Excepted Group Life Assurance Technical Guide

optimal protection

Thank you for choosing Optimal.

By selecting Optimal you have chosen to insure your Group Life benefits with one of the newest and fastest growing Group Risk providers in the UK.

This product is only available from one of our carefully selected advisers with whom we have agreed Terms of Business.

Although Optimal is a new business having been established in late 2013 our heritage is not. We are a wholly owned subsidiary and appointed representative of The Original Holloway Friendly Society Limited which was founded in 1880 and was the first to offer disability insurance in the UK.

Our aim is simple: to provide you with the most reliable and complete customer experience within the corporate protection market.

This Technical Guide aims to provide you with all the information you may need to know about our Group Life policy for Excepted Benefits. You should read this guide alongside your quotation with which it was issued. It does not form part of the policy contract. The policy together with the application form and any statements or declarations will form the contract. Full details of the insurance cover will be contained in the policy conditions, including policy schedule.

If there is anything you are unsure about after reading this guide, please ask your Financial Adviser or alternatively contact one of our dedicated team members at Optimal.

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Terms and Expressions we use

In this guide some words or terms we use have specific meanings. These are listed below together with their meanings.

Actively at work (AAW) means that a person:

- is present at their place of work or is absent for reasons other than sick leave that have been authorised by
- their employer; and
- has not received medical advice to refrain from work; and
- is mentally and physically capable of performing fully the normal duties associated with their job; and
- is working their normal contracted hours at their normal place of employment or at such alternative location as may have been agreed in writing with the employer.

Anniversary date means the date on which the policy is intended to renew.

Benefit is the amount a **member** is covered for under the policy. It is the amount payable in the event of death of the **member**.

Brand New refers to a **scheme** that was not previously insured with another insurer immediately prior to the **commencement date** with us.

Catastrophic Event means the occurrence, event or incident or a series of related ongoing causes, events or occurrences that directly or indirectly results in an accumulation of deaths of insured **members**.

Commencement date means the date on which **cover** starts as stated in your policy schedule.

Cover means the insurance protection provided by the policy.

Cover Cease Age (CCA) means the age at which **cover** for a member ceases.

Discretionary Member means a **member** who:

- is not eligible but who you wish to include
- is an eligible member but who you want to be covered from a different date to their normal joining date
- is a member not joining the scheme at their first opportunity. If such members join the scheme within 6 months of the first opportunity date, we will waive underwriting.

Eligibility Criteria means the conditions for membership set by you and which must be met by the employee before they are included in the **scheme**.

Eligible Member means a **member** that satisfies the **Eligibility Criteria.** Where an individual joins the **scheme** within six months of satisfying the **Eligibility Criteria** they will be deemed an **Eligible Member.** Individuals joining after this six months timeframe will be classed as **Discretionary Members**.

Event Limit means the maximum **scheme** liability on the happening of a **Catastrophic Event**.

Evidence of Insurability means any evidence whether medical or otherwise that **we** may require to include someone as a **member**.

Free Cover Limit means the level of **benefit** that can be automatically provided without the need for **underwriting**. This will be stated on **your** quotation and policy schedule.

HMRC means Her Majesty's Revenue and Customs.

Lifetime Allowance is the tax threshold above which benefits become subject to a Lifetime Allowance charge.

Listed Countries means any of the following : United Kingdom, Channel Islands, Isle of Man, All other EU countries, Andorra, Australia, Canada, Gibraltar, Hong Kong, Iceland, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA and the Vatican City.

Long Term Absentee means a **member**, who has been absent from work as a result of sickness, ill-health or disablement (including current or pending Group Income Protection claimants) , for a consecutive period of three months or more at the time of quoting, at the **commencement date** or the **anniversary date**.

Medical Underwriting means the process of collating and assessing **evidence of insurability**. This might be a simple **Member's Declaration** or may extend to medical evidence.

Member is defined as any employee that satisfies the **Eligibility Criteria** and is included in the policy.

Member's Declaration means the form completed and signed by an individual **member** when medical underwriting is required.

Non-Medical reasons means statutory absences such as maternity, adoptive, paternity, unpaid parental leave or any other reason such as sabbaticals, unpaid or compassionate leave.

Participating Employer means any company, partnership or organisation the employees of whom are to be included in the **scheme**.

Policy Fee means an annual charge per policy towards our costs

Policy Period means the period of time between the **commencement date** and the **anniversary date**

Premium Rate means the underlying group rate that we calculate, which will be specified in the Policy Schedule, on which premiums are calculated.

Relevant UK Individual means the legal interpretation of these words as more fully defined by **HMRC**.

Scheme is defined as the group life arrangement that has been established by the employer or associated company to provide group life insurance **benefits** for members that satisfy the **eligibility criteria.**

Selected Adviser means one of the limited number of Independent Financial Advisers (IFAs) with whom **we** have agreed Terms of Business. It is **our** business practice to only agree Terms of Business with a limited number of carefully selected IFAs.

State Pension Age means the age at which an individual **member** may receive their state pension.

Temporary Absence means a **member's** absence from work during which the **member** retains **Eligible Member** status. For full details, please refer to section 1.2.4 of this document.

Underwriting decision means the outcome of **our** assessment of the evidence obtained during underwriting.

UK trust is a discretionary trust established in the UK which conforms with UK legislation.

Us/We/Our means Optimal, a trading name of HF Life Limited (FRN 613348), an Appointed Representative and subsidiary of The Original Holloway Friendly Society Limited. Registered in England (No. 8649971) Registered Office Holloway House 71 Eastgate Street Gloucester GL1 1PW. The Original Holloway Friendly Society Limited is Registered and Incorporated under the Friendly Societies Act 1992. Registered in the UK No. 145F. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. FRN 109986.

Working Directors/Shareholders/Partners means actively involved in an Executive capacity in the day to day management of the business for a minimum of 7 hours per week.

You/Your means the employer but is also intended to include the Trustees of the **scheme** to whom the policy will be issued on behalf of the employer.

