Policy Terms and Conditions

MetLife®

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Section 1 - The MetLife Group Income Protection policy

1.1 The **policy** sets out the terms on which the **insurer** grants to the **policyholder** income protection insurance in respect of **insured members** of the **scheme**, **eligible employees** and **eligible partners**.

1.2 The quotation, the information provided at the application stage and any other statement made by the **policyholder** form part of the contract between the **insurer** and the **policyholder**.

1.3 The contractual terms of the **policy** are set out in:

a. These **policy** terms and conditions;

b. The **policy schedule** and any **endorsements** to the **policy**;

c. The information provided at the application stage to include the individual applications submitted in respect of this **policy** by or on behalf of the **policyholder**;

d. Any health questionnaire or medical or other written statement relating to an **insured member**;

e. Any acceptance terms issued in writing by the **insurer** in respect of particular **insured member**s; and

f. Any special terms, exclusions and limitations specified in the final quotation.

The documents listed are together referred to as the "**policy**".

1.4 In return for payment of the premiums due under this **policy**, the **insurer** will pay **policy benefits** in accordance with and subject to the terms of this **policy**.

1.5 The **policy benefit** payable under this **policy** shall be limited to the liabilities of the **policyholder** under the **scheme** in so far as those liabilities are or are intended to be secured under this **policy**. The **policyholder** undertakes that any options exercisable and benefits or liabilities secured under this **policy** will be subject to the provisions of the **scheme**.

1.6 **Policies with a policy commencement date on or after 12th August 2016**

The **policyholder** is under a duty to make a fair presentation of the risk being insured and must have disclosed to the **insurer** every material circumstance relating to the **policy**, which the **policyholder** knows, and has conducted a reasonable search of information available to the **policyholder**. All information given by the **policyholder** to the **insurer** must be substantially true, accurate and complete. The duty of fair presentation applies at the application stage, at the **policy review date** and **guarantee expiry date**. If the **policyholder** deliberately, recklessly, or otherwise, fails to comply with the duty, the cover under the **policy** may be void from the start and it may result in the **policy** premium being retained by the **insurer**, a claim for **policy benefit** being rejected or any **policy benefit** payable in respect of a claim being reduced.

1.7 **Policies with a policy commencement date before 12th August 2016**

The **policyholder** is under a duty to disclose facts material to the risk being insured and undertakes that all the information given by the **policyholder** to the **insurer** is true, accurate and complete. This duty of disclosure applies at the proposal stage and continues during the term of the **policy**. If the **policyholder** is unsure about whether a fact is material, the **policyholder** must disclose the fact to the **insurer**. If the **policyholder** does not disclose all material facts, the cover under the **policy** may be void and any claim under the **policy** may be declined.

1.8 In the event of any conflict or inconsistency between these **policy** terms and conditions, the **policy schedule** and any other documentation, the contents of the **policy** terms and conditions will prevail.

Section 2 - Definitions

2.1 In this **policy** the following expressions have the following meanings, except where the context requires otherwise and words denoting the singular include the plural and vice versa:

Actively at work means, in relation to an employee employed by the **employer** or a partner of the **employer** at any relevant date, that they have not received medical advice to refrain from and are actively engaged in or are otherwise following their normal occupation on that date. **Actively** means the employee or partner is, in the opinion of the **insurer**, mentally and physically capable of working their normal contracted number of hours, either at their usual place of business or at the location to which business requires them to travel.

Absence from work does not include holidays, maternity, paternity and adoption leave, or any other authorised leave to beapproved by the **Insurer**.

Basic income benefit means the annual amount of benefit intended to partially replace **earnings** lost through **incapacity** as a result of illness or injury as specified in the **policy schedule**.

Benefit payment period means the maximum period of time for which **policy benefit** will be paid, and is specified in the **policy schedule**.

Catastrophic event means one originating event, accident, cause, occurrence or incident or a series of related originating events, accidents, causes, occurrences or incidents, that directly or indirectly results in the **incapacity** of more than one **insured member**, irrespective of the date of the **Incapacity** or the period of time or area over which the originating events, accidents, causes, occurrences and incidents took place.

Catastrophic event limit means the sum specified in the **policy schedule** in respect of a **catastrophic event**.

Data protection laws means Regulation 2016/679 of the European Parliament and of the Council on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation), and/or any corresponding or equivalent national laws or regulations in the UK, in each case, as in force and applicable, and as may be amended, supplemented or replaced from time to time.

Deferred period means the length of time an **insured member** must be continuously **incapacitated** before any **policy benefit** will be paid and as specified in the **policy schedule**.

The **insurer** will treat separate periods of **incapacity** as being continuous provided that:

a. Each period of **incapacity** is of at least 2 weeks in duration; and

b. All of the periods of **incapacity** are within a 52 week period.

The **insurer** will not combine separate periods of **incapacity** which occur prior to the **policy commencement date**.

Discretionary entrant means any individual who either:

- Satisfies the eligibility criteria but chooses to join the **scheme** after their first opportunity to do so; or
- Does not satisfy the eligibility criteria and wishes to join the **scheme**.

A **discretionary entrant** will be classed as an **insured member** once they have been accepted for cover by the **insurer**.

Earnings are defined in the **policy schedule**.

Eligible employee means any employee employed by the **employer** who meets the eligibility criteria as specified in the **policy schedule**.

Eligible partner means any equity partner of a partnership or an individual listed in the incorporation document of a Limited Liability Partnership who meets the eligibility criteria as specified in the **policy schedule**.

Employer means any company, partnership or organisation which is named in the **policy schedule** as the **employer**, principal company or **employer** group and any associated companies, whose employees and partners are eligible to be covered by this **policy**.

Endorsement means a clause detailing an exemption from or any change to the **policy**.

Escalation rate means the annual increase applied to the **income benefit** as specified in the **policy schedule**.

Free cover limit means the maximum amount of **policy benefit** that may be accepted for cover in respect of a particular **insured member** without **satisfactory evidence of health**.

