

**STATEMENT OF BEST PRACTICE
FOR
INCOME PROTECTION INSURANCE**

**Association of British Insurers
August 2003 (amended 14 January 2005)**

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Income Protection Statement of Best Practice - changes for regulation from 14 January 2005

1) Insurers need to include details of 'How to contact us in the event of a claim' within their IP Key Features document (KFD). This information should be inserted after the 'The deadline for claiming' text within the 'When will the policy pay out?' section.

2) If insurers want to adopt the Policy Summary approach rather than retain the current KFD format they will need to drop the Aim, Your commitment and Risk factors sections of the current KFD. Also, any content they provide in their KFD that doesn't meet the requirements of the Retail Customer Policy Summary table detailed in ICOB5 - 5.5.5 should be removed.

1. Introduction

1.1 The Association of British Insurers is the trade association for insurance companies in the United Kingdom. Of its more than 400 members around 200 transact long-term insurance business and they account for almost 100% of the life insurance and pension business written in the United Kingdom.

1.2 This revised Statement of Best Practice falls under the ABI Life Insurance (Non Investment Business) Selling Code of Practice, and covers the following:

- The description of Income Protection Cover in a Key Features Document
- Guidance notes for certain policy terms and conditions
- Generic Terms
- The review process.

1.3 The Statement updates part of the industry's response to the second report by the Office of Fair Trading (OFT) on Health Insurance, published in May 1998. It was developed by the ABI's Income Protection Working Party, which produced their original proposals following research to discover what consumers would find most useful as an aid to understanding and comparing income protection products. These proposals were validated by further consumer research and have been subject to wide consultation across the industry and with key external partners such as the OFT, the Financial Ombudsman Service (FOS), and others.

2. General Principles

Applicability

2.1 The Statement applies to income protection providers who are members of the ABI. From 29 February 2000, compliance with the Statement of Best Practice has been a condition of ABI membership.

2.2 This Statement applies to individual income protection policies. It is not intended for group income protection policies. However best practice for group income

protection is being developed by Group Risk Development (GRID) insurance industry contributors – see their website www.grouprisk.org.uk

Is Income Protection the right product for the applicant?

- 2.3 Before a potential applicant gets to the stage of applying for an income protection policy and, for example, comparing key features of different companies products they need to decide if income protection is the right type of insurance policy for them. A model leaflet, which companies may wish to adopt to help their customers come to an informed decision, has been issued at the same time as this Statement.

Products Covered by the Income Protection Model Key Features Document (KFD)

- 2.4 If the product is primarily income protection (which may or may not include waiver of premium) then the model KFD should be used. A similar format should apply to the following contracts with appropriate amendments:
- Housepersons policies (i.e. policies for housewives, househusbands etc.);
 - Expenditure related (e.g. mortgage) protection plans.
- 2.5 The Statement does not address policies which incorporate more than one health-related benefit (e.g. critical illness, private medical insurance or long term care insurance in addition to income protection). Nevertheless we recommend that insurers comply with the spirit of the Income Protection KFD when they print their product literature in respect of such policies in addition to the Statements of Best Practice that apply to these products. Protection plans classified as short term under the Insurance Companies Act are not included in the above. Combinations of income protection and unemployment insurance are covered by these provisions, but creditor insurance is not.
- 2.6 The Statement is based on the following concepts.

Clarity

- 2.7 Wherever possible to aid consumer understanding, the preferred wording of the Key Features Document will be in "Plain English" provided that this does not dilute or conflict with the meaning.
- 2.8 The intention behind the guidance notes is that policy terms/conditions should be as robust as possible in differentiating between what is, and is not, covered to:
- 2.8.1 Create a clear expectation of the scope and limitations of the cover.
 - 2.8.2 Allow valid claims to be paid promptly.
 - 2.8.3 Minimise the number of disputed claims to avoid disappointment.

Key Features Document

- 2.9 The requirements of the Key Features Document included in this Statement are in addition to (and, in the event of a conflict, are overruled by) any regulatory, legal, 3rd Life Directive and product specific requirements for Key Features.

- 2.10 The Key Features format is intended to ensure that income protection is described in a way that allows consumers to compare the income protection cover of different providers.

Providers should give Key Features Documents to enquirers and potential customers (via intermediaries as appropriate) at the earliest opportunity to allow them to make meaningful product comparisons before purchase. They may also wish to issue their version of the model leaflet to consumers. The KFD should be issued in addition to the company's marketing and quotation materials.

Implementation

- 2.11 The provisions apply to new policies effected on or after the implementation date adopted by the provider. An increment or increase to an existing policy effected after that date as a new policy may be excluded if it mirrors the original contract.
- 2.12 Companies are currently required to apply the 1999 Statement of Best Practice together with the revised 2001 Key Features document. The timetable for implementing the revised 2003 Statement of Best Practice and Key Features Document is **1 January 2004**.

3. Use of the Key Features Document

General

- 3.1 The model Key Features Document reproduced at Appendix A represents an industry standard template, and should be used taking the points below into account:
- 3.1.1 the front page and the left hand side (headings and subheadings) of the subsequent pages are mandated;
 - 3.1.2 the right hand side – the answers – on the second and subsequent pages are an example text. We recommend that you use this, subject to the qualifications that:
 - 3.1.2.a the wording accurately describes your product;
 - 3.1.2.b material in square brackets should only be used if it applies to your product;
 - 3.1.2.c amendments to the text can also be made to meet PPIAB or other guidelines on plain language. We have tried to incorporate the spirit of these guidelines in the Key Features Document, but brands may amend the text if this is necessary to gain PPIAB or other accreditation;
 - 3.2 Sections should only be omitted where they are inappropriate to the product (eg no relation of benefit to earnings on Housepersons products);
 - 3.3 Providers should ensure that the wording they use accurately describes the limitation of benefits. This may involve changes to the mandated wordings.
 - 3.4 Providers are permitted to use any presentational or print style as long as the order of the questions is the same.

Front Page Headings

- 3.5 The front page headings (“Its Aims”, “Your Commitment” and “Risk Factors”) are already mandated for regulated business. This is extended under this Statement of Best Practice to non-regulated business.

“Questions and Answers”

- 3.6 A brief guide to the key features of the product are given in the form of answers to questions. The questions provided in the Model Key Features Document should be adopted as standard.
- 3.7 Additional questions and answers may be included to describe any material features not covered by the standard questions and answers. Alternatively, such features can be included in the sections headed “What other benefits can I choose?” and “What other features are there?”