Policy Aims

Our Excepted Group Life Assurance policy (also known as death in service policy) aims to provide a lump sum when an insured member dies.

Your Commitment

You need to make some very specific commitments in order for the policy to work correctly.

You must:

- Establish a trust by setting up a discretionary trust
- Tell us immediately if the cover or any part of it, ceases to be regarded as an excepted group life policy, as defined in section 480 (3) of the Income Tax (Trading and Other Income) Act 2005
- Set up a trustees' bank account in the name of the trustees of the scheme for us to pay benefits into in the event of a claim. This must be separate from the employer's trading accounts
- Pay all the premiums we ask for when they are due
- Give us the complete and accurate information and data when you apply for a policy and at each anniversary date within the timescales we have specified. We can change or cancel the policy if you do not give us this information
- Tell us if the eligibility of our group life scheme is linked to pension scheme membership. You will also need to let us know the eligibility for the pension scheme participation and the take up rate of eligible members to the pension scheme
- Tell us immediately whenever the information you have provided to us changes
- Tell us as soon as possible about any early entrants, late entrants, discretionary members or members who require discretionary benefits
- Tell us in advance of changes to participating employers including their activities, location and the relationship between them
- Tell us immediately if there is a change of the employer's location or nature of business
- Tell us immediately if any members change their work location
- Tell us immediately if you wish to change the benefit basis or eligibility criteria
- Tell us if a member's benefit exceeds the free cover limit
- Tell us about any claims as soon as possible and submit any claims as outlined in section 5
- Keep to all the conditions set out in the policy
- Tell us immediately if you wish to cancel the policy

Risk Factors

- If you do not meet your commitments, we may not pay your claims and we may cancel the policy
- We may cancel the policy if there are changes to legislation or regulation which affect excepted group life assurance policies
- We will discontinue cover if we do not receive premiums within 30 days of the premium being due.
- You should seek legal and tax advice to make sure you understand any potential taxation issues for you and your employees and any conflicts with your employees' contracts of employment.
- We do not provide policies where the eligibility is voluntary or discretionary. Therefore, we reserve the right to cancel a compulsory scheme if the take up rate of eligible employees reduces to below 90%
- If we do not receive a completed claim form within 2 years of the date of a member's death, we will not pay the claim.
- We may revise the premium rates at the policy anniversary date or at any other time if a change occurs that affects the premium rate.

Helpful information for excepted group life policies

Employers will often choose a registered group life policy to cover their employees. However, you may wish to choose an excepted group life policy to cover your employees who:

- Already have a high level of registered scheme benefits that are near, or over the lifetime allowance. The lifetime allowance and lifetime allowance charge do not apply to an excepted group life policy. You may wish to provide all or some of these employee's life assurance benefits under this policy.
- Have enhanced or fixed protection. When tax laws changed and tax allowances reduced, the government introduced enhanced and fixed protection. Employees could apply for enhanced protection (before April 2009) or fixed protection (before April 2012) to protect their existing registered scheme pension rights from tax charges. If they did, additional restrictions apply to their registered scheme membership. If they do not keep to these restrictions, they will lose their enhanced or fixed protection and may have to pay more tax when they receive a registered scheme benefit.
- If you cannot include an employee in a registered scheme because they will lose their enhanced or fixed protection, you may wish to include them in an excepted group life policy as this will not affect their protection.
- Are self- employed equity partners or LLP members. They cannot set up a registered scheme just for themselves. Although they can join a registered scheme that also includes their PAYE employees, they may not wish to do so as they are often well paid with large pension investments and need large life assurance cover which may take them over the lifetime allowance.

There are a number of conditions a policy must meet for it to qualify as an excepted group life policy as follows:

1. All members must have the same benefit formula – We can cover benefit as a flat amount (eg £100,000) or as a multiple of earnings. If a multiple of earnings, the earnings definition and frequency we can allow for changes in earnings must be the same for everyone. If you need more than one benefit formulae, you will need to set up a separate excepted group life scheme for each benefit formula. We will normally only need one trust and application form. If we include an exclusion or restriction in our policy terms, we must apply it to everyone included in the scheme.
2. You can only pay the benefit to an individual, charity or trusts set up for individuals - Our policy is a contract between the trustees of the scheme and us, therefore we will only pay the benefit to the trustees. We will not pay the benefit direct to individuals or charities. Although HMRC legislation suggests it is possible to pay the benefits to the estate of the deceased member, our trust deed does not allow for this because:
    - If the policy covers equity partners or LLP members and benefits were paid to the estate, this could create tax issues eg: pre-owned asset tax may be charged every tax year
    - Legislation only allows benefits to be paid to an individual, charity or trust. A person's estate could go to another body that does not meet this condition
3. You cannot pay benefit to another insured member unless they are a relation or dependent of the deceased.
4. You must not take out the policy to avoid paying tax – you may want to talk about this with your legal adviser
5. The policy cannot be used as a business protection arrangement
6. It can only pay lump sum benefits for deaths before age 75
7. If the policy is cancelled, it must not have a surrender / cash value

Setting up a brand new excepted scheme with a trust

First step – Establishing a discretionary trust

You need to set up your scheme using an appropriate discretionary trust document. As an employer it is normal for you to act as the scheme's trustee.

We can provide a specimen draft deed for you to complete or you can use your own version. Our deed has been designed to be set up in the UK in line with English Law. This is available to download, along with notes on how to use and complete the deed, from our website www.optimalprotection.co.uk

We are not able to supply a specimen draft deed for use in the Channel Islands or the Isle of Man.

We recommend that you seek legal advice to make sure that the deed meets your requirements and is suitable for your company / organisation.

You need to set up a trustees' bank account in the name of the trustees of the scheme for us to pay benefits into in the event of a claim. This must be separate from the employer's trading accounts and will help separate the benefit payments from the normal business account.

