

A group of people, including a woman in a white long-sleeved shirt and a man in a blue t-shirt, are shown in profile with their arms raised in a fitness or yoga class. The background is a blurred outdoor setting with greenery.

GROUP PROTECTION

# GROUP INCOME PROTECTION.

We've over 40 years of experience in the market and we are one of the leading providers for Group Income Protection.



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# WELCOME.



**Helping you to bring a fresh approach to traditional Group Income Protection. With over 80 years of expertise and knowledge in the group protection market. We look after over 7,100 policies and provide protection to more than 2.2 million employees as at the end of 2009.**

**71% of our customers rated our service as good or excellent in the ORC Group Risk Track Survey 2010.**

Workplace Recovery is our Group Income Protection (GIP) proposition. It can provide early intervention and rehabilitation plus a monthly income for members who are absent from work because of a long term illness or injury.

We combine expertise with flexible product design to deliver protection benefits.

Our dedicated team has the knowledge and expertise to help provide solutions for small schemes of 50 members to a large complex portfolio of 250,000 members. We review each policy on an individual basis so that we can work with you to help develop your protection package and offer some of the most competitive rates in the market place.

The Financial Services Authority is the independent financial services regulator. It requires us to give you important information to help you decide whether our Group Income Protection is right for you. You should read this document carefully so that you understand what you are buying, and then keep safe for future reference. If you have any doubts over the suitability of the contract please contact a financial adviser.

This technical guide is designed to explain the features of our Group Income Protection product. If we have quoted for your scheme, you should read this technical guide together with the quote.

The full terms and conditions of the product are in the policy document. We'll issue this after we have agreed to provide cover and all the policy details have been finalised. If you would like to see a copy of the standard terms and conditions, please ask.

This technical guide does not form part of the contract. Our quote, which is a part of the contract, may refer to some of the explanations given in this guide.

# ABOUT YOUR POLICY.

Workplace Recovery is our Group Income Protection (GIP) proposition. It can provide early intervention and rehabilitation plus a monthly income for members who are absent from work because of a long term illness or injury.

## IN THIS SECTION

UNDERSTANDING THIS DOCUMENT

AIMS

YOUR COMMITMENT

RISK FACTORS

HOW THE POLICY WORKS



## UNDERSTANDING THIS DOCUMENT

We've used words like 'normally' and 'usually' in this guide. This is because we have a standard approach but for some terms you can choose alternatives. We'll give you the exact terms for your **policy** in the quote.

Where we've had to use a technical term in this guide, we've highlighted this in bold and given a full explanation in our [glossary on page 28](#).

We've based this technical guide on the 'best practice' format recommended by the Group Risk Development Group (GRiD) and the Association of British Insurers (ABI).

## AIMS

### THE POLICY AIMS TO DO THE FOLLOWING:

- Provide insurance to cover the income protection benefits you promise to provide to your employees who cannot work because of a long term illness or injury.
- Work with you, when appropriate, to provide early intervention and rehabilitation for **members** who are absent from work because of a long term illness or injury.
- Offer a choice of cover relating to these benefits.

## YOUR COMMITMENT

### YOU MUST DO THE FOLLOWING:

- Give us all the information we ask for:
  - when you apply for a **policy**;
  - at **renewal dates**; and
  - to support any claims.

You will also need to tell us if any relevant details change. Please ask us if you're not sure if your change is relevant or not.

It's important you give us all this information, as we may not pay claims without it.

- Pay the premiums when we need them.
- Keep to all the conditions set out in the **policy**.
- Tell us about any claims within the time limits set out in the answer to [question 5.3](#).

## RISK FACTORS

### THE POLICY CARRIES THE FOLLOWING RISKS:

- Cover stops if you stop paying premiums.

We'll pay any valid claims that arise before the cover ended.

- We'll usually guarantee premium rates until the end of the second **policy** year, when we will review them. We will then normally review them every two years and guarantee them up until the next review date. The premium rate may go up or down at that date depending on changes in the membership.
- For **unit rated** policies, we can change the guaranteed rate at the **annual renewal date**, if there is a change of more than 25% in the membership or the **aggregate scheme earnings** covered by the **policy** [see question 3.1](#).
- We may also review the premium rates if a change is made to the agreed **scheme** eligibility or benefit structure.
- We can change the **policy** terms at the end of any guarantee period. We'll give you at least two months notice in writing if we do this.
- Depending on the accounting basis, you may need to pay us more for changes in membership.
- We won't pay a claim if the employee doesn't meet the relevant **definition of incapacity** or is not eligible for cover.

- We'll usually need employees to be **actively at work** before we can start their cover. We'll also need them to be **actively at work** before we start covering any increases in their cover. This means we'll not pay benefit for an employee, or their increased benefit, if they are not **actively at work**. We'll start their cover when they are next able to meet our **actively at work** requirements. We define and give full details of **actively at work** in [section 2.4](#).
- If you don't choose to protect benefit payments from inflation, their value, but not the actual amount we pay, could reduce over time ([see section 1.8](#)).
- We'll reduce the benefit payments under the **policy** if the **member** is receiving any other regular income as a result of their illness or injury [see question 5.5](#).
- We can cancel the **policy** if you don't give us the information we need under its terms and conditions. [See section 4.1](#).
- We can change or cancel the **policy** if there are changes to legislation, regulation or **state benefits** which affect income protection **policies**. We'll give you more details of these in the **policy**.
- We'll cancel the **policy** if there are less than five **members** covered. We'll give you at least two months notice in writing if we do this.

## i

### WORKPLACE RECOVERY

Workplace Recovery is our Group Income Protection (GIP) proposition. It can provide early intervention and rehabilitation plus a monthly income for **members** who are absent from work because of a long term illness or injury.



## HOW THE POLICY WORKS

- To start the **policy** we normally need a minimum of 50 **members**. We will normally continue to provide cover as long as the membership does not fall below five **members**. Sometimes we will accept a **policy** with less than 50 **members**. For example, if you have two **schemes** linked together and one of the **schemes** has less than 50 **members**.
- We'll give you the specific terms and conditions that apply to a **policy** in the quote. We will normally guarantee the quote for three months.
- You must pay for the cost of the cover. There are lots of options you can choose which will affect the amount you pay.
- You decide the type and level of benefit and any other optional features outlined within our benefit limits [see questions 1.0 to 1.8](#).
- You decide the eligibility conditions for the **scheme** which we'll set out in the **policy**.
- You must include all eligible employees when they first become eligible.
- You must give us all the information we need when you make a claim.
- We'll send the benefit payments to you when they become due.
- You will be responsible for paying the benefit to the **member** after deducting any Income Tax and National Insurance contributions.
- If we're paying benefit to you for a **member**, we won't charge you premiums for them.
- The **policy** will continue indefinitely as long as you meet its conditions, including paying premiums when we need them.
- The first day of each **yearly accounting period** [see question 4.0](#) will be considered to be the **annual renewal date**. At this time we will need information from you for accounting purposes [see question 4.1](#).
- While you continue to pay premiums, we'll provide cover and pay all the valid claims you make.
- This **policy** has no **cash in value** at any time.

