MetLife - Ireland

Group Life Insurance - Technical Guide

This guide aims to support employers and trustees to understand their rights and obligations under the policy.

Information in this technical guide is effective from 01.01.2026

Introduction

Who is MetLife?

MetLife Europe DAC is an affiliate of MetLife, Inc. and operates under the “MetLife” brand. MetLife Europe DAC is a private company limited by shares, registered in Ireland under company number 415123. Registered office at 20 on Hatch, Lower Hatch Street, Dublin 2, D02 HC80, Ireland. MetLife Europe DAC (trading as MetLife) is regulated by the Central Bank of Ireland.

What is the technical guide?

The technical guide is an important document that is designed to help both employers and trustees understand the features and benefits of a MetLife Group Life policy, including how the policy works, and how to make a claim.

It’s an important document as it aims to guide you through the policy life cycle. If there’s anything you’re not sure about, you can ask either your financial broker or contact MetLife directly. We recommend you keep this document in a safe place in case you need to refer to it in the future.

Please note, the Technical Guide doesn’t specify the standard contractual terms. These can be found in the MetLife Group Life policy terms and conditions specific to your policy.

What is a MetLife Group Life Policy?

Group Life insurance is an insurance policy that is taken out by and paid for by employers wishing to provide life cover to their employees. If an employee dies during the time they work for the company, a lump sum is payable to their dependants.

The lump sum is usually a multiple of the employee’s salary at the time of their death. That multiple is selected by the employer at the policy inception, alongside eligibility conditions which outline the cover in place and the requirements to join the policy. The benefits are held in trust and managed by the appointed trustee.

In the event of a claim, the lump sum is paid by MetLife to the trustee, who is responsible for identifying the financial dependants and ensuring that the benefits are received by the correct beneficiaries.

Contents

1. Policy aims

The policy aims to provide financial protection to employers and their employees. The cover offers employees and their dependants financial security and peace of mind when they need it the most, by insuring lump sum benefits in the event of a member's death. These benefits are subject to the Revenue limits and guidance for exempt approved schemes. The policy can be tailored to suit your company's budget and the needs of your employees.

Policy Aims

For the policy to work well you agree to:

- Confirm the level of benefits and structure of the policy;
- Confirm the eligibility and categories of membership in the policy;
- Provide accurate information about the eligible members at the inception and at each anniversary as required;
- Pay the premiums as agreed;
- Comply with the scheme rules;
- Pass on the benefits paid under the policy in line with the requirement of a Revenue approved exempt scheme;
- Provide any information we require to administer the policy.

For the policy to continue you understand that:

- Cover may stop if you don't pay the premium on time;
- We rely on your timely response to our requirements to administer the policy;
- If we require medical underwriting for any member, their cover will be restricted until we are satisfied that all medical requirements are met;
- Payments of claims may be delayed if you do not provide the information we ask for.

We usually guarantee the rate for three years after the start of the policy however the guarantee may not apply if:

- The number of members goes below 3;
- A regulatory change is required;
- There is a material change in the nature of the business;
- There is a material change to the constitution of the principal employer, including associated employers;
- The total sum insured or number of lives covered changes by more than 30%;
- You have requested a change to the benefits or eligibility;
- The information you have given us to calculate the premium was incorrect;
- The scheme is closed to new entrants.

2. How the policy works

The policy provides a lump sum benefit payable to the trustees in the event of an insured member's death.

What cover can be provided?

We can cover insured members for a lump sum benefit and, if required, an additional lump sum to be used to fund a spouse or dependant's pension.

The level of benefits can vary from one category to another. Most employers will offer either 2 x salary or 4 x salary. If an employer would like to offer an additional lump sum, then we can quote up to 10 x salary.

Please note that the Revenue Commissioners do set out certain limitations on cover and how these benefits are distributed. Please ensure that the benefits covered reflect the benefit commitment given to the member under the policy.

Revenue guidance

Revenue guidance		
Group Life Cover	**Benefit basis**	**Tax treatment**
	Up to 4 x salary	Usually tax free if paid to the spouse.
	More than 4 x salary	Up to 4 x salary usually tax free if paid to the spouse. The balance must be used to provide an annuity or approved retirement fund (ARF) to help fund a continuing pension for any financial dependant.

Who can be covered and how do you decide what benefits to cover?

The employer decides the policy benefit structure and the eligibility requirements to access benefits.