4 Use of the Guidance Notes on Policy Terms and Conditions

- 4.1 The guidance notes cover ten of the most important policy terms and conditions:

- Definition of Incapacity – Own Occupation (Appendix B1a)
- Definition of Incapacity – Any Occupation (Appendix B1b)
- Limitation of Benefit (Appendix B2)
- Proportionate/Rehabilitation Benefits (Appendix B3)
- Change of Occupation (Appendix B4)
- Claims Notification Period (Appendix B5)
- Deferred Period (Appendix B6)
- Waiver of Premium (Appendix B7)
- Pregnancy Clause (Appendix B8)
- Linked Claims (Appendix B9)

- 4.2 For each condition, the Guidance Note describes its purpose, the main features that should typically be covered by the policy wording, the insurer’s obligations to the consumer in describing their practice, and recommendations as to how the wordings should be applied.

- 4.3 For each term or condition included in a policy, the insurer should give proper consideration to the relevant guidance note. The practice of the insurer should be consistent with the guidance unless there is a good business case against such consistency, in which case the actual practice should be clearly explained.

- 4.4 Insurers should adopt these guidance notes when they next review the wording in their policy conditions. Insurers may choose to enhance cover retrospectively for customers with existing policies, but they are not obliged to do so.

5. Generic Terms

- 5.1 When generic terms are used, they should have the meanings shown and other terms should not be used in their place. This is to ensure that the terms always have the same meanings.

- 5.2 The generic terms are as follows:

Deferred Period

- 5.3 The meaning of this term is: “The period of incapacity before any benefit is paid.” Please note that terms such as “waiting period” and “elimination period” should not be used

Incapacity

- 5.4 The term “incapacity” should be used instead of the term “disability”, in particular as regards the definition of disability clause in the policy contract, which should be called the definition of incapacity clause.

Generic Product Name

- 5.5 The terms “Income Protection Cover” and “Income Protection” apply to this type of cover. Providers are free to use marketing names for their products and cover, provided that the cover is described either as: “Income Protection Cover” or by using the words “Income Protection”.

Model Exclusions

- 5.6 The following model exclusion wordings have been created for use by Income Protection and Critical Illness insurers.
- 5.7 Income Protection providers are free to omit or amend any of the model exclusions and may include additional exclusions.
- 5.8 The heading forms part of the model wording.
- 5.9 All exclusions and limitations (not only model exclusions) should be contained in one section of the policy (and key features, as set out above).
- 5.10 Providers should state which exclusions apply to which conditions in their policy (and other benefits as appropriate, e.g. Waiver of Premium Benefit) and should use an introductory policy wording to suit their individual policy style (see the example below).

Example introductory wording for policy exclusions

“ We will not pay an Income Protection claim if it is caused directly or indirectly from any of the following: “

Aviation

Taking part in any flying activity, other than as a passenger in a commercially licensed aircraft.

Criminal Acts

Taking part in a criminal act.

Drug Abuse

Alcohol or solvent abuse, or the taking of drugs except under the direction of a registered medical practitioner.

Hazardous Sports and Pastimes

Taking part in (or practising for) [boxing, caving, climbing, horse-racing, jet skiing, martial arts, mountaineering, off piste skiing, pot-holing, power boat racing, under water diving, yacht racing or any race, trial or timed motor sport.]

HIV/AIDS

Infection with Human Immunodeficiency Virus (HIV) or conditions due to any Acquired Immune Deficiency Syndrome (AIDS).

Self-inflicted Injury

Intentional self-inflicted injury.

War & Civil Commotion

War, invasion, hostilities, (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.

6. Review Process

- 6.1 This Statement of Best Practice, the Key Features Document and the Guidance Notes will be reviewed regularly to ensure they continue to reflect current legislative and regulatory requirements and market practice. The next review will take place, at the latest, by February 2004, subject to FSA proposals on regulating this product. It could, however, take place earlier if this proves necessary.
- 6.2 Changes to any of these documents which are recommended as a result of a review will only be made following consultation with the industry and interested parties.

ABI
2003

Income Protection

Model Key Features Document

This key features document gives you the main points about the income protection plan you're considering. It should be read with any quotation. Please read it carefully and keep it with your other plan documents.

This key features document follows the Association of British Insurers Statement of Best Practice for Income Protection Insurance.

Aims

- To give you a regular benefit if you suffer illness or injury leading to a loss of earnings. Your benefit can [replace some of the earnings you lose][maintain key items of expenditure][or, if you don't work, it can meet additional expenditure].

Your commitment

- To give us all the [medical and other] information we ask for when applying for your plan and when claiming benefit. If you don't do this we may not pay your benefit.
- To make all the regular premium payments we need for the length of the plan.
- [To tell us if you change your [occupation/job/duties] - or if you become unemployed - as required by company – see Change of Occupation].
- To tell us of any claim within the time limits we set.
- To select an appropriate level of cover and review it regularly to make sure you have enough for your needs but not more than we'll pay.

Risk factors

- You won't be covered if you stop paying premiums. [However, premiums are not payable when you're receiving benefit having made a claim].
- The cover may be less than you need if you don't review it regularly to keep it in line with your earnings. On the other hand if your income does not support your chosen cover, then your benefit will have to be reduced. We won't give you back any of your premium payments if this happens.
- The benefit we pay under the plan may affect your claim to some means tested State Benefits. Your entitlement to State Incapacity Benefit won't be affected.
- The benefit we pay under this plan may affect your claim to benefits under other income protection policies.
- State Benefit rules may change.
- The present tax-free treatment of the plan's benefits may change.

- [In future we may change the premium payments for people covered by these plans because of factors such as our claims costs and interest rates, but this won't happen for at least x years and we'll tell you beforehand.]
- [Certain causes of claim won't be covered (see When will the plan not pay out?)]

Questions and answers

What is a [Company] Income Protection Plan?

It is a plan designed to give you a regular benefit if you suffer illness or injury leading to loss of earnings. You select the features of the plan to make sure the cover is right for you.

- You decide:
 - the amount of benefit you require
 - how soon you need the benefit to start
 - [for how long you need the benefit to be paid,] and
 - for how long you want the cover to last.
- You pay regular premiums to keep the cover in force.
- We provide cover until your policy ends no matter how many claims you make.
- You tell us when illness or injury has stopped you working.
- We pay you a [monthly] income for as long as the claim is valid.

