Life Insurance

Policy Terms and Conditions

In this Policy Terms and Conditions document you'll find useful information to help you understand the policy benefits and features.

To apply for this policy, you must be a UK resident, living in the UK for at least 183 days in the last tax year.

The Policy Terms and Conditions together with the Policy Schedule, which would be sent to you once you start your policy, are your contract with Legal and General. In the Policy Schedule, you would find what is covered by your policy and what isn't covered. As well as important dates. If you'd like a copy of this document in another format, please let us know. We can send you a copy in large print, braille or on audio file.

How this policy works

A Life Insurance policy is designed to provide cover if the life insured (the person/s covered by this policy) dies or is diagnosed with a terminal illness before the end of the policy.

You're covered from the policy start date until the policy expiry date. Your policy will end before this if we pay the cover amount or the policy is cancelled.

We'll communicate to you about your policy in English. This policy is governed by English law.

Key words and their meanings

This is not a complete list, as we've explained all terms in the relevant section of this Policy Terms & Conditions. We've included a contents page to help you find the relevant sections.

When we say '**we**', '**us**' or '**our**' in this document, we mean Legal and General Assurance Society Limited.

When we say '**you**' or '**your**' in this document, we mean anyone who's legally entitled to receive the amount of cover when a valid claim is made. This could be a trustee, assignee, personal representative of the life insured. If there's more than one person covered then we mean all lives insured.

The life insured is the person who is covered by the policy. If this is a joint policy, both people will be covered.

When we say 'assignee', we're referring to the person to whom the legal ownership of the policy is transferred.

The UK refers to England, Northern Ireland, Scotland and Wales. It also covers a Crown employee (someone in the UK armed forces, a civil servant or diplomat) or someone in the merchant Navy.

When we say 'incapacity' in this document, we mean:

- the life insured is totally incapable of carrying out their normal occupation due to an illness or injury occurring after the policy start date, necessitating medical or surgical treatment and is not carrying out any other occupation or paid employment, or
- If the life insured is not in paid employment and they are unable to do three or more Specified Work Tasks as a direct result of an illness or injury which occurred after the policy start date.

 For details about our definition of incapacity, please see the section headed '**Waiver of Premium**'.

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How to get in touch with us

Calls may be recorded and monitored. Call charges may vary.

How can we help?	Contact details	Contact address
General enquiries, to change the policy	**Call** 0370 010 4080 Monday to Friday 9am to 5pm **Email** protection.customerenquiries@landg.com	Legal & General Assurance Society Limited City Park The Droveway Hove East Sussex BN3 7PY
Cancellations	**Call** 0370 010 4080 Monday to Friday 9am to 5pm **Email** protection.customerenquiries@landg.com	Legal & General Assurance Society Limited City Park The Droveway Hove East Sussex BN3 7PY
Claims	**For Life or Terminal Illness Cover claims** call us on 0800 137 101 **For Waiver of Premium claims** call us on 0800 068 0789 Monday to Friday 9am to 5pm	Legal & General Assurance Society Limited City Park The Droveway Hove East Sussex BN3 7PY
Complaints	**Call** 0370 010 4080 Monday to Friday 9am to 5pm	Legal & General Assurance Society Limited Four Central Square Cardiff CF10 1FS

How to make a claim

We know that making a claim can be a difficult time. We'll try to make sure the process is stress free, and to keep you updated regularly.

You can find the contact details for our claims team above.

When you let us know about any claim, we'll need to know:

- The policy number (we can still help if you don't have this)
- The life insured's Doctor's details
- Your contact details

We'll also need some additional information depending on the type of claim being made. This may include us sending the claimant a form to fill out and return to us. We'll need details of:

- **Life cover** - the date of death and death certificate of the life insured. We can still consider and accept a claim if the event occurs outside the UK, and we can confirm it is valid.
- **Terminal Illness Cover** - the illness and diagnosis.
- **Waiver of Premium** – how the life insured meets our definition of incapacity. You should let us know about the life insured's incapacity within 16 weeks of it starting. If you don't let us know within this time, we'll consider the start of their incapacity to be 16 weeks before the date we are told. We may not insist on this if there are exceptional medical or other reasons why you did not tell us within 16 weeks of the start of incapacity.

