HOW TO MAKE A CLAIM ON YOUR PERMANENT HEALTH INSURANCE POLICY

Introduction

The aim of this booklet is to guide you through the process of making a Permanent Health Insurance claim ensuring your claim is dealt with as quickly and fairly as possible.

Contents

1. Completing the claim forms

Before completing the claim forms, you should note that your policy is subject to a deferred period from the time you are first off work, during which we will not pay any benefits. Your policy schedule will tell you how long the deferred period is. If the deferred period has been met, or is shortly about to be met and it is certain that you will still be off work after the end of the deferred period, please complete the forms included with this guide.

Forms A, B & C are for you to complete:

- Form A is to give us more information about your illness/injury.
- Form B is to give us more information about your occupation.
- Form C is to give us permission to contact your doctor to request additional information about your illness/injury.

You should complete forms A, B and C. If you have any questions about completing the forms please ring us on **0345 605 7777** so we can help. Once completed send them back to us, along with your original birth certificate (we'll send this straight back to you), in the pre-paid envelope provided.

Form D is for your doctor to complete:

This is to confirm the diagnosis of your illness/injury. You'll need to pass this to your doctor to complete and ask him/her to send it directly back to us in the prepaid envelope provided.

If your doctor charges you for completing the form, please send the original invoice to us and we will reimburse the cost to you. We will also pay for any further information we request.

We may also decide to write to your employer for further information. If we do this we will write to you to let you know.

The claim process can take a few weeks, especially if we have to write to your doctor or employer for further information. The sooner we receive your completed claim forms, the quicker we can look at your claim. If we don't receive your claim forms within 60 days of sending them to you, we'll assume that you don't want to proceed with the claim.

2. Assessing your claim

We would like to be able to pay your claim as soon as possible and when we receive your claim form we will start our assessment process.

It is important that you continue to pay your premiums whilst we assess the claim and during any payment of benefits under the policy. If you stop paying your premiums your policy will lapse and have no value.

During our assessment we will assess whether you:

- meet the definition of the incapacity, as outlined in your policy document

- informed us of all the relevant information covering your health at the time you took out the policy.

We may be able to complete our assessment from the details provided in the claim forms. However, in some cases we may need to request further information from your doctor, other medical practitioner, e.g. your hospital consultant, or possibly your employer. If we do this we'll write to you to let you know. Requesting this information means it could take us a little longer to assess your claim but ensures we make a fair decision. Any charges for requesting this information will be paid for by us.

3. Letting you know our decision

As soon as we have completed our assessment we'll write to you to let you know our decision. Our decision will either be to:

- pay your claim in full
- decline your claim.

Paying your claim

If we agree to pay your claim we will start payment of your claim benefits one month after the end of the deferred period. As explained above, the deferred period is a period of time when you are first unable to work, during which we will not pay any benefits. Your policy schedule will tell you how long your deferred period is. The income we will pay is free from income tax. **It is important that you continue to pay your premiums during any payment of benefits under the policy. If you stop paying your premiums your policy will lapse and have no value.**

Provided your policy remains in-force, the claim payments will continue to be paid to you but are conditional on you being unable to carry out your usual occupation due to accidental injury or sickness. We will contact you on a regular basis to check your situation and may ask for further information to assess your ongoing claim.

We will stop paying your benefits when one of the following first happens:

- you no longer meet the policy definition of being totally unable to perform your own occupation
- you return to work
- you start a different occupation
- the end of the policy term is reached, or
- if you die.

If you return to work for a reduced number of hours, we may pay you a rehabilitation benefit.

Where you have been receiving Incapacity Benefit but you return to work for a reduced number of hours per week in your occupation or another occupation for which we agree to provide insurance cover, we will, instead of paying Incapacity Benefit, pay a Rehabilitation Benefit to you from the date when you return to such work:

- for a period of one year
- until you resume your normal hours of work or
- until the end of the term

whichever is the shortest.

The amount of Rehabilitation Benefit will be the Incapacity Benefit reduced by a proportion which will be calculated by dividing your monthly earnings after returning to work by your average monthly earnings in the 12 months prior to the relevant period of incapacity. In all cases, such earnings will exclude any overtime, bonus or discretionary payments. The Rehabilitation Benefit will be paid at the end of each complete month and a reduced amount will be paid to cover the period from the date of the last full payment of rehabilitation benefit until the date when we stop paying Rehabilitation Benefit.

If, within six months of the end of any period of incapacity, you become incapacitated from the same or a directly related condition, the new period of incapacity will be treated as a continuation of the previous period of incapacity. This means that:

- if your previous period of incapacity ended after you had completed the associated deferred period, a new benefit will start immediately or
- if your previous period of incapacity ended during the associated deferred period, the new deferred period will be limited to the remaining part of the previous deferred period.

If we decline your claim

We may decline your claim for several reasons:

- you do not meet the policy definition of 'incapacitated', i.e. you are not able to carry out your own occupation. However, you will not be considered to be incapacitated if you are unable to follow your own occupation but are following some other occupation. This definition of Incapacitated means that you will not be able to claim Incapacity Benefit if you are able to undertake any form of work in your own occupation or are actually working in some other occupation.
- you gave us incorrect information when you applied for the policy which, had we known, would have resulted in us declining your application for cover.
- you change occupation to one which we don't provide cover for.
- you stop working in your occupation for any reason other than as a result of incapacity.
- you are not resident in the United Kingdom, the Channel Islands or the Isle of Man for at least nine months in each year.

Our letter to you will let you know the exact reason why we have declined your claim. Your cover may be able to continue as before (providing you continue to pay the premiums). However, if we decide we would have declined your application or we were not informed at the time a change was made, i.e. changed

occupation to one we don't cover, no longer in employment or not UK resident for nine months per year, then we will end your policy and send you a cheque for a refund of the premiums paid (for changes made mid term the refund is from the date of the change rather than all the premiums paid).

Appealing our decision

If we decline your claim we'll explain why we've made that decision and give you the opportunity to let us know the reasons why you feel our decision is wrong, if that is the case. Your claim will then be reviewed and we will obtain any further evidence that may be required before we let you know our final decision.

If you remain unhappy with this decision, you can refer your complaint to the Financial Ombudsman Service (FOS), which provides consumers with a free independent service for settling disputes with financial firms. Any referral must be made within six months of the date of our final decision. Contact details are as follows:

Financial Ombudsman Services (FOS)
Exchange Tower
London
E14 9SR.

Telephone: 0300 123 9123

Email: complaint.info@financial-ombudsman.org.uk

4. How to contact us

If you need to contact us simply ring us on **0345 605 7777**. You can ring us Monday to Friday 8am-8pm or Saturday 8am-5pm, including bank holidays but not Christmas Day, Boxing Day and New Years Day. It will be helpful if you have your policy number to hand so we can find your details quicker.

If you prefer, you can write to us at:

Life Policy Claims
Royal London
Churchgate House
56 Oxford Street
Manchester
M1 6EU

If you would like a copy of this leaflet in large print, audio or Braille, please call us on 0345 605 7777.

Lines open Monday to Friday 8am-8pm and Saturday 8am-5pm.

Royal London
Churchgate House, 56 Oxford Street, Manchester, M1 6EU
royallondon.com

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