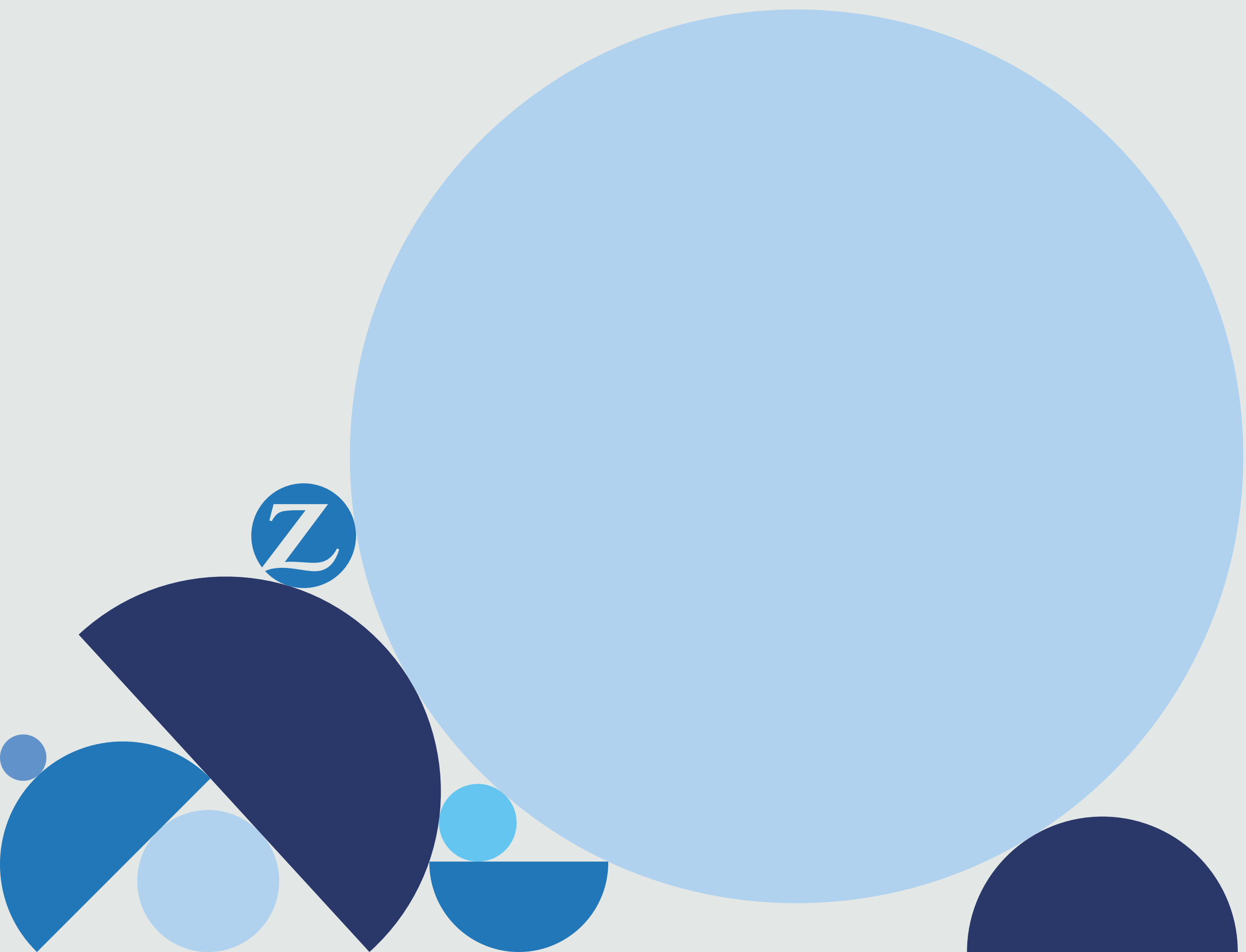
ZURICH

Group Life Policy

Technical guide



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Group Life Policy

The technical guide is an important document that explains the features of our Group Life Policy.

