AVIVA

Retirement
Investments
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Health

Individual protection claims report

Spring 2017

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Introduction

"The following pages provide an insight into our claims payments and processes, of which we are proud. Our starting point for all customers who contact us is that we want to pay their claim and to pay it quickly."

At Aviva we know the vital role that protection insurance plays in helping individuals and their families during some of the most difficult times in their lives. Our customer teams hear on a daily basis just how helpful such insurance can be, from the customer just diagnosed with advanced cancer who realises she no longer has to worry about how to pay off her mortgage, to the customer who's now ready to return to work, after a period of significant illness, having benefited from our rehabilitation service.

Unfortunately we also know that too great a proportion of people don't have any protection in place to help them financially in the event of serious illness or death. Amongst families with dependent children, 76% of parents have no plan for dealing with lost income due to ill health, while 68% have no plan for dealing with their own death or that of their partner.[1]

Misguided beliefs that protection insurance is unaffordable, that it doesn't pay out when you need it, and that it won't happen to me, all play a part in the lack of financial protection amongst UK families. Although the UK protection industry has made good progress in attempting to dispel these beliefs, particularly through the publication of how many claims are paid, there's always more that we can do.

This report sets out the reality of just how many individual life insurance, critical illness and income protection claims were paid by Aviva last year (2016) and the demographic profile of those customers we have helped and their reasons for claiming.

At the same time, we also outline the small proportion of individual protection claims that we were not able to pay, and the reasons why. We understand that if a customer is ill and experiencing a very difficult time there will be calls to 'just pay the claim'. While we will always try to do so, there remain occasions when just paying is not the right thing to do for the sake of fairness to all our customers.

The following pages provide an insight into our claims payments and processes, of which we are proud. Our starting point for all customers who contact us is that we want to pay their claim and to pay it quickly.

We highlight the key considerations we undertake when assessing a claim, our commitment to treating customers fairly and consistently, what customers can expect of us during the claims process, and how our dedicated rehabilitation team offers on-going and invaluable assistance to those income protection customers who are unable to work through illness or injury.

Finally, we hear from some of our customers, whose personal stories are more powerful and thought-provoking than any set of numbers can be.

Paul Brencher
Managing Director, Individual Protection, Aviva

1. Aviva Protecting our Families Report (March 2017)

Key figures

Individual protection claims paid in 2016

+£870 million in 2016

More than **£870 million paid** to UK families in 2016

£2.4 million paid every day

Equivalent to **£2.4 million** paid every day to individual life, critical illness and income protection customers and their families – or **£1,650 every minute**

23,000 customers

More than **23,000 customers** and their families benefitted from individual protection payments

Number of customers claimed	Life insurance (including terminal Illness)	Critical illness (including child critical illness and total permanent disability)	Income protection	Total
	15,525	4,268	3,549	23,342
Benefit paid out	£522m £522,231,139	£311m £311,014,411	£37m £37,032,927	£870m £870,278,477

Our consistent track record in paying claims

	% of life insurance claims paid (inc: terminal illness)	% of critical illness claims paid (inc: child critical illness and total permanent disability	% of income protection claims paid	Total individual protection claims paid out
2016	98.9%	92.3%	92.6%	£870m £870,278,477
2015	98.9%	92.5%	92.4%	£839m £839,913,503
2014	98.9%	93.2%	93.2%	£781m £781,989,954

Note: All data concerning the claims we paid in 2016 include all Aviva and Friends Life Individual Protection policies that are now managed by Aviva.

Life insurance
and terminal illness benefit

WHAT WE PAID IN 2016

Life claims paid (Life insurance and terminal illness benefit)

15,525

customers and beneficiaries

Amount paid out:

+£522 million

£522,231,139 which is not far short of the total government expenditure (£569 million) on bereavement benefits in 2015–2016[2]

Average payout:

£33,638

98.9%

of all life insurance and terminal illness claims were paid

What is life insurance?

A life insurance policy pays out an amount of money when the person covered dies. While the specifics of a policy can vary, they generally fall into one of the following types:

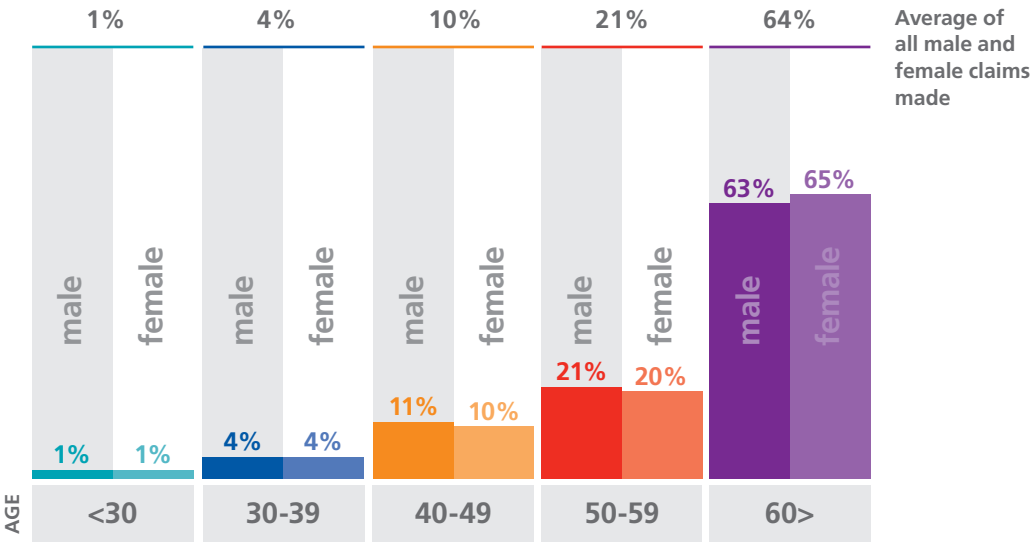
- Cover for a specific amount of time, for example 15 or 20 years, where the policy pays out if the person covered dies within that period of time.
- Cover for the whole of life, where the policy pays out whenever the person covered dies.

Within these two types of cover, it is also possible to choose different cover types:

- Level cover, where the amount paid out stays the same
- Decreasing cover, where the amount paid out decreases over time
- Increasing cover, where the amount paid out increases over time.

Terminal illness benefit is often included within a life insurance policy and is there to help customers who have been diagnosed with a terminal illness and who have less than 12 months to live. In these circumstances, the life benefit is paid out to help the customer sort out their financial affairs before they pass away.

2016 Age at which life insurance and terminal illness claims were made
%

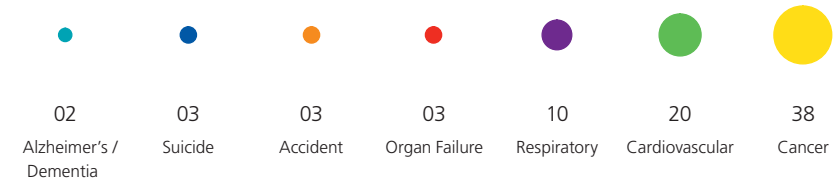


2. Department for Work and Pensions 'benefit expenditure and caseload tables 2016' Outturn and forecast: Autumn Statement 2016. Total expenditure on bereavement benefits for 2015/16: £569 million.

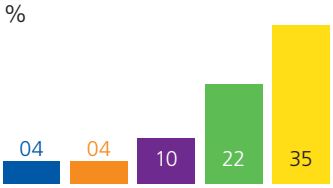
Life insurance and terminal illness benefit
Continued

Most common conditions for life insurance and terminal illness benefit claims:

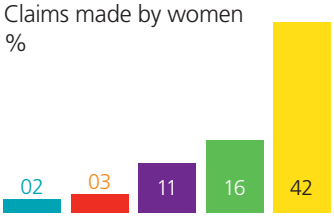
All claims made
%



Claims made by men
%

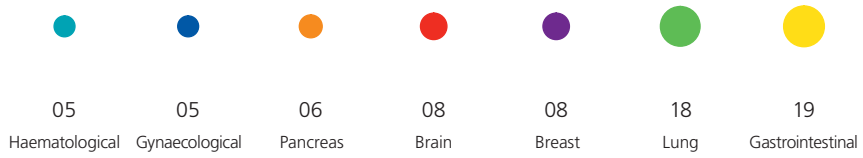


Claims made by women
%



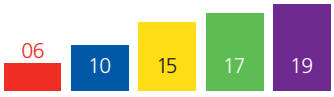
Gender differences in the most common cancer types for life insurance and terminal illness benefit claims:

All cancer claims made
%



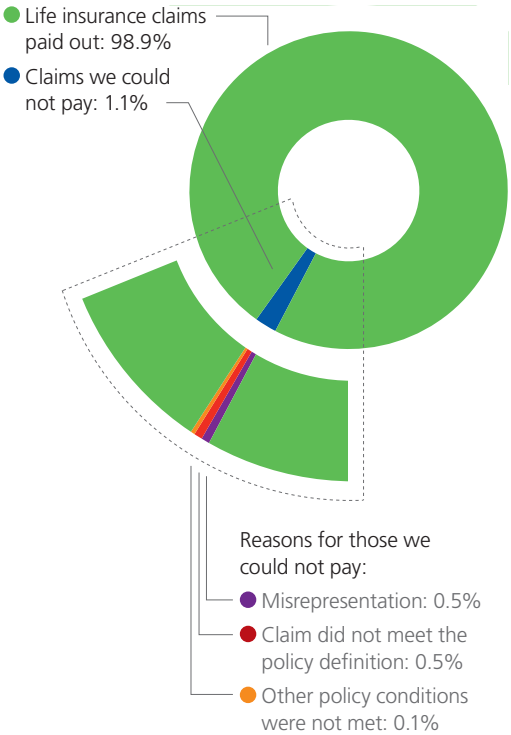
Claims made by men
%

Claims made by women
%



When we can't pay out

We want to pay as many claims as possible and with life insurance, declining a claim is unusual. In 2016 just 1% (or 164) of all our life insurance and terminal illness benefit claims were declined.