### i

We'll stop paying benefit if the employee no longer meets the definition of incapacity. It doesn't matter if the employee doesn't have a job to go back to.

# YOUR QUESTIONS ANSWERED.

## IN THIS SECTION

- 1.0 What factors should I consider in deciding what benefits to provide?
- 2.0 How do I set up a policy?
- 3.0 What premiums will you charge for the cover?
- 4.0 How does the scheme accounting work?
- 5.0 How do I make a claim?
- 6.0 What is not covered?
- 7.0 Can cover be provided for an employee who is not based in the UK?
- 8.0 What tax rules apply?
- 9.0 Can members continue their cover if they leave my employment?



# 1.0 WHAT FACTORS SHOULD I CONSIDER IN DECIDING WHAT BENEFITS TO PROVIDE?



We have a range of benefit options to help you design a scheme that suits your budget and your approach to long term absence.

You don't have to provide the same benefit level to all your employees. Benefits can be different for each defined category, such as an office or production employee, as long as they stay within the conditions set out under [question 1.3](#).

When you set up a group income protection **scheme** for your employees, you can take out an insurance **policy** to insure part or all of the **scheme** benefit. If you only insure part of the benefit you may have to pay the difference yourself.

If you have an existing **scheme**, it's important to make sure your current cover still meets your needs for insuring the benefit.

**Scheme** benefit is normally calculated as a percentage of **scheme earnings**. These are often based on the **member's** basic annual salary, but you can ask us to include other income, such as bonuses or commission. If we do this, we may average these amounts based on the last three years. We'll tell you in the quote if part of a **member's scheme earnings** need to be averaged.

Director's fees and dividends cannot be included as part of a **member's scheme earnings**.

## 1.1 WHO CAN BE COVERED?

Cover can be provided to employees who become eligible to join the **scheme** and have met the:

- eligibility conditions set by you;
- **actively at work** requirement in [question 2.4](#); and
- requirements for medical evidence in [question 2.2](#).

**You will need to set out the eligibility conditions, which should include:**

- 1 The minimum and maximum entry ages for new **members**.
- 2 Any service qualification – the minimum length of time an employee has been in continuous employment with you.
- 3 A description of the eligible category or categories of employees.
- 4 The entry date when employees can join and the date when we will start to cover increases in benefit.
- 5 Details of any link to membership of a pension **scheme**.

The conditions relating to entry ages, entry dates and service qualification must be the same for each employee within a defined category.

You should consider any laws on discrimination or unfair treatment. These laws include those relating to age, equal treatment of men and women, and the treatment of part time, fixed term and disabled employees.

All employees who become eligible to join the **scheme** should be included at the entry date otherwise we'll treat them as **early entrants** or **late entrants** [see question 2.5](#).

### Entry dates and benefit increases

To give you as much flexibility as possible, the entry date for new **members** and when an existing **member** can change their benefit level can be:

<b>YEARLY</b>	At the <b>annual renewal date</b> .
<b>MONTHLY</b>	At a specified date each month.
<b>DAILY</b>	<p><b>New entrants</b> At the first day employees meet all the eligibility conditions.</p> <p><b>Increasing benefits</b> Immediately when a <b>member</b> increases their earnings.</p>

Entry to the **scheme** and benefit increases don't have to be on the same basis, for example, entry could be daily and benefit increases could be yearly.

If a **member** becomes eligible for a different benefit category within the **scheme**, the new benefit level will apply immediately. The normal entry date for that category won't apply, as long as any other requirements we may have set, such as **actively at work**, have been met.

If the new category allows for daily changes, we'll also cover any increase in the **member's scheme earnings**, so that these changes can start at the same time.

### Temporary absence from work

We'll continue to cover a **member** who is off work for a reason other than illness or injury as long as:

- the period of the absence is fixed before it starts, and is not longer than one year;
- the **member** has a right to return to the same job when their absence ends;
- the **member** does not do any work or activity which, in our view, puts them at more risk of illness or injury than they were at in their job with you; and
- you tell us about the absence, in writing, within one month of it starting.

If the **member** becomes ill or is injured during their temporary absence, the **deferred period** [see question 1.5](#) won't start until the temporary absence ends.

If a **member** is on maternity, paternity or adoption leave we'll continue to provide cover as long as they remain entitled to the benefit under the terms and conditions of their employment.

## 1.2 WHEN WILL COVER END FOR MEMBERS?

Under normal circumstances cover will stop for **members**:

- 1 When they leave your employment or are no longer eligible to be a **member**.
- 2 When they reach the **benefit termination date** set out in the **policy**. This is usually the normal retirement date fixed by you or their 70th birthday if this is earlier.
- 3 If they retire early.
- 4 When their period of temporary absence cover ends.
- 5 If they die before benefit starts being paid.

### Cancelling the cover

- We'll continue your cover as long as you meet the conditions set in the **policy**.
- You can cancel the **policy** at anytime by giving us 14 days' written notice.
- We'll give you 14 days' written notice if we have to cancel the **policy** because its conditions haven't been met. All cover will end when the **policy** is cancelled.

## 1.3 WHAT TYPES OF COVER ARE AVAILABLE?

There are two types of cover available, **member's benefit** and **additional benefit**. We will pay these when the **member** meets the definition of incapacity covered [see section 1.4](#). We'll tell you what the definition of incapacity is in the quote.

	MEMBER'S BENEFIT	ADDITIONAL BENEFIT
What does this mean?	This is the benefit we'll pay you to pass to the <b>member</b> if they are long term absent because of illness or injury.	You can cover your continuing liability to pay pension contributions to an occupational or personal pension scheme. You can normally cover some of the <b>member's</b> own pension contribution. You also can cover your liability to pay National Insurance contributions on the <b>member's benefit</b> .
How it works	Cover is available as a percentage of the <b>member's scheme earnings</b> . This can include or exclude state benefit and must not be more than the maximum benefit. You can provide different levels of cover for different categories of <b>members</b> . We can insure any number of categories, as long as the eligibility conditions for each category are clearly defined. The same benefit basis must apply to all <b>members</b> of the same category. You can choose to cover a percentage of <b>scheme earnings</b> less the total benefit a <b>member</b> receives from the State. We need a minimum of 20 <b>members</b> for an integrated policy. This would be a minimum of 50 <b>members</b> at the start of the <b>policy</b> ( <a href="#">see How the policy works</a> ).	We can't provide different levels of <b>additional benefit</b> for each <b>member</b> . Therefore, you'll need to set a percentage of <b>scheme earnings</b> for all <b>members</b> (or category of <b>members</b> ). The total cover for both yours and the <b>member's</b> pension contributions must stay within the maximum limits explained below.
Maximum benefit	We will restrict benefits to the following limits: a) the <b>member's benefit</b> must not exceed £350,000 a year and the total pension contributions must not exceed £75,000 a year. b) the <b>member's benefit</b> and the <b>member's</b> own pension contributions must not exceed 80% of their <b>scheme earnings</b> .	

