us of claims within the time limit set out in your policy documents
- notify us of any change in the employment status of any claimants
- supply us with any information we may ask for

Section B - Risk factors

1. This guide should be read with the accompanying quote. Please note that the quote takes precedence if anything in it differs from this guide.
2. The policy documents take precedence if anything differs between the policy documents, the quote and this guide.
3. Full details of your insurance cover are set out in your policy documents. The policy is issued according to the Laws of England and any dispute will fall under the exclusive jurisdiction of the English Courts.
4. Customers for this product are classed as "Commercial" as defined by the Financial Conduct Authority's (FCA) Insurance: Conduct of Business sourcebook (ICOBS).
5. The way HMRC tax benefits may change in the future. Eligibility rules and the amount of benefit available from the Department of Work and Pensions may also change. If State benefits mentioned in this guide are withdrawn, we will advise you how we will treat the replacement benefits.
6. This document does not provide definitive tax advice. This includes, but is not limited to, any potential liability to corporation tax and income tax. You should take advice from a financial adviser to ensure you understand the impact of tax and legislation.
7. The guarantee period advised in your quote applies to both the premium rate (for Unit Rated policies) - or the underlying rate table (for Single Premium policies) - and the policy conditions. When the guarantee expires at the policy review date, both the premium rate (or underlying rates), and the policy conditions are reviewable.
8. For all policies, the premium rate and policy conditions are usually guaranteed for 2 years. However, we may amend the terms if we believe there is a significant change in the risk profile. The factors we take into account are:
   - a change of 30% or more in the number of members or benefit insured
   - the inclusion of a new subsidiary
   - the disposal of a participating company or closure of part of your business
   - the inclusion of a new member category
   - a change in policy design such as an alteration of benefit level, Terminal Age or terms of eligibility
   - a significant overall change in the occupations of the members or where they work
   - a major change to the level or basis of the social security or income tax systems

   For new policies, we may review the terms offered if there is a 15% or more change in the number of members or benefit in the data provided to produce the quote.
9. If the number of members drops below the minimum number set out in your policy documents, we reserve the right to cancel the policy at any subsequent policy accounting date.
10. The tax treatment on being paid directly may mean that when the claimant leaves the employer's service, their State Benefits relating to incapacity may be reduced.

Section C - How the policy works

Section 1.1 - Types of cover

The PDGIP policy allows you to choose cover to complement your budget and business needs. We can also insure a number of additional employer and employee benefits in addition to the main cover provided.
For more details see section 1.2 Product features.

Feature	Pay Direct Policy
Cover type	Benefits are specified as a percentage of gross pre-incapacity earnings.
State ESA benefits	If you **choose to have** State benefits deducted from the benefits calculation, these will last for the claim's duration, whether the member receives them or not.
Minimum number of members	Available for 5 or more employees.
Maximum Terminal Age	70
Maximum % of insured earnings	80% of pre-incapacity earnings, (including any insured employee pension scheme contributions) for each member.
Maximum monetary amount	The maximum income replacement benefit (excluding additional employer benefits) for any member is currently £350,000 per year and includes any employee pension scheme contributions.
Deferred periods	You can choose a deferred period of 8, 13, 26, 28 or 52 weeks.

Section 1.2 – Product features

Definitions of Incapacity

We offer a range of Incapacity Definitions to suit your business needs.

Definition A: Insured Occupation Cover	Definition B: Combined Cover (Insured Occupation Cover for 24 months Gainful Occupation Cover after 24 months)	Definition C: Gainful Occupation Cover
A member is considered incapacitated if they are: • unable to perform the material and substantial duties of their insured occupation because of illness or injury,	During the first 24 months of a claim, a member is considered incapacitated if they are: • unable to perform the material and substantial duties of their insured occupation because of illness or injury At the end of 24 months, a member is considered incapacitated if they are: • unable to perform the material and substantial duties of their insured occupation because of illness or injury AND • unable to perform the material and substantial duties of any gainful occupation because of illness or injury	A member is considered incapacitated if they are: • unable to perform the material and substantial duties of their insured occupation because of illness or injury AND • unable to perform the material and substantial duties of any gainful occupation because of illness or injury

Additional Information for Incapacity Definitions

1. Where a member is insured under Definition A or B, Definition C will automatically apply if a member's terms of employment require them to hold a licence or certificate issued only when they meet certain medical standards,
2. Insured occupation means the trade, profession or general role the member was actively undertaking for, or at, the employer immediately before incapacity,
3. Gainful occupation means an occupation that is providing, or can be expected to provide, the member with an income within 12 months of their return to work:
   a) which exceeds 2/3rds of their gross earnings immediately before incapacity, increased in line with any percentage increase in the RPI since the date of incapacity, and
   b) for working the same number of hours worked immediately before incapacity
4. Material and substantial duties are those duties normally required for performing the insured occupation at their, or any other, employer and which cannot be reasonably omitted or modified,
5. These are simplified definitions. See your policy documents for the full policy wording,

Escalation

You can choose to protect against inflation or to keep benefits payments level. The annual increase is known as the escalation rate.

Your choices of escalation rate are:

- a fixed rate of 0% (level), 3% or 5%
- in line with the Retail Prices Index (RPI), capped at 2.5% or 5%
- in line with the Consumer Prices Index (CPI) capped at 2.5% or 5%

Benefit in payment will increase annually by your chosen escalation rate - normally on the first of the month of the anniversary when the benefit started, or on the first of the month previously chosen by you.

Where escalation is linked to the RPI or CPI indexes, we will use the rates from a date 3 months before your chosen escalation date.

Payment Term

You can choose how long you want benefit to be paid, up until a set Terminal Age, State Pension Age (SPA) or a limited period of 2, 3, 4 or 5 years. Claims will stop on the earlier of the Terminal Age or, if selected, the end of the limited payment period.

Please note that for certain occupations such as pilots, we may set the maximum Terminal Age.

Benefit payments for fixed-term employees will finish at the end of their current contract or the Terminal Age for the policy, if sooner. We will not extend the payment period if their contract is renewed during a period of absence.

