Group critical illness technical guide

ellipse

Contents

Any reference in this technical guide to employer can include the principal employer and participating employers.

Policy aims

- To provide insurance to pay a lump sum benefit if a member or child of a member (or, if insured, a spouse / civil partner of a member) suffers from one of the insured illnesses specified in the policy.

Your commitment

- To pay the premiums when they are due.
- To comply with the policy terms and conditions.
- To notify us of any potential claims as soon as possible.
- To provide us at the intervals agreed with the information specified in the policy that is needed to ensure effective and timely cover.
- To have obtained all necessary consents from the insured persons to enable us to process their information.
- To ensure that any information you supply is accurate and complete at the time when you provide it.

Our commitment

- We will pay valid claims within five working days from the date we accept the claim is valid.
- We will pay promptly any refunds as they fall due.
- We will request information about you or the insured persons only to the extent it is necessary to ensure the efficient running of your policy.
- We will copy in your adviser to any correspondence we send to you.
- We will not copy you or your adviser into any correspondence sent to individuals in connection with assessing their health (to protect their privacy), but we will ensure you and your adviser are aware of the progress and results of such assessments.

Risk factors

- If you do not pay premiums on time or you fail to comply with the policy terms and conditions we reserve the right to cease the policy and not pay any new claims.
- Any delay in providing the information we require may result in members not being fully covered.
- If you do not fairly present the risk (e.g. the information we have requested is not provided, is incomplete or is inaccurate) then we have the right to adjust the premiums we charge for the cover and/or the terms and conditions.
- Certain types of claims may be excluded – see section 6 'What is not covered'
- We will not pay claims for any pre-existing insured illness or related medical conditions – see section 6 'What is not covered'. The pre-existing insured illnesses and related medical conditions exclusion will also apply in respect of children or a spouse or civil partner (if covered under the scheme)
- The premiums may be reviewed and varied, even within a rate guarantee period, in the circumstances described in the next section 'How does the policy work?'

Your questions answered

How does the policy work?

- You decide the eligibility and the type and level of benefits that you would like us to cover. You can choose different types and levels of cover for different categories of member. Members' children are automatically covered if aged between 30 days and 18 years (21 if in full time education) as long as the member remains covered. You can choose if cover is to be provided to members' spouses or civil partners.
- In order to ensure that you comply with relevant employment and taxation legislation you should obtain appropriate legal and tax advice.
- You pay premiums when they are due. Premiums are normally treated as a business expense for tax purposes but are treated as a benefit in kind for employees. However, you should confirm this with your tax advisers.
- We provide the cover whilst premiums are being paid and the policy remains in force no matter how many claims you make.
- A lump sum benefit becomes payable if an individual covered by the scheme suffers one of the insured illnesses as defined in the policy and survives for more than fourteen days. The survival period begins from the date of formal diagnosis in respect of the illness or the date of surgery where the illness requires surgery.
- The benefits to be paid in the event of claims will be as selected by you at the outset and shown in the policy schedule, unless the scheme is part of a flexible benefits arrangement. In this case you will select the levels of cover members can choose from and the amount paid in the event of a claim will be the level most recently selected by the member from the range available to them. All members will be covered for benefit up to an automatic acceptance limit specific to your policy, providing they join the scheme at their first opportunity within the eligibility conditions. Where benefits exceed the automatic acceptance limit or members join outside of the eligibility conditions they will be subject to individual assessment.
- Once we have admitted a claim we will pay the lump sum to the employee.
- You will be required to provide us with membership data within fourteen days of us requesting it. We will confirm at the start of the policy how often you will provide updated membership data which also needs to be accurate and complete. This should include details of new entrants who have joined the scheme since the previous data refresh. However, we should be informed immediately rather than at the next data update if:
    - a new entrant's benefit exceeds the automatic acceptance limit, or
    - they are joining without fulfilling the normal eligibility conditions, or
    - they are joining other than at their first opportunity

