Registered Group Life Assurance Policy Conditions

optimal protection

Group Life Assurance Policy

Thank you for choosing Optimal.

By selecting Optimal you have chosen to insure your Group Life benefits with one of the newest and fastest growing Group Risk providers in the UK.

This product is only available from one of our carefully selected advisers with whom we have agreed Terms of Business.

Although Optimal is a new business having been established in late 2013 our heritage is not. We are a wholly owned subsidiary and appointed representative of The Original Holloway Friendly Society Limited which was founded in 1880 and was the first to offer disability insurance in the UK.

Policy Statement

This policy is issued by Optimal to the policyholder named in the schedule.

The policy provides insurance to cover benefits payable on the death of a member under a scheme that is set up under a discretionary trust.

The policy document includes:

- The policy conditions which set out the standard terms of the contract
- The policy schedule which sets out the specific details of the cover we have agreed with you together with any amendments or replacements we issue

The policy document tells you:

- What premiums are payable by you and when
- Who you must include, when and for what benefits
- How and when the basis of the policy can change
- How you can make a claim

This policy:

- Is governed by English law
- Will not have or acquire any surrender value
- Does not include Third Party Rights
- Is not assignable (apart from where the policy holder is a trustee and the assignment is to appoint a new trustee, subject to agreement by us)
- Is issued on the basis of the information provided in the quotation request, the On Risk form, the application form completed by the trustees, in addition to any questionnaire completed by a member or the membership list and data provided to produce annual renewal accounts
- Provides evidence of a legal contract between you and us and is effective from the commencement date of cover with us.

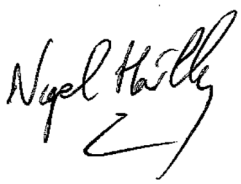
We will:

Pay the trustees the benefits set out in this policy, providing you have paid all the premiums we have asked for and provided that all other requirements of the policy have been met, when they become payable under the terms of this policy.

If you do not comply with all of the policy conditions, we will not pay claims. We may also discontinue cover under the policy and will not be bound to accept any further premiums.

Please read this policy carefully and keep it in a safe place for future reference.

Signed for and on behalf of HF Life Limited, trading as Optimal:



Nigel Hartley, Managing Director, HF Life Limited.

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Terms and expressions we use

Some words or terms we use have specific meanings. These are listed below together with their meanings.

Actively at work (AAW) means that a person:

- is present at their place of work or is absent for reasons other than sick leave that have been authorised by their employer; and
- has not received medical advice to refrain from work; and
- is mentally and physically capable of performing fully the normal duties associated with their job; and
- is working their normal contracted hours at their normal place of employment or at such alternative location as may have been agreed in writing with the employer.

Anniversary date means the date on which the policy is intended to renew.

Benefit is the amount a member is covered for under the policy. It is the amount payable in the event of death of the **member**.

Brand New refers to a **scheme** that was not previously insured with another insurer immediately prior to the commencement date with us.

Catastrophic Event means the occurrence, event or incident or a series of related ongoing causes, events or occurrences that directly or indirectly results in an accumulation of deaths of insured **members**.

Commencement date means the date on which **cover** starts as stated in your policy schedule.

Cover means the insurance protection provided by the policy.

Cover Cease Age (CCA) means the age at which **cover** for a member ceases.

Discretionary Member means a **member** who:

- is not eligible but who you wish to include
- is an eligible member but who you want to be covered from a different date to their normal joining date
- is a member not joining the scheme at their first opportunity. If such members join the scheme within 6 months of the first opportunity date, we will waive underwriting.

Eligibility Criteria means the conditions for membership set by you and which must be met by the employee before they are included in the **scheme.**

Eligible Member or Normal Entrant means a **member** that satisfies the **Eligibility Criteria.** Where an individual joins the **scheme** within six months of satisfying the **Eligibility Criteria** they will be deemed an **Eligible Member.** Individuals joining after this six months timeframe will be classed as **Discretionary Members**.

Event Limit means the maximum **scheme** liability on the happening of a **Catastrophic Event**.

Evidence of Insurability means any evidence whether medical or otherwise that **we** may require to include someone as a **member**.

Free Cover Limit means the level of **benefit** that can be automatically provided without the need for **underwriting**. This will be stated on **your** quotation and policy schedule.

HMRC means Her Majesty's Revenue and Customs.

Listed Countries means any of the following: United Kingdom, Channel Islands, Isle of Man, All other EU countries, Andorra, Australia, Canada, Gibraltar, Hong Kong, Iceland, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, USA and the Vatican City.

Long Term Absentee means a **member**, who has been absent from work as a result of sickness, ill-health or disablement (including current or pending Group Income Protection claimants) , for a consecutive period of three months or more at the time of quoting, at the **commencement date** or the **anniversary date**.