When setting up the policy:

- You decide the level of benefits you need;
- You can choose the eligibility criteria, which must be defined, such as whether to insure all of the employees or a particular subset (known as a category) and you must ensure that everyone who meets the eligibility criteria is given access to cover;
- You choose the benefit cease age for each category. This is the age at which cover ends for the members of the category;
- You are responsible for collating member data and making sure all eligible members are included;
- The employer pays the premium, and the cost may be allowable as a business expense;
- You provide us with the information we require for the ongoing administration of the policy;
- You agree to notify us of any claims as outlined in the claims section of this guide.

We would recommend you seek independent financial advice from a qualified financial advisor when deciding what cover options to put in place and how to set up the policy. You should also consider the scheme rules and make sure that benefits align to these.

What are the benefits?

Lump sum

A lump sum benefit can be either a fixed amount, or a multiple of salary and is payable when an insured member dies. The cover must be within the Revenue limits of an exempt approved scheme.

Additional lump sum

We can insure benefits in excess of the Revenue limits by request. If we do this the benefits of any lump sum or any additional lump sum will be shown on your policy schedule.

In the event of a claim, we will:

- confirm the amount payable following the insured member's death;
- pay the lump sum and any additional lump sum to the trustee.

The trustee must pay the benefit in accordance with the scheme rules. Any balance of the lump sum which exceeds the Revenue requirements will need to be used to provide a pension for one or more dependants.

For any benefit in pension form, an annuity contract or an Approved Retirement Fund (ARF) contract must be taken out. This policy can be taken out with an insurer that is offering annuity contracts at the time.

What is an exempt approved scheme?

The MetLife Group Life Insurance Policy is designed for death in service cover under retirement benefit schemes approved as exempt approved schemes (i.e. by the Revenue Commissioners under Chapter 1 of Part 30 of the Taxes Consolidation Act).

Can you link associated companies for Group Life cover?

It is possible to link different Group Life Insurance policies issued by us taken out by the employer or parent/subsidiary of the employer for the purpose of:

- assessing whether there are enough eligible members to apply a free cover limit;
- setting the free cover limit;
- using 'Once and Done' underwriting; and
- calculating the premium rates.

This will be subject to agreement by us and the terms offered to you will be detailed within your quote and, if the policy is taken out by you, on your policy schedule.

3. Trust options and obligations

What is the role of the trustee?

A trustee is a person or organisation that is legally appointed to manage the benefits under a Group Life policy. They must act in the best interests of the beneficiaries and are required to follow the scheme rules and ensure that policy payments are managed and paid correctly and promptly.

Who can be a trustee?

There are a few options for who can be a trustee:

- The employer can act as the trustee on the policy they are sponsoring, however they need to be aware of the responsibilities of the role;
- A corporate trustee can be appointed, they are qualified and can act as the trustee of your policy. This offers independence to the employer and allows a qualified professional to run the policy. There is a cost to this which you need to consider;
- You can participate in a Master Trust, which is arranged by your insurance provider. These arrangements are cost effective, streamlined and offer participating employers consistency and peace of mind.

When making the decision on who to appoint as trustee, you should seek expert advice from your financial broker.

Does MetLife provide a solution?

Yes, MetLife does offer a Master Trust solution which can offer a safe, independent and cost efficient solution to their trustee needs. More details can be found on our website www.metlife.ie

At MetLife we recommend the employer considers all the available options and seeks professional advice when making this decision.

How does the MetLife Ireland Master Trust work?

The MetLife Ireland Master Trust is sponsored by MetLife Europe DAC. We bring this solution to the market through our partnership with Irwin Mitchell. Having this solution set up in this way allows for independence and a strong legal structure which protects the employer and the employees interests.

In the event of a claim, MetLife Europe DAC will pay the policy benefit to the Master Trust trustee, Eblana MT Trustee DAC. The trustee has discretionary authority to pay the benefit to the appropriate beneficiaries. They also act as the scheme administrator and are responsible for tax reporting in respect of the policy.

In the event that the MetLife policy is terminated, this automatically removes the participating employer from the Master Trust.

How is the MetLife Ireland Master Trust set up?

The Trust is set up and sponsored by MetLife Europe DAC in partnership with Irwin Mitchell. We have designed the plan as follows:

Sponsor: MetLife Europe DAC

Plan: MetLife Ireland Master Trust

Trustee: Eblana MT Trustee DAC

This Master Trust is brought to you through our partnership with Irwin Mitchell, who provide Master Trust arrangements across the UK and Ireland for MetLife.