Deferred Period

You can choose for claims to begin after a set period of absence, either 8, 13, 26, 28 or 52 weeks.

Please note that depending on the policy, not all selections may be available.

Additional Benefits

As well as providing Income Protection benefit, you can also insure the annual amount of other employee or employer-related expenses.

Employer Additional Benefits			Employee Additional Benefits
Employer's Pension Scheme Contributions (PSCs)	**Associated Business Costs (ABC)**	**Employer's National Insurance Contributions (NICs)**	**Employee's PSCs**
You can insure your normal contributions paid to a pension scheme on the employee's behalf. These contributions must be a fixed annual amount - eg. a fixed percentage of pre-incapacity earnings across broad categories of employees. We can cover most types of occupational and group pension schemes. Where contribution rates vary - eg. by age, the amount of contribution we will pay is based on the level applicable at the start of benefit payments.	You can insure the costs associated with an employee on long-term sick leave - eg. holiday pay, Group Life premium, Private Medical Insurance premium, company car allowance. We can also include Employer's PSCs in this category or insure it as a separate item. (see Employer's PSC)	Can be used to insure your liability to pay NICs. The amount of NICs insurable is based on the basic income benefit payable. Any changes in the rate of NICs will not affect the amounts paid on existing claims. These will be paid at the prevailing rate at the start of benefit payments.	Employee PSCs are not normally insured. If we agree to cover all, or part of these, the amount will be treated as part of the basic income benefit. Under Net Pay policies, an employee's PSCs and NICs are taken into account when the benefit is calculated. The amount of benefit insured is such that, once these items - plus Income Tax - are deducted, the employee will receive the percentage of net earnings promised when combined with their State benefits relating to incapacity.
The maximum amount of cover we will consider for the total Employer benefits (ABC cover plus Employer's PSC's) is 60% of earnings, with an overall maximum benefit of £120,000 per member per year.		NICs are covered in full on the basic benefit insured.	The maximum amount of cover we will consider for the total employee benefits (basic income benefit + Employee PSC's) is 80% of gross earnings (90% of net earnings for Net Pay policies), with an overall maximum benefit of £350,000 per member per year.

Note: Additional benefit payments will end if payments are made directly to the member.

Continuation Option

We no longer offer a continuation option.

Section 1.3 – Eligibility

An employee can join the policy if they satisfy the conditions of eligibility defined in your policy documentation and meet the definition of being Actively at Work.

You should clearly state a defined and compulsory eligibility for each membership category, this needs to be the same for each member within a defined category.

This should include:

- the minimum and maximum entry ages allowed for new members
- the categories of member you want covered, and the benefits required
- if a minimum service requirement is in place and the duration
- the date when new members will be covered - and when existing members will be eligible for increases in insured benefits – this can be annually, monthly or daily

Daily entry and increases in benefit will apply unless otherwise agreed.

If cover is dependent on membership of the employer's pension scheme, you will also need to provide the pension scheme's current eligibility requirements.

The FCL will usually apply to all eligible members. Where it does not, medical underwriting will be needed before we can provide cover.

You can include members who are part-time or fixed-term employees in the policy if they satisfy the eligibility. We can cover fixed-term employees for the duration of their current contract under all GIP products - with the exception of Capital Option.

Discretionary, Late and Early entrants

The following terms apply for members who do not meet the eligibility criteria (Discretionary entrant), or want to join the policy prematurely (Early entrant) or after their first opportunity to do so (Late entrant). In addition we have detailed the terms which apply to members joining as a result of auto enrolment in the following table:

Discretionary and Early entrants	Late entrants	Auto enrolment
We need a Scheme Member's Application Form in all cases. Acceptance is at the discretion of our Medical Underwriter. Any member who has previously been treated as a discretionary entrant will continue to have their existing terms applied until they have been re-underwritten.	Prospective members joining the policy within 12 months of their first opportunity may do so if they are Actively at Work on the date of entry. The member must complete a Scheme Members Application for benefit entitlement above the policy's FCL, acceptance of the FCL excess is at the discretion of our Medical Underwriter. Employees wanting to enter the policy more than 12 months after their first opportunity to do so must complete a Scheme Members Application Form before any cover is provided. Acceptance is at the discretion of our Medical Underwriter.	Where eligibility is linked to membership of the employer's pension scheme, prospective members may enter the policy at any auto enrolment or auto re-enrolment event if they are Actively at Work on the date of entry. Changes to the level of the member's benefit entitlement will be covered without medical underwriting until the policy's FCL is exceeded for the first time. The member must complete a Scheme Members Application for benefit entitlement above the policy's FCL, acceptance of the FCL excess is at the discretion of our Medical Underwriter. Employees wanting to enter the policy at a date other than an auto enrolment or auto re-enrolment event will be subject to Late entrant terms.

Temporary Absence

We can insure members during temporary absence from work under the following terms:

Maternity Leave, Adoptive Leave (AL) and Paternity Leave (PL)	· cover continues automatically as long as the member remains employed · during leave, the member is considered to be Actively at Work · any benefit payable will start on the later of either the end of the deferred period, or the date the member must return to work · the benefit insured on the day before leave will be increased in line with any general pay increases made by the employer up to a maximum of 5% p.a. compound
Unpaid Parental Leave	· cover continues automatically for up to 13 weeks' leave as long as the member remains employed · during leave, the member is considered to be Actively at Work · any benefit payable will start on the later of either the end of the deferred period or the date the member must return to work · the benefit insured on the day before leave will be increased in line with any general pay increases made by the employer up to a maximum of 5% p.a. compound
Unpaid Leave, sabbaticals and compassionate leave	· cover continues automatically for up to 3 years as long as the member remains employed · during leave, the member is considered to be Actively at Work · any benefit payable will start on the later of either the end of the deferred period, or the date the member must return to work · the benefit payable remains at the amount insured on the day before the start of the period of leave and will not increase · you must give the member written consent within a reasonable timescale before unpaid leave starts
Absence due to ill-health:	· cover can continue for up to 12 months during the member's absence due to illness or injury if a claim is declined or ceased. · the 12 months applies from the original commencement date in respect of a declined claim, or from the date of our decision for a ceased claim · you must give the member written acknowledgment of their absence within a reasonable timescale from the start of the absence

Members based overseas

We can insure members based overseas under the following terms.