## 1.4 HOW DO YOU DEFINE INCAPACITY?

We assess the claim against the definition of incapacity set out in the **policy**. It can usually be one of the four definitions below. The quote we'll send you will outline the definition we've used.

OWN OCCUPATION	ACTIVITIES OF DAILY WORKING	PROGRESSIVE		
<p>A <b>member</b> is incapacitated if in our opinion, an illness or injury prevents them from performing the essential duties required of their occupation.</p> <p>They continue to be in your employment.</p> <p>They are not doing any job other than one which results in payment of a reduced benefit <a href="#">see question 5.2</a>.</p>	<p>A <b>member</b> is incapacitated if in our opinion an illness or injury means they meet (with or without aids or adaptations):</p> <ul style="list-style-type: none"> <li>• at least three of the criteria in Section 1; or</li> <li>• one of the criteria in Section 2 below:</li> </ul> <p><b>SECTION 1</b></p> <p>A claim under this section should be supported by evidence that they have been prescribed and are taking appropriate medication.</p> <p><b>a) Walking:</b> they cannot walk more than 200 metres on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body.</p> <p><b>b) Rising/Sitting:</b> they are unable to rise and sit using a raised chair with arms without the help of another person.</p> <p><b>c) Dexterity:</b> they are unable to write legibly with a pen or pencil or use a keyboard with either hand.</p> <p><b>d) Communication:</b> they cannot</p> <ol style="list-style-type: none"> <li>clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room in their first language; or</li> <li>understand simple messages in their first language; or</li> <li>speak with sufficient clarity to be clearly understood in their first language.</li> </ol> <p><b>e) Eyesight:</b> their visual ability is reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.</p> <p><b>SECTION 2</b></p> <p><b>a) Severe mental illness classification ICD-10 Code:</b> to qualify, they will be required to be under the supervision of the National Health Service mental health team at its highest level (with or without Supervision Register) or equivalent.</p> <p><b>b) Organic brain disease or injury:</b> they suffer from chronic organic brain disease or brain injury (confirmed by neurological investigation or imaging techniques) affecting their ability to reason and understand to the extent that they require continual supervision by another person 24 hours a day.</p>	<p>A progressive definition combines all of the three definitions described previously.</p> <ul style="list-style-type: none"> <li>• Year one and two are assessed on an <b>own occupation</b> definition.</li> <li>• Year three and four are assessed on a <b>suited occupation</b> definition.</li> <li>• Year five and beyond are assessed on an 'activities of daily working' definition.</li> </ul> <p>You can choose a combination of these definitions with, for example, an <b>own occupation</b> definition applying for the first two years of benefit payment and a <b>suited occupation</b> definition applying after that.</p> <p>You can also change the definition for different categories of <b>member</b>, include a lump sum option <a href="#">see question 1.7</a> or negotiate an alternative definition.</p>		
<p><b>Note:</b></p> <p>This is the most expensive option.</p> <p>A <b>member's own occupation</b> is not necessarily their own job but could be the same occupation for a different employer.</p> <p>Although our quotation may show <b>own occupation</b> for a category, we'll use a different definition for <b>members</b> whose occupation needs a special licence, for example pilots or lorry drivers. We'll cover these <b>members</b> using our <b>suited occupation</b> definition instead.</p>				
SUITED OCCUPATION				
<p>A <b>member</b> is incapacitated if in our opinion, an illness or injury prevents them from doing any job, which is considered to be appropriate to their experience, training or education.</p> <p>They are not doing any job other than one which results in payment of a reduced benefit <a href="#">see question 5.2</a>.</p>				
SWITCH TERMS	MEDICAL UNDERWRITING	HOW TO MAKE A CLAIM	TAX	GLOSSARY

## 1.5 WHEN WILL YOU START PAYING BENEFIT?

Benefit will start when we've assessed all the medical evidence and decided the **member** meets the definition of incapacity.

The **deferred period** is the period of time when we don't pay any benefit. It starts on the date the **member** first becomes unable to work because of their incapacity.

The **deferred period** is normally 13, 26, 28, 39, 41, 52 or 104 weeks, but may also be any other number of weeks in this range. We'll tell you what the **deferred period** is in the quote.

The longer the **deferred period**, the lower the cost of the insurance. This is because it is more likely that we will get **members** back to work before the end of the **deferred period**.

## 1.6 HOW LONG CAN BENEFIT BE PAID FOR?

You will need to decide the date up to which benefit will be paid if a **member** cannot return to work. It is usual for benefit to be paid up to the normal retirement date, as long as this is not later than their 70th birthday.

For certain occupations, such as pilots or test drivers, we will apply an earlier termination date.

As a cost saving option, you can set the benefit payment term at 24, 36 or 60 months. We call this a **limited term**. This option can also be varied so that the benefit continues to be paid if the **member** is permanently disabled, or so a lump sum is paid at the end of the payment term [see question 1.7](#).

We'll regularly review the benefit and it will stop if the **member** no longer meets the definition of incapacity.

## 1.7 CAN A LUMP SUM BE CHOSEN?

If you choose this option, we can pay a lump sum benefit to a **member** at the end of the payment term if they continue to meet the definition of incapacity. This can be an amount equal to the previous year's benefit increased by the **benefit increase rate** if applicable. Alternatively, we can pay a larger lump sum, if chosen, which is calculated by multiplying this amount by between two and five times.

We can also pay a lump sum after four years of benefit payments under the progressive definition.

In both cases, we'll reduce the lump sum proportionately if the period between:

- the date the lump sum payment is due; and
- the age shown in the **benefit termination date** for the **member**

is less than the number of year's benefit payments that make up the lump sum.

## 1.8 CAN BENEFIT PAYMENTS BE PROTECTED FROM INFLATION?

Yes, you can choose to help protect against the value of the benefit payments reducing over time because of inflation. We have different options you can choose from. We call this the **benefit increase rate**.

We can provide for any **member's benefit** and **additional benefit** being paid to increase each year by a fixed rate of your choice. The maximum is 5%.

Alternatively, you may limit the increase to the rate of inflation as measured by the Retail Prices Index (RPI) as long as it is not more than 5%.

We will normally increase the benefit on the anniversary of the date the first monthly payment was made.

# 2.0 HOW DO I SET UP A POLICY?

## 2.1 REQUIREMENTS TO SET UP THE POLICY

The quote is valid for 90 days. If you accept the quote, we'll let you know what other information we'll need. However, you'll need to complete a **proposal form** and pay the first premium within 14 days of the date we agree to provide cover.

### Identity search

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.