We won't be able to process your claim until you send us all the information we ask for.

For details about our definition of incapacity, please see the section headed '**Waiver of Premium**'.

How we'll pay your claim

We'll pay the amount of cover to you. If the owner of the policy is dead, the payment will go to their personal representative (usually the executor named in their will). If the policy has been placed in trust, we'll pay the trustees. If the policy has been assigned, we'll pay the assignees.

Payments are made as a lump sum in British pounds to a bank account in the UK. If you're receiving a payment to a bank account outside the UK, you'll need to pay any costs to arrange this.

What happens if I pay for my policy annually?

If you pay an annual premium for your policy, and a claim is paid under full cover, we'll pay a refund of the premium for the remaining months of that year.

The policy will end when a claim is paid under Life Insurance or Terminal Illness Cover.

When we won't pay a claim

Your claim may be refused or impacted by one of the following if:

- you don't meet the relevant definition for the type of claim you're making when we offered you this policy,
- we told you our offer was subject to you cancelling a specified policy(ies) and you did not cancel it (them),
- you, or someone acting on your behalf, didn't answer our questions correctly during your application for the policy, or during subsequent amendments to the policy meaning the incorrect terms were applied to your cover

If your policy has lapsed due to missed payments prior to any claimable event occurring, you won't be covered, and your claim won't be paid.

If we would have offered you cover with higher premiums had the correct information been given to us, we're entitled to reduce your amount of cover or refuse to pay your claim.

More information on when we won't pay a claim including what happens if you die during the first year of cover can be found in sections headed '**What this policy doesn't cover**' and '**If you miss a payment**'. Any exclusions will be shown in the Policy Schedule you will receive after you take out cover.

Life Insurance

How life insurance works

Life insurance will pay a lump sum if the life insured dies or is diagnosed with a terminal illness during the term of this policy. If this happens, your policy will then end.

If this is a joint policy, we'll pay you when either life insured dies or is diagnosed with a terminal illness which meets our definition.

How Terminal Illness Cover works

This policy will pay you the amount of cover if you're diagnosed with a terminal illness. If this happens, your policy will then end.

Terminal illness is defined as a definite diagnosis by your hospital consultant of an illness that satisfies both of the following:

- The illness either has no known cure or has progressed to the point where it cannot be cured; and
- In the opinion of your hospital consultant and our Medical Officer (a qualified doctor employed by Legal & General), the illness is expected to lead to death within 12 months.

You can't make a claim for Terminal Illness Cover after the life insured dies.

The amount payable will be the amount of cover we calculate on the date the Terminal Illness definition is met. Please note, Terminal Illness Cover is an advanced payment of the death benefit calculated at the time the Terminal Illness definition is met. This can mean that the Terminal Illness benefit paid may be less than would have been paid at death.

Optional benefit you can add to your policy

At the start of your policy, you can choose to add the following benefit for an extra cost.

Waiver of Premium

If the life insured meets our definition of incapacity for 26 consecutive weeks, you won't have to pay premiums. This benefit will start after the 26th consecutive week of incapacity and continue until the earlier of:

- The end of the period of incapacity
- Payment of the amount of cover
- The policy expiry date

Incapacity

Depending on your (the life insured's) employment status when a claim is made, incapacity is defined as:

The life insured is totally incapable of carrying out their normal occupation by reason of an illness or injury which occurred after the policy start date, necessitating medical or surgical treatment and is not carrying out any other occupation or paid employment.

