Your guide to making a Group Income Protection claim

ProActive Protection from MetLife

FOR EMPLOYERS AND INTERMEDIARIES

ProActive Protection from MetLife

With ongoing support from an experienced team

Our approach to claims management is about being proactive and providing you with practical solutions for your business.

When claims are notified after the end of the deferred period, it can already be too late to take any preventative action. At MetLife, we work with you to gain sight of absences early on, in order to trigger intervention as soon as it's needed.

This will help you to:

- avoid long-term sickness absence, and the resulting disruption and costs to the business
- reduce the instance of claims
- lessen the potential for unexpectedly declined claims, as any issues will be highlighted early on in the process.

Your Client Relationship team

We understand how vital it is to have helpful, reliable contacts throughout your policy, to answer any questions you may have. That's why you'll have the back-up of your Client Relationship Manager and supporting team, who will proactively keep in touch with you on a regular basis to identify any absences.

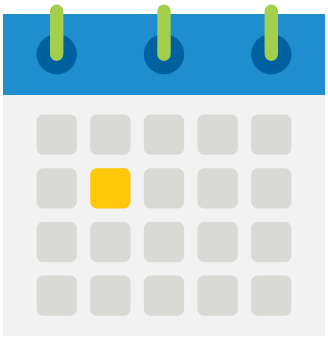
Early intervention

We've teamed up with an independent company, Health Claims Bureau (HCB), to manage early intervention activity. Its independence means it can focus solely on identifying and supporting an employee's ability to work. Our Claims Specialists will work closely with HCB to ensure that the most appropriate early intervention programme is implemented.

We're here to support you and your employees, every step of the way

If you do need to make a claim, your Claims Specialist will make sure everything runs smoothly from start to finish – overseeing each stage, keeping you informed as the claim progresses and helping to make the process as quick and easy as possible.

If an employee has to take a long absence from work due to illness or injury, you and they will be secure in the knowledge that their income is protected up to the agreed insured level. Your Client Relationship team and Claims Specialist will also work proactively with you and your employee to support them on their journey back into work where appropriate.



The claims timetable

The MetLife Group Income Protection team of Claims Specialists have a wealth of experience and expertise.

The team will utilise data to determine best practice for each claim and absence progress.

Absence Weeks 1-2	Absence Weeks 2-4	Deferred period is complete	Claim commencement date and beyond
Employer follows internal absence and sick pay process	HR/Intermediary refers to MetLife claims team using agreed process and consent form	Absence progresses through the deferred period. Claim forms are submitted via post, phone or email	Management of ongoing claims in partnership

Employer resources

Own in-house services e.g. Occupational Health, Line Manager, Human Resources

MetLife resources:

- Health risk assessments
- Emotional and legal information, counselling, lifestyle assessments
- Promotion of health and wellbeing through appropriate easy-to-access information and advice.

MetLife's Claims team

review condition and determine optimum strategy:

- Assess if early return to work support required
- Assess if treatment funding needed
- Assess if claim forms are required
- Produce case specific action plan of support within 5 days of contact. All actions documented as proof of value
- Request expert clinical services input as needed.

MetLife's Claims team

provide:

- Assessment
- Decision
- Payment
- Review.

MetLife's Claims team

actively support and manage the claim – working with all parties (employer, employee, Occupational Health, medical practitioners) to create a claim solution designed for each employee.

Utilising our expertise

The MetLife Group Income Protection Claims Specialists have an average of over 10 years' claims experience each. The team will utilise data and experience to determine best practice for claim and absence progress.

Need help with making a claim?

We'll provide all the help, guidance and support you need when making a claim under your MetLife policy. Your Client Relationship team and Claims Specialist can answer any specific questions you may have – or you may find the answers you need within this handy guide.

What to do if an employee is absent from work

What happens if an employee becomes absent?

If you have an absent employee it is important that you notify us as early as possible. This may be via your intermediary or direct to the Claims Assessment team on **0800 917 1222**.

We will then be able to make an initial assessment as to whether an early intervention assessment would be beneficial, or a claim can be made.

Why is early intervention so important?

To get your employees back to work more quickly it is important to speak to your absent employee as soon as possible.

Once you have spoken to your employee, you should get in touch with your MetLife contacts, who will then work with HCB to progress early intervention that would be beneficial.

HCB can offer support and advice to employers and employees. This could include, for example, advice on any treatment required, return to work plans, offering flexible working and any job adaptations which may help a return to work.

Please note that early intervention treatment applies only during the selected deferred period. Following the deferred period, we offer a similar service which you can read more about in 'Following a Claim' on page 8.

Making a claim

When can I make a claim?

