EMPLOYMENT TRIBUNALS (SCOTLAND)

Case Number: 4104661/2013

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Hearing held in person in Glasgow 4, 6, 11, 13 and 15 July 2022
Deliberations 18 ,19 and 27 July 2022

Employment Judge D Hoey

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Ms C McMahon	**Claimant** **Represented by:** **Mr Woolfson -** **Solicitor**

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AXA ICAS Ltd	**Respondent** **Represented by:** **Ms Skeoch -** **Solicitor**

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JUDGMENT OF THE EMPLOYMENT TRIBUNAL

1. The judgment of the Tribunal is that the claimant's complaint that there was an unauthorised deduction from her wages is well founded.

2. The respondent was contractually due to pay the claimant monthly one twelfths of three quarter of the claimant's fixed or normal annual salary (in respect of the 23 hours she was required to work) less state benefits received. Such monthly sums were to be paid following the claimant's incapacity from work for a period of 26 weeks (which she had established by the provision of fit notes). The sums due were to be increased by 5% on each anniversary of commencement of payment (meaning the foregoing monthly sum was to be increased by 5%, ignoring any salary increase that would have been payable had the claimant been at work). As a result of the foregoing, the sums paid to the claimant by the respondent were less than the sums properly payable, in breach of section 13 of the Employment Rights Act 1996.

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3. The parties are given 42 days to agree the specific sums due, in the absence of evidence in relation to precise sum of state benefits received during the period in question. In the absence of agreement being reached, an order can

be issued requiring the claimant to set out the sums in question (with evidence thereof), which failing (or upon request) a hearing can be fixed to determine same.

REASONS

5 1. By ET1 the claimant raised a claim for unauthorised deductions. The respondent disputed the claims.

2. A number of preliminary issues had arisen in this case. One such issue related to an appeal against an earlier judgment that formed part of the claims which is ongoing and whether the current claim (which is not part of the appeal) 10 should proceed or await the outcome of the appeal. It was decided that given the time that had passed and given the severability of the factual and legal issues it was in the interests of justice to proceed and determine this claim. In the event of a successful appeal, another hearing would be fixed to deal with the matters that were still to be determined.

15 3. It is important to note, for administrative reasons, that the appeal relates to claims under the same case number of the claims being determined in these proceedings.

4. The hearing was conducted in person with both parties being represented. Adjustments had been made for the claimant mirroring those which had been 20 made in previous hearings. Both parties were able to fully and fairly present their cases.

Case management

5. The parties had worked together to focus the issues in dispute and had provided a statement of agreed facts and a list of issues. These documents 25 were refined as the case proceeded and the Tribunal is grateful for the parties working together to assist the Tribunal deal with matters fairly and justly and thereby achieve the overriding objective.

6. A timetable for the hearing of evidence had been agreed and the parties worked together to ensure the case concluded within the allocated time. Each witness gave oral evidence and was appropriately challenged.

Issues to be determined

5 7. The parties had agreed the issues to be determined by the Tribunal which were as follows:

a. What contractual entitlement did the claimant have in respect of permanent health insurance benefit? In essence this was to determine whether the respondent was liable to the claimant for sums set out or
10 whether the agreement was that access to an insurance scheme was the obligation (payable by and subject to the rules of a third party).

b. What were the express and implied terms which applied to the contractual entitlement and what eligibility criteria/conditions needed to be satisfied before payment would be due to the claimant?

15 c. Did the claimant satisfy all the criteria/conditions which the Tribunal determines applied in the circumstances such that the right to payments under the relevant benefit was triggered and as such were the wages sought properly payable for the purposes of section 13(3) of the Employment Rights Act 1996?

20 d. If there had been an unauthorised deduction of wages how should be deduction be calculated, given the parties disputed what "wages" mounted to for the 12 months from May 2011 to May 2012 and the 12 months from June 2012 to May 2013. The claimant argued salary should include monthly overtime and that in respect of year 2 a 5%
25 increase should be applied.

Case management

8. The parties had agreed productions running to 125 pages with documents being inserted in the course of the hearing.

9. The Tribunal heard from the claimant and Ms McGlone, HR Business Partner who had been responsible for administration of health benefits at the time the claimant had been absent from work (but who had not been employed when the contractual and related documents were issued).

5 **Facts**

10. The Tribunal is able to make the following findings of fact which it has done from the evidence submitted to it, both orally and in writing. The Tribunal only makes findings that are necessary to determine the issues before it (and not in relation to all disputes that arose nor in relation to all the evidence led before
10 the Tribunal). Where there was a conflict in evidence, the conflict was resolved by considering the entire evidence and making a decision as to what was more likely than not to be the case. The Tribunal was assisted by the parties reaching agreement, in respect of a large number of facts.

Background

15 11. The respondent is a global provider of employee support, health and wellbeing services.

12. The claimant commenced employment on 24 January 2000. She was employed as a Life Management Consultant.

13. Initially, the claimant was employed by ICAS Ltd. ICAS Ltd was taken over by
20 AXA Group in 2008, and changed its name to AXA ICAS Ltd, the respondent.

Contractual documents and related communications

14. On 5 January 2000 the claimant was provided with an offer letter which set out “the principal terms and conditions of your employment”. The claimant signed the offer letter on 15 January 2000, confirming that she had received
25 a statement of her particulars of employment and “that these constituted [her] contract of employment”.

15. The offer letter set out her commencement date (24 January 2000), location, job title and responsibilities, hours of work (referring to “standard hours of work being 30 hours a week” and that she “may also be requested to work

Saturday and Sunday on a rostered basis for additional payments") and salary (which referred to her salary for her normal hours).

16. Section 7 was headed "Benefits Package" and states: *"On successful completion of a six month probation period, you will become entitled to the following benefits. Please make an appointment with the Director of Human Resources, who will advise you in more detail of the schemes and provide you with the appropriate documents*." There were then 6 bullet points setting out the following benefits: "The Royal and Sun Alliance Medical Insurance Plan, Free Life Assurance, The Sun Alliance Permanent Health Insurance Scheme, Group Personal Pension with Norwich Union, ICAS In-House EAP, Personal development and professional education".

17. The offer letter included other terms, such as holidays, sickness (with reference to the employer "operating a sick pay scheme" with full details of entitlement under the scheme in the Handbook), confidentiality, grievance and discipline, notice of termination and company property.

18. Clause 14 was entitled "changes to your terms of employment" and stated that the employer *"reserves the right, after due consultation, to make reasonable changes to any of your terms and conditions of employment and will notify you in writing of such changes at the earliest opportunity and in any event within 28 days after such changes have taken effect."*

19. The offer letter (at paragraph 15) stated that *"In all other respects your employment will be governed by the rules in force at the time"* which may be updated as the need arose.

20. The claimant was also provided with an Employee Handbook. The Tribunal was provided with a 1998 and 2005 edition. The claimant received both documents, the 1998 one in 2000 and the 2005 update subsequently. The introduction in both was identical and stated that the handbook gave useful information and guidance on policies, procedures and practises. Employees were told to "read it as soon as possible as it forms part of your contract of employment together with your offer letter".

21. The Handbook had 4 sections (albeit it was not clear whether or not there were other sections as the Tribunal was only given an excerpt of the document, with the parties being unable to locate a full copy of the document). The sections were the company's mission, employment policies, other terms and conditions of employment and Employee Benefits.

22. The 1998 edition was given to the claimant upon commencement of her employment and had a section (at page 22) entitled "Permanent Health Insurance Scheme" which stated: *"This scheme enables employees to be paid a proportion of salary, if at the end of a specified period of absence, caused by illness or injury, they are still unable to work. The benefits paid under the scheme are secured by a policy effected with the Sun Alliance, the premiums of which are paid entirely by ICAS. Further details on the scheme will be given on request from the Director of Human Resources. All staff are eligible on completion of a successful 6 month probationary period."* The Tribunal did not have a full copy of this document. The other sections on the excerpt provided were entitled Health Care Plan (to which all permanent staff were entitled on successful completion of the probationary period and which benefit is paid by the company but taxable and which was designed to meet the costs of private medical treatment) and subscriptions (with the employer paying the annual subscription of an appropriate professional organisation).

23. The employer issued an updated Handbook in 2005 which was given to the claimant. This was a version dated November 2005. This Handbook is stated to form part of the claimant's contract of employment together with her offer letter.

24. Only 1 page of the substantive part of the document was provided to the Tribunal. It stated as follows:

*"**Life Assurance***

All permanent employees on successful completion of a 6 month probationary period will be covered for free life assurance. In the event of your death in service a lump sum equal to 4 times your annual salary is payable to our beneficiaries. You will be asked to complete a beneficial nomination form

indicating your wishes. This will be kept on your personnel file and can be changed at any time.

Private medical insurance

ICAS operates a Health Care Plan which is designed to meet in the main costs of private medical treatment. The plan is administered by Manson Warner in conjunction with Royal and Sun Alliance. All permanent staff will be eligible after they have had their position confirmed by ICAS following the satisfactory completion of a 6 month probationary period. The cover includes spouse and dependents up to the age of 21. The benefit is paid by the company but is a taxable item and therefore reported on your P11D. Full details of the scheme will be given to you individually.

Group Permanent Health Insurance Scheme

The scheme enables employees to be paid a proportion of salary, if at the end of a specified period of absence, caused by illness or injury, they are still unable to work. The benefits under the scheme are secured by a policy effected with UNUM the premiums of which are paid entirely by ICAS. Further details on the scheme will be given on request from the Human Resource Department. All staff are eligible to apply for entry to the scheme after they have had their position confirmed by ICAS following the satisfactory completion of a 6 month probationary period.

Professional subscriptions

Membership of professional bodies is an integral part of self development and the company wishes to encourage employees to join those appropriate to their role. Subject to the successful completion of the 6 month probationary period ICAS will pay the annual subscription of one appropriate professional organisation. Please discuss this with your manager"

25. Following the successful completion of the claimant's probationary period she contacted Human Resources for further details as to the benefits due under her contract. She was sent, in the post, a 2 page document (stapled together in an envelope with a with compliments slip and nothing else).

26. This was headed "ICAS Benefits". The benefits document stated the following:

"Private Healthcare

Insurer – Royal & Sun Alliance

Administrator – Manson Warner

5 *Procedure for claiming – in the first instance consult GP and if necessary state that covered by private medical insurance.*

Ring helpline for claim form and be ready to give appropriate details

MUST notify Manson Warner of any potential claim

Manson Warner will send claim form for GP and Specialist to complete

10 *Send completed forms back do not directly settle accounts with the provider.*

In an emergency use the NHS but contact the helpline to discuss options

All the nominated hospitals have private facilities and open visiting hours

Covered as "Cover 2 Hospitals" any hospital shown in the PPP Healthcare directory

15 *What is not covered – pregnancy, cosmetic surgery, self inflicted injuries, Aids, routine check ups, dentistry, chiropody*

Upon request can also provide details of members of special rates for travel insurance.

Reduces waiting time significantly

20 *Cover includes spouse and dependants up to age 21 years*

Premiums paid by ICAS but is a taxable benefit and therefore will be shown on P11D

If decide to take out medical insurance please complete application form and return to me – Lisa Robinson Human Resource Consultant, ICAS

25 *Group Personal Pension Scheme*

The accumulated value of the fund is used to provide a pension payable for life.

All members can receive an annual statement

Can take up to 25% of accumulated fund as a tax free lump sum under current legislation

Retirement benefits may be taken at any time when ages between 50-75

Contributions – Employer = 3% Employee = minimum of 2% of basic salary Contracting out of SERPS (State pension comprises of 2 areas - a Basic old age pension and b SERPS applicable to employed people)

ICAS pension carries the option to contract out ie the DSS will redirect the portion of the employers and individuals national insurance contributions that would normally go towards SERPS or the pension fund

Currently contracting out becomes more favourable the younger you are and dependant upon a minimum level of earnings.

If you leave ICAS contributions will be discontinued but the fund already invested could still grow. Can recommence making contributions provided in receipt of non pensionable earnings or a future employer could contribute to the plan

If you die before retiring in addition to the lump sum death benefit of 4 times annual salary, the accrued value of the pension fund is payable as a lump sum

If you choose to retire early the accrued value of the fund will be used to purchase benefits likely to give a lower pension but a forecast/plan could be worked out in advance

Where are contributions invested? Pension plan is provided by Norwich Union. Funds offered include Specialist Funds, Managed Funds and With Profits – the choice is up to the individual

If no preference then it is invested in a with profits fund

Can switch funds at any time,

Advice on pension and options can be provided by an independent financial adviser

Group Life Insurance

5 *Employees become eligible upon satisfactory completion of 6 months probationary period.*

Covers Death in Service before age 65 and is a sum equal to 4 times annual salary payable to nominated beneficiaries tax free

May be required to provide evidence of health

10 *Premiums paid by ICAS – no contributions from employee*

Required to complete a Beneficiary Nomination Form and return to personnel department to be held on file

27. *Nominated beneficiaries can be amended at any time.*

Group Permanent Health Insurance

15 *All permanent employees (contracted to 16+ hours per week) and who have completed their 6 month probationary period are eligible and are aged between 16 – 65.*

A proportion of normal earnings are paid during a long term absence as a result of incapacity to work.

20 *Benefit is payable following a continuous period of incapacity of at least 26 weeks whilst a member of the scheme.*

Paid monthly in the form of salary commencing one month after the waiting period.

Benefit is monthly 1/12 of 3/4s of the individuals scheme salary less State

25 *Benefit.*

Increased by 5% on each anniversary of commencement of payment for as a long as benefit continues to be payable.

Contributions are paid in full by ICAS – no cost to the employee."

Claimant's working position and absence

5 28. On commencement of employment, in January 2000, the claimant was 37 years of age. The claimant was a permanent employee contracted for more than 16 hours per week. She completed her six month probationary period.

29. The claimant was absent from work from September 2010. This became a period of long-term absence which continued up until the termination of her
10 employment in September 2013.