How do I select the plan's features so that it meets my needs?

This section deals with the choices you make when setting up your plan.

The amount of benefit that can be paid

You choose the amount of benefit you'll need.

Remember that tax and national insurance are deducted from your normal earnings but not from the benefits we pay you.

This means that you should not need benefit which is more than [50%] of your pre-incapacity earnings. This is the maximum percentage of your earnings which we'll pay out.

[We'll never provide benefit of more than [£ insert amount and terms and conditions], regardless of your earnings.]

See also the section "Other income which may reduce your benefit"

The earnings upon which to base your cover

When choosing your cover, remember that if you claim, we'll pay benefit based on your pre-incapacity earnings:

- *If you're employed*, these are your pre-tax earnings for PAYE assessment purposes [excluding benefits in kind] in the [insert number] months before you became unable to work;
- *If you're self-employed*, these are your share of pre-tax profit from your trade, profession or vocation after deduction of trading expenses, as described in Schedule D Case I and II of the Income and Corporation Taxes Act 1988, in the [number] months before you become unable to work.

[Explain treatment of fluctuating income if company specific.]

[We'll ask for evidence of your earnings]

Income received from savings and investments isn't taken into account.

Increasing your cover	<p>You may choose to increase your cover [company specific wording on contractual and forward underwriting options allowed] when you take out this plan.</p> <p>See also the section “the amount of benefit that can be paid”</p> <p>An appropriate premium increase will apply when your cover increases.</p> <p>[Explain company specific effect of declining an increase]</p>
Automatic increases to your benefit payments	<p>You may choose at the start of your plan for your benefit to increase each year [by a set percentage] [or] [in line with inflation] from the date on which any claim becomes payable.</p>
When benefit payments start	<p>There will be a period when you’re first unable to work for which we don’t pay benefit. This is known as the deferred period. You can choose between [1, 3, 6 and 12 months]. The longer the deferred period, the cheaper your policy will be. Benefit is paid (monthly) in arrears</p> <p>Your choice should allow for any earnings which you expect to continue after you stop working, such as sick pay, or how long you’re prepared to live on your savings.</p>
How long the benefits can be paid	<p>[company specific text to explain limited payment periods]</p> <p>Until the plan ends.</p>
How long the cover should last	<p>You choose for your plan to end when you think you would no longer need the benefits but no later than your planned retirement date.</p>
Medical and other details we may need	<p>Your application will include questions about your medical history, earnings, occupation and other personal circumstances. We may request additional medical evidence to support your application at our expense.</p> <p>[give details of Pre Existing Conditions/moratorium if applicable]</p>
[What other benefits can I choose?]	<p>[describe any optional company specific benefits]</p>
How flexible is it?	
<p>This section deals with choices you can make once your plan has started</p>	
Regular review of your cover	<p>You should consider how your earnings and living costs have changed since you last reviewed your cover.</p> <p>If you wish to increase your cover [by more than any automatic options provided by your plan], please contact us. It will be subject to a fresh assessment of your health, earnings, occupation and other personal circumstances.</p> <p>Your premium payments to us will increase.</p> <p>[company specific guidance for reduction in cover]</p>
Suspending your cover	<p>[Company specific rules to suspend/reinstate plans e.g. career and maternity breaks.]</p>
Change of occupation	<p>[You don’t need to tell us if you change your occupation after the plan starts.]</p> <p>[If notification needed, state requirements and consequences of not</p>

doing so.

When will the plan pay out?

When to claim	When you're unable to work, because of illness or injury, resulting in a loss of earnings.
The deadline for claiming	Tell us as soon as possible but [for deferred periods of 3 months or more] no later than [8 weeks from when you're first incapacitated]
The extent of incapacity	Our usual definition of incapacity is [company definition]. We'll tell you when you apply if we wish to use a different definition.
How we assess your claim	We'll look at the duties of your occupation, your ability to do them, [and whether adjustments can be made to help you do them]. We'll ask for evidence of your loss of earnings. [State also any other evidence required.] We'll then consider your ability to work in an alternative occupation You'll qualify for benefit if you're unable to [perform the essential duties of your occupation] [and any occupation to which you are suited by education, training or experience] resulting in a loss of earnings, and are not doing any other work.
How long the claim is paid for	Your benefit will be paid until the first of the following happens. <ul style="list-style-type: none">• you recover and are no longer incapacitated• you no longer suffer a loss of earnings• the term of the plan ends• [the benefit payment period ends - <i>company specific</i>]• you die.
Claiming again after returning to work	There is no limit to the number of claims you can make. You must restart premium payment when your claim ends so your cover is maintained. If you need to claim again for the same cause within [6] months of returning to work then the deferred period won't apply.
Returning to part time or less well paid work	In addition to the money you earn we'll pay you a reduced benefit, which takes account of your lost earnings. [Company specific: explain if this has to follow a period of full incapacity, any time limits on the benefit payments and if the formula is inflation proofed]
How benefits are paid	Benefits are payable [at the end of each month] from the end of the deferred period.
Premium payments when claiming	You should continue to pay premiums until we accept your claim. [However, you don't need to pay premiums to us while benefit is being paid.]

Other income which is likely to reduce your benefit

We'll reduce the benefit we pay if any of the following take you over the maximum allowable (which is explained in "The amount of benefit that can be paid"):

- Continuing payments from your employment - such as sick pay
- Pension payments - unless you were entitled to them while still working
- Other insurance benefits - if they arise because of your incapacity and either result in regular payments to you or make regular payments on your behalf - such as mortgage payments [or company specific wording]
- [Incapacity benefit from Social Security - company specific]

If your benefit is reduced we don't refund any of your premium payments to us and your cover remains unchanged unless you choose to reduce it.

We won't reduce your benefit if you receive:

- [Incapacity benefit from Social Security - company specific]
- Income support or other means tested state benefits. However, benefit payment from your plan may affect your eligibility for means tested state benefits
- Investment income

When will the plan not pay out?

Benefit won't be paid because of: [company specific conditions]

- [incapacity, due to or arising from, HIV or AIDS except when contracted in the course of your normal job]
- [normal pregnancy]
- [war and civil commotion]
- [self-inflicted injury]
- [criminal acts]
- [drug abuse]
- [failure to follow medical advice]

We may add other conditions in some cases. If so we'll tell you before you start your plan.