Medical Underwriting means the process of collating and assessing **evidence of insurability**. This might be a simple **Member's Declaration** or may extend to medical evidence.

Member is defined as any employee that satisfies the **Eligibility Criteria** and is included in the policy.

Member's Declaration means the form completed and signed by an individual **member** when medical underwriting is required.

Non-Medical reasons means statutory absences such as maternity, adoptive, paternity, unpaid parental leave or any other reason such as sabbaticals, unpaid or compassionate leave.

Participating Employer means any company, partnership or organisation the employees of whom are to be included in the **scheme**.

Policy Fee means an annual charge per policy towards our costs

Policy Period means the period of time between the c**ommencement date** and the **anniversary date**

Premium Rate means the underlying group rate that **we** calculate, which will be specified in the Policy Schedule, on which **premiums** are calculated.

PSTR is the Pension Scheme Tax Reference. This is the unique reference allocated by HMRC when a pension scheme has been successfully registered for tax relief and exemptions.

Relevant UK Individual means the legal interpretation of these words as more fully defined by **HMRC.**

Scheme is defined as the group life arrangement that has been established by the employer or associated company to provide group life insurance **benefits** for members that satisfy the **eligibility criteria.**

Selected Adviser means one of the limited number of Independent Financial Advisers (IFAs) with whom **we** have agreed Terms of Business. It is **our** business practice to only agree Terms of Business with a limited number of carefully selected IFAs.

State Pension Age means the age at which an individual **member** may receive their state pension.

Temporary Absence means a **member's** absence from work during which the **member** retains **Eligible Member** status. For full details, please refer to section 2.21 of this document.

Underwriting decision means the outcome of **our** assessment of the evidence obtained during **underwriting**.

Us/We/Our means Optimal, a trading name of HF Life Limited (FRN 613348), an Appointed Representative and subsidiary of The Original Holloway Friendly Society Limited. Registered in England (No. 8649971) Registered Office Holloway House 71 Eastgate Street Gloucester GL1 1PW. The Original Holloway Friendly Society Limited is Registered and Incorporated under the Friendly Societies Act 1992. Registered in the UK No. 145F. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. FRN 109986.

You/Your means the Trustees of the **scheme** named in the policy schedule to whom the policy has been issued on behalf of the employer.

Your commitment

You need to make some very specific commitments in order for the policy to work correctly.

You must:

- Establish a scheme by setting up a discretionary trust, register the scheme with HMRC and provide us with the PSTR number for the scheme
- Set up a trustees' bank account in the name of the trustees of the scheme for us to pay benefits into in the event of a claim. This must be separate from the employer's trading accounts
- Pay all the premiums we ask for when they are due
- Give us the complete and accurate information and data when you apply for a policy and at each anniversary date within the timescales we have specified. We can change or cancel the policy if you do not give us this information
- Tell us if the eligibility of our group life scheme is linked to pension scheme membership. You will also need to let us know the eligibility for the pension scheme participation and the take up rate of eligible members to the pension scheme
- Tell us immediately whenever the information you have provided to us changes
- Tell us as soon as possible about any early entrants, late entrants, discretionary members or members who require discretionary benefits
- Tell us in advance of changes to participating employers including their activities, location and the relationship between them
- Tell us immediately if there is a change of the employer's location or nature of business
- Tell us immediately if any members change their work location
- Tell us immediately if you wish to change the benefit basis or eligibility criteria
- Tell us if a member's benefit exceeds the free cover limit
- Tell us about any claims as soon as possible and submit any claims as outlined in section 8
- Keep to all the conditions set out in the policy
- Tell us immediately if you wish to cancel the policy
- Tell us immediately if the scheme, or any part of it, ceases to be treated as a registered occupational pension scheme

Risk factors

- If you do not meet your commitments, we may not pay your claims and we may cancel the policy
- We may cancel the policy if the registered status of the policy has not been obtained or is withdrawn.
- We will discontinue cover if we do not receive premiums within 30 days of the premium being due.
- You should seek legal and tax advice to make sure you understand any potential taxation issues for you and your employees and any conflicts with your employees' contracts of employment.
- We do not provide policies where the eligibility is voluntary or discretionary. Therefore, we reserve the right to cancel a compulsory scheme if the take up rate of eligible employees reduces to below 90%
- If we do not receive a completed claim form within 2 years of the date of a member's death, we will not pay the claim.
- We may revise the premium rates at the policy anniversary date or at any other time if a change occurs that affects the premium rate.

Section 1 – What is covered?