The guide should be read together with your quotation setting out the cost and other details specific to the cover you requested. This will include any modifications to our standard terms and conditions and any additional requirements we may need.

The full terms and conditions of the product are contained in your policy. It consists of our standard terms and conditions and the policy schedule, which shows details specific to your cover, including any modifications to the standard terms and conditions which are set out in the quotation.

We will issue the policy when all the details of your cover have been finalised, any requirements set out in the quotation have been met and we have agreed to enter into a contract with you. If you'd like to see a copy of the standard terms and conditions earlier, please ask.

We do not provide tax advice and nothing in the policy and the guide should be read as such. For this reason, we strongly recommend that independent tax advice is obtained by you to understand any potential taxation issues for you and the members, and any conflicts with employees' contracts of employment.

Throughout this technical guide where we refer to '**we**', '**us**' or '**our**' we mean Zurich International Life Limited. Where we refer to '**you**' or '**your**' we mean the Trustees. Where we refer to '**member**' we mean a person who is included in the policy.

The policy aims to:

- provide insurance to cover lump sum benefits payable on the terminal illness (where selected) /death of a member.
- offer a flexible range of choices in relation to these benefits and additional options available under the policy.
- offer a range of options tailored to budget and employment philosophy.

Your commitment

- To give us the complete and accurate information we've asked for within the times we've specified.
- To tell us if information that affects the premium changes (see **section 3**).
- To pay all the premiums we ask for, when they are due.
- To tell us about any claims as soon as possible, but in any event within the timescales set out in **section 3.2**.
- To tell us in advance of changes to participating employers including their activities, location and the relationship between them.
- To abide by the terms and conditions of the policy.
- You have a 30 day cooling off period, during which you can cancel if you change your mind. If you want to cancel within this period we will refund any premiums you have paid. The cooling off period begins the day you receive your initial policy documents.

Risk factors

- If you don't meet your commitments, we may not pay your claims and may cancel the policy.
- If you delay giving us requested information or letting us know of changes to participating companies, this could lead to:
  - a premium increase;
  - members not being covered under the policy or not being covered for full benefits;
  - delays in processing claims.
- We may exclude certain causes of claim for some members (see **section 6**).
- We may revise the terms and conditions or rates where:
  - you request we change the basis for calculating the policy benefits;
  - you request we change the eligibility conditions, including admitting or removing groups of employees or participating employers;
  - the number of members included in the policy, varies by more than 25% since the beginning of the rate guarantee period;
  - the number of members at a location varies by more than 25% from that previously notified to us.

Please note, the above list is not exhaustive.

- We may restrict the total amount of benefits payable in respect of multiple claims resulting from a single event, or where members within the policy travel on business together (see **section 6**).

How does the policy work?

We have designed this policy to finance death in service benefits. The benefits must be provided under an irrevocable discretionary trust established on or before the policy start date.

The policy will cover lump sum benefits payable on the death or terminal illness (where selected) of the member.

We agree between us the terms before cover starts, this includes:

- the policy's eligibility conditions;
- the type and amount of benefits.

We'll confirm in writing the amount of cover we'll provide. This cover will apply provided you continue paying premiums when they are due, no matter how many times you claim. If the policy is cancelled we'll continue accepting claims where they arose before cover was discontinued. You must provide us with the information we need to assess a claim.

If you want to make a claim for a member who has died, or is terminally ill (where such benefit has been selected), you must tell us no later than two years after that member's death. If we can admit your claim, we'll pay the lump sum to you as the Scheme Trustees to pay out in accordance with your powers.

Your questions answered

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

The Group Life Policy offers you a flexible approach to meeting the death in service benefits promised to the members. The policy enables you to insure fully or partially any lump sum benefits.

1.1 Who can be covered?

As soon as a member satisfies the 'eligibility' and 'actively at work' conditions below, they can be included in the policy.

There must be a minimum of 3 members when the policy starts.