[If you claim and live outside of the [British Isles] benefits will only be paid for 26 weeks - company specific].

[You cannot claim just because you become unemployed. If you become unemployed your cover can continue - company specific]

[You cannot claim if you are not in [full-time] employment when you become incapacitated.]

What other features are there?

[describe any non-optional company specific benefits]

What will my premium payments be?

Your illustration will show the normal cost of the cover you have chosen.

Your premium payments depend upon your age, sex, occupation, smoking habits, medical history, other personal circumstances and

upon the level and features of the cover you choose. We'll tell you the actual cost you'll pay once we have assessed your application.

Payments to us are by [yearly cheque or monthly direct debit].

[Changes to your premium payments in the future]

[In future we may change the premium payments for people covered by these plans because of factors such as our claims costs and interest rates, but this won't happen for at least x years and you'll be told beforehand.]

[Where are my premiums invested?]

[company specific for investment-linked plans]

[Your plan will end and no premium refund will be paid.]

What happens to the plan if I die?

[Company wording about death benefits]

What are the charges?

The premium payments shown in your illustration include all the costs of administration, underwriting, claim and selling expenses [commission] and the fees payable for any medical examinations, which we ask you to attend.

Your plan and cover will end. [You won't get any money back.]

What if I stop paying premiums?

[Your plan has no cash-in value at any time]

Does the plan have a cash-in value?

[investment return if applicable with a warning that it will be a lot less than premiums paid]

What about tax?

Present UK tax law and Inland Revenue practice means you don't

- get tax relief on premiums
- pay tax or national insurance contributions on your benefits.

This may change in the future.


After [we accept your application or company specific] we'll send you a Cancellation Notice. If you don't want the plan, you will have [30] days to send this Notice back.

Can I change my mind?

How to contact us

[Remember your financial adviser will normally be your first point of contact. We won't be able to give you financial advice.]


If you have any questions at any time, you can phone, or send a fax or e-mail, or you can write to us.

 Call us on **0000 000 0000** during the following times:
Monday to Friday 0 am – 0pm


Saturday 0 am – 0pm

We may monitor calls to improve our service.

24 hour answerphone number – **0000 000 0000**

 Fax number – **0000 000 0000**

 e-mail address – **insurance@somewhere.co.uk**

 Office address
**Insurance Company, XYZ Street, Anytown,
Somewhere, SW1 1SW**

Other information

How to complain

If you ever need to complain, first write to us at the above address. If you're not satisfied with our response, you can complain to:

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

Complaining to the Ombudsman won't affect your legal rights.

Terms and Conditions

These Key Features give a summary of the <company name> Income Protection Plan. They don't include all the definitions, exclusions, terms and conditions.

If you'd like a copy of the full terms and conditions, please [ask your financial adviser or] contact us direct.

[We have the right to change some of the terms and conditions. We'll write and explain if this happens. We'll also send you a copy of anything that's changed. – *if applicable*]

Law

The law [and courts] of [England and Wales] will decide any dispute

Compensation

The UK Financial Services and Markets Act 2000 covers your plan. It is designed to protect you if we become insolvent.

Guidance Note on Definition of Incapacity - Own Occupation

Purpose

The definition of incapacity clause is a key factor in determining the validity of any claim. As such it will be examined by the discerning consumer to determine the product that will be purchased.

Typical wording content

Typical wording

Totally unable by reason of illness or injury to follow their own occupation(s) (as stated herein) and is not following any other occupation.

Key words/phrases

1. *Totally*
2. *Illness or injury*
3. *Own occupation(s)*
4. *(as stated herein)*
5. *any other occupation*

Insurers' Obligations

The insurer should make clear to the policyholder in Key Features Documents the principal characteristics of the definition of incapacity and the criteria on which it will be based.

Guidelines

The following practices are recommended:

1. *Totally*

Traditional industry practice has been to use the word 'totally', not in its literal sense (i.e. 100%) but to make it clear that partial incapacity is not covered. Previous Ombudsman guidance and case law supports this view.

Where 'totally' is used by the insurer, the Key Features Document should explain that the purpose is to distinguish this from partial incapacity and that a reasonable, non-literal interpretation will apply.

Some insurers have clarified the basis on which the person will be assessed by referring to the 'material and substantial' or 'essential' duties of a person's occupation. This is recommended where appropriate.

2. *Illness or injury*

The phrase 'illness or injury' or 'sickness or accident' helps the consumer in understanding that unemployment/redundancy or normal pregnancy are not covered conditions within the policy wording.

3. ***Own occupation***

There are two potential interpretations of the word 'occupation': the generic duties of a trade or profession, or the specific duties currently being performed. Insurers should make it clear which interpretation they will apply.

4. ***Stated Herein***

Some insurers use the words 'stated herein' in their policies. If they do so, and the policy does not contain a change of occupation provision, clear guidelines should be given about the occupation(s) against which claims will be assessed if the claimant has changed jobs in the interim.

5. ***And is not following any other occupation***

The purpose of this phrase is to ensure that a claimant who is unable to perform his own occupation does not receive benefit if he finds alternative employment and suffers no reduction in earnings.

Insurers should note the importance of the word 'and', as to use 'or' would change the meaning to an 'any occupation' wording.

There may be difficulty in assessing whether the claimant's 'new occupation' can be regarded as real work or is voluntary work, therapeutic work or even a hobby from which some income results. Insurers should be clear what criteria they will apply (i.e. would the work normally merit profit, pay or reward?).

Additional factors

If there are any supplementary claims conditions governing the validity of a claim (e.g. a requirement to participate in rehabilitation, a requirement to co-operate with reasonable workplace adjustment under the Disability Discrimination Act, or a requirement for continued medical supervision) this should be made clear.

Insurers should make clear in the Key Features Document that the availability of suitable employment is not a factor in assessing the claimant's ability to work.

Guidance Note on Definition of Incapacity – Any Occupation

Purpose

The definition of incapacity clause is a key factor in determining the validity of any claim. As such it will be examined by the discerning consumer to determine the product that will be purchased.

The 'Inability to follow Any Occupation' definition of incapacity carries with it stricter criteria for claiming than the other occupational based definitions. Policies with this wording are usually issued to policyholders who would find it impossible or prohibitively expensive to obtain insurance on one of the other, occupationally based, definitions of incapacity.

Typical wording content

Typical Wording

In July 2001 the ABI recommended the following specimen wording to reflect the work carried out by the Income Protection Working Party.