## 2.2 MEDICAL EVIDENCE NEEDED BEFORE MEMBERS CAN BE COVERED

FREE LIMIT	
What does this mean?	We can provide cover up to a certain amount without the <b>member</b> having to provide details about their health and pastimes.
How it works	<p>We'll set the <b>free limit</b> when we quote for your <b>scheme</b>.</p> <p>The <b>free limit</b> will depend on the number of eligible <b>members</b> joining and the level of benefit.</p> <p>It will also depend on whether the eligibility conditions you set include membership to your pension scheme, where membership is voluntary. If we don't know this when we produce our quote, we'll assume that at least 75% of eligible employees will have joined your pension scheme at the start date of the <b>policy</b>. We'll reduce the <b>free limit</b> we quoted if this isn't the case.</p> <p>The <b>free limit</b> is usually set as an amount of <b>scheme earnings</b>. This makes it easier to identify <b>members</b> who will need to provide medical evidence as their benefit entitlement is more than the <b>free limit</b>.</p>
Maximum Free Limit	<p>£120,000 benefit.</p> <p>We'll tell you the <b>free limit</b> for your <b>scheme</b> in our quote, usually as an amount of <b>scheme earnings</b>.</p>

### Cover above the free limit

The **member** will need to give us medical evidence if their benefit entitlement is more than the **free limit** and they want full cover.

To do this we'll need a **member's declaration form**. This is a form the **member** fills in to give us information about their medical history and pastimes.

### Tele interviews

To help the **member** fill in the member's declaration form, our **tele interviews** service will put the **member** in touch with a qualified nurse who will help them fill in the form over the phone.

If they prefer to fill in the form manually, you can find the member's declaration in Protection documents on our website [www.legalandgeneral.com/workplacebenefits](http://www.legalandgeneral.com/workplacebenefits). Alternatively, you can ask us for a copy.

Sometimes we may ask for more evidence, which can include a medical examination and blood or other tests.

The **member** 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 if we ask for more evidence.

We'll assess 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 immediately.

Where our letter explaining any special terms includes an extra premium loading, you can tell us in writing within 30 days that you would like to cancel the cover.

Any cover below a **free limit** or which has been previously accepted will not normally be affected.

## 2.2 MEDICAL EVIDENCE NEEDED BEFORE MEMBERS CAN BE COVERED

### CONTINUED

As we need a minimum of 50 **members** at the start of the policy, ONEderwriting will apply. If this falls to fewer than 50 **members**, forward **underwriting** will apply.

	50 MEMBERS OR MORE	LESS THAN 50 MEMBERS
What medical underwriting approach we'll apply	<p><b>ONEDERWRITING</b></p> <p>We'll <b>underwrite</b> once and in most cases, no more medical evidence will be needed.</p>	<p><b>FORWARD UNDERWRITING</b></p> <p>Once we medically <b>underwrite</b> a <b>member</b> they won't normally need to provide more evidence for normal increases in benefit for another five years.</p>
How it works	<p>We'll usually agree increases in cover without the need for more medical evidence where the <b>member</b> has provided medical evidence and we agree to the following terms:</p> <ul style="list-style-type: none"> <li>• ordinary rates;</li> <li>• with a premium loading that you are paying; or</li> <li>• with an exclusion.</li> </ul> <p>As long as their benefit is not more than the maximum benefit (see question 1.3), we won't need medical evidence:</p> <ul style="list-style-type: none"> <li>• for normal increases in benefit resulting from <b>scheme earnings</b> increases; or</li> <li>• where the insured basis is changed at a future date for all <b>members</b>; or all <b>members</b> in a category of more than five lives.</li> </ul> <p>We'll provide the increase in cover on the same terms. Where a premium loading applies you must tell us in advance of the date and the amount of all increases. If you change your mind you can tell us within 30 days after the date of increase that you no longer require it. If you do, then ONEderwriting will no longer apply to the <b>member</b>.</p>	<p>When we medically <b>underwrite</b> a <b>member</b>, as long as we agree cover on the following terms:</p> <ul style="list-style-type: none"> <li>• ordinary rates;</li> <li>• apply a loading of 150% or less;</li> <li>• apply an exclusion for hazardous pursuits;</li> <li>• apply an exclusion for a medical condition;</li> </ul> <p>they won't normally need to provide more medical evidence until one of the events detailed below happens.</p>
When we'll need medical evidence	<p>We'll need medical evidence at the next benefit increase if the evidence previously provided by the <b>member</b> is:</p> <ul style="list-style-type: none"> <li>• restricted;</li> <li>• declined;</li> <li>• postponed;</li> <li>• not proceeded with;</li> <li>• subject to other terms;</li> <li>• medical evidence is not provided; or</li> <li>• a premium loading is declined by you (see above).</li> </ul>	<p>We'll next need medical evidence if any of the above terms apply and any of the following happens:</p> <ul style="list-style-type: none"> <li>• It's been five years since they were last medically underwritten by us.</li> <li>• The <b>member's</b> benefit entitlement increases by more than 15% above the benefit 12 months earlier in those five years.</li> <li>• We've set terms that requests evidence (generally, when an increase in cover is required, depending on the amount or special terms applied).</li> </ul>

When cover starts we'll give you full details of the **policy** requirements relating to medical evidence.

[SWITCH TERMS](#)
[MEDICAL UNDERWRITING](#)
[HOW TO MAKE A CLAIM](#)
[TAX](#)
[GLOSSARY](#)

## 2.3 SWITCHING YOUR SCHEME INSURANCE TO US

We'll normally accept a high level of cover without needing medical evidence, even if the previous insurer applied a premium loading, as long as they meet our switch terms.

We'll need medical evidence at the date of switch for benefit above our **free limit** for **members** who are first eligible for cover at the date of switch.

### Switch terms not met

We are very happy to consider and negotiate terms for taking on the insurance of any **members** who don't meet the conditions under section (i) and (ii) of the **switch terms** even if they had some benefit declined by the previous insurer. We cannot cover these **member's** until you give us their full details. We can then set terms which you will need to accept in writing before we will start their cover. To avoid a break in cover, you'll need to give these details before the switch date.

### Switch terms

For both (i) and (ii) below we'll usually provide cover for these **members** at the same level and on the same terms (but not necessarily at the same cost) as the previous insurer.

- (i) We'll normally accept existing cover for **members** whose cover with the previous insurer:
- was for their full benefit entitlement;
  - was not subject to any special terms;
  - was never subject to medical evidence;
- provided the **member** is not incapacitated (as defined in our **policy**) at the date of switch.

We'll need medical evidence when a **member** first exceeds our **free limit**. If the existing cover with the previous insurer exceeds our **free limit** we'll need medical evidence on the next increase in cover.

