



## Group Life Assurance and Dependants' Pensions

Technical guide for employers

# Welcome to Legal & General

We've been working with intermediaries, pension advisers, risk and benefit consultants for over 80 years and have become one of the leading providers of flexible and voluntary benefits. We currently administer over 7,100 group protection policies which provide protection to more than 2,100,000 employees.

Our dedicated team have the knowledge and flexibility to tailor schemes from standard 50 life schemes to the large complex 250,000 life schemes across multiple locations involving various occupations and complex risk factors. Each policy is reviewed individually on its merit, and applying our extensive knowledge of the protection market relative to the location, occupation, claims history and benefits required, we can 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 this important information in this technical guide to help you decide whether our Group Life Assurance and Dependants' Pensions 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 Group Protection or your financial adviser.

This technical guide is designed to explain the features of our Group Life Assurance and Dependants' Pensions products. You should read it with our quotation. The full terms of the products are contained in our standard contract terms and conditions which form part of the policy document. We'll issue this after we've agreed to provide cover and all the policy details have been finalised. However, if you'd like to see a copy of the standard terms and conditions, please ask.

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

This contract has no cash in value at any time.

# Index

	Page number
<b>Aims</b>	<b>1</b>
<b>Your commitment</b>	<b>1</b>
<b>Risk factors</b>	<b>1</b>
<b>How the policy works</b>	<b>1</b>
<b>Your questions answered</b>	<b>2</b>
<b>1 What factors should I consider in deciding what benefits to provide?</b>	<b>2</b>
1.1 Who can be covered?	2
1.2 When will cover end?	3
1.3 What types of cover are available?	3
1.4 When are dependants' pension payments due?	3
1.5 How long will dependants' pensions be paid for?	3
1.6 Can benefits being paid be protected from inflation?	4
<b>2 How do I set up a scheme?</b>	<b>4</b>
2.1 Requirements to set up the scheme	4
2.2 Medical evidence needed before members can be covered	4
2.3 'Actively at work'	6
2.4 Early entrants	6
2.5 Late entrants	6
2.6 What happens if a claim arises before the medical assessment has been completed?	6
<b>3 What premiums will you charge for the cover?</b>	<b>6</b>
3.1 How will you work out the premiums?	7
3.2 Will there be any unexpected extra premiums?	7
3.3 What commission is allowed for in the premium?	7
3.4 Is there a discount for good claims history?	7
<b>4 How does the scheme accounting work?</b>	<b>7</b>
4.1 What information do you need for accounting purposes?	7
4.2 How are premiums adjusted for members who join, leave or have benefit increases during the policy year?	8
4.3 If the policy is cancelled midyear, will I lose any premiums I have paid in advance?	8
<b>5 How do I make a claim?</b>	<b>8</b>
<b>6 What is not covered?</b>	<b>8</b>
<b>7 Can cover be provided for an employee who is not based in the UK?</b>	<b>8</b>
<b>8 What tax rules apply?</b>	<b>8</b>
<b>9 Can members continue their cover if they leave my employment?</b>	<b>8</b>
<b>Further information</b>	<b>9</b>

## 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 its employees under a 'registered scheme' (see question 1).
- Offer a flexible range of choices relating to these benefits.

## Your commitment

You must do the following.

- Provide all the information we ask for when you apply for a policy, at renewal dates and to support any claims, and tell us when any relevant details change. We may not pay claims if you do not provide this information.
- Pay the premiums when they are due.
- Keep to all the conditions set out in the policy.
- Tell us about any claims as soon as possible.

Note: Where this guide refers to 'you' or 'employer', for the purposes of the policy terms and conditions those references should be read as 'trustees' if the policy is held by separate trustees on behalf of the employer.

## Risk factors

The policies carry the following risks.