Eblana MT Trustees DAC

Eblana, the ancient name for Dublin, is maintained and managed by Irwin Mitchell Trustees Limited (IMTL). Irwin Mitchell LLP is one of the UK's largest law firms. Established in 1912 it now has 3,500 staff and more than 30 offices across the UK.

Irwin Mitchell operates one of the largest trust practices of any UK law firm and its operating subsidiary Irwin Mitchell Trustees Limited act as trustee of many thousand life insurance, pension and other arrangements.

IMTL has unrivalled expertise and experience in life insurance trusteeship. It is trustee of death in service plans covering more than 12,000 employer businesses. Its staff also have expertise in the drafting, tax arrangements and all other legal and regulatory issues relating to a wide range of life insurance and other plans.

IMTL make excellent use of technology to help create a clear communication, management and transparent trustee service in this market.

4. Eligibility

What are the eligibility conditions?

The eligibility conditions will need to be agreed at outset and should include:

- Minimum and maximum entry ages;
- Any service qualification periods;
- The categories of members to be covered; and
- The frequency that new entrants will enter the policy (for example, monthly).

Eligibility conditions covering entry ages, entry dates and waiting periods or service qualification periods, must be the same for each member within a defined category.

Can you include someone who is not eligible?

This may be possible, but they would be considered a discretionary entrant. You must inform us promptly of anyone you would like to cover as a discretionary entrant under the policy. Discretionary entrants are subject to medical underwriting and will only be covered once we have confirmed in writing that they are accepted.

What are the requirements to be 'actively at work'?

Employees must be actively at work to be covered under the policy on:

1. the start date; or
2. on the date they are eligible to join if this is after the start date; or
3. from the date of any benefit basis increases, such as through a switch in category, or if the category benefit basis itself changes.

We will not include for cover as an insured member anyone who is eligible but not actively at work on the working day prior to the start date or the date they became eligible.

Cover (including cover within any free cover limit) will only start when:

(i) they have been actively at work for five consecutive working days; or

(ii) medical underwriting has been completed, and cover has been confirmed; or

(iii) we have otherwise agreed they are eligible.

To be considered actively at work means a member must be:

1. engaged in or otherwise following their normal occupation;
2. not absent from work or working against medical advice;
3. physically and mentally capable of carrying out all their normal duties;
4. working not less than their normal number of contracted hours;
5. working at their normal place of business or at a location where the business needs them to travel.

What is strict actively at work?

We may, from time to time, request a strict actively at work declaration. This is requested at our discretion. When we are applying a 'strict actively at work' definition this means that we require you to confirm that an employee or partner is actively at work and has not failed to be actively at work for 5 or more working days in the last 12 months. The 5 days do not need to be consecutive, as per the description in our standard actively at working requirements.

When can I add members to the policy?

You should tell us at the policy inception about all eligible members that are joining the scheme and at the policy anniversary date or when we request. There is no need to tell us about a member joining during the policy year unless on joining they have benefits that will exceed the free cover limit. You have the option to tell us during the policy year about these members, and we will commence medical underwriting so that we can place this member on their full benefits as soon as possible.

If during the policy year there is a significant change in the number of members or the sum insured, then you must tell us as soon as possible. We reserve the right to alter the unit rate if the number of lives or sum insured has changed by more than 30%.

What if a member is working for an Irish entity but seconded overseas?

We can cover insured members who are travelling or working overseas, or those temporarily seconded to another organisation in a different country as long as:

- they still have an Irish contract of employment, are paid in Ireland and their earnings are subject to Irish taxation under Schedule E of TCA;
- they remain an employee of the principal employer or an associated employer as listed on the policy schedule;
- the policy is not required to be authorised as a cross-border policy under Part XII of the Pensions Act, 1990;

- the premium to cover those members is paid in the currency of the Republic of Ireland by you or the employer; and
- they are still otherwise eligible for cover on the policy.

You must tell us about any eligible members and insured members who are working overseas at the policy start date and at the anniversary date. You must also tell us the countries that they will be working in.

Any overseas member will need to be categorised separately under the policy for ease of administration.

The tax treatment of any benefit paid out for an overseas member may be different from that of a resident and you should seek specific tax advice on this in the event of a claim.

Cover will not be provided to any member of the scheme who travels for business reasons to a country or region where the Department of Foreign Affairs has advised a security status of High Degree of Caution or Do Not Travel. Please refer to their website www.dfa.ie

We will not pay any claim if the payment of any such claim shall expose MetLife Europe DAC to any sanction, prohibition or restriction under United Nations resolutions or any other relevant trade and economic sanctions, laws or regulations.

What about members of a TUPE?