Members employed outside of the UK	**Secondment outside the UK**
Members who work overseas for their UK resident employer are covered, as long as: · the member meets the policy eligibility conditions	Members seconded from their UK resident employer to another company (registered in the UK or overseas) are covered as long as: · the member meets the policy eligibility conditions · the member has a contract of employment with the UK employer · the UK employer retain controls over where and for who the member works · both the UK employer and member expect the latter to resume employment with the UK employer at the end of the secondment (or will retire to the UK if the period of secondment extends to the date the member chooses to retire)

· you must declare each member's nationality and the countries they work in at the start of the policy and at each rate review. This affects the premium rate quoted and our ability to provide cover

· benefits are paid in Sterling and to a UK account. Foreign earnings will be converted to Sterling using the Financial Times exchange rate or, if applicable, the same exchange rate used to convert the non-UK earnings to Sterling to establish the premium payable

· references to the UK include the Channel Islands and the Isle of Man

Extended Cover

If a member works beyond the Terminal Age, cover may be continued up to age 70 - subject to being Actively at Work at their existing Terminal Age. We will review any medical underwriting on benefits in excess of the FCL. Becoming a member after the Terminal Age is subject to being Actively at Work on the date of joining and completion of a Scheme Members Application Form for benefits above the FCL.

Section 1.4 – Insured earnings

You must choose an insured earnings definition for calculating the members' benefits. Common definitions of pre-incapacity or insured earnings include but are not limited to the following:

Basic annual salary	Basic annual salary plus fluctuating payments during the last 12 months	Basic annual salary plus fluctuating payments averaged over the last 3 years	Total earnings	P60 earnings
The member's basic salary excluding other payments such as bonus, commission or dividends.	This can be limited to specific fluctuating payments, such as overtime and/or bonuses and/or commissions etc. The fluctuating payments are limited to 20% of basic annual salary.	This can be limited to specific fluctuating payments, such as overtime and/or bonuses and/or commissions etc. The fluctuating payments are averaged over the last 3 years without the 20% limitation.	The earnings received during the previous 12 months. Including variable forms of pay such as overtime, bonuses and commissions. Any fluctuating payments will be limited to 20% of basic annual salary. As an alternative, the average of the last 3 years' total earnings can be used to smooth benefit changes so they are not based on a particularly high or low year.	The earnings received during the previous tax year (up to 5th April) - This would only change the benefit level when passing 6th April each year. Any fluctuating payments will be limited to 20% of basic annual salary. As an alternative, the average of the last 3 years' P60 earnings can be used to smooth benefit changes so they are not based on a particularly high or low year.

Employees

It is important that your members' chosen definitions are clear and unambiguous – eg. are all fluctuating payments to be included? Or only bonuses or other specific payments?

Different categories of member may have different definitions outlining how they are paid – eg. members involved in sales may have a large portion of performance-related pay, while administration staff only have a basic salary.

Changes to earnings are usually either daily or annual.

Where an employer operates salary sacrifice – eg. in favour of childcare vouchers or pension contributions, we can cover insured earnings reflecting the 'pre-sacrifice' figure.

Equity partners

Equity Partners in partnerships and LLP members of Limited Liability Partnerships, share in the profits of the partnership, which can vary from year to year, and are taxed by HMRC under Schedule D. The normal definition of insured earnings is average of the last 3 years' earnings, after the partnership expenses have been deducted.

Working directors

We can include dividends from the employer in an insured earnings definition, but this only applies to working directors.

As dividend income is irregular (depending upon the profitability of the business and the director's shareholding), we treat it the same as other fluctuating payments:

- basic annual salary plus average of the last 3 years' dividends
- total earnings averaged over the last 3 years including dividend payments

The working directors must receive a basic annual salary.

As we are covering 'loss of income', dividends insured as part of the earnings definition would normally be expected to stop in the event of a claim. If they do not, we will limit the benefit paid.

Section 2 – Preparing a Quote

We prepare a quote based upon the risk specification supplied by your intermediary together with:

- the membership data
- claims history over the last 6 years (if previously insured)
- the industry type
- the occupation and location profile of the members to be covered under the policy
- details of any employees who have had benefits declined or have had adverse underwriting decisions.

The membership data must be as up-to-date as possible and show details relating to a date within the last 12 months of the date the quotation was requested. Your intermediary can prepare quotes quickly and simply over the internet via our UnumOnline facility or by submitting a written request via our Regional Sales Offices which cater for a wider range and more complex benefit bases.

Once we have the data, specification and claims experience, we will supply a quote detailing the applicable rate (if Unit Rated), premium and FCL. The premium we charge will depend on a number of factors. These include the nature and level of the benefits to be provided and details of the employees you want to insure, such as, but not limited to:

- definition of incapacity selected
- period of income benefit payment selected
- Terminal Age for cover
- eligibility and entry conditions
- rate at which the income benefit increases, if any, while it is being paid
- deferred period
- age and gender of employees
- occupation, industry and locations of employees
- claims history, if previously insured
- our then current minimum annual premium

Section 3 – Starting and ending cover

Setting up the policy

Your intermediary needs to contact us in writing in advance to advise us when you want us to go on risk. So a 1st January start date will go on risk at 00.01 a.m. on 1st January - subject to satisfactory answers to any specific caveats shown in our quote. We will not backdate acceptance of risk.

Once you have accepted our quote, you will need to provide the following information within the 30-day conditional cover period:

- a fully completed QAAF signed by the policyholder
- membership data at the start date
- Actively at Work Declaration
- deposit premium or Direct Debit mandate (Premiums must be paid from a UK bank account in pounds sterling)

You need to inform us of any material changes in the risk profile of the membership between the accepted quotation and the on risk date - eg. changes in the locations where members work, their occupations, industries or claims history. We will then advise you if we will continue cover, of any additional requirements and if needed, the revised premium.

Please note that the QAAF includes a Direct Debit mandate to be signed by the policyholder and a customer verification statement that, if requested, should be signed by your intermediary.