“Totally unable by reason of illness or injury to follow any occupation. This means that if after that injury or the onset of that illness there is an occupation that you are able to perform, irrespective of whether or not you do so, you will not receive payment”.

Key words/phrases

1. *Totally*
2. *Illness or injury*
3. *Any*

Insurers' Obligations

The Insurance Ombudsman has stated that, as with other definitions of incapacity, the insurer should make clear the principal characteristics of the definition of incapacity and the criteria on which it will be based.

Ombudsmen have expressed concern about this particular definition of incapacity as being the one most capable of being misunderstood by the proposer. There seems little doubt that the Ombudsman will find against insurers who fail to spell out the restrictive nature of this wording in their KFD or other documentation.

The 'Inability to follow Any Occupation' definition of incapacity may be offered to a proposer who originally applied for another definition which the insurer, for underwriting reasons, is not prepared to offer. In such circumstances the proposer will often have read a KFD describing another definition of incapacity. It is the insurer's responsibility therefore to draft its counter-offer such that the restrictive nature of this wording is explained.

Guidelines

The use of this wording must be interpreted and applied reasonably. Severely disabled people can often show tremendous resilience and motivation going to extraordinary lengths to perform an occupation. People who are virtually totally paralysed but who, perhaps, can type by using a specially designed typewriter that enables them to select the letter by use of their mouth, is such an example. It would be regarded as unreasonable to deny a claim under this definition in such circumstances.

The ability to work only in a sheltered working environment, limited to disabled people, is not a reason to deny a claim.

Similarly, a claimant who is severely disabled but could do an hour or so employment a day would nevertheless satisfy this definition of incapacity.

It is the ability to perform the occupation rather than the availability of that occupation that is the criterion that needs to be satisfied.

It is the responsibility of insurers to clearly state **credible** alternative occupation(s) that the claimant could perform, having determined his/her physical and mental capabilities. In some circumstances the insurer may consider it appropriate to offer help in the form of vocational assessment, re-training and preparation to return to work and this is likely to be viewed positively should any dispute arise over the claimant's ability to work.

Meanings

1. ***Totally***

Traditional industry practice has been to use the word 'totally', not in its literal sense (i.e. 100%) but to make it clear that partial incapacity is not covered. Previous Ombudsman guidance and case law supports this view.

Where 'totally' is used by the insurer, the Key Features Document should explain that the purpose is to distinguish this from partial incapacity and that a reasonable, non-literal interpretation will apply.

2. ***“Illness or injury.”***

The phrases 'sickness or accident' or 'illness or injury' help the consumer in understanding that unemployment/redundancy or normal pregnancy are not covered conditions within the policy wording.

3. ***“Any”***

The specimen wording is consistent with ABI guidance of 7 November 1997, which emphasised the need to clarify the context when the word "any" was used in policies defining disability.

Additional factors

If there are any supplementary claims conditions governing the validity of a claim (e.g. a requirement to participate in rehabilitation, a requirement to co-operate with reasonable

workplace adjustment under the Disability Discrimination Act, or a requirement for continued medical supervision) this should be made clear.

Guidance Note on Limitation of Benefit

Purpose

Insurers limit the level of benefit paid to claimants to a stated percentage of their pre-incapacity earnings and/or a maximum monetary amount. This is to ensure that the claimant is not better off financially on claim than in work (or, in the case of monetary maxima for housepersons, to restrict the benefit to a figure which meets the reasonable needs of the claimant), thereby preserving an incentive to return to former duties.

Percentages and benefit maxima vary considerably and are key factors influencing consumer choice. Higher percentage maxima may be accompanied by a greater tendency to offset other sources of income such as State benefits.

Typical wording content

Wordings stipulate that the benefit stated in the policy (as adjusted by any subsequent increases) will be subject to a maximum percentage of the claimant's pre-incapacity earnings and/or a maximum monetary amount. The basis upon which 'pre-incapacity earnings' are calculated is shown, and other sources of continuing income that may be offset against this by the insurer are listed.

Insurers' Obligations

This is a key clause that will influence the consumer's choice of product and determine the benefit they will receive in the event of a claim. As such, a full explanation of this clause must be given in the Key Features Document. In particular, clear information needs to be provided to the consumer on the following:

- (a) the percentage and monetary maxima applied;
- (b) how these maxima are affected by any subsequent benefit increases through indexation or increase options;
- (c) what constitutes 'pre-incapacity earnings';
- (d) what other forms of income might reduce the benefit paid and a warning to the applicant that if they have a policy with different benefit formula and intend to keep it in force they should consult the first insurer before taking out the new policy to clarify the potential impact of the second policy on their benefit entitlement and ensure that they are properly protected;
- (e) the tax basis used in the calculation of 'pre-incapacity earnings';
- (f) the tax basis on which benefit is paid;

- (g) what happens in the event of over-insurance (ie. benefit limitation/any return of premiums).

Guidelines

Monetary Maxima

The following practices are recommended:

1. It should be clearly stated that any monetary maximum applies to the aggregate of all Income Protection policies (including group policies) effected for the benefit of the policyholder with all insurers.
2. If the insurer wishes to take into account other forms of insurance (e.g. short term Personal Accident and Sickness, Critical Illness or Waiver of Premium) the policy classes in question should be clearly set out.
3. Insurers should liaise to achieve a fair and reasonable outcome for policyholders who are over-insured in a way that reflects the product design and pricing of the two or more products.
4. It should be made clear whether such maxima are adjusted or are subject to review in the light of inflation.

Percentage Limitations

The following practices are recommended:

1. The definition of “pre-incapacity earnings” should include:
 - (a) the basis for the assessment of earnings for the employed and the self-employed. The recommended practice is:
 - Employed: earnings for PAYE purposes;
 - Self-employed: share of profit for the purposes of Schedule D Case I and II of the Income and Corporation Taxes Act 1988 (ie. share of profit after deduction of trading expenses).
 - (b) whether the earnings calculation is based upon pre-tax or net income.
 - (c) the status of benefits in kind, bonuses, commission, drawings and dividend payments in the calculation.
 - (d) the period over which earnings are assessed and averaged.
2. A clear statement regarding the effect on benefit of:
 - (a) State benefits (Incapacity Benefit, disability related awards such as Industrial Injuries Benefit and Disability Living Allowance and means tested benefits such as Income Support). Insurers offsetting Incapacity Benefit should clearly state what rate is used ie. short term or long term, single person’s (and whether this includes age allowances) or full benefit (including dependants allowances). It should also be clear whether any Incapacity Benefit deduction is automatic or only applied if the claimant actually receives it. Finally, it should be clear how any subsequent change

in State benefit payments would affect the claim (eg. cost of living adjustments, withdrawal of an existing benefit or receipt of a new benefit).