30. The claimant's absence from work was covered by fit notes provided by the claimant's GP which the claimant provided to the respondent. The reason the claimant was unfit for work was given in the fit notes as "stress", "stress at work", "anxiety" and/or "depression".

15 31. The fit notes confirmed the claimant was unfit to work initially for periods of two or four weeks, and latterly for periods of six or eight weeks, and always had an end date. None of the fit notes provided by the claimant stated that she had a permanent incapacity to work. The reasons set out in the fit notes were not disputed by the respondent who accepted the claimant was unfit for
20 work for the stated reasons during her absence up to her dismissal.

Correspondence between the parties as to PHI sums

32. On 27 September 2012 the claimant wrote to an employee within the HR department stating: *"As you will know under my contract of employment I have a contractual right to a Permanent Health Insurance payment under the Royal
25 and Sun Alliance Insurance Scheme with ICAS Ltd and in existence since the year in which I was employed, in 2000. I have been unfit to work since 23 September 2010 due to discrimination, harassment, victimisation, personal injury and injury to feelings in the workplace. Due to my ill health I have been unable to address this matter until recently."*

33. She then asked what had been done about making a claim for the claimant under the Royal and Sun Alliance policy, when the claim was made, whether it was made within the policy time limits (the claimant believing the time limit to be 28 weeks from the start of her illness), when did Royal and Sun Alliance know and what was the outcome of the claim and if no claim has been made why not.

34. In June 2012 Ms McGlone joined the respondent as Senior HR Business Partner. She had no knowledge as to the claimant's contractual position and was not aware as to the specific wording of the claimant's contract (nor of the Benefits Document issued to her).

35. By letter dated 9 November 2912 Ms McGlone responded to the claimant's letter. She introduced herself. She stated: *"As part of my role, I am responsible for the administration of the Health Services benefits. A recent audit revealed there was an administration error in 2011 which meant that you were not covered for Permanent Health Insurance through our external provider Canada Life. Unfortunately once this error had been recognised your absence had passed the trigger date for a claim through our external provider. I can only apologise for this error and will ensure that moving forward all documentation is accurate and given my personal attention.*

The company has arranged for you to make an application for Permanent Health Insurance through AXA's Group Income Protection Scheme. I have enclosed a copy of the policy. Please note that under the section Entitlement you are entitled to receive 75% as per the Canada Life Scheme and not 50% as stipulated in the policy. I can confirm that should you meet all the categories of eligibility you will not be caused a detriment as a result of this administration error. Acceptance onto the Scheme is subject to independent medical assessment. We are happy to arrange for an impartial Occupational Health Physician who is not associated with the Company to carry out your assessment."

36. The claimant replied on 26 November 2012 noting that she had no knowledge of a Canada Life scheme. She stated that her rights are *"contractual rights to*

payments from the Permanent Health Insurance Scheme ICAS had for my benefit with Royal and Sun Alliance. My rights to payments under this Permanent Health Insurance Scheme with Royal and Sun Alliance has been part of my contractual benefits package since 2000. I refer you to my contractual documentation which makes this clear. I reasonably expected you to have checked my contractual documentation prior to replying about payments due to me under the Permanent Health Insurance scheme with Royal and Sun Alliance Insurance." She believed she had contractual right to the Royal and Sun Alliance Insurance scheme.

37. On 14 December 2012 Ms McGlone replied to the claimant. She stated that Group Income Protection and Permanent Health Insurance referred to the same benefit and were terms used interchangeably. She said that her original letter referred to the claimant's contractual right to permanent health insurance.

38. Ms McGlone referred to the administration error which meant the claimant was not covered for Permanent Health Insurance through their external provider, who at the time was Canada Life (which changed in 2008). She noted that although the claimant's contract referred to Royal Sun Alliance that was an error as it was not the company's policy to stipulate providers of benefits which the company changes from time to time. She said that the company was not aware of the clause in the claimant's contract when the provider changed to Canada Life. She stressed that the claimant's access to the benefit and the terms of the benefit *"have not altered and you have not been caused a detriment as a result of this change of provider".*

39. She stated that to ensure the claimant did not suffer any detriment as a result of the error, the company arranged for the claimant to make an application for PHI through the AXA Group Income Protection Scheme, which had been enclosed in the last letter. She asked the claimant to confirm whether she wished to make a claim under that scheme.

40. On 9 February 2013 the claimant wrote again to Ms McGlone with a letter headed "My rights under contractual permanent health insurance scheme".

The claimant noted that she had been told that the Canada Life policy was the "same benefit" as the Royal and Sun Alliance contractual policy to which she was entitled. She asked for more information about the scheme and more information about the error that was made.

5 41. On 26 March 2013 Ms McGlone replied to the claimant noting that she had been out the office and apologised for the delay. She stated that the claimant's PHI claim was not made within he stipulated time frame due to human error and having reviewed the terms of the scheme she believed the PHI Benefit from Canada Life was the same as the original PHI scheme. As that was not 10 possible the respondent was willing to offer the claimant *"the same cover she would have received under the Canada Life policy through the ACA Group scheme."* And the claimant would not be caused a detriment as a result. It was not possible for the claimant to participate in the Canada Life scheme.

42. Ms McGlone noted that they had been corresponding since 27 September 15 2012 and asked the claimant to confirm whether she wished to make a claim through the AXA Group Policy. If the claimant wished to do so she was to confirm the position in writing by 19 April 2012 which failing the opportunity would be lost. Forms were included to allow the claimant to pursue a claim.

43. The claimant replied on 5 April 2013 asking for more time given she wanted 20 to consider her options. She asked for more information about the administration error and the persons responsible.

44. On 2 May 2013 Ms McGlone replied to the claimant stating that the error had been a human error by an employee in the HR team which error was discovered "*in response to your letter dated 26 November 2013".* She stated 25 there were no documents relating to the error and it was not appropriate to provide individual names. She noted that the change from Royal and Sun Alliance to Canada Life took place prior to the respondent acquiring the claimant's employer's business in 2007 and she did not have any additional information.

30 45. Ms McGlone concluded stating that the claimant is unable to pursue a PHI claim through Canada life but the company would offer the claimant the same

cover she would have received via Canada Life through the AXA Group Scheme and she "would not be caused a detriment". She asked the claimant for her written agreement to pursue a PHI claim before 24 May 2013 which failing the opportunity to participate in the PHI scheme would be withdrawn.

5 46. On 16 May 2013 the claimant replied stating she needed further information before being able to make a decision.

47. On 21June 2013 Ms McGlone wrote to the claimant asking for a decision by 5 July 2013. The claimant did not respond within the set timescale.

Claim form

10 48. The ET1 was prepared by the claimant herself and lodged on 25 June 2013 and accepted on 1 July 2013.

49. At paragraph of the claim form the claimant was asked "how many hours on average did you work each week". She said 23 hours. She was asked how much for was paid for those hours and she said £1,191 and that her "normal 15 take home pay (including overtime, commission, bonuses and so on)" was £1,054 per month. The claimant made no reference to her additional hours or pay in respect of weekend work.

Further correspondence

50. On 16 July 2013 the respondent wrote to the claimant inviting her to a formal 20 meeting to discuss her absence at work and next steps. The claimant replied noting other disputes she had with the respondent (and other entities). She stated that any decision to end her employment would be in beach of the implied term of her contract not to do so hoven her contractual right to monthly wage payments from the respondent under the PHI Scheme. She stated that 25 she had appropriate evidence as to her incapacity to work including from independent medical practitioners which could be supplied once the question as to the identity of her employer has been "legally settled by the tribunal and courts".

51. On 7 September 2013 the claimant wrote to Ms McGlone and noted that the AXA Scheme was not equivalent to the scheme she believed she was contractually entitled to. She disputed that the law forced her to agree to either the AXA or Canada Life scheme. She argued the sums due to her under the Scheme are contractual.

52. Although the claimant had been told she would not suffer a detriment if she made a claim under the insurance schemes offered to her, the alternative schemes did not provide the same level of benefits set out in her contract. They were inferior.

53. In a letter dated 12 September 2013 the claimant was advised that she had failed to attend the hearing that had been fixed to consider her employment and her employment had been terminated.

Evidence of incapacity

54. A report was produced on 21 December 2012 by Dr Smith, Speciality Registrar, in respect of the claimant, which was *“prepared at the request of Mrs McMahon for an employment tribunal and other legal processes”.*

55. The claimant did not provide a copy of the 2012 Report to Ms McGlone prior to the claimant’s employment terminating. The 2012 Report confirmed that the claimant, as at December 2012, was unable to undertake any type of work, even with adjustments, due to her mental health, and that her mental state should be reviewed in six months.

56. The medical evidence which the claimant provided directly to Ms McGlone during the course of their correspondence was the fit notes provided by her GP which confirmed that the claimant was incapable of work.

57. A report was produced on 19 June 2022 by Dr Kinniburgh, Consultant Psychiatrist, in respect of the claimant.

No payments received or made

58. The respondent did not receive any payments from any insurance provider relating to permanent health insurance in respect of the claimant.

59. The claimant did not receive any payments in respect of permanent health insurance from the respondent.

Claimant's monthly pay

60. The claimant's gross rate of pay was £1191.75 per month for the period 28 May 2011 until 27 March 2012. That was in respect of her normal hours of 23 hours per week. She would often be rostered to work one weekend in four. The claimant considered that she required to work the weekends when she was rostered. She regularly worked one weekend in four from around 2005 until her long term absence (and then dismissal). The payment in respect of the additional hours she worked in respect of the weekend rota (which was ordinarily one weekend in four) was £160.43.

61. From 28 April 2012 until 27 May 2013 her salary had increased to £1233.50 per month (had she been working). There was no evidence as to precisely what the overtime payment would have been (if it had increased).

62. Following the claimant's absence she received statutory sick pay of "around £80" which was paid for "around 6 months".

Observations on the evidence

63. Broadly speaking the Tribunal found that each of the witnesses did their best to recall events and provide credible and reliable evidence. In this case there were little disputes on material issues. The matter revolved around the correct legal interpretation of the paperwork that had been issued to the claimant.

64. One difficulty that arose in this case was that the facts in issue occurred in 2012 and 2013. The claimant did her best to recall the position as she understood it and it was clear that the passage of time had an impact upon the quality of evidence at times. The same applied in respect of Ms McGlone.

65. The challenge for the respondent was that the evidence they led was from the HR Business Partner who had not been involved at the time the contract was entered into. Ms McGlone joined the business some time after the claimant had been given the documents that were material to this claim. She was

unable to provide evidence in relation to the material issues with regard to the contractual position as it subsisted when the claimant's contract was formed (or when the Benefits document she received pursuant to her contract) was issued. Ms McGlone had not seen the Benefits document before. In many respects therefore the respondent was unable to challenge what the claimant said had occurred at the time (or what her terms were).

66. The focus of the respondent's evidence was in relation to PHI schemes that they wished to provide the claimant in place of the benefit set out in her contract. That arose, in part, as a result of Ms McGlone being appointed following the commencement of the claimant's absence with her focus being on the commercial aspects (the desire to provide the claimant with a PHI scheme the respondent had introduced by the time Ms McGlone had joined) rather than upon precisely what had been provided to the claimant in terms of her contractual position. Regrettably neither the claimant nor the respondent clearly set out in writing at the material times precisely what had been agreed and precisely why what was being offered in terms of the alternative policies was not in accordance with what the documents the claimant had been given said. This resulted in both parties focussing on slightly different issues with the key dispute not being fully considered. Thus the claimant was focused on the error that had occurred and Ms McGlone was focused on providing the PHI benefit in place at the time she was writing to the claimant.

67. The respondent did request information from the claimant as to her health position but this was not to satisfy itself that she was incapable of carrying out her work but rather to allow it to pursue a separate insurance policy. On a fair reading of the claimant's contractual entitlement there was no requirement to undergo an independent examination nor to provide anything other than reasonable evidence of her incapacity for the relevant time. At no stage did the respondent dispute that the claimant was incapable of carrying out her work.

68. Had the respondent appreciated the issues arising in this case and addressed them at the time, the outcome may have been different. The respondent believed that they were offering the claimant a benefit consistent with what

she had been given in her contract. Regrettably the claimant had not set out clearly during the correspondence why it was not necessary for her to do so. While Ms McGlone believed she was offering a benefit that would cause the claimant no detriment, in fact the policies she had provided to the claimant were inferior to the benefit set out in the claimant's contract.

69. The claimant had produced a letter which Ms McGlone had not sent, page 108 of the bundle. The Tribunal considered this letter had been a previous draft and had been provided to the claimant during a subject access request. The Tribunal did not find this letter to be material to the issues to be determined, which were essentially based upon the contractual position, rather than either party's interpretation of the contract following its conclusion.

70. Another difficulty that arose in this case was that the parties had only produced excerpts from some of the key documents, such as the Handbook. The Tribunal expressed a concern that other parts of the Handbook could have had a bearing upon the matters being determined given the importance of context but it was only possible to determine the issues from the material provided.

Law

71. Section 13 of the Employment Rights Act 1996 provides workers with the right not to suffer unauthorised deductions from their wages. Section 13(3) defines a deduction as *"where the total amount of wages paid on any occasion by an employer to a worker employed by him is less than the total amount of the wages properly payable by him to the worker on that occasion".*

72. Accordingly, there cannot be a deduction unless the wages claimed were "properly payable" in the first place. In order to determine what is *"properly payable" for the purposes of section 13(3), the Tribunal is required to "make findings as to the claimant's contractual entitlement to pay or…payments that were properly payable by reference to her employment in order to identify whether and to what extent there had been a shortfall"* (**Davies v Droylsden Academy** UKEAT/0044/16, paragraph 37).

73. In so doing, the Employment Tribunal has jurisdiction to make a determination on the terms of the worker's contract, including questions of contractual interpretation (**Agarwal v Cardiff University** [2018] EWCA CIV 2084). That may involve a requirement to consider not just the construction of the contract in question, but also general rules of contract law (**Cleeve Link Ltd v Bryla** 2014 IRLR 86).