The **free cover limit** which applies to the **policy** is specified in the **policy schedule**. This amount may be subsequently revised in respect of particular **insured members** from time to time as agreed between the **insurer** and the **policyholder**.

Guarantee expiry date means the date, if any, specified as such in the **policy schedule**, or any replacement date subsequently agreed from time to time between the **insurer** and the **policyholder**.

Guarantee period means the period from the **policy commencement date** (or, if applicable, the previous **guarantee expiry date**) to the **guarantee expiry date**. If no **guarantee expiry date** has been agreed, there will be no **guarantee period** for the purposes of the **policy**.

Incapacity means an **insured member**, or in respect of the temporary cover, an **eligible employee** or **eligible partner**, is incapacitated if the **insurer** is satisfied the **incapacity** definition selected for that **insured member**, **eligible employee** or **eligible partner**, is met. The applicable **incapacity** definition for each group of **insured members**, **eligible employee**s or **eligible partners**, will be specified in the **policy schedule**. **Incapacitated** shall be construed accordingly.

The **incapacity** definition will be one of the following definitions:

- Unable to perform their own occupation - an **insured member**, **eligible employee** or **eligible partner**, is incapacitated if:
  - they are unable to perform, due to illness or injury, the **material and substantial duties** required of them in their own occupation which they were performing immediately prior to being **incapacitated**; and
  - are not following any other occupation.
- Unable to perform their own or another suitable occupation - an **insured member**, **eligible employee** or **eligible partner**, is incapacitated if:
  - they are unable to perform, due to illness or injury, the **material and substantial duties** required of them in their own occupation which they were performing immediately prior to them being **incapacitated**;
  - are not following any other occupation; and
  - are unable to perform, due to illness or injury, the **material and substantial duties** of any other reasonable occupation to which they are suited by reason of training, experience or education.
- Unable to perform their own occupation switching to Unable to perform their own or another suitable occupation once an **incapacitated member** has been **incapacitated** for at least two years.

Incapacitated member means an **insured member** who, in the opinion of the **insurer**, satisfies the applicable definition for **incapacity**.

Income benefit means the annual total of the:

- **Basic income benefit**;
- **National Insurance contributions benefit**; and
- **Pension scheme contributions benefit**;

and is payable to the **policyholder** under the **policy** as a result of the **incapacity** of an **insured member**, **eligible employee** or **eligible partner**.

Insurer means MetLife Europe d.a.c., which is the insurance company that provides this insurance cover, and its successors and assigns.

Insured member means any individual who:

- Fulfils the definition of **eligible employee** or **eligible partner**;
- Joins the **scheme** at their first opportunity; and
- Meets the **actively at work** requirements of this **policy**.

A **discretionary entrant** will be classed as an **insured member** once they have been accepted for cover by the **insurer**.

Limited benefit payment period policy means a **policy** taken out with a **benefit payment period** other than "until **termination age**".

Linked claim means a claim where an **insured member** has returned to work following a period of **incapacity** but has then become **incapacitated** again within 12 months of returning to work, and the **deferred period** is treated as waived.

Material and substantial duties means occupation-related duties that:

- are normally required for the performance of an occupation; and
- cannot be reasonably omitted, changed or modified.

Maximum basic income benefit means the maximum annual amount of **basic income benefit** which will be insured for an **insured member** under this **policy** as specified in the **policy schedule**.

Maximum entry age means the maximum age at which an **eligible employee** or **eligible partner** may join the **scheme** to be insured under this **policy** as specified in the **policy schedule**.

Maximum income benefit means the annual total of the:

- **Maximum basic income benefit**;
- **Maximum National Insurance contributions benefit**; and
- **Maximum pension scheme contributions benefit**;

  as specified in the **policy schedule**.

Maximum National Insurance contributions benefit means the maximum annual amount of **National Insurance contributions benefit** which will be insured for an **insured member** under this **policy** as specified in the **policy schedule**.

Maximum pension scheme contributions benefit means the maximum annual amount of **pension scheme contributions benefit** which will be insured for an **insured member** under this **policy**, as specified in the **policy schedule**.

Maximum temporary cover benefit means the maximum annual amount of **temporary cover benefit** payable and is shown in the **policy schedule**.

Minimum entry age means the minimum age at which an **eligible employee** or **eligible partner** may join the **scheme** to be insured under this **policy** as specified in the **policy schedule**.

Minimum on-risk charge means the minimum charge specified in the **policy schedule**.

National Insurance contributions benefit means the annual amount of benefit payable, if selected by the **policyholder**, in addition to the **basic income benefit** for an **incapacitated member** towards the maintenance of the **employer's** National Insurance contributions applicable to the **basic income benefit** as specified in the **policy schedule**.

Personal data means any information relating to an identified or identifiable natural person.

Pension scheme contributions benefit means the annual amount of benefit payable, if selected by the **policyholder**, in addition to the **basic income benefit** for an **incapacitated member** towards the maintenance of the **employer's** and / or **insured member's** contributions applicable to the appropriate pension scheme as specified in the **policy schedule**.

Policy means the documents specified in clause 1.3.

Policy benefit means any income benefit payable in respect of an **insured member**.

Policy commencement date means the date shown in the **policy schedule** as the date cover started under the **policy**.

Policyholder means the **employer** as stated in the **policy schedule**.

Policy schedule means the **policy schedule** provided by the **insurer** in respect of the **policy**.

Reduced income benefit means **income benefit** payable if an **incapacitated member** returns to work after the end of the **deferred period** under medical supervision, in a reduced capacity, on reduced duties, reduced income or in a lower paid occupation.

It is calculated as the **incapacitated member's** pre-**incapacity earnings** minus their current **earnings**, which is then divided by their pre-**incapacity earnings**; multiplied by the **income benefit**.

$$\textbf{Reduced income benefit} = \frac{(\textbf{pre-Incapacity Earnings} - \textbf{current Earnings}) \times \textbf{income benefit}}{\textbf{pre-Incapacity Earnings}}$$

Pre-**incapacity earnings** are enhanced at the date the **reduced income benefit** is first payable, then on every 12 month anniversary after this date. The enhanced amount to be added to the pre-**incapacity earnings** prior to **reduced income benefit** being calculated is calculated as follows:

= ((RPI Two – RPI One) / RPI One) x pre-incapacity earnings

Where:

- **RPI One** is the UK Retail Price Index measured over the preceding one month period three months before the date of first day of **incapacity**, then at the date of the last enhancement for any subsequent enhancements; and
- **RPI Two** is the UK Retail Price Index measured over the preceding one month period three months before the date the **reduced income benefit** is payable from.

