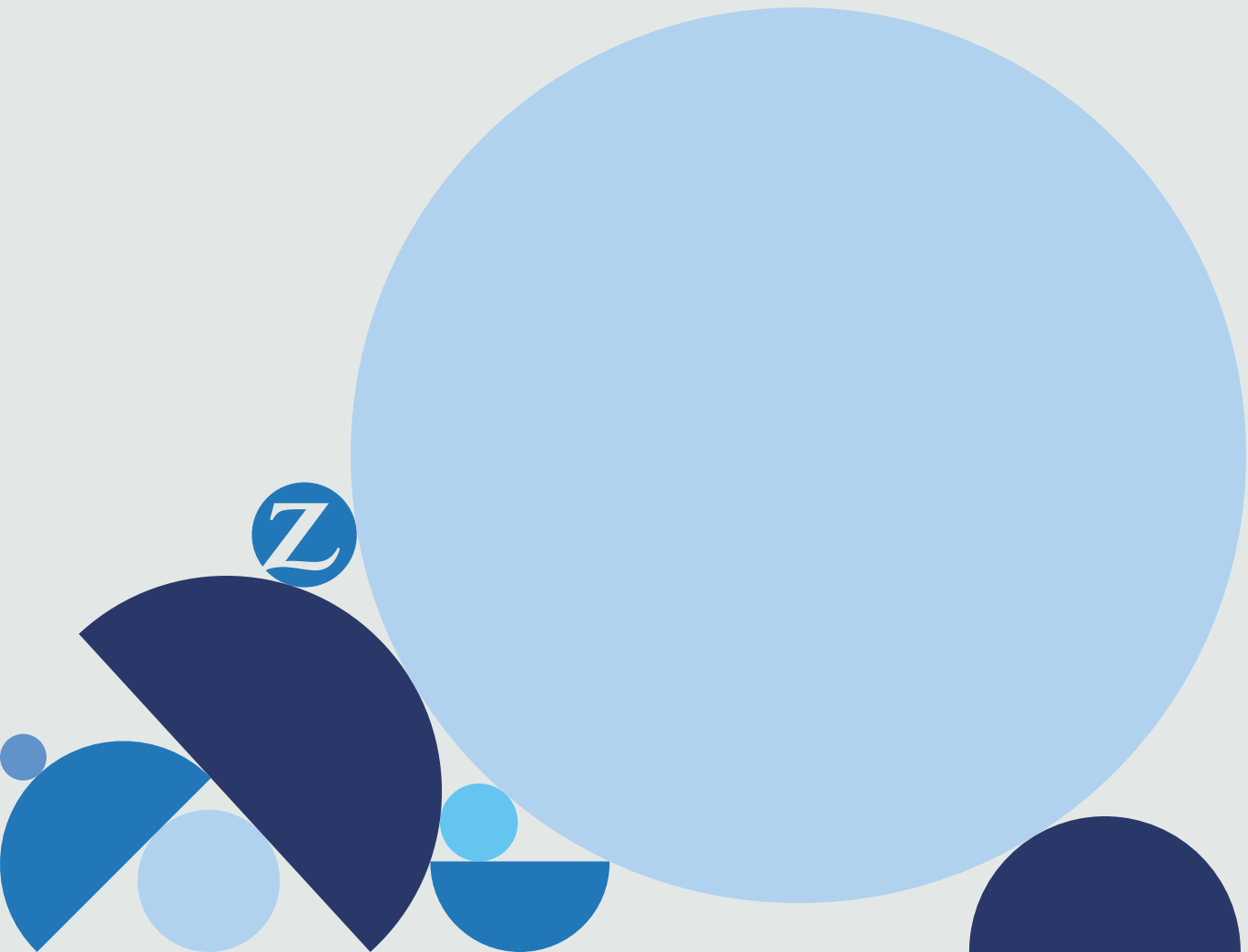
Group Income Protection Policy

Technical guide



Contents

Group Income Protection Policy

The technical guide is an important document that explains the features of our Group Income Protection 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 technical 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 your employees, and any conflicts with your 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 policyholder. Where we refer to '**group member**' we mean a person who is included in the policy.

