



GROUP PROTECTION

GROUP LIFE ASSURANCE AND DEPENDANTS' PENSIONS.

We were rated in the top tier for overall service, Group Life proposition and premium rates in the April 2010 ORC Group Risk Track Survey.

TECHNICAL GUIDE



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WELCOME.



We've been working with employers and intermediaries to help look after the financial security of employees and their dependants for over 80 years. In 2009 we paid £186 million in Group Life Assurance and Dependants' Pensions claims to help loved ones in times of despair. Plus 81% of advisers rated our Group Life proposition as very good or excellent in the April 2010 ORC Group Risk Track Survey.

Group Life Assurance and Dependants' Pensions cover can provide dependants with a lump sum and a dependants' pension should a **member** die in service. Group Life Assurance and Dependants' Pensions is also known as death in service 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 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 Life Assurance and Dependants' Pension is right for you.

You should read this document carefully so that you understand what you're buying, and then keep it 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 Life Assurance and Dependants' Pensions 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.

Group Life Assurance and Dependants' Pensions provide employers with a valuable employee benefit. It helps give members peace of mind that their loved ones could be financially secure when it really matters.

IN THIS SECTION

UNDERSTANDING THIS DOCUMENT

AIMS

YOUR COMMITMENT

RISK FACTORS

HOW THE POLICY WORKS

A small white lowercase letter 'i' inside a blue square, used as an information icon.

This guide refers to 'you' and 'employer'. For the purposes of the **policy** terms and conditions, you should read these references as 'trustees' if separate trustees hold the **policy** for the employer.

UNDERSTANDING THIS DOCUMENT

We've used words like 'normally' and 'usually' in this guide. This is because we have a standard approach which means we'll normally or usually do something. For some terms you can choose alternatives for your **policy**. 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 25](#).

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 POLICIES AIM TO DO THE FOLLOWING:

- Provide insurance to cover the death in service lump sum or the dependants' pension benefits, or both, that an employer promises to provide for their employees under a 'registered scheme' [see question 1](#).
- Offer a flexible range of choices of cover for 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'll also need to tell us if any relevant details change. Please ask us if you're not sure if your change is relevant.

It's important you give us all the information, as we may not be able to 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 as soon as possible.

RISK FACTORS

THE POLICIES CARRY THE FOLLOWING RISKS:

- Cover stops if you stop paying premiums;
 - We'll continue to pay any dependants' pensions that we started to pay before the cover ended.
- We'll usually guarantee premium rates until the end of the second **policy** year then we'll 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's a change of more than 25% in the membership or the **total benefit** 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.
- For new **schemes** with a membership of less than 100, we'll usually need employees to be **actively at work** before we can start their cover.

If an existing **scheme** transfers to us, we'll usually need employees to be **actively at work** if, because of a change made at the transfer date, they are either:

- newly eligible to be included for the first time; or
- have had an increase in their cover.

This means we will not cover an employee for lump sum benefits or dependant's pensions, or their increase in cover, 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](#).

- We can cancel the **policy** if registration is withdrawn.
- 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.
- If we include an event limit, we'll restrict the total amount of benefits we'll pay out for claims if a catastrophe occurs [see question 6](#).
- We won't pay a claim if the employee is not eligible for cover.
- If you don't register the **scheme**, you will not be able to get tax relief on your premiums and income tax will need to be paid on the benefits unless the **scheme** meets the criteria of an excepted group life policy.
- We can cancel or change 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 is any change in the law or practice affecting the taxation or operation of Group Life Assurance and Dependants' Pensions schemes. We'll give you full details of our cancellation rights in the **policy**.
- If you choose not to protect dependants' pension benefits from inflation, their value, but not the actual amount we pay, could reduce over time [see section 1.6](#).