Lump sum

This benefit is payable as a lump sum when a member dies. The amount of benefit payable in respect of a member is stated in the policy schedule.

Discretionary benefits

If you specifically request, we may agree to include a member for discretionary benefits. We will need to medically underwrite the member before we can accept cover for any benefit. We will let you know what evidence we need and the date that any cover for that member commences. These benefits will not be stated in the policy schedule.

Section 2 – Who is covered?

2.1 Normal entrants

You will have decided and agreed the eligibility criteria with us before the cover commenced. Members who meet the agreed eligibility criteria will be considered normal entrants.

We will include a normal entrant as a member:

- on the commencement date, if they joined the scheme on or before that date (within 6 months of meeting the eligibility criteria), or
- from their normal entry date or within 6 months of this date, if they join the scheme after the commencement date, or
- where eligibility of this scheme is linked to pension scheme membership, employees who join the pension scheme as a direct result of an auto enrolment exercise, or
- where eligibility of this scheme is linked to pension scheme membership, employees who join the pension scheme after their first opportunity but as a direct result of auto enrolment at the first staging date

2.2 Early entrants

An early entrant is a member who wishes to join the scheme before they complete the qualifying service period or before they reach the first entry date.

If a member requires cover before they become eligible and they join the scheme within 3 months of their employment start date, we will automatically cover them for benefits up to the free cover limit (subject to actively at work fulfilment if this is a scheme requirement).

2.3 Can cover be provided for discretionary and late entrants?

If you specifically request, we may agree to include a discretionary or late entrant in the policy as a member. We will need to medically underwrite the member before we can accept cover for any benefit. We will let you know what evidence we need and the date that any cover for that member commences.

2.4 Free Cover Limit

The free cover limit will be stated within the policy schedule.

Schemes with 3 or more members at the commencement date or anniversary date are usually given a free cover limit. The free cover limit set will be a minimum of £500,000.

We do not provide policies where the eligibility is voluntary or discretionary. Therefore, if the take up rate of eligible employees reduces to below 90% we reserve the right to reduce or remove the free cover limit.

For members who are included within the scheme as soon as they satisfy the agreed eligibility criteria and on the agreed benefit basis for that category of member (or within 6 months of first becoming eligible), medical underwriting will not be required for benefit amounts up to the free cover limit, however will be subject to the actively at work requirement being fulfilled if this is a policy condition (see section 2.6).

The free cover limit will not apply to any discretionary benefits and benefits for discretionary entrants / members.

We reserve the right to review the free cover limit if either the number of members or value of benefits at the policy anniversary date varies by more than 25% for schemes with 20 or more members or 15% for schemes with less than 20 members.

2.5 What happens if a member's benefit exceeds the free cover limit?

Benefits that exceed the free cover limit will be subject to medical underwriting and to acceptance by us.

If a member's benefit above the free cover limit has been underwritten and as a result been declined or postponed, the member may not benefit from any future increases in the free cover limit.

2.6 What happens if a member is unable to fulfil the Actively at Work requirement where this is a policy requirement?

The policy schedule will state whether or not our actively at work requirement applies to this policy.

Unless we have waived the actively at work requirement, any person who is not actively at work on the last working day prior to commencement of cover with us will not be covered for any benefit until they either:

- complete seven consecutive working days with the employer (excluding days taken as holiday), or
- provide evidence of insurability to us and we confirm our acceptance of the member's benefit.

Confirmation that any actively at work requirement has been met must be provided by you in writing.

Please see the table below for our actively at work requirements.

Actively at Work requirements		
Number of lives	**Brand new scheme with no previous insurer**	**Existing insured schemes switching to us**
2 - 49	**Applied** – to all members. **Additionally**, if there are less than 5 members in any one benefit category at the commencement date, our stricter AAW is applied to members in such categories. This means we will require confirmation in writing from you that no employees have been absent from work for a total of 10 days or more within the last 12 months, as a result of illness or injury. If any member does not fulfil this actively at work condition, medical underwriting may be required to consider including the member in the Scheme.	**Waived** - for existing / increases to insured benefits and new members **Applied** – to increases in benefits if you make a change to the current insured basis (e.g. the benefit basis, eligibility criteria, cover cease age)
50+	**Waived** – for all members	As above

Additional notes –

For previously insured schemes switching to us, where we have agreed to waive our actively at work requirements, any member who is not actively at work will continue to be covered for the period of time that they would have been covered under the previous insurer's policy.

Once a policy is in force, where actively at work requirements have been waived, new entrants are covered as soon as they have satisfied the eligibility criteria irrespective of whether they are actively at work or not. However, where actively at work requirements have not been waived, new entrants must have satisfied the eligibility criteria and be actively at work before their cover can commence.