Second step – Setting up cover with Optimal

Your IFA will complete our On Risk form which will have been supplied to them along with our quotation. This will need to be submitted to us in advance of the commencement date in order for us to provide cover.

Section 1 – Who can be covered?

1.1.1 Eligibility

You must decide the eligibility criteria before the scheme commences.

There might be different rules for different categories of employee and, perhaps, different benefit bases between each category but the rules on eligibility and benefits must always be clear and transparent and agreed with us before cover commences. If you would like to change these after cover commences, you must agree the change with us before it can take effect.

The maximum benefit we can insure for a member is £5 million.

When deciding what benefits to provide, you should take into consideration:

- Benefit promises you have made to your employees
- The salary basis you wish to use for benefit purposes, for example basic salary only or perhaps you would like to limit the member's salary by applying a notional earnings cap
- Whether or not you wish to limit the member's benefit, for example, to the amount of Lifetime Allowance
- Any laws on discrimination or unfair treatment
- The age at which you wish cover to cease. This can be up to a maximum of age 75 or linked to state pension age
- Whether you would like to give the same level of benefit to all members
- Whether you would like to group the members into separate categories and have different benefit amounts between categories. If the benefit amount or multiple varies from one category of member to another, you must insure each category under a separate policy
- Whether you would like to limit membership to certain categories of employment, for example "all directors"
- All eligible employees must be included in the policy

The eligibility criteria will normally include the following:

- The minimum and maximum entry ages and any service qualifications
- The cover cease age
- The eligible categories of employee, normally by occupation or job title that you want to be included in the scheme
- The entry date for new members, for example daily immediate entry, on the scheme anniversary date or perhaps at a fixed date in the year
- When members may have increases in their benefits
- If eligibility is linked to pension scheme membership, you will also need to let us know the eligibility for the pension scheme participation and the take up rate of eligible members to the pension scheme. The take up rate is the percentage of individuals who have actually joined the pension scheme out of the total number of individuals who are eligible to join. Please note, the pension benefits must be available to all individuals as of right and not solely at your invitation. You will need to let us know the take up rate before cover commences with us and at the end of each rate guarantee period

The above eligibility criteria can vary from one category of member to another, but you must agree what you want with us before the commencement of cover with us.

If someone does not join the scheme when they are first eligible, or within 6 months of first becoming eligible, they will be considered a discretionary member and will require medical underwriting.

There must be at least 2 members when cover commences with us.

Members must be:

- Between the ages of 16 and 74 attained at commencement of cover or anniversary date whichever the later
- Employed and ordinarily working in the United Kingdom, Channel Islands or the Isle of Man. Non UK residents and/or non UK nationals of a UK employer may be considered for inclusion subject to our underwriting consideration
- Actively at work, as defined and as more fully detailed in Section 1.1.5
- Not involved in an excluded industry (chemical or other industries involving toxic or explosive substances) unless we have confirmed their inclusion
- Actively involved in the day to day running and management of the business if they are Working Directors/Shareholders/Partners
- Able to satisfy the eligibility criteria as set by you and agreed with us

1.1.2 Joiners and Leavers

Our policy is set up on a non-notification basis which means new employees that satisfy the eligibility criteria and who have benefits within the scheme free cover limit can join the scheme automatically subject to satisfying the actively at work conditions (where applicable, see section 1.1.5). We only need to be notified of any changes to the membership in the following circumstances:

- A member does not satisfy the actively at work condition as set out in Section 1.1.5, or
- A member has benefits above the scheme Free Cover Limit, or
- The new joiner is a discretionary member, or
- A member is over the scheme cover cease age or State Pension Age, or
- At the anniversary date

1.1.3 Early Entrants

An early entrant is a member who wishes to join the scheme before they complete the qualifying service period or before they reach the first entry date.

If a member requires cover before they become eligible and they join the scheme within 3 months of their employment start date, we will automatically cover them for benefits up to the free cover limit (subject to actively at work fulfilment if this is a scheme requirement).

1.1.4 Travel and Residence outside of the UK, Channel Islands and Isle of Man

We can usually provide cover for members who may be working abroad providing they remain eligible members and as long as the majority of employees work in the UK. We can also usually provide cover for members who travel outside of the UK for normal business purposes. We will need full details of the countries involved as we will need to assess if we can cover them and if we need to apply special terms.

You need to tell us before the commencement date of cover with us and at each policy anniversary date –

- Known or anticipated travel outside of the listed countries (see definitions for complete list).
- Residence or secondment outside of the UK, Channel Islands or Isle of Man.

If you do not tell us the above, this may invalidate or restrict cover.

Members on secondment or permanently based overseas must have a contract of employment with the UK registered company. Members who are not paid in UK currency, will have their salary converted to UK currency based on the exchange rate at the time the quotation or renewal documentation is produced. The payment of any benefits in the event of a claim would also be calculated at that exchange rate.

If a member is seconded or permanently based overseas and the continuation of their membership is not automatic we may not be able to continue cover. If we decide we can continue cover, they will be considered to be a discretionary member and will require medical underwriting before we can continue cover.

1.1.5 Our Actively at Work Requirements

For all schemes whether previously insured or not and whether the actively at work requirement has been waived or not, we will require full details, prior to commencement and each anniversary date, of Long Term Absentees. The details required are:

- date of birth
- gender
- date first absent
- reason for absence (nature of illness / injury)
- benefit amount

We will not be on risk for any long term absentees until full details have been provided and we have specifically confirmed that we can offer cover for each long term absentee.

Unless we have waived the actively at work requirement, any person who is not actively at work on the last working day prior to commencement of cover with us will not be covered for any benefit until they either:

- complete seven consecutive working days with the employer (excluding days taken as holiday), or
- provide evidence of insurability to us and we confirm our acceptance of the member's benefit.

Confirmation that any actively at work requirement has been met must be provided by the employer in writing.

If the actively at work requirement is not satisfied we reserve the right to medically underwrite the member(s). This could result in an additional premium and/or special terms or insurance cover for the member being declined.

