

The **co-operative** insurance
good with money

Income Protection Cover

Guide to making a claim

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What you'll find in this guide	Page
Understanding your Income Protection Cover	3
<ul style="list-style-type: none">• What do I do if I need to make a claim?• How is my claim managed?• What if I have an Expenditure Protection Plan (EPP) and a Mortgage Payments Protection Insurance (MPPi) Plan?• What claim forms need to be completed?	
Medical information	4
<ul style="list-style-type: none">• What medical information is required?• Who pays for the medical information?• What happens when the medical information is received?	
Medical examination and functional capacity assessment	4
<ul style="list-style-type: none">• How is the medical examination or functional capacity assessment arranged?• Who pays for the medical examination or functional capacity assessment?• Access to a medical report prepared by our appointed specialist	
How do we assess your claim?	4
<ul style="list-style-type: none">• How do we make a decision about your claim?• What happens if your claim is declined or ceases?• What happens if I return to work after a short period?	
What earnings is your claim based on?	5
How do we make benefit payments to you?	5
<ul style="list-style-type: none">• How is the first benefit payment made?• How are subsequent payments made?• What do I need to do if there are changes to my circumstances?	
How is my claim reviewed?	6
<ul style="list-style-type: none">• Who pays for the claim review information?• How can we help you in your rehabilitation process?• What other help do we provide?• What happens if I have a relapse?	
In what circumstances would we stop paying benefits?	7
<ul style="list-style-type: none">• What if I disagree with Claims Services International's decision on a claim?	

Understanding your Income Protection Cover

This booklet explains how to make a claim, how your claim will be processed and what medical evidence may be collected during the process. This is necessary so that we can assess your claim accurately. It also describes the role and service provided by our Vocational Rehabilitation Consultants.

If you do need any further information or assistance, please do not hesitate to contact us on **0845 601 8241**. You may call us at any time to check on the current position of your claim.

What do I do if I need to make a claim?

In the event that you need to make a claim, the first step is to contact Claims Services International who will handle your claim on our behalf. They will send you a claim form. You can telephone them on **0845 601 8241**.

Please note that we monitor telephone conversations from time to time for the purposes of training and in the interests of continually improving and developing the quality of service we provide.

It is very important that we receive your completed claim form well before the end of the deferred period (the continuous period from the date of incapacity until benefit becomes payable).

Tell us as soon as possible but:

- for 4 week deferred periods, within 2 weeks from when you are first incapacitated
- for 8 and 13 week deferred periods, within 4 weeks from when you are first incapacitated
- for deferred periods of more than 13 weeks, within 10 weeks from when you are first incapacitated.

We may refuse to pay your claim if you don't tell us within 90 days following the end of the deferred period.

This will help to ensure that we make an immediate review of your situation and start the assessment process.

Where you have a longer deferred period (e.g. 52 weeks) and you are unlikely to recover before the end of that period, you may notify us earlier.

If you delay submitting your claim form, you might miss the expiry date of the deferred period. This could affect your claim. The later the claim is submitted, the more difficult it is for us to collate medical evidence.

Please note that under the terms of the policy, we are entitled to refuse applications for benefit where claim forms are received more than 90 days after the expiry of the deferred period.

How is my claim managed?

To help you through the claims procedure, we will assign a Claims Management Specialist to look after your claim. They will send you a claim form for completion together with a form for your General Practitioner to complete. They will also contact you to discuss any issues or to request any information they may need.

What if I have an Expenditure Protection Plan (EPP) and a Mortgage Payments Protection Insurance (MPPI) Plan?

If you are one of our customers that has an MPPI plan and an EPP plan with a 60-week deferred period, it is likely that if you have found the need to submit a claim, you will have already started the claims process under your MPPI plan. In order to avoid unnecessary duplication when you make a claim under your EPP plan, we will review the claims information already submitted for your MPPI plan. We will contact you before benefit payments cease on your MPPI plan (if you have not already contacted us) in order that we can begin the claims assessment on your EPP plan.

What claim forms need to be completed?

The Claims Pack consists of the following forms:

Application form

This form asks for your personal details, together with details of your incapacity. Also included is the Claim Processing Consent form, giving us your permission to obtain medical evidence, including copies of medical records.