Additionally, where actively at work requirements have not been waived, we will not increase existing members' benefits until they are next actively at work.

2.7 Which members will require medical underwriting?

The following members will normally be required to provide evidence of insurability:

- Any member who is not able to satisfy the actively at work requirements and who also requires cover before being able to satisfy the actively at work requirement
- Any member of a brand new scheme, with less than 50 members and with less than 5 members in any one benefit category, who does not satisfy the actively at work requirements (no more than 10 days absent from work in the last 12 months)
- Any member of a scheme which does not qualify for a free cover limit
- Any member with benefits that are in excess of the free cover limit (unless we were able to accept those benefits under our no worse terms facility at the commencement date)
- Increases in benefits above the Free Cover Limit and/or the agreed forward underwriting bar
- Any member who is to be included in the scheme as a discretionary member
- Any member requiring discretionary benefits
- Any member with benefits that have not been accepted by a previous insurer
- Any member who has been subject to underwriting by a previous insurer, where special terms were imposed unless we are able to accept the benefit under our no worse terms facility
- Any member who has been subject to underwriting by a previous insurer, where benefits were declined or postponed
- Any member working beyond cover cease age

We must be informed immediately if cover is required for any member in the above situations so that we can advise what evidence of insurability we will need to consider providing cover.

2.8 Will any cover be provided before a medical underwriting decision has been made?

If a member has benefits in excess of the free cover limit they will require underwriting but we will be able to provide cover for a maximum period of 90 days, or until we have finalised our underwriting decision if sooner. We call this temporary cover.

If a member dies during temporary cover we will not pay the benefit amount above the free cover limit if they die from any medical condition they were diagnosed with, or were displaying symptoms of, within the five years before temporary cover starts.

Temporary cover will be provided subject to the following conditions:

- A maximum benefit level, including all policies issued or subject to underwriting by us, of £3 million
- The member has not been previously declined, postponed or had special terms imposed either by us or any other insurer
- The member is an eligible member able to benefit from the scheme free cover limit
- The member has not previously refused to provide medical evidence required for underwriting
- The member is not a discretionary member

In the event that a member requires temporary cover but is unable to satisfy the conditions above, it may be possible to provide limited temporary cover on an accidental death only basis. However, deaths that occur as a result of alcohol, drugs, suicide or intentional self-injury will be excluded.

2.9 What underwriting decisions can me made?

When we have received and assessed all of the evidence of insurability, we will decide if we can offer cover and if any special terms are appropriate.

As a result of underwriting we may:

- Accept the benefits at standard terms
- Charge additional premiums
- Apply special terms
- Exclude certain hazardous activities
- Postpone or decline the amount of benefit that was being underwritten

Benefit amounts that are accepted after medical underwriting will commence on the date we notify you of our terms.

If we do apply any special terms we will write to you and explain the terms. If our terms include charging additional premiums and you decide you do not want to pay the additional premiums, you can cancel the cover the additional premium is for by letting us know in writing within 30 days.

Unless we tell you otherwise, the special terms will not affect the cover below the free cover limit or any cover we have previously accepted.

If we do not receive the evidence of insurability we need to be able to complete medical underwriting for a member, we will restrict their benefit as follows:

- To the member's previously accepted benefit if they have been previously underwritten
- To the free cover limit if they have not been previously underwritten and they are being underwritten only because their benefit exceeds the free cover limit
- To the member's normal benefit they are eligible for if they are being underwritten for a discretionary benefit
- To zero benefit if the member is being underwritten as a discretionary entrant / late entrant

2.10 Future medical underwriting requirements for members who have previously been underwritten by us - Forward Underwriting

Forward underwriting is the agreed level of additional benefit to cover future salary increases that may be covered without the need for further underwriting. We can forward underwrite up to a maximum benefit level per member of £5,000,000. Forward underwriting is only applied when we have medically underwritten a member.

This means, once we medically underwrite a member and agree cover on any of the following terms:

- The member was accepted at ordinary rates or with a medical loading of +200% or less
- The member fulfils our actively at work requirement at the time of the increases in benefit (if applicable)
- The member was accepted with an exclusion for hazardous pursuits

they will not normally need to give us more medical evidence for an increase until the earliest of:

- The total of all increases after medical underwriting is more than £300,000
- The member's benefit increases by more than 50% of the original accepted benefit amount
- It's been 5 years since they were last medically underwritten by us

However, any member who requires cover beyond the scheme cover cease age (and therefore discretionary) will not be eligible for forward underwriting.

Where we have applied forward underwriting after we have medically underwritten a member, we will apply the last medical underwriting terms to each increase.

2.11 What cover is provided during temporary absence from work?

Cover may continue while a member is temporarily off work.