Please see the table below for our actively at work requirements.

Actively at Work requirements		
Number of lives	**Brand new scheme with no previous insurer**	**Existing insured schemes switching to us**
2 - 49	**Applied** – to all members. **Additionally**, if there are less than 5 members in any one benefit category at the commencement date, our stricter AAW is applied to members in such categories. This means we will require confirmation in writing from you that no employees have been absent from work for a total of 10 days or more within the last 12 months, as a result of illness or injury. If any member does not fulfil this actively at work condition, medical underwriting may be required to consider including the member in the Scheme.	**Waived** - for existing / increases to insured benefits and new members **Applied** – to increases in benefits if you make a change to the current insured basis (e.g. the benefit basis, eligibility criteria, cover cease age)
50+	**Waived** – for all members	As above

Additional notes –

For previously insured schemes switching to us, where we have agreed to waive our actively at work requirements, any member who is not actively at work will continue to be covered for the period of time that they would have been covered under the previous insurer's policy.

Once a policy is in force, where actively at work requirements have been waived, new entrants are covered as soon as they have satisfied the eligibility criteria irrespective of whether they are actively at work or not.

However, where actively at work requirements have not been waived new entrants must have satisfied the eligibility criteria and be actively at work before their cover can commence.

Additionally, where actively at work requirements have not been waived, we will not increase existing members' benefits until they are next actively at work.

1.1.6 When does cover end?

We will normally stop covering a member:

- When they reach the cover cease age, or
- The date that they cease to be an eligible member of the scheme, or
- When they cease to be a partnership member (if they are a partnership member), or
- When they cease to be a Relevant UK individual for a UK trust, or
- If they retire early, unless the policy specifically provides for cover during early retirement, or
- The date that they leave your employment, or
- When their period of temporary absence cover ends (see section 1.2.4 for full details)

Where the cover cease age is linked to State Pension Age, if State Pension Age changes for a member, the cover cease age will be based on the member's new State Pension Age.

It may be possible for cover for individual members to continue beyond cover cease age (see section 1.2.1).

Please also see section 1.2 for details of the options available to you to continue cover in certain other circumstances.

In all circumstances cover cannot continue beyond a member's 75th birthday.

In respect of the overall scheme, cover will normally end on:

- The expiry date of the policy, or
- The date that you advise us in writing cover is to be cancelled, or
- The date we advise you that cover will be cancelled, or
- The anniversary date after the scheme membership falls to less than 2 eligible members, or
- The first anniversary date after the date you appoint a new Financial Adviser if that new Financial Adviser is not one of our Selected Advisers.

1.2 Options available to continue a member's cover beyond the time cover normally ends

1.2.1 Working beyond the Cover Cease Age

If a member requires cover to continue beyond the cover cease age, they will be considered to be a discretionary member.

For cover to continue up to the maximum possible age of 75:

- Members must be actively at work (as defined in Section 1.1.5) and will be subject to medical underwriting
- Temporary absence for all members working beyond cover cease age, will be restricted to a maximum period of 12 months from date of first absence or to the end of contractual employment if earlier.

It may be possible for underwriting to be waived if the member has been underwritten in the last 5 years by us or another insurer. If the member is over age 70 they must have been underwritten in the last 12 months for underwriting to be waived.

1.2.2 Redundancy cover

Lump sum benefits can continue for someone who leaves employment due to redundancy.

Free redundancy cover for up to 3 consecutive months from the date of redundancy is automatically included.

For an additional charge, we can extend the period of redundancy cover to 2 years. If you would like to include this option you must select it at outset of cover with us and it must apply to all eligible members. For both redundancy cover options, cover for individual members that are made redundant during the policy can continue but will end on the earliest of:

- The date the member commences new employment (including self-employment), or
- The member's cover cease age, or
- The specified redundancy period as stated on the policy schedule.

Benefit levels will be restricted to the amount that was in force at the date of redundancy.

1.2.3 Early Retirement cover

If you would like to include this option you must select it at outset of cover with us (for an additional charge) and it must apply to all eligible members.

If a member retires before their normal expected pension age and at that time is granted a pension from your occupational pension scheme, they will continue to be treated as an eligible member and remain included as a

scheme member providing that:

- The pension is due to incapacity, or
- The member is entitled to continued life cover which is permissible under HMRC regulations, or
- The member joined the pension scheme before 1st October 1991.

The benefit amount cannot exceed the amount of benefit the member was entitled to immediately before retiring and will remain fixed.

The cover will end when the member reaches the cover cease age or their expected normal retirement age, whichever is earlier, assuming the scheme remains insured with us.

1.2.4 Continuing cover for members who are temporarily absent from work

Cover may continue while a member is temporarily off work.

The scheme rules will specify the period of time for which cover, if any, continues during periods that members may be absent from work as a consequence of illness or injury or non-medical reasons. The 3 options from which you can chose are as follows:

1. No cover during temporary absence is provided, or
2. Cover continues for a fixed period of 3 years irrespective of whether the temporary absence is a result of illness or injury or non-medical reasons, or
3. Cover continues until the State Pension Age or cover cease age (if later) if the temporary absence is a result of illness or injury and for a period of 3 years if the reason for temporary absence is for non-medical reasons.

If a member is on a fixed term contract cover cannot continue beyond the end date of the contract in force at the time the member was first absent.

If a member is absent from work on the commencement date and immediately before that date the member's benefits were insured under any other policy, cover under our policy will stop when cover would have ceased for the member under that other policy.

Temporary absence for all members working beyond cover cease age, will be restricted to a maximum period of 12 months from date of first absence or to the end of contractual employment if earlier.

Continuation of an individual member's cover during a period of temporary absence is subject to them remaining a member of the scheme, the scheme remaining insured with us and you continuing to pay premiums.

If you want benefit increases during a member's period of temporary absence we can increase them in line with any general pay awards granted by the employer subject to a maximum annual increase of 5%.