HOW THE POLICY WORKS

- To start the **policy** we normally need a minimum of 50 **members**. We'll normally continue to provide cover as long as the membership doesn't 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'll 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 1.6](#).
- You will be the **scheme administrator** unless you appoint someone else.
- The **scheme administrator** will need to register the **scheme** with HM Revenue & Customs (HMRC) if it hasn't been done before. This needs to be done at least five working days before cover is needed and you'll need to give us confirmation of the registration. You can find details of how to register a **scheme** at www.hmrc.gov.uk
- You decide the eligibility terms 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.
- If you make a valid claim, we'll pay the lump sum benefit to you as **trustees** of the **scheme**. You will then be responsible for paying the lump sum to the **member's** dependants. You'll need to decide who receives the benefit, after considering any wishes the **member** may have made.
- The **scheme administrator** must give HMRC certain information about a **member** at the date of their death in some circumstances.
- We'll pay dependants' pensions to the **trustees** of the **scheme** who will then pay the dependants. We can also act as an agent of the **trustees** and pay the dependants direct. Whoever pays the dependant must first deduct any income tax due.
- 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'll 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.

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's not covered?
- 7.0 Can you provide cover for an employee who's based outside 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?

A HMRC registered scheme offers various levels of tax advantages, (find out more in question eight). If you're considering death in service benefits for your employees, you can provide any benefit that the rules allow. We have given some details of this below.

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 **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 that the current cover still meets your needs for insuring the benefit.

When you think about the type and level of benefit to provide, you should also consider the HMRC allowances that apply. Broadly, these are:

Lump sum benefit – The Finance Act 2004 introduced a **Lifetime Allowance** which restricts the amount of tax free lump sum benefits that can be paid from a registered **scheme**. The **Lifetime Allowance** is set by the Treasury and is £1.8 million for the tax years 2010/2011 to 2011/2012.

The maximum lump sum benefit that we'll insure is £10 million. Any benefits paid over the **Lifetime**

Allowance are subject to a tax charge unless the **scheme** allows them to be used to buy a dependants' pension. When you calculate if there is a tax charge on a death in service benefit, you also need to consider other lump sum payments that might be paid from other registered **schemes**. For example, this could be a return of funds under a money purchase pension **scheme**.

Dependants' pensions – There's no limit on the amount of dependants' pension you can pay.

If you choose to cover a multiple of **scheme earnings**, then we usually base this on the basic annual salary of the **member**. However, if it's more appropriate, you can ask us to include other income such as bonuses or commission.

You can limit earnings to a **notional earnings cap** or to your own maximum. Before 6 April 2006 there was a mandatory earnings cap set by the treasury for death in service benefits. You don't need to apply this after 6 April 2006, but a **notional earnings cap** will continue to be set during the transitional period until 2010/2011. You will need to tell us if you want to apply the **notional earnings cap** or any other maximum.

If you have **members** with lump sum benefits above the **Lifetime Allowance** or who have enhanced protection you can consider using our Lifetime Plus (LTP) policy. Enhanced protection was available to anyone with pension rights at 5 April 2006. To qualify for enhanced protection, an employee would have had to apply to HMRC before 5 April 2009. The LTP policy is a relevant life policy, which meets the 'excepted group life policy' conditions. The LTP can be used to provide benefits above the **Lifetime Allowance** without the tax charge (although there may be a small inheritance tax charge) or for all benefit. The cover under the LTP must be under a separate non registered **scheme**. Please ask us for details if you want to provide benefits in this way.

1.1 WHO CAN BE COVERED?

Employees and non employees can be insured once they meet the eligibility terms. They may also need to meet the **medical evidence** [see questions 2.2](#) and **actively at work** [see question 2.4](#) conditions.

Examples of non employees are spouses, registered civil partners and equity partners (that's a partner with an equity share in the firm and whose share of the firms trading profits is taxed as income). You can only include non employees in a registered **scheme** that provides cover to employees.

You'll 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 when we'll 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 relevant 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:

YEARLY	At the annual renewal date .
MONTHLY	At a specified date each month.
DAILY	<p>New entrants At the first day employees meet all the eligibility conditions.</p> <p>Increasing benefits Immediately when a member 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 benefit changes, we'll also cover any increase in the **scheme earnings** of the **member**, so that these changes can start at the same time.

Temporary absence from work

Normally **schemes** allow cover to continue while a **member** is off work. Our standard basis for providing this temporary absence cover is three years if an employee is off work because of illness or injury and one year for absence due to any other reason. We're flexible and will consider other periods of temporary absence cover to match your needs.