The policy schedule will state the period of time for which cover, if any, continues during periods that members may be absent from work as a consequence of illness or injury or non-medical reasons. There are 3 available options:

1. No cover during temporary absence is provided, or
2. Cover continues for a fixed period of 3 years irrespective of whether the temporary absence is a result of illness or injury or non-medical reasons, or
3. Cover continues until the State Pension Age or cover cease age (if later) if the temporary absence is a result of illness or injury and for a period of 3 years if the reason for temporary absence is for non-medical reasons.

If a member is on a fixed term contract cover cannot continue beyond the end date of the contract in force at the time the member was first absent.

If a member is absent from work on the commencement date, and immediately before that date, the member's benefits were insured under any other policy, cover under our policy will stop when cover would have ceased for the member under that other policy.

Temporary absence for all members working beyond cover cease age, will be restricted to a maximum period of 12 months from date of first absence or to the end of contractual employment if earlier.

Continuation of an individual member's cover during a period of temporary absence is subject to them remaining a member of the scheme, the scheme remaining insured with us and you continuing to pay premiums.

If you want benefit increases during a member's period of temporary absence we can increase them in line with any general pay awards granted by the employer subject to a maximum annual increase of 5%.

If a member's benefit reduces during a period of temporary absence, perhaps as a result of a reduction in earnings, we will keep the level of benefit at the same amount as when temporary absence commenced.

2.12 Can cover be provided for Travel and Residence outside of the UK, Channel Islands and Isle of Man?

We can usually provide cover for members who may be working abroad providing they remain eligible members and as long as the majority of employees work in the UK. We can also usually provide cover for members who travel outside of the UK for normal business purposes. We will need full details of the countries involved as we will need to assess if we can cover them and if we need to apply special terms.

You need to tell us before the commencement date of cover with us and at each policy anniversary date –

- Known or anticipated travel outside of the listed countries (see definitions for complete list).
- Residence or secondment outside of the UK, Channel Islands or Isle of Man.

If you do not tell us the above, this may invalidate or restrict cover.

Members on secondment or permanently based overseas must have a contract of employment with the UK registered company. Members who are not paid in UK currency, will have their salary converted to UK currency based on the exchange rate at the time the quotation or renewal documentation is produced. The payment of any benefits in the event of a claim would also be calculated at that exchange rate.

If a member is seconded or permanently based overseas and the continuation of their membership is not automatic we may not be able to continue cover. If we decide we can continue cover, they will be considered to be a discretionary member and will require medical underwriting before we can continue cover.

Section 3 – Optional additional cover

The policy schedule will state whether any additional cover is included under the policy.

3.1 Redundancy Cover

Lump sum benefits can continue for someone who leaves employment due to redundancy.

Free redundancy cover for up to 3 consecutive months from the date of redundancy is automatically included.

For an additional charge, we can extend the period of redundancy cover to 2 years. This additional cover must have been selected at outset of cover with us and it must apply to all eligible members. For both redundancy cover options, cover for individual members that are made redundant during the policy can continue but will end on the earliest of:

- The date the member commences new employment (including self-employment),
- The member's cover cease age, or
- The specified redundancy period as stated on the policy schedule

Benefit levels will be restricted to the amount that was in force at the date of redundancy.

3.2 Early Retirement Cover

This additional cover must have been selected at outset of cover with us (for an additional charge) and it must apply to all eligible members.

If a member retires before their normal expected pension age and at that time is granted a pension from your occupational pension scheme, they will continue to be treated as an eligible member and remain included as a scheme member providing that:

- The pension is due to incapacity, or
- The member is entitled to continued life cover which is permissible under HMRC regulations, or
- The member joined the pension scheme before 1st October 1991.

The benefit amount cannot exceed the amount of benefit the member was entitled to immediately before retiring and will remain fixed.

The cover will end when the member reaches the cover cease age or their expected normal retirement age, whichever is earlier, assuming the scheme remains insured with us.

Section 4 – When does cover end?

We will normally stop covering a member:

- When they reach the cover cease age, or
- the date that they cease to be an eligible member of the scheme, or
- when they cease to be a Relevant UK individual, or

- if they retire early, unless the policy specifically provides for cover during early retirement, or
- the date that they leave your employment or when you are no longer treating the member as an employee for the purposes of the scheme, or
- when their period of temporary absence cover ends (see section 2.11 for full details)

Where the cover cease age is linked to State Pension Age, if State Pension Age changes for a member, the cover cease age will be based on the member's new State Pension Age.

It may be possible for cover for individual members to continue beyond cover cease age (see section 1.2.1 of our Group Life Technical Guide for full details).

In all circumstances cover cannot continue beyond a member's 75th birthday.