Review date is the date stated in the **policy schedule** as the **review date**. It is also known as the 'renewal date'.

Satisfactory evidence of health means evidence in such form as the **insurer** may reasonably require establishing, to the satisfaction of the **insurer**, that the state of health of the individual who is being assessed is of acceptable standard.

Scheme means the **scheme** stated in the **policy schedule** which is a group income protection **scheme** provided by the **employer** for their employees and / or partners.

Single premium means, if stated, the **single premium** amount set out in the **policy schedule** or any replacement amount subsequently agreed from time to time between the **insurer** and the **policyholder**.

Temporary cover benefit is the amount of **policy benefit** applied for that requires **satisfactory evidence of health**.

This amount will be reduced to:

- Zero, where the **policy benefit** already accepted by the **insurer** exceeds the **maximum temporary cover benefit**; or
- The **maximum temporary cover benefit** less the **policy benefit** already accepted by the **insurer** where the **policy benefit** applied for exceeds the **maximum temporary cover benefit** but the **policy benefit** already accepted by the **insurer** is less than the **policy benefit** applied for.

Temporary cover period means the period which commences on the later of:

- The **policy commencement date** or the time of becoming eligible for cover if later; or
- The date on which the **insurer** is told cover, or increase in cover as appropriate, for the **eligible employee**, **eligible partner** or **discretionary entrant** is to be effective from;

and terminates on the earlier of:

- The **insurer** notifying the **policyholder** in writing of the underwriting decision; or
- The expiry of 90 days after the **temporary cover period** commenced (or a longer period at the discretion of the **insurer** and notified to the **policyholder** in writing).

Termination age means the age at which cover normally ceases for an **insured member** as specified in the **policy schedule**.

Unit rate of premium means the premium rate per unit stated in the **policy schedule**, or any replacement premium rate per unit subsequently agreed from time to time between the **insurer** and the **policyholder**.

Section 3 - Minimum requirements for the MetLife Group Income Protection policy

3.1 No **policy benefit** is payable unless the following are provided to the **insurer** within 30 days of the **policy commencement date** or any later date agreed in writing by the **insurer**:

a. A fully completed proposal form and any other information requested by the **insurer** at the application stage;

b. A premium cheque, direct credit (BACS) payment, completed standing order form or completed Direct Debit mandate in respect of the premiums payable under the **policy**;

c. Full **scheme** data which means full employee data and partner data at the start of the cover is required including but not limited to location, names, gender, salaries and dates of birth; and

d. Written answers given by the **policyholder** to the questions raised by the **insurer**.

If these requirements are not met within 30 days or any later date agreed in writing by the **insurer**, the **policy** may be cancelled and the **minimum on-risk charge** may be payable by the **policyholder** in accordance with clause 17.5.

The **insurer** may charge an administration fee in the event of late payment of any premium and / or late provision of full **scheme** data.

Section 4 - Eligible employees and eligible partners covered at the policy commencement date

4.1 **Policies of fewer than 20 eligible employees and / or eligible partners**

Cover under the **policy** will be provided from the **policy commencement date** to an **eligible employee** or **eligible partner** if they:

a. meet the definition of **insured member**;

b. are **actively at work** on the day before the **policy commencement date**; and

c. have not failed to be **actively at work** for 10 or more working days in the previous 60 calendar days prior to the **policy commencement date**. The 10 working days need not be continuous.

Unless otherwise agreed in writing by the **insurer**, for each **eligible employee** and **eligible partner** who is not **actively at work**:

a. on the day before the **policy commencement date**; and / or

b. has failed to be **actively at work** for 10 or more working days in the previous 60 calendar days prior to the **policy commencement date**, the 10 working days not needing to be consecutive;

the **policyholder** must provide **satisfactory evidence of health** to the **insurer** before the **insurer** will consider accepting them as an **insured member** (see section 7 – *Underwriting*).

4.2 **Policies of 20 or more eligible employees and / or eligible partners**

Cover under the **policy** will be provided from the **policy commencement date** to an **eligible employee** or **eligible partner** if they:

a. meet the definition of **insured member**; and

b. are **actively at work** on the day before the **policy commencement date**.

For each **eligible employee** and **eligible partner** who is not **actively at work** on day before the **policy commencement date**, cover will commence in respect of such **eligible employees** and / or **eligible partners** when they are **actively at work** for at least one working day after the **policy commencement date**.

4.3 No cover will be provided from the **policy commencement date** to a **discretionary entrant** until **satisfactory evidence of health** is provided and the **insurer** has agreed the level of cover to be provided in writing (see clause 7.4). However, whilst being underwritten, the **discretionary entrant** will be covered by temporary cover (see section 8).

4.4 The level of **policy benefit** covered by the **insurer** for an **insured member** will be subject to requirements of section 7 - *Underwriting*.

Section 5 - Eligible employees and eligible partners joining after the policy commencement date

5.1 After the **policy commencement date**, an employee or partner who wishes to join the **scheme** will automatically become an **insured member** under the **policy**, provided that they:

a. Meet the definition of **eligible employee** or **eligible partner**;

b. in respect of policies of fewer than 20 **insured members**: are **actively at work** on the day that they first become an **eligible employee** or **eligible partner**, and have not failed to be **actively at work** for 10 working days or more in the previous 60 days prior to the day they first become an **eligible employee** or **eligible partner**;

c. in respect of policies of 20 or more **insured members**: are **actively at work** on the day that they first become an **eligible employee** or **eligible partner**;

d. Join the **scheme** at their first opportunity;

e. Are not a **discretionary entrant**;

f. Are not on a temporary employment contract of less than one month; and

g. Are not resident outside of the United Kingdom.