- (ii) For other existing **members** we'll normally accept their existing cover without medical evidence if:
- their benefit is not more than £200,000 and any premium loading does not exceed +300%; or
  - their benefit is above £200,000 (but not above our **maximum benefit** limit) and any premium loading is not more than +150%;

as long as:

- cover with the previous insurer was for their full benefit entitlement;
- the **member** is not incapacitated (as defined in our **policy**) at the date of transfer; and
- the **member** has undergone medical **underwriting** within the five years immediately before the date of transfer.

We'll need to receive a copy of the insurer's latest letter of acceptance or a **Declaration – switch terms form**. You'll need to provide these when the **policy** starts otherwise we won't be able to pay a claim for these **members**.

### Future medical evidence for members in section (ii) of switch terms accepted without medical evidence.

- (i) Where cover was accepted by a previous insurer under an **ONE**derwriting (or equivalent)

approach, in most cases no further medical evidence will be needed. Medical evidence will not be needed for:

- increases in a **member's** benefit; or
- where the insured basis is changed for all **members**.

Benefit cannot be increased during the **deferred period** [see question 1.5](#) and cannot be more than our maximum benefit [see question 1.3](#).

- (ii) Where cover was accepted by the previous insurer on a forward **underwriting** basis with a premium loading not more than 150%, medical evidence will next be required at the earliest of:

- five years from the date last underwritten by a previous insurer;
  - when a **member's** benefit entitlement increases by more than 15% within any 12 month period starting on or after the **policy's** start date;
- or, if later, when cover first exceeds our **free limit**.

Benefit cannot be increased during the **deferred period** [see question 1.5](#) and cannot be more than our maximum benefit [see question 1.3](#).

- (iii) For all other **members**, if existing cover with the previous insurer exceeds our **free limit**, we'll need medical evidence on the next increase in cover. This could be at the switch date if cover is increased at that date. Otherwise we'll need medical evidence when a **member's** benefit first exceeds our **free limit**.

## 2.4 ACTIVELY AT WORK

In certain circumstances we'll apply an **actively at work** requirement.

ACTIVELY AT WORK	
What does this mean?	This means the employee must be in full active employment, physically and mentally able to perform all the duties associated with their normal job on the day the cover is due to start.
How it works	<p>For a new <b>scheme</b> (or an existing <b>scheme</b> which is being insured for the first time) an <b>actively at work</b> requirement will apply at the date we start cover.</p> <p>If you are transferring the insurance of an existing <b>scheme</b> to us the <b>actively at work</b> requirement will apply, for cover up to the <b>free limit</b>, for employees who:</p> <ul style="list-style-type: none"> <li>• become eligible for membership at the date of the transfer (either by meeting the eligibility conditions or because you change the <b>scheme</b> basis); or</li> <li>• have an increase in benefit entitlement because you change the <b>scheme</b> basis at the date of the transfer.</li> </ul> <p>We may apply an <b>actively at work</b> requirement to new <b>members</b> included after the start date of the <b>policy</b> and to normal benefit increases.</p> <p>Where an <b>actively at work</b> requirement applies, we will not cover any employees who do not meet this requirement at the date their cover is due to start, or for their increase in cover, until they are next <b>actively at work</b>.</p>



## 2.5 EARLY AND LATE ENTRANTS

	EARLY ENTRANTS	LATE ENTRANTS
What does this mean?	An employee for whom cover is needed before their normal entry date within the eligibility conditions.	An employee who didn't join the <b>scheme</b> at their first opportunity and for whom cover is now needed.
When an employee can join	If the employee is joining the <b>scheme</b> within three months of being employed by you, we'll agree cover up to the <b>free limit</b> without any additional requirements provided the employee is <b>actively at work</b> see question 2.4.	If the employee is joining the <b>scheme</b> up to six months after their normal entry date within the eligibility conditions, we'll agree cover up to the <b>free limit</b> provided the employee is <b>actively at work</b> see question 2.4.
What if an employee does not meet the requirements above?	All other <b>early</b> and <b>late entrants</b> will need to complete a <b>discretionary entrant's declaration form</b> before we can consider providing cover.	
	We may also need more evidence before we make a decision. If we agree to provide cover on special terms, we will let you know whether or when we need medical evidence on future increases.	

## 2.6 WHAT HAPPENS IF YOU NEED TO MAKE A CLAIM BEFORE WE'VE FINISHED OUR MEDICAL ASSESSMENT?

From the date we know a **member** needs to provide medical evidence, we'll provide temporary cover. The **member** won't be entitled to benefit if their incapacity is caused by any medical condition that they were diagnosed with or displaying symptoms of within the previous five years.

We'll provide temporary cover for up to 90 days or until we have carried out the assessment, whichever is earlier. It'll be restricted so that the total value of the **member's** cover is not more than £120,000.

This temporary cover will not apply:

- to any **member** whose cover has been refused, is restricted or already has special terms attached; or
- if the **member** has refused to provide evidence, either now or in the past.

When we can't provide temporary cover, we'll provide 'accident cover' for the same period, but we won't accept claims for accidental disability caused by:

- alcohol abuse;
- the influence of drugs;
- medical treatment; or
- surgical treatment (except treatment that is needed because of the accident).

Attempted suicide and intentional self injury are also not covered.

We'll give you the full details of the terms for temporary and accident cover after we've agreed to provide cover. If you'd like to see a copy of these terms beforehand, please ask.

## 3.0 WHAT PREMIUMS WILL YOU CHARGE FOR THE COVER?



The premiums we charge will depend on a number of things as well as the amount of cover you need. These include:

- the age and sex of eligible employees;
- their type of occupation;
- where they work;
- the rate at which the benefit increases while it is being paid; and
- the claims history if the scheme was previously insured or self insured (usually needed where there are more than 100 members).

There is no minimum premium or extra policy fee. We won't charge premiums for members while we are paying benefit for them.

### 3.1 HOW WILL YOU WORK OUT THE PREMIUMS?

	UNIT RATE BASIS	EXACT COST BASIS (Also known as Single Premium or Current Cost basis)
How it works	We'll work out a <b>unit rate</b> of premium as the cost of providing each £100 of the <b>total scheme earnings</b> to be insured under the <b>policy</b> . We'll apply that rate to the <b>total scheme earnings</b> at the beginning of each <b>policy</b> year.	We'll work out premiums for each <b>member</b> from age related premium rates which we apply to the amount of cover at the beginning of each <b>policy</b> year.
Requirements	<b>10 or more members.</b> As we normally need a minimum of 50 <b>members</b> , we will use a <b>unit rate</b> for most <b>schemes</b> . However, if your <b>scheme</b> membership were to fall below 10, we would switch to <b>exact cost</b> basis to work out premiums. We'll tell you before we change this.	<b>Up to 9 members.</b> If membership increases to 10 or more, we'll use the <b>unit rate</b> basis to work out premiums. We'll tell you before we change this.

### 3.2 WILL THERE BE ANY UNEXPECTED EXTRA PREMIUMS?

We'll usually guarantee premiums rates until the end of the second **policy** year. We'll then review them following which we'll usually guarantee rates for a further two years (as described in the section **Risk Factors**).