Or

If the life insured is not in paid employment and they are unable to do three or more of the following Specified Work Tasks as a direct result of an illness or injury which occurred after the policy start date:

The Specified Work Tasks are:

- **Walking:** The ability to walk more than 200 metres on a level surface.
- **Climbing:** The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
- **Lifting:** The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
- **Bending:** The ability to bend or kneel to touch the floor and straighten up again.
- **Getting in and out of a car:** The ability to get into a standard saloon car, and out again.
- **Writing:** The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

The life insured may be required to have a medical examination by an appropriate medical specialist appointed by us regardless of the incapacity definition applied at claim.

Countries where this benefit is provided

The life insured is covered for Waiver of Premium if they:

- reside or travel within the UK,
- reside or travel within the European Union, or
- travel outside of the UK or European Union for no more than three consecutive months in any 12 months.

If the life insured travels outside of the UK or the European Union for more than three consecutive months in any 12 months we will act reasonably when assessing whether the life insured meets the definition of incapacity.

For details about how to make a Waiver of Premium claim, please see the section headed '**How to make a claim**'.

What this policy doesn't cover

If you die within the first year

The policy will be cancelled if within the first year of the policy, the life insured dies as a result of:

- Suicide
- Intentional and serious self-injury
- An event where, in our reasonable opinion, the life insured took their own life

Assessing a claim for death in the first year

If a suicide verdict is not given, we may decide in our reasonable opinion that the life insured has taken their own life. We will take into account:

- The method and timing of death
- The evidence available from the time and place of death
- Any documentation left by the deceased or available from others
- Previous medical history that we are reasonably entitled to obtain

Paying for your policy

Premiums can be paid monthly or annually.

If you miss a payment

Your policy will be cancelled if your premium isn't paid. We won't refund any premiums you've already paid.

If your premium remains unpaid for any reason 60 days after the due date of any missed payment, your policy will be deemed cancelled and cover will automatically end.

Choosing your cover type

Level

Level cover if you want your cover to stay the same

If you choose level cover the amount of cover will stay the same unless you change it using the options available in the section headed 'Making changes to your policy' during the period of cover.

What happens to premiums?

You can choose to have:

- guaranteed premiums - which means they'll stay the same unless you make changes to your policy.

Decreasing

Decreasing cover if you want your cover to decrease

If you choose decreasing cover the amount of cover will reduce during the period of cover and is often used to help protect a repayment mortgage.

What happens to premiums?

You can choose to have:

- guaranteed premiums - which means they'll stay the same unless you make changes to your policy.

How does it work?

An interest rate is applied to your policy. This estimates the amount that you repay each month on your repayment mortgage, and the amount you're covered for will therefore decrease accordingly. The interest rate we apply will be shown on your Policy Schedule, which we'll send to you when your policy starts.

If the interest rate we apply is less than the interest rate that is actually applied to your repayment mortgage, or your mortgage changes, the amount we pay out may not be enough to repay your mortgage in full.

You should check regularly that your amount of cover will be enough to pay off the rest of your repayment mortgage. Remember to also check that the interest rate we use in our calculation and apply to your policy is equal to or higher than the interest rate on your mortgage.

Increasing

Increasing cover if you want your cover and premiums to increase in line with changes in inflation

You may have the option to choose increasing cover. The amount of cover will increase in line with changes in inflation on each policy anniversary. We won't ask any further questions about your health.

To do this, we increase the cover amount to match inflation in line with the changes in the Retail Prices Index (RPI) over a 12 month period. If we can't use RPI we'll use an index comparable to the RPI instead.

- If the change in the RPI is less than 1% we will not increase the amount of cover.
- If the change in the RPI is more than 10% we will only increase the amount of cover by 10% per annum.

Your premiums will also increase in line with the changes in the Retail Prices Index (RPI) multiplied by 1.5, subject to a maximum increase of 15% per annum.

We'll contact you at least three months before the policy anniversary to tell you what the increase in the amount of cover and premium will be. You'll have the option of accepting the increase or not. We've put together some information below to help you understand how these options will affect your policy:

Your options

- **Accept the increase**
  You don't need to do anything. Your cover amount and premiums will increase as described above and we'll update your Direct Debit with your new premium.
- **Decline the increase**
  When we notify you of an increase, we will also give you the option to decline the increase. You'll need to let us know before the deadline on the letter or email. We'll include instructions on how to do this.

