



GROUP PROTECTION

GROUP CRITICAL ILLNESS COVER.

Helping you understand our policy.

This is an important document which we suggest you keep in a safe place.

TECHNICAL GUIDE

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USING THIS DOCUMENT.

WHAT IS A TECHNICAL GUIDE?

The Financial Services Authority is the independent financial services regulator. It requires us, Legal & General, to give you important information to help you decide whether our Group Critical Illness Cover is right for you. You should read this document carefully so you understand what you're buying, and then keep it safe for future reference.

If there's anything you need to ask about once you've read it, you can ask us or your financial adviser.

BEFORE YOU START READING

We've used plain language to make the technical guide easy to understand. You'll find explanations of any technical terms we use in the glossary on page 25 of this document. Where terms covered in the glossary appear in the main text, we've highlighted them in bold, **like this**.

We use words like 'normally' and 'usually' in this guide. This is because some of our terms will depend on the information you give us for the quote and the choices you make about the cover you want. We'll give you the exact terms and **policy** options in our quote and fix these at the start of the **policy**. You'll only be able to change these if we agree.

We can also provide cover for equity partners or members of a Limited Liability Partnership (LLP). If the partnership is a LLP, 'equity partners' and 'partners' will mean 'members of an LLP'.

You can ask us, or your financial adviser, if you need more details about how the **policy** works.

OTHER DOCUMENTS

This technical guide is not part of our contract but if we've given you or your financial adviser a quote, you should read this guide alongside that quote to help you understand the **policy**.

Our quote, which is a part of the contract, may refer to some of the explanations we give in this guide.

Our full terms and conditions will be in our **policy**. We'll send this to you after we've agreed to provide cover (see question 2.1 to see what we need to set up your **policy**). You can ask us, or your financial adviser, if you would like to see a copy of our standard **policy** terms and conditions.

ABOUT LEGAL & GENERAL

The Legal & General Group, established in 1836, is one of the UK's leading financial services companies. As at 30 June 2011, we were responsible for investing £370 billion worldwide on behalf of investors, policyholders and shareholders. We also had over seven million customers in the UK for our life assurance, pensions, investments and general insurance plans.

Legal & General Group is one of the biggest providers of index-tracking investments in the UK, managing £232 billion as at 30 June 2011.

We're a leading provider of Group Protection cover with over 80 years of expertise and knowledge. We looked after over 6,300 group protection **policies** and provide protection to more than 2.3 million employees as at 30 June 2011.

Our dedicated team has the knowledge and expertise to help provide solutions for small **policies** of 50 **insured employees** to large complex **policies**. We review each **policy** individually so we can work with you to help develop your protection package and offer some of the most competitive rates in the market place.

AIMS, COMMITMENTS AND RISKS.

ITS AIMS

Our Critical Illness Cover **policy** aims to:

- Provide insurance to pay a lump sum benefit to an **insured employee** who suffers from an insured condition and survives for a set time period.

Please see question 1.7 for the full list of the conditions we cover and question 5 for the time periods.

- Provide cover for only the illnesses defined in the **policy** and no others.
- Automatically include cover for the **children** of an **insured employee** at no extra cost.
- Offer cover to the **spouse** or **registered civil partner** of the **insured employee**. This will increase the premium.
- Offer a choice of cover for these benefits.

YOUR COMMITMENT

You need to make some very specific commitments for the **policy** to work properly:

- Give us all the information we ask for when you apply for a **policy** and at **annual renewal dates**. We can cancel the **policy** if you don't give us this information.

Please see question 4.1 for more details.

- Tell us about any new entrants, leavers and discretionary entrants you would like us to cover. For any discretionary entrants, we'll let you know if we can cover them and if we'll need to change the premium.

Please see question 2.7 for more details.

- Give us all the information we ask for to support any claims, and tell us of a claim within the time limits set out in section 5. Without this we won't be able to pay the claim.
- Pay the premiums on the dates we ask for them.
- Keep to all the conditions set out in the **policy**.

RISKS

There are some risks you need to understand about the **policy**.

- We won't pay a claim if an **insured person** has a pre-existing condition.

Please see question 2.5 for more details of pre-existing conditions.

- We may not pay a claim for an **insured person** because of a related medical condition.

Please see question 2.6 for more details of related conditions.

- The premiums may go up or down depending on changes in the membership. We'll usually guarantee the **unit rate** until the end of the second **policy** year. We will then review it, following which we will usually guarantee the new **unit rate** for the next two years.
- The premiums and the **unit rate** may go up or down if there is a change of more than 25% in the membership or the **total members' benefit** (or **total scheme earnings**) we've used to work out the **unit rate**. We can change the **unit rate** at the **annual renewal date** if this happens.

Please see question 3.1 for more details.

- You may need to pay an additional premium depending on the type of accounting we use.

Please see question 4.2 for more details.

- We will stop cover if you stop paying premiums. We'll tell you in writing 14 days before we do this.

HOW THE POLICY WORKS.

- To start the **policy** we need a minimum of 50 **insured employees**. We can cancel the **policy** if membership falls to less than five **insured employees**. If we do this, we'll write to you at least two months before we cancel the **policy**. Sometimes we'll start a **policy** with less than 50 **insured employees**. For example, if you have two **policies** linked together.
- You pay the cost of the cover.
- We'll give you the specific terms and conditions in the quote. We'll guarantee the quote for three months unless we tell you otherwise.
- There are **policy** options you can choose which affect how much you pay. We'll fix your chosen options, including the eligibility, cover and terms at the start of the **policy**. You'll need to tell us if you want to change these as we need to assess if we can agree the change. We may also need to set new terms and change the **unit rate** and the premium we charge you.
- You must include all employees, or equity partners, for cover under the **policy** as soon as they are eligible.
- We won't pay a claim if the **insured employee** is not eligible for cover.

Please see question 1 for more details about eligibility.

- You must give us all the information we need when you make a claim.
- If you make a valid claim, we'll pay a lump sum to you, as trustees. We'll pay this as a cheque, payable to the **insured employee**, for you to pass it on.

Please see question 5 for more details.