Contract Law

74. The basic principles of contract formation dictate that in order for a contract to exist, there must be an agreement made between the parties and that the terms must be sufficiently certain for the courts to be able to give meaning to them. When considering a written contract, as is most often the case, this requires an exercise in identifying which documents contain the relevant contractual provisions.

75. Additionally, where an apparently complete document states that it contains the whole terms of the parties' agreement (often referred to as an "entire agreement" clause), such a term is generally to be considered conclusive. Entire agreement clauses do not preclude the courts importing certain terms by implication (**Burnside v Promontoria (Chestnut) Ltd** 2017 CSOH 157).

Construction and Interpretation

76. Once the terms of the contract are identified, the exercise turns to determining what they mean, by considering the contract's construction and interpretation. That is an objective exercise. Leading commentary describes this approach as: *"those resolving disputes about the meaning of words need to adopt the position of a reasonable and disinterested third party."* (Gloag & Henderson: The Law of Scotland, 15th Edition, Chapter 6, paragraph 6.24).

77. The law in this area was helpfully set out by Lord Hoffmann in his speech in **Investors Compensation Scheme Ltd v West Bromwich Building Society** [1998] 1 WLR 896 at pp.912–913:

"... I think I should preface my explanation of my reasons with some general remarks about the principles by which contractual documents are nowadays construed...

5 *The result has been, subject to one important exception, to assimilate the way in which such documents are interpreted by judges to the common sense principles by which any serious utterance would be interpreted in ordinary life. Almost all the old intellectual baggage of "legal" interpretation has been discarded. The principles may be summarised as follows:*

10 *(1) Interpretation is the ascertainment of the meaning which the document would convey to a reasonable person having all the background knowledge which would reasonably have been available to the parties in the situation in which they were at the time of the contract.*

15 *(2) The background was famously referred to by Lord Wilberforce as the "matrix of fact", but this phrase is, if anything, an understated description of what the background may include. Subject to the requirement that it should have been reasonably available to the parties and to the exception to be mentioned next, it includes absolutely anything which would have affected the way in which the language of the document would have been understood by a*
20 *reasonable man.*

25 *(3) The law excludes from the admissible background the previous negotiations of the parties and their declarations of subjective intent. They are admissible only in an action for rectification. The law makes this distinction for reasons of practical policy and, in this respect only, legal interpretation differs from they way we would interpret utterances in ordinary life. The boundaries of this exception are in some respects unclear. But this is not the occasion on which to explore them.*

30 *(4) The meaning which a document (or any other utterance) would convey to a reasonable man is not the same as the meaning of its words. The meaning of words is a matter of dictionaries and grammars; the meaning of the document is what the parties using those words against*

the relevant background would reasonably have been understood to mean. The background may not merely enable the reasonable man to choose between the possible meanings of words which are ambiguous but even (as occasionally happens in ordinary life) to conclude that the parties must, for whatever reason, have used the wrong words or syntax: see ***Mannai Investments Co Ltd v Eagle Star Life Assurance Co Ltd*** *[1997] AC 749.*

(5) The "rule" that words should be given their "natural and ordinary meaning" reflects the common sense proposition that we do not easily accept that people have made linguistic mistakes, particularly in formal documents. On the other hand, if one would nevertheless conclude from the background that something must have gone wrong with the language, the law does not require judges to attribute to the parties an intention to which they plainly could not have had. Lord Diplock made this point more vigorously when he said in ***Antaios Compania Naviera SA v Salen Rederierna AB*** *[1985] AC 191, 201: "if detailed semantic and syntactical analysis of words in a commercial contract is going to lead to a conclusion that flouts business common sense, it must be made to yield to business common sense."'*

78. The starting point is therefore to consider the words used, placed in the context of the contract as a whole. In the Supreme Court case of **Arnold v Britton and ors** 2015 AC 1619 Lord Neuberger summarised this as the courts' requirement to focus on the meaning of the words "in their documentary, factual and commercial context." He went on to state: *"That meaning has to be assessed in the light of (i) the natural and ordinary meaning of the clause, (ii) any other relevant provisions of the [contractual agreement], (iii) the overall purpose of the clause and the [agreement], (iv) the facts and circumstances known or assumed by the parties at the time that the document was executed, and (v) commercial common sense, but (vi) disregarding subjective evidence of any party's intentions." (paragraph 15).*

79. **Arnold** was an endorsement of two key earlier decisions: in **Chartbrook Limited v Persimmon Homes Limited [**2009] 1 AC 1101 and **Rainy Sky SA**

v Kookmin Bank Co Ltd 2011 UKSC 50. In the former, Lord Hoffman described the approach *as "the question is what a reasonable person having all the background knowledge which would have been available to the parties would have understood them to be using the language in the contract to mean"* (paragraph 14).

80. In **Rainy Sky** Lord Clarke summarised it as: *"The exercise of construction is essentially one unitary exercise in which the court must consider the language used and ascertain what a reasonable person, that is a person who has all the background knowledge which would reasonably have been available to the parties in the situation in which they were at the time of the contract, would have understood the parties to have meant. In doing so, the court must have regard to all the relevant surrounding circumstances. If there are two possible constructions, the court is entitled to prefer the construction which is consistent with business common sense and to reject the other."* (paragraph 21).

81. In the case of **Wood v Capita Insurance Services Ltd** [2017] AC 1173, in respect of a contractual claim of wrongful dismissal and interpretation of a share purchase agreement, the Supreme Court rejected a suggestion that **Arnold** had departed from prior principles of contractual interpretation. Lord Hodge at paragraph stated: *"The court's task is to ascertain the objective meaning of the language which the parties have chosen to express their agreement. It has long been accepted that this is not a literalist exercise focused solely on a parsing of the wording of the particular clause but that the court must consider the contract as a whole and, depending on the nature, formality and quality of drafting of the contract, give more or less weight to elements of the wider context in reaching its view as to that objective meaning."*

82. In Scotland, this line of authority was endorsed by the Inner House of the Court of Session in **HOE International Ltd v Andersen** 2017 SC 313 (at paragraphs 21 and 22) and **Ashstead Plant Hire Co Ltd v Granton Central Developments Ltd** 2020 SC 244 (paragraphs 9 and 10).

83. As well as this more general objective approach to the exercise of interpretation, there are other principles which have developed through case law which the courts may turn to if the need arises (summarised at paragraphs 4.36 and 4.37 in MacQueen and Thomson on Contract Law in Scotland, 5th Edition, Chapter 4):

(a) Meanings which give rise to an absurd result should be resisted;

(b) Vague general terms should be limited by more precise terms, where they exist (the *specialia generalibus derogant* rule);

(c) where a list of specific things is provided for in a contract, followed by a conclusion using more general words, the latter is limited in scope to only those things of the same class or type as those explicitly listed (the *ejusdem generis* rule); and

(d) where there are "ambiguous terms contained in contract documents which have been prepared by one of the parties rather than being the outcome of negotiation between the parties, the court will prefer the construction which is least favourable to the party putting the term forward (the *proferens*) or which is against (*contra*) that party's interest" (the *contra proferentem* rule) (paragraph 4.37).

84. Finally, as McBryde on Contract Law in Scotland (at paragraph 8-03) says: *"Leaving aside exceptional cases—such as when the contract contains a clerical error—a contract is construed according to what the parties have said, not what they intended to say. As it has been put, "the question to be answered always is, 'What is the meaning of what the parties have said?' not, 'What did the parties mean to say?'"."*

Implied terms

85. In addition to considering the construction and interpretation of the express terms of a contract, implied terms may also exist. Such terms fall into two categories: those implied by law (applying to all contracts or all contracts of a certain type e.g., employment contracts) and those implied by fact (applying to a specific contract where the express terms do not operate to deal with a

particular issue). The distinction between the two is that *"while terms implied in law are included unless the parties otherwise intend, terms implied in fact are only included if the parties' intention to do so can be made out in accordance with the rules on the subject."* (MacQueen and Thomson, paragraph 4.41).

86. Any implied terms said to be included within a contract cannot operate to supersede or contradict any express terms and will not be incorporated where any express provision excludes them. Lord Hoffman observed in **Johnson v Unisys Ltd** [2003] 1 AC 518, that *"any terms which the courts imply into a contract must be consistent with the express terms. Implied terms may supplement the express terms of the contract but cannot contradict them."*

87. The terms implied by law may be implied by statute, by common law (such as, in the employment context, the implied duty of trust and confidence) or by custom (provided it is sufficiently ascertainable within a certain commercial area or practice). More general implied terms governing how the parties to a contract should behave have also developed over time (outlined at paragraph 4.48 in MacQueen and Thomson and the citation thereon). Those include implied terms requiring that: parties cooperate in order to ensure the contract is carried out; performance is carried out within a reasonable time; one party does not do anything which would inhibit the other from being able to perform the contract; or any discretionary powers conferred should be applied reasonably.

88. When it comes to terms implied by fact, there are several principles which apply and often overlap. This was first laid out in **BP Refinery v President, Councillors and Ratepayers of the Shire of Hastings** (1977) 52 ALJR 20 as: *"[F]or a term to be implied, the following conditions (which may overlap) must be satisfied: (1) it must be reasonable and equitable; (2) it must be necessary to give business efficacy to the contract, so that no term will be implied if the contract is effective without it; (3) it must be so obvious that 'it goes without saying'; (4) it must be capable of clear expression; (5) it must not contradict any express term of the contract."*

89. This approach was expanded upon more recently by the Supreme Court in **Marks and Spencer plc v BNP Paribas) Ltd** 2016 AC 742. The dicta from **BP Refinery** quoted above was approved and added to, and it was confirmed that points (2) and (3) could be alternatives so that only one of them need
5 apply. The test of obviousness is often referred to as "the officious bystander" test.

Specific authorities regarding permanent health insurance entitlement

90. There are a number of authorities which considered the issue of contractual interpretation in relation to permanent health insurance benefits.

10 91. In **Villella v MFI Furniture** 1999 IRLR 468 the issue was whether the employee, who was in receipt of benefits under the employer's long-term disability scheme, ceased to be entitled to them when his employment ended. The employer relied upon a provision in the insurance policy to that effect. The documents that the claimant had been given were a letter and a
15 "memorandum". The memorandum began by stating that *"[t]he company has introduced a long-term disability scheme which is ensured with NEL Permanent Health Insurance Ltd. Brief details of the scheme are given in this leaflet, which is intended to serve as a guide only."* That document set out the level of benefit that would be provided in various specified circumstances.

20 92. In holding that the employer could not rely on the clause in the insurance policy, the Court referred, at paragraphs 28 to 33, to a number of factors, including (a) the policy was not shown to the employee or drawn to his attention. Although this was "not a ticket case", the principle in **Thornton** applied; (b) the only documents given to him were the letter and the
25 memorandum. The letter described the memorandum as providing full details. The conflict between that and the memorandum's self-description as "brief details" was to be resolved in favour of the employee; (c) the memorandum described the benefit in clear terms, inconsistent with it being subject to approval by the insurer or terminable as claimed; (d) a provision concerning
30 the effects of leaving service carried the inference that, whilst disabled, an employee would not lose benefits; and (e) "The memorandum, whilst referring

to the existence of insurance, does not refer to the terms thereof or suggest their relevance."

93. In **Earl v Cantor Fitzgerald international** [2000] EWHC 555 (Queens Bench Division) the employer provided a "Long Term Disability Insurance" scheme. The Judge concluded that it was clear from the rules that were provided to the employee that this was not a contract of insurance (or subject to a contract of insurance) but an undertaking by the employer to make certain payments to the employee in certain situations. The payments were to be as salary. The fact the employer had insured its liability under the scheme and the insurer played a prominent part in the administration of the scheme did not detract from that. The language was to be given its natural meaning having due regard to the nature of the scheme, its function as part of the contract of employment and the general commercial context, including, to the extent relevant, that the insurance contract.

94. At paragraph 29 the Court noted that even taking account that there was an insurance contract in place, there was nothing to support the proposition that the insurer was the final arbiter or the insurer could determine whether the employee had provided sufficient evidence of incapacity. There were no express provisions to that effect communicated to the employee. There was therefore no implied term that the employee's rights were subject to the terms of the insurance policy between the employer and insurance company, the terms of which had not been brought to the employee's attention.

95. In **Anite Systems Ltd v Williams-Key** [2001] UKEAT 898 the contract of employment issued to the employee stated that, subject to being accepted as suitable risk by the insurance company, the employee would be provided, at no cost to them, with PHI from their first day of employment. The sums that would be paid were set out in the handbook, which was said to be contractual and which made reference to the PHI being "subject to the conditions of the Scheme".

96. The Tribunal found that the contract referred to rights arising from a scheme, which was to be provided via a third party insurance company. It was clear

from the facts that what was to be provided was access to an insurance policy via a third party insurance company. There was no direct obligation on the employer to make payment themselves of the sums set out. The obligation on the employer was to enter a PHI insurance scheme and pass on the benefit of that scheme to the employee. The Handbook had referred to the scheme and the minimum benefits the insurance provided, which the employer was bound to maintain.

97. The Employment Appeal Tribunal upheld the decision finding that while reference was made to a specific scheme and there was no mention of the right to change the scheme, the employer was bound to maintain PHI insurance and provide the minimum level of benefits set out at no burden to the employee. The obligation was to maintain a specific PHI scheme via an insurer rather than provide the benefits themselves.

98. In **Jowitt v Pioneer Technology (UK) Ltd** 2003 IRLR 256 the relevant clause of the handbook began: *"The company runs a scheme that is designed to provide an income during lengthy periods of absence due to prolonged sickness or injury." It set out the entitlement and eligibility conditions attaching to it. A less favourable eligibility condition in the insurance policy was not incorporated. At [12] Sedley LJ observed that the handbook clause "represents in simple terms that the company itself makes provision ('runs a scheme') for pay during long-term disability or illness, and spells out what the provision is".* The Court of Appeal concluded that, properly construed, the respondent had agreed to provide a scheme to pay an employee in respect of long term disability and spelt out in documents given to the employee what the terms of that scheme were. It was prudent for the employer to cover its potential liability by insurance but that policy was not referred to (and the employee did not know of its existence, far less any of its terms). Had the policy been cancelled, the employee would still have been entitled to the sums set out (if the conditions that were communicated to the employee were satisfied).