- If you stop paying premiums, or you fail to keep to the policy terms and conditions, all cover under the policies will end. However, we will continue to pay dependants' pensions for deaths that happened before the cover ended.
- We normally guarantee the premium rates that apply to a policy until the end of the second policy year, when we then review them. We normally carry out further reviews every two years and, after each review, we guarantee the rates up to the next review date. However, for Unit Rated policies (see question 3.1) we can alter the guaranteed rate at an annual renewal date before then if there is a change of more than 25% in the membership of, or total benefit provided by, the policy.
- We may also review the premium rates if a change is made to the agreed eligibility conditions or benefit structure.
- We can change the policy terms at the end of any guarantee period, although we will give you at least two months' written notice of any change.
- We can cancel the policy if 'registration' is withdrawn.
- We can cancel the policy if the number of members falls below five.
- We may restrict the total amount of benefits we will pay out for claims which result from a catastrophe (see question 6).
- We will give you the specific terms and conditions that apply to a policy as part of our quotation which will usually be guaranteed for three months.

## How the policy works

- We will normally need at least 50 members to be covered when the policy starts.
- You meet the cost of the cover.
- You decide the type and level of benefit and any other optional features (see question 1).
- You will be the scheme administrator unless you appoint someone else to this role.
- The scheme administrator will need to register the scheme with HM Revenue & Customs (HMRC). You will need to provide confirmation of registration to us. If the scheme is not already registered, you should start the registration process at least five working days before the cover is required. We can provide details of how to register a scheme.
- You decide the eligibility conditions for the scheme. These will be set out in the policy and you must include all eligible employees when they first become eligible.
- You give us all the information we need when you make a claim.
- If you make a valid claim, we will 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 will need to decide who is to receive the benefit, taking account of any wishes the member may have made.
- The scheme administrator must give HMRC set information about a member at the date of their death in certain circumstances.
- We will pay dependants' pensions to the trustees of the scheme who will then pay the dependants. Or, we will act as 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 they are due. However, for administrative purposes the first day of each yearly accounting period (see question 4), 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). Premium rate reviews (see Risk factors) will always take effect from an annual renewal date.
- While you continue to pay the requested premiums and meet the policy conditions, we will provide cover and pay all the valid claims you make. If the policy is cancelled, we will continue to pay any dependants' pensions for deaths that happened before the cover ended.

# Your questions answered

## 1 What factors should I consider in deciding what benefits to provide?

A 'registered' scheme is one that is 'registered' with HMRC under the provisions of the Finance Act 2004. Such schemes offer various tax advantages, more information of which is given in question 8. If you are considering a death-in-service benefits scheme for your employees, you may provide any benefit allowed by the rules. We have given broad details of this below.

You do not need to provide the same benefits for all employees. If you have clearly defined categories of employees (for example, office staff and production staff), the benefits can be different for each category.

It is usual, although not necessary, to fully insure all the benefits a new scheme would provide. This avoids the need for you to separately finance any part of the benefit if a claim arises.

If you have an existing scheme, it is important to make sure that the cover provided under the insurance policy meets your needs for insuring the benefit which could become due.

When considering the type and level of benefit to provide, you need to know the HMRC allowances that apply. Broadly, these are as follows.

- Lump-sum benefit – The Finance Act 2004 introduced a Lifetime Allowance (LTA) up to which lump sum benefits from a registered scheme can normally be paid tax free. The LTA is set by the Treasury. For the tax year 2009/2010 the LTA is £1.75 million. This will rise to £1.8 million in 2010/2011.

The maximum lump sum benefit that we will insure is £10 million. Any benefits paid over the LTA are subject to a tax charge unless they are used to buy dependants' pensions. When calculating if a tax charge is due on a death-in-service benefit, you also need to consider other lump sum payments that might be due. For example, this could be any return of funds under a money purchase pension scheme or an individual pension term assurance policy.