- We'll need up-to-date information from you at each **annual renewal date** so we can check the premium and give you accurate accounts.

Please see question 4.1 for more details.

- We can change the **policy** terms at the end of any rate guarantee period. If we do this, we'll write to you at least two months before we change the terms.
- The **policy** will continue indefinitely as long as you meet its conditions, including paying premiums when we ask for them.
- We can change or cancel the **policy** if there are changes to legislation or regulation, which affect the **policy**. We'll give you more details of these in the **policy**.

YOUR QUESTIONS ANSWERED.

In this section we've answered some commonly asked questions to give you a bit more information about how our **policy** will work.

1.0 WHAT SHOULD WE CONSIDER WHEN DECIDING WHAT BENEFITS TO PROVIDE?

DIFFERENT BENEFIT CATEGORIES	HOW MUCH TO INSURE	CHECK OUR QUOTE
<p>We suggest you keep the benefit as simple as possible, ideally having the same basis for all insured employees. We can insure benefit as an amount of money, or a multiple of scheme earnings.</p> <p>You can group the insured employees into separate categories and can have different amounts of cover for different categories. All insured employees in the same category must have the same benefit level. As this is a group policy, it must cover all your eligible employees or equity partners.</p> <p>You should also consider any laws on discrimination or unfair treatment. For example, those about age, equal treatment of men and women, and the treatment of part-time, fixed-term and disabled employees.</p> <p>We can insure any number of categories, but it's important we know which insured employees are in which category. We must therefore agree the eligibility conditions for each category at the start of the policy. Examples of a category eligibility could be 'all directors' or 'all employees'.</p> <p>We'll tell you the agreed eligibility conditions in our quote.</p>	<p>You can choose to take out an insurance policy to insure part or all the benefit you want to pay to your employees.</p> <p>If you only insure part of the benefit you may have to pay the difference yourself.</p> <p>For example, if you promise to pay a benefit of four times their earnings but only insure three times their earnings, you would have to pay the remaining one times yourself.</p>	<p>Please check that our quote matches what you'd like us to insure.</p> <p>If you'd like us to change the options we've used, please tell us so we can change the quote. We'll tell you how any changes will affect the terms, unit rate and premium.</p>

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1.1 WHO CAN THE POLICY COVER?

The **policy** can cover employees and equity partners. Equity partners are partners who have an equity share in the firm and whose income from the firm is taxed as trading profits.

For an extra premium, we can also cover **spouses** and **registered civil partners** of the **insured employees**. Please ask us if you'd like to include this cover.

We'll automatically include cover for the **children** of all the **insured employees** at no extra cost.

We will only start cover for each employee when they meet:

- the eligibility conditions;

We'll tell you the agreed eligibility conditions in the quote.

- our medical evidence requirements; and

Please see question 2.2 for more details of medical evidence.

- our switch terms, if you're switching the insurance from another provider.

Please see questions 2.4 for more details of switch terms.

The agreed eligibility conditions will include a description of the employees eligible for each category, the entry ages, any service qualification and details of any link to pension scheme membership.

We will not pay a claim if an **insured person** has a pre-existing condition.

Please see question 2.5 for more details of pre-existing conditions.

We may not pay a claim if an **insured person** has a related medical condition.

Please see question 2.6 for more details of related conditions.

1.2 WHEN CAN YOU COVER NEW EMPLOYEES UNDER THE POLICY?

The 'entry date' is when we'll start covering new employees under the **policy**.

The entry date can be:

YEARLY	We only include new employees once a year at the annual renewal date .
MONTHLY	Cover for new employees starts at a specified date each month.
DAILY	We include new employees on the first day they meet the eligibility conditions.

Our quote and **policy** will show the entry date. All new employees must meet the **policy** eligibility before we will start their cover.

If you have new employees who don't meet the eligibility we've agreed on, we may be able to cover them as 'discretionary entrants'. Discretionary entrants are employees who want cover to start under the **policy** before or after the date they are first eligible.

You can read more about our requirements for discretionary entrants in question 2.7.

If an **insured employee** becomes eligible to change to a different benefit category, we'll cover the new benefit level immediately as long as any other requirements we've set are met.

1.3 WHEN CAN INSURED EMPLOYEES INCREASE THEIR COVER?

A 'benefit increase' is when we'll start covering increases in an **insured person's** cover, for example, after a pay rise.

If we work out the benefit using a multiple of an **insured employee's** earnings, benefit increases can be:

YEARLY	We only increase an insured employee's cover once a year at the annual renewal date . This means, if you make a claim, we'll use the insured employee's earnings at the last annual renewal date to work out their benefit, even if their earnings have increased since.
MONTHLY	We'll start covering increases for insured employees at a specified date each month.
DAILY	We increase the cover for insured employees immediately when they change.

Our quote and **policy** will show the benefit increase date.

If an **insured employee** becomes eligible for a different category with a different benefit level, for example because of a promotion, we'll start covering the new benefit level immediately as long as any other requirements we have set are met. If the new category allows for daily changes, we'll also consider any increase in the **insured employee's** earnings at the same time. Otherwise the changes to their earnings will not take effect until the next normal date for benefit changes in that category.

If the benefit is a fixed sum, for example £100,000, you'll need to tell us when you'd like to increase the amount. Before we agree, we'll check if our terms, **unit rate** and premium need to change.

1.4 WILL COVER CONTINUE IF AN INSURED EMPLOYEE IS TEMPORARILY OFF WORK?

Yes, we'll continue to provide cover for temporary absence for up to three years if the **insured employee** is off work because of illness or injury, or up to one year for absence because of any other reason. This is our standard temporary absence cover. Please ask us if you'd like other options.

If we work out the benefit using a multiple of an **insured employee's** earnings, we'll continue that cover. If you reduce their earnings while they are off work, we'll continue to cover the same benefit as before the reduction.

The temporary absence cover doesn't apply to equity partners. However, even if they are off work, we'll still cover them as long as they are still equity partners and are entitled to a share of the profits.

We'll continue to provide cover if an **insured employee** is on parental leave as long as they remain entitled to the benefit under the terms and conditions of their employment.