When cover starts we normally work out the initial premium based on the membership data provided for the quote. We'll ask for updated membership data as at the **policy** start date and work out the premium due from that date. This means the actual cost of cover could increase or decrease from that shown in the accepted quote.

If a **member** has provided us with medical evidence, we may charge an extra premium which reflects the **member's** state of health or dangerous pastimes. This will be effective immediately, unless you tell us to the contrary in writing within 30 days of the date of our letter telling you of the extra premium. Then the cover for which the extra premium was to be charged will not be provided. Although the extra premium will apply immediately, you will not have to pay it until the next **annual renewal date**.

### 3.3 WHAT COMMISSION IS ALLOWED FOR IN THE PREMIUMS?

We'll pay commission to your adviser as a percentage of each premium you pay. The standard rate is 12%. We can pay different levels of commission although this will affect the premium we charge. Our quote will show the rate we have allowed for.

### 3.4 IS THERE A DISCOUNT FOR GOOD CLAIMS HISTORY?

We consider a **scheme's** past **claims history** when working out the **unit rate**. We'll adjust the premiums for a good or bad **claims history**, particularly for larger **schemes**. A good **claims history** will usually mean a cheaper premium than a bad history.

## 4.0 HOW DOES THE SCHEME ACCOUNTING WORK?



The policy has a yearly accounting period and premiums are due in advance, usually either yearly or monthly. Yearly premiums are approximately 2% lower than the total of 12 monthly premiums.

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

We base our accounts on the employee and payroll details you gave us for the quote. As these details have probably changed since then, we'll recalculate the accounts using the accurate details which are correct at the policy start date. This may mean the cost increases or decreases. Once we have worked out the accurate premium, you will have to pay, or we will refund, any difference between the approximate and accurate premiums.

## 4.1 WHAT INFORMATION DO YOU NEED FOR ACCOUNTING PURPOSES?

UNIT RATE SCHEMES		EXACT COST SCHEMES (Also known as Single Premium or Current Cost basis)	
<p><b>At the start of a policy and at each rate review date we need a list showing each member's:</b></p> <ul style="list-style-type: none"> <li>• Gender.</li> <li>• Date of birth.</li> <li>• <b>Scheme earnings.</b></li> <li>• Benefit category (if there is more than one).</li> </ul>	<p>At any other <b>renewal date</b> we need:</p> <ul style="list-style-type: none"> <li>• Total number of <b>members.</b></li> <li>• <b>Total scheme earnings</b> (at that date).</li> </ul> <p>For the sweep up account (see 4.2 below), we'll need the same information but at the date immediately before the rate review or <b>renewal date.</b></p>	<p>At the start of a <b>policy</b> and at each <b>renewal date</b> we need:</p> <ul style="list-style-type: none"> <li>• Gender.</li> <li>• Date of birth.</li> <li>• <b>Scheme earnings.</b></li> <li>• Benefit category (if there is more than one).</li> </ul>	<p>We'll also need dates of entry and any 'daily increases' (where included) together with the dates on which any <b>members</b> left the <b>scheme</b> during the <b>policy</b> year.</p>

It's important we get the renewal information quickly so we can calculate the right premium and give you accurate accounts.

## 4.2 HOW ARE PREMIUMS ADJUSTED FOR MEMBERS WHO JOIN, LEAVE OR HAVE BENEFIT INCREASES DURING THE POLICY YEAR?

UNIT RATE SCHEMES		EXACT COST SCHEMES (Also known as Single Premium or Current Cost basis)	
<p><b>SWEEP UP ACCOUNTING</b></p> <p>Any extra premium or refund will be paid at the beginning of the next <b>policy</b> year.</p> <p>These operate on a 'simplified accounting' basis where (unless entry dates and benefit increases are yearly) we adjust premiums at the end of each <b>policy</b> year based on the assumption that all changes in membership and cover took place midway through the year.</p>	<p><b>NO CHANGE ACCOUNTING</b></p> <p>As an alternative we may be able to make an allowance in the <b>unit rate</b> to reflect changes in membership and cover during the <b>policy</b> year. This avoids the need for adjusting premiums at the end of the year unless changes that are not in line with the agreed eligibility conditions or benefit basis have been made.</p> <p>We'll tell you which accounting basis we're using in the quote.</p>	<p>We will adjust premiums at the end of each <b>policy</b> year to reflect the actual period covered and the amount of cover provided for each of the <b>members.</b></p> <p>Any extra premium or refund will be paid at the beginning of the next <b>policy</b> year.</p>	

## 4.3 IF THE POLICY IS CANCELLED MIDYEAR, WILL I LOSE ANY PREMIUMS I HAVE PAID IN ADVANCE?

UNIT RATE SCHEMES	EXACT COST SCHEMES (Also known as Single Premium or Current Cost basis)
<p>No. We will produce a final account for the cover provided up to the date the <b>policy</b> is cancelled. We will either send you a refund or you will have to immediately pay any premiums you owe us.</p>	

# 5.0 HOW DO I MAKE A CLAIM?

## 5.1 WHEN CAN I MAKE A CLAIM?

### Under what circumstances?

For us to pay a claim the **member** must meet the definition of incapacity set out in the **policy** at the end of the **deferred period**.

### How incapacitated must the member be?

The **policy** will tell you which definition of incapacity is being used [see question 1.4](#).

### How will a claim be assessed?

We will need suitable evidence of the **member's** incapacity so that we can decide whether or not it meets the definition of incapacity in the **policy**.

1

#### Complete an Absence notification form by week four of absence.

This gives us information about the **member**, including details of their earnings, the job they were doing and whether they could continue to do any part of that job.

2

#### Medical assessment

The **member** will then have to give us information about their incapacity, the doctors they are consulting and the treatment they are receiving. They will also need to give us permission to ask their doctors for more information if we need it.

We will try to ask for as little information as possible, but the **member** may need to have an independent medical examination or assessment.

We can also consider any medical reports or extra information that you or the **member** want to show us.

### Can rehabilitation help?

From the early stages of a claim we will work with you to help the **member** cope with their changing lifestyle and encourage them to return to work as soon as possible. With our help, the **member** may be able to cope with, or overcome, their incapacity.

For instance:

- we may be able to contribute to the cost of adapting their workplace; or
- give the **member** access to programmes aimed at getting them back to work; or
- call on our network of independent professional advisers and consultants who may be able to offer assessments of their abilities, disability counselling and career counselling.

Under the Disability Discrimination Act you may have to adapt the workplace to meet the needs of a disabled person. Some of the services we provide may help you to do this.

## 5.2 HOW LONG WILL YOU PAY BENEFIT FOR?

We will pay benefit until the earliest of:

- the termination date set out in the **policy**;
- the date the **member** no longer meets the definition of incapacity. It doesn't matter if the employee doesn't have a job to go back to;
- the date the **member** dies.

