

Guide to Understanding Claims

Long Term Disability

What is our key objective?

We aim to deal with all claims efficiently and equitably to ensure that all benefits due are paid on time and any further distress to the member and /or their dependants is minimised.

What is the claim notification procedure?

In order to ensure prompt and efficient payment of claims, it is essential that Generali Worldwide are advised of any potential claim as early as possible. The employer should provide us with the name, date of birth and current salary data of the potential claimant for us to begin the process.

What are the policy requirements for notification of claims?

As per the policy terms and conditions ('Notice of Incapacity'), written 'Notice of Incapacity' of a member must be given by the employer to us at least 4 weeks prior to the termination of the 'Deferred Period'. Notice can be given by email indicating the details of the member (name, date of birth, salary) and the date they became incapacitated.

What are the consequences of late notification?

If the employer fails to give the required notice to Generali Worldwide, the 'Deferred Period' will be deemed to end 4 weeks after the actual date of receipt of the notice.

What documents are required for the claim assessment?

- Group Disability Claim Form – Employer's Notification.
- Group Disability Claim Form – Employee's Notification.
- A Medical Report to confirm the extent of the incapacity.
- A certified copy of the claimant's Birth Certificate or passport.
- A certified copy of the claimant's Marriage Certificate (*female claimants only*).
- Additional medical certificates to indicate periods of absence from work.
- A copy of the claimant's most recent job description.
- Proof of eligibility as per the policy terms and conditions.

What next?

The employer will be forwarded all the necessary claim forms by us and these, together with the required documents, should be completed and returned to us by the employer.

Communication

Having confirmed receipt of the claim forms, we will start assessing and investigating the facts of the potential claim and will update the employer on a regular basis.

What if further evidence is required?

We may request additional reports from the claimant's general practitioner and / or consultant. In addition, we may also request information of a financial or employment nature, which may include a Home Visitor call on the claimant and the employer.

Who pays for any translation costs, if required?

In the event that medical reports are provided in a language other than English, a certified translation of the document will be required at the expense of the employer.

How is the Claim assessed?

Our Chief Medical Underwriter reviews all medical information submitted in order to determine the validity of the claim. The requirements of the claimant's occupation are then compared to the definition of 'Incapacity' as defined in the policy terms and conditions, to determine how the incapacity affects the claimant.

How will the decision be communicated?

We will advise the employer in writing of the decision, which may be:

- Acceptance of the claim including breakdown of payments.
- Declinature of the claim including reasons why it has been declined.

The employer is then responsible for advising the member of this decision. Every effort will be made by us to reach a decision by the end of the 'Deferred Period'.

What is the 'Deferred Period'?

Also known as the 'Waiting Period', this is the period of time which must pass, before benefit is paid, after an illness or injury has been diagnosed and reported to us. This period may be 13, 26 or 52 weeks depending on the policy terms and conditions.

What if a decision has not been reached before the expiry of the 'Deferred Period'?

In some instances, particularly if there have been delays in receiving the requested evidence, a decision within this time may not be possible. Should we be unable to reach a decision by the end of the 'Deferred Period', and should the claim subsequently be accepted, the first payment will cover the period of time from the end of the 'Deferred Period' to the date the claim is admitted.

How are the benefits paid?

In accordance with the policy terms and conditions, benefits are paid monthly in arrears directly to the employer's account (grantees of the policy).

How can the claim be paid to the claimant directly?

Payment of the claim may be made by Generali directly to the claimant. In order to do so, we require the grantees to complete and return a 'Discharge Form' including the necessary payment instructions. The employer will need to ensure that we are kept updated of any changes to these details in the future.

Note: Payments will be made gross from us and it is the member's responsibility to ensure that any tax liability is met.

Can a member receive an income from other sources whilst incapacitated?

In accordance with the policy terms and conditions, any income from other sources received by a claimant should be immediately notified to Generali Worldwide initially in the 'Employee Claim Form' and in writing should the claimant's circumstances change at any point in the future.

What could these other sources include?

The sources may vary according to the policy terms and conditions and may include any of the following:

- National Insurance or Social Security benefit.
- Other insurance policies.
- Pension and or a salary.

What is the claim review procedure for Long Term Disability claims?

Under the policy terms and conditions, benefit will continue to be paid as long as the evidence continues to support the claim. When the claim is first accepted, the claimant will be advised directly by Generali Worldwide of the date that their claim must next be reviewed depending on their individual circumstances.

The objective of the medical review is to assess the continued validity of the Long Term Disability claim in payment.

The member's medical results will need to reach us by the review date so that the member's disability can be assessed without delay and payments can be maintained as applicable. As a consequence, the member will need to organise the medical examination with their doctor or an independent consultant, as required, in advance of that date.

Who pays the medical expenses for the claims reviews?

The bill for medical expenses incurred by the member, in respect of the medical review will be paid by the member themselves. Should we require additional tests, these expenses shall be paid directly or reimbursed to the member by us.

What happens if the member fails to provide evidence for the claim review?

If the member does not provide evidence that they are still incapacitated within the required timeframe, payment of the claim shall be suspended.

When could Long Term Disability claim payments change or cease?

The circumstances under which benefit payments will stop are:

- The claimant recovers and returns to work.
- The claimant's employment contract is terminated.
- The claimant reaches Normal Retirement Date.
- The claimant dies.

The circumstances under which benefit payments may be reduced are:

- The claimant returns to work on a full or part-time basis. In this instance, the benefit payments that are being made under this policy will be reduced proportionately in accordance with the policy terms and conditions.

The circumstances under which benefit payments may be increased are:

- In accordance with the policy terms and conditions, the benefit is indexed annually.

What happens if the claimant returns to work and their incapacity resumes?

If the member returns to work and becomes incapacitated again as a result of the same cause as the original claim and within a period of returning to work specified in the policy terms and conditions, they will not need to serve a further 'Deferred Period'. Benefit will be resumed, subject to further evidence showing that they continue to meet the definition of 'Incapacity' as per the policy terms and conditions.

What happens in the event of disagreement with the decision?

In this event, the claimant or the grantees should write to Generali Worldwide setting out their reasons for disagreement.



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