The policy aims to:

- provide insurance that helps you pay your employees, or those of a participating employer, a regular income if illness or injury stops them working and earning.
- provide you with the option to cover pension scheme contributions.
- provide a reduced replacement income in proportion to an employee's loss of earnings if illness or injury forces them to take a part-time or lower-paid job.
- offer you a range of options to tailor the cover to your 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 5.3.
- To tell us in advance of changes to participating employer including their activities, location and the relationship between them.
- To let us know if a group member's benefit should end.
- To abide by the terms and conditions of the policy.

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 employers, this could lead to:
  - a premium increase;
  - group members not being covered under the policy or not being covered for full benefits;
  - delays in processing claims.
- We may reduce the benefits we pay if a group member receives other income arising from their incapacity. If applicable, this will be set out within your policy schedule.
- We may exclude certain causes of claim for some group members (see section 6).
- We may revise the policy 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;
  - the number of employees included in the policy, or their total salaries, vary by more than 25% since the beginning of the rate guarantee period;
  - you change your location or the nature of your business.

Please note, the above list is not exhaustive.

How does the policy work?

- We agree between us the terms before cover starts, this includes;
  - the policy's eligibility conditions;
  - the type and amount of benefits;
  - how soon we'll start, and for how long we'll pay, the benefit;
  - the definition of disability you require; and
  - whether the benefit payments will increase each year.
- We'll confirm in writing the amount of cover we'll provide. This cover will apply provided you continue paying premiums when they're due, no matter how many times you claim. We'll continue accepting claims where disability arose before cover was discontinued. You must provide us with the information we need to manage a claim.
- We pay benefits quarterly in advance for as long as claims are valid.

Your questions answered

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

We offer you a wide choice of cover to meet your organisation's objectives. Before the policy starts, or changes in any way, we must agree with you the formula for calculating any group member's benefit and the circumstances in which a claim will arise.

1.1 Who can be covered?

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

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

1.1.2 Eligibility conditions

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

- the categories of employees to be covered;
- the minimum and maximum entry ages. Only people aged from 16 to 70 can be included as group members;
- service qualifications.

Categories of employees

You can choose to define eligible group membership categories in a number of ways, for example by job grade, salary bands or job type (for example directors, clerical workers, manual workers). Membership must be compulsory for all employees within the defined category or categories.

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

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.

1.1.3 'Actively at work' requirements

Actively at work means that an employee 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, employees 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.

1.2 Pre-approved leave

If a group member is away from work not exceeding three years in duration and you still regard them as an employee of an employer included within 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 on pre-arranged absence, for example statutory leave (maternity or paternity leave etc) or holiday to be actively at work. This will not apply if their medical records show 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

Employees 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 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 employees who join the policy at their first opportunity and satisfy the actively at work requirements.

We express this limit based upon the sum assured at benefit level and you should make sure we always know the current salary of group members who earn more than the limit in order to ensure that they receive the cover to which they are entitled.

When you change insurer

If you're continuing cover from a group arrangement previously insured with another insurer, we will only cover any employee absent from work through illness or injury on the day before cover transfers to us, once the employee has returned to work in their normal capacity for 30 consecutive days.

An employee not actively at work will be covered for benefits up to the automatic acceptance limit, or for benefits we have accepted following underwriting by a previous insurer, when they are next actively at work.

If the cover increases as a result of a change to the basis of calculation of benefits 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 until they have returned to work.

New group members of an existing policy at any time

New group members must be actively at work on the day they are eligible to join. We'll cover those not actively at work on the day cover starts for their benefits up to the automatic acceptance limit when they're next actively at work.

Increases in benefit at any time

For benefit increases resulting from an increase in salary not requiring underwriting (see also section 2.2 for benefit increases above the automatic acceptance limit) group members must be actively at work on the effective date of the increase in their cover. Those who do not qualify will become entitled to their increased cover when they are next actively at work.

1.3 When will cover end?

1.3.1 Under normal circumstances

Group members will not normally be covered when any of the following happens:

- they reach the terminating age set out in the policy (the earlier of the age set by you or age 70);
- they no longer meet the eligibility conditions in the policy;
- they are no longer employed by you;
- immediately if they become actively involved in an act of war or terrorism;
- the coverage end date specified for each benefit;
- the date the policy ends (as indicated in the policy schedule);
- when the group member remains for more than three years on pre-approved leave as defined in section 1.2, unless agreed differently with us in writing.