The following are the main reasons for declining a claim:

- The customer did not make accurate statements about their health and lifestyle when they applied for the policy, which would have affected our ability to offer them cover. This is known as a misrepresentation of the facts.
- The policy definition was not met, for example a customer who has received a terminal diagnosis but won't be eligible for a payment until their prognosis meets the 12 month criteria.
- Suicide in the first year of the policy.

Common errors that may lead to a claim being rejected for misrepresentation

Just under half of the small number of claims that we are unable to pay are on the grounds of misrepresentation, where customers applying for life insurance withhold information during the application process which would have affected our decision as to whether we could provide cover.

While omissions or inaccuracies may not be deliberate, it is important that customers thoroughly check the accuracy of the information they have provided when their documentation is issued during the application process.

Errors commonly occur with the following customer information:

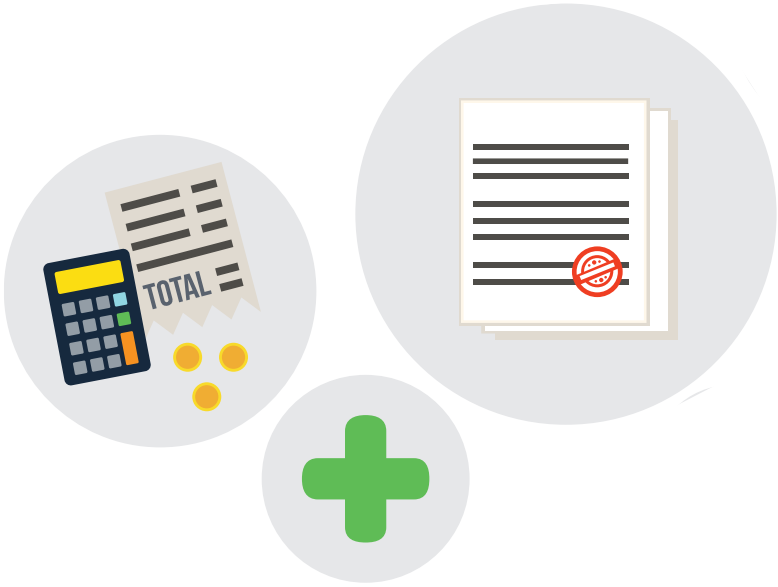
- their correct height and weight, from which we calculate body mass index, in order to assess the likelihood of them suffering from a range of life-threatening conditions in the future.
- their drinking and smoking history.
- their general health including mental health.
- any family history of specific medical conditions of illnesses.

Common misconception around the purpose of terminal illness benefit

The number of claims made for terminal illness benefit has been steadily increasing in recent years, which may be due to a combination of factors such as increased life insurance sales, increased awareness of this benefit, and more customers living longer with a terminal diagnosis due to medical advances.

However some customers confuse terminal illness benefit with critical illness cover and seek to use their terminal illness benefit to help them with treatment or make adaptations to their home, rather than for the purpose it was designed for, which is to help get their financial affairs in order when their life expectancy is less than twelve months.

"Almost all life insurance claims are paid: we paid 98.9% in 2016."



Critical illness cover

WHAT WE PAID IN 2016

Critical illness claims paid[3]:

4,268

customers

Amount paid out:

+£311million

£311,014,411

Average payout:

£72,871

92.3%

of all critical illness claims were paid

What is critical illness cover?

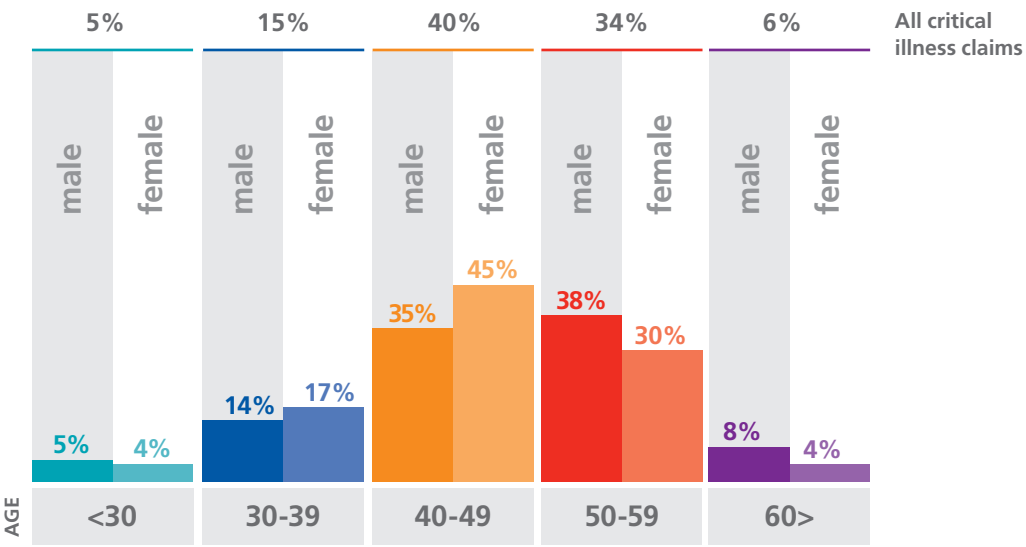
Critical illness cover is a policy that pays out an agreed cash sum if the person covered is diagnosed with a critical illness as defined by the policy's terms and conditions. Such payments can relieve the financial burden of having a serious illness so that customers can concentrate on getting better.