1.1.1 Eligibility conditions

The 'eligibility' conditions will need to be agreed between us before the cover starts and may include factors such as:

- different groups of members to be covered;
- the minimum and maximum entry ages. Only people aged from 16 to 69 can be included as members;
- service qualifications.

Groups of members

You can choose to define eligibility criteria in a number of ways, for example by job grade, salary bands or job type (for example directors, clerical workers, manual workers). All eligible members in a defined group must be included in the policy.

Eligibility conditions covering entry age, entry dates and service qualifications must be the same for each member within a defined group.

Both full and part time employees (that is those on a permanent contract working a reduced number of hours) must be eligible.

You should take account of any laws relating to discrimination or unfair treatment, such as those relating to age or sex discrimination and the treatment of part-time, fixed term or disabled employees.

1.1.2 'Actively at work' requirements

Actively at work means that a member to be included in the policy has not received medical advice to refrain from work, is not absent from work or restricted from working due to illness or injury and is actively following their normal occupation. This means working at their normal capacity for the normal number of hours required by their contract of employment, either at their normal place of business or at a location at which they are required to travel for business purposes.

Where the requirement to be actively at work refers to a particular day, which is not a working day, members will be considered to be actively at work unless their medical record shows that they were suffering from a medical condition which would reasonably have been expected to prevent them from working normally.

1.1.3 Pre-approved leave

If a member is away from work not exceeding three years in duration and you still regard them as a member of the Scheme, included in your policy and continue to pay premiums in respect of them, we will maintain cover for illness and injury up to the terminating age.

We may agree to extend cover for longer periods in some circumstances.

We'll consider those members on pre- arranged absence, for example statutory leave (maternity or paternity leave etc.) or holiday to be actively at work, if approved by you in advance. This will not apply if their medical record shows that on the day when cover starts under the policy they were suffering from a medical condition which would reasonably have been expected to prevent them from working normally.

When you take out insurance for the first time

Members must be actively at work on the day cover starts. Those not actively at work on the day cover starts will be covered on the day they are next actively at work.

Automatic acceptance limit (sometimes known in the group insurance market as the free cover limit) is the maximum level of cover that is automatically given (without medical underwriting) to members who join the arrangement at their first opportunity and satisfy the actively at work requirement. We express this limit as a level of benefit that would be paid on the death of a member. You should make sure we always know the current entitlement for members who qualify for a higher level of benefit in order to ensure that they receive the cover to which they are entitled.

When you change insurer

If you're continuing cover for a previously insured group arrangement, the actively at work requirement is waived for all existing insured benefits.

If any individual is not actively at work on the day before cover transfers to us, but is on pre-approved leave, that was agreed with the previous insurer, we'll continue to provide cover to the end of that temporary absence period.

If the cover increases as a result of a change to the basis of calculation of benefit from that applicable under the previously insured policy, individuals who are not actively at work on the day before cover transfers to us, will not be covered for the increase in benefit basis until they have met the actively at work requirements.

New members of an existing policy at any time

New members must be actively at work on the day they are eligible to join. Those not actively at work on the day cover starts, will be covered for their benefits, up to the automatic acceptance limit when they're next actively at work.

1.2 When will cover end?

1.2.1 Under normal circumstances

Members will not normally be covered under the policy when any of the following happens:

- they reach the terminating age set out in the policy;
- they no longer meet the eligibility conditions in the policy;
- they are no longer employed by a participating employer.

Cover is not available for people aged 75 or older.

1.3 What types of cover are available?

Lump sum benefits can be either a fixed amount or a multiple of salary. The benefits can vary between different categories of membership, but must be the same basis for all members within a specified category.

1.3.1 What is policy salary?

We must agree between us the definition of salary to be used. This normally means the employee's basic yearly salary.

However, other definitions of salary can be used.

Any variable components of pay, such as bonus, commission, overtime and incentive payments, can be included and averaged where that is considered appropriate.