- Dependants' pensions – There is no limit on the amount of dependants' pension you can pay.
- To qualify as a dependant, a person other than a spouse, registered civil partner or child must be financially dependent on the member or be dependent because of disability. A member's unmarried partner may also qualify if they are financially dependent on the member.

If you choose to base cover on a multiple of earnings, then these earnings (Scheme Earnings) are usually the member's basic annual salary. You may use other earnings if this is more appropriate (for example, to allow for other income such as bonuses or commission).

You may limit earnings to a notional 'earnings cap' or to your own maximum. The 'earnings cap' was a limit on earnings for death-in-service benefits before 6 April 2006. You do not 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 LTA 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 LTA without the tax charge (although there may be a small inheritance tax charge) or 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 can be covered for the policy benefits once they have become members of the scheme. They need to have met the eligibility conditions and the conditions relating to being 'actively at work' (see question 2.3) and 'medical evidence' (see question 2.2).

You can also choose to include 'non-employees', for example, Equity Partners (that is, a partner with an equity share in the firm and whose share of the firm's trading profits is taxed as income).

#### a) You will need to set out the eligibility conditions which will include:

- the minimum and maximum entry ages for new members,
- any service qualification (the minimum length of service needed);
- a description of the eligible category or categories of employees;
- the entry date when employees can join and the date on which members become entitled to benefit increases, and;
- 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 take account of any relevant laws on discrimination or unfair treatment, such as those relating to equal treatment of men and women, age discrimination and the treatment of part-time, fixed-term and disabled employees.

You must include all eligible employees in the scheme on the entry date on which they first meet all the eligibility conditions, otherwise we will treat them as 'early entrants' (see question 2.4) or 'late entrants' (see question 2.5).

#### b) Entry dates and benefit increases

To allow as much flexibility as possible, the entry date for new members may be:

- the annual renewal date (yearly entry);
- a specified date each month (monthly entry); or
- the first day on which all the eligibility conditions are met (daily entry).

# Your questions answered (continued)

Similarly, benefit increases for existing members may take place:

- on the annual renewal date (yearly changes);
- on a specified date each month (monthly changes); or
- immediately when a member's earnings are increased (daily changes).

It is not necessary for entry and benefit increases 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 regardless of the normal entry date for that category as long as any other requirements we may have specified (for example, being 'actively at work') have been met. If the new category allows for daily changes, we will also take account of any increase in the member's Scheme Earnings at the same time. Otherwise the changes in the member's Scheme Earnings will not take effect until the next normal date for benefit changes in that category.

## c) Temporary absence from work

Schemes usually 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 will consider other periods of temporary absence cover to match your needs.

We will continue to base the member's cover on their Scheme Earnings. However, if their Scheme Earnings are reduced at any time while they are off work, cover will continue at the same level as before that reduction. Or, you may arrange cover to increase each year at a fixed rate of up to 6%.

## 1.2 When will cover end?

### a) Under normal circumstances

Cover for a member normally ends:

- when they leave your employment or are no longer eligible to be a member;
- when they reach the Benefit Termination Date set out in the policy;
- if they retire early; or
- when their period of temporary absence cover ends.

If you need it, when the policy is set up we can provide cover for lump-sum benefit 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.

### b) Cancelling the cover

The policy will continue until you cancel it so long as all its conditions are met. You will need to give us 14 days' notice in writing if you want to cancel the policy. Similarly, we will give you 14 days' notice in writing if we have to cancel the policy because its conditions have not been met. All cover provided will end when the policy is cancelled.

## 1.3 What types of cover are available?

### a) Lump-sum benefit

You can get cover either as a multiple of the earnings used for scheme purposes (Scheme Earnings), or as a fixed amount, and you can vary it between membership categories.

You can also have a multiple of earnings limited to a specified maximum, for example, the LTA or you could set your own maximum benefit.

### b) Dependants' pensions

You can get a choice of cover including:

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

If a dependant who is not a child is more than 10 years younger than the member, we will reduce the amount of pension to reflect the age difference unless we have agreed otherwise. The bigger the age difference the greater the reduction.