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1.5 WHEN WILL COVER END?

a) Under normal circumstances

We will stop covering an **insured person** when the **insured employee**:

- leaves your employment or no longer meets the eligibility conditions;
- reaches the benefit termination date we show in the **policy**. This the day our cover ends and is usually the greater of age 65 and their **state pension age**;
- retires early;
- reaches the end of a period of temporary absence cover; or
- dies before we're due to pay benefit.

We'll stop covering a **spouse, registered civil partner** or **child**, if they no longer qualify for benefit or die. We won't cover **spouses** or **registered civil partners** beyond age 70.

Apart from eligible **children**, where we limit cover to between the ages of six months and 18 years, we can provide cover to age 70. For Terminal Illness and Total and Permanent Disability cover, we will stop cover at the greater of age 65 or the **insured person's** individual **state pension age**.

b) If you, or we, cancel the cover

All cover will end when you, or we, cancel the **policy**.

- We'll continue your cover as long as you meet the conditions we show in the **policy**.
- You can cancel the **policy** by giving us 14 days' notice in writing.
- We'll give you 14 days' notice in writing if we have to cancel the **policy** because you haven't met its conditions.

1.6 WHAT IS THE MAXIMUM BENEFIT YOU WILL COVER?

The maximum benefit we will cover is the lower of:

Insured employees

- five times their **scheme earnings**; and
- £500,000.

Spouses and registered civil partners

- an amount equal to the **insured employee's** benefit; and
- £150,000.

Children's benefit (we provide this cover automatically at no extra cost)

- an amount equal to 25% of the **insured employee's** benefit; and
- £20,000.

This is for each **child** and there's no limit to the number of **children** we'll cover.

1.7 WHAT TYPES OF COVER ARE AVAILABLE?

There are two types of cover available, Core and Additional. The Additional cover also includes cover for the core conditions. We'll tell you in our quote which one we're covering.

The definitions of the conditions indicated by an asterisk (*) are the same as the guidelines published by the Association of British Insurers (ABI) in their Statement of Best Practice (February 2011). Those indicated with two asterisks (**) improve on the ABI's published guidelines.

These headings are only a guide as to what we cover. The full definitions of the conditions are in the **policy**. We'll also include them with our quote. These typically use medical terms to describe the conditions, and in some cases the cover may be limited. For example:

- Some types of cancer are not covered.
- To make a claim for some conditions, the **insured person** needs to have permanent symptoms.

Please see question 6 for details about our exclusions.

CORE – CONDITIONS COVERED	
Alzheimer's Disease*	resulting in permanent symptoms
Cancer* (including Hodgkin's disease)	excluding less advanced cases
Coronary Artery By-Pass Grafts*	with surgery to divide the breastbone
Creutzfeldt-Jakob Disease (CJD)	resulting in permanent symptoms
Heart Attack**	of specified severity
Kidney Failure*	requiring dialysis
Major Organ Transplant*	
Motor Neurone Disease*	resulting in permanent symptoms
Multiple Sclerosis*	with persisting symptoms
Parkinson's Disease*	resulting in permanent symptoms
Pre-senile Dementia	resulting in permanent symptoms
Stroke*	resulting in permanent symptoms

Please ask us if you would like to see a list of the full definitions before we give you a quote.

ADDITIONAL – CONDITIONS COVERED (INCLUDES CORE CONDITIONS ALSO)

Angioplasty	to treat specific conditions of specified severity
Aorta Graft Surgery**	requiring surgical replacement
Aplastic Anaemia	with permanent bone marrow failure
Bacterial Meningitis	resulting in permanent neurological deficit
Balloon Valvuloplasty	to relieve heart valvular abnormalities
Benign Brain Tumour*	resulting in permanent symptoms
Blindness*	permanent and irreversible
Cardiomyopathy	of specified severity
Coma**	resulting in permanent symptoms
Deafness*	permanent and irreversible
Encephalitis	resulting in permanent neurological deficit
Heart Surgery	with surgery to divide the breastbone
Heart Valve Replacement Or Repair*	with surgery to divide the breastbone
HIV Infection*	caught in a specified country from a blood transfusion, a physical assault or at work in an eligible occupation (see opposite#)
Liver Failure	of advanced stage

ADDITIONAL – CONDITIONS COVERED (INCLUDES CORE CONDITIONS ALSO) – continued

Loss Of Hands Or Feet*	permanent physical severance
Loss Of Independent Existence (including muscular dystrophy)	permanent and irreversible
Loss Of Speech*	permanent and irreversible
Paralysis Of Limbs*	total and irreversible
Pulmonary Artery Surgery	to excise and replace with a graft
Respiratory Failure	of advanced stage
Rheumatoid Arthritis	of specified severity
Terminal Illness*	before the greater of age 65 or state pension age
Third Degree Burns*	covering 20% of the body's surface area
Total And Permanent Disability	permanent, irreversible and before the greater of age 65 or state pension age
Traumatic Head Injury*	resulting in permanent symptoms

#The specified countries for HIV Infection are Australia, Channel Islands, Canada, a European Union country, the Isle of Man, Japan, New Zealand and USA.

The eligible occupations for HIV Infection caught at work are:

- Emergency services – police, fire and ambulance.
- Medical profession – including administrators, cleaners, dentists, doctors, nurses and porters.
- Armed forces.

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2.0 HOW DO WE SET UP A POLICY AND WHEN DO WE NEED TO GIVE YOU MEDICAL EVIDENCE?

2.1 WHAT DO YOU NEED TO SET UP THE POLICY?

If you accept the quote, we'll let you know what information we'll need. You'll need to fill in a proposal form and pay the first premium within 14 days of the date we agree to provide cover.

You'll also need to:

- Give us a membership list correct at the **policy** start date so we can give you an accurate account.

Please see questions 4 and 4.1 for more details.

- Check if any **insured employees** need to give us medical evidence.

Please see question 2.2 for more details about medical evidence.

To protect you and us from financial crime, we may need to confirm your identity. We may do this by using reference agencies to search sources of information about you (an identity search). This will not affect your credit rating. If this identity search fails, we may ask you for documents to confirm your identity.