Occupational questionnaire

This requests details of the occupation you were following immediately prior to incapacity. If you are employed, you will need to send this form to your employer, who will then return it to us. If you are self-employed you will need to return the completed form direct to us.

Medical summary

This is a form that you need to ask your General Practitioner to complete. We will also provide a pre-paid return envelope.

Once we have received your completed claim forms we will write to you acknowledging receipt and requesting any outstanding information.

If you have indicated that you wish to read the medical reports before they are sent to our Chief Medical Officer, you will be notified in writing of each request as it is sent.

Medical information

What medical information is required?

If you are receiving specialist care from a Consultant, we may ask them to provide us with detailed medical information from your case notes.

If the Consultant has not seen you recently, or the medical evidence is not conclusive, an examination may be required, either by your own Consultant, or an Independent Medical Examiner who will be appointed by us.

We have a dedicated team who will begin to process your claim as soon as it is received. However, as you will appreciate, collecting all the medical evidence can take time and we have to rely on people in the medical profession to reply promptly. Unfortunately, we do sometimes encounter delays in obtaining all the information we need.

Who pays for the medical information?

We pay the fees for all the medical information that is supplied at our request, whether this is at the initial assessment of your claim or at a later review. We will also reimburse any reasonable costs incurred by you if we ask you to attend an examination by a specialist.

What happens when the medical information is received?

At this stage there will usually be sufficient medical evidence for us to make a decision on the claim. However, this is not always the case and in some cases further clarification may have to be requested from your General Practitioner or the Consultant.

Medical examination and functional capacity assessment

We may require further medical information, in which case we will ask you to undergo a medical examination and/or a functional capacity assessment. We will choose an appropriate specialist, who has not treated you before, to undertake the examination and/or assessment. This is simply another element in the process of obtaining sufficient detailed medical information to assess your illness/injury.

How is the medical examination or functional capacity assessment arranged?

Certain matters must be taken into account when arranging a medical examination or functional capacity assessment:

1. **The specialist** – the appropriate specialist has to be found.
2. **The location** – we want to arrange the examination as near as possible to where you live, but outside your own health authority, so that an impartial view may be obtained.
3. **The waiting list** – when possible the waiting list should not exceed 3 weeks, but this is becoming increasingly difficult with some specialists. However, this should rarely delay the claim where claim forms have been submitted on time.

Who pays for the medical examination or functional capacity assessment?

We pay the fee for this report and for any reasonable costs you may incur in attending the examination. Where you are residing outside the UK, we will not be liable for any costs over and above the cost of a UK examination.

Access to a medical report prepared by our appointed specialist

Please note a medical examination or functional capacity assessment, prepared by a specialist who has not previously treated you, is not covered by the Access to Medical Reports Act 1988. The information received is confidential to the examiner and to us. However, you may ask to see the report, in which case, we will make a copy available to your General Practitioner.

How do we assess your claim?

How do we make a decision about your claim?

When assessing your claim we will consider your occupation (the occupation you were following immediately before your illness or injury occurred). The claim will also be referred to one of our Medical Officers, or nurses, within our Medical Services Unit.

We will use all the available medical evidence to determine the extent to which you are unable to perform the material and substantial duties of your occupation – in other words, the extent of your illness/injury. (It is important to note that diagnosis of a condition does not necessarily mean that you cannot perform the material and substantial duties of your occupation.)

We will also consider very carefully the information provided in the Occupational Questionnaire to help establish which duties are material and substantial to your occupation. We will then consider whether various duties could reasonably be modified or omitted in order to allow you to continue working. Please note that employers are now obliged under the Disability Discrimination Act 1995 to provide reasonable adjustments in the workplace to enable disabled employees to continue working.

At this stage a decision is made either to approve or decline the claim. If your claim is approved, a letter will be sent confirming our acceptance and giving details of the benefit payable.

What happens if your claim is declined or ceases?

If your claim is declined or ceases, we will advise you of the decision and the reasons behind it. Our letter confirming the decision will also include details of the complaint procedure.

What happens if I return to work after a short period?

Recovery and a return to work may be expected within a short period. In this case we will accept liability for this limited period only, after which benefit payments will cease. Should you recover earlier than this, you should tell us immediately so payments can be adjusted accordingly. However, should you not recover within the stated period, we need you to tell us so that we can make further enquiries.