On request and subject to us approving this request we can include members being added to a policy due to a TUPE agreement, once you notify us promptly. To confirm cover we require:

1. The date of the employment transfer;
2. Details of any eligible members who have had their benefit loaded, declined, restricted, postponed or accepted at special terms under a previous policy;
3. Long term absentee information;
4. An actively at work declaration confirming that all eligible members are actively at work on the date of the employment transfer;
5. Details of existing cover in place and current benefit basis;
6. Details of any change in cover or increase in benefits as a result of the transfer.

We reserve the right to withhold benefits until all of the above requirements are received and/or request medical underwriting if we need to for any member or members not satisfying our acceptance criteria. Cover is only in place once we have confirmed this in writing.

What about keeping cover in place, in the event of temporary absence?

From time to time there will be employees in the policy that take temporary absence. We are happy to allow cover to continue in most cases, once we are notified of the reason for absence, we have approved the continuation of cover, and the employee remains an Irish employee and continues to have an Irish contract of employment. Where absence is not due to illness or injury, we can in some cases keep cover in place for up to 36 months.

Where an insured member is off work due to illness or injury, the cover can continue up to the cease age providing premiums continue, they are still a member, and they continue to have an Irish contract of employment with the employer or associated employer listed on the policy schedule.

When will cover stop?

You choose the benefit cease age which can be any age up to a maximum of age 70. Once this is agreed we will stop covering insured members under this policy if:

- they die;
- they leave the policy;
- they cease to be an employee;
- in the case of redundancy, unless we have agreed to continue cover;
- they reach the benefit cease age;
- premiums have not been paid within 30 days of the due date;
- you ask us to cancel the policy; or
- we cancel the policy in any of the circumstances provided for in the terms of the policy; whichever happens first.

Redundancy cover

We will, following the redundancy of an employee or a group of employees, and at the request of the employer, continue to cover the eligible members for up to 3 months after they have left employment (while they find alternative employment); they reach the cease age or they are no longer a member of the scheme; or the policy is cancelled; whichever happens first. To do this the employer must continue to include these members in the data and continue to pay the premium due.

5. How is the policy set up?

How do I get a quote?

You can request a quotation through your financial broker.
To ensure the quotation is as accurate as possible first time, we need:

Full details of eligible employees including:

- gender;
- dates of birth;
- salaries;
- benefit basis/level or category;
- eligibility terms;
- occupations;
- benefit cease age;
- long term absentees;
- previous medical underwriting decisions.

We may also need full details of any:

- category definitions;
- previous scheme history;
- previous claims history; and
- regular overseas travel completed by employees.

If any of the details or assumptions we have made differ from those on the initial quote, the quotation may be revised or withdrawn.

What do we need to set up a new policy?

To complete the setup of the policy, we need:

- a fully completed and signed application form;
- a deposit premium or direct debit mandate;
- confirmation of trust arrangements, including confirmation of Revenue approval and pensions authority number (if applicable);
- a completed membership schedule, or confirmation that membership details shown in the quotation are correct;
- individual details of any insured member whose total benefits are above the free cover limit (shown on the quotation).

We require the above information within 30 days of confirming on risk to you. If we do not receive all of the requirements to set up the policy, we reserve the right to remove cover.

What do we need to provide for existing policies transferring to MetLife?

You will need to provide all of the requirements above, as well as:

- written confirmation from the previous insurer that any members above the free cover limit have previously been underwritten, the amount underwritten, the underwriting decision and the date of acceptance;
- details of the existing trust arrangements;
- evidence of Revenue and pension board approval.

Please see our handy guide to switching for help with the process www.metlife.ie
We require the above information within 30 days of confirming on risk to you. If we do not receive all the requirements to set up the policy, we reserve the right to remove cover.

Duty of disclosure

Your disclosures to us about your business structure and the information you give us about yourself and your employees are hugely important when we are pricing your scheme and continuing your cover. Failure to disclose all relevant information requested by us during the application, underwriting and/or claims process could render your contract void or result in a claim being denied or may result in benefits being reduced, premiums increased (and set off against any benefits payable), no benefit being paid or in certain cases could lead to the policy being cancelled with or without a refund of premiums and/or MetLife Europe DAC recovering any benefits already paid.

6. Medical Underwriting

Will any benefits be underwritten

We will only require underwriting in the following circumstances:

- For members whose benefits are above the free cover limit;
- To assess discretionary entrants;
- To assess late new entrants;
- On a policy transfer when there is an increase in benefits at the time of the transfer.

We will request satisfactory evidence of health to confirm a member's acceptance.