If a member's benefit reduces during a period of temporary absence, perhaps as a result of a reduction in earnings,

we will keep the level of benefit at the same amount as when temporary absence commenced.

Section 2 – Setting up the scheme

In order for us to assume risk the policy must start within 3 months of the date the quotation was produced. You must contact us to agree terms before cover starts.

Cover will only be effective once we have confirmed in writing that we will assume risk, cover cannot be backdated.

We will need a fully completed "on risk form" which will be completed by your Financial Adviser. We will also need any information requested in your quotation.

The "on risk form" will ask your Financial Adviser to confirm details such as:

- Eligibility conditions
- Benefit structure and earnings definition
- Scheme history (if a previously insured scheme) to include up to date claims history and details of previous underwriting decisions
- Details of long term absentees (i.e. those who have been absent from work for more than 90 days as at the commencement date). Please note, cover for long term absentees will not be in place until full details have been provided and we have confirmed that we are on risk for such members

The "on risk form" will also ask for:

- Membership data as at the cover start date
- The location, by reference to the geographical postcode of the building, for all policy members to be covered. We must be able to calculate the sum assured at each postcode.
- Trust details / trust forms

Once we have received the "on risk form" from your Financial Adviser we can consider whether or not we can assume risk. If the risk differs from the quotation we will let you know what else we require and whether we need to change the premium or terms.

Once the cover commences and in order for cover to continue, you must also give us, within 30 days of the date that your cover commences:

- Any information we identify as missing or not being fully complete in the "on risk form" as described above
- A completed and signed trustee application form to include details of any employees not actively at work at the commencement date (where actively at work is a scheme requirement)
- The premium or a completed Direct Debit Mandate

If all of our requirements are not received within 30 days of the cover commencing, then cover will cease immediately. A premium will be charged for the period cover was on risk.

It is important that you do not cancel the cover you may have with an existing insurer before all of the outstanding

requirements have been received by Optimal.

Upon receipt of all of our requirements, we will provide you with your policy document.

Section 3 – Evidence of Insurability and Medical Underwriting

Any member who is required to provide evidence of insurability will need to give us medical evidence. We call our assessment of this evidence, medical underwriting.

In the first instance, a member will need to complete a member's declaration form. This form asks for details of a member's medical history, pastimes and business travel. Depending on the information a member gives us and / or the level of benefit they require, we will sometimes need to ask for more evidence. This could include a report from the member's own doctor or a medical examination and blood or other tests. We will pay for the cost of any medical evidence we require.

We will assess all the evidence and decide if we can offer cover and if any special terms are appropriate.

As a result of underwriting we may charge additional premiums, apply special terms, postpone or decline cover to reflect an individual member's medical condition, hazardous occupation or participation in any hazardous pastimes.

If we do apply any special terms we will write to you and explain the terms. If our terms include charging additional premiums and you decide you do not want to pay the additional premiums, you can cancel the cover the additional premium is for by letting us know in writing within 30 days.

Unless we tell you otherwise, the special terms will not affect the cover below the free cover limit or any cover we have previously accepted.

3.1 Which members will require underwriting?

The following members will normally be required to provide evidence of insurability:

- Any member who is not able to satisfy the actively at work requirements and who also requires cover before being able to satisfy the actively at work requirement (see section 1.1.5 for full details)
- Any member of a brand new scheme, with less than 50 members and with less than 5 members in any one benefit category, who does not satisfy the actively at work requirements (no more than 10 days absent from work in the last 12 months, see section 1.1.5 for full details)
- Any member of a scheme which does not qualify for a free cover limit
- Any member with benefits that are in excess of the free cover limit (unless we are able to accept those benefits under our no worse terms facility, see section 3.4)
- Increases in benefits above the Free Cover Limit and/or the agreed forward underwriting bar
- Any member who is to be included in the scheme as a discretionary member
- Any member requiring discretionary benefits
- Any member with benefits that have not been accepted by a previous insurer

- Any member who has been subject to underwriting by a previous insurer, where special terms were imposed unless we are able to accept the benefit under our no worse terms facility
- Any member who has been subject to underwriting by a previous insurer, where benefits were declined or postponed
- Any member working beyond cover cease age

We must be informed immediately if cover is required for any member in the above situations so that we can advise what evidence of insurability we will need to consider providing cover.

3.2 What happens if a claim arises before a medical underwriting decision has been made?

If a member has benefits in excess of the Free Cover Limit they will require underwriting but we will be able to provide cover for a maximum period of 90 days, or until we have finalised our underwriting decision if sooner. We call this temporary cover.

If a member dies during temporary cover we will not pay the benefit amount above the free cover limit if they die from any medical condition they were diagnosed with, or were displaying symptoms of, within the five years before temporary cover starts.

Temporary cover will be provided subject to the following conditions:

- A maximum benefit level, including all policies issued or subject to underwriting by us, of £3 million
- The member has not been previously declined, postponed or had special terms imposed either by us or any other insurer
- The member is an eligible member able to benefit from the scheme free cover limit
- The member has not previously refused to provide medical evidence required for underwriting
- The member is not a discretionary member

In the event that a member requires temporary cover but is unable to satisfy the conditions above, it may be possible to provide limited temporary cover on an accidental death only basis. However, deaths that occur as a result of alcohol, drugs, suicide or intentional self-injury will be excluded.

3.3 Free Cover Limit

For schemes with 3 or more members at the commencement date or anniversary date we usually allow a free cover limit. The free cover limit set will be a minimum of £500,000.

Where this excepted group life scheme is linked to a registered group life policy also insured with us and the beneficiaries are clearly the same, we may share the free cover limit between the 2 schemes.

The free cover limit will be stated within the quotation and policy schedule.

We do not provide policies where the eligibility is voluntary or discretionary. Therefore, if the take up rate of eligible employees reduces to below 90% we reserve the right to reduce or remove the free cover limit.