99. At paragraph 13 the court noted that there was no foundation for incorporating the policy into the contract of employment (directly or indirectly) saying: *"In*

some cases there is no doubt a clause like this would be uncertain without reference to another source for details but here there is sufficient spelled out for the parties to be able to quantify the amount payable." There were some uncertainties, such as what scheme salary meant but the court concluded *"there are plenty of contracts which make similar provision which have to be construed against the background of the facts and practice into which they came into being and this is no exception."* He concluded that the contract was not unenforceable because of such uncertainty, and without implying into the contract the insurance provision. Sedley J concluded; *"There is all the difference between a term which although imperfect can be made to work and one which is simply unworkable. This is the former".* The court therefore found that the scheme the employer introduced created direct contractual rights upon which the claimant could rely.

100. **Smith v Gartner** UKEAT/0279/15/LA was an appeal against strike out of a claim. The claimant had continuous employment going back to 1989 but had transferred to the respondent. The claimant's offer letter referred to a benefits package, including a "Disability plan", stating: *"All benefits offered are subject to the rules in force at that time. Cover for certain benefits may require a medical examination. Copies of such schemes can be obtained from Manager of European Disbursements. Please note however, that the Company will always endeavour to operate a competitive and attractive package of benefits, but reserves the right to terminate or offer alternative benefits wherever appropriate."* The claimant accepted these conditions. There was also a "Guide to Company Benefits" which provided:

"This guide describes your benefits in detail, in conjunction with your terms and conditions of employment. You will find descriptions of your coverage and choices in each benefit area. In summary we offer the following benefits to our employees

Permanent Health/Disability Insurance

The company provides Permanent Health Insurance to all employees, subject to your terms and conditions of employment. However, the maximum waiting

period for membership in this scheme is three years. This insurance provides 75% of salary or 75% of prior tax year earnings; whichever is the greater, after 26 weeks of continuous absence through certified illness or disability. The insurance will continue until either return to work, retirement in service, or death in service. During the 26-week qualifying period, prior to the commencement of the insurance scheme you will receive a mixture of Company Sick Pay and social security benefits.

This insurance is provided to you at no expense."

101. The claimant was on long term sickness and received payments under the Scheme. The claimant was told when this was to cease, which she believed amounted to discrimination. She sued her employer and not the insurance company, arguing that the employer was contractually obliged to continue payment.

102. Eady J (as she then was) noted that the main issue was whether the claimant's entitlement was to benefits under an insured scheme (via the insurer) or simply to such benefits (directly from the respondent). At paragraph 16 having reviewed some of the authorities in this area, Eady J noted that *"The guidance that I derive from these and similar authorities is that each scheme has to be construed carefully with particular attention to the terms as described to the employee."*

103. The key issue in the case was the construction of the contract. The offer letter and statement of terms and conditions provided to the claimant made clear it was committing to putting in place a Disability Benefits Scheme. The detail of such a scheme was not provided, but the claimant was told the benefits offered would be subject to the rules in force at that time. Eady J found that the natural reading of that statement would alert the employee to the fact that there were rules governing the Scheme that must be contained elsewhere. The claimant argued that must refer to the Guide rather than the insurance policy. Eady J was of the view that even if the Guide had contractual force and was incorporated into the contract of employment, it did not help. The Guide defined the previously vague reference to a disability

plan as "Permanent Health/Disability Insurance". Whilst it referred to that insurance as being subject to the employee's terms and conditions of employment that took the reader back to the previous reference to benefits being subject to the rules in force at the time.

5 104. She also noted that although the Guide made reference to salary, that was in terms of providing a reference point for the level of benefit that the insurance will provide. The (repeated) reference to insurance was important. She believed that was different to the express commitment to the continuance of salary as happened in **Earl**.

10 105. She concluded that adopting an objective construction of the contractual documentation (including the Guide), and allowing for the context (these are documents being provided generally to a wide range of employees and are inevitably worded in a way that is informative rather than adopting more formal contractual language), she considered it to be plain that the commitment 15 being made was to put in place insurance that would cover certified permanent health/disability.

106. If that were not so, there would be no need to distinguish this benefit from company sick pay and there would be no need to tell employees that it was an "insurance". She also found that it would make no sense to conclude (as 20 the relevant part of the Guide does) by assuring that the "insurance is provided to you at no expense".

107. She concluded that the commitment was to provide Permanent Health Insurance, subject to the rules of the insurance policy and dismissed the appeal.

25 108. In **H Awan v ICTS UK Ltd** UKEAT/0087/18/RN the contract of an employee contained a clause which stated that "[t]he company has established a Pension and Death and Disability benefits plan" for eligible employees and set out the benefits provided. It stated that "information" on this plan was to be found in a particular booklet. The booklet stated that the benefits "are 30 provided by an Insurance Policy." The policy was not attached, nor were its terms set out, notified or provided to employees. The claimant's employment

transferred to the respondent, which was not able to avail itself of the original insurance policy; and its own insurers did not accept liability in respect of the claimant.

109. The Employment Appeal Tribunal rejected the argument that the employee's entitlement was limited to such benefits as the employer was able to obtain from its insurers and found that the respondent was liable directly. Simler P said:

"35. I do not accept this argument which flies in the face of the contractual documentation in this case. I start with the Claimant's contract itself, which is clear. Clause 6 represents that the employer has established (among other schemes) a disability benefits plan for all eligible employees. The word plan simply signifies an arrangement or scheme. Clause 6(c) sets out precisely the benefits that "will" be provided under the plan as "an annual payment of two thirds of salary". In other words, the benefit provided under the plan is expressed in clear and unambiguous terms as payment of salary. That this benefit is grouped with other benefits is simply a function of the fact that they are benefits provided under schemes set up by the employer to make provision for disability, retirement or death. There is no reference to third party providers or funders of these benefits and no reference to any insurance policy in this clause.

36. Mr Kohanzad did not contend that the insurance policy itself was incorporated into the Claimant's contract (and I can see no arguable basis for such a contention on the material provided to me – there is simply no evidence that the insurance policy was ever provided to employees, although its existence was referred to in the Booklet). The employment contract could have stated that eligibility for disability benefits was subject to the provisions of a relevant insurance policy or the rules of a particular insurance provider. It could have said that the obligation to make payments to the employee would only arise if and when payments were paid out by the insurer. However none of this was said.

37. *Nor is there any substance in the contention that clause 6 would have been expressed as part of clause 5 if it conferred benefits payable as salary by the employer. The two entitlements are different and differently expressed. There is no compelling reason why they should have been dealt with together.*

38. *Nor in my judgment does the Booklet offer any support for Mr Kohanzad's argument. Section G of the Booklet, set out in full above, is consistent with clause 6 of the Claimant's contract, in providing, in the event of absence from and inability to work for a continuous period of 26 weeks or more, for the receipt of "disability income" of two thirds of base annual salary, less relevant benefits. Moreover the benefit described as "disability income" is expressly treated as "normal pay". To that end, it explains that PAYE deductions will be made. Since PAYE deductions are made by the employer, it is inherent in this section of the Booklet that the income paid as disability benefit, and treated as normal pay, is paid by the employer. It seems to me that the contract and Booklet could not have been clearer in providing for the right to payment by the employer of a benefit broadly calculated as two-thirds annual, and treated as pay.*

39. *The other references in the Booklet relied on by Mr Kohanzad do not alter this conclusion. It was plainly sensible for the employer to obtain insurance cover for any liability under the disability scheme. However, the statements that the benefits are provided by an insurance policy, and that the cost of the insurance is borne by the employer do not begin to convert the express contractual right set out in clause 6(c) and section G of the Booklet into a right to the provision of insurance cover only, or to the payment of benefits contingent on the availability of insurance cover. That is simply not stated or communicated to employees anywhere in the contract or Booklet. The statements merely convey limited information to the reader that there is an insurance policy, and that it is paid for by the employer. The obligation on the employer to pay benefits under the disability plan is regardless*

of whether the insurer pays under the policy or not."

110. In **Amdocs System Group v Langton** [2021] UKEAT 001237/19/2408 the issue was whether the claimant had the contractual right to permanent health insurance. The offer letter stated that the claimant's remuneration package included an income protection plan which would result in the company paying staff on sick leave after the first 13 weeks that they are ill 75% of their salary, less basic rate tax, up to their 60th birthday. The document said *"Please see the attached "Statement of Benefits" for further information about the above benefits."* Attached to the offer letter was a document entitled "Statement of Benefits". The statement said:

"In order to protect you and your family from the potential loss of income resulting from long term sickness or disability, the company have established an Income Protection Scheme with Sun Life Financial of Canada. In the event of your premature death, the company have established a Group Life Assurance Scheme with Royal Sun Alliance.

When am I included? You are included in both Schemes if you are a permanent employee from the day you commence employment with Cramer Systems. You will cease to be included in the Schemes at age 60, or on ceasing to satisfy the eligibility conditions.

What benefits are provided? Under the Group Income Protection Scheme, the payment of benefit commences after the first 13 weeks of incapacity. You will be asked to provide medical certification for the insurance company in respect of any incapacity lasting longer than this period. After benefits have been paid continuously for 52 weeks the benefit will increase by 5% every year, until you return to work. In this way, your benefits will have a degree of protection from inflation. Under the Group Life Assurance Scheme, a payment would be made to your Estate, or a nominated individual, following your death.

How much is the benefit? For the Group Income Protection Scheme, the maximum initial benefit is 75% of your salary less a deduction in respect of the State benefit for a single person. For the Group Life Assurance Scheme, the benefit is four times your annual basic salary.

Do I have to pay towards the benefit? No. Cramer pays the whole cost, which does not count as part of your income for tax purposes.

What happens if I leave the company? Should you leave employment with Cramer Systems your cover in both Schemes automatically ceases on the date that you leave.

NOTES The operation of both Schemes is governed by the terms of the Group policies, and nothing in this summary will override the terms of that document."

111. In relation to income protection insurance, the Employment Handbook stated that *"Subject to satisfying any eligibility criteria imposed by the Company's insurers, the Employee shall be entitled to participate at the Company's expense in an income protection scheme, providing up to 75% of salary less an amount equal to basic rate state invalidity benefit, underwritten by such reputable insurers as the Company shall decide from time to time. The Company may from time to time change the benefit provider and vary or amend the extent of the cover or the basis on which it is provided. This benefit will cease on termination of employment."*

112. In addition to the offer letter and "Statement", the claimant was provided with a written "contract of service", which contained the following provisions:

"6. The Employee is entitled to the following benefits to the extent and in the circumstances set out in the Manual and outlined in the employee's letter of offer: i. Salary Protection Plan ii. Pension Fund Participation iii. Life Assurance iv. Equity Participation v. Private healthcare

7. Provisions relating to absence through illness shall be those set out in the Manual.

11. Where the rights and liabilities of the parties are set out in the Manual they shall be varied whenever and in the manner set out in any amendments made to the Manual by the Company. Such amendments will be communicated to each employee individually.

> *22. Save as may have been specifically agreed and provided herein or in any other agreement between the parties the Company and the Employee hereby adopt and incorporate into this Agreement the general terms and provisions (including any provision of amendment or variation) of the Manual herein referred to."*

113. During 2009 the claimant was diagnosed with a long-term illness and he began sick leave. The claimant's claim for PHI was approved but no escalator was applied at any point. The Employment Judge had found that the claimant had a contractual right to the sums, which had included the escalator, the annual increase. The respondent appealed.

114. Auerbach J observed that the outcome of the appeal turned on the correct construction of the relevant written documents, which was a question of law: **Thorner v Major** [2009] 1 WLR 776 at [82]. At paragraph 58 he stated that the court's task is to ascertain the objective meaning of the language which the parties have chosen. Commercial common sense cannot be invoked with hindsight to escape or mitigate the objective natural meaning of the language of the contract.

115. At paragraph 59 he observed that in the employment context a frequent complicating factor is that contractual terms are not invariably to be found in a document that is, in terms, described as the contract. Often there is no such document and there is another title. If the language used in a document, objectively construed, is the language of entitlement, particularly where it relates to an important matter such as remuneration, he opined that that feature is liable to be more significant than the title of the document in which it appears, or whether other documents have described it as, for example, being for information.

116. From paragraph 67 he analysed the authorities in this area. He noted that in the majority of the cases he considered the employee had been provided with documentation which told them the benefit existed and set out, unambiguously, essential provisions as to the level of benefit and the

circumstances in which it would be provided, which objectively conveyed a contractual commitment.

117. At paragraph 68 he said there was a consistent theme that, if there is any ambiguity or uncertainty as to whether the employer's obligation to provide benefits is to be limited by reference to the specific terms of the employer's insurance cover, any such ambiguity will be resolved against the employer and in favour of the employee.

118. Art paragraph 69 he said that a reference to the fact that the employer has arranged insurance in respect of the benefit, was not by itself sufficient to make good the contention that the employer's commitment was limited by reference to the terms of that policy. He opined: *"To be effective, the limitation of the employer's exposure must be unambiguously and expressly communicated to the employee, so that there can be no doubt about it. That might be done by spelling out unambiguously, in a document provided to the employee, or drawn to their attention, what the particular limitations are, by stating in terms that the employer's obligation will be limited to the amount of payments made by the insurer, or something unambiguous of that sort."*

119. On the facts of the case he held that the Tribunal was correct to find the entitlement to the escalator had become contractual. The contract had incorporated as contractually binding the terms of the offer letter and summary of benefit. The offer letter set out the headline terms with clarity and while the summary of benefits was providing "further information" it was not stated to be non-contractual. He found that the fact it was a "summary" did not alter its effect since what mattered was the content not the title and the language used which was language of entitlement repeating unambiguously the headline terms from the offer letter and setting out the precise terms of the escalator.