If you decline the increase, your cover will stay the same for another year.

If you decline the increase three years in a row we'll remove this option, and you won't have the option to increase the amount of cover in line with changes in inflation, for the remaining policy term. This means that your amount of cover will stay the same, as the costs of goods and services rise in the future.

For joint life policies, we'll need approval from both policy holders to decline an increase.

What's the Retail Prices Index (RPI)?

The RPI gives an idea of the rate of inflation on a monthly basis. The RPI measures the average change in the price of goods and services. This includes petrol, groceries such as bread and milk, and housing expenses such as mortgage interest payments.

Making changes to your policy

Increasing your cover

If certain life events happen, you may be able to increase your amount of cover without having to give us any more medical information. You can only do this if the policy started before the life insured's 55th birthday. Your Policy Schedule (which you'll receive when your policy starts) will say if you have this option.

You can increase your amount of cover if one of the following happens:

- the life insured gets married or enters into a registered civil partnership
- the life insured gets divorced or dissolves a registered civil partnership
- the birth of a life insured's child
- the life insured legally adopts a child
- the life insured's income increases if they get a promotion or new job
- the life insured's mortgage increases because they move house or are carrying out major home improvements.

You'll need to let us know within six months of the above happening to be able to use this option. We might ask for some documents relating to the life event. For example, we might ask to see a copy of the life insured's marriage certificate if they get married.

Limits to increases in cover

Your amount of cover can be increased by the lower of:

- 100% of the original amount of cover; or
- £200,000; or
- If your pay increases due to a promotion or new job, the original amount of cover multiplied by the percentage increase in your earnings; or
- If your mortgage increases due to moving house or undertaking major home improvements, the amount of increase in the mortgage.

You can apply to increase your cover multiple times. However, the total amount you can increase your cover by can't be more than the lower of £200,000 or 100% of the original cover amount, across all changes applied.

If you increase your cover this way, we'll set up an additional policy that takes the increase into account. This will:

- mean you can't increase your cover on the new policy without further medical evidence
- end at your 65th birthday, or one year after the policy expiry date, whichever comes first
- only have increasing cover if this was selected when the policy was taken out and the option to increase has been accepted by you in line with our terms and conditions
- be subject to the premiums, and terms and conditions at the time the new policy is issued.

If we can't offer you what you ask for when you apply to increase your cover when using this option, we'll offer you a reasonable alternative.

When this option is not available

You won't be able to increase your cover:

- after the life insured's 55th birthday (if two people are covered by this policy, this applies when the eldest person covered reaches 55)
- if you've made a claim for Waiver of Premium, until the end of the period of incapacity
- if the life insured has been diagnosed with or is receiving (or has received) medical treatment for our definition of a terminal illness

Joint life policy separation

If you take out a joint life policy, you can separate it if you get divorced or you dissolve your registered civil partnership. You can also separate the policy if one of you takes over an existing mortgage in one name or takes out a new mortgage in one name.

You must make the request within six months of the event being finalised.

We'll then cancel this policy and start a new single life policy for each life insured.

What we need to process your request

To separate your policy, we'll need evidence such as:

- A decree absolute if you get divorced; or
- A final order for the dissolution of your registered civil partnership; or
- Proof of ownership of the relevant mortgage.

We'll also need consent of both lives insured by completing and returning an amendment form issued by us. This will include a short questionnaire about the life insured's health, medical history, residency and leisure activities.

If either life insured answers 'yes' to any of the questions in the amendment form, we'll need you to complete a full application form in order to set up a single life policy. Where we undertake a full medical and lifestyle assessment, depending on the answers there may be circumstances where we may not be able to offer cover to both of the lives insured.

How we'll provide cover after separation

The new single life policies will include the same cover as the original policy. We won't change the cover in any other way, other than making it a single life policy.

The new single life policies will be subject to premiums, terms and conditions available at the time you make the change.