For members who are included within the scheme as soon as they satisfy the agreed eligibility criteria and on the agreed benefit basis for that category of member (or within 6 months of first becoming eligible), medical

underwriting will not be required for benefit amounts up to the free cover limit, however will be subject to the actively at work requirement being fulfilled where applicable (see section 1.1.5).

The free cover limit will not apply to any discretionary benefits and benefits for discretionary entrants / members.

If a member's benefit above the free cover limit has been underwritten and as a result been declined or postponed, the member may not benefit from any future increases in the free cover limit.

We reserve the right to review the free cover limit if either the number of members or value of benefits at the policy anniversary date varies by more than 25% for schemes with 20 or more members or 15% for schemes with less than 20 members.

3.4 No Worse Terms (NWT) for schemes switching to us from another insurer

Schemes switching to us from another insurer, can usually be transferred to us on a no worse terms (NWT) basis. This means we can accept members at the same benefit level on the same terms (but not necessarily at the same cost), including any agreed forward underwriting bar.

Members must meet the conditions below:

- An additional premium loading of +300% or less
- The member, if aged 69 or under, has been medically underwritten within the last 5 years
- The member if aged 70 or more, has been medically underwritten in the last 12 months
- A benefit not more than £5,000,000
- The member being aged 74 or under

You will need to give us a copy of the previous insurer's acceptance terms providing evidence of the accepted benefit amount (including any forward underwriting bar) and any loading/ special terms applied to the member. This must be supplied to us before cover commences with us or we will not be able to pay a claim for these members.

Any future increases in benefit above a pre-agreed forward underwriting bar will be subject to underwriting.

3.5 Future medical underwriting requirements for members who have previously been underwritten by us - Forward Underwriting

Forward underwriting is the agreed level of additional benefit to cover future salary increases that may be covered without the need for further underwriting. We can forward underwrite up to a maximum benefit level per member of £5,000,000. Forward underwriting is only applied when we have medically underwritten a member.

This means, once we medically underwrite a member and agree cover on any of the following terms:

- The member was accepted at ordinary rates or with a medical loading of +200% or less
- The member fulfils our actively at work requirement at the time of the increases in benefit (if applicable)
- The member was accepted with an exclusion for hazardous pursuits

they will not normally need to give us more medical evidence for an increase until the earliest of:

- The total of all increases after medical underwriting is more than £300,000
- The member's benefit increases by more than 50% of the original accepted benefit amount
- It's been 5 years since they were last medically underwritten by us

However, any member who requires cover beyond the scheme cover cease age (and therefore discretionary) will not be eligible for forward underwriting.

Where we have applied forward underwriting after we have medically underwritten a member, we will apply the last medical underwriting terms to each increase.

3.6 Increasing the cover cease age for schemes switching to us from another Insurer

We can consider increasing the cover cease age from the existing age up to a maximum age of 75. The new cover cease age must apply to the whole scheme, not specific members only. Please refer to the table on the next page for our underwriting requirements:

Underwriting requirements to increase the cover cease age		
	Benefits below our free cover limit	**Benefits above our free cover limit**
Requirements	**Existing members** - must fulfil our AAW at the date the CCA changes	**Existing members** - the portion of existing members' benefits above the free cover limit will require medical underwriting***** as well as the need to fulfil our AAW
	New members - joining at their first opportunity will have the same requirements as above	**New members** - joining at their first opportunity will have the same requirements as above
	Re-joiners as a result of the increase in CCA- will have the same requirements as above	**Re-joiners** as a result of the increase in CCA - will have the same requirements as above *Medical underwriting may be waived for: Members up to age 69 if the member has been underwritten by another insurer within the last 5 years, or Members aged 70 and over if the member has been underwritten by another insurer within the last 12 months

Section 4 – What premiums will be charged for the cover?

The premiums we charge are calculated to reflect a number of factors including:

- The level of benefits
- The cover cease age
- The eligibility criteria and any entry conditions
- The age, gender, location and occupations of the members
- Any past claims experience
- Any additional cover, for example Redundancy Cover
- Policy fee

Our minimum annual premium is £400.00 and our minimum monthly premium is £40.00.

4.1 Payment of premiums

Our preferred payment method, whether annual or monthly, is by Direct Debit, but you can also pay annual premiums by bank transfer or by cheque.

All premiums must be paid within 30 days of their due date. Failure to pay premiums within this, or otherwise agreed, grace period may mean cover will be cancelled. Please see section 1.1.6.

In the event of a claim happening within the grace period and the premium not having been paid, we will pay the benefit amount less a deduction to reflect the unpaid premium.

4.2 How do we work out the premiums?

We use a unit rate basis to work out the premiums.

We will work out the cost for each £1000 of total benefit. We will multiply the unit rate with the policy's total benefit amount at the start of each policy year to work out that year's premium.

If the period of cover from the commencement date to the policy anniversary date is less than 1 year, the premiums calculated will be a proportion of a full year's cover.

4.3 Will there be any unexpected extra premiums?

If the information we need to calculate the premium is delayed or inaccurate, your premiums could change because you may not be paying the correct premium.

We will usually fix the unit rate until the end of the 2nd policy year. This is called the rate guarantee period. We will then review the rate, following which we will usually fix the unit rate for another 2 years.

However, we can change the unit rate (so the unit rate and premiums may go up or down) at each policy anniversary date (renewal date) if during the previous scheme year or at renewal any of the following happens:

- A change in the eligibility criteria
- Addition of a new member category
- An addition of a new or removal of a participating employer
- Information we requested from you in setting up the policy or at any subsequent review of the terms is found to have been omitted, materially inaccurate or otherwise incomplete
- A change in the taxation of the scheme benefits and/or premiums
- A change of more than 25% in the membership size or total benefit at the anniversary date for schemes with 20 or more members
- A change of more than 15% in the membership size or total benefit at the anniversary date for schemes with less than 20 members
- A change in the basis for calculating benefits
- The business location of an employer or a group of members (which affects more than 25% of the membership size for schemes with 20 or more members, 15% for schemes with less than 20 members) included in the policy changes

If a member has given us medical evidence, you may need to pay us an extra premium because of their medical conditions or participation in any hazardous pastimes. Although the extra premium will apply immediately, we will not ask you to pay it straight away. Instead, we will add it to your next account. If you tell us within 30 days that you do not want the cover that the extra premium applies to, we will not charge the extra premium.