(b) ongoing payments from the claimant's employer or business (including salary, commissions, bonuses and dividend payments etc.).

(c) pension payments.

(d) other insurance payments (what forms of insurance are covered, lump sum or income and whether this includes benefits such as creditor insurance or waiver where no payment is received by the claimant).

(e) compensation payments and court awards.

(f) income from savings or investments.

3. An indication of the evidence normally required as initial proof of claim, e.g. P60, audited accounts etc.

Guidance Note on Proportionate/Rehabilitation Benefits

Purpose

The purpose is to motivate claimants to return to work in a reduced capacity or to take up a new occupation. This is in the interests of both insurer and insured.

As a general rule, the expression 'proportionate benefit' applies to claimants who take up a new occupation, while 'rehabilitation benefit' applies to claimants who return to their own job. However, not all insurers differentiate between these two categories. It is also common for a number of insurers to restrict the period during which 'rehabilitation benefit' is payable.

As a general rule, policies using an 'own occupation' definition of incapacity would contain such provisions. However, those containing an 'any occupation' definition of incapacity are unlikely to contain such a wording as, *prima facie*, being able to return to work in any capacity would result in the definition of incapacity not being met.

Typical wording content

The wording will vary from insurer to insurer but the main features will be as follows:

After being on full benefit

Most insurers require the claimant to have been in receipt of full benefit before he is able to claim for a Proportionate/Rehabilitation Benefit. Others require there to be a period of 'full time' absence from work within the deferred period whilst some allow the benefit even if there has been no 'full time' absence from work.

When proportionate/rehabilitation benefits might apply

There are a number of different scenarios where a proportionate/rehabilitation benefit may be allowed because of continuing incapacity. These scenarios would include:

- (a) A return to work in the claimant's previous occupation but where there is some limiting factor, e.g. number of hours worked.
- (b) A return to work in a different occupation but with the same employer.
- (c) A return to work in a different occupation with a different employer. The latter would include becoming self employed or vice versa.
- (d) A therapeutic return to work or into sheltered employment where the objective is to provide rehabilitation back into the work place in the longer term.

Suffer a reduction in earnings

In order to qualify for payment as a valid claim, all claimants must be both medically unable to work to their normal capacity and demonstrate a financial loss. To qualify for proportionate or rehabilitation benefits, the claimant must continue to demonstrate a reduction in earnings. However many, if not most, insurers would allow some form of inflation proofing before applying this rule.

Proportionate/rehabilitation benefit claims can reduce to zero where, even though the claimant has been unable to fully resume their former occupation, their level of earnings is comparable to their pre-incapacity earnings. In these circumstances, most insurers would be happy to leave the claim open for a period equal to their linked claims period, to ensure that, should the claimant be unable to sustain this level of earnings due to the same or related cause of claim the claim can be re-activated without the need to serve a further deferred period. This is subject to any overriding time limitation on the rehabilitation benefit.

Calculation Formula

Some insurers give only the most general description of the way that proportionate or rehabilitation benefits will be calculated. Others give a detailed and prescribed formula.

Insurers' Obligations

The insurer has certain obligations as set out below:

1. Insurers should bring the policyholder's attention to the proportionate/rehabilitation benefits in the Key Features Document.
2. The word 'partial' should not be used, as it may imply payment of benefit when a person is partially incapacitated but still able to undertake his normal occupation.
3. Insurers who place a time limit on payment of proportionate/rehabilitation benefits should state clearly in the Key Features document the period of time for which the benefit may be payable.
4. Insurers who use a "switched" definition of incapacity should make it clear in the Key Features document whether eligibility for proportionate benefit is affected once the new definition is applied.
5. Insurers should make it clear in the Key Features document whether it is possible to be in receipt of proportionate benefit without having previously been in receipt of full benefit.
5. Those insurers who allow 'inflation proofing' of benefits should state in the policy documentation the method, and index, used to make the calculations.
6. Insurers should state, in the policy documentation, whether the proportionate benefit will be adjusted to take account of any loss of State Benefits on returning to work in a reduced capacity.
7. Insurers should state in the policy documentation for how long they will keep open claims without the need to serve a further deferred period, where the claimant is still not working to their former capacity but no payment is due because of the level of earnings being received.

Guidelines

This is one area where it is very difficult to provide guidelines that suit all likely circumstances. It is recommended that:

1. The Key Features Document should describe in what circumstances the policy provides for payment of proportionate/rehabilitation benefit.
2. The policy documentation should clearly set out how these benefits are calculated and in what circumstances they are payable.
3. As proportionate/rehabilitation benefits offer encouragement to return to the workplace, which reflects an important strand of government policy, insurers should consider these benefits when reviewing or redesigning their policies.
4. Recognising that it is in their own (and their policyholders') long term interest to facilitate a return to employment in some form, insurers should be prepared to adopt a flexible approach to proportionate or rehabilitation benefits in order to reach a financial agreement with the claimant to this end.
5. Subject to any time limitation on the payment of rehabilitation benefit, insurers should be prepared to keep open claims where the claimant is not yet working to their full capacity but no payment is due because of their level of earnings, for a period equal to their linked claims period, in order to avoid the claimant needing to serve a further deferred period where such earnings are not sustained due to the same or a related cause.

Guidance Note on Change of Occupation

Purpose

Some insurers have a requirement that policyholders notify them of any change of occupation (or in some cases change of occupational duties) during the currency of the policy. Any claim submitted by the policyholder will be at risk of being declined or reduced if the occupational risk category has changed and the insurer has not confirmed that cover continues.

Typical wording content

The wording will vary from insurer to insurer, and will range from those who require notification following a change of occupation, to those who require notification of any change of duty within the occupation declared at the outset.

Insurers may also vary in their attitude to stating the policyholder's normal occupation in the policy document.

Insurers' Obligations

The insurer has certain obligations as set out below:

Key Features Document

Those insurers who require notification of a change of occupation must make this requirement clear in the Key Features Document.