1.4 What types of cover are available?

The section below describes the different types of cover available and the maximum amount we'll pay.

The maximum amount we'll pay in the event of a claim relates directly to the group member's salary immediately before they become disabled. We'll limit the maximum yearly amount of income benefit we pay for each group member to the amount stated in your quotation.

1.4.1 Income protection benefit

We specify the benefit you choose as a fixed amount or percentage of the member's gross salary.

The maximum amount we'll pay in the event of a claim will be limited so as to help to ensure there is a financial incentive to return to work as a result of accident only, illness only or either.

Determining whether a group member satisfies the definition of disability can be established through reference to the occupational definition selected. There are five options available – these are as follows:

i) Own occupation – The group member's own occupation.

ii) Own or similar occupation –
The group member's own occupation or any other occupation they could do because of their transferable skills at the time. The occupation should provide a reasonable, though not necessarily comparable, salary and status to the group member's own occupation. When we assess transferable skills, we will consider education, training and experience of the individual.

iii) Any occupation –
The group member's own or similar occupation or any occupation at all that can be followed by the group member for remuneration or profit.

iv) Own occupation for 24 months, thereafter own or similar occupation –
When a benefit is in payment the claim will only be payable for a period of 24 months whilst the group member is unable to follow their own occupation. Thereafter the benefit will only continue to be paid if the group member is unable to follow their own or similar occupation.

v) Own occupation for 24 months, thereafter any occupation
When a benefit is in payment the claim will only be payable for a period of 24 months whilst the group member is unable to follow their own occupation. Thereafter the benefit will only continue to be paid if the group member is unable to follow any occupation.

1.4.2 What is policy salary?

We must agree a salary definition with you. This is normally 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.

1.4.3 Optional additional protection

You may insure a yearly amount to maintain your ordinary yearly contributions to a pension scheme.

You are responsible for making sure the pension scheme contribution is in accordance with the pension rules.

1.4.4 Lump sum option

With the lump sum option, if a group member continues to meet the suited definition of disability throughout the specified limited term of benefit payment (that is two, three, four or five years' of benefit payment) you can ask us to pay a lump sum.

Where a group member is within five years of the policy's terminating age when a lump sum becomes payable, their benefit will be reduced by multiplying it by the number of complete months remaining to the terminating age divided by 60.

Cover for a group member under the policy will end following a lump sum payment.

1.5 Continuing cover up to the terminating age

We must agree in advance to what age you want to continue cover. This cover is available up to age 70.

If we don't receive any one of the requirements we ask for when they're due, the cover will end.

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 group members who've been medically underwritten, including those subject to special terms.

1.6 Will increased earnings be covered?

Cover will increase when the policy salary increases, provided it doesn't exceed the automatic acceptance limit. Increases exceeding this limit will require underwriting (see section 2.2).

Notification of increase in earnings will be subject to the administration method.

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 including any information requested in our quotation, which includes:

- group membership data as at the cover start date, including details of previous underwriting decisions;
- details of long term absentees;
- Location for all group members to be covered.

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

2.2 Does any evidence of health have to be provided before group 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 group members of a policy, we will set a limit called the automatic acceptance limit, below which, 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, when the rate guarantee period expires.

For benefit amounts above the automatic acceptance limit, or for those group 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 group member exceeds the automatic acceptance limit, or if an existing group member's cover increases above this limit. We will need details of the group member's health and activities and may require the group member to be examined by a doctor.

If our medical underwriting identifies that a group 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 group member these will apply to future increases and within the limits described below. We won't normally need further evidence of health for increases provided the group member is actively at work. There may be circumstances when our underwriters decline or limit underwriting for individual group members.

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

If you transfer a policy to us, for those group members who have been medically underwritten, we may agree to honour those terms, subject to the benefit levels being equal to or less than the existing benefit. We may ask for additional medical evidence regarding previously underwritten group members.

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

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

While a group 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 the benefit

This section deals with the common questions, which arise when a group member becomes disabled.

3.1 When can claims be made?

You can claim at any time if the policy is in force or the group member's disability began when the policy was in force.

- Under what circumstances?

  We will consider a claim when we're notified of a group member's disability.

  The benefit will be paid at the end of the waiting period.

- How ill or injured must the group member be?

  The group member's illness, or their injury, as a result of an accident must satisfy the definition of disability shown in the policy schedule.

