For customers

Illness and disability claims guide

At Aegon, we realise that making a claim can seem complicated. So we've put together this guide to explain the process and answer any questions you might have.

Our philosophy is to provide a professional and fair claims service by paying all valid claims as soon as possible. When you make a claim, we aim to:

- Provide a personalised, professional, supportive and sympathetic service, right from the start
- Get the information we need from your GP and specialists as quickly as we can, without inconveniencing you
- Make sure all payments are made accurately and on time
- Look for ways to help you get back into work – supporting you as much as we can

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Contents

What you need to know about claims

The team

When you contact us about a claim, we'll assign you your own personal claims assessor, from our experienced team. They'll be available to help you with your claim and answer any questions you have.

Our claims assessors recognise that all claims are different and need personal attention. Their priority is to pay valid claims quickly, with as little hassle as possible.

The team's objectives are to:

- Gather the key details about your illness, over the phone or by sending out a claim form within one working day of your initial request
- Reply to all correspondence within five working days - if this isn't possible (for example when we've had to request additional information), we'll keep you updated on progress, by phone
- Get the best quality information from your GP and any consultants involved in your care to help us assess your claim
- Get independent expert medical advice when we need to
- Make recommendations that might help you get back to work

The claims process

You or your representative will need to let us know if you want to make a claim.

Call us on 03456 00 04 93 or write to us at:

Claims Department
Aegon
Edinburgh Park
Edinburgh
EH12 9SE

We offer a tele-claims service to help you submit a claim with the minimum amount of stress. One of our experienced claims assessors will gather the key details about your illness over the phone with you – removing the need for you to complete a claim form.

If you prefer, we'll send you or your representative a claim form to fill in, along with a letter to take to your GP.

It's important that you give us as much information as you can. If you have copies of any medical reports that your GP or consultant has given you, please send them to us. They might help us to assess your claim without having to contact your GP or consultant, making it quicker for us to give you a decision on your claim.

If necessary, your claims assessor may need to contact your GP or consultant, by writing directly to them with some specific questions about your illness/incapacity. We might also need to ask your GP to verify your past medical history. We'll pay any costs incurred in this part of the process.

If we need any more information we'll refer to our network of specialists, whose services include:

- Independent medical examinations
- Functional assessments
- Home visits
- Career counselling
- Workplace assessments
- Other specialist assistance

Once we've got enough details, we'll assess your claim.

Critical illness claims

We'll assess your claim against the relevant policy definition. You can find a full list of our critical illness definitions in your original policy conditions booklet.

Income protection and total permanent disability claims

We'll assess your claim against the definition of disability that applies to your policy. This means that we might not always just be looking to see if you can perform your own occupation. Depending on your policy definition, we might also be assessing your ability to perform other occupations or certain listed tasks. Please see your policy schedule and conditions for the definition of disability that applies to your policy.

For total permanent disability claims, we might not always be able to give you an immediate decision because we have to consider the permanency of your disability. We might have to postpone our decision until more information is available about your prognosis or you've completed all the possible treatment options.

For income protection claims, we need to assess your claim medically and financially.

Decision

Critical illness/total permanent disability claims

Once we've reached a decision and if your claim is accepted, we'll make a payment to the policyholder(s). If the policy is held in joint names, we'll make the payment to a joint account or split it equally between both policyholders. Similarly, if there's a trust, we'll make the payment to a bank account in the joint names of all the trustees, or to a solicitor's client account.

Income protection claims

Once we've reached a decision and if your claim is accepted, we'll start your monthly payments. We'll keep in touch with you to see how you are and if there's anything we can do to help you get back to work.

After accepting your claim we'll still need to conduct a regular review. The frequency of the review will depend on the cause of your absence from work. At the time of the review, we might need to request more medical and/or financial evidence. Once we've considered all the information we'll let you know if we've approved your ongoing claim.

A quick guide to your claim

This flowchart takes you through the key stages of a claim.

1. You or your representative gets in touch with us to say that you need to make a claim.

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2. We'll gather the key details about your illness over the phone, or we'll send you a claim form to complete along with a letter for your GP and/or consultant – whichever is most convenient to you.

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3. If you used our tele-claims service, we'll send you a copy of the information you provided over the phone, and details of any other information we need.

   If you didn't use our tele-claims service, you'll need to return the completed claim form to us to progress your claim.

   If you have copies of any medical reports, please send them to us as it could make it quicker for us to give you a decision on your claim.

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4. Once we've received the form (and proof of earnings for income protection claims), we'll let you know it's arrived safely.

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5. If we didn't ask you to take a letter to your GP and/or consultant, we'll write to them directly.

   Once we've received a reply from your GP and/or consultant, we'll see if we can make a decision using the information they've provided. If not, we'll ask for more information and we might arrange a medical examination or a visit from a nurse.