If the information we asked for is not provided within 30 days, cover will stop. We will then charge a premium for the 30 days of cover provided, calculated on a pro-rata basis and based on the time we have provided cover.

Ending cover after the policy starts

The policyholder

You can cancel the policy at any time, provided you do so in writing. Cover will then end and you will not be liable for payments for periods after this date. Cancellation cannot be backdated.

If the policy is cancelled, we will still consider and pay claims for long-term illness or injury starting before the cancellation date, and continue to pay current, valid claims, provided that there are no outstanding premiums.

Unum

We cannot cancel the policy unless:

- the number of members insured under the policy drops below the number of lives stipulated for the policy
- premiums are overdue
- you fail to provide all the information we ask for when applying for the policy, administering the policy or when claiming for benefit relating to a member
- the company ceases to trade
- trade sanction controls are put in place against members with a significant shareholding
- the policy no longer complies with current legislation
- you assign the policy without our agreement

Section 4 – Premium rates and policy accounting

	Unit Rated or Simplified Administration policies (20 or more members)	Single Premium policies (between 5 and 19 members)
Quote	The 1st-year premium advised at the start date of your policy is provisional. The premium is based on the total salary roll or total benefit roll at the start date the unit rate (expressed as a percentage of salary or as a percentage of benefit). Our quote states an estimated 1st-year cost assuming an annual premium is paid and that all members can be accepted for their full benefit entitlement at ordinary rates.	Premiums will be calculated for each member according to our current premium rates. Premiums are recalculated each year and depend on the age of the members at each policy accounting date. Our quote states an estimated 1st-year cost assuming an annual premium is paid and that all members can be accepted for their full benefit entitlement at ordinary rates.
Rate Guarantee	Unit rates are usually guaranteed for 2 years and are then reviewable. New rates may apply at the end of this period.	The underlying premium rate table is usually guaranteed for 2 years and is then reviewable. A new rate table may apply at the end of this period.
Costing basis	If the number of members insured under an existing policy falls below 20 at a policy accounting date, we may calculate the premium on the Single Premium basis from the following policy accounting date.	If the number of members insured under an existing policy increases to 20 or more at a policy accounting date, we may calculate the cost on the Unit Rated basis from the following policy accounting date.
Additional premiums	Premiums may vary if there are: • members whose benefits exceed the FCL and they have been declined for the excess benefits or loaded on the excess benefits • members who have been restricted to the FCL due to non-provision of medical evidence • members who are joining outside the normal eligibility conditions, (Discretionary, Early or Late entrants). Additional premiums or restrictions may be due to particular medical conditions or if the member takes part in an unusually hazardous pursuit. If applicable, additional premiums are payable from the date we make the decision.	
Account	We calculate a premium adjustment at the end of each policy accounting period, based on the average total salary roll or total benefit roll for all members covered by the policy during that time. This means changes in salary and membership are treated as if they occurred halfway through the accounting period.	We calculate a premium adjustment at the end of each policy accounting period, taking into account joiners, leavers and changes in benefit throughout that time. This means that premiums are calculated on the specific duration and level of cover for each member.

Continued...

	Unit Rated or Simplified Administration policies (20 or more members)	Single Premium policies (between 5 and 19 members)
Data requirements	At the start date and at each policy accounting date, we require a list of all members showing: · name · date of birth · gender · salary · benefit entitlement · membership category · date of joining or date of leaving (if appropriate). You must identify members whose benefits exceed the FCL or who are joining outside the policy's normal eligibility conditions.	
Non-annual premium payment	Premiums are normally paid annually or monthly by Direct Debit. There is a standard load of 3% for all non-annual payments.	
Commission	Any commission paid to your intermediary is a percentage of the gross premium paid. The premium shown in our quote includes the level of commission payable.	
New joiners	Other than at the policy accounting dates, we only need details of new joiners if their benefit exceeds the FCL or if they are joining outside the normal eligibility conditions of the policy.	

Section 5 – Medical underwriting

Our Group policies are designed to cover all employees who satisfy the eligibility conditions. Generally, the more employees that meet eligibility, the higher the FCL we can offer. We do not usually need a Scheme Member's Application Form for benefits below the FCL. However, an Actively at Work requirement will always apply for new members and for any changes in benefit entitlement for existing members at the date of entry or change.

A FCL only applies to eligible employees who join the policy at their first opportunity, within 12 months of that opportunity or at an auto enrolment event. Acceptance at any other time is subject to medical underwriting.

If a category of membership includes fewer than 3 members, a FCL will not apply to these members unless Unum states otherwise on the quotation. These members will not benefit from temporary cover pending medical underwriting.

The FCL for the policy may be reviewed at each policy accounting date or when a rate review is triggered.

Employees with benefit exceeding the FCL, or employees where the FCL does not apply, will be asked to complete a Scheme Member's Application Form giving details of their health and any pastimes which might affect their insurability or our chargeable premium. Depending on these answers, we may ask for medical evidence that could include a report from the member's GP, a medical examination or blood or other tests.

Currently, if we accept the employee, any further increases in benefit will not need further underwriting when all of the following conditions are met:

- the policy is unit rated and has 20 or more members
- the insured benefit is based on a percentage of salary or earnings (ie not stated or flat benefit) and is not selected by the member (ie not flex or voluntary)
- we have not received a claim for the member

These terms are offered at our discretion and can be withdrawn.

If we accept the employee, but the above does not apply, we will only require further medical underwriting if an annual increase in benefit exceeds £3,000 or 10% of the current benefit on risk, whichever is greater.

Switch Terms for a policy with existing members whose benefits have been medically underwritten

We need details of the previous insurer's FCL and of any members whose cover has been medically underwritten or restricted to that FCL - showing for each member:

- name
- date of birth
- gender
- full underwriting decision
- special term or restriction applied (including percentage loadings and amount of benefit above which the loading/restriction applied)
- benefit on risk at previous policy cancellation date

Where cover is being switched from another insurer, Actively at Work means that the member must be Actively at Work on the last working day of the previous policy.

Generally, if cover is switched on the same basis, no member will receive stricter underwriting terms than imposed by the previous insurer.