Where any of these conditions are not satisfied, the employee or partner will be treated as a **discretionary entrant** (see clause 5.3).

5.2 Subject to satisfying the conditions in clause 5.1, the new **insured member's policy benefit** is automatically covered up to the **free cover limit**. Any cover exceeding the **free cover limit** is subject to clause 7.3.

5.3 Cover under the **policy** will not be provided by the **insurer** in respect of a **discretionary entrant** who wishes to join the **scheme** after the **policy commencement date** unless **satisfactory evidence of health** is provided and the **insurer** has agreed the level of cover to be provided in respect of the **discretionary entrant** in writing (see clause 7.4). However, whilst being underwritten, the **discretionary entrant** will be covered by temporary cover (see section 8).

Section 6 - Increases in policy benefit after the policy commencement date

6.1 **Policies of fewer than 20 insured members**

Where the **policy benefit** in respect of an **insured member** increases after the **policy commencement date** and:

a. the **insured member** is **actively at work** on the day the increase occurs; and

b. has not failed to be **actively at work** for 10 or more working days in the previous 60 days prior to the day the increase occurs;

cover in respect of the increase will be subject to clause 7.3.

Where the **policy benefit** in respect of an **insured member** increases after the **policy commencement date** and:

a. the **insured member** is not **actively at work** on the day the increase occurs; and / or

b. has failed to be **actively at work** for 10 or more working days in the previous 60 days prior to the day the increase occurs;

cover in respect of the increase will be subject to the **insured member** being **actively at work** for at least six working days, having not failed to be **actively at work** for 10 or more working days in the previous 60 days and clause 7.3.

6.2 **Policies of 20 or more insured members**

Where the **policy benefit** in respect of an **insured member** increases after the **policy commencement date** and the **insured member** is **actively at work** on the day the increase occurs cover in respect of the increase will be subject to clause 7.3.

Where the **policy benefit** in respect of an **insured member** increases after the **policy commencement date** and the **insured member** is not **actively at work** on the day the increase occurs, cover in respect of the increase will be subject to the **insured member** being **actively at work** for at least one working day, and clause 7.3.

6.3 Where the **policy benefit** in respect of an **insured member** increases, and the increase goes above the **insured member's free cover limit**, the **policyholder** must notify the increase to the **insurer** before the date or on the date the increase occurs.

6.4 Where the **policy benefit** in respect of an **insured member** increases, if the increase results in a 30% or more change in the number of **insured members** and / or the total **policy benefit**, the **policyholder** must notify the increase to the **insurer** before the date or on the date the increase occurs, and section 9 applies.

Section 7 - Underwriting

7.1 Except where this **policy** provides that cover will be granted without **satisfactory evidence of health**, or where the **insurer** agrees otherwise in writing in any particular case, the grant of cover under the **policy** in respect of any **insured member** will be subject to provision of **satisfactory evidence of health** in respect of that individual. If the evidence indicates that the health of that individual is below the standard acceptable to the **insurer** for cover under the terms of the **policy**, the **insurer** may refuse cover or impose such terms, conditions, exclusions and restrictions or additional premiums as it considers appropriate in respect of that individual.

7.2 **New place of work for an insured member**

The **policyholder** must notify the **insurer** in writing if any **insured member** is assigned to work at a new place of work (within the UK or overseas) not previously notified to the **insurer** or on secondment for another **employer** or firm. Such notice must be given at or before the time when the change takes place. The **insurer** will be entitled to withdraw cover under this **policy** in respect of that **insured member**, or to make such cover subject to special terms and conditions, with effect from the date when the change takes place. The **insurer** will notify the **policyholder** in writing as soon as reasonably practicable if it decides to withdraw cover or to impose special terms and conditions.

7.3 **Policy benefit above the free cover limit**

Subject to clauses 7.4 to 7.6 inclusive, where an **insured member** satisfies the **actively at work** requirements under the **policy** on the day before the **policy commencement date**, or at the time of becoming eligible for cover or at the time an increase in cover occurs but the **policy benefit** applied for in respect of the **insured member** is greater than the **free cover limit**, the **insured member** will be covered automatically for the amount of the **free cover limit**. Only the **policy benefit** in excess of this will be subject to underwriting.

However, whilst being underwritten, the **insured member**, **eligible employee** or **eligible partner** will be covered for the benefit being underwritten by temporary cover (see section 8).

7.4 **Policy benefit for discretionary entrants**

The **insurer** will not provide **policy benefit** for any **discretionary entrant** until it has been provided with **satisfactory evidence of health**. Cover will only be provided by the **insurer** once it has notified the **policyholder** in writing.

However, whilst being underwritten, the **discretionary entrant** will be covered by temporary cover (see section 8).

7.5 **Free cover limit for existing schemes**

Subject to clause 7.6, if the **scheme** is an existing **scheme** appointing the **insurer** on the same basis as the previous **insurer** and a **free cover limit** applies in relation to the **scheme**, the **insurer** will cover each member of the **scheme** to the same level as the previous **insurer** up to the **free cover limit** without requiring **satisfactory evidence of health**. Where the **policyholder** wishes to maintain an existing **policy benefit** above the **free cover limit**, or to increase benefits above the existing levels, this will be subject to providing **satisfactory evidence of health** for each **scheme** member concerned. Pending underwriting by the **insurer**, cover will be provided under the **policy** up to the **free cover limit** or, if less, the level of existing benefit, unless the **insurer** indicates otherwise in any particular case.

7.6 After the **policy commencement date**, where an **insured member** has been rated, declined or limited to a **free cover limit** (or any equivalent level) by the **insurer** or through their own choice, the **policyholder** will be required to provide **satisfactory evidence of health** before that member will be accepted for any further cover under this **policy**.

However, whilst being underwritten, the individual will be covered by temporary cover (see section 8).