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6. We'll phone you or send you a letter to explain the current position and what will happen next.

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7. We'll complete the claim assessment once we've received all outstanding information.

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8. We'll phone you and follow up with a letter explaining the outcome of our assessment and our claims decision. If we've agreed your claim, we'll arrange payment.

   For income protection claims, we'll make regular monthly payments to your bank or building society account. We'll review the claim as and when our doctors think necessary.

Your questions answered

When should I get in touch with you about a claim?

Let us know about a potential claim as early as you can. For income protection and waiver of premium claims, you should let us know no later than shown in the table below.

Deferred period	Notification period
4 or 8 weeks	by week 2
13 weeks	by week 4
26 weeks	by week 6
52 weeks	by week 12

If you don't tell us within these time limits, it might affect our claims decision and could lead to a delay in us paying the benefit amount.

You'll have chosen a deferred period for your income protection or waiver of premium benefit when you first took out your policy. This will be shown on your policy schedule. This is the period of time that you must be continuously incapacitated, before we'll pay a valid claim.

How do I tell you about a claim?

Call us on 03456 00 04 93 or write to us at:

Claims Department
Aegon
Edinburgh Park
Edinburgh
EH12 9SE

When will I hear about my claim?

If we didn't collect full details of your illness over the phone when you first contacted us, we'll send our claim form within one working day of your first call. Your claims assessor will keep you updated on the progress of your claim throughout our assessment.

How long will my claim take?

We'll work with you and your GP or specialist to get all the information we need as quickly as possible. As soon as we have it all, we can make a decision on your claim.

For certain conditions, the disability definition requires there to be permanent symptoms. In these cases we might not be able to make a decision until you've had further treatment. We'll set a future date to review your claim, and continue to keep you updated of any progress in the meantime.

Will I need to attend an independent examination?

We'll try to assess your claim on the information your GP and/or consultant(s) give. Sometimes this information isn't enough and in these cases we might need you to see an independent doctor, who will report on your medical condition. This is more likely for total permanent disability and income protection claims than for critical illness protection claims. If we do need you to have an examination we'll contact you to arrange this. We'll also meet any costs involved.

How are benefits paid?

If we agree your claim, we'll pay the benefit into a bank or building society account, as instructed.

Why are claims declined?

We may decline to pay a claim if you've been diagnosed with an illness that's covered in your policy, but you haven't met the policy definition. If we've declined your claim because it's too early, you'll still be able to claim if your illness progresses and meets the definition.

We may also decline a claim if we become aware that the medical information you gave us when you applied for your policy was incorrect - this is called material misrepresentation. We offered you cover based on the medical information you provided us. The important medical information that you didn't provide would have affected the insurance terms and conditions that we did offer you, including whether we were able to offer you any cover at all. This is why it's important that you give us details of your full medical history when you apply for a policy.

Income protection claims

When will payments begin?

If you've contacted us well before the end of your deferred period, we'll do our best to get all the information we need to pay your claim once the deferred period has ended.

How often are benefits paid?

We pay benefits monthly in arrears. However, we like to pay all claims a few days early so that the money is available to you by the due date.

How long will a claim be paid for?

As long as you remain unfit to work (according to the definition of incapacity that applies to your policy) or until your benefit expires.

Will my claim be reviewed?

We review all claims – how often depends on the circumstances of the claim. Your claims assessor will consider what evidence we need at the time of the review.

If I go back to work but find that the incapacity returns, will I have to wait for the deferred period again?

If you return to work and your illness reoccurs within six months, you won't need to wait for the end of the deferred period before any benefits are paid. However, if it reoccurs after six months, you will.

With adaptations to the workplace I could return to work. What should I do?

Since the introduction of the Disability Discrimination Act, all employers must do what they can to address employees' needs. Practically, this means that if medical opinion demonstrates you could return to work, you can insist that reasonable changes to your workplace or role are made.

What income will my claim replace?

Your policy is designed to replace income that's lost when you can't work because of sickness or incapacity. There's only so much benefit you can get, so there's an incentive to return to work.

Income is generally taken to be 'any pre-incapacity earnings that will be lost in the event of incapacity'.

If you're employed, income is taken to be your gross taxable earnings in the 12 months before incapacity.

If you're self-employed, income is taken to be your net trading profit from your occupation, averaged over the three years before incapacity, as assessed for income tax and as shown on an agreed notice of assessment provided by HM Revenue & Customs.

What's the maximum allowable benefit?

The maximum allowable benefit is 55% (or 75% if you have executive income protection) of your income less any applicable deductions, or the benefit amount, if lower.

The applicable deductions are:

- Any continuing income
- Benefits paid from other income protection policies
- Pensions paid in the event of ill health
- Waiver of premium benefits from other policies and other creditor insurance where the benefits can be paid for more than two years
- Employment and Support Allowance (or a similar benefit if amended or replaced) if you have an executive income protection policy

The benefit payable can't be more than the insured monthly benefit amount.