The **member's** cover will continue based on their **scheme earnings**. If their **scheme earnings** are reduced at any time while they're off work, cover will continue at the same level as before that reduction. Alternatively, you may arrange cover to increase in line with average pay increases or each year at a fixed rate of up to 6%.

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 75th birthday if this is earlier).
- 3 If they retire early.
- 4 When their period of temporary absence cover ends.

Our flexibility means when a **policy** is set up we can provide cover for lump sum benefits to continue if the **member** retires early or continues working after their normal retirement date. If a **member** puts off their retirement, cover may continue until the **member** actually retires or their 75th birthday if this is earlier.

Canceling 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 reasonable notice if we have to cancel the **policy** because its conditions haven't been met. We'll give you full details of our cancellation terms in the **policy**.
- All cover will end when the **policy** is cancelled.

1.3 WHAT TYPES OF COVER ARE AVAILABLE?

Lump sum benefit – You can get cover either as a multiple of **scheme earnings** or as a fixed amount, or you can vary it between membership categories. You can also have a multiple of earnings limited to a specified maximum. For example, the **Lifetime Allowance** or you could set your own maximum benefit.

Dependants' pensions – You can get cover to:

- pay a pension to the **member's** spouse or registered civil partner, with or without it continuing to any children after the spouse's or registered civil partner's death;
- pay a pension to the **member's** spouse or registered civil partner or, if there's no spouse or registered civil partner to any other financial dependant; or
- pay a separate children's pension.

Qualifying as a financial dependant – Means a person, other than the **member's** spouse, registered civil partner or child, who must be financially dependent on the **member** or be dependent because of disability. A **member's** unmarried partner may also qualify if they're financially dependent on the **member**.

If a dependant is more than 10 years younger than the **member** and not a child, we'll reduce the amount of pension because of the age difference unless we've agreed otherwise. The bigger the age difference the greater the reduction.

We'll usually allow any number of categories in a **scheme** as long as the eligibility conditions for each category are clearly defined and the same benefit basis applies to all **members** of the category.

1.4 WHEN ARE DEPENDANTS' PENSION PAYMENTS DUE?

We'll pay dependants' pensions to you every month in advance from the date of the **member's** death. However, to make things easier for you, we can act as your agent and pay benefit direct to the dependant if you prefer.

1.5 HOW LONG WILL DEPENDANTS' PENSIONS BE PAID FOR?

We'll pay pensions to adult dependants until they die. Pensions for children, either continuing from an adult dependant's pension or as a separate pension, stop when the youngest child reaches age 18. However, payment for children can be extended up to the age of 23 if you've chosen this as a feature of the **scheme**. Another option is for payment to continue for the life of disabled children.

1.6 CAN BENEFITS BEING PAID BE PROTECTED FROM INFLATION?

Yes, you can choose to help protect against the value of dependants pension benefits payments reducing over time because of inflation. We have different options you can choose from.

We can provide dependants' pension that increases:

- in line with the Limited Price Indexation (LPI) requirements under the Pensions Act 2004;
- by a fixed yearly rate of up to 8.5%; or
- in line with the yearly change in the Retail Price Index (RPI), up to a specified maximum not more than 8.5% (or, any minimum you have specified in that year if the RPI is lower).

We'll also consider other increases.

When you're deciding what type of cover to provide, you should think about the legal requirements relating to pension increases, for example LPI. If a **scheme** has different increase rates on different portions of the pension, we can provide cover on the same basis.

We'll increase benefit each year on the anniversary date of the **member's** death, unless you'd like to set a particular date.

2. HOW DO I SET UP A POLICY?

2.1 REQUIREMENTS TO SET UP THE SCHEME

You should set your **scheme** up using an appropriate trust document and as an employer it's normal that you should act as the **scheme administrator** and trustee. For new **schemes** we'll automatically give you a specimen declaration of trust.

We'll also give you the **scheme** rules that you'll need to adopt. These will explain who's eligible to be covered, what the benefit structure is and how the benefits will be paid. They also include the responsibilities of the **trustees** when paying lump sum benefits under a trust which gives them powers to decide who should get the benefit.