Your new policy will cover either £1,000,000 or your original amount of cover - whichever is lower.

Your new policy will end on your 70th birthday or one year after your original policy expires - whichever comes first.

Replacing a joint life policy – if one of you makes a claim

If one of you makes a valid claim for

- Life insurance or Terminal Illness Cover

you can ask us to create a new policy for the other person. This is sometimes referred to as 'replacement cover'.

You need to ask us to set this up within six months of a valid claim being paid.

What we need to process your request

For us to set up the new policy for you (the person who hasn't made a claim), we'll need you to give your consent and complete a replacement cover form. It asks some questions about your health, medical history, leisure activities you take part in and where you live. If you answer 'yes' to any of the questions, you'll need to fill out a full application.

Your premiums and terms and conditions might change. They will be explained in your new policy documents.

Where we undertake a full medical and lifestyle assessment, there may be circumstances where we may not be able to offer cover to the life insured.

How we'll provide your replacement cover

The new single life policy will include the same amount of cover as the original policy. We won't change the cover in any other way, other than making it a single life policy.

If Decreasing Life Insurance is chosen, the amount of cover will be the remaining amount of cover at the time a valid claim was paid on the original policy.

Your new policy will end on the life insured's 70th birthday or one year after your original policy expires - whichever comes first.

The new single life policy will be subject to premiums, terms and conditions available at the time you make the change.

Other changes you can make to your policy

You might be able to ask us to:

- change the amount of cover
- change the length of your policy
- remove one person from the policy (if you chose a joint policy)
- change the frequency of your premiums between annually and monthly

We'll need some information from you to make these changes:

- Consent to make the changes
- You'll have to fill out and send an amendment form to us. It asks some questions about your health, medical history, residency and leisure activities. If you answer 'yes' to any of the questions, you'll need to fill out a full application.
- Any documents reasonably required by us to support what you're asking us to change

We might ask you to fill out a new application. This might include having a medical and lifestyle assessment.

We'll let you know whether we can make the changes or not.

Making changes to your policy might change your premiums. We'll confirm if the change you've requested means the original policy has to be cancelled and a new policy issued, which may have different terms and conditions.

When we can make changes to your policy

During the application process we will ask you questions about your personal circumstances and we may request additional information from you in order to make an assessment and offer you a policy. The life insured is required to answer all of our questions honestly and accurately.

- If you (or an agent acting on your behalf) deliberately or recklessly provide inaccurate information we are entitled to cancel the policy and refuse to pay the amount of cover. In these circumstances we may not refund any premiums you have already paid.
- If you (or an agent acting on your behalf) provide inaccurate information through carelessness, we are entitled to amend the policy to reflect the terms that would have been offered had the accurate information been known. In these circumstances:
    i. if we would not have issued the policy had the accurate information been provided, we are entitled to cancel the policy, however we will refund any premiums you have already paid;
    ii. if we would have issued the policy on different terms and conditions (other than those relating to premiums) had the accurate information been provided, we may make changes to the policy terms and conditions and treat the policy as if it had been issued on the different terms and conditions;
    iii. in addition, if we would have issued the policy with higher premiums had the accurate information been provided, we may reduce the amount of cover to reflect the higher premiums that would have applied had the accurate information been provided. The following formula will be used in these circumstances:

$$\textbf{New amount of cover} = \frac{\text{Premium actually charged} \times \text{Original amount of cover}}{\text{Higher premium}}$$

How to cancel your policy

You can cancel your policy at any time. Once your policy starts, we'll let you know about your right to cancel.

You can cancel your policy within 30 days of receiving your welcome pack. In this case, we'll refund any premiums you've paid.

If you cancel your policy after 30 days of receiving your welcome pack, and pay monthly premiums, we won't refund any premiums you've paid. If you pay annually, you will receive a proportionate refund of your annual premium.

If you cancel your policy your cover will end and no further premiums will be payable.