In particular there needs to be clarity over what constitutes 'change' and how 'occupation' is defined. For example, does the insurer need to know about a change to a job for which the original occupational title is no longer appropriate, a change of duties within the same occupation, a change of employer, or periods of unemployment?

The insurer should make clear the consequences to the policyholder of any change in occupation. In this context those insurers who change the definition of incapacity, regardless of whether they have a Change of Occupation clause within their policy, upon the policyholder becoming unemployed or taking up the role of a houseperson should set out such details.

Notifying the Policyholder of his obligations to advise Changes of Occupation

As income protection tends to be written on a long term basis, often without the need for the insurer to notify the policyholder of changes of premium and conditions on an annual basis, it is unreasonable to expect the insurer to periodically remind the policyholder of his obligation to notify changes of occupation.

However, where the insurer periodically writes to the policyholder because of the need to review premium rates or to increase premiums or benefits, it should bring to the policyholder's attention his duty to notify any change of occupation.

Guidelines

Re-underwriting during the Currency of the Policy

The insurer has the right to re-underwrite the risk upon receiving notification of change of occupation. However, such re-underwriting should be confined to the circumstances arising as a result of the change of occupation/duties and should not seek to address any change in other risk features (e.g. health status) of which the insurer may have become aware.

For those insurers who only require notification of change of occupation (as opposed to changes of duties), any changes to duties, change of location or change of employer should not result in re-underwriting.

Those insurers who require notification of change of duties, and who have brought this to the policyholder's attention, may re-underwrite as above on changes of duty but such insurers should have internal procedure notes to ensure a fair and consistent approach.

When determining whether an additional premium is payable or indeed whether cover can continue, the insurer should look to the occupational class that the 'new' occupation would have been placed in at the inception of the policy. Insurers should not change premiums or alter cover merely because their underwriting approach to a particular occupation has moved it from one class to another since the policy commenced.

If the insurer requires notification of change of occupation to be done within a certain period, the guidance note on Claims Notification Periods should be followed.

Claims without a prior notification of a change of occupation

Insurers should follow these guidelines in the event that the first notification of a change in occupation (or occupational duties) is made at the claim stage:

1. If the change of occupation is one that is unacceptable to the insurer, it has the right to refuse the claim.
2. If the change of occupation is one that would only be acceptable to the insurer on a 'harsher' definition of incapacity, then that 'harsher' definition will be applied.
3. If the change of occupation is such that the policyholder remains in the same occupational class as before then cover and level of premiums should continue unchanged.
4. If the insured has changed from one occupation class to a 'worse risk' occupational class, the amount payable will be determined by the application of the principle of proportionality: namely that proportion of the annual benefit otherwise payable as the premiums paid bear to the premiums that should have been paid. The insurer must determine the premium basis to be used, e.g. gross premium, risk premium, etc.

5. If the policy states that the definition of incapacity shall change because the policyholder has become, for example, unemployed or a houseperson then the insurer shall adjudicate the claim against the changed definition.

All the above shall be subject to satisfactory proof of claim to the insurer and to any restrictions in payment that may be imposed because of the application of another policy clause such as a Limitation of Benefits clause.

Premiums in respect of claims without a prior notification of change of occupation

The following guidelines should be followed:

1. If cover is declined, the insurer should refund the premiums from the date of the change of occupation.
2. Similarly, if the insured has moved from an occupational class to a 'better' occupational class, he shall be entitled to a refund of any 'excess' premiums paid.
3. However, in the event that the policyholder has changed to a 'worse risk' occupational class, it is not appropriate that he should be asked to pay any additional premiums with effect from the date of change of occupation. The remedy is, as described above, a proportionate reduction in the benefit that might be payable.
4. In all of the above, interest is not payable (although this is at the insurer's discretion).

Guidance Note on Claims Notification Period

Purpose

In order to improve claims handling effectiveness, insurers ask for notification of a potential claim prior to the date on which the claim becomes eligible for payment. Traditionally, claims notification was requested shortly before the expiry of the deferred period, allowing sufficient time for the necessary claims administration procedures to be completed prior to the determination of the claim. In recent years, however, insurers have requested earlier notification, in order both to be proactive in assisting the claimant to return to work, where possible, and to ensure that valid claims are paid without delay.

Typical wording content

Such policy wordings have the following main features:

- (a) A stipulation as to how the claim should be notified (e.g. in writing).
- (b) A time limit for notification of the claim. This may be fixed by reference to:
 - (i) a designated period from the onset of incapacity, or
 - (ii) a designated period prior to the expiry of the deferred period.
- (c) A time limit may also be stipulated for the return of a claims form following the initial notification.
- (d) A description of the consequences of not observing these time limits, e.g. failure may postpone the claimant's eligibility to claim by the length of the delay unless the office is satisfied that failure to do so was no fault of the claimant.

Insurers' Obligations

The claims notification period should be included in the Key Features Document. Additional product literature must also be clear about the time limits to be applied by the insurer and the consequences of their not being followed.

Guidelines

The ABI Statement of Long Term Insurance Practice states: 'Under any circumstances regarding a time limit for notification of a claim, the claimant will not be asked to do more than report a claim as soon as reasonably possible.'

It is therefore recommended that the following guidance be given to policyholders as to when notification of a potential claim should be given:

'Please notify us as soon as you believe that you may wish to claim, but in any event:

- (a) within a claims notification period of 8 weeks from when first unable to work for deferred periods of 13 weeks or more;
- (b) within a claims notification period of 4 weeks from when first unable to work for a deferred period of 8 weeks;
- (c) within a claims notification period of 2 weeks from when first unable to work for a deferred period of 4 weeks.'

The claim should be paid from the end of the deferred period if the policyholder is able to satisfy the insurer that, in the circumstances, the delay was not unreasonable.

Guidance Note on Deferred Period

Purpose

The purpose of a deferred period is to both reduce claims costs to the insurer and premiums for the insured by eliminating claims during the deferred period. The period chosen may be influenced by any occupational sick pay arrangements.

This reduction in costs results in a smaller premium as the policyholder effectively self funds for his sickness needs during the deferred period.

Typical wording content

There are two ways of approaching such wording with the majority of insurers using the first:

- (a) To make it a requirement that the absence from work during the deferred period must be continuous.
- (b) To express the deferred period as a total of X weeks' absence during Y weeks.

Using the second format, the claimant has the opportunity of adding together a series of absences over the stated period and, once he reaches a certain figure, he may make a claim.