120. Finally, at paragraph 84 he found that even if the terms had incorporated the insurance policy, the policy which would have been incorporated would have been the policy that was in place at the time the contract was entered into, which had the escalator included, There was no requirement to rely upon any

implied terms. The respondent had made a commitment which it was bound to honour, whether or not the sums were underwritten by an insurance policy.

121. The Employment Appeal Tribunal's decision has been the subject of an appeal, which was heard recently. and the Court of Appeal's judgment is awaited. It is open to the parties to ask the Tribunal to reconsider this decision in the event it is considered to be in the interest of justice to do so. The Tribunal has applied the legal principles set out in the above authorities in reaching its decision.

122. In **Pelter v Buro Four Project Services Ltd** [2022] EAT 105 Taylor J at paragraph 55 stated: *"Under an employment contract the employee provides work in return for payment of salary, and other benefits. The benefits may include provision for circumstances in which, as a result of illhealth, the employee is not able to work. Some employers only offer statutory sick pay ("SSP"). Many employers offer company sick pay for a limited period, at full or partial salary, followed by SSP. Some employers offer to continue paying full, or partial salary, until retirement age. To do so is risky for an employer because it might have to pay full salary for a long period during which the employee is not able to work. An employer could choose to continue paying full, or partial, salary to retirement age funded by an insurance policy. Alternatively, an employer could agreed to provide access to its employees to the benefit of an insurance scheme pursuant to which the insurer will fund benefits should the employee become permanently incapable of work. This is more common than an employer itself agreeing to fund payment of ill-health benefits to employees."*

123. At paragraph 58 he stated that: *"The authorities establish that there is a distinction of principle between an employer agreeing to provide access to the benefit of permanent health insurance to its employees and an employer agreeing that it will fund sickness benefits to retirement, or some other age, should the employee become permanently incapacitated, albeit potentially funded by insurance the employer has taken out for itself."*

Submissions

124. Both parties produced written submissions and the parties were able to comment upon each other submissions and answer questions from the Tribunal. The Tribunal gave the parties time to consider the submissions and respond appropriately. The decision deals with the parties submissions as relevant below, but does not repeat them in detail. The parties' full submissions were taken into account.

Decision and reasons

125. The Tribunal spent time considering the evidence that had been led, both in writing and orally and the full submissions of both parties. The Tribunal deals with issues arising in turn referring to the parties' submissions where appropriate applying the legal principles set out above.

What contractual entitlement did the claimant have in respect of permanent health insurance benefit?

126. The first issue to be determined is what the claimant's entitlement, in terms of her contract of employment, was to permanent health insurance. In other words was the claimant's entitlement to be provided with access to an insurance scheme that provides permanent health insurance (as contended by the respondent) or was the entitlement to be paid directly by the respondent (as the claimant argues).

127. The claimant's agent argued that the relevant documents are those provided to the claimant by ICAS Ltd between around January and July 2000: the offer letter, the staff handbook and the benefits document. There was no statement that the benefit was subject to the terms and conditions of any insurance policy. The information the claimant receive was contractual. The claimant received the further document upon asking for more information. There was nothing in that document which suggested it was not contractual and at no point did the claimant agree to vary her entitlement.

128. The claimant's agent argued the additional information she was given "is the language of entitlement" and in the absence of reference to the entitlement

being subject to specific insurance terms, it is not possible to imply such a restriction. It was also argued that the respondent was not entitled to restrict its contractual obligation to the claimant or rely on its administration error to deprive the claimant of payments to which she is entitled.

5 129. In short, as no policy or terms and conditions were brought to the claimant's attention and the respondent did not state that its liability for PHI payments was conditional on it receiving payments from an insurer, the terms communicated to the claimant apply without limitation, which were the only terms provided to her. It was argued they are clear and unambiguous and
10 amount to a contractual commitment. Reference to other schemes (which were less beneficial) was irrelevant as the claimant was entitled to the benefit set out in her contract. There was no requirement to complete any paperwork to be due the sums set out in her contract which are clear and unambiguous.

130. The fact the claimant knew there was some insurance arrangement between
15 the respondent and an insurer did not alter the claimant's contractual entitlement with the respondent. She believed the respondent had sought to underwrite any liability it had to the claimant, at their own cost.

131. The claimant's agent argued that there was no need to imply any terms into this contractual arrangement given the terms of the documents in this case.
20 The claimant's agent argued that the implied terms relied upon by the respondent's agent were not terms that had been raised before but they were irrelevant. As the authorities on contractual interpretation made clear, it is not for the court to redraft a contract or to "fix a bad bargain". Looked at objectively, the mutual intention of the parties was clear.

25 132. The implied terms argued by the respondent's agent were said to be too vague and uncertain. All that was required was evidence of incapacity. That could take various forms and it is not for the court to introduce terms which were not agreed. Evidence by way of Fit Notes of incapacity to work ought to be sufficient.

30 133. There was no suggestion in the documents provided to the claimant that the policy only applied where permanent incapacity to work was evidenced. It was

possible such benefits covered temporary incapacity. The terms of the contract made it clear that the entitlement is engaged following incapacity after 26 weeks. There was no reference to permanent incapacity (whether in respect of the claimant's role or any role)

134. It was argued that the contract can clearly work without the need to imply any terms. The test is of necessity not reasonableness. If the employer wished to limit the entitlement in some way it would have said so.

135. The claimant had provided evidence of her unfitness to work, by a medical professional, which had not been challenged. It may well be sensible for the employer to have an insurance arrangement in place but without saying the claimant's entitlement was subject to it in any way, such a restriction should not be implied.

136. The respondent accepted that there was a contract of employment between the claimant and respondent, the dispute being what the content of the contract was (expressly and by implication) and what entitlements (if any) in respect of PHI benefit flowed from that content.

137. It was argued that only the offer letter and handbook were contractual and that the Benefit document was providing information which was not contractual. The respondent's primary position was that only the offer letter and the handbook constituted express written content of the contract. What was conferred on the claimant was a contractual right to participate in an insurance scheme (provided by a third-party insurer) facilitated by the respondent for its employees with permanent ill-health. There were 4 reasons for this submission which are considered below.

138. The respondent's agent also argued that it was necessary to imply a number of terms into the contract. These are considered below. It was submitted the respondent's interpretation (whether that includes the Benefits Document or not) met the legal tests, and plainly gives rise to a balanced and commercially sensible arrangement which accords with the generally understood manner in which PHI benefits are conferred and released.

139. The respondent's agent argued that the Tribunal should accept the clear and unequivocal evidence on how PHI schemes operate, including that such schemes involve participation by an employer and employee in a process dictated by an insurer; the employer is not in control of the decision as to whether the benefit is payable to the employee – this is up to the insurer; an employee would need to consent to a claim being made and complete necessary paperwork; an employee would need to submit more by way of medical evidence than fit notes, including but not limited to GP records/reports/specialist reports and independent OH reports and if a claim is made successfully, the benefit is typically (but not always) paid to the employer by an insurer, and then via payroll to the employee.

140. It was said to be highly irregular for an employer to run its own scheme whereby it agrees to pay an employee to cover such an extended period of time. Such an arrangement would effectively be sick pay, removing the need to have a PHI benefit, something which was separately catered for in the offer letter and which the claimant had already received. The normal arrangement is that the employer commits to pay the cost of insurance premiums in order to allow the employee to access the relevant policy should the need arise. Weight had to be given to the other relevant provisions of the agreement, the overall purpose of the clause and commercial common sense.

141. The respondent's agent submitted that the "reasonable person" would understand that what the claimant was conferred with was "eligibility to participate" in her employer's PHI scheme which is consistent with business common sense, the claimant's construction leading to an absurd result.

142. It was argued that when the documents are assessed as a whole what the claimant was entitled to was eligibility to participate in permanent health insurance scheme, which required certain steps to be taken – and conditions to be met - before an entitlement to payment was triggered. It was not enough simply for her to be incapable of working in order for her to become entitled to payment. That analysis of the relevant documents is untenable and unreasonable, and a manipulation of otherwise clearly understood requirements of PHI/income protection benefits. Such an analysis does not

reflect the ordinary meaning of the applicable terms of the contract, nor does it bear resemblance to the common sense understanding of group insured benefits.

Decision as to contractual entitlement

5 143. In deciding what was properly payable it is necessary to consider what the parties had agreed at the outset. In determining this the Tribunal considers the ordinary and natural meaning of the words used within context and in light of the contractual agreement and matrix and commercial common sense. The subjective intention of the parties is irrelevant but the contract as a whole 10 within context should be construed to determine the objective meaning applying common sense.

144. The offer letter created an entitlement to "The Sun Alliance Permanent Health Insurance" (with further detail of the "scheme" available from the director of HR). The handbook, which was stated to be contractual referred to the 15 Permanent Health Insurance scheme which would "enable" employees to be paid a proportion of "salary" if certain conditions were satisfied. The benefits under the scheme were "secured" by a policy effective with the named insurer, the premiums for which were paid by the respondent. The original handbook noted that all staff are eligible following their probation. That was changed in 20 2005 to say all staff are eligible to apply for entry to the scheme after 6 months but by that stage the claimant had passed her probation and the difference is not material.

145. The contract therefore entitles the claimant to a specific benefit – "the Sun Alliance Permanent Health Insurance". Rather than set out precisely what the 25 entitlement was, details were to be provided. It is understood (albeit no evidence was provided) that Sun Alliance was a (then existing) insurance company, there was no evidence provided as to any specific policy or insurance document with Sun Alliance. There was no evidence, for example, of any specific Sun Alliance Permanent Health Insurance Scheme that was 30 said to be what was referred to. No such document was ever provided to the claimant, nor alluded to.

146. The Tribunal did not consider that calling the scheme "The Sun Alliance Permanent Health Insurance" by itself, taking the entire contractual matrix into context, and applying commercial common sense, was so obviously a reference to a specific insurance scheme, rather than, potentially, the name the employer chose for the scheme it decided to run internally (albeit funded via an insurance policy from which the employer may benefit and for which the employer paid). The description of the scheme by reference to an insurer did not of itself, either expressly or impliedly, important into the contract a third party scheme as between the employer and another.

147. The employer also called the sick pay entitlement the sick pay scheme, which was obviously contractual (and run by the employer) and so calling this particular benefit a PHI Scheme did not by itself render the matter outwith the employer's control.

148. Furthermore at no stage in any documentation (contractual or otherwise) was the entitlement said to be subject to the terms of any insurance policy or agreement with a third party and no such specific policy nor such terms were ever communicated to the claimant or offered to her to consider. No such policy was presented in evidence.

149. Both contractual documents (the offer letter and handbook) entitle the claimant therefore to the benefit of a scheme which would enable salary to be paid when certain conditions are satisfied. The scheme is not said to be dependent upon a third party confirming eligibility or subject to other conditions. The contract says staff are eligible to apply for entry once probation has been passed. There is no suggestion that is anything other than an administrative process. There is no suggestion it would be open to the employer to refuse access to the scheme if a third party decided not to cover the employer in a particular case. To that extent the entitlement is similar to that discussed by Sedley LJ in **Jowitt**, It is also similar to the provisions discussed in **Villella** where there was reference to an insurance policy but not the specific terms.

150. The entitlement in this case is to a proportion of "salary", as they were in **Earl** (where the insurer played a large part in the administration) but the express terms were not brought to the employees attention. That is similar to the situation here where the payment is expressed as "a proportion of salary" with the benefits under the scheme are secured by a policy with an insurer paid by the company.

151. While the respondent's agent argues this indicates that the scheme is subject to the terms of an insurance policy, viewed objectively that is not, reasonably, what is intended (even if that was the subjective intention of the employer, then or now, which is irrelevant in objectively construing the contract). The benefits are "secured under" an insurance policy. In other words, the employer has secured insurance to cover any liability for which the employer would be responsible. This is on all fours with **Awan**. Just as in that case, here neither the policy nor its terms were set out in the documents given to the employee nor suggested in any way to be engaged or relevant.

152. Reference to a plan was interpreted by Simler P in **Awan** to mean a scheme or arrangement. In that case the contract said the benefits "will" be provided as a specific amount of salary. Here the contract said the scheme (the arrangement the employer has created) "enables employees to be paid a proportion of salary". This is clearly and unambiguously payment of salary as was the case in **Awan**. The sums to which the employee becomes entitled are secured by an insurance policy the employer has with a named third party but there is no suggestion such a policy is of any relevance to an employee who is otherwise entitled to the benefit of the scheme under this clause.

153. While in **Awan** there was no reference to the insurance company at that juncture, in this case, objectively viewed, reference to the insurance company is simply how the employer proposes to fund any liability that arises. As Simler P noted in **Awan** the contract could have specifically stated that entitlement to the sums due was subject to the employer's receipt of funds from the insurance company with which it had a policy from time to time or could have stated that the employee's entitlement was expressly subject to

the terms of the insurance policy (if sufficiently clear and precise). That is not what is stated nor, reasonably viewed, what was intended.

154. This is not a clause whereby the employer is agreeing to provide employees with access to an insurance benefit (the benefit of which is funded by the employer)., Rather, objectively viewed and applying the rules of interpretation, the employer has set up a scheme which would pay to staff who meet the conditions a proportion of their salary which is (or may be) funded (perhaps) by an insurance policy.

155. This case differs from the position in **Smith** which made it clear in its contractual documents that the entitlement was to “insurance”, referring to the “insurance” being provided to the employee at no cost and the “insurance” providing specific sums in specific situations which was expressly stated to be subject to the rules from time to time in force, the rules being those set out in the insurance policy from time to time in force. Entitlement in that case was not to salary but to the benefit of an insurance policy. That is materially different to the situation in this case. While there is reference in this case (in the offer letter) to the employment being subject to the rules in force from time to time, that is not objectively intended to refer to the rules within an insurance agreement between the employer and an insurance company which were not stated to be applicable to the scheme in place in this case. The insurance policy was for the employer’s benefit, not for the employee (whose benefits and entitlement was set out in the benefits document, again not said to be subject in any way to rules within an insurance contract between the employer and an insurance company).