Policies usually offer cover for a specific amount of time, for example over the lifetime of a mortgage, often around 20 years, and will pay out if the person covered is diagnosed as having one of the defined critical illness within that time.

Cover can be level, where the amount that would be paid out stays the same over the time of the policy; decreasing, where the amount to be paid decreases over time; or increasing, where the amount to be paid out increases over time. Critical illness cover is available as a standalone policy or in combination with life insurance cover.

Many policies include children's benefit, which will also pay an agreed cash sum if any dependent children are diagnosed with a children's critical illness covered by the policy, or if they were to die during the policy term.

Critical illness claims by age and gender
%

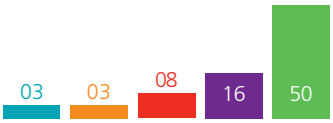


3. Critical illness claims paid data includes critical illness, child critical illness and total permanent disability claims.

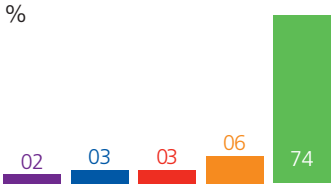
Most common reasons for critical illness claim:

All claims made
%

Claims made by men
%



Claims made by women
%

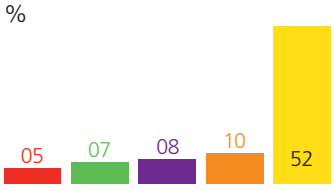


Gender differences in the most common cancer types for critical illness claims:

All cancer claims made
%

Claims made by men
%

Claims made by women
%



Critical illness cover
Continued

Child's critical illness claims

In 2016, Aviva paid out **£3,256,832** to customers whose children had been diagnosed with a defined critical illness or condition, supporting them at a really difficult time.

The average value of children's benefit paid was £17,994.

Top 5 reasons for Child critical illness claims
% of child benefit claims

Haematological Cancer	30%
Benign Brain Tumour	13%
Brain Cancer	6%
Major Organ Transplant	5%
Bacterial Meningitis	4%

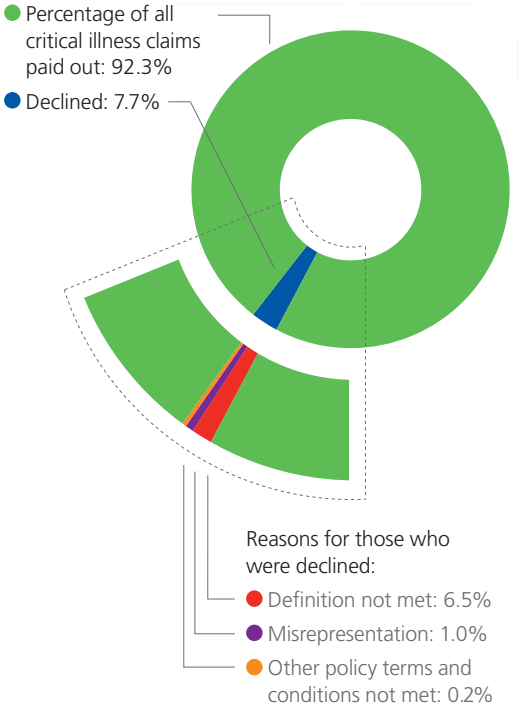
Child benefit paid in the last three years*

(*combined Aviva and Friends Life claims)

Year	Total benefit paid
2016	£3,256,832
2015	£2,312,435
2014	£2,505,651

We might not be able to pay every claim our customers ask us to consider, but for each claim request received we do start out with the principle that we want to find a way to pay. As such, our claims processes aim to obtain the necessary information to prove the claim is valid, but there are some reasons in a small number of cases why we might not be able to pay.

When we can't pay out %



Definition not met

In order to offer competitively priced critical illness cover at the point the policy is taken out, insurers set out clearly in their product literature which specific illnesses or surgeries are covered and the circumstances in which they do and do not result in a claim payment.

For the industry as a whole, it is not possible to cover all conditions that might be considered 'critical' in a wider sense, as the associated premium levels would discourage people from taking out valuable cover. The balance the industry takes is one where insurers are able to provide significant benefit to customers in times of commonly experienced critically ill health, in an affordable way.