Section 8 - Temporary cover

8.1 For the purpose of clauses 7.3 to 7.6:

a. Temporary cover provides cover for **policy benefit** that requires **satisfactory evidence of health** in respect of the **incapacity** of the **insured member**, **eligible employee**, **eligible partner** or **discretionary entrant** as appropriate.

b. Temporary cover applies during the **temporary cover period**.

c. The **temporary cover benefit** is the amount of benefit provided under temporary cover.

d. No **temporary cover benefit** will be payable if the **incapacity** of the **insured member**, **eligible employee**, **eligible partner** or **discretionary entrant** directly or indirectly results from, or is attributed to or contributed to by, any disease, illness, infirmity, condition, physical defect, injury or any related condition:

i. Which the employee or partner was aware of in the five years before the commencement of the **temporary cover period**, whether or not the disease, illness, infirmity condition, physical defect, injury or any related condition had been diagnosed; or

ii. About which the employee or partner had at any time in the five years before the commencement of the **temporary cover period** consulted a doctor or other medical or health professional or medical or health adviser and been recommended to take further advice, or take medication, or undergo investigations or treatment, whether or not the disease, illness, infirmity, condition, physical defect, injury or any related condition had been diagnosed.

Section 9 - Premiums, guarantee period and reviews

9.1 The frequency and due date(s) for payment of premiums are specified in the **policy schedule**. Premiums are payable by the **policyholder** to the office and /or bank account of the **insurer** designated from time to time in writing by the **insurer**.

9.2 If there are fewer than three **insured members**:

a. The **insurer** will charge a **single premium**;

b. The **free cover limit** will be zero; and

c. The premium and the **policy** terms and conditions will be reviewed each year.

If the number of **insured member**s in an existing **scheme** increases to three or more, the cost will be calculated on the basis of a **unit rate of premium**, as outlined in clause 9.3.

9.3 If there are three **insured members** or more:

a. The premium charged for the **policy benefit** will be based on the **unit rate of premium**;

b. Where there are fewer than twenty **insured members**, the **policy** will be costed and administered without the calculation of a year-end adjustment to the premium, and the **unit rate of premium** will be fixed until the end of the **guarantee period** , unless an event occurs which results in the re-rating of the **policy** as set out in the provisions of section 9;

c. Where there are twenty or more **insured members**, the **policy** will be costed and administered on a simplified administration basis with the calculation of a year-end adjustment to the premium, assuming all changes occur half way through the **policy** year, and the **unit rate of premium** will be fixed until the end of the **guarantee period** , unless an event occurs which results in the re-rating of the **policy** as set out in the provisions of section 9;

d. On each **review date**, the premium charged for the **policy benefit** will be based on the **unit rate of premium** and on the information provided to the **insurer** in respect of that **review date**; and

e. The **insurer** reserves the right to cancel the **policy** or change the costing basis to **single premium** as outlined in clause 9.2, with no **free cover limit** applicable, if the number of **insured members** falls below three.

9.4 The **insurer** reserves the right to re-rate and re-underwrite the **policy** at the end of the **guarantee period**, and otherwise at any time, if:

a. In the opinion of the **insurer**, there is a change in the nature of the risk underwritten or there is an alteration in the premium due;

b. If any new regulation (or change in legislation or HMRC practice) comes into force which affects the way that premiums and/or **policy benefits** are treated for tax purposes for the **employer** or any others, the **insurer**, the **insured member** or any recipient of **policy benefit**, or which otherwise affects this **policy**.

c. The **insurer** agrees to a change to the definition of **eligible employee** or **eligible partner** or to the terms for **policy benefits**, or other **policy** terms and conditions; or

d. There has been a 30% or more change in the number of **insured members** or the total **policy benefit** since the later of the **policy start date** and the previous **review date**.

9.5 Where the **insurer** re-rates and / or re-underwrites the **scheme** in accordance with clause 9.4, it may do any or all of the following:

a. Determine a new **unit rate of premium** (or, where applicable, a **single premium**) for this **policy**;

b. Amend the levels of **policy benefit** under this **policy**, or any of the other terms and conditions of this **policy**; and

c. Amend any of the definitions as set out in section 2.

9.6 The **insurer** will notify the **policyholder** of any changes that it makes to this **policy** in the course of re-rating and / or re-underwriting the **scheme** and will give notice in writing of those changes to the **policyholder** at least 5 days before they take effect.

Where a new premium rate is imposed, it will accumulate from the date on which the event giving rise to re-rating occurs, or any later date specified by the **insurer** to the **policyholder**. An adjusting premium or refund of premium in the amount calculated by the **insurer** will become due 30 days after that date and the amount of subsequent premiums will be amended as notified by the **insurer**.

9.7 Upon re-rating and / or re-underwriting of the **policy**, cover will cease if the information requested of the **policyholder** is not received by the **insurer** within 30 days of the date on which the event giving rise to re-rating and / or re-underwriting occurs or on any later date specified by the **insurer** to the **policyholder**.

9.8 Upon review of the **policy**, the **policyholder** must provide to the **insurer** full individual data within 30 days of the **review date**, to include but not limited to all details of any current or pending claims under the **policy**, and members exceeding their **free cover limit** in addition to details of members who are temporarily absent from work and have been so absent for a continuous period of 90 days or more. Details regarding current or pending income protection and critical illness claims will also be required.

If individual data is not received in full within 30 days of the **review date**, this **policy** may be terminated at the end of that period.

Section 10 - Policy benefits

10.1 Subject to the definitions, any exclusions, conditions and **endorsements** to this **policy**, the **policy benefit** and **temporary cover benefit** (if applicable) will be payable by the **insurer** to the **policyholder** if the **insurer** receives proof satisfactory to the **insurer**, that the **insured member** has been **incapacitated** for the **deferred period** and continues to be **incapacitated**.

10.2 If a **policy benefit** becomes payable in respect of the **incapacity** of an **insured member**, the **insurer** will pay the **policy benefit**. This will always include the **basic income benefit**. If selected by the **policyholder**, the following additional benefits will also be covered:

a. The **National Insurance contributions benefit**; and

b. The **pension scheme contributions benefit**.