When we can cancel your policy

We can cancel your policy, deny a claim or take reasonable action to comply with laws, regulations, sanctions regimes, international guidance and/or demands from any authorities, relating to Financial Crime Risk Management Activity.

If you, or someone acting on your behalf, gives us incorrect information, we retain the right to cancel your policy, even where we may have been able to offer alternative terms. If we do this, we won't pay claims, and may not refund the premiums paid to that point.

How to make a complaint

Our number one priority is to provide you with the highest level of customer service, but we know that sometimes things can go wrong. We'll try to find a solution as quickly as possible.

We can usually sort out most issues straightaway. If it takes longer, we'll contact you to let you know who will be dealing with it and what the next steps are.

After looking into your complaint we'll respond as quickly as possible. We'll keep in touch with you until your complaint has been resolved. If you disagree with our decision, feel we have misunderstood anything or you would like to give us more information please let us know.

You can contact us by phone, letter or email using the details in the section headed 'How to get in touch with us'.

You can also contact us by secure message if you have access to your online account.

If you're unhappy with our final response to your complaint, the Financial Ombudsman Service may be able to help.

You can find out more about the Financial Ombudsman Service at www.financial-ombudsman.org.uk or you can contact them:

Making a complaint will not affect your legal rights.

By phone	By email	By post
Call 0800 023 4567 or 0300 123 9123	complaint.info@financial-ombudsman.org.uk	The Financial Ombudsman Service Exchange Tower London E14 9SR

Additional information and general conditions

We may make changes to the policy terms and conditions that we reasonably consider are appropriate due to a change in any applicable legislation, regulation or taxation. In such circumstances, we will notify you in advance of any changes being made.

We have the right by notifying you to:

- cancel this policy; and
- not pay a claim on this policy; and
- take other reasonable action

In order to comply with laws, regulations, sanctions regimes, international guidance and/or demands from any authorities, relating to Financial Crime Risk Management Activity.

The right to exercise any option under the policy or to exercise any right conferred by the policy is limited to such as are allowed in the terms of the policy and as are compatible with the requirements of Paragraph 19(3) of Schedule 15 of the Income and Corporation Taxes Act 1988 for a qualifying policy.

The Financial Services Compensation Scheme (FSCS)

The FSCS is designed to pay compensation if a firm is unable to pay claims, because it has stopped trading or been declared in default. So, if we run into financial difficulties, you may be able to claim via the FSCS, for any money you've lost.

However, before looking to pay compensation, the FSCS will first see if they can arrange for the continuity of your current policy. The FSCS may arrange for the policy to be transferred to another insurer or arrange for a new policy to be provided.

Most of our customers, including most individuals and small businesses, are covered by the FSCS. Whether or not you can claim, and the amount you could claim, will depend on the specific circumstances of your claim. The FSCS will pay 100% of the value of the claim.

You can find out more about the FSCS, including eligibility to claim, by visiting its website
www.fscs.org.uk
or calling
0800 678 1100.

Solvency and Financial Conditions Report (SFCR)

Legal & General are required to publish an annual Solvency and Financial Condition Report (SFCR) describing our Business and its Performance, our System of Governance, Risk Profiles, Valuation for Solvency Purposes and Capital Management. Our latest SFCR is available at: www.legalandgeneralgroup.com/investors/library.

Our Regulator

We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. We are registered on the Financial Services Register under number 117659. You can check this at register.fca.org.uk or telephone them on 0800 111 6768.

Alternative formats

If you would like a copy of this in large print, braille, PDF or in an audio format, call us on **0370 010 4080**. We may record and monitor calls. Call charges will vary.

legalandgeneral.com

Legal and General Assurance Society Limited

Registered in England and Wales No. 00166055

Registered office: One Coleman Street, London EC2R 5AA

We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

QGI12849 - 2026/01

Critical Illness Cover

Policy Terms and Conditions

In this Policy Terms and Conditions document you'll find useful information to help you understand the policy benefits and features.