We will usually insure any number of categories of employee 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 will pay dependants' pensions to you every month in advance from the date of the member's death. If you prefer, we will act as your agent and pay benefit direct to the dependant.

## 1.5 How long will dependants' pensions be paid for?

It is usual for pensions for adult dependants to be paid 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 this is a feature of the scheme. A further option is for payment to continue for the life of disabled children.

# Your questions answered (continued)

## 1.6 Can benefits being paid be protected from inflation?

We can provide for the amount of a dependants' pension being paid to increase each year:

- in line with the appropriate 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 exceeding 8.5% (or, any minimum you have specified in that year if the RPI is lower).

We will also consider other increases.

When you are deciding what type of cover to provide, you should take account of 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.

Increases will be made each year on the anniversary of the date of the member's death unless you would like to set a particular date on which all pensions being paid under the policy will be increased.

## 2 How do I set up a scheme?

### 2.1 Requirements to set up the scheme

A scheme should be set up by an appropriate trust document and it is usual for you, as the employer, to act as the scheme administrator and trustee. For new schemes we will automatically provide a specimen Declaration of Trust for this purpose.

We will also provide the scheme rules that you will need to adopt. These will explain who is 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.

It is suggested that the trustees set up a bank account to receive claim payments to separate them from the employers normal business account. If the benefit is under a pension scheme trust this is a legal requirement.

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

Note - A non-registered scheme is usually classed by HMRC as an Employer Financed Retirement Benefits Scheme (EFRBS). This has significant tax disadvantages to you and the scheme members. It's therefore important to make sure the scheme is registered before placing cover with us.

## 2.2 Medical evidence needed before members can be covered

### a) Free Limit

A group scheme that includes all employees who meet the eligibility conditions will usually get a certain amount of cover without the need for members to provide details about their health and pastimes.

In order to do this we will normally provide cover by setting what is known as a 'Free Limit'. The Free Limit is an amount of cover up to which we will not need medical evidence.

The Free Limit we give will depend on the number of members and the level of benefit entitlement. We will usually set it as an amount of Scheme Earnings to make it easier to identify those members who will need to provide medical evidence as their benefit entitlement has gone over the Free Limit. Or, we may set the Free Limit as an amount of benefit, which means that any dependants' pensions will need to be converted into a lump-sum value. This is because the Free Limit will apply to the total lump-sum value of a member's benefit entitlement. We will show the Free Limit in the quotation.

### b) Cover above the Free Limit

If a member's benefit entitlement goes over the Free Limit they will need to provide medical evidence if they want full cover. To begin with the member will need to complete a Member's Declaration form, but we may ask for more evidence which could include a medical examination and blood or other tests. We will assess the medical evidence and decide 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 advise us in writing within 30 days that you no longer require the cover to which the loading relates. Any cover within a Free Limit or which has been previously accepted will not normally be affected.

### c) 50 or more members

For policies insuring 50 or more members we will provide ONEderwriting. This means if we accept the cover for which a member provides medical evidence:

- at ordinary rates,
- with a premium loading that you are paying, or
- with an exclusion,

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

- for normal increases in benefit resulting from earnings increases;
- where the insured basis is changed at a future date for:
  - all members;
  - all members in a category of more than five employees;
  - all partners and LLP Members, where there are six or more, in a policy that also insures employees;

## Your questions answered (continued)

provided a member's benefit does not exceed £5 million. A member must also meet the conditions relating to being 'actively at work' (see question 2.3) for each increase and change in benefit.

We will provide the increase in cover on the same terms as applied when the member was last medically underwritten. 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 advise us within 30 days after the date of the increase that you no longer require it. If you do, then ONEderwriting will not apply for this member and medical evidence will be needed for any increase in cover.

Medical evidence will be needed for cover above £5 million.