In respect of the overall scheme, cover will normally end on:

- The expiry date of the policy, or
- The date that you advise us in writing cover is to be cancelled, or
- The date we advise you that cover will be cancelled, or
- The anniversary date after the scheme membership falls to less than 2 eligible members, or
- The first anniversary date after the date you appoint a new Financial Adviser if that new Financial Adviser is not one of our Selected Advisers.

Section 5 – Policy limitations

5.1 Catastrophic Event

A catastrophic event is the occurrence of a single event or series of events, if they happen within a 72 hour period that directly or indirectly causes the deaths of more than one member either at the time of the event or within 12 months of it.

Examples of Events that might be considered to be a catastrophic event include:	
War (whether declared or not)	Earthquake
Windstorm	Flood
Terrorist Activities	Pandemic Illness
A sudden release of atomic energy or nuclear radiation	Radioactive contamination (whether controlled or uncontrolled)

Biological or chemical substances	

Your policy schedule will specify the event limit for your location. If you operate from more than one location your policy schedule will confirm event limits for each location.

If the catastrophic event occurs, at a location not specified in your policy schedule, the maximum benefit payable at that location will be £10 million (reducing to £5 million for EC or E14 London postcodes).

If you have multiple locations and more than one location is affected by a catastrophic event, then the deaths at each location will be assessed against the catastrophic limit at each location, however we will limit the combined maximum amount payable to £100 million.

Claims will be settled in the order notified to us until the relevant limit has been reached.

If we are covering members under a number of different associated policies, we will treat the policies as if they were one single policy. The maximum payable in respect of any one location will be the highest maximum individual event limit for that location rather than the sum of the limits for that location across all policies. The maximum amount we will pay out from all policies will be £100 million.

5.2 Travel Limitation

If a catastrophic event results in the deaths of more than one member where a group of members is travelling together then the maximum benefit payable will be limited to the lower of:

- the maximum event limit specified in the policy schedule, or
- £25 million.

This limit applies both during travel and at the destination if that is not the normal place of work.

Section 6 – How do we work out the premiums?

The premiums we charge are calculated to reflect a number of factors including:

- The level of benefits
- The cover cease age
- The eligibility criteria and any entry conditions
- The age, gender, location and occupations of the members
- Any past claims experience
- Any additional cover, for example Redundancy Cover
- Policy fee

We use a unit rate basis to work out the premiums. The unit rate will be stated in the policy schedule.

We will work out the accounts at the start of the policy and then every year at the policy anniversary date (annual renewal date). We will work out the cost for each £1000 of total benefit. We will multiply the unit rate with the policy's total benefit amount at the start of each policy year to work out that year's premium.

To work out the cost of each member, the unit rate that applies at that date is multiplied by the relevant member's insured benefit.

Our minimum annual premium is £400.00 and our minimum monthly premium is £40.00.

If the premium is paid annually by cheque or bank transfer, we will request a deposit premium for the policy accounting period. The deposit premium will be based upon 2 months of the previous year's annual premium.

If the period of cover from the commencement date to the policy anniversary date is less than 1 year, the premiums calculated will be a proportion of a full year's cover.

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

At each anniversary date we will calculate a premium adjustment for changes that are in line with the agreed eligibility conditions and benefit basis. To keep things simple, we will assume that all changes took place half way through the policy year. We will charge you an extra premium or pay you a refund at the beginning of the next policy year.

6.12 What information is required for accounting purposes?

We will tell you in advance of each anniversary date what information we require. At each anniversary date (renewal date), you will need to give us an up to date membership list before we can issue renewal accounts.

At the start of the policy, and at each anniversary date (we will tell you in advance of each anniversary date what information we require) you will need to give us a membership list which as a minimum should include:

- Name
- Date of Birth
- Gender
- Salary
- Benefit
- Occupation
- Geographic location/postcode
- Date of joining company
- Category of membership (if different rules apply to different members)
- Medical evidence if a member's benefit goes over the free cover level, or if our terms ask for it

You will also need to clearly identify members:

- Who are in a period of temporary absence from work or income protection claim. You will need to tell us the date they were first absent and the reason for absence (nature of illness/injury)
- Who require cover to continue during ill health early retirement, or redundancy, if these cover options apply to the policy
- For whom restricted benefits apply
- For whom special terms apply
- Whose total benefits exceed the free cover level

If membership of this policy is linked to pension scheme membership, you will need to confirm the current take up rate of employees to the pension scheme.

You also need to tell us at each policy anniversary date –

- Known or anticipated travel outside of the listed countries (see definitions for complete list).
- Residence or secondment outside of the UK, Channel Islands or Isle of Man.