  This is because we will need to assess them before we can confirm cover.
- The policy terms and conditions and the underlying premium rate table are normally guaranteed for two years and will not be reviewed during that time unless one of the following occurs:
    - a greater than 25% variation in the number of members or their total salaries
    - the number of members drops below two
    - the new inclusion of an associated employer, or a TUPE transfer

- the disposal of a participating employer or closure of a part of an employer's business
- the inclusion of a new member category
- a change in policy design such as an amendment to the benefit level, the age cover normally ceases or eligibility conditions
- a change in the nature of an employer's business
- more than 25% of the total number of members or total salary changes location
- there is no longer an adviser acting for you in connection with this policy
- there is a change in legislation, regulation, HMRC practice or taxation which affects the treatment of this policy
- if you do not give us complete and accurate information

These matters define the risk as a whole.

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

We can provide a wide range of options to match your budget and needs.

1.1 Who can be covered?

Full time, part time and fixed term contract workers can be included in the policy. A member will be covered once they fulfil the eligibility conditions. Members' children are automatically covered if aged between 30 days and 18 years (21 if in full time education) as long as the member remains covered. You can choose if cover is to be provided to members' spouses or civil partners.

Cover can be provided for equity partners, providing all equity partners are included.

1.1.1 Eligibility conditions

The eligibility conditions must be clearly defined and agreed with us before the policy starts. Different eligibility conditions can be applied to different categories of membership.

All eligibility conditions must take account of any relevant employment or discrimination legislation and will include:

- the minimum and maximum entry ages
- any service qualification (for example, you might specify that a employee must have completed three months' service)
- the date on which new entrants will be included, for example, on the day they satisfy the eligibility conditions or on the first of the following month
- the date on which benefit increases are applied, which can be daily, monthly or annually

Eligibility can be linked to membership of an occupational pension scheme. Where this is the case, membership of the pension scheme must be open to all individuals who satisfy the eligibility conditions.

We consider an employee joining the pension scheme within twelve months of first becoming eligible as joining at their first opportunity.

Individuals who meet the eligibility conditions are covered for their benefits up to the policy's automatic acceptance limit. We will regard anyone to whom membership is offered without their having fulfilled the eligibility conditions as a discretionary entrant.

1.9 Additional benefit provided at no extra cost

Claimants and their families are offered RED ARC's Critical Illness Service, including the allocation of a personal nurse adviser for as long as they are needed. The nurse adviser may commission a specialist nurse home visit or a programme of therapy or counselling – whichever is the most appropriate – free of charge at point of use. The acceptance or otherwise of a claim and the amount of any benefit that might be paid are entirely unaffected, irrespective of whether or not the claimant decides to take up the offer.

The RED ARC service is provided on a non-contractual basis and may be withdrawn without notice at any time.

1.10 Flexible Benefits

We can provide cover under a flexible benefits scheme, whereby members can decide the level of cover that is most appropriate for their lifestyle. Increases in benefit can be selected at policy accounting date and following a 'lifestyle event', such as marriage or the birth of a child. Additional terms and conditions, including actively at work conditions, will apply to flexible benefit schemes and these will be set out in our quotation.

2 Setting up the policy

2.1 What are the requirements for setting up the policy?

The information we require to prepare a quotation is detailed at the beginning of section 3. 'What premiums will be charged for the cover?' We will prepare a quotation based on the information you provided and it is normally valid for three months. If you want us to assume risk, you or your adviser will need to confirm this, and supply any outstanding information that is shown in the quotation as subject to our review and approval before cover can be provided.

We will create an application form which has been partially completed with the information you have provided and post it on our secure website.

If your adviser has provided your email address, we will send you an email with details of how to register to access the site. Once you have registered and downloaded the form, you must:

i. review this application form to ensure that the information it contains is accurate and complete, Please pay particular attention to the section on the application form headed 'Information you provided on which we produced our quotation'. It is essential that you tell us if this information is incomplete or inaccurate.
ii. answer all our questions clearly and completely and provide any further material information requested or tell us if you do not have the information we requested.
iii. insert any information that is shown as required (for example, we will need the scheme name and cover start date).
iv. sign the form and the direct debit mandate (if you are paying by direct debit) and return it to us by the policy start date (cover cannot be backdated).