You can make a claim if an employee has an illness or injury which is impacting their ability to work, under the definitions that you have chosen for your Group Income Protection policy with MetLife.

How do I make a claim?

If you have an employee who may be absent for a prolonged period, please contact our MetLife claims team no later than four weeks after the start of your employee's absence from work.

Your employee does not need to be totally absent from work to be able to claim. For example, if they are only able to work part-time or on reduced duties as a result of their illness or injury, we can still consider a claim.

When should I submit the claim forms?

The sooner you can get the process started, the better – and there's no need to wait until the expiry of the deferred period that you have chosen with your policy. The deferred period is the length of time an insured member must be absent from work through illness or injury before any policy benefits will be considered. For example, if you have chosen a 26-week deferred period, we would not pay any benefit until the first day following 26 weeks of absence. If you have a 13-week deferred period – we would like to receive your claim forms no later than six weeks after your employee's absence from work begins.

If you have a deferred period of 26 weeks – we would like to receive your claim forms no later than 13 weeks after your employee's absence from work begins, however, you should notify us as soon as possible so that we can consider early intervention support.

How to claim

What forms do I need to complete, and what other documents will I need to submit?

There are two forms to complete:

- **Employer's claim form**
  to be completed by you – this form contains essential information we need to progress the claim.
- **Employee's claim form**
  to be completed by your employee – this form contains essential information to allow us to understand their situation more fully. It also contains a consent form so that we can request medical information which would support the claim.
- **Request for Medical Records form**
  which allows us to access the case notes of the employee's GP or attending consultant alongside the completed claim forms.

You will also need to include the following documents:

- Copy of the employee's job description
- Absence records
- Proof of earnings – this could be a copy of three pay slips prior to absence, or the most recent P60. Please refer to the policy schedule which defines 'salary' and provide corresponding proof of earnings
- Any medical information you have on the employee, including any applicable Occupational Health reports. This can greatly speed up the assessment process.

The claims process

What supporting information might be required?

As soon we receive a claim, we pass the forms and supporting documentation to your dedicated Claims Specialist.

The Claims Specialist starts the preliminary processing of the claim, including eligibility checking. Following their initial assessment, the Claims Specialist will request any additional evidence that may be required to assess the claim further.

You will receive confirmation of the claim, along with any request for additional evidence as required.

How will MetLife process the claim?

This would normally be a request for medical evidence from the attending GP or Consultant.
We might also request additional administrative or technical information.

Once we receive this information, we will then re-assess the claim based on the new evidence.

Timescales

How long does the initial assessment take?

We will always attempt to make our initial decision as soon as possible, based on the information provided to us, as it is important to get the employee back to work as quickly as possible. However, there may be occasions where this is not possible – in which case, we may need to request further evidence to consider the claim further.

If we are unable to make a decision based on the evidence of the GP or Consultant, we may ask the employee to attend an Independent Medical Examination or Functional Capacity Assessment (please see top of following column).

How do MetLife make their decision?

We gather all the available evidence to substantiate a claim against the definition of 'incapacity' selected under the policy.

Incapacity definition

This is the definition we use to assess the claim. There are two choices available:

Own occupation

Under this definition we will be assessing if your employee is unable to perform, due to sickness or injury, the material and substantial duties of the occupation they were performing before their incapacity (duties which are normally required for the performance of an occupation and cannot be reasonably modified).

Own or suited occupation

Under this definition we will be assessing if your employee is unable to perform, due to sickness or injury, the material and substantial duties of the occupation they were performing before their incapacity, and any other reasonable occupation to which they are suited by reason of training, experience or education.

As part of our assessment we need to ascertain if your employee is unable to work, due to their condition, according to one of these policy definitions.

What happens if the employee needs to attend an Independent Medical Examination or Functional Capacity Assessment?

Although this is not required in the majority of claims, in a case where the employee has not yet been seen by a Consultant or Specialist, or if we are unable to confirm the validity of the claim, we may ask the employee to attend an Independent Medical Examination or Functional Capacity Assessment.

These assessments are expected to provide valuable information to enable us to be able to provide you with a full and fair decision on the claim. We work with a number of established service providers and can, if required, provide details of their credentials at the time of the referral.

We aim to make the process as easy as possible for your employee and will liaise with them directly to arrange the appointment, which will be as near as possible to their home location. We will pay for all reasonable travel costs incurred by your employee in attending the appointment.

Once we've received the findings from this assessment we will be able to re-assess the claim and provide you with a full service.

How long does it take to process a claim?

If the claim matches the terms of the policy, we aim to give you an initial decision before the deferred period ends, dependent on timely claims notification and availability of supporting information.