At Aviva we regularly review our current critical illness cover against medical advances and feedback from customers about conditions they have which are not covered. This can result in new conditions being added to future versions of the cover, or changes being made to the criteria required in order for a claim to be valid for conditions where medical advances have improved outcomes.

The terms of each policy are shared very clearly and agreed at the outset, with pricing set accordingly. It is not possible to change the cover on customers' existing policies at any later point of claim.

We understand that when customers are faced with a diagnosis of a serious illness, reviewing a list of conditions covered or not covered by their policy won't be at the top of their list of things to do. If a specific diagnosis is not covered by the policy, we do make every effort to see if we can pay a claim under any other policy cover, for example Total Permanent Disablement either now or in the future.

Misrepresentation

A small number of claims could not be paid because of misrepresentation during the application for the policy, meaning customer statements about their health and lifestyles were not accurate. While this may not have been deliberate, the terms and pricing of policies are decided based on the answers given by the applicant at the time.

We try to minimise the impact of customer misrepresentations. Where we find that incorrect or incomplete information was provided, we carefully consider how that might have happened. It is only on rare occasions that we find evidence that information was deliberately withheld that would have altered the terms we offered. In these cases the policy has to be cancelled with no claim payment.

Where we find the inaccuracy is reasonable or that a simple mistake is the most likely explanation, we will consider what would have happened had we been given the correct information at the time. This might mean making a reduced claim payment to take into account the percentage of the correct premium that has been paid, or that a claim payment cannot be made at all because the circumstances of the claim would have been excluded from the policy's cover at outset.

We do not regularly request reports from GPs to check applications. We only look into the relevant medical history of a claimant where the circumstances of their claim raises a concern about the accuracy of the information provided during their application. Examples might include a customer who stated they were fit and well on their application then shortly after made a claim for a serious illness that is known to develop over time; or a customer diagnosed with a condition which is significantly more prevalent in smokers or those with a family history of the same condition who had not disclosed either of these factors when taking out cover.

Treating all customers fairly

We treat all our customers fairly with conclusions on payments of claims applied consistently for all customers. Regulations also require a fair and consistent approach and as such we are unable to pay on a claim that does not meet the policy's terms and conditions whilst also declining to pay on another claim under equal circumstances.

Critical illness cover
Continued

Chris's story

Chris, who was diagnosed with a rare form of bowel cancer when she was 54, recalls the moment her worst fears were confirmed.

"It was a long and difficult day with lots of very raw emotion," she said.

"When you receive the news, you worry about everything. I worried about my family, how would they cope with the news? I worried about my work as I work for a small company and didn't want to let them down.

"I worried about myself, would I be able to make a full recovery and still be able to take my dogs on long walks? Would my husband and I still be able to go scuba diving together?"

It wasn't until after surgery to remove part of her bowel that, in January 2016, Chris looked at her critical illness policy with Aviva to enquire about a claim. She had set the policy up through her financial adviser in order to pay off their mortgage if she was ever to become critically ill.

"When I took out the policy, I was the main breadwinner and I was very conscious that if something went wrong health wise we would not be able to afford to pay the mortgage," she explained.

"I hadn't told anybody at all about the policy. Not even my husband knew anything about it.

"On the day that the funds were actually there I remember jumping up from my chair and my husband walking past at the time and saying "you look like you've found fifty quid" and I said "well actually let me tell you a story.

> "You never know what's around the corner but following the operation, I'm lucky enough to have now made a full recovery so I'm able to look forward again."

"It was all sorted really quickly with no stress. It was reassuring to know that whatever happened, the finances were taken care of allowing me to concentrate on getting better.

"It just gives you that piece of mind at the time when you really seriously need some support, that you're not going to end up worrying about money as well as all the other things that are going on in your life at the time.

"You never know what's around the corner but following the operation, I'm lucky enough to have now made a full recovery so I'm able to look forward again.

"This whole experience has changed the way I am. Now there's more emphasis on doing the right things; travelling and seeing people and doing what's important in life after having quite a big negative that's behind us."

Our claims approach

Carl, one of Aviva's Technical Claims Managers with more than 12 years experience, offers an insight into our individual protection claims team.

"I feel privileged to perform the role I do, as every day I get to see the difference we make in people's lives and just how much our claims assessors care about the job they do for our customers. People often think our job is about saving money by paying as few claims as possible. That couldn't be further from the truth.

"Each claim that comes to us is treated with respect and with the aim of paying. For a critical illness claim we typically offer the customer the opportunity to discuss their claim over the phone, as speaking directly to the assessor about their claim helps both parties to get the information needed.

"While my colleagues and I deal with claims every day, we know that for our customers it's likely to be their first time. Our assessors answer any questions and talk to customers about the process, what cover they actually have with us, the best way to get the supporting medical details that we need, and when they'll next hear from us.