156. As Simler P observed at paragraph 29 the fact the insurance exists and is paid by the employer does not, by itself, mean the insurance has thereby become part of the contractual agreement between the employer and employee. That, as here, was simply not stated in the contractual documentation. It was open to the employer to say so, if that was the case but it was not done and there was no basis to imply such a position. The obligation was to pay the sums set out regardless of the position as between the

employer and the insurance provided the express conditions precedent for payment were satisfied.

157. This point is confirmed in **Amdocs** where the scheme the employer provided was stated to be provided "with" a named insurance company. The contract stated that the employee had to be approved by the insurer to join. Auerbach J reviewed the authorities and confirmed that for a contract of employment to be subject to the terms of an insurance policy, such a position required to be unambiguously stated or at least expressly communicated such that an employee would readily understand the entitlement was subject to the terms of another contract. That was not present in this case.

158. The respondent's agent notes that the claimant herself subsequently asked about the position with regard to the insurance company. It was suggested she understood at that time that her entitlement was subject to third party action. The purpose of contractual interpretation is to assess what was the ordinary and natural meaning of the words at the time the contract was entered into disregarding subjective intention, particularly an intention shown after the event. The claimant's position in evidence was that she believed the respondent had an insurance policy. It was not unreasonable to see whether the respondent had secured payment from that policy but that did not mean contractually it had been agreed the claimant's entitlement was conditional upon the respondent receiving payment first – even if that is what the claimant thought was the case and even if that is very common with PHI insurance schemes. The issue is what the parties agreed when concluding the contract.

159. Whilst it may be common for PHI benefits to be subject to a third party process, the authorities require the specific wording in each case to be considered and interpreted by what is said, within context. The fact the claimant may, after the event, have believed an insurer would require to assess the position does not affect the bargain the parties had reached, looking at the wording used. It was clear that the employer did have insurance and the claimant not unreasonably wished to understand whether the employer had secured the benefit of its insurance policy, but that did not mean the claimant was required, contractually, to await such an outcome. The fact

such a position is common does not affect what was agreed in this case which can only be assessed by interpreting the wording used and applying common sense.

160. Had no further information been provided other than that set out in the offer letter and handbook clearly the contractual entitlement would lack precision, not least given the absence of what sums were to be paid and the "further details" that were to be provided. The claimant was given further details of each benefit to which she was contractually entitled. There is nothing within the benefits document that suggests the employee required to do anything else to join the scheme. To be "eligible" (in other words to be able to secure the benefits of the scheme) an employee needs to complete their probation and be between 16 and 65. There is no suggestion at all that entitlement to the benefits set out is in any way limited by a insurance policy or the employer's agreement with a third party.

161. The Tribunal considered whether eligibility meant once the employee fell ill on a long term basis and then sought to join the scheme but again the wording used by the parties does not support that position. Any ambiguity should be construed against the party relying upon it. Joining the scheme, applying common sense, is completing probation and asking for the information as directed. There is nothing to suggest an applicant requires to do anything more or anything substantive.

162. A proportion of normal earnings "are paid" during incapacity. As with the position in **Awan**, this is not stated to be conditional upon certain events occurring. It is clear and unambiguously setting out entitlement, without any reference to an insurance policy. It is also to be paid as salary (unlike the position in **Smith**).

163. Looked at objectively, the entitlement is as the position was in **Villella**. Specific terms and conditions within the insurance policy the employer had with the insurer were not brought to the employee's attention and while reference is made to insurance, the terms nor the relevance thereof were not unambiguously stated. The contractual matrix and general context is

inconsistent with the employee's entitlement being subject to approval of an insurer.

164. The position in **Awan** and **Amdocs** is also similar to this case. The fact insurance was in existence and paid for by the employer did not, by itself, mean the employee's entitlement is subject to terms in existence in the agreement between the employer and insurance company. There was no communication of such terms expressly or unambiguously.

165. The fact some terms are uncertain, such as "scheme salary" does not mean, by itself, the term must be void for uncertainty or the conditions of insurance should be implied into the employee's contract. The position is not dissimilar to that which existed in **Jowitt**. As with there, this is a term which is imperfect but which can be made to work by considering the context. It is not unworkable.

166. It is also not correct to say this interpretation renders this essentially like sick pay which is absurd since there is separate sick provision. That is because sick pay deals with sickness (whether short term or long term) – hence it is called the sick pay scheme - whereas this scheme deals with a certain type of absence, namely absence on grounds of incapacity over 26 weeks. It is different therefore to sick pay.

167. The contractual entitlement was to the benefit of a scheme. The employer had sought to limit its exposure by underwriting its exposure via an insurance policy. The contractual entitlement was explained in the benefit document. There is no suggestion that was not communicating material which was contractual. It was the "further details" to which the contractually binding handbook referred. There was no suggestion that the employer could unilaterally decide to alter the entitlement set out in the benefits document.

168. As Auerbach J noted in **Amdocs** a document is not always obvious as a contractual document since much depends upon context and the substance of the words used and words regarding remuneration are to be considered particularly significantly. The employer provided the claimant with the further information relating to the scheme to which the claimant was contractually

entitled (which included what salary the employee would be paid and under what conditions). That information was not expressly or impliedly limited to any insurance policy or any third party.

169. The Tribunal did not consider it necessary to resort to the implication of terms. The Tribunal must consider the words the parties have used, disregarding subjective (or post contractual) intention and consider the contract as a whole within context to determine the objective (ie the natural and ordinary) meaning applying commercial common sense.

170. The Tribunal considered the contract between the parties to be clear and workable without the need to resort to the terms the respondent sought to imply. The Tribunal did not agree that the interpretation it has found leads to any absurdity. It may not be what the respondent wants and may it not be in accordance with what many PHI schemes provide but it was a fair and objective assessment of what was agreed at the time. The terms relied upon are not so obvious as to be implied into this contract nor is it necessary to give the contract business efficacy. The contract can be given effect to by using the words the parties used and giving them their natural and normal meaning. The contract is effective without the implied terms sought in this case.

171. The Tribunal did not accept that reference to the handbook for "further details" was such as not to amount to a contractual document. The offer letter and handbook both stated that further information would be given in relation to the scheme upon request. The claimant did as directed in terms of her contract and was given the benefits document (which does not state that entitlement is based upon any insurance policy or that there are other terms (which were not disclosed to the claimant) that were somehow relevant to secure the entitlements set out in the document). This is not analogous to other information documents as submitted by the respondent such as family friendly policies, since this information is critical to the employee – it relates to remuneration and as Auerbach J noted, has to be interpreted carefully. There is nothing within the document that suggests the employer could unilaterally change what was set out as the entitlement. The information was in fact the only information given to the claimant as to the entitlement stemming from the

offer letter and handbook. There was nothing in the document that could reasonably result in the benefits set out not being the claimant's entitlement.

172. The Tribunal did not find that the language used was "non-contractual" as submitted. While the document does not say "we will pay you" or "you will receive" it does state that "a proportion of normal earnings *are* paid" and "benefit *is* payable" and "benefit *is* monthly". The language used is consistent with contractual entitlement.

173. The Tribunal did not find the 4 reasons relied upon by the respondent's agent to assert the entitlement to be to participate in a scheme rather than an entitlement to payment (in respect of which the employer had sought insurance to cover its own liability)

174. The first argument was that the offer letter stated that the employee "will become entitled to the Sun Alliance Permanent Health Insurance Scheme". That was said to be a reference to a third party scheme which cannot be interpreted without proper consideration of the context in which the entitlement arises. The clause in which that is found states that "more detail of the scheme" will be provided. The handbook states the scheme pays a proportion of salary and the benefits are secured under a policy. It was argued that that is not saying that the employee's entitlement is to the insurance scheme but that the employer has secured the benefits under a policy of its own. In any event the benefits document which is the further information on the scheme set out in the offer letter and Handbook makes it clear that the entitlement is to be paid a proportion of normal earnings paid monthly.

175. While the claimant understood there was a policy in place she stated that the contractual documentation made it clear. She was entitled to the "Sun Alliance Permanent Health Insurance Scheme". Rather than the contractual documentation making it clear that this was to the benefits of a separate insurance product the employer had purchased on behalf of employees the documentation made it clear that the Sun Alliance Permanent Health Insurance Scheme was to payments from the employer (who had secured

some form of insurance to protect their position). The policy is only relevant as between the employer and insurance company.

176. The second argument relied upon by the respondent's agent was that the entitlement was described as a "scheme" which "enables" a proportion of salary to be paid. It is not accurate to say that this means salary was not "guaranteed". "Enables" is a way of saying if the conditions within the scheme are satisfied, the scheme would pay the relevant sums, enable payment. The Tribunal considered that the fact the document states benefits under the scheme are "secured by a policy", for the reasons set out above, did not make it clear that benefits were contingent upon an insurance policy or that the respondent was only committing to paying insurance premiums. The position in **Amdocs** and **Awan** is materially similar. In **Amdocs** the scheme was "with" a named insurance company. In **Awan** the benefits were "provided" by an insurance company. In each of these cases the policy was not attached nor were the terms set out and from a reasonable interpretation the entitlement was to the benefit of the sums set out in the documents without limitation via a third party provider. The position is the same in this case.

177. The third argument was that the handbook stated all staff were "eligible" to apply for entry to the scheme. It was suggested being eligible for entry was not the same as being eligible. But there is no suggestion as to what the claimant was to do, other than to comply with the contractual direction to seek further information, which she did. Even the further information the employer provided failed to set out any further limitations or restrictions upon entitlement. Both versions of the handbook make it clear that staff are eligible to apply and both versions say nothing as to what an employee is to do, other than contact HR for more details. Had HR set out some conditions which required to be satisfied to access the scheme, or made it clear that entitlement was subject to the conditions of the insurance policy, the position may have been different but the information presented to the claimant made it clear that she was eligible to apply for entry following her probation being completed. She completed her probation and sought further information as set out in the contractual documents. She was given further information and complied with

the conditions set out in that document. There was nothing provided by the respondent which set out what further steps needed to be taken to gain access to the benefit set out in her contract, other than what the claimant was told, instructions she followed.

178. The final argument relied upon by the respondent in support of its position that the entitlement was to the benefits of insurance rather than specific sums from the respondent was that neither the offer letter nor the handbook set out the precise details and the use of the word “scheme” made it clear this was a plan or arrangement, namely an insurance policy, for the benefit of an employee. That argument does not take into account the benefit document the claimant was provided upon asking for the further information to which she was directed under her contract. This was similar to the position in **Amdocs** and **Awan**. As Simler P found in **Awan** reference to a “scheme” means an arrangement or plan and the wording in that case as in this was redolent of contractual entitlement being paid to the employee from the employer – reference to salary, for example – with the employer having protected its position by securing an insurance policy (see paragraph 39). The contractual document uses the word “scheme” elsewhere in a contractual sense, such as the sick pay scheme.

179. Applying the rules of contractual construction in light of the authorities in this area, the respondent agreed to provide the claimant with the sums set out, provided the conditions they had placed upon the sums were satisfied. There was no condition that any insurance policy required to be followed nor that its terms were relevant to the employee’s entitlement.

180. The respondent’s agent also argued that 5 terms ought to be implied into the contract. The Tribunal considered these applying the legal tests necessary for implication.

181. The first term the respondent’s agent should be implied was that receipt of any benefit would be subject to the terms of the relevant insurance scheme/policy (which would inevitably contain terms relating to level of cover, duration of cover, payment levels and mechanism for application and

assessment of eligibility). It was argued that such a term was inherently obvious when considering the terms of the offer letter and handbook. The references to a scheme belonging to or being administered by a third party insurance provider, and the particular wording in the handbook that the benefits are "secured by" a policy demonstrated this. If this was not the intention, such references would not have been included.

182. The Tribunal did not find this a term which could be implied into the contract the parties had concluded. Firstly the contract was perfectly capable of being performed without implying such a term – the term was not necessary to give the contract business efficacy. Secondly it was not so obvious as to be implied and finally there was no custom or practice in this case that such a term was necessary. Applying the ordinary and natural meanings of the words used within the context in which they were used, with the benefit of commercial common sense, the parties agreed the employer would secure the sums from the employer (who had secured an insurance policy for their own benefit). A term that the employee's entitlement is somehow restricted to or affected by an insurance policy the employer had secured is entirely at odds with the authorities in this area (where the context was similar) and does not satisfy the legal tests necessary to become an implied term. It was obvious that the employer had an insurance scheme for its own benefit. The terms the respondent seeks to imply do not assist with regard to the claimant's position given the clear intention of the parties.

183. The second term the respondent's agent argued should be implied was that the identity of the insurer providing the benefit may change from time to time. It was submitted that such a term was necessary to give business efficacy to the contract and/or was so obvious that it goes without saying. An employer must be able to change its provider in order to access the best rates available, as a matter of commercial common sense and to ensure it is getting the best for its employees. If that were not allowed an employer may find itself in a position where it is unable to provide the benefit at all for its employees, for example if the provider was to cease to exist or stopped providing the

particular benefit. Such a situation would produce an absurd result, making the benefit unworkable.

184. Given the legal test for implication of the first term had not been met, the second term would not make sense. The insurance policy the employer had secured was a matter for it. It could naturally change its insurance at any time but that would not affect the claimant's entitlement as set out in her contract. The contract as interpreted above does not produce an absurd result. It is entirely workable. While not common, such a position is not unique as the case law shows, where employers have been found to have agreed to provide the benefits of permanent health insurance directly (notwithstanding their insurance arrangement with an insurance company). In this case there was no evidence that showed what the specific scheme the respondent said was in place actually was.

185. The third term which the respondent's agent argued should be implied into the contract of employment was that receipt of the benefit would be subject to the claimant and the respondent cooperating with each other to give effect to the terms of the contract and that neither party would do anything which would inhibit the other from being able to perform the contract. It was submitted that such a term was necessary to give business efficacy to the contract and/or is so obvious that it goes without saying. It was so essential for the benefit to effectively function that it was obviously intended to apply.