4.4 What about commission?

The premium payable will include the level of commission payable to your Financial Adviser. We can pay different levels of commission although this will affect the premium we charge. We will confirm the rate of commission in our quotation and annual accounts.

4.5 How does the policy accounting work?

We will work out the accounts at the start of the policy and then every year at the policy anniversary date (annual renewal date).

You will need to pay the premiums to us in advance, either annually or monthly.

When we first quote for your policy, we will calculate your first year's premium using the membership list you gave us for the quote. If the membership list changes between the dates the quote was produced and the date cover commences with us we will ask you for an updated membership list and identify who we are covering and work out the new accurate premium.

4.6 What information is required for accounting purposes?

For all policies, at each anniversary date (renewal date), you will need to give us an up to date membership list before we can issue renewal accounts.

At the start of the policy, and at each anniversary date, you will need to give us a membership list which as a minimum should include:

- Name
- Date of Birth
- Gender
- Salary
- Benefit
- Occupation
- Geographic location/postcode
- Date of joining company
- Category of membership (if different rules apply to different members)
- Medical evidence if a member's benefit goes over the free cover level, or if our terms ask for it

You will also need to clearly identify members:

- Who are in a period of temporary absence from work or income protection claim
- Who require cover to continue during ill health early retirement, or redundancy, if these cover options apply to the policy
- For whom restricted benefits apply
- For whom special terms apply
- Whose total benefits exceed the free cover level
- Who require cover beyond the scheme cessation age

You should also ensure that the data you give us accurately reflects any salary basis or limitations that you have agreed with us.

If membership of this policy is linked to pension scheme membership, please confirm the current take up rate of employees to the pension scheme.

It is important that we know exactly who is covered under the policy. If you do not include an employee who you should have included on the membership list at the start of the policy or the anniversary date, we will not pay a claim for them.

4.7 How are the accounts adjusted for members who join, leave or have benefit increases during the year?

At each anniversary date we will calculate a premium adjustment for changes that are in line with the agreed eligibility conditions and benefit basis. To keep things simple, we will assume that all changes took place half way through the policy year. We will charge you an extra premium or pay you a refund at the beginning of the next policy year.

4.8 If the policy is cancelled mid-year, will premiums paid in advance be lost?

Premiums paid in advance will not be lost. We will work out a final account for the cover we have provided up to the policy's cancellation date. We will either send you a refund or you will have to pay us any premiums you owe.

Section 5 – Claiming benefit

We will try and ensure that all valid claims are settled quickly. You need to notify us as soon as possible after a member's death and ideally within 3 months of the date of death.

We will not pay a claim if:

- Any information relating to any aspect of the scheme that we have asked for is outstanding
- The premiums we have asked for have not been paid when due
- A completed claim form has not been received by us within 2 years of the date of a member's death

5.1 How to make a claim

In order for us to assess the claim and make payment to the trustees as soon as possible, we will require the following:

- A fully completed claim form signed by the trustees (our claim form can be obtained from your Financial Adviser or from our website www.optimalprotection.co.uk)
- Original death certificate (this will be returned to the sender by recorded delivery within 3 working days of receipt)
- Evidence of earnings and eligibility (for example, a member's last 3 pay slips or P60)

We may also ask for:

- Medical records relating to the deceased
- Any employer's absence records relating to the deceased
- Original marriage certificate or decree absolute or legal change of name document if the deceased member has a different name to that supplied on the most recent renewal data

5.2 How will benefits be paid?

When a claim has been agreed by us payment will normally be made by Electronic Fund Transfer and will only be made in the name of the trustees of the scheme.

The payment will be made directly into the bank account established by the trustees specifically for the purposes of receiving claims payments. Payments will not be made to anyone else other than the trustees of the scheme.

The trustees will have absolute discretion as to whom they pay the benefits. If the member completed an expression of wish form nominating the people they want the benefits to be paid to, we will not divert the claim payment to the nominated people. It is entirely the responsibility of the trustees to distribute the payment.

5.3 Is the benefit taxable?

Benefits paid to the trustees are paid free of income tax and do not count towards the member's lifetime allowance. However, benefits are subject to the normal inheritance tax rules for discretionary trusts. This means that exit and periodic charges may apply.

As benefits are paid by us to the trustees, the benefits are viewed as separate from the deceased's estate and so avoid the need for probate or letters of administration.

5.4 What happens to a claim if the policy is cancelled?

If a member dies before the policy is cancelled with us, we will assess your submitted claim as normal.

If a member dies after the policy is cancelled with us, we will not pay the claim.

Section 6 – What is not covered?

Unless we have told you about an exclusion, for example after medical underwriting, we will cover death from any cause.

If we do exclude death as a result of a specific cause (for example hazardous pastimes or members based in certain overseas locations), the quotation and policy schedule provided by us will show if any exclusions apply to your policy.

Members cannot continue their cover with us if they stop working for you.

Temporary cover is provided subject to the pre-existing condition exclusion as set out earlier in section 3.2.

We also apply limitations to the overall cover under the policy.

6.1 Catastrophic Events

A catastrophic event is the occurrence of a single event or series of events, if they happen within a 72 hour period that directly or indirectly causes the deaths of more than one member either at the time of the event or within 12 months of it.

Examples of Events that might be considered to be a catastrophic event include:	
War (whether declared or not)	Earthquake
Windstorm	Flood
Terrorist Activities	Pandemic Illness
A sudden release of atomic energy or nuclear radiation	Radioactive contamination (whether controlled or uncontrolled)
Biological or chemical substances	

Your quotation and policy schedule will specify the event limit for your location. If you operate from more than 1 location your quotation and policy schedule will confirm event limits for each location.