We suggest the **trustees** set up a bank account to receive any claim payments. This will help separate benefit payments from the normal business account. It's a legal requirement to do this if the benefit is under a pension scheme trust.

Our quote will set out any requirements for starting cover under a particular **scheme**. We'll need to receive a proposal form, confirmation of HMRC registration and the first premium within 14 days from the date we agree to start cover.



A non-registered scheme is usually classed by HMRC as an Employer Financed Retirement Benefits Scheme (EFRBS). This has significant tax disadvantages for you and the members of the scheme. Therefore it's important the scheme is registered before placing cover with us.

2.2 WHAT MEDICAL EVIDENCE IS NEEDED BEFORE MEMBERS CAN BE COVERED?

We normally only need medical evidence for employees who's benefit is more than the **free limit**.

	FREE LIMIT
What does this mean?	We can provide cover up to a certain amount without the member having to provide details about their health and pastimes.
How it works	<p>We'll set the free limit when we quote for your scheme.</p> <p>The free limit will depend on the number of eligible members 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 policy. We'll reduce the free limit we quoted if this isn't the case.</p> <p>The free limit is usually set as an amount of scheme benefit. This makes it easier to identify members who will need to provide medical evidence as their benefit entitlement is more than the free limit.</p>
Maximum free limit	<p>Depending on the number of lives covered, we can offer a maximum free limit of £1.8 million benefit.</p> <p>We'll tell you the free limit when we quote for your scheme.</p>

2.2 WHAT MEDICAL EVIDENCE IS NEEDED BEFORE MEMBERS CAN BE COVERED? continued

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** form in Protection documents on our website 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 WHAT MEDICAL EVIDENCE IS 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 will apply	<p>ONEDERWRITING</p> <p>We'll underwrite once and in most cases, no more medical evidence will be needed.</p>	<p>FORWARD UNDERWRITING</p> <p>Once we medically underwrite a member 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 member has provided medical evidence and we agree the following terms:</p> <ul style="list-style-type: none"> • ordinary rates; • with a premium loading that you are paying; or • with an exclusion. <p>As long as the member is actively at work at the time of the increase, we'll then only normally need medical evidence:</p> <ul style="list-style-type: none"> • where a future increase takes the cover for a member over £5 million; • where the insured basis is changed at a future date for all members in a category of five lives or less or where the policy covers flexible benefits; • where a member with flexible benefits flexes up at a date other than a lifestyle event; or • where a member with flexible benefits flexes up by more than one step at a lifestyle event. <p>If we accept a member's cover of over £5 million at ordinary rates or with a loading of 50% or less, we'll normally accept the next £300,000 of benefit without the need for medical evidence. If we agreed their cover with a loading above 50%, then we'll need medical evidence on all future increases.</p> <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 member.</p>	<p>When we medically underwrite a member, as long as we agree cover on the following terms:</p> <ul style="list-style-type: none"> • ordinary rates; • apply an additional loading of 50% or less, which you are paying; or • apply an exclusion for hazardous pursuits; <p>they won't normally need to provide 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 member isn't actively at work. We'll also need medical evidence at the next benefit increase if the details previously provided by the member resulted in cover being:</p> <ul style="list-style-type: none"> • restricted; • declined; • postponed; • not proceeded with; • subject to other terms; • not provided; or • a premium loading is declined by you (see above). 	<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"> • It's been five years since they were last medically underwritten by us. • The member's benefit entitlement increases by more than 15% above the benefit 12 months earlier in those five years. • The member's benefit entitlement increases by more than £300,000 above that since they were last medically underwritten. • We've set terms that requests evidence (generally, when an increase in cover is required, depending on the amount or special terms applied).

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

2.3 SWITCHING YOUR SCHEME INSURANCE TO US

We can normally accept a high level of cover for existing **members** who meet our switch terms without needing medical evidence, even if the previous insurer added a premium loading. When we accept these **members**, we'll normally provide cover for them at the same level and terms (but not necessarily at the same cost) as the previous insurer.