We'll send you the **policy** when we have confirmed and finalised all the details. The **policy** is the contractual document, which tells you the terms and conditions and what we will and will not cover.

2.2 WHAT MEDICAL EVIDENCE WILL YOU NEED BEFORE YOU'LL COVER EMPLOYEES?

A) Free limit

We'll usually set a **free limit** when we quote. The **free limit** is the amount of cover we can give without the **insured employees** needing to give us medical evidence. Medical evidence is information about their health and pastimes. We'll tell you the **free limit** in the quote.

We also have a pre-existing condition exclusion for cover up to the **free limit**. This means we won't pay a claim for any condition the **insured person** was

suffering from at, or before, the start of their cover. We also won't pay claims for conditions occurring within two years of their cover starting which are related to a condition which existed at, or before, the start of their cover.

Please see questions 2.5 and 2.6 for more details about these exclusions.

b) Cover above the free limit

If an **insured employee** wants cover above the **free limit**, they will need to fill in a member's declaration form to give us medical evidence. We call our assessment of this evidence, **medical underwriting**.

To help the **insured employee** fill in the member's declaration form, we use qualified nurses from a tele-interviews service. The nurse will call the **insured employee** and fill in the form over the phone.

If they prefer to fill in the form themselves, you can find the member's declaration form in the literature section on our website www.legalandgeneral.com/workplacebenefits. Alternatively, you can ask us for a copy.

Depending on the information an **insured employee** gives us in the member's declaration form, we sometimes need to ask for more evidence. This could include a medical examination and blood or other tests. The **insured employee** will have the choice of carrying these out at home or at work by a qualified nurse. We'll pay for the cost of the medical examination and tests if we ask for more evidence.

We'll assess all the medical evidence to decide if we can offer cover and if any special terms are appropriate. If we do apply special terms, these will apply straight away.

If we accept cover above the **free limit**:

- Any special terms we set will apply to all the **insured employee's** cover. This includes their cover below the **free limit**.
- The pre-existing and related conditions exclusions will no longer apply to the cover we've agreed to.

- If you're not happy with any special terms we've set, you'll have 30 days to write to us and cancel the cover above the **free limit**. If you do, we'll re-instate the pre-existing and related conditions exclusions for cover below the **free limit**.

We will not need any medical evidence for **spouses', registered civil partners'** or **children** when their cover starts. However we'll always apply the pre-existing and related conditions exclusions to their cover.

2.3 IF YOU HAVE MEDICALLY UNDERWRITTEN AN EMPLOYEE, WHEN WILL THEY NEXT NEED TO GIVE YOU MEDICAL EVIDENCE?

We'll give you full details of our **policy** requirements for medical evidence when we start cover.

Once we **medically underwrite** an **insured employee** they won't normally need to give us more medical evidence for increases in benefit for another five years.

The medical evidence we need will depend on the amount of the increase and any existing special terms. However, unless we tell you otherwise, our standard approach will be:

If we **medically underwrite** an **insured employee**, and agree cover at ordinary rates, they won't normally need to give us more medical evidence and we won't apply our exclusions for pre-existing and related conditions for an increase until:

- It's been five years since we last **medically underwrote** them.
- The **insured employee's** benefit increases by more than 15% above their benefit 12 months earlier in those five years.
- Total increases in benefit during the five-year period add up to more than £50,000.
- If our terms for a change to the **policy** ask for medical evidence.

If we **medically underwrite** an **insured employee** and apply any other terms to the requested cover, we'll need medical evidence before we'll consider any further increase in their cover.

2.4 WHAT ARE YOUR TERMS IF WE'RE SWITCHING THE INSURANCE TO YOU FROM ANOTHER INSURER?

We'll give you full details of our **policy** requirements for medical evidence when we start cover.

TERMS FOR INSURED EMPLOYEES WHO ARE ELIGIBLE FOR COVER FOR THE FIRST TIME AT THE SWITCH DATE

We'll apply our pre-existing and related condition exclusions. We'll need medical evidence for the portion of their benefit, which is above our **free limit**.

We give more information about pre-existing and related conditions in questions 2.5 and 2.6.

SWITCH TERMS FOR EXISTING INSURED EMPLOYEES PREVIOUSLY INSURED

We'll usually provide cover for these **insured employees** at the same level and on the same terms (but not necessarily at the same cost) as the previous insurer.

We'll normally accept existing cover for **insured employees** whose cover with the previous insurer was:

- for their full **benefit entitlement**;
- not subject to any special terms, or for which an extra premium of no more than 100% of the normal premium was charged and paid;
- the acceptance terms were issued within the five years immediately before the transfer; and
- the total value of benefit for the **insured employee** doesn't exceed the lower of our **free limit** or £250,000.

We'll need you to give us a copy of the previous insurer's latest letter of acceptance or fill in a [Declaration – switch terms form](#). You'll need to give this to us when the **policy** starts or we won't be able to pay a claim for these **insured employees**.

We'll need medical evidence on the first benefit increase for an **insured employee** meeting the above switch terms, whose cover:

- is over our **free limit**; or
- was accepted by the previous insurer with special terms attached.

TERMS FOR ANY INSURED EMPLOYEES WHO DO NOT MEET OUR SWITCH TERMS

We're happy to consider and negotiate terms to insure any **insured employees** who don't meet the switch terms conditions. If you give us their full details, we'll consider if we can cover them. If we can then set terms, you'll need to accept them in writing before we will start their cover. To avoid a break in cover, you'll need to give us these details before the switch date.

2.5 WHAT IS YOUR PRE-EXISTING CONDITIONS EXCLUSION?

FOR A NEW INSURED PERSON

We apply a pre-existing conditions exclusion to all benefit. If we **medically underwrite** an **insured employee** and accept their cover we'll usually remove the exclusion applying up to the **insured employee's** benefit level we've **medically underwritten**.