"When we consider a claim my colleagues and I always have in mind what is in the best interests of the customer. We're also continuously looking for ways to gather the information we need more efficiently, to make things easier for customers and to reduce the time it takes to make a decision and to pay valid claims.

"For example, we now take necessary payment details during the initial phone call, so customers don't need to worry about further paperwork and we can activate a payment as soon as we've received evidence to support the claim. We're also working with customers and other organisations to understand how we can gather evidence elsewhere, rather than waiting for busy Consultant Specialists to send us reports.

"We've recently extended our opening hours to ensure customers can speak to us at a time that works for them, which might be at the weekend or in the evening after traditional office hours.

"Feedback that we seek from all our claims customers includes stories of how their lives have been changed by their conditions and the service we've provided at difficult times in their lives. I'm always thrilled to see positive comments, but in some ways I learn more from those rarer occasions when customers feel let down because they wanted their claim to be paid quicker or because we said we can't pay. There are always improvements we can make and we continue to look for these, never just accepting that our service is 'good enough'.

"Turning down a claim is not something I enjoy but is sometimes the only fair and reasonable thing to do once we have considered the issues very carefully. We all know that the potential impact on customers when we can't pay can be massive. We don't shy away from these decisions and we try our best to explain them to the satisfaction of the customer. This can be difficult to do when the customer is understandably focused on what this will mean for their future as they face the physical and emotional trauma of their condition.

"We always provide this information during a telephone conversation where we can. The initial reaction is often emotional and I've been called many names. It can be hard sometimes to avoid taking this personally, as I will have argued and considered any points in favour of the customer, to ensure they have been taken into account.

"Thankfully, we're able to pay the majority of claims and we will always review claims where new information might enable us to change our decision. As our decisions are some of the most important ones that we make for our customers, the authority to decline claims is only granted to assessors who have demonstrated sufficient knowledge over a large volume of claims.

"At the end of the day we are ordinary people, with our own families, and we are customers too. This enables us to treat our claimants with empathy and respect and to help them out to the best of our ability, as we would expect to be helped if anything happened to us or one of our loved ones."

"Each claim that comes to us is treated with respect and with the aim of paying."

Income protection

WHAT WE PAID IN 2016

Individual income protection claims paid in 2016:

3,549

customers

Amount paid out:

+£37million

£37,032,927

We paid out

92.2%

of claims

Average length of claim across all customers in claim during 2016:

3 years and 16 weeks

Average age at incapacity:

45 years

% of claimants aged under 40:

29%

% of claimants aged 40 or over:

71%

What is Income protection cover?

Income protection is a long-term policy designed to replace a proportion of your income if you can't work and suffer a loss of earnings due to illness or injury. Payments typically provide up to 75% of your income and for a defined period of time. There is a period of time before payments are made and this is known as a deferred period, which is chosen at the policy outset. The policy does not cover unemployment or redundancy.

The monthly benefit paid on valid claims can help customers and their families maintain their standard of living by helping to pay for regular household outgoings, giving peace of mind during challenging times when recovery can take months and sometimes even years.

Recognising that getting back to work after an illness can present a number of challenges, income protection policies offer a range of invaluable support services to help. These often make the difference between being off for a couple of weeks and being unable to work for a much longer period.

The support and success of Aviva's rehabilitation claims team is detailed later in this report.

Top 3 reasons for claim
% by volumes of claims

Mental Health conditions	28%
Musculoskeletal conditions	20%
Cancer	12%

Sample benefits from customers in claim in 2016

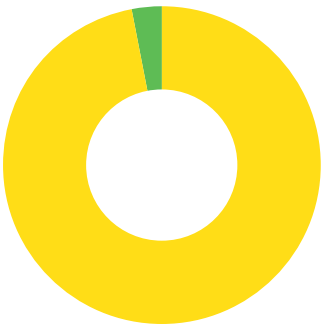
Occupation: **Financial Controller**
Condition: Psychiatric
Monthly Benefit: £500 full benefit (12 months) then £250 rehabilitation benefit (2 months)
Time off work: 14 months
Monthly premiums: £42.70
Time policy in force: 14 years, 6 months
Claimant received support from our rehabilitation team to achieve a return to work.

Occupation: **Self-employed electrician**
Condition: Musculoskeletal (following a RTA)
Monthly Benefit: £1,203.00
Time in claim to date: 17 years, 5 months
Monthly premiums: £36.10
Time policy in force: 18 years, 3 months

Occupation: **Account manager**
Condition: Cancer
Monthly Benefit: £1,616.00
Time in claim to date: 9 months
Monthly premiums: £69.53
Time policy in force: 10 years, 2 months

Income protection claims paid out

%



Percentage of all Income protection claims paid out:	92.6%
Declined	7.4%

When we can't pay out

In 2016 we paid out 92.6% of all individual income protection claims. For the 7.4% of claims that we were unable to pay, there are common reasons why we were unable to do so.