What earnings is your claim based on?

Your plan is designed to help replace lost earnings, so it is important that you do not receive a higher income whilst claiming than when working. For this reason your plan has a Limitation of Benefit clause, which allows you a maximum benefit of 50% of your earnings before deduction of tax in the 12 months prior to incapacity. This figure would then have the following deducted:

1. Any other sickness or accident policies where benefit is payable for more than two years.
2. Any continuing income from any trade or profession e.g., sick pay.
3. Any Early Retirement Pension you will receive in the event of incapacity.

Early Retirement Pension would not be deducted from the total if we consider you to be totally and permanently unable to follow any occupation.

You will already have provided proof of your earnings in the year prior to becoming incapacitated. Your claim form will tell us of any other sickness and accident policies you hold, or any other income you will continue to receive.

For example:

Earnings	£25,000
x 50%	£12,500
less continued profits on business	£4,000
<hr/>	
Maximum benefit	£8,500

Our calculations will be based on your taxable earnings. If you are employed, we will look at the gross earnings on your most recent P60 or payslips.

If you are self-employed we will look at your most recent self-assessment tax calculation (SA302) and most recent Trading Profit and Loss Accounts where necessary.

If the sum you have insured is **higher** than the maximum benefit calculated, the claim payment will be reduced to the maximum benefit figure.

If the sum you have insured is **lower** than the maximum benefit calculated, the benefit is restricted to the sum you have insured.

It is therefore recommended that you review your policy with your Co-operative Financial Adviser regularly. This will ensure that your benefit level is appropriate in relation to any increases or decreases in your earnings.

How do we make benefit payments to you?

How is the first benefit payment made?

Benefit is always paid one month in arrears. The first benefit payment may be made by cheque. This will cover the period from the date the benefit was due to commence to the end of the previous month.

Please note, if we are not notified of the claim until after benefit was due to start, we are not liable to pay benefit for the period between the start date and the notification.

How are subsequent payments made?

All other payments will be credited directly to your bank account three working days before the end of each month.

Benefit will continue to be paid under the terms of the policy as long as the medical evidence and any other relevant evidence continues, in our opinion, to support the claim.

What do I need to do if there are changes to my circumstances?

Recovery

To ensure accurate benefits are paid, it is very important you tell us immediately if you return to work, either full or part time. If you undertake any work at all, paid or otherwise, you must tell us. Any change in circumstances needs to be notified to us within 14 days.

Address or bank account changes

In order for payment of benefit to be credited to the correct account, it is vital that you tell us, in advance, of any change to your bank account. Similarly, if you change address, it is important you give us your new address immediately in order that any correspondence reaches you promptly.

How is my claim reviewed?

All claims are reviewed periodically and are based on medical evidence. If your condition is expected to improve within a certain timeframe, then the review will be carried out during this time.

A claim review is normally started by obtaining a combined form that incorporates the following:

1. Up-to-date medical information
2. Claim processing consent.

We may also obtain updated information from your Consultant about your current incapacity. In some cases your Consultant may wish to examine you. A medical examination or functional capacity assessment by our chosen specialist may also be required.

Who pays for the claim review information?

As with the original claims assessment, we pay the General Practitioner's and the Consultant's fees for any information we ask for. However, we do not pay for any incidental expenses you may incur in connection with the claim review, unless this is travelling expenses for a medical examination or functional capacity assessment we have arranged.

How can we help you in your rehabilitation process?

Our Vocational Rehabilitation Consultants may be able to help you in your efforts to get back to work, either in your own occupation or in a suitable alternative. Although you may not be able to resume your original occupation on a full-time basis, you may recover sufficiently to be able to work part time. Alternatively you may be able to take a different job on lower earnings. In these circumstances a proportionate benefit will be payable, so you do not suffer financially as you make this step towards rehabilitation. The proportionate benefit is calculated in such a way that the combination of your new earnings and the benefit from us would be greater than your benefit alone.

It is very important when benefit is being paid on this basis that you tell us about any increase in your earnings, so benefit can be adjusted before incorrect payments occur.

Rehabilitation is only considered where appropriate; not all individuals will be considered for rehabilitation. For example, if an individual were due to retire shortly, rehabilitation would not be considered. The decision to rehabilitate an individual is looked at on a case by case basis. Many factors are taken into account, including the motivation of the individual to return to work and the attitude of their employer with regard to offering them alternative roles within the organisation.