The pre-existing conditions exclusion means, we won't pay benefit for any insured condition which the **insured person**:

- has suffered from or undergone before they join the **scheme**;
- is already in a qualifying period for an insured condition when they join the **scheme**. For example, as part of the qualification for Multiple Sclerosis specified symptoms must persist for six continuous months; or
- has previously received benefit for that insured condition.

For this purpose, we'll consider the suffering or the undergoing of the following to be the same disease:

Angioplasty	to treat specific conditions of specified severity
Aorta Graft Surgery	requiring surgical replacement
Balloon Valvuloplasty	to relieve heart valvular abnormalities
Cardiomyopathy	of specified severity
Coronary Artery By-Pass Grafts	with surgery to divide the breastbone
Heart Attack	of specified severity
Heart Surgery	with surgery to divide the breastbone
Heart Transplant	
Heart Valve Replacement Or Repair	with surgery to divide the breastbone
Pulmonary Artery Surgery	to excise and replace with a graft
Stroke	resulting in Permanent symptoms

Also, where an **insured person** has suffered from any malignant tumours, defined as Cancer, then we won't pay benefit for any subsequent Cancer. For this purpose, the Cancer doesn't have to be connected to, or associated with, the earlier diagnosis.

Where we use 'Cancer', please remember this excludes less advanced cases.



We will not pay benefit for the following conditions if the disablement or illness started before the **insured person** joined the **scheme**:

Loss Of Independent Existence (including muscular dystrophy)	permanent and irreversible
Terminal Illness	before the greater of age 65 or state pension age
Total And Permanent Disability	permanent, irreversible and before the greater of age 65 or state pension age

For the following illnesses:

Loss Of Independent Existence (including muscular dystrophy)	permanent and irreversible
Paralysis Of limbs	total and irreversible
Terminal Illness	before the greater of age 65 or state pension age
Total And Permanent Disability	permanent, irreversible and before the greater of age 65 or state pension age

We won't pay benefit if:

- the **insured person** has at any time, suffered or undergone any of the insured conditions; or
- a medical adviser chosen by us, believes it has resulted from any condition which the **insured person** was known to be suffering from at, or before, joining the **scheme**.

As long as a later diagnosis confirms this, we'll consider an **insured person** to have:

- suffered;
- undergone; or
- been in a duration period included in the definition of;

an insured condition before they joined the **scheme**, even if the insured condition hasn't been formally diagnosed.

FOR INCREASES

Each time an **insured person's** benefit increases we'll apply a new pre-existing conditions exclusion to that increase. For this purpose, wherever the exclusion refers to the date of joining the **scheme** or cover starting, it should be read as the day of the benefit increase.

If cover for a **child, spouse** or **registered civil partner** starts after the **insured employee** joins the **scheme**, we'll apply the pre-existing conditions exclusion from the day the **child, spouse** or **registered civil partner** is included for cover.

2.6 WHAT IS YOUR RELATED CONDITIONS EXCLUSION?

FOR A NEW INSURED PERSON

We apply a related conditions exclusion to all benefit. If we **medically underwrite** an **insured employee** and accept their cover we'll usually remove the exclusion applying up to the **insured employee's** benefit level we've **medically underwritten**.



The related conditions exclusion means we won't pay benefit for any insured condition occurring within two years of an **insured person** joining the **scheme** that resulted from any related condition. Related conditions include those for which the **insured person**, on or before the date they join the **scheme**:

- has received treatment;
- has suffered symptoms of;
- has sought advice on; or
- was aware of.

For this exclusion, the insured condition may have directly or indirectly resulted from a related condition. The decision as to whether a condition is a related condition will be based on the opinion of a medical adviser chosen by us.

We'll tell you the related conditions in our quote and **policy**.

FOR INCREASES

Each time an **insured person's** benefit increases we'll apply a new related conditions exclusion to the increased amount. For this purpose, wherever the exclusion refers to the date of joining the **scheme** or cover starting, it should be read as the day of the benefit increase.

If cover for a **child, spouse** or **registered civil partner** starts after the **insured employee** joins the **scheme**, we'll apply the related conditions exclusion from the day the **child, spouse** or **registered civil partner** is included for cover.

2.7 WHAT MEDICAL EVIDENCE DO YOU NEED FOR EMPLOYEES WHO WANT COVER BEFORE OR AFTER THEY ARE ELIGIBLE?

We can cover employees before or after they are eligible. We call these 'discretionary entrants'. We've given more details in the table on the right:

	EARLY ENTRANTS	LATE ENTRANTS
What does this mean?	An employee you want to start cover before the date they meet the eligibility conditions.	An employee you want to cover from a date after the first opportunity they had to meet the eligibility conditions. For example if the policy eligibility conditions need an employee to join the employer's pension scheme. An employee who doesn't join the pension scheme until after the day they were first able to do so will be a late entrant.
When can an employee's cover start?	If you want cover to start for the employee within three months of their employment starting, we'll agree to cover them up to the free limit without any medical evidence.	If you need to include an employee up to six months after the date of their first opportunity to join, we'll agree to cover them up to the free limit without any medical evidence.
What if an employee does not meet the requirements above?	All other early and late entrants will need to fill in a discretionary entrant's application for cover form. This will allow us to assess if we can cover them, if we need more medical evidence, and if we need to give them special terms or ask for extra premiums.	

2.8 WHAT HAPPENS IF WE NEED TO MAKE A CLAIM BEFORE YOU'VE FINISHED YOUR MEDICAL ASSESSMENT?

We'll give employees temporary accident cover, starting from the later of:

- the date cover is needed from; or
- the date we know they need to provide their medical evidence.

Our temporary accident cover will end at the earliest of the date we finish our assessment or the end of 90 days. However, there are some limits for temporary accident cover:

- We'll only pay a claim if the accident happens during the period of temporary accident cover.
- An accident is an unforeseen and unintended casualty or mishap caused by violent accidental external and visible means during the temporary accident cover period and is the exclusive and immediate cause of the insured condition.

Temporary accident cover excludes:

- Claims caused directly or indirectly in whole or in part by alcoholic intoxication, the influence of narcotics or drugs and medical or surgical treatment (except if necessary because of the accident).
- Claims caused by, or happening through, suicide, attempted suicide or intentional self-injury.