**What happens if the member's employment is terminated or the business goes into liquidation?**

If we are paying a claim for the **member** and you end the **member's** employment or your business goes into liquidation, we will continue to pay the **member's benefit**. If this happens, we will pay **member's benefit** direct to the **member**.

Any **additional benefit** in respect of pension contributions may continue. Any **additional benefit** in respect of National Insurance contributions will stop.

**What happens if an employee's illness or injury means that they can work part time or in a reduced capacity?**

We'll pay a reduced benefit which will reflect the number of hours the **member** works and their reduction in earnings, with an allowance for inflation. We don't need to pay a full claim before we'll consider a claim for reduced benefit.

We'll adjust the amount of reduced benefit if the **member's** earnings change (for example, if the number of hours they work increases). If the change results in no benefit being paid, the claim will end. However, we'll consider reinstating the claim without the **member** having to complete a new **deferred period** if, within the next 52 weeks, they suffer a relapse. If a relapse occurs after 52 weeks, we will treat it as a new claim.

## 5.3 WHEN DO YOU NEED TO KNOW ABOUT A MEMBER WHO WE MAY MAKE A CLAIM FOR?

The earlier we start collecting information about a **member's** incapacity the better. This allows us to give appropriate support at the earliest opportunity, work with you to provide effective absence management and to pay benefit without delay.

If you think the **member** may be off work for longer than the **deferred period**, we'd like to know no later than four weeks after the start of their absence.

If you don't tell us until after the end of the **deferred period** we won't backdate the benefit. If you don't tell us within 90 days following the end of the **deferred period** we will not accept the claim.

### Early notification bonus

For **schemes** with over 250 members who tell us of at least 80% of all absence by the sixth week of the date of their first absence, we will pay a bonus of 5% of the **policy** premium.

Read more in our [Early notification bonus guide](#) or ask us for details. Terms and conditions apply.

## 5.4 WHO PAYS FOR MEDICAL EVIDENCE?

We pay the cost of all reports, tests and examinations that we ask for.

## 5.5 DOES OTHER INCOME THE MEMBER RECEIVES AFFECT THE AMOUNT YOU PAY OUT UNDER THIS POLICY?

It is essential that any **member** receiving any benefit from this **policy** does not receive, in total, an amount that is higher than the salary they received when they were working. This is to provide an incentive for them to return to work, so we'll take other regular income into account. If necessary, we'll reduce the amount we pay so that the total, when added to the **basic allowance** and **work related activity component** is not more than 90% of their total earnings immediately before the start of the **deferred period**.

Other regular income includes payments from other insurance policies. For example loan protection policies. It does not include income that the **member** was already receiving before the start of their incapacity such as share dividends or pensions.

## 5.6 AFTER A MEMBER RETURNS TO WORK, CAN ANOTHER CLAIM BE MADE FOR THAT MEMBER?

Yes. If their incapacity is from a different cause they will be treated as making a new claim. So they will have to meet the definition of incapacity and complete a new **deferred period** before benefit can be paid under the **policy**.

If their incapacity is from the same cause and the **member** is off work again within 52 weeks of the date they returned to work, we'll treat this as a **linked claim**. We'll start paying out under the **policy** again as soon as we receive proof that the absence is through the same cause. The amount we pay will be at the level we would have paid if the **member** had not returned to work.

Where payment is limited to a certain number of months, benefit will start being paid again (as above), but the **limited term** will be extended to allow for the time the employee was back at work.

## 5.7 WHAT HAPPENS TO CLAIMS IF THE POLICY IS CANCELLED?

As long as premium payments are up to date when the **policy** is cancelled, we will continue to pay any benefit we were paying at the time the **policy** ended.

If the **policy** is cancelled because the insurance is being transferred to another insurer, the following will apply to **linked claims**.

- If, on returning to work, the **member** meets the new insurer's **actively at work** requirement (and so becomes covered under the new **policy**), we will pay benefit for a **linked claim** until the end of the **deferred period** under the new insurer's **policy**. From then on, the new insurer will be responsible for the claim under the terms of its own policy.
- If, on returning to work, the **member** does not meet the new insurer's **actively at work** requirement (and so does not get cover under the new policy), we'll continue to be responsible for the claim.

This means that the **member** will not lose the benefit of a **linked claim** as a result of the insurance of the **scheme** being transferred to another insurer.

We'll also pay out under the **policy** for any **members** who, when the **policy** was cancelled, were in the **deferred period** as long as they stay in your employment and the claim is valid.

## 6.0 WHAT IS NOT COVERED?

For **members** who provide medical evidence, our terms for providing cover may state that we will not pay out for a specified medical condition.

We may also restrict cover if we have agreed to provide cover for employees based in certain overseas locations.

We'll not pay if the **member** doesn't meet the definition of incapacity or if the employee was not eligible for cover.

## 7.0 CAN COVER BE PROVIDED FOR AN EMPLOYEE WHO IS NOT BASED IN THE UK?

We will usually cover employees working abroad as long as they do not form the majority of the **scheme** membership.

We will need full details of any overseas employees as we may need to change our standard terms and conditions. We will not provide cover until we have set any special terms necessary.

Cover for employees who travel abroad for normal business purposes but who are based in the UK will not usually have any special terms attached.

Where a **member** remains outside the UK we will only pay claims for a maximum of 26 weeks unless they are resident in one of the following countries:

- Australia
- Austria
- Belgium
- Canada
- The Channel Islands
- Cyprus
- Denmark
- Eire
- Finland
- France
- Germany
- Greece
- Iceland
- The Isle of Man
- Italy
- Luxembourg
- Malta
- The Netherlands
- New Zealand
- Norway
- Portugal
- Spain
- Sweden
- Switzerland
- USA

## 8.0 WHAT TAX RULES APPLY?

Our understanding of the current tax rules for group income protection **schemes** is as follows:

- The premiums you pay for employees who are not major shareholders in your company are tax deductible and can be offset against your profits for tax purposes.
- Your premiums are not treated as a 'benefit in kind' for employees.
- The amount we pay to you will be taxable as a trading receipt. However, when you pay the amount to the **member** it will be deductible for tax purposes.
- The amount you pay to the **member** under the rules of the **scheme** will be treated as earned income, on which Income Tax and National Insurance contributions are due in the same way as on the **member's** salary.
- If a lump sum option is selected, the tax treatment will depend on how you as the policyholder use it. You should obtain legal advice before selecting this option.

## 9.0 CAN MEMBERS CONTINUE THEIR COVER IF THEY LEAVE MY EMPLOYMENT?

**Members** cannot continue cover at their own expense when they stop working for you.

# FURTHER INFORMATION.

## IN THIS SECTION

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## WORKLIFE SOLUTIONS – EMPLOYEE ASSISTANCE PROGRAMME.

This free telephone based Employee Assistance Programme is provided by PPC Worldwide and is automatically available to your **policy members**.