186. Again as the contract the employer and employee agreed was such that the employee's entitlement was as set out in the contract, any insurance policy the employer had was for its own benefit and could not reasonably be regarded as limiting an employee's entitlement to the sums set out (provided the conditions set out had been satisfied). The Tribunal did not consider it relevant to look at what other PHI schemes on the market provided or what the respondent's witness (who was not familiar with what the claimant had been given in terms of her contract as she had joined many years later). It is necessary to imply a term, as in most contracts, that the parties would reasonably cooperate with each other to ensure a contract can work and its terms are given effect. There was no agreement an employee's entitlement

to the benefit in this case would be subject to anything the employer had agreed with another party and it was not necessary nor right to imply such a term.

187. The fourth term which the respondent's agent argued should be implied was that receipt of the benefit would be subject to the claimant completing appropriate paperwork in order that her eligibility for receipt of the benefit could be assessed. It was submitted that such a term was necessary to give business efficacy to the contract and/or is so obvious that it goes without saying. It is self-evident that in order to access a benefit provided under an insurance-backed scheme, an employee would need to provide the details requested of them. The claimant has failed to provide any coherent or logical reason as to why that should not be required. The benefit would be unable to function, as only the employee is in a position to provide accurate, up to date and complete personal details or information about their health.

188. While some schemes, particularly those which are governed by the terms and conditions of an insurance policy, may require paperwork to be completed, it cannot be said that such a term is necessary to give this contract business efficacy given the wording used. If evidence is provided that satisfied the express conditions that required to be satisfied and there is no express requirement to provide anything further, no further documents would be needed. The express terms make it clear that sums are paid out where there is absence after a specified time following "a continuing period of incapacity". That is a matter of fact to be established. Appropriate evidence or paperwork could, potentially, be fit notes. In this case the respondent did not seek any further evidence to satisfy itself of the position set out in the contract. The respondent did not challenge the claimant was incapable of work and had been for the relevant period. Their focus was to satisfy another insurer as to the position, a matter not relevant for the entitlement in this case.

189. The fifth term the respondent's agent argued was to be implied was that receipt of the benefit would be contingent on sufficient medical evidence, including but not limited to the claimant undergoing a medical assessment by an independent third party, to demonstrate permanent incapacity for work. It

was submitted that such a term is necessary to give business efficacy to the contract and/or is so obvious that it goes without saying. As a matter of public policy and the prevention of insurance fraud it has to be ascertainable that the insured against event (in this case long term incapacity to work) has in fact occurred. The only way this can be achieved is by providing satisfactory evidence demonstrating that is the case. The benefit would be unworkable otherwise.

190. The fifth term was similar to the fourth and for the reasons stated it is not necessary to imply this condition. The employer set out the position clearly – if the employee is incapable of working and is absent for at least 26 weeks, the entitlement arises. There are no conditions attached to this and it is not necessary to attach any conditions. The legal test is not satisfied to imply this term.

191. The case law in this area is fact sensitive and as the parties' rightly submitted each case must be considered on its own facts. It is correct, as the respondent's agent submitted that **Villella**, **Awan** and **Amdocs** involved employees who were in receipt of the PHI benefit/payment such that the dispute centred on what - if any - right the employer had to stop the payments/deviate from the underlying policy terms. This is not the case in these proceedings (no entitlement to payments ever having been crystalised). Nevertheless those cases do provide insight as to the contractual position in light of their specific facts, which in material respects are on all fours with the current case.

192. The respondent's agent is correct to note that there is an exercise which must be conducted at the interpretation stage to decide whether the contractual entitlement in question relates to access to a benefit (insurance) or a direct payment from their employer. Applying the law as set out in the cases to the facts of this case, this case clearly falls into the latter category. That is reached when viewed the words the parties used and the context in which they appear, applying commercial common sense.

What were the express and implied terms which applied to the contractual entitlement and what eligibility criteria/conditions needed to be satisfied before payment would be due to the claimant?

193. The next issue was what the eligibility conditions were that required to be satisfied from the contract to entitle the claimant to payment.

194. The claimant's agent argued that in order to be a member of the scheme, the claimant needed to meet the conditions set out in the first bullet point in the benefit document. In order to be entitled to payments, the claimant needed to meet the conditions set out in the third bullet point (a continuous period of incapacity of at least 26 weeks). She had satisfied each condition.

195. The respondent's agent argued that if their interpretation of the relevant terms of the contract is accepted (in either sense), it falls to be considered what participation in the scheme looks like in order for the claimant to access the benefit, and therefore the wages sought. This involves an assessment of whether the terms the respondent says should be implied were satisfied.

196. The respondent's agent argued it was necessary to imply terms into the contract. These are considered below. The respondent's agent argued that the clear and unambiguous terms of the correspondence shows that the implied terms were not met. Ms McGlone gave the claimant the opportunity to pursue a claim under the AXA scheme. The claimant did not provide confirmation i that she wished to pursue a claim, nor did she complete the relevant forms. At the very minimum, an application form was required to be completed. Accordingly, no claim could proceed in respect of the claimant as she did not do so. The respondent did not, at any point, receive payment from any PHI insurance provider in respect of the claimant.

197. It was stated that (although no evidence was led on the point) the historic scheme with Royal and Sun Alliance had ceased to exist prior to AXA's acquisition of the shares of the respondent's parent company. Canada Life was the insurance provider in place from 2008 onwards. The deadline for making a claim to Canada Life in respect of the claimant's absence was missed – no successful claim was made. The respondent honoured its

obligation to provide the claimant with eligibility to access a PHI scheme by offering her the chance to participate in the self-insured scheme provided by the AXA Scheme. This policy had the same level of cover as the Canada Life Policy, and the respondent reassured the claimant that she would receive 75% (not 50%) of salary.

198. The respondent's agent noted the claimant accepted that she was required to provide evidence of her incapacity to work in order to access any payments from the respondent. The claimant accepted in cross examination that she did not provide any medical evidence confirming her incapacity to work to Ms McGlone, save for the fitnotes she received from her GP. Nowhere in the express terms is this stated to be sufficient for PHI purposes. It was submitted that plainly something more than fit-notes would be required to release a permanent health insurance benefit.

199. The very name of the benefit used throughout the documentation, permanent health insurance, also supports the respondent's position. The word "permanent" indicates something enduring. It is an agreed fact that the fitnotes the claimant supplied covered varying periods of time between two and eight weeks. They always had an end date, and the claimant accepted in evidence that none of the fitnotes she provided gave details of her having a permanent incapacity to work.

200. The claimant had produced a medical report from December 2012 which was not made available to the respondent at the time. The respondent does not accept that it or its representatives were provided with the 2012 Report prior to the claimant raising these proceedings. In any event the focus must be on what was evidenced at the time not the 2012 report or a report provided subsequently.

201. The respondent's agent argued that even if the PHI benefit was not backed by an insurance policy, the employer would need to be satisfied about the employee's health and their capacity to work. The claimant's own evidence was that she was aware she was required to evidence her incapacity to work. The claimant failed to satisfy the express condition that she was incapable of

working. The evidence provided was insufficient. It was implied within those terms that the claimant would provide evidence of her incapacity to work to the satisfaction of her employer.

202. If the respondent's interpretation of the relevant contractual documents is accepted, it was submitted that the claimant failed to address the necessary steps to participate in the scheme, and thereby to satisfy the conditions triggering payment.

Decision on contractual terms

203. The claimant's agent argued that there was no need to rely upon any implied terms as the contract could be given effect from the express terms. The respondent's agent argued a number of terms should be implied and these are considered in turn.

204. The first term the respondent's agent said should be implied was "receipt of the benefit would be subject to the terms of the relevant insurance scheme/policy (which would inevitably contain terms relating to level of cover, duration of cover, payment levels and mechanism for application and assessment of eligibility)". It was argued that this should be implied regardless of which insurer was providing the benefit, since, as a minimum, there would be a process involving the claimant's participation. The process to be followed under PHI schemes was clear and had not been followed.

205. The difficulty with this argument is that the express terms used by the respondent in creating the contract were clear. This was not an agreement that was to provide an insurance policy (such as in **Smith**) and thereby was reasonably found to have been intended to be subject to the terms of the insurance policy. As in **Awan** and **Amdocs**, there was no express term that the agreement between employer and employee was to be subject to the terms agreed between the employer and an insurance policy. It was open to the employer to have expressly stated this and as noted by Simler P at paragraph 38. Auerbach J made the position clear in **Amdocs** stating that to be subject to an insurance policy the position needs to be unambiguously and/or expressly communicated. That is not the case here.

206. In any event the Tribunal did not consider that the legal tests for the implication of the terms sought were satisfied. It is not obvious that such a term should be implied. It is not necessary to imply the term to give the contract business efficacy. There is no custom or practice either that such a term should be implied, given the express terms in this case. The fact other PHI providers may operate their schemes in a particular way does not assist in construction of this particular contract.

207. The second term the respondent's agent argued should be implied was "receipt of the benefit would be subject to the claimant and the respondent cooperating with each other to give effect to the terms of the contract/one party does not do anything which would inhibit the other from being able to perform the contract." This term is unexceptional and is implied into the contract between the parties. The parties would require to work together to ensure the contract is effective. That works both ways. If the employee provides the evidence which satisfies the express conditions, the employer would be expected to provide that which is due.

208. The third term was "receipt of the benefit would be subject to the claimant completing appropriate paperwork in order that her eligibility for receipt of the benefit could be assessed." In order to imply terms, the term requires to be clear and precise. "appropriate paperwork" is entirely unspecific. In order to give the contract in this case effect it would be necessary for the claimant to establish "a continuous period of incapacity" for the relevant period. It is not necessary (nor relevant) to require the claimant to provide anything other than this. Such a term does not satisfy the legal tests for implication.

209. The fourth term was "receipt of the benefit would be contingent on sufficient medical evidence, including but not limited to the claimant undergoing a medical assessment by an independent third party, to demonstrate permanent incapacity for work." The express terms of the contract required the employer to pay the relevant sums following a "continuous period of incapacity of 26 weeks". At no point was there communication to the employee of there being any requirement to provide specific evidence of this (such as via an independent third party). Applying the ordinary natural

meaning of the words and to give the contract commercial sense the implied obligation was to provide the employer with medical evidence that established incapacity for the relevant period of time.

210. The respondent's agent argues that the claimant failed to engage with regard to a claim under the AXA scheme. The claimant did not provide confirmation in writing that she wished to pursue a claim under that scheme, nor did she complete the relevant forms provided to her. However, the claimant was absent from work due to illness and had been for a lengthy period of time. The claimant had made it clear that she wished the entitlement set out in her contract to be respected.

211. Regrettably the respondent did not fully engage with the claimant with regard to what her contract said. The claimant's contract with the respondent was to the benefit set out, not to the benefit under another scheme. It is equally regrettable that the claimant did not provide to the respondent the benefits document that supported her position clearly. No evidence was provided to the Tribunal from the individuals who issued the documents are the time and accordingly the respondent was unable to challenge the claimant's position.

212. The respondent's agent notes that it is the claimant's position that the fitnotes she supplied were sufficient evidence of her incapacity to work. The fitnotes she supplied were not challenged by the respondent. At no stage had the respondent argued the evidence the claimant provided had not established that the claimant was incapable of work. While the fit notes have a start date and end date, there was no suggestion that the impairment from which the claimant suffered was not accurate. The express wording did not require evidence to be provided of permanent incapacity. The contract required the payment to be made where there was "long term absence as a result of incapacity to work". That is expressly what the contract says. There is therefore no requirement to provide any evidence of permanent incapacity or inability provided the employee satisfies the employer that they are absent for the requisite period by reason of incapacity. There is no reason why fit notes from a GP could not satisfy this condition (particularly in the absence of any other conditions that required to be satisfied before payment was to be made).

213. The respondent's agent argued that something more than fitnotes would be required to release a permanent health insurance benefit and that it is well-established and accepted that this is the case not least because the very name of the benefit used throughout the documentation, permanent health insurance, also supports the respondent's position. The word "permanent" indicated something enduring. It is an agreed fact that the fitnotes the claimant supplied covered varying periods of time between two and eight weeks. They always had an end date, and the claimant accepted in evidence that none of the fitnotes she provided gave details of her having a permanent incapacity to work.

214. It was, however, accepted that permanent health insurance can cover periods of temporary absence. The issue in this case is not what other contract arrangements or scheme provide but what the claimant and respondent agreed to in terms of their contractual arrangement. There was no requirement to provide a specific type of evidence, provided the claimant had established that she was incapable of working for at least 26 weeks. The reference to "permanent" in permanent health insurance refers therefore to absence beyond 26 weeks. It refers to absence that has no end date in the sense of being finite or temporary. There was no evidence in this case that the claimant's absence was temporary or finite. The respondent did not challenge the evidence the claimant provided to establish her absence. There was no suggestion at all that the claimant's absence was not genuine nor that she was incapable of working for the relevant period.

215. A medical report had been obtained by the claimant in 2012. The respondent had not seen this (although they knew of its existence). In terms of the contractual position, such a report was not necessary. The claimant had established that she was incapable of work and had been absent for the requisite period. The medical reports that were provided to the Tribunal were not provided to the respondent at the time and were not relevant to its assessment of the claimant at the time. The only issue is whether the claimant had satisfied the conditions within the contract that required to be satisfied

before payment could be made, from the information available at the time. It is self evident that the claimant had done so.

216. The respondent's agent argued that even if such a PHI benefit was not backed by an insurance policy, the employer would evidently need to be satisfied about the employee's health and their capacity to work and the claimant had not done so.

217. The difficulty with this argument is that at no stage did the respondent advise the claimant the evidence she provided did not establish that she was incapable of work. The evidence patently showed she had done so (and the facts were not in dispute). The purpose of the respondent asking the claimant to attend a third party occupational health provider was to determine entitlement under another PHI scheme. At no point was there any evidence from the respondent that the evidence she provided did not satisfy the respondent that she was incapable of work for the requisite period or that the information she had provided had not satisfied the conditions that were set out in her contract. She had complied with those conditions.

218. The other PHI schemes which were offered to the claimant were inferior in terms to the clear and unambiguous entitlement set out in the claimant's contract. She was under no contractual obligation to accede to the requests to proceed with a lesser benefit than that to which she was contractually entitled.