What other help do we provide?

In some circumstances, we may refer you to our 'Open Door' Vocational Assessment Guidance Centre staffed by our team of experienced and registered professionals. Their role is to provide a comprehensive service of objective functional capacity and psychological assessments and vocational exploration. Following an assessment, Open Door can make a recommendation for treatment or retraining that may enable you to return to work, either in your own occupation or an alternative.

All the Open Door assessments are carried out by a team of qualified, registered and experienced occupational therapists and occupational psychologists. Open Door offers functional capacity assessments at Dorking or Leeds and, where appropriate, psychological assessments in a person's own home. Should you at any point be referred to Open Door, as with any other medical examination we request, reasonable travelling expenses would be reimbursed.

What happens if I have a relapse?

You may return to work, either in your own or a different occupation. However, your original condition may subsequently worsen to such an extent that you are no longer able to continue working. In these circumstances, if you have been back at work for less than 12 months, we will consider linking the claim. This means another deferred period will not have to be served and payment of benefit will resume from the date you stopped working. Benefit would be at the same level as when it stopped, providing there is objective medical evidence to support this relapse.

We must stress this applies only if the reason for the second absence is directly related to the original incapacity.

In what circumstances would we stop paying benefits?

If, in our opinion, the evidence at review supports the claim, then benefit will continue. However, if there is no longer any objective evidence to confirm that you are incapacitated under the terms of the plan, we will be unable to authorise the continued payment of benefit in the future. We will tell you if this happens.

If we decide to stop benefit we will tell you in writing and in good time to allow you to appeal if necessary. As with the initial claims assessment, our letter will give the reasons behind our decision and will also explain the appeals procedure.

What if I disagree with Claims Services International's decision on a claim?

How do I complain about the claim decision?

If we decide to decline your claim, we will provide you with:

- a letter giving you a clear explanation of the reason the claim has been declined
- an enclosure that presents the next options open to you should you disagree with our decision, namely:

Option 1:

If you have further or new evidence, which you feel would influence the claim decision, you can send this to the Claims Department, Claims Services International, Milton Court, Dorking, Surrey, RH4 3LZ, who will consider it as part of the claim liability decision.

Option 2:

If you do not have any further or new evidence but would like the claim decision to be completely reviewed by an independent team, you should contact the Customer Feedback Department at the address above, outlining the reason(s) why you believe the wrong decision has been made.

Within our Customer Feedback Department, an Adjudicator will carry out a thorough and objective review of all the information on file, in line with Claims Services International's complaint process, to ensure that a fair and reasonable decision was made. The outcome of the complaint is called the Final Decision, that might:

- overturn the decision of the Claims Department
- stand by it; or
- make a recommendation for further investigations to be carried out by the Claims Department.

The Customer Feedback Department adheres to the Financial Services Authority guidelines and best practice when dealing with your complaint. We will send you:

- an acknowledgement letter confirming our understanding of your complaint and letting you know who your dedicated point of contact is, within 5 working days
- updates to let you know how we are progressing with the review; and
- if we have not completed the review within 8 weeks, we will tell you why, when you can expect to hear from us again and also tell you how to access the Financial Ombudsman Service.

Once a Final Decision has been made, the Adjudicator will send you a final decision letter confirming the outcome of the complaint review. The final decision letter also includes details of how to contact the Financial Ombudsman Service if you remain unhappy with our decision.

The Financial Ombudsman Service (FOS)

The Financial Ombudsman Service was set up by law to help settle disputes between consumers and financial firms on an independent basis.

Financial Ombudsman Service

South Quay Plaza

183 March Wall

London

E14 9SR

Telephone: 0845 080 1800

You should be aware that there is a six month time limit in which to submit a complaint to the Financial Ombudsman Service – our final decision letter contains a reminder to this effect.

If the complainant accepts the Financial Ombudsman Service decision, it is binding on both Claims Services International and the complainant. The decision from the Financial Ombudsman Service will conclude the complaint process, with the exception of litigation.

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Co-operative Financial Services Limited, Registered Office: New Century House, Manchester M60 4ES. Registered Number IP29379R.

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