10.3 The maximum benefit that may be payable in respect of any **insured member** is limited by the following:

a. The **maximum basic income benefit**;

b. The **maximum National Insurance contributions benefit**; and

c. The **maximum pension scheme contributions benefit**.

10.4 The total **policy benefit** paid in each year under the **policy** in respect of all **insured members** whose **incapacity** occurs directly or indirectly as a result of any one **catastrophic event** will be limited to the amount specified in the **policy schedule** as the **catastrophic event limit**.

Section 11 - Claims

The **policyholder** must comply with all applicable anti-discrimination legislation, including the Equality Act 2010 (the 'Act') and any subsequent legislation which amends, supercedes or replaces it, and any subordinate legislation, and where appropriate make reasonable adjustments to the workplace in compliance with the Act.

11.1 **Claim notification**

11.1.1 The **policyholder** must notify the **insurer** in writing as soon as reasonably practicable if an **insured member**, eligible employee, **eligible partner** or **discretionary entrant** has been continuously absent from work, or has been working on a reduced basis, for a period of at least four weeks, due to **incapacity**, which may result in a claim. The **insurer**, upon receipt of such notice, will provide the **policyholder** with a claim form.

11.1.2 The claim form should be completed and returned to the **insurer** as soon as reasonably practicable after issue by the **insurer** and in any event by completion of half of the **deferred period**.

11.2 **Providing evidence of a claim**

11.2.1 The claim form must, at the **policyholder's** expense, be accompanied by evidence of age of the **insured member**, **eligible employee**, **eligible partner** or **discretionary entrant** and evidence of membership of the **scheme** (where applicable) and **earnings**, and any other requested documentation as specified in the claim form.

11.2.2 The **insurer** has the right to carry out investigations and require and obtain any further information it deems appropriate to assess the claim, which may include, but is not limited to, obtaining medical evidence.

11.2.3 The **insurer** reserves the right to arrange for a specialist claims visitor to visit the **insured member** and **policyholder**. A visit may be carried out before the expiry of the **deferred period**. The **insurer** reserves the right to obtain medical reports by one or more medical practitioners or consultants chosen by the **insurer**.

11.2.4 The **insurer** will undertake periodic medical reviews, at the **insurer's** expense, to ensure the **insured member** who is the subject of the claim continues to satisfy the applicable definition of **incapacity**. Failure by the **insured member** to attend a medical examination, failure to cooperate with a reasonable request for a claims visit or failure by the **policyholder** to provide requested information within the time notified or as soon as reasonably practicable thereafter may result in the claim being declined for that **insured member** by the **insurer**. Where the claim has been admitted by the **insurer**, any further payment of benefit may be discontinued.

11.2.5 Where an **insured member** lives overseas, any costs in respect of returning the **insured member** to the United Kingdom to attend any medical examination the **insurer** may require must be met by the **policyholder**. After 6 months living overseas, the **insurer** may require the **insured member** to return to the United Kingdom or to visit another country as instructed by the **insurer** to attend a medical examination.

11.3 **Payment of policy benefit**

11.3.1 Claims will only be payable provided that all premiums due have been received by the **insurer** in full. The claims will be payable in the same currency as premiums received. The payment of the **income benefit** will discharge the **insurer** from all liability in respect of the claim.

11.3.2 The payment of **policy benefit** and / or **temporary cover benefit** is subject to section 12. The payment of **temporary cover benefit** is also subject to section 8.

11.3.3 Benefit will be paid at the rate of 1/12 (one twelfth) of the **income benefit** and will be paid monthly in arrears. A proportionate payment will be made in the month when the **insured member** no longer meets the definition of **incapacity**.

11.3.4 Income benefit is not payable by the **insurer** to the **policyholder** until the **insured member** has remained **incapacitated** for at least the **deferred period**.

11.3.5 **Policy benefit** will not be payable by the **insurer** to the **policyholder**:

a. If a completed claim form is not received by the **insurer** within 90 days of the expiry of the **deferred period**; or

b. During the **deferred period**.

11.3.6 The income benefit shall increase by the **escalation rate** on the first anniversary of the day when the benefit became payable and subsequently on each consecutive anniversary year of the **policy benefit** payment.

11.3.7 In the event an **incapacitated member** returns to work after the end of the **deferred period** under medical supervision, in a reduced capacity, reduced income, reduced duties or in a lower paid occupation, **reduced income benefit** will be payable.

11.3.8 If selected by the **policyholder** at the **policy commencement date**, the definition of **incapacity** will be changed from 'unable to perform their own occupation' to 'unable to perform their own occupation or another suitable occupation' once an **incapacitated member** has been receiving **policy benefit** for a period of at least two consecutive years, subject to the **benefit payment period** selected.

11.4 **Limitation of policy benefit**

11.4.1 The **income benefit** (excluding any increases due to the **escalation rate** if selected), plus any income from other sources shall not exceed 80% of the **insured member's** gross **earnings**, or in the event they are an **eligible partner** of the **employer**, 50% of the **insured member's** average **earnings** over the 3 years, immediately prior to their **incapacity**.

11.4.2 Where the total of **income benefit** (excluding any increases due to **escalation rate** if selected), plus any income from other sources would exceed 80% of the **insured member's** gross **earnings**, or in the event they are an **eligible partner** of the **employer**, 50% of the **insured member's** average **earnings** over the 3 years, immediately prior to their **incapacity**, the **income benefit** will be reduced by the amount of any other income the **insured member** is receiving as a result of their **incapacity** from other sources. Any other income can include but it not limited to:

a. any uninsured sickness payments or benefit payments made to the **insured member** by the **policyholder** (excluding payments related to this **policy**);

b. annuity or ill health early retirement pension payments that started after the date of **incapacity**;

c. income arising from any other insurance policy as a result of illness, injury or disablement; and

d. income from a mortgage, loan or credit protection policy.

Any other income which is not subject to tax will be adjusted appropriately for calculation purposes to make it comparable to taxed income.

