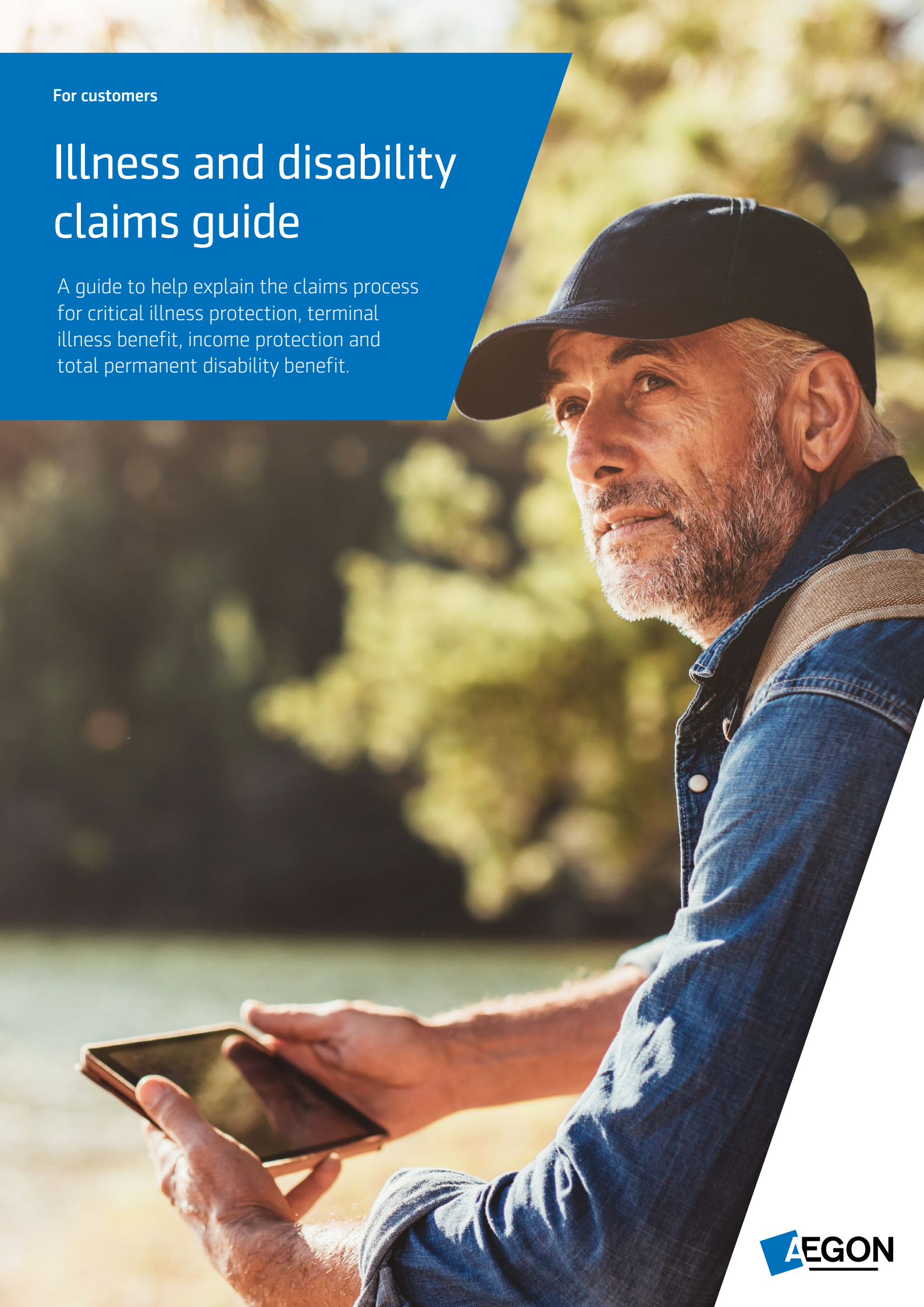
For customers

Illness and disability claims guide

A guide to help explain the claims process for critical illness protection, terminal illness benefit, income protection and total permanent disability benefit.



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Contents

If your personal circumstances mean you need any additional support, or if you'd like a large print, Braille or audio CD version of this document, please call 03456 00 14 02 (call charges will vary) or visit aegon.co.uk/onlineform

What you need to know about claims

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, and
- look for ways to help you get back into work – supporting you as much as we can.

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 of your claim, over the phone or by sending out a claim form;
- get the best quality information from your GP and any specialists involved in your care to help us assess your claim;
- get independent expert medical advice when we need to, and
- make recommendations that might help you get back to work.

The claims process

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

Alternatively, we can 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've any copies of medical reports from your GP or specialist, please send them to us. They might help us to assess your claim without having to contact your GP or specialist, making it quicker for us to give you a decision on your claim.

The assessor looking after your claim may need to write to your GP or specialist, to ask them some specific questions about your illness or incapacity. We may also need to verify your past medical history with your GP. We'll pay any costs if we need to do this.

If we need any more information we'll refer to our network of specialists, who can provide:

- independent medical examinations;
- functional assessments;
- home visits;
- career counselling;
- workplace assessments, and
- other specialist assistance.

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

Call us on 03456 00 04 93 (call charges will vary)

Write to:
Aegon Protection
Sunderland
SR43 4DJ

A quick guide to your claim

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

You or your representative gets in touch with us to make a claim.