If your adviser has not provided your email address, the application form will be sent to the adviser, who will contact you about completion.

If any of the information used to pre-populate the application form is incorrect or information you subsequently add affects the risk presented, it may mean the terms of our quotation, including the premium, are invalidated and may have to be reviewed, or even that we have to withdraw our quotation entirely.

Once we have confirmed cover can start, we need details of the terms of acceptance for members who have been individually assessed (underwritten) by the previous insurer to be sent to us within fourteen days.

We will also request membership data (including employee National Insurance numbers) as at the policy start date, and require that to be supplied within fourteen days of our request.

Premiums payable on an annual basis will be paid by bank transfer. Premiums payable quarterly or monthly will be paid by direct debit.

If we do not receive complete data within fourteen days of our request we will request payment based on the estimated annual premium in the quotation.

For annual paying policies which pay premiums by bank transfer we will issue an invoice for the estimated annual premium and payment must be made within fourteen days.

For quarterly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 25% of the estimated annual premium and payment must be made within fourteen days.

For quarterly paying policies which pay premiums by direct debit we will request a payment for 25% of the estimated annual premium.

For monthly payment polices who are temporarily paying premiums by bank transfer we will issue an invoice for 1/12th of the estimated annual premium and payment must be made within fourteen days.

For monthly payment policies which pay premiums by direct debit we will request a payment for 1/12th of the estimated annual premium.

If, once the data is received, there is a greater than 25% variation in the number of members or total salary compared to the data used for the quotation we reserve the right to review our pricing and/or terms and conditions.

If, once the data is received, there is a material change in the risk, it may mean we have to withdraw our offer or review our pricing and/or terms and conditions. We would withdraw our offer if the change in the risk is such that if we had known about it when we were asked to quote we would have declined to quote, for example, all of the employees were based outside the UK.

If any of these requirements are not provided when they are due, we reserve the right to withdraw cover. We will notify you that we have ceased the policy and charge you for the cover provided between the policy start date and the date we ceased the policy.

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

One of the advantages of a group policy is that it is normally possible to provide cover for all eligible employees up to a certain limit without the need to individually assess them. This limit is known as the automatic acceptance limit. Members who meet the eligibility conditions and are joining at their first opportunity are automatically covered for benefits up to the policy's automatic acceptance limit.

The automatic acceptance limit is reviewed at the end of every rate guarantee period (usually two years) and is dependent on the number of members and benefits insured.

Any individual whose benefits have been restricted or accepted on non-standard terms will not benefit from any increase in the automatic acceptance limit.

We reserve the right to individually assess previously accepted members if the automatic acceptance limit decreases as a result of the membership reducing by more than 25%.

Where there are fewer than five members in a scheme, no automatic acceptance limit will be given.

2.2.1 What happens if the automatic acceptance limit is exceeded or doesn't apply?

Any individual whose promised benefits exceed the automatic acceptance limit or who is joining outside of the eligibility conditions of the scheme will need to be individually assessed for their excess benefit and total benefit respectively. We must be told about these individuals immediately as their level of cover cannot be confirmed until the individual assessment has been completed.

Individuals who need to be assessed will be sent an email containing a link to our secure online questionnaire. During this questionnaire they will be asked questions about their health and lifestyle and they will be expected to take reasonable care not to make a misrepresentation. In many cases a decision as to what cover can be provided and on what terms, is given at the end of the assessment. In some cases further medical information is needed, e.g. blood tests, independent medical examination, etc., before a final decision can be made. If further tests or examinations are required, the individual will be sent instructions as to how to make an appointment with one of our medical test providers in order for the tests to be carried out. On rare occasions we may need to get further information from the individual's GP and/or other medical professionals who have attended them. The individual continues to have a duty to take reasonable care not to make a misrepresentation during this process.