The actual amount charged for any medical loading may differ from the previous insurer because our underlying premium rates may be different.

Temporary cover pending underwriting

Temporary Cover	Where a member's benefit needs underwriting because it exceeds the FCL, we provide a maximum period of 3 months' temporary cover in respect of the amount being underwritten.
Temporary cover pending underwriting is subject to ALL of the conditions opposite	· the member not already being subject to any special or restricted terms imposed by us or a previous insurer · the member being Actively at Work (in the case of switched insurance the members must be Actively At Work on the last working day of the previous insurance cover) · the member not being a Discretionary, Early or Late entrant, or an Extended cover member · premiums being paid up to date During this period, any benefit that exceeds either the FCL or the member's insured benefit level immediately before the start of the policy will be subject to a pre-existing conditions exclusion. This means we will not pay benefit for any medical condition where the member received treatment, care or services (including diagnostic measures), or took prescribed drugs or medicines during the 12 months before the date they first became eligible, or the date of any increase in cover.
Temporary cover starts	· either the date the member joins the policy with benefits above the FCL, or · the effective date of an increase in benefit above the FCL
Temporary cover ends on the first date either of the following events occur	· we issue terms following completion of medical underwriting, or · the 3-month period of temporary cover expires For underwriting purposes, a new member of a policy that has no FCL is treated as a Discretionary entrant. Once we have agreed full cover, we treat a Discretionary, Late or Early entrant or an Extended cover member, in the same way as an ordinary member, granting temporary cover the next time we underwrite an increase in cover.
What happens if an incapacity arises before we have agreed full cover?	If a member claims after the temporary cover period ends, but before we have agreed full cover, benefit is restricted to: **In the case of new business** either our quoted FCL, or, if previously insured, any amount the member was covered for and which we have agreed to accept without additional medical underwriting. **In the case of existing business** For new joiners our quoted FCL and for existing members the amount insured with us immediately before the effective date of the increase being underwritten.

Section 6 – Policy documents

Once a policy goes live, we will issue a copy of your Policy Documents.

The policy is issued on the basis of the information provided:

- in the quotation request or specification
- the QAAF completed by you
- any questionnaire completed by a member
- any proposal or supplementary proposal made by, or on behalf of, the policyholder

The policy comprises the policy conditions, the schedule (including any endorsements) and any special provisions or notices specified in writing by us.

Your policy conditions could change following any event which triggers a rate review.

Section 7 – Claims

This section explains how we treat potential claims that arise when a member suffers a long-term illness or injury, likely to last beyond the end of the deferred period. Our guide to comprehensive claims management provides further information and can be downloaded from our website at **http://online.positiveimagesuk.com/unum/images/UP2204.pdf.**

How to notify Unum of a claim

You can download claim forms from our website at **http://www.unum.co.uk/claims/group-income-protection**. Alternatively, you can call our Customer Care department on **01306 873243** or email **customercareclaims@unum.co.uk**.

Claims forms

We need a claim form completed by you, the employer, which includes details of the claimant's occupation and any adjustments or modifications which may have been made or considered to enable them to remain in, or return to, work. We also need:

- absence records
- evidence of membership and earnings
- confirmation of their age or an original copy of the claimant's birth certificate

From the employee we need:

- a claim form completed by them providing us with details of their medical condition, symptoms and treatment, and their daily routine and activities they can or cannot perform
- consent forms signed by them giving us authority to ask for further information from their doctors, such as details of their medical history and treatments for their illness or injury

The claimant should also give their doctor a 'Request for copies of medical records' form with a second copy of their consent. The doctor will send medical records directly to us.

When to submit a claim

You should submit a claim by the earlier of halfway through the deferred period or 14 weeks - eg. for a 26-week deferred period, you should submit your claim no later than 13 weeks after the date the claimant was first absent.

Claims assessment

We will pay income benefit when a claimant satisfies the policy's chosen Definition of Incapacity and their illness or injury lasts longer than the deferred period.

Premiums for the policy must be paid in full for the deferred period applicable.

Incapacity assessment

When we assess a claim, we look for evidence of the claimant's medical condition, its severity, how long they have had it and whether the chosen Definition of Incapacity has been satisfied.

We will need evidence they are still receiving medical advice, when appropriate, and that their treatment options have been investigated and explained to them.

We may ask the claimant to attend an independent medical examination with one or more medical practitioners or consultants - at our expense - and selected by us.

We may need to visit you and the claimant. We will advise you both in advance if this is necessary.

Completion of the deferred period

To complete the deferred period, the claimant does not need to be absent from work full time on a continuous basis. A deferred period can be made up of:

- shorter periods of absence linked together

These periods must be for at least 2 weeks, be medically supported and be for the same illness or injury. Absences added together must equal the policy's deferred period within a time no more than twice the length of the deferred period.

Example

a claimant may be absent for 16 weeks, then return to work for up to 26 weeks before suffering a further period of 10 weeks to complete a 26-week deferred period. (26 weeks of absence completed in a period of no more than 52 weeks).

- or, periods working part time or in a lower-paid role or undertaking restricted duties

Example

a claimant may be absent from work full time for a period of 16 weeks then return to work 2 days per week for a further 10 weeks to complete a 26-week deferred period.

Benefit payments

When we accept a claim, we will pay benefits to you by Direct Credit, monthly in arrears on the 3rd last working day of each month.

Initial or final part-month payments will be calculated using the formula: 12 x monthly benefit x number of days ÷ 365.

We may reduce benefits paid under the policy if the claimant receives other regular income during illness or injury – eg. from an individual Income Protection policy.