See section 2.12 for full details.

It is important that we know exactly who is covered under the policy. If you do not include an employee who you should have included on the membership list at the start of the policy or the anniversary date, we will not pay a claim for them.

You should also ensure that the data you give us accurately reflects any salary basis or limitations that you have agreed with us.

6.13 Will there be any unexpected extra premiums?

If the information we need to calculate the premium is delayed or inaccurate, your premiums could change because you may not be paying the correct premium.

We will usually fix the unit rate until the end of the 2nd policy year. This is called the rate guarantee period. We will then review the rate, following which we will usually fix the unit rate for another 2 years.

However, we can change the unit rate (so the unit rate and premiums may go up or down) at each policy anniversary rate (renewal date) if during the previous scheme year or at renewal any of the following happens:

- A change in the eligibility criteria
- Addition of a new member category
- An addition of a new or removal of a participating employer
- Information we requested from you in setting up the policy or at any subsequent review of the terms is found to have been omitted, materially inaccurate or otherwise incomplete
- A change in the taxation of the scheme benefits and/or premiums
- A change of more than 25% in the membership size or total benefit at the anniversary date for schemes with 20 or more members
- A change of more than 15% in the membership size or total benefit at the anniversary date for schemes with less than 20 members
- A change in the basis for calculating benefits

- The business location of an employer or a group of members (which affects more than 25% of the membership size for schemes with 20 or more members, 15% for schemes with less than 20 members) included in the policy changes

If a member has given us medical evidence, you may need to pay us an extra premium because of their medical conditions or participation in any hazardous pastimes. Although the extra premium will apply immediately, we will not ask you to pay it straight away. Instead, we will add it to your next account. If you tell us within 30 days that you do not want the cover that the extra premium applies to, we will not charge the extra premium.

6.14 What about commission?

The premium payable will include the level of commission payable to your Financial Adviser. We can pay different levels of commission although this will affect the premium we charge. We will confirm the rate of commission in our annual accounts.

6.15 Payment of premiums

Our preferred payment method, whether annual or monthly, is by Direct Debit, but you can also pay annual premiums by bank transfer or by cheque

All premiums must be paid within 30 days of their due date. Failure to pay premiums within this, or otherwise agreed, grace period may mean cover will be cancelled.

In the event of a claim happening within the grace period and the premium not having been paid, we will pay the benefit amount less a deduction to reflect the unpaid premium.

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

Premiums paid in advance will not be lost. We will work out a final account for the cover we have provided up to the policy's cancellation date. We will either send you a refund or you will have to pay us any premiums you owe.

6.17 What will happen if you do not pay your premiums?

You may not simply stop paying your premiums as a way of cancelling your policy with us.

If you do not pay your premiums within the 30 days of the date they are due, we may:

- Agree to allow you more time
- Consider that premium payments have stopped and we will discontinue cover

If we agree to allow you more time to pay your premiums, we will confirm this to you in writing.

If we discontinue cover, we will confirm in writing the date that cover ends. Premiums will be due for cover

provided up until that date.

6.18 How can you cancel the policy?

You are entitled to cancel this policy at any time, but you need to tell us in writing in advance of the date you want to cancel the policy and its cover. The cancellation date cannot pre-date the date of your written notification. The policy will continue until we receive your written notification.

6.2 Reinstatement of the policy

If the policy has been cancelled, we may consider reinstating the policy if we receive written notification from you within 30 days of the date the policy cancelled.

You will need to complete and return our reinstatement form within 10 days of it being issued to you. We will not be liable for any claims arising during the period from the date of cancellation to the date of reinstatement.

We reserve the right not to reinstate the policy.

Section 7 – Making alterations to the policy

You can request an alteration to the policy cover at any time. You need to tell us in writing before the date you want to alter the policy. We will tell you what evidence of insurability we will require in order to consider making the alteration. Any amendments made cannot pre- date the date of our written acceptance of the revised terms.

You should tell us immediately if:

- There are changes to participating employers (including the addition or removal of) including their activities, location and the relationship between them
- There is a change of the employer's nature of business
- The business location of an employer or a group of members (which affects more than 25% of the membership size for schemes with 20 or more members, 15% for schemes with less than 20 members) included in the policy changes
- You wish to change the benefit basis
- You wish to change the eligibility criteria (a change to the scheme rules that affects someone's inclusion or exclusion as a member or affects the member's scheme benefits)
- You wish to add a new member category

Requirements to increase the cover cease age of the policy

We can consider increasing the cover cease age from the existing age up to a maximum age of 75. The new cover cease age must apply to the whole scheme, not specific members only. We will need the following underwriting requirements in the table on the next page –