11.5 **When claims cease**

11.5.1 Subject to section 12, the **income benefit** will cease to be payable on the expiry of the **benefit payment period** or when the **insured member**:

a. dies;

b. reaches **termination age**;

c. retires;

d. is no longer employed by the **employer**;

e. is no longer incapacitated;

f. is no longer suffering loss of **earnings**;

g. takes up any form of employment without the **insurer's** agreement; or

h. refuses to take appropriate medical advice given by their treating doctor or medical or health professional or medical or health adviser, or to attend a medical examination requested by the **insurer** or any available retraining or rehabilitation courses where it is deemed appropriate by the **insurer**.

11.5.2 When there is a claim in respect of an **insured member** which arises outside of the United Kingdom, the **insurer** may require the **insured member** to return to the United Kingdom or to visit another country as instructed by the **insurer** within 6 months of the date on which benefits started to be paid, otherwise benefits may cease to be paid by the **insurer**.

11.6 **Linked claims**

11.6.1 In the event of a **linked claim** for **policy benefit** which has been accepted by the **insurer**, the date the **escalation rate** is applied shall be delayed by the length of time the **insured member** no longer satisfied the definition of **incapacity**, and thereafter applied annually from that date.

11.6.2 In the event of a **linked claim**, and subject to **satisfactory evidence of health** being provided to the **insurer**, the **income benefit** will be payable at the same rate as at the end of the previous period of **incapacity**. The **deferred period** will not apply but the **insured member** must be **incapacitated** for at least 2 weeks before the **income benefit** will be payable.

11.6.3 In the event of a **linked claim**, this is considered by the **insurer** as a continuation of a previous claim. In respect of limited **benefit payment period** policies, **income benefits** payable as a result of **linked claims**, will be payable for a maximum of the **benefit payment period**.

11.7 **Switching to a new insurer**

11.7.1 If this **policy** is terminated and switched to a new **insurer**, then if an **insured member** for whom benefits are currently being paid by the **insurer** (or for whom benefits will become payable once the **insured member** has reached the end of the **deferred period**) returns to work after the transfer and meets the **actively at work** conditions of the new **Insurer**, no further benefit payments will be made.

11.7.2 Any future claims will be the responsibility of the new insurer, except in the following situations:

a. If the **insured member** meets the **actively at work** criteria of the new insurer but subsequently suffers a relapse and in the absolute discretion of the **insurer** it is treated as a **linked claim**, **income benefits** based on the **insurer's policy**, not the benefit basis of the **policy** switched on to, will be reinstated for a period equal to the **deferred period** of the new **insurer**. The new **insurer** will then be responsible for the claim and any benefit payments from the end of this period; and

b. if the **insured member** fails to satisfy the **actively at work** criteria of the new insurer, the **insurer** will continue to pay any future **income benefit** based on the **insurer's policy**, not the benefit basis of the **policy** switched on to, until such time as the new insurer's actively at work criteria is satisfied or the member is accepted for cover by the new insurer.

Section 12 - What is not covered (exclusions)?

Specific exclusions and limitations to the cover provided by the **policy** will be advised in any acceptance terms issued in writing by the **insurer** in respect of a particular **insured member**.

Section 13 - Information

The **policyholder** shall provide certain information to enable the **insurer** to assess the **scheme**. The **policyholder** must inform the **insurer** in writing as soon as practicable if there is any material change in the facts disclosed prior to the **policy commencement date** or to the information requested by the **insurer** at any time while this **policy** remains in force.

Section 14 - Membership data

14.1 The **insurer** relies upon the **policyholder** to discharge its duties to **insured members** under the **data protection laws** in respect of any **personal data** shared with the **insurer.** The **policyholder** warrants that it has complied with its obligations under the **data protection laws** and that all **personal data** (including any special categories of **personal data**, such as health data) provided by the **policyholder** to the **insurer** for the purposes of this **policy** have and will continue to be provided in accordance with the **policyholder's** obligations to **insured members** under the **data protection laws**, including, but not limited to, obtaining any required consent and making **insured members** aware that their **personal data** may be shared with the **insurer**.

14.2 The **policyholder** will keep a complete record of all details of **insured members** provided to the **insurer** for the purposes of the administration of the **policy**. The **policyholder** will provide the **insurer** with any infomation the **insurer** may require from time to time in respect of the **insured members** as may reasonably be considered to have a bearing on the administration of this **policy** and on the determination of premium rates. Such records of the **policyholder** shall be open for inspection by the **insurer** at any reasonable time.

14.3 The **policyholder** will be responsible for ensuring that any **personal data** it provides to the insurer shall be adequate, relevant and limited to the information requested by the **insurer** as necessary for the purposes of the **insurer** providing insurance on the terms of this **policy**.

14.4 The **policyholder** must notify the **insurer** of any errors as soon as practicable. The **insurer** is entitled to make any appropriate adjustment to the premiums to take account of any corrected errors.

14.5 The **policyholder** must provide the **insurer** with any information the **insurer** may requirefrom time to time in respect of the **insured members** as may reasonably be considered necessary for the administration of this **policy.** Failure to provide any such information in respect of an **insured member** may result in the **insurer** being unable to provide, or continue to provide, insurance for such **insured member**.

14.6 The **insurer** will use **personal data** provided by the **policyholder** to administer the **policy** and will do so in accordance with its duties and obligations under the **data protection laws.** Details of the ways in which the **insurer** may collect, share or process **personal data** are explained in the **insurer's** privacy notice. A copy of the privacy notice is available from the **insurer's** website: www.metlife.co.uk.

Section 15 - Cancellation of cover in respect of an insured member

Cover in respect of an **insured member** will terminate automatically with immediate effect when the **policy** ceases, or if the **insured member**:

a. Ceases to be an employee employed by the **employer** or a partner of the **employer**;

b. Ceases to be an **eligible employee** or **eligible partner**;

c. Reaches **termination age** as specified in the **policy schedule**; or

d. Dies.

Section 16 - Extensions of cover

There are no standard extensions of cover available under the **policy**.