What is satisfactory evidence of health

The satisfactory evidence of health requirement can differ between members, ranging from a simple health questionnaire to more detailed doctors' report and sometimes medical tests or examinations. Our underwriting team will confirm our requirements.

Any non-standard terms must be accepted within a specified period as stated by MetLife, otherwise, the benefit will be restricted and notified to you in writing.

MetLife will pay for any medical tests or examinations that it requests.

What is a free cover limit and how is this calculated?

A free cover limit is the amount of benefit that an individual member can have, without the need for medical underwriting. There are a number of factors that we take into account when calculating the free cover limit to apply to your policy. These can include:

- the number of insured members;
- whether there are any linked policies.

Once we agree a free cover limit for the policy, any member that joins the policy as a standard new entrant is automatically included for cover up to this limit, without underwriting. Only benefits in excess of this limit will be underwritten.

The standard maximum free cover limit we offer for Group Life is €1,800,000.

Once and Done underwriting

For policies with 50 or more eligible members, those members who are above the free cover limit will, in most circumstances, only be medically underwritten once up to a maximum total benefit of €5,000,000.

This allows future benefit increases, arising from a change in salary, to be automatically accepted without underwriting on the same terms.

Existing 'once and done' terms from another insurer will also be accepted on business transfer to us, if we agree to do so at the time of transfer.

What if I need to make a claim before underwriting is complete?

We will provide a temporary cover level of benefits until the earlier of 90 days or the date our underwriting decision is made. Cover will start from the date of joining the policy, or the effective date of an increase in benefits.

Temporary cover:

1. is restricted to the maximum of €1,000,000 of benefit insured above the greater of the free cover limit or previously underwritten benefit;
2. will exclude any claim which arises in respect of any pre-existing conditions; and
3. is not applied to any member who has previously:
    - been declined by us or another insurer;
    - been postponed by us or another insurer;
    - been restricted by us or another insurer; or
    - declined to provide full medical information.

What happens to a benefit already accepted by another insurer?

We will accept the previously insured level of cover on medical underwriting terms that are no worse than those provided by the previous insurer. This is subject to the following:

- there has been no increase in benefit levels;
- there has been no break in cover;
- any insured members that were declined or excluded above a certain level will only be covered for the benefit they had with the previous insurer. This is regardless of whether they are now below our free cover limit;
- we have been informed about any long-term absentees and any adverse underwriting decisions;
- you have provided written confirmation from the previous insurer of any members above the free cover limit that were previously underwritten, the amount underwritten, the underwriting decision and the date of acceptance and we have received confirmation of Actively at Work.

What is a discretionary entrant

A discretionary entrant is an employee:

(i) who is not an eligible member, but you request us to include in the policy (including joining before the date they are first eligible to join);

(ii) who was not included as an insured member after they were first eligible to join;

(iii) who is an eligible member but was not actively at work on the date they wanted to join the policy and who was not included as an insured member after they were first eligible.

What is a late entrant

A late new entrant is a member of the scheme that did not join at their first opportunity and who you now want to join the policy. To add a member like this to the policy we will require medical underwriting. Cover is only in place once we have received all satisfactory evidence of health and we have confirmed this in writing.

Benefit increases

During the course of the policy, we don't need to be notified about new entrants or leavers in the policy, except at the policy anniversary. At each policy anniversary we take account of all the changes that have taken place since the policy inception or the last policy anniversary.

However, if during the year a member with significant benefits is being added to the policy, you may notify us before the policy anniversary, so that we can start the medical underwriting process. This will ensure that the member is covered as soon as possible for their full benefits, once the underwriting process is complete and we have confirmed acceptance.

If during the policy year there is a significant change to the employer's business or number of employees, you may also contact us so we can review the rates, if necessary.

Things that could change the unit rate during the rate guarantee period are:

- The membership or benefits insured changes by 30%;
- The policy is closed to new entrants;
- There is a material change to the employer's business;
- There is a transfer of employment or TUPE which alters the business structure or membership.

Are there any limits to the cover provided under the policy?

For certain business types and locations, we may apply an event limit on policies that pose an additional risk for a catastrophic event.

If a catastrophic event, as defined below and in our policy terms and conditions, occurs, an overall limit may apply on the total claim amount paid. If MetLife has already paid benefits to the catastrophic event limit which is set out in the policy schedule for one catastrophic event, then no further benefits will be paid out for that event.

Otherwise, our maximum level of cover available to any one insured member is €5,000,000.

7. Claims

How do you make a claim?