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How this policy works

Critical Illness Cover helps financially protect you and your family if you're diagnosed with a condition or have a medical procedure that meets our definition. You can find a list of conditions and procedures that are covered in the 'Critical Illness Cover Definitions' section.

You're covered from the policy start date until the policy expiry date. Your policy will end before this if we pay the cover amount or the policy is cancelled.

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Key words and their meanings

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When we say '**you**' or '**your**' in this document, we mean anyone who's legally entitled to receive the amount of cover when a valid claim is made. This could be a trustee, assignee, personal representative of the life insured. If there's more than one person covered then we mean all lives insured.

The life insured is the person who is covered by the policy. If this is a joint policy, both people will be covered.

When we say 'assignee', we're referring to the person to whom the legal ownership of the policy is transferred.

Where we say a "**relevant child**" this means a natural child, legally adopted child (from the date of adoption), or stepchild (by marriage or registered civil partnership) of the life insured.

- For **Children's Critical Illness Cover**, the **relevant child** is covered between 30 days of age, up to and inclusive of the **relevant child's** 18th birthday, or 21st birthday if in full-time education.

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Complaints	**Call** 0370 010 4080 Monday to Friday 9am to 5pm	Legal & General Assurance Society Limited Four Central Square Cardiff CF10 1FS

How to make a claim

We know that making a claim can be a difficult time. We'll try to make sure the process is stress free, and to keep you updated regularly.

You can find the contact details for our claims team above.

When you let us know about any claim, we'll need to know:

- The policy number (we can still help if you don't have this)
- The life insured's Doctor's details
- Your contact details

We'll also need some additional information depending on the type of claim being made. This may include us sending the claimant a form to fill out and return to us. We'll need details of:

- **Critical Illness Cover (including Children's Critical Illness Cover)** - the illness and diagnosis.
- **Children's Critical Illness Cover** – you'll need evidence of the child you're claiming for (the relevant child). This may be: the birth certificate for a natural child, the legal adoption certificate for a legally adopted child, or the marriage certificate or certificate of a registered civil partnership for a stepchild.

If you're making a claim for Total and Permanent Disability your claim will be assessed against either the 'Own Occupation', or 'Specified Work Tasks' definition.

More information on this can be found in the '**Critical Illness Cover Definitions**' section of this document.

We won't be able to process your claim until you send us all the information we ask for.

How we'll pay your claim

We'll pay the amount of cover to you. If the owner of the policy is dead, the payment will go to their personal representative (usually the executor named in their will). If the policy has been placed in trust, we'll pay the trustees. If the policy has been assigned, we'll pay the assignees.

Payments are made as a lump sum in British pounds to a bank account in the UK. If you're receiving a payment to a bank account outside the UK, you'll need to pay any costs to arrange this.

What happens if I pay for my policy annually?

If you pay an annual premium for your policy, and a claim is paid under full cover, we'll pay a refund of the premium for the remaining months of that year.

If you choose to add Critical Illness Cover alongside your Life Insurance as a separate policy (also referred to as Additional or Independent Critical Illness Cover), and we accept your claim for Critical Illness Cover, your Critical Illness Cover policy will end.

It's important to know the policy will not end if we pay a claim under the 'Additional cover' or 'Children's Critical Illness Cover' sections of the policy.

When we won't pay a claim

Your claim may be refused or impacted by one of the following if:

- you don't meet the relevant definition for the type of claim you're making when we offered you this policy,
- we told you our offer was subject to you cancelling a specified policy(ies) and you did not cancel it (them),
- you, or someone acting on your behalf, didn't answer our questions correctly during your application for the policy, or during subsequent amendments to the policy meaning the incorrect terms were applied to your cover

If your policy has lapsed due to missed payments prior to any claimable event occurring, you won't be covered, and your claim won't be paid.

If we would have offered you cover with higher premiums had the correct information been given to us, we're entitled to reduce your amount of cover or refuse to pay your claim.

More information on when we won't pay a claim including what happens if you die during the first year of cover can be found in sections headed '**What this policy doesn't cover**' and '**If you miss a payment**'. Any exclusions will be shown in the Policy Schedule you will receive after you take out cover.