Section 17 - Termination of the policy

17.1 This **policy** can be terminated at any time by written notice from the **policyholder** to the **insurer**. Any such notice must specify the date on which termination is to take effect and notice must be given at least 7 days in advance of that date.

17.2 If a premium is not paid in full within 30 days of the due date, this **policy** may be terminated at the end of that period. The **insurer** may, at its absolute discretion, provide a different termination date and will confirm that date to the **policyholder** in writing.

17.3 The **insurer** will be entitled to terminate the **policy** or to amend its terms or to require the issue of a new **policy**, in each case in such manner as the **insurer** may consider appropriate and with immediate effect, in any of the following circumstances:

a. If there is any material change after the **policy commencement date** in the nature of trade or business carried out by the **employer** or in the nature of occupation or geographical location of the **insured members**;

b. If the **policyholder** makes or proposes to make any amendment to the **scheme** which, in the reasonable opinion of the **insurer**, would adversely affect this **policy** or the operation of this **policy**;

c. If the number of **insured members** falls below three;

d. If the **policyholder** is in material breach of this **policy** and, in the case of a breach capable of remedy, fails to remedy the breach within 30 days of written notice being given by the **insurer**, which specifies the breach and requires it to be remedied; or

e. If any new regulation (or change in legislation or HMRC practice) comes into force which affects the way that premiums and/or **policy benefits** are treated for tax purposes for the **employer** or any others, the **insurer**, the **insured member** or any recipient of **policy benefit**, or which otherwise affects this **policy**.

17.4 Any premium paid or payable in respect of the period in which termination occurs will be calculated pro-rata on a time basis and an adjusting payment will be made between the **insurer** and the **policyholder** on the date on which termination takes effect.

17.5 A **minimum on-risk charge** applies to new policies which are cancelled in the first 12 months after the **policy commencement date**.

17.6 If the **employer**:

- ceases to carry on business;
- enters into a voluntary arrangement;
- has a liquidator, receiver or manager appointed other than by a Court order; or
- if an order is made or a resolution is passed for the winding-up of the **employer**;

then in respect of any **insured member** of the **employer** who became an **incapacitated member** before one of the above events occurred, the **insurer** may, on the **insurer** exercising their absolute discretion, pay **policy benefit** to that **incapacitated member** subject to the agreement of the **policyholder**, **insurer** and **incapacitated member**, and subject to the following:

The terms and conditions of this **policy** that were in existence as at the date of one of the above events occurring will apply, subject to the applicable definition of **incapacity** being:

- Unable to perform their own or another suitable occupation - an **insured member** or **eligible employee**, is **incapacitated** if:
  - they are unable to perform, due to illness or injury, the **material and substantial duties** required of them in their own occupation which they were performing immediately prior to them being **incapacitated**;
  - are not following any other occupation; and
  - are unable to perform, due to illness or injury, the **material and substantial duties** of any other reasonable occupation to which they are suited by reason of training, experience or education.

17.7 If the business of the **employer** is assigned or succeeded to by another person or organisation which undertakes all the duties and responsibilities of that **employer**, then provided the **insurer** agrees in writing, that new person or organisation shall be treated as the **employer** of that individual, for the purposes of this **policy** from the date of the assignment or succession.

Section 18 - Notices

Any notices to the **insurer** under this **policy** should be given to it at its offices at Invicta House, Trafalgar place, Brighton BN1 4FR, or such other address as it may notify to the **policyholder** for this purpose from time to time. Any notices to the **policyholder** under the **policy** will be given to the **employer** at its address set out in the **policy schedule**, or such other address as may be notified by the **policyholder** to the **insurer** for this purpose from time to time.

Section 19 - Fraudulent claims

If any claim under this **policy** shall be in any respect fraudulent, the **insurer** shall:

- be under no liability in respect of such claim;
- be entitled to recover from the **policyholder** any sums paid to the **policyholder** by the **insurer** in respect of the claim. If the **insurer** paid any sums in respect of the claim directly to the **insured member**, the **insurer** shall be entitled to recover the sums paid from the **insured member**; and
- the **insurer** may by notice to the **policyholder** and the **insured member** treat the **policy** cover in respect of the **insured member** as having been terminated with effect from the time of the fraudulent act and may retain any premiums paid under the **policy** in respect of that **insured member**.

Section 20 - Amendments to the policy

The **insurer** can amend this **policy** at any time. The **insurer** will give the **policyholder** 30 days written notice of any amendment. The **policyholder** has the right to cancel the **policy** after written notice has been given by the **insurer**. The **policyholder** may request an amendment to this **policy** at any time. The **policyholder** must give the **insurer** advance written notice of any proposed amendments to the **scheme**. The **insurer** has the right to refuse any request for the **policy** to be amended at its absolute discretion. Amendments will only take effect by an **endorsement** to the **policy** (authorised by the **insurer**) or by an amendment to the **policy** signed by the **insurer** and the **policyholder**. Any amendment will be without prejudice to any claim notified to the **insurer** prior to the date on which the amendment took effect.

Section 21 - Currency

All premium payments are to be paid in pounds sterling or such other currency as may be agreed in writing between the **policyholder** and the **insurer**. **Policy benefits** will be payable in the same currency as premiums.

Section 22 - Surrender value

This **policy** does not acquire a surrender value.

Section 23 - Continuation option

A continuation option allowing cover to continue for employees or partners leaving the **employer** is not included in this **policy**.

Section 24 - Governing law

This **policy** will be governed by and construed in accordance with the laws of England and shall be subject to the exclusive jurisdiction of the English courts to settle any dispute arising out of or in connection with this **policy** (including a dispute relating to the existence, validity or termination of this **policy** or any non-contractual obligation arising out of or in connection with this **policy**).

Section 25 - Contracts (Rights of Third Parties) Act 1999

The Contracts (Rights of Third Parties) Act 1999 does not apply to the **policy**. The **insurer** and the **policyholder** do not intend that any of the **policy's** terms and conditions will be enforceable by any person not a party to the **policy**. No consent of any third party shall be required under the Contracts (Rights of Third Parties) Act 1999 to any cancellation or termination or variation or alteration of this **policy**.

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