For new **members** at the date of switch, we'll need medical evidence for any cover above the **free limit**.

Switch terms

We'll normally accept cover for **members** whose cover with the previous insurer:

- was for their full benefit entitlement;
- was accepted with no special terms attached or had an extra premium of not more than 300% of the normal premium;
- had acceptance terms issued within the five years immediately before the switch; and
- was not higher than a total of £5 million.

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

Future medical evidence for members accepted under our switch terms

- i) If accepted by the previous insurer under ONEderwriting (or equivalent) approach.

As long as the **member** is **actively at work** we won't need more medical evidence until the **member's** benefit exceeds £5 million.

- ii) If accepted by the previous insurer on any of the following terms:

- ordinary rates;
- an additional premium loading of 50% or less that you are paying;
- an exclusion for hazardous pursuits; but not on a ONEderwriting (or equivalent) approach. We won't normally need more medical evidence for an increase until either one or more of the following:
 - It's been five years since the **member** was last medically **underwritten**.
 - The **member's** benefit increases by more than 15% within any 12 months period starting on or after the **policy** start date.
 - The total of all increases after medical **underwriting** is more than £300,000.
- If our terms for a change to the **policy** ask for medical evidence; the date you ask us to make the change from.

- iii) If accepted with other terms attached:

- we'll need medical evidence for the first increase in cover above that accepted by the previous insurer or, if later, when cover first exceeds the **free limit**.

Switch terms not met

Our flexible approach means we're happy to consider and negotiate terms for taking on the insurance of any **members** who don't meet the conditions for the **switch terms**. We'll consider this even if they've had some benefit refused by the previous insurer.

We can't cover these **members** until you give us their full details. We'll then set terms which you'll need to accept in writing before we'll start their cover. To avoid a break in cover you'll need to give us these details before the switch date.

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 scheme (or an existing scheme which is being insured for the first time) an actively at work requirement will apply at the date we start cover. We'll usually ignore this requirement for schemes with 100 or more members at that date.</p> <p>If you're transferring the insurance of an existing scheme to us, at the date of the transfer, we will not need:</p> <ul style="list-style-type: none"> • existing members; or • employees who become eligible for membership at that date; <p>to be actively at work.</p> <p>However, if you make a change to the scheme at the date of the transfer, and this change:</p> <ul style="list-style-type: none"> • increases benefit entitlement; or • extends the eligibility conditions to include other employees; <p>we'll need employees with an increase in their cover, and newly eligible employees, to be actively at work before we will cover them for benefit up to the free limit.</p> <p>We won't normally apply an actively at work requirement to new members included after the start date of the policy, or to normal benefit increases. However, we may do so in certain circumstances, such as for new entrants to an exact cost scheme see question 3.1 with daily entry and benefit increases for members who have been ONEderwritten see question 2.2.</p> <p>Where an actively at work 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're next actively at work.</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 scheme at their first opportunity and for whom cover is now needed.
When an employee can join	If the employee is joining the scheme within three months of being employed by you, we'll agree cover up to the free limit without any additional requirements.	If the employee is joining the scheme up to three months after their normal entry date within the eligibility conditions, we'll agree cover without any additional requirements. If the employee is joining the scheme late, three to six months after their normal entry date within the eligibility conditions, we'll agree cover provided the employee is actively at work see question 2.4 .
What if an employee doesn't meet the requirements above?	All other early entrants will need to complete a discretionary entrant's declaration form 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.	All other late entrants will need to complete a discretionary entrant's declaration form before we can consider providing cover.

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

We'll provide temporary cover from the date we know a **member** needs to provide medical evidence. If we provide a **member** with temporary cover, we won't pay benefit if they die from any medical condition that they were diagnosed with or displaying symptoms of within the previous five years. The cover will be for 90 days or until we've carried out the assessment, whichever is earlier. Also, the temporary cover will be restricted so that the **member's** total cover does not go over the **free limit** by more than £2 million, and is not higher than £3 million.

The temporary cover won't apply to any **member** whose:

- cover has been refused;
- cover has been restricted;
- already had special terms attached; or
- refused to provide medical evidence now or in the past.