- How will this be assessed?

  When you notify us of a claim, the claims team will require the group member's full name and date of birth together with further details such as cause of disability, date of event giving rise to the claim and policy number. The more information you can provide the quicker we can assess the claim.

  When we receive a claim, the case will be allocated to a claim's assessor. The claim's assessor dealing with your claim will decide on the next steps having reviewed the initial notification details.

After validating your claim notification, we will advise you of the medical and other evidence that we require to assess the claim.

For a disability claim, initially, this will include, but is not limited to:

i) our disability claim assessment form completed by the group member and an accredited medical practitioner; and

ii) our disability claim form completed by the Policyholder and

iii) a copy of the group member's valid passport or official photographic identity card or as agreed by you with us an equivalent photographic document showing the date of birth; and

iv) confirmation that the group member was included in this policy at the time of the event that resulted in the claim; and

v) proof of salary and employment at date of the event giving rise to the claim.

The aim is to assess objectively the nature of the disability and determine whether or not the group member could undertake the essential tasks involved in their occupation, as defined in the policy schedule.

We may need to request medical information from the group member's general practitioner plus any relevant hospital notes and reports. This will provide us with full details of the current medical condition and the history of symptoms.

Where necessary, we'll also seek a report direct from any treating hospital specialist.

- When will benefit payments start?

  Benefits become payable at the end of the 'waiting period' for valid claims (see section 5).

> The '**waiting period**' is the period of time we don't pay benefits following the event, resulting in the disability, of the group member.

You can find your waiting period in your quotation. The waiting period may be 3, 6, 12 or 24 months.

We'll pay the benefits quarterly in advance while the group member is disabled.

We may add a group member's periods of disability together to determine when the waiting period ends. We'll do this if:

- the group member suffers separate periods of disability from the same cause; and

- the total time that has elapsed since the first period started doesn't exceed twice the waiting period.

3.2 For how long do you want the benefits to be paid?

You can specify how long you want us to pay benefits. We'll usually pay benefits up to the terminating age for valid claims.

Alternatively you can select a 'limited period' for us to pay benefits. This means we can agree to pay for a period up to two, three, four or five years only in respect of a disability connected directly or indirectly to the same cause.

3.3 Can benefit in payment be inflation protected?

Where indexation has been selected as part of your policy, the first increase will be 12 months after the first payment date of the claim. Indexation options available are 1%, 2% or 5% per annum.

Benefits will not be reduced in a deflationary period where there is an annual decrease in the retail prices index.

To ensure ongoing validation of the claim, we'll perform periodic reviews. As part of this, we may also need to obtain further medical and other evidence.

Rehabilitation

Rehabilitation is the process of helping the group member return to work safely at the earliest opportunity, thereby reducing the cost of long-term illness to you.

Active rehabilitation and return to work programmes are an integral part of our claims management process. They are designed to help group members regain their health and return to work, wherever possible, maximising the group member's contribution to your organisation.

We have the services and advice of independent experts who specialize in the various aspects of rehabilitation. Our rehabilitation partners provide a range of options covering a multitude of disabilities. They are able to work with you and the group member and, where appropriate, implement a rehabilitation programme and timetable that helps the group member in their attempts to reintegrate back into the workplace.

3.4 For how long will the benefit be paid?

We'll pay the benefit quarterly in advance, until the earliest of:

- the group member returning to work or no longer satisfying the eligibility criteria within the terms and conditions;
- the group member no longer satisfying the definition of disability;
- the group member reaching the terminating age specified in the policy schedule;
- the group member retiring;
- the group member leaves service except where the conditions set out overleaf apply;
- the group member undertaking any form of employment without our agreement;
- the benefit period ending under a limited term policy;
- the group member dying.

- What happens if the group member's illness or injury means that they work on a part-time basis or in a reduced capacity?

  We will consider paying a benefit in proportion to the reduction in the group member's earnings.

  We will consider a claim for partial benefits even if a full claim has not been paid.

- What happens if a group member leaves service during the claim?

  If this happens, you should consult us as soon as possible.

  We will pay the benefit direct to a group member if they have to leave your employment through illness or injury provided that:

  - the waiting period has been completed;
  - we've agreed that the claim is, or remains, valid.

3.5 When do we need to know about a potential claim?

We ask that you notify us as soon as practicably possible about a potential claim where supporting evidence is available.