If you need to make a claim you must give us written notice as soon as possible after an insured member's death. You can email us at, ebclaimsireland@metlife.com and we will respond confirming our requirements. You must provide us with any documents and information that we may need to process your claim. We cannot pay any claim until all requirements have been received.

How are claims submitted?

To submit a claim, you can email us at, ebclaimsireland@metlife.com and we will respond with our requirements.

What do you need to pay a claim?

If you need to make a claim you must give us written notice as soon as possible after an insured member's death. You can do this by email to the above address.

As part of the claim assessment, we will require the death certificate or coroner's interim certificate for the insured member.

The following may also be required to enable a claim to be paid:

(i) medical records of the insured member;

(ii) any necessary employment records;

(iii) any relevant authorisation showing who is empowered to sign for and act on behalf of the trustees;

(iv) evidence of membership and earnings;

(v) evidence of age of the insured member;

(vi) evidence which verifies the bank account to be paid to.

Please note we will not pay any claims made more than 2 years after the earlier of:

(i) the day the trustee first knew of the insured member's death; or

(ii) the day on which the trustee could reasonably have known of the insured member's death.

Once a claim is admitted, we will pay the policy benefits to the trustees. The trustee is responsible for the distribution of the claim proceeds and the identification of the correct beneficiaries. In the event that we have paid the claim, and in accordance with the terms of this policy, this will be a full and final discharge of our liability under the policy, and we will not be liable for any subsequent decision taken by you with regards to payment of any benefit paid to you. Please note that we cannot pay any claim until all requirements have been received.

No cover will be provided for any employee who has been diagnosed with a terminal illness prior to joining the firm and becoming your employee.

In the event that you are transferring your policy from MetLife to another provider, you are still required to notify us of any claims as soon as possible.

Who are payments made to?

Claims are paid to the appointed trustee, who is responsible for identifying all financial dependants and ensuring that benefits are distributed to the correct beneficiaries in a timely manner. The trustee is usually someone other than the employer and acts independently and in the interests of the policy members at all times.

8. Premiums

How is the premium calculated?

The policy premium is calculated on a unit rate basis which operates on one year accounting periods. Premiums are payable by you and must be paid annually (in advance), by direct debit or electronic fund transfer (EFT), or half-yearly, quarterly or monthly by direct debit.

What does Unit Rate basis mean?

We will calculate the total premium by multiplying the total insured members' benefits by the unit rate that applies at the start date and at each anniversary date. An adjustment will be made if any additional premiums are required following medical underwriting.

If the period from the start date to the anniversary date is not a complete policy year, we will charge premiums for the number of days for which cover is provided.

We will not apply a premium adjustment to account for any leavers or joiners in a policy with fewer than 20 lives. For policies with 20 or more lives, at each anniversary date, we will calculate an adjustment to reflect any changes which are made during the policy year in respect of leavers, joiners and changes in benefits. Any adjustment is charged as if these changes occurred halfway through the policy year. This adjustment will be made to the total premium calculated for the next policy year.

A statement of account will be issued to you confirming the payment / refund due at the start date and then at each anniversary date.

In the event of the policy being cancelled, any adjustment for the previous year will still be due. If this is the case, we will notify you of the total amount due and you will be required to pay within 30 days following notification and we will be entitled to recover the amount due as a debt due to us from you.

What information is required for accounting purposes?

At inception and at each review date, membership data will be required, and the premium will be calculated based on the data provided.

We reserve the right to change the unit rate or the policy terms if:

- the policy is no longer open to new entrants;
- there is a 30% change to either the total sum assured or membership since inception or the last review;
- the number of members goes below 3;
- there is a change in legislation which requires us to make a change; and
- for changes in any participating company or category/group of members.

In the event that the policy membership goes below 3, we retain the right to cease the benefits of the policy immediately.

What happens at the end of the rate guarantee period?

At the end of the unit rate guarantee period, we review the current unit rate. To do this we require updated membership data within 30 days of the rate guarantee expiry date.

The data should include details of all members including any discretionary entrants, confirmation of any claims, including potential claims that have not yet been notified and details of members who are currently absent from work and have been absent from work for 90 consecutive days or more.

On receipt of the data, revised terms are advised. Any changes to the policy terms and conditions, the free cover limit or the unit rate of premium will be effective from the commencement of the next rate guarantee period. You have a duty to ensure that you disclose all relevant information.