Using the results of the online questionnaire and any other information

gathered, we confirm if the individual can be accepted at standard rates or if we need to apply special terms, decline or postpone our decision. (We may postpone it, for example, if the individual is about to undergo an operation which could radically affect their state of health once completed.) Special terms will take the form of a premium loading or an exclusion for a specific condition. We will advise both the individual and you of our decision. If there is a premium loading we will assume that it is acceptable and adjust future premium collections accordingly, unless you write to tell us otherwise. If this is the case, we will remove the loading and restrict the member's benefits accordingly.

Wherever possible, we aim to limit the number of times any individual needs to be assessed. Therefore, if we are able to offer terms, individuals will normally not need to be assessed again. We reserve the right to individually assess members again if their benefit increases as a result of a change in benefit basis, or their cover cease age increases, or, where benefit is based on a member's salary there is an increase in salary of more than twenty percent in a twelve month period.

2.2.2 If members have been assessed by a previous insurer, do they need to be re-assessed when we commence cover?

Where a scheme transfers its insurance to us from another insurer (with the exception of a Lloyd's syndicate insurer), we will normally take over the benefits accepted by the previous insurer on the same terms, provided we get sight of the acceptance by the previous insurer detailing the terms of acceptance. The transfer of an individual's cover from a Lloyd's syndicate insurer will be subject to individual consideration.

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

Whilst we are assessing an individual we will provide them with temporary cover for a maximum period of 30 days or until our assessment is completed, if earlier.

Temporary cover starts from the date we are advised of the level of benefit required. It is subject to the pre-existing insured illness and related medical condition exclusion – see section 6 'What is not covered?'

Temporary cover will not be given to any individual who

i. has previously been declined, offered cover on non-standard terms or where a decision on their benefits has been postponed (either by Ellipse of another insurer)
ii. has failed to provide medical evidence that has been requested
iii. is joining outside of the eligibility conditions or is being offered a benefit greater than the rules of the scheme provide for
iv. is a late entrant

If we are unable to complete our assessment before the temporary cover expires,

the individual's cover will be restricted to their previous accepted level of cover. If the previous accepted level of cover was based on an assessment carried out by an insurer other than Ellipse, we will require documentary proof of the previous acceptance terms.

3 What premiums will be charged for the cover?

The premium we charge depends on a number of factors including:

- the benefit options you select
- the amount of cover provided
- the eligibility and entry conditions
- the age cover ceases
- the age and genders of members to be covered
- if cover is provided for members' spouses or civil partners, their age and genders
- the nature of the industry you are in and your principal activity
- the salaries of the members
- the location of the workforce (postcode if in the UK or country if outside the UK)
- the claims experience

3.1 How will premiums be calculated?

Premiums are calculated for the cover provided to each member (and spouse or civil partner if applicable) based on age-related premium rate tables which we apply to the amount of their insured benefit.

3.2 Will there be any extra premium?

Premium loadings may be imposed on members' cover as a result of them being individually assessed. Any loading will reflect their medical condition or hazardous pursuit and will apply only to the benefit that has been individually assessed.

The actual premium payable will depend on the membership and benefits provided during each accounting period.

We normally guarantee the policy terms and underlying premium rate tables for two years until the second policy anniversary date. They will be reviewed at the end of the guarantee period and a new guarantee period will be set. However we may review them part way through a guarantee period if any one of the following occurs:

i. a greater than 25% variation in the number of members or their total salaries
ii. the number of members drops below two
iii. the new inclusion of an associated employer or a TUPE transfer
iv. the disposal of a participating employer or closure of a part of the employer's business
v. the inclusion of a new member category
vi. a change in policy design such as an amendment to the benefit level, the age cover ceases or eligibility conditions
vii. a change in the nature of an employer's business
viii. more than 25% of the total number of members or total salary changes location
ix. there is no longer an adviser acting for you in connection with this policy
x. there is a change in legislation, regulation, HMRC practice or taxation

which affects the treatment of this policy

xi. you have not given us complete and accurate information.

3.3 Is there a discount for a good claims history?

Claims experience, both good and bad, can have an impact when calculating the premiums for policies. Generally, the larger the policy, the greater the significance that will be attached to claims experience.

