

GROUP INCOME REPLACEMENT INSURANCE

Information for Employers

Fact Sheet G5 ~ How To Claim

You can make a *Claim* if an *Employee* is *Incapacitated* and remains so after the end of the *Waiting Period*.

We have some clear definitions of *Incapacity* to help you make *Claims* in the right circumstances.

An *Employee* will be considered *Incapacitated for Work* and therefore eligible to become a *Claimant* as follows: ~

1. For the first 24 months that *Regular Benefit* is paid in respect of a single episode of *Illness* if, as a result of that *Illness*, he or she is unable to perform the main duties and activities required of them in their normal *Pre Incapacity Occupation* and who are not following any other occupation.
2. After the first 24 months for Premier and Employee Cover Enhancement Plans, the above will still apply, but with the additional condition that there is no reasonable alternative occupation which they would be able to perform. This does not need to be comparable in salary and status to their *Pre Incapacity Occupation*.
3. There are special rules which cover termination of an *Employee's* contract of employment during a *Claim*. If *Regular Benefit* continues to be paid after termination we will apply (1) above for the remainder of the first 24 months of *Claim*

After the first 24 months the former employee will be eligible to continue his or her claim if they are unable to undertake any occupation for which they may be suited by training, education or experience, or for which they could reasonably retrain.

Please also refer to Fact Sheet G4 "Keeping Your Plan Up To Date"

The Claims Process.

Step 1 – Notification

You must notify us as soon as you become aware that an employee's incapacity may result in a *Claim*. This can be done by phone, post or electronically, and must be done within 4 weeks of an *Employee* becoming *Incapacitated*. We do not normally accept claims for *Employees* who have returned to work before the notification is received.

Step 2 – Claim form

When you notify us of a *Claim*, we will send you a claim form and a certificate of absence which you need to complete and return to us as soon as you can. At this point we will also ask you to certify your *Employee's* average earnings for the period leading up to their first day of absence from work.

We will also require copies of any *Medical Certificate(s)* you have received ~ if you are unable to provide these we will request them directly from your *Employee*. Normally, we do not accept or continue to pay a *Claim* without *Medical Certificates* covering all the periods for which we pay *Regular Benefit*, but we may waive this, at our sole discretion, if we are able to obtain suitable alternative information in support of the *Claim*.

Step 3 – Acceptance

We will check your claim form and the information provided to make sure that the *Claim* is valid. We will, for example, check that the *Employee's Cover* is within the limits that we can insure and that there are no special terms that might affect payment. We may also seek information from the *Employee* or from his or her doctor. It is important that you notify us of your *Claim* promptly (even before expiry of the *Waiting Period*) so that we can assess it with the minimum delay to the commencement of payment.

Step 4 – Payment

Once we have validated and accepted your *Claim*, payment will be made at the frequency specified in your *Plan Terms and Conditions*, from the beginning of the week after the end of your selected *Waiting Period*.

This sheet continues overleaf

An explanation of the terms in *italics* can be found in [Fact Sheet G10 "Glossary of Terms Used"](#)

Claim Limits.

There is no limit to the number of **Claims** you can make. You should note that the length of time a **Claim** can be paid, for a single incident of **Incapacity**, is limited, under Plan 52 and Plan 104, to a maximum of 52 and 104 weeks respectively. **Claims** under premier plans have no pre-set limit of duration.

If an **Employee** returns to work and within one year again suffers **Incapacity** because of the same **Illness**, we will treat this as “A Relapse” and link the new **Claim** to the original to determine how long **Regular Benefit** should continue.

In such cases **Regular Benefit** commences immediately and we will aggregate all periods of relapse with that of the original **Claim** when assessing its duration. In these cases assessment is made in light of the overall monetary value paid and so a relapse **Claim** may be payable for a longer period than specified in your **Plan Terms and Conditions**.

If your selected **Plan** has the reducing benefit option (**Regular Benefit** reduces to 50% after the first year of payment) and a **Claim** includes periods of relapse, the above process also will be used to determine the date of reduction.

“A Relapse” occurring more than twelve months after **Regular Benefit** has ceased will be treated as a fresh **Claim**.

Claims During Pregnancy.

Pregnancy is not considered to be an **Illness** and therefore Claims cannot be made as a direct consequence of this condition.

We will only accept **Claims** for **Illness** arising from pregnancy complications and which prevent an **Employee** from returning to work at the end of her pre arranged maternity leave. **We** will also consider an earlier **Claim** if the pregnancy terminates in still birth, because of natural causes or because of medical necessity and the **Employee** is unable to return to work as a direct consequence.

Claims for pregnancy complications can only be considered or accepted if full **Cover** is maintained during the whole period of maternity leave ~ that is to say **Cover** is not suspended at the commencement of, or during maternity leave.

Please also refer to Fact Sheet G4 “Keeping Your Plan Up to Date” for information on policy suspension; and Fact Sheet G8 “What is Not Covered”

Claims Relating to Accidents

Work related accidents are those occurring whilst any of the following apply: ~

The Employee is at work	The Employee is working for an employer	The Employee is attending a function or event; at the request of, or organised by, the employer
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Non work related accidents qualify for payment of **Regular Benefit** from the first day of **Incapacity**. The minimum claim duration is one week, and the claim will continue until it meets the conditions for **Claim** cessation outlined earlier.

Claims arising from **work related accidents** will be subject to acceptance after the end of the **Waiting Period**.

In the case of **Claims** for **work related accidents** we will require you to notify your business insurer and legal adviser that we are providing insurance and paying a **Claim**. They should be authorised to communicate with us about the income related aspects of any claim you or the **Employee** make under your Employers Liability or other insurance(s).

If an **Employee** pursues third party actions in respect of **non work related accidents** they will need to authorise their legal representatives to contact us about the income related aspects of their third party claim.

In both cases we may agree with the insurer concerned or legal team that **Regular Benefit** paid by the Society is to be included in the third party action and that we may be reimbursed, in full or in part, from the proceeds.

Cessation of Claims.

“**The Criteria for Claim Cessation**” ~ **Claims** will cease when the “**Claim** Duration Limit” of the **Plan** is reached, or if earlier, the **Claimant** returns to work, recovers to fitness and is no longer **Incapacitated**, dies, attains **Retirement Age**, or retires before that age. **Regular Benefit** may also cease if the plan is cancelled ~ *Please refer to Fact Sheet G4 “Keeping your Plan up to Date”*

An explanation of the terms in *italics* can be found in **Fact Sheet G10 “Glossary of Terms Used”**