It provides 24 hour access to qualified counsellors to support managers and employees through life's challenges when they need it most. Complementing our telephone support, WorkLife Solutions also boasts exceptional online support which provides a wealth of information on how to cope with life events.

Although WorkLife Solutions is provided for free, you are able to purchase a Group Protection **policy** without this benefit in which case there would be no change to your premium.

## PREMIER WORKLIFE SOLUTIONS.

Some employers may wish to enhance the support they offer to their employees by selecting our Premier WorkLife Solutions.

Premier WorkLife Solutions is provided by PPC Worldwide and consists of vastly discounted face to face counselling models, free online health risk assessments and online reporting updated every 24 hours.

## COMPLAINTS HANDLING.

1

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

2

If you then need to speak to us, you should send the details of your question and complaint to our **Group Protection Director**. You can find our contact details at the back of this technical guide. Making a complaint won't affect your right to take legal action.

3

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.

If we can't meet our liabilities, you may be entitled to compensation under the Financial Services Compensation Scheme. If you would like more information, their contact details are at the end of this guide.

## THE LAW.

The **policy** will be governed by English Law.

Under our standard **policy**, **members** do not have any rights under the Contracts (Rights of Third Parties) Act 1999, which means that they do not have to be involved in decisions about the insurance provided by the **policy**. However, if we've paid a benefit direct to a **member** because you stop trading or are wound up, the **member** will have rights under the Act as far as the claim is concerned.

References in this guide to the tax treatment of premiums and benefits are based on our understanding of current law and HM Revenue & Customs practice, which may change.

## LANGUAGE.

All communications from us will be in English. The 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 [www.fsa.gov.uk/register/](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).

## PROVIDING INSURANCE.

Group Income Protection policies are provided by Legal & General Assurance Society Limited.

The Legal & General Group is one of the UK's leading financial services companies. As at 31 December 2009, we were responsible for investing £334 billion worldwide on behalf of investors, policyholders and shareholders.

# GLOSSARY.

<b>Actively at work</b>	This means the employee must be in full active employment, physically and mentally able to perform all the duties associated with their normal job on the day the cover is due to start.	<b>Early entrant</b>	An employee who you need cover for before their normal entry date within the eligibility conditions.
<b>Additional benefit</b>	Cover for contributions to a pension you've set up for your employees. It can also cover your liability to pay National Insurance contributions.	<b>Employment and support allowance</b>	One or more of the parts of the Employment and Support Allowance payable by the Department for Work and Pensions.
<b>Annual renewal date</b>	The anniversary of the start date of the <b>policy</b> or another yearly date that we've agreed with you.	<b>Exact cost</b>	This is how we calculate the cost of a <b>policy</b> with nine or less <b>members</b> . We'll calculate the cost for each <b>member</b> using their age, gender and amount of cover. This is also known as single premium or current cost.
<b>Basic allowance</b>	The annual basic rate of benefit payable after the assessment phase of the <b>Employment and Support Allowance</b> .	<b>Free limit</b>	The maximum monetary limit for which we'll normally provide cover without the need for medical evidence.
<b>Benefit increase rate</b>	The yearly increase in <b>member's benefit</b> and/or <b>additional benefit</b> (if applicable).	<b>Inception date</b>	The date the <b>policy</b> starts.
<b>Benefit termination date</b>	The last date to which we'll pay benefit payments for a <b>member</b> .	<b>Late entrant</b>	An employee who didn't join the <b>scheme</b> at their first opportunity and you now need to cover.
<b>Cash in value</b>	Some insurance policies have a 'cash in value' which means you get some money back if you cancel the <b>policy</b> . This <b>policy</b> has no cash in value at any time.	<b>Limited term</b>	An option you can ask for under our <b>policy</b> that provides a maximum limit on the length of time we'll pay benefit for. We'll start the <b>limited term</b> on the day after the end of the <b>deferred period</b> .
<b>Claims history</b>	The historical record of claims made under the <b>scheme</b> .		
<b>Deferred period</b>	The period of time when we don't pay any benefit. It starts on the date the <b>member</b> first becomes unable to work because of their incapacity.		

## GLOSSARY continued

<b>Linked claim</b>	A second claim for a <b>member</b> within 52 weeks after the first claim for them ended, where the absence is caused by the same incapacity. For linked claims we'll waive the <b>deferred period</b> for the second claim.	<b>Scheme earnings</b>	The earnings we use to calculate the scheme benefit.
<b>Member</b>	An employee included for benefits within the <b>scheme</b> and insured under the <b>policy</b> .	<b>State benefits</b>	These are benefits that form part of the <b>Employment and Support Allowance</b> . For <b>schemes</b> set up on an integrated basis we can also allow for Enhanced Disability Premium and Severe Disability Premium.
<b>Member's benefit</b>	The basic benefit we pay to you to pass on to the <b>member</b> . This is usually calculated as a percentage of <b>scheme earnings</b> .	<b>Suited occupation</b>	A <b>member</b> is incapacitated if in our opinion, an illness or injury prevents them from doing any job, which is considered to be appropriate to their experience, training or education.
<b>Own occupation</b>	A <b>member</b> is incapacitated if in our opinion, an illness or injury prevents them from performing the essential duties required of their occupation.	<b>Total scheme earnings</b>	The total <b>scheme earnings</b> for all insured <b>members</b> .
<b>Policy</b>	The legal contract between you and us. You choose how much of the benefits you've promised under the <b>scheme</b> that you want to insure under the <b>policy</b> .	<b>Underwrite</b>	The process we use to assess any risks and decide how much your premiums will be.
<b>Renewal date</b>	The <b>annual renewal date</b> .	<b>Unit rate</b>	This is how we calculate the cost of a <b>policy</b> with 10 or more <b>members</b> . We'll calculate the cost for each £100 of cover and multiply this with the <b>total scheme earnings</b> for the <b>policy</b> .
<b>Scheme</b>	The <b>scheme</b> you have set up to pay the benefits promised to your employees.	<b>Work related activity component</b>	The annual rate of the <b>work related activity component</b> , payable after the assessment phase, of the <b>Employment and Support Allowance</b> . It's paid by the Department for Work and Pensions.

# CONTACT DETAILS.

GROUP PROTECTION PRINCIPAL OFFICE QUESTIONS AND COMPLAINTS	FINANCIAL OMBUDSMAN SERVICE	FINANCIAL SERVICES COMPENSATION SCHEME
<p>Group Protection Director Legal &amp; General Assurance Society Limited Legal &amp; General House Kingswood Tadworth Surrey KT20 6EU</p>	<p>If we can't settle 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> <b>0845 072 0751</b> We may record and monitor calls. Call charges will vary. Lines are open from 8.30am to 5.30pm Monday to Friday.</p>	<p><b>0800 0234 567</b> or <b>0300 1239 123</b></p>	<p><b>020 7892 7300</b> or <b>0800 678 1100</b></p>
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