219. It was not therefore necessary to imply any terms into the agreement reached, which could be determined from the express terms agreed between the parties.

Did the claimant satisfy all the criteria/conditions which the Tribunal determines applied in the circumstances such that the right to payments under the relevant benefit was triggered and as such were the wages sought properly payable for the purposes of section 13(3) of the Employment Rights Act 1996?

220. The third issue in this case was whether the conditions precedent for payment were satisfied.

221. The claimant's agent argued that the claimant met all of the conditions, having done what was required of her to obtain details of the scheme (contact the Director of Human Resources), and having met all of the conditions, the claimant was a member of the scheme from July 2000. This meant that the claimant was entitled to PHI payments if she was absent from work due to incapacity for a continuous period of at least 26 weeks. The claimant's agent noted that no evidence was led as to what the Royal and Sun Alliance scheme would have required even if that policy was implied into the claimant's contract and so the respondent is not entitled to rely upon any Royal and Sun Alliance policies and procedures (or indeed any other policies and procedures) with regard to evidence of incapacity. It was not in dispute that the claimant was signed as unfit for work continuously for three years from September 2010 to dismissal. There is no suggestion she was anything other than unfit for work. She therefore met the conditions for payment under the scheme and as such, the PHI payments were "properly payable".

222. The respondent's agent argued that the conditions relating to PHI benefit had not been satisfied and no entitlement to PHI benefit crystalised. No claim to any insurer was successfully made on behalf of the claimant. No payments from any insurer were ever received in respect of the claimant's absence. No entitlement to payments under any PHI was triggered in the circumstances, despite the respondent's attempts to facilitate that, and so no payments were payable. Accordingly, no unauthorised deduction was made from the claimant's wages by the respondent and the claim should be dismissed.

223. The Tribunal finds that the claimant's agent's submissions have merit and are upheld. The claimant satisfied the express terms of the contract between the parties. The fact the claimant did not satisfy the conditions pertaining to a different entitlement did not affect her position with regard to what she had agreed with the respondent at the material time. The respondent did not engage with her position during her employment and expressly consider what had been expressly agreed.

224. The offer letter and handbook set out the contractual entitlement, further details of which would be given to the claimant. She obtained those further details and there was no reference to any insurance policy governing the claimant and respondent's position nor was it reasonable to infer such a position. The information communicated to the claimant once she was eligible to join the scheme was evidence of the contractual position (as in **Amdocs**). Ms McGlone had not seen the benefits document and it was not suggested this document had not been issued by the respondent. In any event the Tribunal found it had been sent and did provide the further information pursuant to that set out in the offer letter and handbook.

225. There was no suggestion at the point the claimant had been absent for at least 26 weeks due to incapacity that she required to provide specific evidence, such as via an occupational health specialist. The claimant provided evidence from a medical specialist (her GP). The respondent did not state that the evidence she provided, for the purposes of her contractual entitlement, was insufficient. At no stage did the respondent consider that position. The focus of the respondent was with regard to the claimant's application under another scheme (which Ms McGlone wished to provide the claimant, believing it was a reasonable alternative to the scheme that had previously existed, but without fully understanding what the claimant's contractual entitlement actually provided). As the claimant did not engage with the alternative schemes being offered, the respondent took no action.

226. The respondent failed to consider what had been agreed in terms of the contractual position. There was no evidence to suggest the information the claimant had been given was incorrect or that the benefit document was

expressly subject to a third party requirement. As in **Villella** the insurance policy and its terms were not communicated to the claimant. There was some uncertainty as to the applicable terms but as set out in **Jowitt** it was possible, using the rules of contractual construction, to give commercial effect to the bargain the parties struck. It is not the function of contractual interpretation to make the agreement the parties reached more or less favourable that what focussing on the meaning of the words used within context applying their natural and ordinary meaning in context with commercial commence sense was intended.

227. The express terms of the entitlement were clear. The offer letter confirmed the claimant was entitled to "The Sun Alliance Permanent Health Insurance Scheme" with details to be advised. The contractual handbook noted the scheme pays a proportion of "salary" if the individual is unable to work due to incapacity after a certain period of absence. The benefits of the scheme (which the employer receives) were underwritten by an insurance scheme but there was no term that the employee's entitlement was in any way subject to the employer's agreement with the insurer. The handbook stated further details would be given.

228. Further details were then given to the claimant in the benefits document confirming that a proportion of "normal earnings" would be paid to the employer following a period of incapacity. Contributions were paid by the employer (but as in **Awan** that did not mean the employee was thereby subject to any third party agreement). The further details were good evidence of the contractual entitlement, given the entitlement related to remuneration (as set out in **Amdocs**). At no stage did the respondent advise the claimant her entitlement was limited in any other way. Clearly if the employer gave further details by making it clear that the policy was subject to the terms of an insurance policy (providing such terms) the position would be different but at no stage was there any suggestion the entitlement was in any way restricted to anything beyond what was in the documents given to the claimant.

229. On the facts of this case the claimant satisfied all the express terms of the contract. At no stage did the respondent request further information to satisfy

themselves she was incapable of work. The respondent accepted her fit notes. While they sought independent evidence in respect of an application to another PHI scheme, there was no suggestion that the claimant had failed to provide evidence that she was incapable of work and had been following a continuous period of incapacity of at least 26 weeks.

If there had been an unauthorised deduction of wages how should be deduction be calculated, given the parties disputed what "wages" amounted to for the 12 months from May 2011 to May 2012 and the 12 months from June 2012 to May 2013. The claimant argued salary should include monthly overtime and that in respect of year 2 a 5% increase should be applied.

230. The final issue in this case was what sums should be awarded in the event the claimant was successful. The parties had agreed upon basic salary but disputed what "normal earnings" meant and whether the claimant was entitled to an escalator.

231. The claimant argued that overtime is part of "normal earnings" and any ambiguity in the scheme should be construed in the claimant's favour. While the claimant was unable to provide precise figures an attempt had been made to calculate the sums reasonably and it was submitted that should be relied upon.

232. The respondent's agent argued that if the Tribunal determined that there had been an unauthorised deduction t the sum should be calculated on the following basis to cover the agreed period of deductions (May 2011 to May 2013 – 24 months): 75% of the claimant's gross base monthly salary as at the start of the period of the deductions, in respect of the first twelve months; and use the same calculation for the second twelve months, but apply a 5% uplift to the claimant's gross base monthly salary.

233. In respect of both years, a deduction was to be made to account for any state benefit the claimant received during the period of deduction (which information the claimant had still to provide).

234. The claimant asserted that her monthly salary for the purposes of the calculation should also include an element to account for overtime payments she received. It was understood that the basis for that assertion was a single reference to “normal earnings” in the benefits document. The respondent submitted that the correct interpretation does not support the claimant’s assertion. The amount of payment is not referred to in any way in the offer Letter, and the handbook only makes reference to “salary”. If the Tribunal determined that the benefit document formed part of the contract, it was submitted that it cannot be interpreted as the claimant contends. The benefit document states that the benefit is “paid monthly in the form of salary” and “benefit is 1/12 of ¾’s of the individuals scheme salary less state benefit”.

235. Ms McGlone had provided evidence that it is the norm for payments under a permanent health insurance scheme to only cover base salary and not variable elements of pay. Furthermore, it is submitted that the claimant has not provided the Tribunal with sufficient evidence to support an assertion that overtime payments were part of her “normal earnings”.

236. The respondent submitted that when the documents are assessed as a whole, it is clear that what was provided for was a proportion of the claimant’s gross base salary only. The claimant’s analysis does not reflect the ordinary meaning of the applicable terms, nor accord with a common sense understanding of this benefit.

237. It was also the claimant’s assertion that the 5% uplift which is applied to the benefit in the second twelve month period, should be applied not to what was paid in the first twelve month period, but applied to what the claimant’s salary (including overtime) would have been at the start of the second twelve month period, taking account of any uplift in pay that may have applied in the meantime. It is unclear on what basis such an assertion is made. The respondent submits that such an approach is not provided for by the terms of the contract. The amount of payment is not referred to in the offer letter, and the handbook only makes reference to “salary”. The only increase provided for is the annual increase of 5%, nothing further.

238. It was agreed that the claimant's gross base salary increased in April 2012, in line with the respondent's usual salary increase practices. That increase equated to an uplift of around 3%. If this were to be used to calculate the wages in the second twelve month period, as well as the 5% uplift provided for in the contract, the claimant would receive a windfall as she would in fact receive an increase of 8%.

239. The respondent submitted that when the documents are assessed as a whole, that was not was being provided for and that only the 5% increase should be applied to the wages the claimant received in the first twelve month period.

Decision on sums due

240. The Tribunal concluded that the claimant had satisfied the conditions set out in the contract, properly construed, that triggered an entitlement to payment. As was the case in **Jowitt,** the express terms did not unambiguously deal with each of the issues and as a result the Tribunal requires to determine what the parties intended with regard to the entitlement. The Tribunal applied the rules as to contractual construction to assess what was properly payable to the claimant.

241. The entitlement is to a proportion of "normal earnings". That is what the scheme sets out as the basis upon which the payment is calculated (and must be the "individuals scheme salary" set out later in the document). The issue is therefore what "normal earnings" means, with reference to her salary and the position as understood when the contract was entered into.

242. Focussing upon the ordinary and natural meaning of the phrase, the entitlement was to the claimant's normal earnings, what she would normally earn when working for the respondent in terms of her contract. There is no suggestion that the entitlement was based upon an average of the sums the claimant would receive where her earnings would fluctuate or if she would earn more money by working hours in addition to her normal hours. A normal and common sense interpretation of normal earnings within the context of the position the parties found themselves applying commercial common sense is the sum to which she is guaranteed under her contract since that is the sum

she would normally earn. The intention of the scheme was to provide employees with an income when they could not work. The scheme would replace the normal earnings, the sums to which the employee would be guaranteed if able to work, the normal rate of pay in terms of the contract.

5 243. In this case the claimant was contracted to work normal hours and could be asked to work more, namely weekends for which she would be paid more money but those additional sums are not guaranteed and could fluctuate. Those sums are not normal earnings. The contract stated that the claimant "may be requested" to work weekends – it was not guaranteed nor a 10 contractual requirement that she accede to such a request, albeit the claimant chose to do so. There is no ambiguity and so there is no need to refer to the rules of construction when interpreting an ambiguous phrase. The ordinary and natural meaning of the term within context, applying common sense, is clear.

15 244. The offer letter refers to "normal hours" and the payment referable to that. She may be asked to work weekends and the respondent had not challenged the evidence that the claimant did work (and believed she was required to work) one weekend in four which were in addition to her normal hours.

245. In the ET1 the claimant prepared herself stated that her "normal take home 20 pay" was that based on her normal hours, namely the fixed weekly hours (not including any weekend work). The claimant did not consider the sums she received for working the additional weekends to be normal pay.

246. The entitlement is therefore based upon the claimant's normal earnings for the period in question, the sum she would contractually have been paid had 25 she worked her normal hours as set out in the contract. The respondent's agent's submissions in this regard have merit. As the respondent also noted, there is no evidence to find what her entitlement actually was for the full period. The earnings the claimant received in addition to her normal pay had not been established. The time that had passed was such that there was no 30 clear evidence as to exactly what overtime the claimant had worked and what the rate was. Although the claimant said she was asked to work and agreed

to work one weekend in four, the position, for example, during holidays was not clear or whether she actually worked every weekend in four. There was no evidence as to what, if any, increase applied to the position in the second year claimed. While the claimant's agent reasonably tried to estimate the position and provide his view as to the figures, had normal pay included overtime, there was no clear evidence before the Tribunal that would have allowed a calculation of such an entitlement to be made for the full period given the passage of time. It was not clear, for example, that as a matter of fact the claimant did work one weekend in four for the entire period.

247. The entitlement, as set out in the benefits document, is increased by 5% on each anniversary of commencement of payment for as long as the benefit continues to be payable. That is what the claimant's employer told her she was due when they provided additional details of the scheme (which they were required to do in terms of the offer letter and Handbook). As in **Amdocs**, the entitlement to an increase is a contractual right, there being no suggestion such an increase is discretionary or subject to any conditions and applying the rules of construction. The 5% increase was, however, to the initial sum when the entitlement was triggered – the scheme salary. That is the normal and natural meaning of the words used.

248. There was no suggestion the entitlement increased both by any wage increase to the normal scheme salary *and* by 5%. To provide the claimant with a 5% increase to any normally increased salary would be to confer upon the claimant a windfall and would not be consistent with the normal and ordinary meaning of the words taken in context, applying commercial common sense.

249. A normal interpretation is that the entitlement is based upon the salary the claimant normally earned when carrying out her normal duties. In this case she was entitled to £1,191.75 per month (her normal salary), less state benefit. The 5% increase is applied to that sum – her normal salary (the scheme salary).

250. For the period from 28 April 2012 until 27 May 2013 she was entitled to 75% of £1191.75 plus 5% (£59.59), namely £1251.34 per month, less state benefits received.

251. The entitlement is expressly stated to be “less State Benefit”. The precise sums had not been provided. The claimant stated that she had received statutory sick pay for “around 6 months” and received “around £80 per week”.

252. The parties are required to work together in light of the foregoing to agree the sums payable to the claimant and resolve same. In the absence of a resolution within 42 days, an order can be issued requiring the claimant to set out (and evidence) the position in respect of benefits claimed during the period in question to allow the final sum to be identified (which failing a further hearing can be fixed to enable the precise sums due to be calculated). It is in the interests of justice to provide the parties with time to finalise this matter. The parties had worked together and there is no evidence that the parties could not cooperate to determine this outstanding issue.

253. The claim in respect of unlawful deduction of wages therefore succeeds.

254. By way of final observation, the Tribunal wishes to thank both parties for their professionalism in the conduct of this case.

Employment Judge: **D Hoey**
Date of Judgment: **28 July 2022**
Entered in register: **29 July 2022**
and copied to parties