Insurers' Obligations

Insurers should include in their Key Features Documents the choice of deferred periods available with a clear explanation of how the wording works. The explanation should include information as to when claim payments are made and, if incapacity does not need to be continuous, the qualification criteria (e.g. X weeks in Y weeks) should be explained. Insurers should explain when benefit becomes payable after the deferred period.

Guidelines

Possibilities for claims disputes include the following scenarios:

- (a) The claimant makes an attempt to return to work during the deferred period, is unsuccessful, and in consequence potentially fails the requirement for the absence to be continuous.

Generally it is unfair and unreasonable for the insurer to penalise a claimant for an unsuccessful but genuine attempt to return to work.

- (b) There may be a requirement that a single cause of incapacity precludes the claimant's ability to work. This may occur particularly in conjunction with the approach outlined at (b) under 'Typical wording content' above.

The insurer should apply a test of reasonableness. Two distinct causes of incapacity may well strictly fail such a requirement but illnesses can be interconnected and diagnoses can be imprecise on occasions.

Name of Clause

Insurers currently have different names for the clause described in this guidance note. However, when comparing products across the healthcare range, consumers can be confused where one clause can have different meanings, or where several terms have the same meaning. The expression 'deferred period' should therefore be used for the purpose described in this guidance note and for no other purpose. Other terms, such as 'waiting period' or 'elimination period' should no longer be used to describe this clause.

Guidance Note on Waiver of Premium

Purpose

As a further contribution towards supporting the policyholder in times of financial difficulty, most insurers agree to waive premium payments during periods of incapacity. The main exceptions to this rule are the Friendly Societies who instead provide profit sharing schemes for their members. In addition, some insurers provide a facility whereby premiums can be waived for career break purposes (a maximum period may be stipulated).

Typical wording content

Such policy wordings have the following main features:

- (a) A definition of incapacity governing eligibility for Waiver.
- (b) The length of the deferred period before becoming eligible for Waiver.
- (c) The level of premium waived. There are two main alternative approaches:
 - (i) any premium falling due whilst the main benefit is being paid is waived; or
 - (ii) a refund of premiums is made proportionate to the period of claim.

Insurers' Obligations

The insurer has certain obligations as set out below:

1. The availability of Waiver should be included in the Key Features Document. Additional product literature must be clear about the level of premium waived, particularly whether any of the benefit criteria differ from those applying to the payment of the main benefit and whether the clause will continue to operate during periods of proportionate or rehabilitation benefits.
2. The insurer must make it clear in the policy document, in respect of policies with increasing or reviewable premiums, the level of premium that will be waived.

Guidelines

The definition of incapacity for waiver should be no stricter than that applying to the main benefit.

For guidance on 'definition of incapacity' and 'deferred period' see elsewhere in these guidance notes.

Guidance Note on Pregnancy Clause

Purpose

Some insurers operate a pregnancy exclusion. This has two main purposes. It first of all emphasises that pregnancy in itself is not a valid cause for claim. Incapacity must be related to illness or injury. Secondly, it defines normal pregnancy as including a recovery period after birth or other termination.

Typical wording content

Practice varies considerably but can be summarised as follows:

- Some insurers have no pregnancy exclusion.
- Some insurers exclude only the term of the pregnancy itself (not the recovery period).
- Some insurers exclude both the pregnancy and the recovery period (which is generally 3 months but can be up to 6 months).
- Some insurers extend the exclusion to cover 'complications of pregnancy' as well as the pregnancy itself. The effect of this is that anyone with medical incapacity arising from complications of pregnancy has to go through the recovery period and then the normal deferred period before they become eligible for benefit.
- Some insurers will not cover complications of pregnancy at all.

Insurers' Obligations

The presence of a pregnancy exclusion should be brought to the applicant's attention in the Key Features Document.

Guidelines

Whilst there may be some merit in excluding normal pregnancy (to avoid any misunderstanding over what is or is not covered), it is recommended that any medical complications should be covered.

In considering this recommendation, insurers should be aware of the 1998 Equal Opportunities Commission (EOC) ruling regarding similar exclusions on Creditor Insurance policies, where the Commission deemed the blanket exclusion of pregnancy claims to be discriminatory to women under the Sex Discrimination Act.

The EOC did not dispute that insurers needed to exclude claims arising from normal pregnancy. However, they were concerned that claims relating to complications arising from pregnancy should be covered. As a result of this, Creditor insurers agreed a new exclusion clause with EOC allowing claims for 'complications arising from pregnancy, subject to the policy's general conditions relating to payment of benefits, which are diagnosed as such by a doctor, or consultant, who specialises in obstetrics'. The 'general conditions' referred to above effectively state that cover is only provided where the person is working or, where applicable, on statutory maternity leave.

Consequently, it is recommended that insurers should:

- (a) cover claims arising from complications of pregnancy diagnosed by a doctor, or consultant, who specialises in obstetrics.
- (b) cover such complications from the date on which they become incapacitating i.e. without any extension of the standard deferred period.

Guidance notes on Linked Claims

Principle

The Linked Claims Clause is intended to encourage claimants to attempt to return to work by eliminating the need for a second deferred period if they suffer from the same disability within a specified period. It is designed to apply to the period following a full time return to work but similar arrangements may apply to some proportionate/rehabilitation claims (see Appendix B3).

Construction of the wording

A typical wording will cover the following points :

- Subsequent period(s) of incapacity must result from the same or a related cause.
- The Linked Claim period commences on the first day of return to work and will be effective for typically six or twelve months.
- The number of occurrences which can be linked for the purposes of a claim.

Insurers' Obligations

A Linked Claims Clause is a valuable safety net for claimants who attempt to return to work. Insurers should make it clear in their Key Features Documents how it works and its relevance to claimants.

If this clause is not offered, the Key Features Document must state that a further deferred period will apply.

Guidelines

- The insurer should remind the policyholder of the Linked Claims Clause when a claim is first assessed, periodically thereafter and, most importantly, if rehabilitation is undertaken.
- Usually, the Linked Claims Clause will require that subsequent periods of incapacity must result from the same or related condition. It is recommended that proper regard should be had to appropriate medical opinion when determining whether conditions are related.
- Rehabilitation is an increasingly important part of claims management, potentially reducing claims costs and returning the claimant to active employment and a better level of income. The insurer should not penalise the claimant financially by assessing the benefit on the level of earnings immediately prior to the linked claim and should also give regard to the claimant's earnings before the initial period of incapacity.