MetLife will assume cover is to be continued beyond the end of the rate guarantee period and the policyholder will be liable for the cost of cover provided during the period from this date to the earlier of:

- the date upon which we are advised in writing by the policyholder (or their appointed advisor) that cover is to cease; and
- the date that we advise the policyholder that the policy is terminated.

Such cover will be charged at the revised rates which would have applied from the rate guarantee expiry date from the previous review.

9. Tax Considerations

All references to taxation and Revenue requirements are based on our understanding of current tax law and practices at the time of writing (January 2026). Tax law and practices could change in the future. We recommend that you get professional advice from your own tax adviser.

What tax considerations are there for payment of premiums and benefits under the policy?

The Group Protection Life Insurance Policy is designed for death in service cover under retirement benefit schemes approved as exempt approved schemes by the Revenue Commissioners under Chapter 1 of Part 30 of the Taxes Consolidation Act (TCA) 1997.

These schemes are governed for tax purposes by Chapter 1 of Part 30 of the Taxes Consolidation Act (TCA) 1997 (as amended) and related Revenue requirements.

The employer pays the whole premium for the policy and premiums are usually allowable as a business expense and receive tax relief. Premiums paid on an employee's behalf are not normally treated as a 'benefit in kind'.

In the event of the death of an insured member, the lump sum is paid by MetLife to the trustee, who is responsible for identifying the financial dependants and ensuring that the benefits are received by the correct beneficiaries. The tax treatment of these benefits depends on the individuals receiving the benefits.

We would recommend that you get professional advice from your own tax adviser.

Tax Requirements

The Group Life policy is designed for death in service cover under retirement benefit schemes as an exempt approved scheme.

The Revenue requires that as part of the administration of this policy:

- The policy is issued to you as trustee under the scheme rules;
- There are rules around the amount and form of death in service benefits payable under an exempt approved scheme;
- There is a maximum level of benefit that can be paid in lump sum form (currently 4 x salary) to the beneficiaries;
- Except as provided under the scheme rules and in line with Revenue requirements, it is not possible to surrender (i.e. cash in) or assign (i.e. transfer) to anyone else ownership of or rights or benefits under this policy;
- We will advise the Revenue Commissioners of any matter which is relevant to the policy;
- We can deduct any tax, duty or levy relevant to the benefits under this policythat we may be obliged to deduct or for which we may be accountable.

10. General Information

Legal Basis

The policy is a contract between you (the employer named in the policy schedule) and us (MetLife Europe DAC) and is designed to provide certain benefits on death in service of the insured members.

The contract is effected for the benefit of the insured members under retirement benefit schemes approved as exempt approved schemes by the Revenue Commissioners under Chapter 1 of Part 30 of the Taxes Consolidation Act (TCA) 1997.

Details of the contract can be found in these policy terms and conditions, the policy schedule, the application form and any endorsements.

Duty of Disclosure

Failure to disclose all relevant information requested by us during the application and/or claims process could render your contract void or result in a claim being denied or may result in benefits being reduced, premiums increased (and set off against any benefits payable), no benefit being paid or in certain cases could lead to the policy being cancelled with or without a refund of premiums and/or MetLife Europe DAC recovering any benefits already paid.

Currency and jurisdiction

This policy is issued in the Republic of Ireland and is governed by the laws of the Republic of Ireland. All payments to or by us under this policy will be made in the currency of the Republic of Ireland.

Who is the Insurer?

The Group Life Insurance policy is underwritten by MetLife Europe DAC.

11. Contact Details

If you require any support or assistance with this guide, please contact one of our team members by phoning the number below, or by email:

Phone number: 1800 500276
Email address: ebireland@metlife.com

12. Definitions

Throughout this document there are a number of defined terms. The meaning of these words is set out on the following pages.

Actively at work

Means an eligible individual is actively at work and not working against medical advice. In addition, the eligible individual must be:

- engaged in or otherwise following their normal occupation;
- not absent from work or working against medical advice;
- physically and mentally capable of carrying out all their normal duties;
- working not less than their normal number of contracted hours; and
- working at their normal place of business or at a location where the business needs them to travel.

Anniversary date

An anniversary of the start date, or any other date as agreed. This date is stated in the policy schedule.

Application form

The application form for this policy. It includes any other relevant information given to us in relation to you taking out this policy with us.

Catastrophic event

Means one originating event, accident, cause, occurrence or incident or a series of related originating events, accidents, causes, occurrences or incidents, that directly or indirectly results in the deaths of more than one insured member, irrespective of the date of those deaths or the period or area over which the originating events, accidents, causes, occurrences and incidents took place.