We'll give you full detail of the terms for accident cover after the **policy** start date. Please ask us if you'd like to see a copy of these terms earlier.

3.0 WHAT PREMIUMS WILL YOU CHARGE FOR THE COVER?

The premiums we charge depend on many things, including the:

- amount of cover;
- age and sex of the **insured employees**;
- type of work;
- work locations; and
- claims history, if the **policy** was previously insured or self-insured.

We don't charge a minimum premium.

Please read question 3.4 for more details about claims history.

3.1 HOW WILL YOU WORK OUT THE PREMIUMS?

We'll use either a **unit rate** or an exact cost to work out the premiums. We'll tell you which one we'll use in our quote.

Unit rate – For policies with 10 or more insured employees

We'll work out the cost for each £100 of **total members' benefit** or **total scheme earnings**. We call this cost the **unit rate**. We'll multiply the **unit rate** by the **total members' benefit** or **total scheme earnings** at the start of each **policy** year to work out a year's premium.

If the membership falls below 10, we'll change the way we work out premiums to exact cost. We'll tell you before we do this.

Please read question 4.2 for more details.

Exact cost – For policies with nine or less insured employees

We'll work out a premium for each **insured employee** from age related premium rates. We'll multiply the amount of cover to these rates at the beginning of each **policy** year.

Please read question 4.2 for more details.

If the membership increases to 10 or more, we'll change the way we work out premiums to **unit rate**. We'll tell you before we do this.

3.2 WILL THERE BE ANY UNEXPECTED EXTRA PREMIUMS?

We'll usually fix the **unit rate** or the age related premium rates until the end of the second **policy** year. We will then review them, following which we will usually fix the **unit rate** or the age related premium rates for another two years. However, we can change a **unit rate** during this period if there is a change of more than 25% in the membership or the **total members' benefit** (or **total scheme earnings**) covered by the **policy**. If this happens, we can change the **unit rate** from an **annual renewal date**. This means the premiums and the **unit rate** may go up or down.

If an **insured employee** has given us medical evidence, you may need to pay us an extra premium because of their health or dangerous pastimes. Although the extra premium applies immediately, we won't ask you to pay it straight away. Instead we'll wait and add it to your next account. If you tell us in writing within 30 days that you don't want this cover we will not charge the extra premium.

The premiums may also change at the start of the **policy** when we work out accurate premiums.

Please read question 4 for more details.

3.3 HOW MUCH COMMISSION WILL YOU PAY OUR ADVISER?

We may pay commission to your adviser. The standard rate is 12% of the premium you pay. We can pay different levels of commission although this will affect the premium we charge. Our quote will show the commission level we've allowed for.

3.4 IS THERE A DISCOUNT FOR A GOOD CLAIMS HISTORY?

Yes, we consider the past claims history of our **policy**, and any previous **policies**, when working out the **unit rate**. We'll adjust the premiums for a good or bad claims history, particularly for larger **policies** with more than 100 **insured employees**. A good claims history usually means the premiums will be lower than for a bad history.



4.0 HOW DOES THE ACCOUNTING WORK?

We'll work out the accounts at the start of the policy and then every year at a date we call the **annual renewal date**.

You'll need to pay us premiums in advance, either yearly or monthly. Yearly premiums are approximately 2% lower than the total of 12 monthly premiums.

You can pay yearly premiums by cheque or bankers automated clearing system (BACS). You can only pay monthly premiums by direct debit.

When the **policy** starts we'll work out and ask you to pay estimated premiums based on the membership list you gave us for the quote. This is because membership lists used for quotes often change by the time a **policy** starts. If it has changed, we'll ask you for an up-to-date membership list that's accurate on the day the **policy** starts. We'll use the updated list to work out the accurate premium and identify who we're covering. You will then have to pay, or we will refund, any difference between the estimated and accurate premiums.

Similarly, at each annual renewal date, we'll work out estimated premiums until you give us the up-to-date membership list. We'll then work out the accurate premiums.

4.1 WHAT INFORMATION DO YOU NEED FOR ACCOUNTING?

FOR UNIT RATE POLICIES

At the start of the **policy**, and at each rate review date, for each current **insured employee** you will need to give us their:

- name;
- gender;
- date of birth;
- **scheme earnings** (if applicable)
- benefit;
- eligibility category (if there's more than one); and
- medical evidence if an **insured employee's** cover goes over the **free limit**, or if our terms ask for it.

If we're also covering **spouses** and **registered civil partners** you'll also need to include their name, gender and date of birth alongside each **insured employee's** details.

At other **annual renewal dates**, as long as there isn't a change of more than 25% in the data totals since the last **annual renewal date**, you'll only need to send us:

- the total number of **insured employees**;
- the **total members' benefit**; and
- medical evidence if an **insured employee's** cover goes over the **free limit**, or if our terms ask for it.

If the **policy** is set up on sweep up accounting we'll also need to know the **total members' benefit** at the day before each **annual renewal date**. We use this to work out the end of year adjustment.

Please read question 4.2 for more details about the sweep up accounting adjustment.

It's important we get this renewal information quickly so we can work out the accurate premium and give you accurate accounts. It's also important that we know exactly who's covered under the **policy**. If you don't include an **insured employee**, or if insured a **spouse** or **registered civil partner**, who you should have included on the membership list at the start of the **policy** or the **annual renewal date**, we won't pay a claim for them.

FOR EXACT COST POLICIES

At the start of the **policy** and at each **annual renewal date** we'll need a list showing each current **insured employee's**:

- name;
- gender;
- date of birth;
- **scheme earnings**;
- benefit;
- eligibility category (if there's more than one);
- date of joining for employees whose cover started between **annual renewal dates**;
- date of leaving for employees whose cover ended between **annual renewal dates**;
- if the **policy** allows, the amount and date of any changes to benefit since the last **annual renewal date**;
- medical evidence if an **insured employee's** cover goes over the **free limit**, or if our terms ask for it.

If we're also covering **spouses** and **registered civil partners** you'll also need to include their name, gender and date of birth alongside each **insured employee's** details.