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

- alcohol abuse;
- the influence of drugs;
- medical treatment; or
- surgical treatment (except treatment that's 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 gender of eligible employees;
- their type of occupation;
- where they work;
- the rate at which the dependants' pensions increase while they are 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's no minimum premium or extra policy fee.

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	<p>We'll work out a unit rate of premium as the cost of providing each £100 of the total benefit to be insured under the policy.</p> <p>We'll apply that rate to the total benefit at the beginning of each policy year.</p>	<p>We'll work out premiums for each member from age related premium rates which we apply to the amount of cover at the beginning of each policy year.</p>
Requirements	<p>10 or more members</p> <p>As we normally need a minimum of 50 members, we'll use a unit rate for most schemes. However, if your scheme membership falls below 10, we will switch to exact cost basis to work out premiums.</p> <p>We'll tell you before we change this.</p>	<p>Up to 9 members</p> <p>If membership increases to 10 or more, we'll use the unit rate basis to work out premiums. We'll tell you before we change this.</p>

3.2 WILL THERE BE ANY UNEXPECTED PREMIUMS?

We'll usually guarantee premium 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 don't normally have to pay it until the next **annual renewal date**.

3.3 HOW MUCH COMMISSION IS INCLUDED?

We'll pay commission to your adviser as a percentage of each premium you pay. The standard rate is 4%. 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 assess the **scheme's** past **claims history** when we work out a **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 RATED SCHEMES		EXACT COST SCHEMES (Also known as Single Premium or Current Cost basis)	
<p>At the start of a policy and at each rate review date we need a list showing each member's:</p> <ul style="list-style-type: none"> • Gender • Date of birth • Scheme earnings or benefit. • Benefit category (if there is more than one). • If it applies, the level of dependants' pension (split into portions if different increase rates apply to different parts of the pension). <p>We also need this information if there's a 25% change in membership or total benefit.</p>	<p>At any other renewal date we need:</p> <ul style="list-style-type: none"> • Total number of members • Total benefit (at that date) <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 renewal date.</p> <p>If a member's cover goes over the free limit, we'll need information on the individual. There may also be circumstances where we need extra information.</p>	<p>At the start of a policy and at each renewal date we need:</p> <ul style="list-style-type: none"> • Gender • Date of birth • Scheme earnings or benefit • Benefit category (if there is more than one). • If it applies, the level of dependants' pension (split into portions if different increase rates apply to different parts of the pension). 	<p>We'll also need dates of entry and any 'daily increases' (where included) together with the dates on which any members left the scheme during the policy year.</p> <p>If a member's cover goes over the free limit, we'll need information on the individual. There may also be circumstances where we need extra information.</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>SWEEP UP ACCOUNTING</p> <p>Any extra premium or refund will be paid at the beginning of the next policy year. These operate on a 'simplified accounting' basis where (unless entry dates and benefit increases are yearly) we adjust premiums at the end of each policy year based on the assumption that all changes in membership and cover took place midway through the year.</p> <p>We'll tell you which accounting basis we're using in the quote.</p>	<p>NO CHANGE ACCOUNTING</p> <p>As an alternative we may be able to make an allowance in the unit rate to reflect changes in membership and cover during the policy year. This avoids having to adjust premiums at the end of the year unless the changes are not in line with the agreed eligibility conditions or benefit basis.</p> <p>We'll tell you which accounting basis we're using in the quote.</p>	<p>We'll adjust premiums at the end of each policy year to reflect the actual period covered and the amount of cover provided for each of the members.</p> <p>Any extra premium or refund will be paid at the beginning of the next policy year.</p> <p>We'll tell you which accounting basis we're using in the quote.</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 policy 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?

We'll normally need the following from you;

- A completed claim form.
- The **member's** death certificate.
- Confirmation of the age of the **member** and, if dependants' pensions are provided, of the dependants' ages.

We'll also need payment instructions and tax details if we are to act as your agent by paying the dependants' pensions direct to those dependants.

If you wish, you can convert the dependants' pension to an equivalent lump sum. This will be based on the age of the beneficiary and our opinion of the value of the pension payable at that date. The lump sum will count towards the **lifetime allowance** see [section 1](#) of the **member**. You should ensure the **scheme** rules allow this as an option at the discretion of the **trustees**.