When benefit payment ends

We will stop paying benefits for a claimant on the earliest of the following dates:

- when the claimant is no longer considered incapacitated
- when the claimant stops being an employee (other than when we have agreed to pay benefit directly to the claimant as described in the next section - note that payment of benefit is not affected if an Equity Partner or an LLP member stops being an Equity Partner or LLP member)
- when the claimant reaches the Terminal Age
- when the claimant dies
- when the claimant starts any alternative work without the knowledge and consent of the policyholder
- when the claimant returns to work (except as provided under proportionate benefit)
- when the limited-benefit cover maximum payment period ends
- when the fixed-term contract ends, if the claimant is on a fixed-term contract of employment
- when the claimant fails to attend any examination or to provide requested information in the time provided, as requested by us
- when the claimant withdraws their consent that provides us with the authority to access medical reports and records concerning their health
- when the claimant provides information which is untrue, or misleading or they do not provide material information
- when the claimant is imprisoned

Paying benefit direct to former employees

PDGIP gives employers the discretion to instruct Unum, once a claim has been admitted, to continue to pay the regular income benefit directly to their former employee after they have left service.

The following step-by-step guide describes the process after a claim has been admitted.

Step 1 Income benefit is paid directly to the employer for payment to the employee via payroll.

Step 2 Following the start of income benefit payments being made, the employer may instruct that future income benefit payments be made directly to their former employee once they have left service.

Step 3 Unum will issue:

i. A form for the employer to complete providing details of the change in benefit payment and requesting details of the former employee's UK bank account. The claimant will also be granted the right to enforce those aspects of the policy which relate to their claim.

ii. A Continuation of Benefit statement to the former employee that sets out the basis upon which the continuing regular income benefits payments will be made.

Step 4 When direct payments begin, any additional benefits that were being made to the employer (for example in respect of employer's pension fund contributions and/or national insurance contributions) will cease.

Step 5 Regular income benefits will be paid directly to the former employee after the deduction of the basic rate of tax and under the terms of the Continuation of Benefit statement.

State benefits relating to incapacity

Under the Welfare Reform and Pensions Act 1999 and the Welfare Reform Act 2007, income from one of a number of sources which exceeds the prescribed threshold of £85.00 per week, before tax, will reduce State benefits relating to incapacity by 50p for every £1 of income that exceeds the threshold.

This offset does not apply to individual or Group Income Protection schemes where benefit is paid to the employer and the employee remains in service. This offset does not apply to Equity Partners or Barristers as they pay their own premiums.

Under PDGIP, if employment is terminated and benefit payments continue directly to the individual, the offset will apply.

Claimant returning to work on a reduced basis

If a claimant is unable to return to their insured occupation, but returns to work on a reduced basis in their own role or to a lower-paid role, we will pay a proportionate benefit based on their earnings loss.

The main principles of proportionate benefit are:

- you pay salary to the claimant for the work undertaken in addition to our benefit
- we will reduce our benefit by a percentage equal to the percentage of salary received – eg. if the claimant receives 40% of their salary, we would pay 60% of their benefit
- the total money the claimant receives will increase as the weekly hours worked (or duties undertaken) increases (and vice versa).
- proportionate benefit cannot exceed basic benefit

A guide to proportionate benefit can be found on our website at **http://online.positiveimagesuk.com/unum/images/up2189.pdf**

Linked claims

If a claimant who has received income benefit returns to work with you, but becomes absent again within 52 weeks and again meets the Definition of Incapacity, while the policy remains in force, we will pay income benefit without imposing a new deferred period. This is known as a Linked Benefit claim.

The second period of incapacity can be due to the same or a different cause.

The Linked claim starts at the same benefit level as the previous claim. However, if the claimant received a salary increase or the benefit basis changed while they were Actively at Work, any increase in the benefit amount will be reflected in the benefit paid after a period equivalent to the deferred period.

Multiple claims under limited benefit policies

Under limited-benefit period policies, if a claimant who has received income benefit returns to work with you and subsequently becomes absent again:

- where they have returned to work for less than 4 weeks, the claim will continue for up to the balance of the limited-benefit period
- where they have returned to work for more than 4 weeks (including Linked Benefit claims), the whole of the limited-benefit period becomes payable again, regardless of the cause of incapacity

Example

Under a 2-year limited payment period, if a claim has been paid for 14 months and the claimant returned to work but then suffered a further period of absence within 4 weeks of returning, the second claim will be paid for a maximum of 10 months.

If the claimant returned to work for more than 4 weeks, the second claim will be paid for up to 2 more years.

Once a benefit payment period has been reached, the claim will finish. The claimant must meet Actively at Work requirements for a period of at least 4 weeks before re-entering the scheme and the linked claims provision would not apply to any subsequent absence meeting the Definition of Incapacity.

If a former employee who is receiving benefits payments direct following termination of employment returns to work, any linked claim will only be for the balance of the limited benefit period and at the same level as the previous claim.

Cover switching from Unum to another insurer

Any claims already being paid will continue to be paid for as long as they continue to meet the payment criteria.

If we are paying benefit to a claimant who returns to work with you after cover is switched and meets the Actively at Work conditions of the new insurer, payment will finish.

Any future claims will be the responsibility of the new insurer, but if the absence meets the Definition of Incapacity and is within 52 weeks of returning to work, we will treat it similarly to a Linked Benefit Claim and reinstate benefit payments for a period equal to the new insurer's deferred period.

Impact on claims if a policy is discontinued

All benefits remain payable, provided the premiums have all been paid when the claimant suffers a long-term illness or injury.

We will pay benefit in the usual way unless this is not possible – eg. if the employer has stopped trading. In these cases, we will deal directly with the claimant.

If the claimant is no longer employed, optional additional benefits - eg. employer's National Insurance Contributions will also finish.

Claims for overseas-based members

Any claims for members based abroad and foreign nationals will be paid in Sterling to the UK employer.

Any foreign earnings will be converted to Sterling using the exchange rate (Financial Times) on the policy accounting date that precedes the date the claimant was first absent - or, if applicable, the same exchange rate that was used to convert the non-UK earnings to Sterling to establish the premium payable.

We will ask for medical evidence in the same way as for UK members. However, we will only reimburse fees up to a comparable level to those for the UK. Any fees in excess of this will be your liability. Medical evidence should be in the original language it was written and will pay for the translation into English.

Appeals process

If we end or decline a claim because we decide the claimant does not (or no longer) satisfies the definition of incapacity and you are not satisfied with our decision, you can ask us to review it.