Around a third of claims declined in 2016 were because the customer did not meet the policy's definition of total disability, where they were totally unable to carry out their occupation.

Another third were declined because there was no loss of income experienced by the customer, and a similar proportion were declined due to misrepresentation of relevant medical information which would have affected our ability to offer income protection cover.

Income protection
Continued

Getting customers back to work: our rehabilitation approach

Income protection isn't just about providing replacement income in the event of illness or injury. For our self-employed and small business customers in particular, this is just one part of the equation. Providing the right rehabilitation and clinical support to enable customers to make a quick recovery and return to the work is key to reducing the wider ramifications of their absence from their businesses.

For income protection customers who are in consultancy roles, the stability of their client base is dependent on their availability to work, and for those running small businesses, the stability of the company and their employees' jobs are reliant on their presence to steer the business.

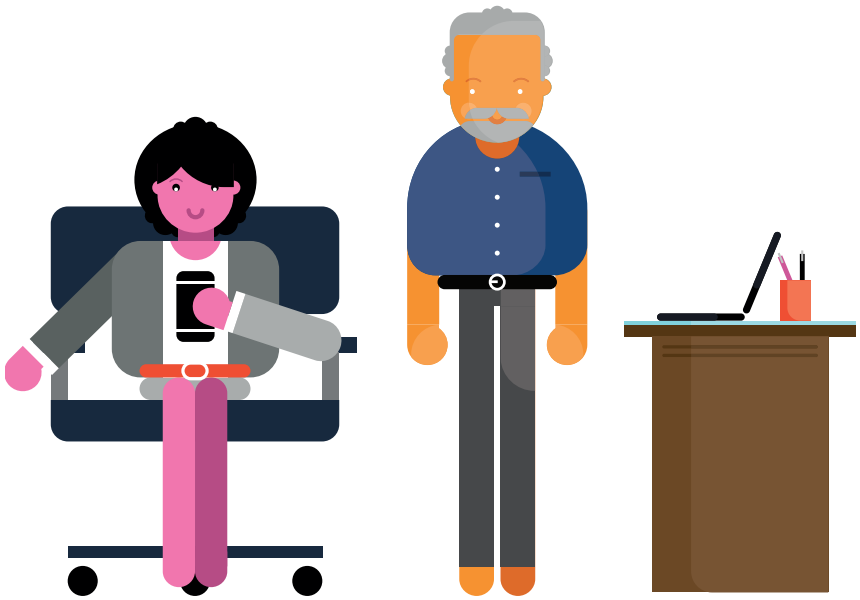
A delayed return to work due to long term sickness absence also puts the worker at risk of becoming disassociated from the work place and reliant on long-term benefits, which often don't meet the financial demands of their existing lifestyle, family life and retirement expectations.

That's why Aviva's income protection products provide much more than income replacement benefit. A customer who calls into our claims and rehabilitation team benefits from the support of their own dedicated case manager, the expertise of our clinical team (including physiotherapists, occupational therapists, specialist nurses and the chief medical officer), and where required, the provision of specialist clinical and rehabilitation treatment services provided by our rehabilitation partners.

We might receive a call from a self-employed builder, business consultant or an employee of a company to inform us that they're off work because of a back injury. On receiving their call, our case manager will talk to them about their injury, the medical support they're currently receiving, any workplace adjustments that could be made to enable them to return to work, and the financial support they will need while they're away from work.

Having completed this initial needs assessment, the case manager will then help the customer to put together a return-to-work plan with their employer and will co-ordinate the clinical and occupational services they require, for example physiotherapy or a workplace ergonomic assessment, to enable them to make a rapid and successful return to work.

Hand in hand with this, the case manager will assess the financial aspect of the customer's claim and ensure that their income protection benefit supports them throughout their phased return to work. They provide all the rehabilitation and financial support the customer needs, so that they can focus on their recovery and continuing their employment or running their business.



Tony's story

Married with two young children, Tony from Hertfordshire had always considered himself a fit and healthy person who led an active and busy life. When he was diagnosed with a succession of chest infections in the Spring of 2015, Tony just thought himself unusually ill and carried on. By late-June however his health had deteriorated significantly and Tony, aged 38, was admitted to hospital.

Tony recalls the speed with which events then unfolded.

"I had a bone marrow biopsy the next day and was diagnosed the day after," he said.

"It was so quick. Because I had what's known as an acute leukaemia, they couldn't mess around. I was transferred to another hospital the same day I was diagnosed and chemotherapy started the following week."

Tony had taken an individual income protection policy out in 2009.

"When the consultant broke the news, my brain went into immediate overdrive on all the practical things and in the first hour I was in contact with the broker I used for the policy," he recalls.

"I never expected to need it, I always considered it a bit of a waste, yet there I was as someone who hadn't ever conceived that I would get any significant illness, literally out of the blue I suddenly had."

Aviva was able to provide Tony's benefit after a short deferred period, giving him peace of mind that throughout his treatment, a bone marrow transplant and his recovery, he didn't have to worry about the financial impact of his illness.