If we accept cover above £5 million at ordinary rates or with a loading of 50% or less we will next need medical evidence when benefit increases by another £300,000, and thereafter at each further £300,000 increase. If we accept cover with a loading above 50% then medical evidence will be needed for the next increase.

ONEderwriting will not apply, and medical evidence will be needed for the next increase in cover, where the cover for which a member provides medical evidence is:

- restricted,
- declined,
- postponed,
- not proceeded with,
- subject to other terms, or
- medical evidence is not provided.

If you wish to change the insured basis you must notify us in advance. We will not be on risk until we have provided any terms and conditions, and if necessary you have confirmed your acceptance of these in writing.

### d) Less than 50 members

For policies insuring less than 50 members, once a member has provided medical evidence, if an increase in cover is needed at a later date, we may ask for more medical evidence. When more medical evidence will be needed will be stated in our decision letter and will depend on the amount of the increase and any special terms that already apply.

If we have agreed cover at ordinary rates, applied a loading of not more than 50%, or applied an exclusion for any hazardous pursuits, we will usually operate 'forward underwriting'. This means that we may not need any more evidence for another five years. We will need more medical evidence if, during that time, the member's benefit entitlement:

- increases by more than 15% in the first 12 months, or
- increases by more than 15% above the benefit 12 months earlier, or
- the total increase is more than £300,000

### e) Transferring insurance of an existing scheme

If you are transferring the insurance of an existing scheme to us from another insurer, we'll not normally need medical evidence for an existing member if the conditions detailed below are met.

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. To do this, we'll need to receive a copy of the insurer's latest letter of acceptance or a Declaration - Switch Terms. No cover will be provided before we receive a copy of the letter or the declaration unless they have been accepted for their full benefit entitlement at ordinary rates. For members accepted for their full benefit at ordinary rates, we'll normally provide cover up to our Free Limit before we receive a copy of the letter or declaration.

We'll not need medical evidence for an existing member as long as:

- cover with the previous insurer was for the full benefit entitlement;
- the cover was accepted with no special terms attached or for which an extra premium of no more than 300% of the normal premium was charged;
- the acceptance terms were issued within the five years immediately before the transfer; and
- the total value of benefit is not higher than £5 million.

If the cover was accepted by the previous insurer under a ONEderwriting (or equivalent) approach then in most cases we'll never need medical evidence again (provided cover doesn't exceed £5 million). Our 'actively at work' requirement (see question 2.3) will apply to all increases in benefit. Medical evidence will be needed for cover above £5 million.

For cover accepted with no special terms attached or with a loading of not more than 50% but not under a ONEderwriting (or equivalent) approach, we won't need medical evidence for any increase until the earliest of:

- five years from the date last medically underwritten by the previous insurer;
- benefit increasing by more than 15% within any 12 month period starting on or after the policy's start date; or
- all increases in Scheme Benefit from the date the Member was last medically underwritten exceeding £300,000.

For cover accepted under our 'switch terms' with other terms attached, we'll need medical evidence on the first increase in cover above that accepted by the previous insurer or, if later, when cover first exceeds our Free Limit.

If the previous insurer's terms for any members do not fall within the terms shown above, we are very happy to consider each case if you provide us with full details. However, no cover will be provided

## Your questions answered (continued)

before we receive these details and terms are agreed and accepted in writing. These details should therefore be provided before the date of the transfer so that we can provide terms that can be accepted before the date of transfer to avoid a break in cover for these members.

We will need medical evidence at the date of transfer for benefit above our Free Limit for members who are first eligible for cover at the date of transfer.

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

### 2.3 'Actively at work'

In certain circumstances an 'actively at work' requirement will apply. 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. 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 take on the risk. We will usually ignore this requirement for schemes with 100 or more members at that date.