3.4 What commission is included within the premium?

You and your adviser are responsible for deciding the level of commission, if any, to be paid by us to your adviser. The premium charged will include the level of commission payable. We will confirm the rate of commission payable to your adviser in your quotation and at regular intervals during the life of the policy.

4 How does the policy accounting work?

During the year, you will send us updated membership data at a frequency agreed when the policy starts. The frequency can be quarterly or every twelve months. For policies that use our Livewire™ automated data link data can be updated monthly. After each data refresh, the cost of providing the cover will be recalculated to reflect the actual cover being provided.

The quotation will show the estimated first year cost assuming that all members are accepted at standard terms for their full benefit entitlement, based on the data supplied. The actual premium payable will vary from this:

- if the membership data changes (which will happen as people join or leave the company, or the amount of their salaries – and therefore benefits – change)
- if any of the circumstances set out in section 3.2 'Will there be any extra premium?' arise

4.1 What information is required for accounting purposes?

When each data update is due, you must provide complete and accurate details of all current members (and their spouse or civil partner if cover is to be provided for them) including their:

- National Insurance number
- name
- gender
- date of birth
- salary (based on the policy salary definition)
- benefit category
- location (postcode if in the UK or country if outside the UK)
- date of joining / leaving (if applicable)
- amount of benefit.

For the avoidance of doubt, fair presentation of the risk at a data refresh is providing the information we ask for completely and accurately.

You need to identify any members who are joining outside of the eligibility conditions, absent from work or are working past the age cover normally ceases.

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

Premiums will be adjusted according to the latest data received, allowing for joiners, leavers and benefit changes. Where premiums are collected monthly or quarterly, the amount collected each month will be adjusted from the next due date. Where premiums are paid annually, at each policy anniversary date we will calculate if any premium is due or to be refunded, based on the actual cover provided since the previous anniversary date.

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

No, a final account will be produced based on the cover we provided up until the date you cancelled the policy.

5 Claiming benefit

We know the importance of handling claims quickly and efficiently. In this section we have set out how we handle claims made in respect of an insured person.

5.1 How are claims made?

To ensure a claim is processed quickly, you must advise us as soon as possible of the potential claim by calling our claims helpline on 020 3003 6161. We will collect information about the member and the claim which we will use to populate a claim form and send it to you to complete and return to us. To ensure no breach of the member's right to medical confidentiality, the form will not contain any information about the member's condition.

A separate form, also populated with any information we already hold, will be sent to the member for them to complete.

In order to assess a claim we will need the following information:

- a completed claim form signed by the policyholder
- proof of the member's age (for example the member's passport or birth certificate, or confirmation that you have seen one of these documents)
- an assessment form completed by the insured person – this will include their consent for us to seek further medical information as required by the Access to Medical Reports Act
- proof of membership and earnings
- if a claim is being made for a spouse or civil partner, we will need their birth certificate, and either the marriage or civil partnership certificate (a photocopy is not acceptable)
- if a claim is being made for a child, we will need their birth or adoption certificate (a photocopy is not acceptable)
- if the claim is being made for total permanent disability on either an own occupation or suited occupation basis, a copy of the member's job description detailing their regular duties

This list is not exhaustive and there may be times where more information is required.

Upon receipt of a claim, we will deal with it promptly and fairly and will provide appropriate information on the progress of the claim. Once all the information required has been received, we will settle eligible claims within 5 days.

We will assess your claim based on the medical evidence provided compared to the definition of the relevant insured illness. Any diagnosis or medical opinions must be given by a medical professional who is a specialist in an area of medicine appropriate to the cause of the claim and is acceptable to our chief medical officer.

Payments will be made to the employee by direct credit.

5.2 Can another claim be made for an individual?

Yes, provided it is not for the same insured illness, a related medical condition or the earlier claim is not directly or indirectly associated with the new insured illness– see section 6 'What is not covered'. If a claim was paid for a member by a previous insurer of your scheme a claim cannot be made in respect of that member for the same or related condition under this policy.

6 What is not covered?

6.1 Pre-existing insured illnesses exclusion

Insured illnesses are any of the illnesses defined within the policy contract that are within the options – core illnesses, core plus additional illnesses, with or without cover for total permanent disability - selected by the policyholder.