Any request for a decision review should be addressed to our Quality Assurance Manager, Claims Department, Unum, Milton Court, Dorking, Surrey, RH4 3LZ and detail the reasons why you disagree with our decision, plus any additional evidence (medical or otherwise) that you would like us to consider. Any request for a review should be made within 90 days of the date of the decision.

If you remain dissatisfied, you can make a formal complaint at any time. See our Complaints section for details.

Section 8 – Vocational Rehabilitation

Can Vocational Rehabilitation help?

Our Medical Services staff and Vocational Rehabilitation Specialists will work with you and your member's medical advisers to help them return to work, wherever possible.

We can also guide you on making any reasonable adjustments to the workplace.

Vocational rehabilitation has two major advantages. First, it helps minimise the cost of long-term illness or injury to your company, such as money spent on recruiting and training replacement staff. Second, it allows you to retain the valuable skills and knowledge that experienced staff bring to your business.

To achieve a successful return to work, you should make sure that vocational rehabilitation and reintegration programmes are investigated and implemented wherever appropriate.

Working conditions, physical features and other arrangements can often be adjusted relatively easily, allowing an ill or injured member to continue working.

The Equality Act requires employers to make reasonable efforts to implement such adjustments. For the purposes of the policy, we assume that these requirements are met.

Section 9 – Exclusions

There are no standard exclusions under this policy, if there are any specific exclusions these will be illustrated in your policy documentation.

Section 10 – Taxation

Employers insuring members subject to PAYE.

The whole cost of a PDGIP policy is met by the employer

Income benefit	Premiums
• income benefit received is a trading receipt while payments passed on as salary are a trading expense, giving a neutral tax situation • income benefit received by the employee as salary is taxed as PAYE	• premiums are not treated as a P11D benefit for employees • the HMRC does not normally grant tax relief on premiums paid for any employees with a financial interest in the company. However, they may sometimes grant tax relief provided that a substantial number of other employees are entitled to similar benefits. In these cases, you should ask your local Inspector of Taxes or your intermediary for clarification • for tax purposes, premiums are treated as a business expense

For specific cases, you should ask your local Inspector of Taxes or your intermediary for advice.

This information is based on our understanding of current UK tax legislation.

You should ask your professional advisers about the tax implications for you and your employees.

Section 11 – Equity Partners and Barristers

Background

The Terms and Conditions of our standard GIP policy for employers will generally apply to our policy for Equity Partners/Barristers.

Some aspects of our GIP policy for Equity Partners/Barristers may differ from our standard policy Terms and Conditions as noted below.

The policy for Equity Partners is available to those partners with an equity share in the firm and whose earnings from the firm is taxed under Schedule D.

Earnings definition

Benefits are only provided on a gross pay basis.

The maximum income benefit is 50% of the Equity Partner's/Barrister's normal Net Income from the firm/Chambers, averaged over the last 3 years (or since the partnership/Chambers has been operating if less than 3 years). The maximum monetary amount insured is £350,000.

Net Income for Equity Partners is the taxable earnings, after deduction of the business expenses, received by the member from the Partnership.

Net Income for Barristers means the gross receipts net of VAT, less Chambers' expenses received by the practising member.

Payment of premiums

Each Equity Partner/Barrister (taxed under Schedule D) pays for their own cover, but all premiums are paid by the partnership/Chambers together in one payment.

Participation

You must include all Equity Partners/Barristers for cover under the policy when they first become eligible.

Evidence of earnings

We may occasionally need evidence of earnings and expenses.

Expenses

Equity Partners

The policy can provide Additional Expenses cover for the Equity Partner's share of the total partnership's normal costs of running the business for up to 3 years and averaged over the previous 3 years.

Additional Expenses cover is:

- limited to the lower of £50,000 p.a. or one-third of earnings
- available to a minimum of two Equity Partners.
- only available when basic benefit is insured

Please note that Associated Business Costs can be insured, but not when Additional Expenses cover is in place.

Barristers

The policy can provide cover for the Barrister's share of the normal Chambers' expenses averaged over the last 3 years for either 2 or 3 years.

This additional cover is:

- limited to the lower of £50,000 p.a. or one-third of earnings
- available to a minimum of two Barristers.
- only available when basic benefit is insured

Policy Accounting

We normally calculate benefits using the Single Premium Costing method regardless of the number of lives insured. This is so premiums can be illustrated for all members who are expected to pay their own premiums.

Claiming benefits

Claims must be made by the Partnership/Chambers.

Once the deferred period has ended, we will pay the income benefits to the incapacitated member on a monthly basis, for the benefit payment period selected when the policy was taken out and for as long as the claim remains valid.

In addition to the requirements for a standard claim, we also need:

- evidence of policy membership and earnings
- for Equity Partners, details of the Partnership's accounts for the last 3 years (or if less than 3 years, since the partnership has been in business)
- for Barristers, details of the Barrister's last 3 years' income from the Clerk of the Chambers (or if less than 3 years, for as long as is available)

Taxation – Income benefit

This information in this and the following section (Taxation – Premiums) is based on our understanding of current UK tax legislation. Please contact your financial adviser for any potential tax implications.

Income benefit is tax free and paid gross directly to the incapacitated Equity Partner/Barrister.

Where chosen, additional expenses cover is paid directly to the Firm/Chambers and used to cover each Equity Partner's/Barristers' share of the ongoing business expenses.

Additional expenses cover is treated as a trading receipt and used for administration costs treated as a trading expense - resulting in a neutral tax situation.

Taxation – Premiums

Each Equity Partner/Barrister (taxed under Schedule D) pays for their own cover.

There is no tax relief on the premium paid.

Other

Lump Sum Benefit is not available for Equity Partners/Barristers.

Equity Partners

You have the option to provide cover for any "salaried partners" within the Equity Partners policy.

Terms and Conditions for "salaried partners" cover are the same as for employees under a standard GIP policy.

Barristers

Barristers cover is not available via UnumOnline.

Section 12 – UnumOnline

UnumOnline is our quick and simple online quote and on-risk facility. Your intermediary can use UnumOnline for:

Product Variants	• Standard GIP • Pay Direct GIP • Dual Benefit GIP • Pay Direct Dual Benefit GIP
Number of Lives	• policies with 3–100 members
Categories	• up to 4 membership categories can be included

Continued...