If you are transferring the insurance of an existing scheme to us, at the date of the transfer the 'actively at work' requirement will not apply to existing members or to employees who become eligible for membership at that date. However, if you make a change to the scheme at the date of the transfer, and this increases benefit entitlement or extends the eligibility conditions to include other employees, the 'actively at work' requirement will apply to any extra benefit and new employees arising from the change for benefit up to the Free Limit.

We will not normally apply an 'actively at work' requirement to new members included after the start date of the policy, nor 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 2.2c).

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 are next 'actively at work'.

### 2.4 Early entrants

An early entrant is an employee for whom cover is needed before their normal entry date within the eligibility conditions.

If the employee is joining the scheme within three months of being employed by you we'll agree cover without any additional requirements.

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 when we need medical evidence on future increases.

### 2.5 Late entrants

A late entrant is an employee who didn't join the scheme at their first opportunity and for whom cover is now needed.

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 2.3).

All other late 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 when we need medical evidence on future increases.

### 2.6 What happens if a claim arises before the medical assessment has been completed?

From the date we know a member needs to provide evidence of insurability, we will provide temporary cover. A member provided with temporary cover will not be entitled to 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 have 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.

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 temporary cover does not apply we will provide 'accident cover' for the same period. However, we will not accept claims for accidental death caused by alcohol abuse, the influence of drugs, medical or surgical treatment (except treatment that is needed because of the accident). Suicide and death resulting from intentional self-injury are also not covered.

We will give you full details of the terms for temporary and accident cover.

### 3 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;

## Your questions answered (continued)

- the rate at which any dependants' pensions will 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 is no minimum premium or extra policy fee.

### 3.1 How will you work out the premiums?

#### a) For schemes with 10 or more members - 'Unit Rate' basis

We will work out a Unit Rate of premium as the cost of providing each £100 of the total benefit to be insured under the policy (the Aggregate Benefit). We will apply that rate to the Aggregate Benefit at the beginning of each policy year.

If membership falls below 10, we will change the way we work out the premiums to that set out in 'b' below. We will tell you before we change this.

#### b) For schemes with up to nine members - 'Exact Cost' basis (also known as Single Premium or Current Cost basis)

We will 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.

If membership increases to 10 or more, we will change the way we work out premiums to that set out in 'a' above. We will tell you before we change this.

### 3.2 Will there be any unexpected extra premiums?

We will usually guarantee premium rates until the end of the second policy year. We will then review them, following which we will usually guarantee rates for a further two years (as described in the section 'Risk factors').

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 advise us to the contrary in writing within 30 days of the date of our letter advising the extra premium. If you do this the cover for which the extra premium was to be charged will not be provided. Although the extra premium will apply immediately, you will normally not have to pay it until the next renewal date.

### 3.3 What commission is allowed for in the premium?

We will pay commission to your adviser as a percentage of each premium you pay - the standard rate is 4%. We can provide for different levels of commission although this will affect the premium we charge. Our quotation will show the rate we have allowed for.

### 3.4 Is there a discount for good claims history?

We take account of past claims history when we work out a Unit Rate. A good claims history will usually be reflected in the premiums we charge, particularly for larger schemes.

## 4 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.

Until we receive accurate information, we will charge approximate premiums. 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?

#### a) Unit Rate schemes

At the start of the policy and at each rate review date you will need to supply a list showing each current member's:

- sex;
- date of birth;
- Scheme Earnings;
- benefit category (if there is more than one); and
- if it applies, the level of dependants' pension (split into portions if different increase rates apply to different parts of the pension).

At any other renewal date, the only information we need is the total number of members and the Aggregate Benefit at that date, unless there is a 25% change in membership or total benefit (see Risk Factors). If this is the situation you will need to supply the details as set out in the preceding paragraph.

If we are going to adjust premiums (see 4.2 below), we will need the total number of members and the Aggregate Benefit but as at the day before the rate review or renewal date.