A pre-existing insured illnesses exclusion will always apply to a member's benefit unless we have individually assessed the member and confirmed the removal of the exclusion in writing. In any event a pre-existing insured illnesses exclusion will always apply to children, spouses or civil partners (if they are covered under the scheme).

The pre-existing insured illnesses exclusion means no benefit will be payable for any insured illness or repeat of the same insured illness which the insured person:

- has received treatment for,
- has sought advice on, or
- was diagnosed with

before entry to the scheme.

The same exclusion applies to any increase in benefit.

For the purpose of the policy the illnesses in each group below will be considered to be the same insured illness:

Group 1	Group 2	Group 3
Aorta graft surgery Coronary artery by-pass grafts Heart attack Heart transplant (under the major organ transplant) Heart valve replacement or repair Stroke Cardiomyopathy Open heart surgery Primary pulmonary hypertension For example, where an insured person suffers a heart attack then no benefit shall be payable in respect of any subsequent stroke claim.	Kidney failure Kidney transplant (under the major organ transplant) For example where an insured person suffers from kidney failure then no benefit shall be payable in respect of any subsequent claim for kidney transplant under the major organ transplant definition.	Where the insured person has suffered from any malignant tumours, defined as 'cancer – *excluding less advanced cases*', then no benefit shall be payable in respect of any subsequent cancer –, whether or not this is connected to, or associated with the prior diagnosis of cancer.

In addition, no benefit will be payable for any insured illness which the insured person:

- has received treatment for,
- has sought advice on, or
- was diagnosed with

before entry to the scheme and which leads to a claim for coma, loss of independent existence, loss of speech, paralysis of limbs, terminal illness or total permanent disability.

For example, where a member claims under the terminal illness benefit, but had suffered from cancer before entering the scheme, this claim will be declined.

The criteria under this pre-existing insured illnesses exclusion shall also apply to any increase in benefit. In this case, rather than 'no benefit' being payable, the exclusion means that 'no increase in benefit will be payable' and rather than only applying to insured illnesses or repeat of the same insured illness suffered 'before entry to the scheme' it also applies to ones suffered before the benefit increase.

6.2 Related condition exclusion

A related condition is defined as any medical condition, which in the opinion of our chief medical officer, is either directly or indirectly associated with or is likely to have led to the occurrence of the insured illness.

We will not pay any claim for an insured illness where a related condition existed prior to entry to the scheme unless the insured person had neither received any treatment, nor suffered symptoms, nor sought advice for that related condition for at least two consecutive years since entry to the scheme.

In addition, we will not pay any claim in respect of an increase in benefit for an insured illness which had a related condition unless the insured person had neither received any treatment, nor suffered symptoms, nor sought advice for that related condition for at least two consecutive years since the increase.

We will not pay any claim for coma, loss of independent existence, loss of speech, paralysis of limbs, terminal illness or total permanent disability benefit where a related condition existed before either entry to the scheme or the last increase in benefit.

For example, where a member had chest pain prior to joining the scheme, then has a heart attack after joining the scheme, this claim will be excluded unless the insured person had not had any treatment, symptoms, or advice for chest pain for at least two consecutive years since either entry to the scheme or the last increase in benefit.

6.3 Additional exclusions applied after assessment

After the assessment of either discretionary entrants or members whose benefits are over the automatic acceptance limit, exclusions may apply for claims arising from certain specified medical conditions or in specified circumstances.

6.4 Additional exclusion in relation to children

A claim will not be covered for children's critical illness cover if:

- the child's insured illness or any related condition (as defined in section 1.2) was present at birth, or
- symptoms first arose or treatment was provided before the child was covered.

6.5 Excluded claims

Where a claim has already been paid and a new claim is made where in the opinion of our Chief Medical Officer, the earlier claim is either directly or indirectly associated with or is likely to have led to the occurrence of the new insured illness, then this new claim will not be met.

For example if a claim has previously been admitted for a stroke, we will not consider a claim for total and permanent disability benefit where the stroke has led to the disablement.