Earnings Definitions	· basic annual salary plus all fluctuating payments averaged over the last 3 years · non-PAYE taxed (e.g. Equity Partners) - average annual net taxable earnings received in the previous 3 years · gross earnings in the previous 12 months (fluctuating payments are limited to 20% of basic annual salary) · P60 earnings in the previous tax year (fluctuating payments are limited to 20% of basic annual salary) · basic annual salary plus all fluctuating payments received in the last 12 months (fluctuating payments are limited to 20% of basic annual salary)
Additional Benefits	· Employer Pension Fund Contributions · Employer National Insurance Contributions
Escalation	· Nil, 3% or 5% · RPI (RPI up to 2.5%, 5% or 12%) · CPI (CPI up to 2.5% or 5%)
Deferred Period	· 13 weeks · 26 weeks · 41 weeks
Eligibility	· the client must be a UK-registered company or a UK-based Equity Partnership · the policy must be open to new entrants and not have a closed eligibility
Locations	· quotes cannot be provided via UnumOnline where members travel to, or work outside of the following locations: - European Union - Australia - USA - Canada - Hong Kong - Switzerland - Iceland - Japan - Singapore - New Zealand - Norway
Occupations	· quotes cannot be provided via UnumOnline for the following occupations: - professional sportspeople - entertainers - air crew, air traffic controllers - ships crew - offshore, underground or underwater working - fire fighters, ambulance crew, police or armed forces - forestry, mining or quarrying - dealing with asbestos, nuclear, explosive materials or firearms - regular dealing or trading in Money Market instruments
Premium	· premiums must be paid via Direct Debit if quoted via UnumOnline · where a quotation is produced by your intermediary via UnumOnline, the estimated 1st-year cost will also include any loadings (medical or non-medical) supplied at the time the quote was produced

Section 13 – Complaints

We want you to be entirely satisfied with your Group Income Protection policy. If you do have a query or complaint, please contact the intermediary who arranged the policy for you. If there was no intermediary, please contact us directly.

If you are still not satisfied, please write to:

Technical Complaints Team Leader, Unum, Milton Court, Dorking, Surrey, RH4 3LZ

Tel: 01306 644761

If you are still dissatisfied, you have the option to contact the Financial Ombudsman Service at the address below up to 6 months after our final decision. Your legal rights are not affected.

The Financial Ombudsman Service, Exchange Tower, London, E14 9SR

Tel: 0800 023 4567

E-mail: complaint.info@financial-ombudsman.org.uk

Section 14 – Compensation

If we cannot meet our liabilities, you may be entitled to compensation under the UK Financial Services and Markets' Act 2000. Information is available from us on request.

Section D – Glossary

A Group Income Protection (GIP) policy is a policy taken out by the employer on behalf of their employees with the employer meeting the whole cost of the policy.

Actively at Work (AAW) means a member:

- has not received medical advice preventing them from working and is actively following their normal occupation, AND
- is working the normal number of hours required by their contract of employment - either at their normal business or at another business location

An employee is considered to be actively working if fully capable of doing so, if not for a leave of absence previously authorised by their employer, or the requirement for actively working falling on a day they are not contracted to work.

An employee must be Actively at Work at the start of cover and for all increases in benefit.

Auto enrolment means a legal obligation on employers to automatically enrol employees into a qualifying workplace pension scheme if they are not already a member of one, and to make a required level of contribution on the employee's behalf.

Auto enrolment event means an event specified by law where auto enrolment is required to take place.

Conditional Cover is where we agree to provide the quoted cover from the required start date for a period of up to 30 days, pending receipt of the information required to make a decision.

Deferred period is the period of time from the date a member becomes incapacitated until the date benefit becomes payable.

Discretionary entrants are employees to be included in the policy outside the usual eligibility criteria. This option is not available at UnumOnline.

Early entrants are employees to be included in the policy before completing the service qualification period. This option is not available at UnumOnline.

Free Cover Limit (FCL) is the maximum insured benefit before we need medical underwriting although Actively At Work requirements may still apply.

Late entrants are employees who want to join the policy after their first opportunity to do so.

Policy accounting date is the date from when we calculate the premium due for the next policy accounting period.

Policy accounting period is the period between the policy accounting dates.

Policy review date is the date we review and guarantee the premium rate, and terms of the policy for a further period (typically 2 years).

QAAF is Quotation Acceptance Application Form.

Start date is the date when we agree to provide the quoted cover.

State benefits relating to incapacity refers to Employment and Support Allowance.

Terminal Age is the age when benefit payments under the policy stop. This can be a set age or linked to the member's State Pension Age (SPA). If SPA is chosen, any changes to the SPA will apply to all members - except those incapacitated before the date the change passes into law.

The SPAs are set out in the table on our website in 'State Pensionable ages=Policy Terminal age' (UP2105) at: **http://online.positiveimagesuk.com/unum/images/UP2105.pdf**

The maximum Terminal Age is 70 for Gross Pay GIP policies. Benefit can stop at any pre-agreed point in the month when the member reaches Terminal Age, such as the last day of the month. Unless we state otherwise, benefit will stop at 23:59 on the day the member reaches their Terminal Age.

About Unum

Unum is one of the UK's leading providers of financial protection with more than 40 years' experience.

Unum helps employers protect their workers by providing access to financial protection, safeguarding employees from the financial consequences of serious illness, injury or death.

At the end of 2013, Unum protected almost 1.6 million people in the UK and paid claims of £320 million - representing in excess of £6 million a week in benefits to our customers - providing security and peace of mind to individuals and their families.

In the UK, Unum has a financial strength rating of A- (Strong) from Standard & Poor's with a stable outlook.

Its US parent company, Unum Group, traces its history back to 1848 and is one of the leading providers of employee benefits products and services, and the largest provider of group and individual disability insurance in the United States. Premium income for Unum Group and its subsidiaries totaled $7.6 billion in the year ended 31 December 2013, with reported revenues for the group totaling $10.4 billion. Total assets were $59.4 billion at 31 December 2013.

For more information please visit **www.unum.co.uk**

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