1.3.2 Optional additional protection – terminal illness

The group life policy offers terminal illness as an additional option which is available at an additional cost.

This benefit is payable in the event of terminal illness that is likely to lead to the death of the member within 6 months of diagnosis.

The terminal illness must be diagnosed by an accredited medical practitioner who is approved by us.

The benefit payment is 50% of the group life sum insured for the member, subject to the maximum amount stated in the policy schedule. Where the sum insured is a multiple of salary, the benefit amount will be calculated using the salary as at the date the member last attended work before they were declared to be terminally ill.

The member's sum insured under the group life benefit will be reduced by any amount paid under the terminal illness option.

1.4 Will increased earnings be covered?

Cover will increase when the policy salary increases provided it does not exceed the automatic acceptance limit. Increases that exceed the automatic acceptance limit will require underwriting (see **section 2.2**).

Notification of increase in earnings will be subject to the administration method (see section 5.2).

2. Setting up the policy

2.1 What are the requirements for setting up the policy?

You must contact us to agree terms before the cover starts. We need a completed Application Form together with any information requested in your quotation. We'll also need confirmation that a trust for the purpose of holding and distributing policy benefits is in place.

Within 30 days from the date the cover starts, we'll also require the premium.

We allow a 25% variation in the number of members between quotation and on risk data but the quotation basis will be applied to the up-to-date information you provide.

If we don't receive any one of the requirements we ask for when they are due, we may cancel the policy.

For previously insured policies we'll normally accept the underwriting terms offered by the previous insurer up to the level of benefits they provided when the cover transferred to us.

We'll need details of those members who have been medically underwritten, including those who have been subject to special terms.

2.2 Does any evidence of health have to be provided before members are covered?

Group cover is intended to be provided on a non-discretionary basis where the 'eligibility' and the 'actively at work' conditions apply.

To reduce the need to medically underwrite all the members of a policy, we'll set a limit called the automatic acceptance limit, below which, medical evidence of health will not be required. The automatic acceptance limit will be specified in your quotation and may be revised from time to time, for example, at the policy anniversary date.

For benefit amounts above the automatic acceptance limit, or for those members not eligible for the limit, our underwriters will ask for evidence of health. Therefore, you must let us know straightaway if the cover you need for a new member exceeds the automatic acceptance limit, or if an existing member's cover increases above this limit. We will need details of the member's health and activities and may require the member to be examined by a doctor.

If our medical underwriting identifies that a member has a medical condition, we may impose special terms. This may result in an additional premium or cover restriction.

2.2.1 Once and done underwriting

Once we have agreed the terms of cover for a member these will apply to future increases and within the limits described below. We won't normally need further evidence of health for increases.

There may be circumstances when our underwriters decline or limit forward underwriting for individual members.

Members are subject to further medical underwriting once their sum insured exceeds the medical underwriting bar, stated in the policy schedule and their increase is 15% or more in any 12 month period.

If you transfer a policy to us, for those members who have been medically underwritten, we will honor those terms, subject to the benefit levels being equal or less to the existing benefit.

If we are unable to accept the previous insurer's underwriting terms then,
cover will be limited to the automatic acceptance limit.

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

While a member is undergoing medical underwriting, their benefit will be restricted to the automatic acceptance limit or the previously accepted sum insured if higher.

3. Claiming benefits

This section deals with the common questions, which arise following a member's death.

3.1 How are claims made?

If you wish to make a claim it is important you notify Zurich direct or via your Intermediary.

When you notify a claim, Zurich will ask you for details of the member's name, date of birth, cause and date of death if known. The more information that we can establish, the quicker we can assess the claim.

On receipt of a claim notification, the case will be allocated to a claims assessor. The claims assessor dealing with your claim will decide on the next steps having reviewed the initial notification details.

Initially we will need a completed death benefit claim form together with the following documents:

- an original or certified copy of the member's death certificate;
- copy of the member's valid passport or equivalent photographic document showing the date of birth;
- confirmation the member was included in the policy at date of death;
- evidence of the member's earnings and employment at the date of death;
- at our discretion, a detailed medical report.