A further example is where an insured person had a claim admitted for cancer, then submits a claim for terminal illness as a result of cancer. In this case we will consider the terminal illness claim to be related to the cancer claim and this new claim will be declined.

7 Can cover be provided for a member who is not based in the UK?

7.1. Members who travel outside the UK

We will provide cover for members based in the UK who travel outside the UK for work purposes.

7.2. Members seconded outside the UK

We will provide cover for members who are temporarily seconded outside the UK providing:

i. they satisfy the eligibility conditions of the scheme
ii. the country of secondment is declared for each employee at the start of the policy and at each data refresh.

7.3. Members permanently based outside the UK

We will provide cover for members who are permanently working outside the UK in any of the following locations; European Union, Andorra, Australia, Canada, Channel Islands, Hong Kong, Iceland, Isle of Man, Gibraltar, Liechtenstein, Monaco, New Zealand, Norway, San Marino, South Africa, Singapore, Switzerland or the USA, providing:

i. they satisfy the eligibility conditions of the scheme
ii. the country of residence is declared for each employee at the start of the policy and at each data refresh.

Where employees are working outside the UK the amount of salary and/or benefit advised at each data refresh must be expressed in pounds Sterling.

Where a scheme includes employees who are resident outside the UK, the company must satisfy itself regarding any taxation consequences.

Where members are outside the UK, and provision of their benefits is subject to individual assessment, they will be invited to complete our online questionnaire as described in section 2.2.1 'What happens if the automatic acceptance limit is exceeded or doesn't apply'. If after this further medical information is required to enable us to complete our assessment, the member will be responsible for arranging and paying for the tests to be conducted. Examinations, tests or reports may only be arranged / conducted at a centre or provider with prior approval from Ellipse otherwise we will not be liable for any costs and the member may also be required to undertake another set of tests with an approved centre/provider.

We will reimburse the member for the tests we have requested, to a maximum of the amount we would pay for the same test in the UK. Reimbursement will be in pounds sterling to a UK bank account and the exchange rate used for reimbursement will be our bankers' rate of exchange on the date of reimbursement.

All results and/or reports must be provided in English.

8 Taxation of policies

The following outlines our understanding of legislation and HMRC practice.

8.1 Payment of premiums

The whole cost of the policy will be met by you.

For tax purposes, premiums paid by you in respect of employees are treated as a business expense. They are treated as a P11D benefit for employees.
Tax relief on premiums paid in respect of any employees who have a proprietorial interest in the company will not normally be available. HMRC may agree to allow such 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.

Equity partners pay for their own premiums and there is no tax relief on these premiums.

8.2 Payment of benefits

Policy benefits to the members (including equity partners) are not normally subject to income tax. We will always pay them gross of any tax that may be due.

9 Your duty of fair presentation of the risk

You must answer our questions completely and accurately. You need to disclose every material fact which you know or ought to know of. If you do not have complete information, you must tell us.

9.1 What you know or ought to know

You must conduct a reasonable search for, and tell us of, all material facts available to you, senior management of any employers covered under this policy, or anybody responsible for your insurance. This may include your adviser or your contractors.

You do not need to tell us about a material fact if:

- it diminishes the risk
- we know it
- we ought to know it
- we are presumed to know it (because it is common knowledge) or
- we specifically say we do not require the information.

9.2 Material facts

A material fact is something that would influence our decision whether or not to offer cover and, if so, on what terms.

9.3 When the duty of fair presentation applies

The duty of fair presentation applies to policies that start or have a rate review on or after 12 August 2016 as well as changes to existing policies which are agreed on or after 12 August 2016.

9.4 Paying claims in full means that we are contracting out of this part of the Insurance Act 2015

Under the Insurance Act 2015 if you make a misrepresentation of the risk (but you have not been deliberate or reckless in doing so) we can proportionally reduce the claim. We believe it is fairer to members to pay claims in full and charge you the correct higher premium. In order to do this we have to contract out of this part of the Act (i.e. Schedule 1 paragraphs 6 and 11 of the Insurance Act 2015). The other remedies available for misrepresentation may be applied as outlined below.