Underwriting requirements to increase the cover cease age		
	Benefits below our free cover limit	**Benefits above our free cover limit**
Requirements	**Existing members** - must fulfil our AAW at the date the CCA changes	**Existing members** - the portion of existing members' benefits above the free cover limit will require medical underwriting***** as well as the need to fulfil our AAW
	New members - joining at their first opportunity will have the same requirements as above	**New members** - joining at their first opportunity will have the same requirements as above
	Re-joiners as a result of the increase in CCA- will have the same requirements as above	**Re-joiners** as a result of the increase in CCA - will have the same requirements as above *Medical underwriting may be waived for: Members up to age 69 if the member has been underwritten by another insurer within the last 5 years, or Members aged 70 and over if the member has been underwritten by another insurer within the last 12 months

Section 8 – Claiming benefit

We will try and ensure that all valid claims are settled quickly. You need to notify us as soon as possible after a member's death and ideally within 3 months of the date of death.

We will not pay a claim if:

- Any information relating to any aspect of the scheme that we have asked for is outstanding
- The premiums we have asked for have not been paid when due
- A completed claim form has not been received by us within 2 years of the date of a member's death

8.1 How to make a claim

In order for us to assess the claim and make payment to the trustees as soon as possible, we will require the following:

- A fully completed claim form signed by the trustees (our claim form can be obtained from your Financial Adviser or from our website www.optimalprotection.co.uk)
- Original death certificate (this will be returned to the sender by recorded delivery within 3 working days of receipt)
- Evidence of earnings and eligibility (for example, a member's last 3 pay slips or P60)

We may also ask for:

- Medical records relating to the deceased
- Any employer's absence records relating to the deceased
- Original marriage certificate or decree absolute or legal change of name document if the deceased member has a different name to that supplied on the most recent renewal data

8.12 How will benefits be paid?

When a claim has been agreed by us payment (always in UK currency) will normally be made by Electronic Fund Transfer and will only be made in the name of the trustees of the scheme.

The payment will be made directly into the bank account established by the trustees specifically for the purposes of receiving claims payments. Payments will not be made to anyone else other than the trustees of the scheme.

The trustees will have absolute discretion as to whom they pay the benefits. If the member completed an expression of wishes form nominating the people they want the benefits to be paid to, we will not divert the claim payment to the nominated people. It is entirely the responsibility of the trustees to distribute the payment.

Payment by us will be in full and final settlement of our liabilities for that claim.

The receipt of any payment by the trustees will mark the end of our responsibilities for that payment.

Section 9 – Further information

The Company

Optimal
4200 Waterside
Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YN

Optimal is a trading name of HF Life Limited (FRN 613348), an Appointed Representative and subsidiary of The Original Holloway Friendly Society Limited. Registered in England (No. 8649971) Registered Office Holloway House 71 Eastgate Street Gloucester GL1 1PW. The Original Holloway Friendly Society Limited is Registered and Incorporated under the Friendly Societies Act 1992. Registered in the UK No. 145F. Authorised by the Prudential

Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. FRN 109986.

Questions and Complaints

We want you to be entirely satisfied with your Registered Group Life policy. If you do have a query or complaint, then in the first instance please speak to your Financial Adviser who arranged this policy for you.

If you then need to speak to us, you can call us or send the details of your question or complaint to our Managing Director at the following address:

Optimal
4200 Waterside
Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YN

As an Appointed Representative of The Original Holloway Friendly Society Limited, if we are unable to resolve your complaint to your satisfaction, you may escalate the matter, or indeed you may choose to write in the first instance, to the Original Holloway Friendly Society Limited, which has its own complaints procedures.

Please write to:

The Chief Executive
The Original Holloway Friendly Society Limited
Holloway House
71 Eastgate Street
Gloucester
GL1 1PW

If we are unable to settle your complaint you may be able to refer it to the Financial Ombudsman Service at the address below. Making a complaint won't affect your right to take legal action.

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London
E14 9SR

Compensation

In the unlikely event that we cannot meet our liabilities you may be entitled to compensation from the Financial Services Compensation Scheme (FSCS). Further information is available from the FSCS at its website http://www.fscs.org.uk

Data protection

For the purposes of the Data Protection Act 1998 Optimal is a joint data controller with you, the policy holder.

We will process all personal data in respect of this policy in accordance with our obligations under the Data Protection Act 1998. We will only use this information solely for the purposes of underwriting, quoting for and providing and administering the policy. As a result we may need to pass on information to The Original Holloway Friendly Society and our reinsurers.

Where we need evidence of insurability for a member, we will be responsible for obtaining appropriate consent from the member during the course of medical underwriting. Any information collected will be carefully protected under our obligations of the Data Protection Act 1998.

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