It's important we get this renewal information quickly so we can work out the accurate premium and give you accurate accounts. It's also important that we know exactly who's covered under the **policy**. If you don't include an **insured employee**, or if insured, a **spouse** or **registered civil partner**, who you should have included on the membership list at the start of the **policy** or the **annual renewal date**, we won't pay a claim for them.

4.2 HOW DO YOU ADJUST PREMIUMS FOR EMPLOYEES WHO JOIN, LEAVE OR HAVE BENEFIT INCREASES DURING THE POLICY YEAR?

We'll normally use exact cost accounting for **policies** with nine or less **insured employees**, and for all others either sweep-up or no change accounting. We'll tell you in our quote which accounting we'll use.

SWEEP-UP ACCOUNTING

We'll adjust premiums at the end of each **policy** year. Our adjustment assumes all changes in membership and cover took place midway through the year. We'll charge an extra premium or pay you a refund at the beginning of the next **policy** year.

NO CHANGE ACCOUNTING

Our premium will allow for changes in membership and cover during the **policy** year. This means we don't need to adjust the premiums at the end of the **policy** year for changes that are in line with the agreed eligibility conditions and benefit basis.

EXACT COST ACCOUNTING (ALSO KNOWN AS SINGLE PREMIUM OR CURRENT COST BASIS)

Exact cost means we'll adjust the premiums at the end of each **policy** year for the exact time and amount of cover we provide for each **insured employee**. We'll charge an extra premium or pay you a refund at the beginning of the next **policy** year.

4.3 IF YOU OR WE CANCEL THE POLICY MID YEAR, WILL WE LOSE ANY PREMIUMS WE HAVE PAID IN ADVANCE?

No. We'll work out a final account for the cover we've provided up to the **policy's** cancellation date. We will either send you a refund or you will have to pay us any premiums you owe immediately.

5.0 HOW DO WE MAKE A CLAIM?

For most insured conditions we'll pay the lump sum if the **insured person** survives for 14 days after meeting the definition for the insured condition. Firstly, we'll need you to send us a claim form within 30 days of the **insured person** meeting the definition of an insured condition.

We'll assess the information on the claim form to check if the **insured person** is eligible for cover. We'll also need medical information to help us check the claim against the insured condition definition as well as our pre-existing and related conditions exclusions. This medical information could be a report from the **insured person's** doctor or medical consultant. We'll pay the cost of any medical reports we ask for.

If you make a valid claim, we'll pay the lump sum to you, as trustees. We'll pay this as a cheque, payable to the **insured employee**, for you to pass it on.

We also have some other requirements for a few specific insured conditions as follows:

TERMINAL ILLNESS CLAIMS

We'll only pay claims for terminal illness if you send us the claim form before the **insured person** is 65, or their **state pension age** if later.

You must also send us the claim form before the **insured person** dies.

TOTAL AND PERMANENT DISABILITY CLAIMS

You should tell us about a potential claim after three months of continuous disability.

We'll only pay claims for Total And Permanent Disability before the **insured person** is age 65, or their **state pension age** if later. The **insured person** must also have been continuously disabled for six months.

HIV INFECTION

The definition of the insured condition must be met. A second blood test, within 12 months of the event, must confirm the presence of HIV or antibodies to that virus.

6.0 WHAT DON'T YOU COVER?

We won't pay a claim if the condition is not insured. The conditions we can insure are listed in question 1.7.

We include the full definitions of the conditions listed in question 1.7 with our quote and policy.

We won't pay a claim if the **insured person** doesn't meet the definition of the insured condition.

We won't pay a claim for Terminal Illness submitted to us after an **insured person's** death.

We won't pay a claim if the **insured person** had a pre-existing condition.

Please read question 2.5 for more details about pre-existing conditions.

We won't pay benefit for any insured condition occurring within two years of an **insured person** joining the **scheme** that resulted from a related condition.

Please read question 2.6 for more details about related conditions.

We won't pay a claim if the **insured person** is not eligible for cover.

For **insured employees** who give us medical evidence, we may set terms to exclude specific medical conditions. We'll tell you if we restrict cover in this way.

We may also restrict cover if we've agreed to cover **insured employees** based in certain overseas locations. We'll tell you if we've done this.

7.0 CAN YOU COVER AN EMPLOYEE WHO IS NOT BASED IN THE UK?

We'll cover **insured employees** who live and are employed in the United Kingdom while they are travelling overseas on company business.

We'll usually cover **insured employees** based overseas as long as they don't form the majority of the **insured employees**. We'll need their full details, as we may need to give you special terms for their cover. We won't start covering them until we've told you our terms.

In addition to any special terms, we'll also apply the following additional standard terms to an **insured person** while they are based outside the United Kingdom:

- You must pay all premiums, and we'll pay all benefit, in the UK in sterling.
- We'll fix any currency conversion rates at each **annual renewal date**.
- We reserve the right for a consultant to examine the **insured person** in a country of our choice. We define a consultant as: a recognised consulting doctor holding an appointment in a hospital in the United Kingdom or Republic of Ireland, or a recognised consulting doctor holding an appointment in a hospital in another country.
- If we need medical examinations and evidence when we assess a claim, we'll only pay the costs up to a similar level as if the claim had occurred in the United Kingdom.
- All diagnosis and medical reports must be in English.
- We limit the insured conditions Angioplasty and HIV Infection to specified countries. We'll tell you these in our quote.

8.0 WHAT TAX RULES APPLY?

Our understanding of the tax rules for this **policy** are:

- Premiums you pay for your employees are tax-deductible and can be offset against your profits for tax purposes.
- Your premiums will be treated as a benefit in kind for employees whose earnings, including the value of all the benefits in kind, are more than £8,500 a year. This means these employees will pay tax on the premiums you pay for them.
- Your employees will not need to pay income tax on the lump sum we pay.
- Premiums which equity partners' pay for their own cover, as opposed to those paid for their employees, are not deductible but if we pay a lump sum, it will be tax-free.

9.0 CAN EMPLOYEES CONTINUE THEIR COVER IF THEY LEAVE MY EMPLOYMENT?

No, an **insured person** cannot continue cover at their own expense if the **insured employee** stops working for you.