Once we have received our evidence requirements we'll then assess the claim.

If we can admit a claim, we'll make payment to the Trustees of the Scheme.

All payments will be made in the policy currency.

3.2 When do we need to know about a claim?

Please notify us as soon as possible after a member's death.

The policy schedule will state whether terminal illness has been selected. Where it has been, please notify us as soon as possible after the diagnosis of the terminal illness.

4. What premiums will be charged for the cover?

We currently charge a minimum premium of £1000 a year.

The premium we charge for a policy will depend on the cover you need and factors such as:

- the level of benefits;
- the eligibility;
- the age when cover ends;
- ages;
- genders;
- occupations;
- locations of the workforce;
- claims history.

If you do not accept our medical underwriting decision, you need to inform us in writing within 30 days of the date you were advised of our decision. In this case, the automatic acceptance limit or the previously accepted sum insured, if higher, will continue to apply.

4.1 How will we calculate the premiums?

To minimise administration, at the start of the rate guarantee period, we will either calculate a unit rate that applies to all members, or an individual rate that is applicable at a member level.

At the beginning of each year, we'll calculate a provisional premium, basing it on either the policy unit rate or the combined individual rates (subject to the type of type of rate selected) and the total benefit in force on that date.

The process for adjusting premiums for members will depend on which administration method has been selected and further information regarding the process for each is set out within **section 4.2**.

4.2 Will there be any unexpected extra premiums?

We usually guarantee unit rates for two years. We'll review them when the rate guarantee expires and we set a new rate guarantee expiry date. The review will consider any changes in the details of insured people and other factors mentioned earlier in the section. It will also reflect any change in the claims we expect from policies of this type; interest rates; and the cost of administrating and distributing such policies.

We'll remove the guarantee and recalculate the premium if:

- the number of members under the policy change by 25% or more;
- the occupations or locations of the members varies by more than 25%.

We may charge extra premiums for members who have undergone medical underwriting. Any extra premiums will only relate to the benefit we underwrite. The extra premiums will normally be worked out using the method for calculating the normal policy premiums and applying any additional loading to that part of the premium that relates to the underwritten benefit. Once we reach an underwriting decision we'll put into effect immediately the cover we can provide and will write to tell you. If you do not wish to pay the extra premiums you should tell us within 30 days of our written confirmation.

4.3 Is there a discount for good claims history?

There may be, as we consider past claims when working out premiums.

5. When do you pay premiums?

The policy is a long term insurance policy which offers a rate guarantee of either 1, 2 or 3 years. Unless you agree an alternative with us, you will pay premiums in annual installments in advance every year by electronic transfer. In certain circumstances, you can also pay monthly, quarterly or half-yearly.

While we're waiting for accurate information from you, we'll charge you a provisional premium. However, when we've calculated the accurate premium, you must pay any shortfall between this and the provisional premiums. If you've paid too much, we'll refund the difference to you.

5.1 What information is required for accounting purposes?

We'll let you know what information we need at least 90 days before each yearly revision date.

At each yearly revision date, we need information on:

- the total number of members per category;
- the total salary roll or benefit amount per category;
- each member whose benefits exceed the automatic acceptance limit; to whom we've applied special terms; who has extended cover; or who is temporarily absent from work.

We'll ask for more detailed information when the rate guarantee expires, when we need to recalculate the unit rate or when the number of members falls below 3 or changes by 25%.

The information needed at that time will include a list of all members at each yearly revision date showing their:

- unique identifier;
- occupation;
- gender;
- date of birth;
- policy salary;
- benefit;
- benefit category;
- workplace location;
- participating employer name and address;
- the date they joined or left.

You should also list members who are temporarily absent from work.

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

The process for adjusting premiums for members will depend on which of the following administration method is applied to each group of members.