With that in mind, we will process and assess each piece of evidence and respond to you within five working days of receipt. This will include our preliminary assessment when we receive the claim forms, and any re-assessment we may need to take following any additional evidence.

We will keep you informed throughout the process, and we will make sure you are always aware of what actions are outstanding on a claim.

You'll receive an update every 14 days following the receipt and assessment of any new evidence. During this time, if you have any information relating to the employee that could help us, please do contact us. Regular, open communication ensures that claims are dealt with quickly and employees can get back to work as soon as possible.

How can I help with the claims process?

You can help by:

- Making sure that all claim forms are fully completed and that these, together with any other documentation, are submitted to us in good time.
- Responding to any requests for additional evidence as quickly as possible.
- Follow up on medical requests – we will of course chase any outstanding information on a regular basis, but you can also help in the assessment of the claim by asking your employee to follow up with their GP to progress any medical requests.

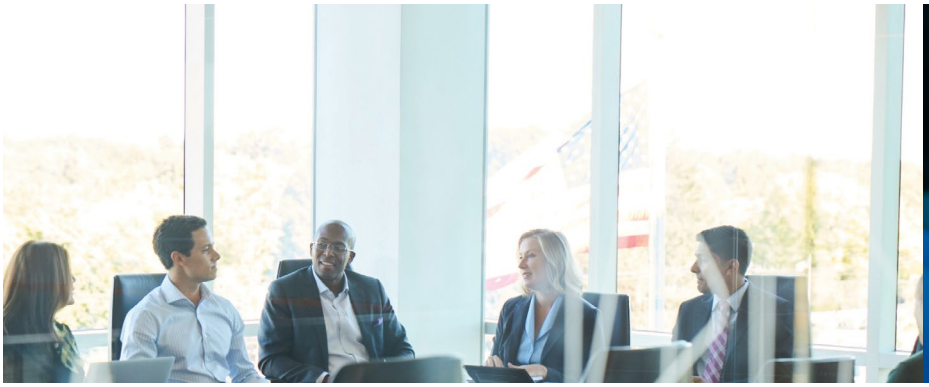
In our experience most delays occur while waiting for GP and Consultant information. We have found that when an employee chases this information directly it often leads to our request being turned around more quickly. We would therefore be grateful if you could make your employee aware of any medical requests, and ask them to follow this up with their medical practitioner.

What happens if my employee is overseas?

With all claims we require access to information that enables us to complete our assessment and understand all the issues relevant to your employee's absence from work. We are equipped to work with medical professionals overseas in order to obtain information needed to validate the claim. We do require that information to be available to us in English and at a reasonable cost.

There will be occasions where this is not possible, and we might therefore require your employee to return to the UK to attend a medical examination so that we can assess the claim. In this situation we will be happy to make arrangements direct with your employee. We will also pay all reasonable travel costs once in the UK but will not pay for any costs travelling to and from the UK or for accommodation in the UK.

Where your employee is able to return to work we will not continue the claim purely because your employee resides in a different country from the required work location.



Claim decision

If the claim is accepted, how are benefit payments made?

We make claim payments monthly in arrears to you, the employer, by direct credit into the nominated bank account. We prefer to make payments by direct credit, which in our experience is more secure, quicker and avoids any payments being lost. If applicable, any outstanding benefit will be backdated to the claim commencement date.

What happens if the claim is declined?

If a claim is declined, we will telephone you and explain our decision. We will follow this up in writing to provide you with a full and thorough explanation as to why we have made the decision. We will also provide you with full details of what options are available to you should you wish to appeal the decision.

If claims are reviewed, how and when will this take place?

If a claim is accepted, we will send you a letter confirming this, which will include details of when we plan to medically review the claim and what evidence we will ask for.

We periodically review all claims to assess if your employee has shown any improvement. If so, we may be able to help them get back to work.

We review claims on a case-by-case basis in line with the medical evidence we have received. Our review would normally start with a request for an update from either the employee or from the GP, but we may need to obtain further evidence to support the claim.

Following a claim

What happens when my employee is ready to come back to work?

We recognise that returning to work after a period of absence can be challenging. If the employee is in a position to return to work, our expert rehabilitation team at HCB will help support them in taking that next step.

The rehabilitation team will liaise with you, your employee and their GP, to help facilitate a successful return to work and overcome any barriers that may be preventing the employee from returning to the workplace.

What if an employee is unable to return to their contracted role?

If an employee is unable to return to their contracted role, during or after the end of the deferred period, we can consider reduced income benefit. The deferred period will need to be completed before the benefit becomes payable.

If it can be medically supported, we would encourage the employee to return to work in a reduced capacity or in a different role. If the employee receives a reduced income for the work they are doing, then a reduced income benefit will be payable.