#### b) Exact Cost schemes

At the start of the policy and at each renewal date you will need to supply a list showing each current member's:

- name;
- sex;
- date of birth;
- Scheme Earnings;
- benefit category (if there is more than one); and
- if it applies, the level of dependants' pension (split into portions if different increase rates apply to different parts of the pension).

We will 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.

If a member's cover goes over the Free Limit, we will need information on that individual member. There may be other circumstances where we need extra information.

#### 4.2 How are premiums adjusted for members who join, leave or have benefit increases during the policy year?

##### a) Unit Rate schemes

These operate on a 'simplified accounting' basis where 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. Any extra premium or refund will be paid at the beginning of the next policy year. This is generally known as 'sweep-up accounting'.

On the other hand, we can make an allowance in the Unit Rate to reflect changes in membership and cover during the policy 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. This is generally known as 'no change accounting'.

##### b) Exact Cost schemes

We will 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. Any extra premium or refund will be paid at the beginning of the next policy year.

#### 4.3 If the policy is cancelled midyear, will I lose any premiums I have paid in advance?

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.

#### 5 How do I make a claim?

We will normally need the following from you.

- A 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 will also need payment instructions and tax details if we are to act as your paying agent and pay 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 member's Lifetime Allowance (see section 1). You should ensure the scheme rules allow this as an option at the discretion of the trustees.

#### 6 What is not covered?

All causes of death are covered 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' which could restrict the total amount of benefits we will pay out for claims which result from a catastrophe. For the purpose of the event limit, a catastrophe is 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 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.

#### 8 What tax rules apply?

Our understanding of the current tax rules for registered schemes is 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 LTA is free of income tax and, if it is 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 LTA. 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 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

### Providing insurance

Group Life Assurance and Dependents' Pension policies are provided by Legal & General Assurance Society Limited whose principal office for the purposes of the policies is at:

Legal & General House  
Kingswood  
Tadworth  
Surrey  
KT20 6EU

Phone: 0845 072 0751

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

### WorkLife Solutions - Employee Assistance Programme

This free telephone based Employee Assistance Programme is provided by Corporate Support and is automatically available to you and 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 Premier WorkLife Solutions.

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

### Questions and complaints

If you have a question or complaint about the policy, you should first speak to the adviser who arranged it for you. If you then need to speak to us, you should send the details of your question or complaint to:

Director (Group Protection)  
Legal & General Assurance Society Limited  
Legal & General House  
Kingswood  
Tadworth  
Surrey  
KT20 6EU.

Phone: 0845 072 0751

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

If we cannot settle a complaint you may be able to refer it to:

Financial Ombudsman Service  
South Quay Plaza  
183 Marsh Wall  
London  
E14 9SR.

Phone: 0845 080 1800

Email: [complaint.info@financial-ombudsman.org.uk](mailto:complaint.info@financial-ombudsman.org.uk)

Website: [www.financial-ombudsman.org.uk](http://www.financial-ombudsman.org.uk)

Making a complaint will not affect your right to take legal action.

### Compensation

If we cannot meet our liabilities, you may be entitled to compensation under the Financial Services Compensation Scheme.

You can get more information from the Financial Services Compensation Scheme at:

7th Floor, Lloyds Chambers  
1 Portsoken Street  
London  
E1 8BN

Phone: 0207 892 7300

Email: [enquiries@fscs.org.uk](mailto:enquiries@fscs.org.uk)

Website: [www.fscs.org.uk](http://www.fscs.org.uk)

### 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.

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

### About Legal & General

The Legal & General Group, established in 1836, is one of the UK's leading financial services companies. Over 6.5 million people rely on us for life assurance, pensions, investments and general insurance plans. The Legal & General Group is responsible for investing £287 billion worldwide (as at 30 June 2009) on behalf of investors, policyholders and shareholders.

Legal & General is one of the biggest providers of index-tracking investments in the UK, managing £180 billion as at 30 June 2009.

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

### 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

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W8849 12/09 H103385