If the catastrophic event occurs, at a location not specified in your quotation or policy schedule, the maximum benefit payable at that location will be £10 million (reducing to £5 million for EC or E14 London postcodes).

If you have multiple locations and more than 1 location is affected by a catastrophic event, then the deaths at each location will be assessed against the catastrophic limit at each location, however we will limit the combined maximum amount payable to £100 million.

Claims will be settled in the order notified to us until the relevant limit has been reached.

If we are covering members under a number of different associated policies, we will treat the policies as if they were one single policy. The maximum payable in respect of any one location will be the highest maximum individual event limit for that location rather than the sum of the limits for that location across all policies. The maximum amount we will pay out from all policies will be £100 million.

6.2 Travel Limitation

If a catastrophic event results in the death of more than one member where a group of members is travelling together then the maximum benefit payable will be limited to the lower of:

- the maximum event limit specified in the policy schedule, or
- £25 million.

This limit applies both during travel and at the destination if that is not the normal place of work.

Section 7 – What taxation rules apply?

The benefit will be paid to the trustees to enable the benefit to be paid in accordance with the scheme rules.

Our understanding of the current tax rules for excepted schemes are as follows:

For UK trusts

Payment of premiums -

- The premiums you pay are normally tax-deductible and can be offset against your profits for tax purposes. Tax relief on premiums paid by the employer in respect of employees who have a proprietorial interest in the company will not normally be available. HMRC may agree to allow tax relief if similar benefits are provided for a substantial number of other employees. Clarification of the tax position in such cases should be sought from your tax advisers.
- Your premiums are not treated as a benefit in kind for employees.
- Premiums for partnership partners or members who are taxed on a self-employed basis will not normally be allowed as a business expense i.e. they cannot get tax relief on the premiums they pay for their cover.

Payment of benefits –

- Payments of benefits are subject to the normal inheritance tax rules for discretionary trusts. This means exit and periodic charges may apply.
- Benefits are free of income tax.
- Benefits will not count towards the member's lifetime allowance.
- The policy is exempt from the chargeable event provisions of the Income Tax (Trading and Other Income) Act 2005. Therefore a chargeable gain and income tax charge will not be charged on benefits paid on second and subsequent deaths.

For non UK Trusts

We are unable to comment on the taxation position of premiums or benefits for trusts set up in the Channel Islands or the Isle of Man.

Section 8 – Employee Assistance Programme

Optimal has partnered with Health Assured to provide your employees and their immediate family members with unlimited access to our confidential telephone support service (0800 030 5182), free of charge, 24 hours a day.

Our Employee Assistance Programme is designed to provide confidential help and support when it's most needed in a professional, friendly and non-judgemental manner.

This service can be used for:

- Family Issues
- Gambling
- Domestic Abuse
- Debt
- Childcare
- Family Matters
- Financial
- Insurance Claims
- Legal (excluding employment Law)
- Work
- Drugs & Alcohol
- Relationships
- Consumer Issues
- Stress
- Housing

In addition, our programme also includes instant and unlimited access to Health Assured's on-line health portal providing instant access to:

- Support video content
- Fitness videos
- Over 200 easy to understand medical fact sheets
- Personal coaching and health assessment areas allowing employees to produce clear reports and advice.

To help promote the EAP services included free of charge with every Optimal Group Life policy, Health Assured will contact every employer covered to offer guidance and advice in respect of the services provided. They will also be on hand throughout the life of the insurance contract if required to ensure maximum value and employee engagement is achieved.

Additionally, you will also receive an official welcome pack containing vital information to help promote the services provided. Each pack contains:

- PDF Employee Leaflet
- PDF promotional poster
- Employee announcement templates
- Login Details for the Online Health Portal - **www.healthassuredeap.co.uk**

Section 9 – Further information

The Company

Optimal
4200 Waterside
Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YN

Optimal is a trading name of HF Life Limited (FRN 613348) and is an Appointed Representative and subsidiary of The Original Holloway Friendly Society Limited. Registered in England (No. 8649971) Registered Office Holloway House 71 Eastgate Street Gloucester GL1 1PW. The Original Holloway Friendly Society Limited is Registered and Incorporated under the Friendly Societies Act 1992. Registered in the UK No. 145F. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. FRN 109986.

Surrender Value

This policy does not acquire a surrender value.

Third Party Rights

Third Party Rights under the Contracts (Rights of Third Parties) Act 1999 do not apply.

Questions and Complaints

We want you to be entirely satisfied with your Excepted Group Life policy. If you do have a query or complaint, then in the first instance please speak to your Financial Adviser who arranged this policy for you.

If you then need to speak to us, you can call us or send the details of your question or complaint to our Managing Director at the following address:

Optimal
4200 Waterside
Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YN

As an Appointed Representative of The Original Holloway Friendly Society Limited, if we are unable to resolve your complaint to your satisfaction, you may escalate the matter, or indeed you may choose to write in the first instance, to The Original Holloway Friendly Society Limited, which has its own complaints procedures.

Please write to:

The Chief Executive
The Original Holloway Friendly Society Limited
Holloway House
71 Eastgate Street
Gloucester
GL1 1PW

If we are unable to settle your complaint you may be able to refer it to the Financial Ombudsman Service at the address below. Making a complaint won't affect your right to take legal action.

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London
E14 9SR

Compensation

In the unlikely event that we cannot meet our liabilities you may be entitled to compensation from the Financial Services Compensation Scheme (FSCS). Further information is available from the FSCS at its website www.fscs.org.uk

Law

This policy is governed by English law.

Under our policy, members do not have any rights under the Contracts (Right of Third Parties) Act 1999. This means that there is no requirement to involve members in day to day decisions on the administration and insurance of the policy.

HMRC rules regarding the taxation of premiums and benefits may change in the future.

Language

All communications from us will only be available in English.

2017-002