This benefit will support the employee financially on their return to the workplace, while keeping the incentive to return to their contracted role if/when they are able to.

Complaints

At MetLife, we are committed to providing a high standard of service. However, if a problem should arise we want to:

- Make it easy for you to raise your complaint
- Listen to your complaint
- Consider how you'd like us to remedy your complaint
- Make sure you're satisfied with how your complaint is handled.

To find out more, please visit the FCA's website at: **www.fca.org.uk**

We aim to resolve all complaints internally. However, if you are not satisfied with our final response to your complaint, or if eight weeks have passed since you first brought your complaint to our attention, you have the right to refer your complaint to the Financial Ombudsman Service.

If you want the Financial Ombudsman Service to look into your complaint, you must contact them either after eight weeks have elapsed since you first complained to us or within six months of the date of any final response issued.

To be covered under the FOS scheme, you must be an eligible complainant, defined as a:

- Consumer (i.e. an individual)
- A charity with an annual income of less than £1 million
- A trustee of a trust with a net asset value of less than £1 million, or
- A micro enterprise.

The criteria for an entity to be considered a micro enterprise are:

a. employs fewer than 10 persons; and

b. has a turnover or annual balance sheet that does not exceed £2 million.

You can write to them at:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Alternatively you can telephone **0800 023 4567**.
You can also visit the Financial Ombudsman website at **www.fos.org.uk**

The Financial Ombudsman Service offers a free independent service and it can help with most financial complaints. However, there are some limitations on what the Financial Ombudsman Service can look into, and further information about this can be obtained from them directly.

Examples of a claim

How our claims process can work in practice

Case study 1

John, an Account Manager for a Telesales team

After the loss of a family member, John went absent from work. His GP diagnosed a bereavement reaction – then, after four weeks, amended this to a depressive illness and prescribed medication.

John's employer referred the case to the MetLife Claims Specialist, who arranged for an HCB specialist to visit John and discuss his situation. The visit highlighted that not only was John finding it difficult to cope with his bereavement, but he was also worried about going back to work and meeting his targets while not feeling 100%. John felt he needed more time off, supported by his GP, who was also discussing counselling – for which there was a six month waiting list.

The MetLife Claims Assessment team were concerned that this situation had the potential to progress from a short-term issue to one of longer-term absence, and took a proactive approach to help:

- The HCB specialist contacted the employer to discuss John's role and possible adjustments, and it was agreed that John could return without the expectations of sales targets for a set period.
- With agreement from John's GP, MetLife arranged immediate counselling.
- Counselling was followed up with work-focused Cognitive Behavioural Therapy (CBT), to provide John with life management and coping skills.
- The HCB specialist devised a graded return to work plan over 10 weeks - managing hours worked, tasks accomplished and goal setting.
- John successfully progressed to full duties and tasks.

The MetLife-funded CBT continued for four weeks after John's return to work, to provide him with longer-term, sustainable skills. All activity was completed within the deferred period.

Case study 1

Jane, a Production Operative

Jane works as a Production Operative on a food processing line in a factory. Her role involves a lot of repeated physical movements in just a few postures.

When Jane went to her GP with back and neck problems, he diagnosed mechanical back pain and advised painkillers as needed and rest.

Jane's employer referred the case to the MetLife Claims Specialist, who arranged for an HCB specialist to visit Jane and discuss her injury.

The HCB specialist found that Jane was finding it difficult to cope with the role and her normal daily activities. Jane believed that her role had caused her symptoms and a return to work would worsen her health.

The MetLife Claims Specialist team were concerned that Jane's situation could move from a short-term absence into something longer term.

Taking a proactive approach, the HCB specialist contacted Jane's employer to discuss her role and consider adjustments:

- A review was arranged to determine the true demands of Jane's job, and compare these with Jane's functional capacity. To achieve this, the HCB specialist arranged for a full workstation analysis plus ergonomic profile - and actioned a referral to gain an objective assessment of Jane's capacity.
- The specialist also encouraged Jane to ask her GP to refer her for a short course of physiotherapy to assist with core strengthening exercises. This was arranged within two weeks.
- The assessments showed that Jane had the capacity to start work part-time and build up her hours. It was also suggested that Jane would benefit from changing postures at work.
- The HCB specialist devised an eight-week return to work plan - and also provided Jane with guidance on how to manage her work tasks with a variety of movements and postures.
- Jane was back to work on 75% of her hours at the end of the deferred period.

MetLife paid the claim on a proportionate basis for four weeks, while Jane progressed to full hours.

0800 917 1222 **ebclaims@metlife.uk.com** **metlife.co.uk**

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