6.0 WHAT'S NOT COVERED?

We cover all causes of death under the standard **policy** terms. If we agree to provide cover in special circumstances, for example, for employees based in certain overseas locations, the terms may not include certain causes of death.

Our quotation may include an event limit. This means the total amount of benefits we may pay for a claim as a result of a catastrophe could be restricted. We consider a catastrophe as an accident or event (or a series of accidents or events arising within a 72-hour period) which, within six months, results in the death of four or more **members**.

7.0 CAN YOU PROVIDE COVER FOR AN EMPLOYEE WHO'S BASED OUTSIDE THE UK?

We'll usually cover employees working abroad as long as they don't form the majority of the **scheme** membership. We'll need full details of any overseas **members** as we may need to change our standard terms and conditions. We cannot provide cover until we have set any special terms necessary.

We won't usually attach any special terms to cover for employees who travel abroad for normal business purposes but who are based in the UK.

8.0 WHAT TAX RULES APPLY?

Our understanding of the current tax rules for registered **schemes** are as follows:

- The premiums you pay to insure the **scheme** benefits 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.
- Lump-sum benefit up to the **Lifetime Allowance** is free of income tax and, if it's paid under a discretionary trust, will not normally be liable for inheritance tax.
- A tax charge of 55% will be due on any lump sum benefit above the **Lifetime Allowance**. This charge will not apply if you use this amount to buy a dependants' pension.
- Income tax is due from dependants' pensions and should be deducted before the pension is paid.

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

Members cannot continue cover under the **policy** at their own expense when they stop working for you. However, they may be able to take out life cover on an individual basis with us by calling 0800 282 404.



FURTHER INFORMATION.

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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 **members** of your **policy**.

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.

COMPENSATION

If we can't meet our liabilities, you may be entitled to compensation under the Financial Services Compensation Scheme. If you'd 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**.

In this guide, we've based references to the tax treatment of premiums and benefits 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/ 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 Life Assurance and Dependants' Pension 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 30 June 2010, we were responsible for investing £331 billion worldwide on behalf of investors, policyholders and shareholders.

GLOSSARY.

Actively at work	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.	Lifetime allowance	The maximum amount of tax free lump sum benefits that can be paid from a registered scheme .
Annual renewal date	The anniversary of the start date of the policy or another yearly date that we've agreed with you.	Member	An employee included for benefits within the scheme and insured under the policy .
Benefit termination date	This is usually the normal retirement date fixed by you or the member's 75th birthday if this is earlier.	Member's declaration	A form a member fills in to give us information about their medical history.
Cash in value	Some insurance policies have a 'cash in value' which means you get some money back if you cancel the policy . This policy has no cash in value at any time.	Notional earnings cap	A maximum amount of scheme earnings that's based on the value that would have applied to the earnings cap if it had remained in force.
Claims history	The historical record of claims made under the scheme .	Policy	The legal contract between you and us. You choose how much of the benefit you've promised under the scheme that you want to insure under the policy .
Early entrant	An employee who you need cover for before their normal entry date within the eligibility conditions.	Renewal date	The annual renewal date .
Exact cost	This is how we calculate the cost of a policy with nine or less members . We'll calculate the cost for each member using their age, gender and amount of cover. This is also known as single premium or current cost.	Scheme	The scheme you have set up to pay the benefits promised under the scheme to your employees.
Free limit	The maximum monetary limit for which we'll normally provide cover without the need for medical evidence.	Scheme earnings	The earnings we use to calculate the scheme benefit.
Inception date	The date the policy starts.	Scheme administrator	A person that takes responsibility for the day to day running of the scheme including registering the scheme with HMRC.
Late entrant	An employee who didn't join the scheme at their first opportunity and you now need to cover.	Unit rate	This is how we calculate the cost of a policy with 10 or more members . We'll calculate the cost for each £100 of cover and multiply this with the total benefit for the policy .
		Underwrite	The process we use to assess any risks and decide how much your premiums will be.

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 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> 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 7892 7300 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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