Experience shows that the longer someone is absent from work the less likely it is that they'll return successfully to their job.

There is a much greater chance that we will be able to help someone to return to a full and active life, including resumed employment, if we can work with you and the group member to establish the nature of the problem.

3.6 Who pays for medical evidence?

Where we ask for medical evidence we'll pay for it.

3.7 After a disabled group member returns to work, can another claim be made for that group member?

Yes. If the benefit has been paid and disability occurs again from the same or related cause within 12 months of the group member returning to work, the waiting period won't apply again.

If disability is from another cause, the group member will have to serve another waiting period.

If the policy has a limitation on the time for which a claim will be paid then periods of disability attributable to the same cause will be added together to calculate the payment duration.

When the policy ends and the scheme moves to a new insurer then, if a group member for whom you're claiming meets the 'actively at work' requirements of the new insurer but subsequently relapses from the same cause as the previous claim within the linked claims period, we'll pay benefit up to the end of the new insurer's waiting period. However, this is subject to the terms of our policy.

3.8 What happens to claims if the policy is discontinued?

If the policy is stopped, current claims remain payable and, if all premiums due have been paid, new claims will be considered if the disability began before the policy was stopped.

4. What premiums will be charged for the cover?

We currently charge a minimum policy premium of £1,000 a year.

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

- the amount of income benefits and supplementary benefits (if any);
- the eligibility;
- the waiting period;
- your chosen disability definition;
- your maximum income benefit payment period;
- the age when cover ends;
- the rate by which we increase income benefit payments (where this is included);
- 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?

At the start of the rate guarantee period, we calculate a yearly rate that applies to all group members. Prior to the end of the rate guarantee period, we'll calculate a premium, basing it on the policy rate and the total benefit in force on that date, for the forthcoming rate guarantee period.

The process for adjusting premiums for group 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 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 reserve the right to amend the rate guarantee, revise the premium rates or the terms and charge an immediate adjustment if:

- the number of group members changes by more than 25%

We may charge extra premiums for group 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, with any additional loading being applied to the part of the premium that relates to the underwritten benefit. Once we reach an underwriting decision we will write to confirm this to you, stating the effective date.

4.3 Is there a discount for good claims history?

There may be, as we consider past claims when calculating 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 instalments 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 on each renewal date?

We'll let you know what information we need at least 90 days before each yearly renewal date, which includes renewal membership data.

You should also list group members who are on pre-approved leave.

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

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

5.2.1 Simplified administration:
Prior to each policy anniversary date you will provide us with updated information regarding group members as at the forthcoming 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 group 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?

There are no general policy exclusions, but exclusions may apply as a result of underwriting for group members with benefits in excess of the automatic acceptance limit.

We will not make claim payments if:

- material information relating to the policy or a claim that we've asked for is outstanding;
- you haven't paid the premiums we asked for.

We may also restrict or decline cover for employees based in certain countries.

6.1 Cancelling the cover

You may cancel the policy at the 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, a failure to 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 continue any claims already in payment and consider any valid claim where disability occurred before the date cover was cancelled.

We'll refund any overpaid premiums.

6.1.1 Can you withdraw from the policy?
You have a 30 day cooling off period, during which you can cancel your policy 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.

7. Continuation option

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

8. Further information

The Company
This Group Income Protection Policy is issued by Zurich International Life Limited, whose head office is in the Isle of Man.

Its address is:

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

Surrender value
This Group Income Protection Insurance 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
British Isles

Telephone: 01624 691038

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

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

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

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.

Zurich International Life Limited is not authorised to offer insurance products for sale in the United States.

Materials are not intended as an offer to invest and do not constitute an offer or a solicitation of an offer to buy securities in any other country or other jurisdiction in which it is unlawful to make such an offer or solicitation.

Zurich International Life Limited (a company incorporated in the Isle of Man with limited liability) provides life assurance, investment and protection products and is authorised by the Isle of Man Financial Services Authority.

Registered in the Isle of Man number 020126C.
Registered office: Zurich House, Isle of Man Business Park, Douglas, Isle of Man, IM2 2QZ, British Isles.
Telephone +44 1624 662266 Telefax +44 1624 662038 www.zurichinternational.com

IB2B1717 (723047002) (06/24) ff