Example

John is employed, earning £20,000 a year, according to his latest P60. He has an insured benefit amount of £900 a month. We calculated the maximum benefit he's entitled to as follows:

Earnings on P60	£20,000 (A)
Maximum allowable benefit (55% of A)	£11,000 (B)
Monthly equivalent (B ÷ 12)	£916.66
Insured monthly benefit amount	£900.00 (C)

The benefit calculation information above is for personal income protection. You can find information about benefit payments for key person or executive income protection in the **Key features of the Business Protection policy** booklet that you got when you took out your policy. If you don't have this, your financial adviser can give you a copy.

This case study is fictional. It doesn't represent a real customer.

What's proportionate benefit?

If you're ill or incapacitated, although you might not be able to return to your previous occupation, you might be able to take up alternative work with a lower income. In these circumstances we'll consider a proportionate benefit. We generally calculate this as shown below to make sure there isn't a financial loss.

Example

Continuing the previous example, John's returned to work but on a lower income.

John's income before he became ill		£20,000 (A)
New lower income	-	£12,000 (D)
Shortfall on what John used to earn (A – D)	=	£8,000 (E)
We show the shortfall as a proportion of John's income before he became ill (E ÷ A)	=	0.4 (F)
Yearly insured benefit amount (£900 x 12)		£10,800 (G)
We use the shortfall proportion against the amount John protected, to work out what we'll pay him (G x F)		
John's reduced benefit amount	=	£4,320

What's rehabilitation benefit?

If you're only able to return to your previous occupation in a reduced role and with a lower income, we'll pay a reduced benefit, calculated in the same way as shown for proportionate benefit. We're committed to helping you return to work and are keen to discuss ways to help you start working again sooner. These could include contributing towards the cost of private healthcare (including surgery if the waiting lists are long) and helping with any training or retraining which might allow you to begin alternative work.

Total permanent disability claims

What do you mean by 'permanently disabled'?

We'll assess your claim against the definition of disability that applies to your policy. This means that we might not always just look at your ability to perform your own occupation ever again. For example some policies have an 'unable to do any occupation at all ever again' definition, which means that we're looking at your ability to perform not just your current role, but also your ability to work in any other occupation that you could reasonably perform.

For all of the definitions of incapacity available for total permanent disability benefit, we're also looking at whether your condition is expected to last throughout life with no prospect of improvement, no matter when your cover ends or when you expect to retire. For example, if you have the 'unable to do any occupation at all ever again' definition of incapacity, we'd consider you to have a valid claim if there was no reasonable possibility of your condition improving enough to let you return to any reasonable occupation of any kind at all, despite the best medical and rehabilitation intervention.

With adaptations to the workplace I could return to work. What action could I take?

Since the introduction of the Disability Discrimination Act, all employers must do what they can to address employees' needs. Practically, this means that if medical opinion demonstrates you could return to work, you can insist that reasonable changes to your workplace or role are made. In some circumstances, if adaptations would allow you to return to work, we might not accept a total permanent disability claim.

More than just financial support

If you have any questions about your claim that we haven't covered here, please get in touch with your intermediary or a member of our claims team on 03456 00 04 93.

Supporting you and your family

When it comes to protection, we offer more than just financial support. As an Aegon protection customer, you can access our health and wellbeing service, provided by our partners Health Assured, 24 hours a day, 365 days a year. This gives you, and those closest to you, access to confidential support and guidance on a wide range of issues whenever you need it.

To speak to Health Assured's qualified and experienced counsellors over the phone, in confidence call 08000 28 90 95. Or access the online hub at healthassuredeap.co.uk using the login details.

Scheme administrator: Aegon

User ID: aegon

Password: support4u

Useful contacts

Here are some useful phone numbers to contact for confidential advice, counselling or simply general information. Your GP can also provide you with information and numbers for other support groups.

All details are correct at the time of publication (December 2018).

Anxiety UK Infoline
03444 775 774

BackCare
0208 977 5474

Breast Cancer Care
0808 800 6000

The British Heart Foundation Heart Helpline
0300 330 3311

Diabetes UK Helpline
0345 123 2399
0141 212 8710 (if calling from Scotland)

Different Strokes Information Line
0345 130 7172

Epilepsy Society Helpline
01494 601 400

MacMillan Cancer Support
0808 808 00 00

Mind Infoline
0300 123 3393

Multiple Sclerosis Society
0808 800 8000

Prostate Cancer UK
0800 074 8383

Stroke Association Helpline
0303 3033 100

For more information on claims and how they're processed, go to aegon.co.uk/support and search for 'claim' or call 03456 00 04 93 (Monday to Friday, 9am to 5pm).