"It was an enormous comfort to know that the benefit was there to make sure my wife and family were provided for. Whatever the period of treatment was, it was there to support us" he said.

Tony remained in hospital for the rest of the year. His income protection benefit continued to support him throughout his recovery in 2016.

In October 2016, on the anniversary of his transplant, Tony and his wife undertook a very personal challenge to raise money for the Anthony Nolan Trust, which had helped match his bone marrow. The couple raised £17,000 by walking a 75km route that took them to the various hospitals where Tony had been treated.

Tony felt ready to return to work but had concerns because his role in accountancy had been particularly stressful just before he fell ill. Aviva's rehabilitation team were able to help him by arranging for specialist support and Cognitive Behavioural Therapy.

"It was great to have the policy and suddenly it was worth all those years of paying," said Tony.

"It's been an enormous comfort to know that there's no pressure financially to get back to work before it's right to do so. That's been the most important thing; that I can recover from this properly.

"Just after my diagnosis I had to claim on a number of insurance policies and Aviva were by far the easiest company I had to deal with. The process at a time of struggle for me and my relatives was all made so easy, it was such a relief.

"It was done in a very compassionate and understanding way and I've never felt any pressure at all as there was an understanding of how long the recovery process would take.

"For somebody who was in the position that I was, coming to terms with what was happening, Aviva couldn't have made it easier. In the circumstances, that was incredibly well received by us."

Tony has successfully returned to work part-time and Aviva continues to support him as he works towards a full-time return.

"It's been an enormous comfort to know that there's no pressure financially to get back to work before it's right to do so. That's been the most important thing; that I can recover from this properly."

Person shown in picture is for presentation purposes only.

Conclusion

"Making payments of £870m in 2016 has made a real difference in the lives of more than 23,000 customers and their families."

A report of this nature can only give a snapshot view of how we help our individual protection customers on a daily basis. The numbers of customers and value of pay-outs tell one story, but they cannot encapsulate the many difficult personal experiences in which those claims were made. There are likely 23,000 individual stories like Chris's or Tony's behind those figures.

The financial peace of mind we provide for customers in the unfortunate event of an unexpected serious illness or early loss of life is the bedrock of financial resilience planning that Aviva, other life insurers and independent financial advisers provide.

How we go about providing this peace of mind at Aviva is of utmost importance to us. Our teams are continually looking at ways to improve the protection claims process for our customers, to make claims simpler and quicker while retaining a very human and compassionate approach, to provide more help and certainty when the unexpected happens.

With a desire to pay protection claims more quickly, we are making good progress on digitising our processes for when we need to request and review medical information in order to support a claim. The speed with which medical data can be securely shared through a digital rather than a paper response will greatly improve the speed with which we can confirm outcomes for our customers.

We are one of the UK's largest insurers, but for our claims team, our customers are considered like friends or family members. At this sensitive time we place them at the heart of our business. We are continually trialling how we can make things easier for relatives after a customer has passed away. When a relative notifies us that a life insurance customer has passed away, we now offer a concierge service to ensure that if the customer has any other Aviva policies, such as home insurance, an individual pension or an annuity, the relative only has to tell us of their bereavement once and we will sort the rest.

The proportion of individual protection claims that we paid last year demonstrates that in the significant majority of cases we are delivering our purpose to help customers to defy financial uncertainty from unexpected events. Making payments of £870m in 2016 has made a real difference in the lives of more than 23,000 customers and their families.

Paul Brencher
Managing Director Individual Protection, Aviva

Protection insurance health check for customers

We want customers to be aware of the common reasons that lead to a small number of claims not being paid across the industry, so that they can take action to prevent this scenario ever happening to them and we in turn ensure that we can be there when it matters most.

Independent Financial Advisers have a key role alongside insurance providers in helping people and families to consider protection solutions as part of their overall financial resilience planning for unexpected events, and to provide simple and clear explanations to customers of the importance of checking information on their policy applications.

Our recommendations to customers:

- ✓ Dig out documentation for any protection insurance that you may have. These may be policies you took out when you bought a house. Don't forget to look at whether you have cover through your employer too.
- ✓ Review the details of the policies, ideally with an independent financial adviser if you have one.
- ✓ Has your circumstance changed since you took the policy out, for example do you have a bigger mortgage or now have children, and does the cover still meet your needs? We recommend that policies are reviewed particularly at key life stage changes such as living with a partner, buying a house, having a family, or if you are getting divorced.
- ✓ Familiarise yourself with any exclusions that may be detailed in the policy and discuss with your adviser whether the policy is still suitable for your needs.
- ✓ Be aware that although newer protection insurance products may include more medical conditions, the definitions for other conditions may be stricter due to medical advances, which means it may be harder to claim for compared with older policies. Seek advice on this from your financial adviser.
- ✓ Are your details correct on the documentation? If not, please discuss with the insurance provider or your independent financial adviser.

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