Catastrophic event limit

Means the sum specified in the policy schedule in respect of a catastrophic event.

Cease age

Midnight on the day before the insured member reaches the cease age identified on the policy schedule. Cover stops at the cease age.

Dependant

This means:

1. a person who was married to, or a Civil Partner of, the member at the date of the member's death; or
2. any child; or
3. a person who in your reasonable opinion having regard to the scheme rules and Revenue requirements at the date of the insured member's death was financially dependent on the insured member.

Discretionary entrant

A discretionary entrant is an employee:

1. who is not an eligible member, but you request us to include in the policy (including joining before the date they are first eligible to join);
2. who was not included as an insured member as soon as they were first eligible; or
3. who is an eligible member but was not actively at work on the date they wanted to join the policy and who was not included as an insured member after they were first eligible.

Eligibility

The criteria under the policy rules which if fulfilled means a person is entitled to the benefits that you are seeking to be covered by the policy. These eligibility criteria must be provided by you to us at outset and are shown in the policy schedule. The term "eligible" shall have a corresponding meaning.

Employee

An employee of an employer.

Employer

An employer that is participating in the policy.

Evidence of age

Passport, driving license or birth certificate.

Exempt approved scheme

A policy approved as an exempt approved scheme under Section 774 of the TCA.

Free cover limit

The level of benefit identified as such on the quote and policy schedule below which that we won't seek to medically underwrite.

Insured member

Means:

(i) an eligible employee who is included for cover under the policy in accordance with the eligibility basis; or

(ii) an employee you have requested us to cover as a discretionary entrant and has been specifically accepted by us for cover under the policy.

Late new entrant

A late new entrant is an member of the policy that did not join at their first opportunity and who you now want to join the policy.

Long term absentee

An eligible member who is not actively at work and has been absent from work for more than three continuous months immediately before the start date or anniversary date.

Member

An employee who is a member of the policy.

Overseas

Any country that is not the Republic of Ireland.

Policy

The policy conditions, the policy schedule together with any amendments that we notify to you and the application form which together form the contract between you and us.

Policy schedule

The current schedule (as issued by us from time to time including any subsequent amendments that we notify to you) showing specific details of the policy such as policy name, employers, cover provided by this policy and any endorsements (if applicable).

Policy year

The period between:

1. the start date and the first anniversary date;
2. one anniversary date and the next anniversary date; or
3. an anniversary date and the date of cancellation of the policy (if cancellation occurs before the next anniversary date).

Pre-existing condition

A condition that is directly or indirectly linked to any medical and/or related condition or complication that the insured member or prospective insured member was:

1. aware of; or
2. experienced symptoms of; or
3. received medication, advice counselling or treatment for;

in the previous five years immediately preceding the 90-day period for which we will provide temporary cover.

Resident

Means resident for tax purposes in the Republic of Ireland and having an address in the Republic of Ireland.

Revenue/Revenue Commissioners

The Office of the Irish Revenue Commissioners.

Revenue requirements

Means the relevant limits and requirements of the Revenue Commissioners under Chapter 1 Part 30 of the Taxes Consolidation Act 1997 in relation to the operation of an occupational pension policy which has been approved as an exempt approved scheme.

Satisfactory evidence of health

Information including but not limited to medical history and lifestyle factors, required to fully assess the prospective insured member and enable us to make an underwriting decision.

Scheme

The exempt approved scheme named as the policy in the policy schedule.

Scheme rules

The provisions governing the policy by whatever name they are called.

Spouse

The legal spouse of the insured member at date of death or an insured member's Civil Partner at date of death registered under the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010.

Start date

The date the policy starts, as stated in the policy schedule.

Strict actively at work

Means an eligible individual is actively at work, can confirm they have not been absent for 5 days in the last 12 months, and the days do not need to be consecutive, and they are not working against medical advice.

In addition, the eligible individual must be:

- engaged in or otherwise following their normal occupation;
- not absent from work or working against medical advice;
- physically and mentally capable of carrying out all their normal duties;
- working not less than their normal number of contracted hours; and
- working at their normal place of business or at a location where the business needs them to travel.

TCA

The Taxes Consolidation Act, 1997.

Travel limit

A monetary limit which applies to the total amount of claims that would be paid by us in relation to insured members who are travelling together for work purposes.

Trustees

The trustees of the policy.

TUPE

A transfer of employer's rights and obligations under the European Communities (Protection of Employees on Transfer of Undertakings) Regulations 2003.

Unit rate

The rate of premium payable for every €1,000 of lump sum benefit insured by MetLife Europe DAC.

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