FURTHER INFORMATION.

PROVIDING INSURANCE

This Group Critical Illness Cover **policy** is provided by Legal & General Assurance Society Limited. Our principal office for the purpose of the **policy** is at:



Legal & General House
Kingswood
Tadworth
Surrey
KT20 6EU



01737 370 370

Call charges will vary. We may record and monitor calls.

WORKLIFE SOLUTIONS – EMPLOYEE ASSISTANCE PROGRAMME

WorkLife Solutions is a free telephone based Employee Assistance Programme provided by PPC Worldwide. We provide this automatically to all your **insured employees**.

It gives your **insured employees** 24-hour access to qualified counsellors to help them through life's challenges when they need it most. It also gives online support including information on how to cope with life events.

Although we give you WorkLife Solutions free, you are able to buy a Group Protection **policy** without it, but this would not change your premium.

QUESTIONS AND COMPLAINTS

If you have any questions or complaints, please speak to your adviser who arranged this **policy** for you.

If you then need to speak to us, you should call us or send the details of your question or complaint to our Group Protection Director. You can find our contact details at the back of this technical guide.

If we can't settle the complaint you may be able to refer it to the Financial Ombudsman Service. You can find their contact details at the back of this technical guide.

Making a complaint won't affect your right to take legal action.

COMPENSATION

You may be entitled to compensation from the Financial Services Compensation Scheme (FSCS) if we cannot meet our liabilities. You can find out more about the amounts and eligibility from the FSCS. Their contact details are at the end of this guide.

LAW

The **policy** is governed by English law. References in this guide to the tax treatment of premiums and benefits are based on our understanding of law and HMRC practice, which may change.

Under our **policy**, an **insured person** does not have any rights under the Contracts (Rights of Third Party Act) 1999. This means you don't have to involve them in decisions about the insurance **policy** we provide.

LANGUAGE

All communications from us, including our terms and conditions, will only be available in English.

INDUSTRY REGULATION

We're authorised and regulated by the Financial Services Authority. We're entered on their register under number 117659. You can check this at



<http://www.fsa.gov.uk/register/>

or telephone them on



0300 500 5000

This technical guide is for commercial customers as defined in the Financial Services Authority's Insurance: Conduct of Business sourcebook (ICOBS).

GLOSSARY.

Our terms explained.

Annual renewal date	The anniversary of the start date of the policy or another yearly date that we've agreed with you.	Insured employee	An employee or equity partner we've agreed to cover for benefit under the policy .
Benefit entitlement	This is the amount of benefit an insured person is covered for under the policy . Sometimes this can be restricted. For example, if a portion of benefit is declined after medical underwriting . Their full benefit entitlement would therefore be the amount of benefit before any portions are restricted or declined.	Insured person	A person we're covering for benefit under the policy . This can be an insured employee and their spouse, registered civil partner or child .
Child/Children	Any child, aged not less than six months but less than age 18 years, who is: <ul style="list-style-type: none"> • unmarried, • a child of the insured employee, or • a step child of the insured employee from a marriage or registered civil partnership entered into by the insured employee who is financially dependent upon the insured employee, or • legally adopted by the insured employee. 	Medical underwriting	The process we use to assess the health and pastimes of an insured employee . At the end of the process we may apply special terms.
Free limit	The maximum monetary limit for an insured employee which we'll normally provide cover without the need for medical evidence. We'll tell you the free limit in our quote as a level of benefit or scheme earnings .	Policy	The legal contract between you and us. You choose how much of the benefits you've promised to your employees that you want to insure under the policy.
		Registered civil partner	A person whom the insured employee has registered a civil partnership with as defined in the Civil Partnerships Act 2004 which has not been dissolved or annulled and is less than age 70.
		Scheme	The scheme you have set up to provide critical illness benefits to your employees. You decide how much of the benefits to insure under the policy .

GLOSSARY continued**Scheme earnings**

These are the earnings we use to work out an **insured employee's** benefit if it's based on a multiple of earnings. Scheme earnings are usually the **insured employee's** basic annual salary, but you may use other earnings if this is more appropriate, for example, to allow for other income such as bonuses or commission. You cannot include directors' fees as part of scheme earnings. For equity partners, we'll usually base benefits on earnings averaged over the last three years for which accounts have been produced.

Spouse

The **insured employee's** current or only husband or wife who is less than age 70.

State pension age

The age at which eligible people begin to receive their state pension from the Government.

Total members' benefit

The total insured benefit for all **insured employees**.



Total scheme earnings

The total **scheme earnings** for all **insured employees**.

Unit rate

This is one of the ways we calculate the cost of a **policy**. We'll calculate the cost for each £100 of cover and multiply this with the **total members' benefit** or **total scheme earnings** for the **policy**. We'll tell you the unit rate in our quote.

CONTACT DETAILS.

GROUP PROTECTION PRINCIPAL OFFICE QUESTIONS AND COMPLAINTS	FINANCIAL OMBUDSMAN SERVICE	FINANCIAL SERVICES COMPENSATION SCHEME
<p>Group Protection Director Legal & General Assurance Society Limited Legal & General House Kingswood Tadworth Surrey KT20 6EU</p>	<p>If we can't resolve a complaint you may be able to refer it to: Financial Ombudsman Service South Quay Plaza 183 Marsh Wall London E14 9SR</p>	<p>7th Floor, Lloyds Chambers 1 Portsoken Street London E1 8BN</p>
<p> 0845 072 0751 We may record and monitor calls. Call charges will vary. Lines are open from 8.30am to 5.30pm Monday to Friday.</p>	<p>0800 0234 567 or 0300 1239 123</p>	<p>020 7741 4100 or 0800 678 1100</p>
<p> group.protection@landg.com www.legalandgeneral.com/workplacebenefits</p>	<p>complaint.info@financial-ombudsman.org.uk www.financial-ombudsman.org.uk</p>	<p>enquiries@fscs.org.uk www.fscs.org.uk</p>

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[HOW TO MAKE A CLAIM](#)
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