5.2.1 Simplified administration:

Prior to each policy year you will provide us with updated information regarding members as at the policy anniversary date. This will be compared against the information received for the previous period, in order to calculate a premium adjustment. We will assume that all changes occurred in the middle of the policy year, and therefore the adjustment is obtained by using 50% of the difference.

The adjustment will either be invoiced to you, refunded or offset against the next premium due.

5.2.2 Individual administration:

You must inform us in writing of any changes to the details of the members, including sum insured within 30 days of such changes becoming effective.

At the end of each invoice cycle, we will calculate a premium adjustment reflecting the changes to the coverage for that period.

The adjustment will either be invoiced to you, refunded or offset against the next premium due.

6. Are there any exclusions applied?

Death caused by accident or illness is covered, however, exclusions may apply as a result of underwriting or for members with benefits in excess of the automatic acceptance limit.

Claim payments may be withheld if:

- material information relating to the policy or a claim that we have asked for, is outstanding;
- or we may also restrict or decline cover for members seconded to in certain overseas locations.

6.1 Single event limit

If a single event limit applies, it will be stated in your policy schedule.

This is the maximum amount we will pay on all individual claims arising from a single event. The limit is expressed as an aggregate of all the members' benefits.

A single event limit is considered when an event or occurrence result in the death of two of more members. A pandemic or epidemic declared by the World Health Organisation is considered a single event.

6.2 Group travel limit

If a group travel limit applies, it will be stated in your policy schedule.

The limit is the maximum amount we will pay under the policy in respect of members who die as a result of an incident that occurred whilst travelling together on business.

6.3 Cancelling the cover

You may cancel the policy at a policy anniversary date by giving us not less than 30 days prior notice in writing. The policy will continue until you cancel it provided you comply with its terms and conditions.

We can only cancel the policy for a material breach of its terms and conditions (for example, disclose a material fact or a failure to pay a premium within 30 days of the date when it is due, etc.). If we cancel the policy in these circumstances, we reserve the right to end cover on the date the material breach occurred.

We won't backdate any cancellation and we'll charge premiums for the time the policy was running.

All cover will end when the policy is cancelled. However, we'll consider any valid claim that happened before the date cover was cancelled.

We'll refund any overpaid premiums.

7. Continuation option

This policy doesn't provide a member leaving the company with the option to buy a personal policy to replace the cover they lose.

8. Further information

The Company

This Group Life Policy is issued by Zurich International Life Limited, whose head office is in the Isle of Man. Our address is:

Zurich International Life Limited
Zurich House
Isle of Man Business Park
Douglas
Isle of Man
IM2 2QZ

Surrender value

This group insurance policy doesn't acquire a surrender value.

Queries and complaints

For further information, or if you ever need to complain, contact us at:

Zurich International Life Limited
PO Box 67
Douglas
Isle of Man
IM99 1EF

Telephone: 01624 691038

Email: zigrs.admin@zurich.com

You can get details of our complaints- handling process on request.

Law

The policy is issued subject to the law of the Isle of Man.

You may enforce the benefits and rights granted to you under the policy. Nothing in the policy shall confer or is intended to confer rights on any third party or parties including the members.

Please read this document with the quotation. This document doesn't override the Terms and Conditions, which contain full details of the policy.

ZURICH

Important information

Zurich Integrated Benefits is a business name of Zurich International Life Limited.

Zurich International Life Limited is authorised under the Isle of Man Insurance Act 2008 and is regulated by the Isle of Man Financial Services Authority which ensures that the company has sound and professional management and provision has been made to protect planholders.

For life assurance companies authorised in the Isle of Man, the Isle of Man's Life Assurance (Compensation of Policyholders) Regulations 1991 (as amended), ensure that in the event of a life assurance company being unable to meet its liabilities to its planholders, up to 90% of the liability to the protected planholders will be met.

The protection only applies to the solvency of Zurich International Life Limited and does not extend to protecting the value of the assets held within any unit-linked funds linked to your plan.

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