9.5 What happens if you do not make a fair presentation of the risk

9.5.1 Deliberate or reckless misrepresentation of the risk

If you deliberately or recklessly do not make a fair presentation when setting up the policy we may avoid the policy from the beginning and recover claims paid. In the case of a deliberate or reckless failure to make a fair presentation of the risk at rate review or when you ask us to make a change to the policy, cancellation shall take effect from the rate review date or the date the change to the policy was made (as applicable).

9.5.2 Not deliberate or reckless misrepresentation of the risk

If you do not make a fair presentation but you have not been deliberate or reckless the outcome depends upon what we would have done if we had

known the material facts:

- if we would not have entered into the policy we may avoid the policy from the beginning and recover any claims paid. If this misrepresentation happened at the rate review or when you asked us to make a change to the policy, cancellation shall take effect from the rate review date or the date the change to the policy was made (as applicable).
- if we would have applied different terms and/or an additional premium we will apply those different terms and/or premium from the beginning. If this misrepresentation happened at the rate review or when you asked us to make a change to the policy, the additional premium and/or different terms will apply from the rate review date or the date the change to the policy was made (as applicable).

9.6 Fraudulent claims

The Insurance Act 2015 also sets out remedies if there is a fraudulent claim. If there is a fraudulent misrepresentation by a member which affects our acceptance of a claim made in respect of that member we will not pay the claim in respect of that member. If there is fraudulent claim made by you we will not pay the claim and we reserve the right to terminate the policy.

- Troponin T > 1.0 ng/ml
- AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- other acute coronary syndromes including but not limited to angina

Kidney failure – *requiring dialysis*
Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

Major organ transplant
The undergoing as a recipient of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or inclusion on an official UK waiting list for such a procedure.

For the above definition, the following is not covered:

- transplant of any other organs, parts of organs, tissues or cells

Motor neurone disease – *resulting in permanent symptoms*
A definite diagnosis of motor neurone disease by a consultant neurologist.
There must be permanent clinical impairment of motor function.

Multiple sclerosis – *with persisting symptoms*
A definite diagnosis of multiple sclerosis by a consultant neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months.

Parkinson's disease – *resulting in permanent symptoms*
A definite diagnosis of Parkinson's disease by a consultant neurologist.
There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability.

For the above definition, the following are not covered:

- Parkinson's disease secondary to drug abuse
- Parkinsonian syndromes

Stroke – *resulting in permanent symptoms*
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- transient ischaemic attack
- traumatic injury to brain tissue or blood vessels

12 Further information

Ellipse is a trademark of the UK branch of ERGO Lebensversicherung Aktiengesellschaft. Cover is provided by ERGO Lebensversicherung, UK Branch.

ERGO Lebensversicherung Aktiengesellschaft is regulated by BaFin. The registration number is 1184.

ERGO Lebensversicherung AG, UK Branch is registered in England. The registration number is BR010594.

The registered office is 5th Floor, 15 Bermondsey Square London SE1 3UN

ERGO Lebensversicherung Aktiengesellschaft is a German insurance company with headquarters in Hamburg.

Questions and complaints

If you have any queries please contact your adviser in the first instance. If you wish to raise any queries with us, or make a complaint, please contact our Chief Executive Officer at:

5th Floor
15 Bermondsey Square
London
SE1 3UN

or by email to puttingitright@ellipse.co.uk
or by calling 020 3003 6160 (Calls may be recorded for training and monitoring purposes)

If you are still dissatisfied following a formal response to your complaint, you can approach the Financial Ombudsman Service at:

Financial Ombudsman Service South Exchange Tower
1 Harbour Exchange Square
London
E14 9SR
Tel 0800 023 4 567

Compensation

If we are unable to meet our liabilities, you may be able to claim compensation from the Financial Services Compensation Scheme. Further information is available from the Financial Conduct Authority or the Financial Services Compensation Scheme.

Further information about compensation scheme arrangements is available from:

Financial Services Compensation Scheme
10th floor, Beaufort House
15 St Botolph Street