By phone – we'll gather the details about your claim over the phone.

We'll send you details of any other information we need.

We'll write to your GP and/or specialist.

Paper form – we'll send you a claim form to complete and a letter to give your GP and/or specialist.

Return your completed claim form to us with any copies of medical reports that you may have.

Once we've received a reply from your GP and/or specialist, we'll see if we have enough information to make a decision. If not, we'll ask for more information and we may need to arrange a medical examination or a visit from a nurse.

We'll call you to provide an update to your claim and let you know what will happen next.

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

We'll call you to explain the outcome of our assessment and our claims decision. If we agree your claim, we'll arrange payment. We'll also follow up this call with a letter.

Critical illness protection

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

Decision

Once we've reached a decision and if we accept your claim, 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.

Terminal illness benefit

This benefit is a feature of life protection policies. It's the early payment of the life protection benefit when you've been diagnosed with a condition that's incurable and you've 12 or less months to live.

The early payment of this benefit means you can sort out your financial affairs before you die, rather than leaving the task to family members after you've gone.

Decision

Once we've received your completed claim form, and all of the information you can provide us about your diagnosis from your GP and specialist, we'll be able to assess your claim. We'll only be able to pay the claim if our Chief Medical Officer agrees with the diagnosis provided by your specialist.

Total permanent disability benefit

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'll look 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 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.

If a medical opinion identifies that you could return to work, the introduction of the Disability Discrimination Act, means that employers must do what they can to support employees' needs to help them return to work. This may mean changes to your workplace or role. In some circumstances, if adaptations would allow you to return to work, we might not accept a total permanent disability claim.

Decision

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.

Once we've reached a decision and if we accept your claim, 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

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

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.

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

If you are expecting to make an income protection claim, you should let us know no later than shown in the table below. If you don't tell us within these time frames, it might affect our claims decision and could lead to a delay in us paying the benefit amount.

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

Decision

Once we've reached a decision and if we accept your claim, 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.

Benefit payments

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

Income protection questions

How long will you pay a claim for?

If you have our full term income protection, we'll pay your monthly benefit for as long as you remain unfit to work (according to the definition of incapacity that applies to your policy) or until your benefit ends.

If you have our 2-year income protection, we'll pay the monthly benefit amount for a maximum of two years, starting from the end of your chosen deferred period. We'll continue paying this until you're fit enough to return to work, or for a maximum period of 24 months. Once you've been back at work for a continuous six-month period, we can consider another claim for the same condition or illness, if required.

Will you review my claim?

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 a continuous period, as shown in your policy conditions, you won't need to wait for the end of the deferred period before we pay any benefits. This is known as a linked claim. If you have our 2-year income protection cover, further payments can not be made if you have already received 24 monthly payments in connection with the illness.

You need to remember to restart paying your monthly premiums after each claim ends to make sure your cover continues.

What income will my claim replace?

Your policy is designed to replace income that's lost when you can't work due to sickness or incapacity.

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 will depend on when you took your protection policy out. Please see your policy schedule and conditions for the maximum allowable benefit that applies to your policy.

We will deduct:

- Any continuing income
- Benefits paid from other income protection policies
- Pensions paid in the event of ill health

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

What's a 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 opposite to make sure there isn't a financial loss.

What's a 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 a 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.

Example proportionate income protection calculation

John's employed and 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 (65% of earnings up to and including £20,000)	=	£13,000 (B)
Monthly equivalent (B ÷ 12)	=	£1,083.33
Insured monthly benefit amount		£900.00 (C)

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 John's reduced benefit amount (G X F)		= £4,320 a year (£360 a month)

Does my income protection include fracture cover?

If you took out personal income protection on or after 24 January 2022, your policy will include fracture cover. These policies will show the code IP19 or above on the front cover of your policy conditions booklet.

For these policies, this allows you to claim a lump sum payment if you fracture certain bones. You'll find details of the bones covered, benefit amount available and any circumstances when fracture cover isn't available in your policy conditions booklet.

You should phone us if you need to make a claim for fracture cover. Your claims assessor will ask for details about your fracture and how it occurred, and will be able to confirm if you have a valid claim. They may ask you for copies of any hospital reports detailing your fracture, or may contact the hospital directly.

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.

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 you a claim form. 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'll make a decision on your claim.

Will I need to attend an independent examination?

We'll try to assess your claim on the information your GP and/or specialist(s) give us. Sometimes this information isn't enough and 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. If we do need you to have an examination, we'll contact you to arrange this and 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 by you.

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.

How do I tell you about a claim?

Call us on 03456 00 04 93 (call charges will vary)

Write to:
Aegon Protection
Sunderland
SR43 4DJ

More than just financial support

At Aegon, you get more than just financial support with our protection policies. You and your immediate family also have access to Policy Plus – our range of support services.

With Policy Plus you can get tailored support and guidance with access to counselling, legal advice and a second medical opinion service. Find out more about Policy Plus at aegon.co.uk/insurance

Useful contacts

Here's some useful phone numbers to call for confidential advice, counselling or 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 (March 2022). Call charges may vary.

Anxiety UK Helpline
03444 775 774

BackCare
0208 977 5474

Breast Cancer Now
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 we process them, visit aegon.co.uk/claims

For any other questions about your claim, please get in touch with your financial adviser or call us on 03456 00 04 93, Monday to Friday, 8.30am to 5.30 pm (call charges will vary).

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