Critical Illness Cover

How Critical Illness Cover works

Critical Illness Cover will pay you the amount of cover if you are diagnosed with a condition or undergo a medical procedure as listed in Critical Illness Cover Definitions. Your policy will then end.

We'll pay you the amount of cover if you're diagnosed with a condition or undergo a medical procedure listed in Critical Illness Cover Definitions, and survive for 14 days from diagnosis, even if this is after the policy end date.

The diagnosis must come from a verified medical UK consultant whose specialism we consider appropriate to the relevant critical condition.

You and your **relevant child/children** are covered if they're a resident of one of the following places:

- Any European Union country
- Australia
- Canada
- The Channel Islands
- The Isle of Man
- New Zealand
- United Kingdom
- USA

We'll accept a claim from a country that's not listed above if we can confirm the claim and supporting documentation is valid. We'll act reasonably when reviewing evidence to support the validity of a claim.

If you choose to add Critical Illness Cover alongside your Life Insurance as a separate policy (also referred to as Additional or Independent Critical Illness Cover), and we accept your claim for Critical Illness Cover, your Critical Illness Cover policy will end. This doesn't apply to claims covered under 'Additional cover included with Critical Illness Cover' and 'Children's Critical Illness Cover'.

Critical Illness Cover Definitions

When we say "definitions" we mean a critical illness or condition that meets the criteria set out below.

Condition	Definition
Aorta graft surgery - requiring surgical replacement	The undergoing of surgery to the aorta with excision and surgical replacement of a portion of the aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. For the above definition, the following are not covered: • any other surgical procedure, for example the insertion of stents or endovascular repair.
Aplastic anaemia - with **permanent** bone marrow failure	A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be **permanent** bone marrow failure with anaemia, neutropenia and thrombocytopenia.

Condition	Definition
Bacterial meningitis - resulting in **permanent** symptoms	A definite diagnosis of bacterial meningitis by a hospital consultant resulting in **permanent neurological deficit with persisting clinical symptoms.** For the above definition, the following are not covered: • all other forms of meningitis other than those caused by bacterial infection.
Benign brain tumour - resulting in either surgical removal or permanent symptoms	A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in either surgical removal or **permanent neurological deficit with persisting clinical symptoms.** For the above definition, the following are not covered: • tumours in the pituitary gland; • tumours originating from bone tissue; • angioma and cholesteatoma.
Blindness - **permanent** and **irreversible**	**Permanent** and **irreversible** loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart.

Cancer - excluding less advanced cases	Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.
	
	The term malignant tumour includes leukaemia, sarcoma, pseudomyxoma peritonei, essential thrombocythaemia, polycythaemia vera, primary myelofibrosis, Merkel cell cancer and lymphoma except those that arise from and are confined to the skin (including cutaneous lymphomas and sarcomas).
	
	For the above definition, the following are not covered:
	• All cancers which are histologically classified as any of the following:
	  o pre-malignant;
	  o cancer in situ;
	  o having either borderline malignancy; or
	  o having low malignant potential.
	• All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to

Condition	Definition
	at least TNM classification cT2bN0M0 or pT2N0M0 following prostatectomy (removal of the prostate). • All urothelial tumours unless histologically classified as having progressed to at least TNM classification T1N0M0. • Malignant melanoma skin cancers that are confined to the epidermis (outer layer of skin). • All cancers (other than malignant melanoma) that arise from or are confined to one or more of the epidermal, dermal, and subcutaneous tissue layers of the skin (including cutaneous lymphomas and sarcomas). • All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0. • **Neuroendocrine tumours** without lymph node involvement or distant metastases unless classified as WHO **Grade** 2 or above. • Gastrointestinal stromal tumours without lymph node involvement or distant metastases unless classified by either AFIP/Miettinen and Lasota as having a moderate or high risk of progression, or as UICC/TNM8 stage II or above.
Cardiac arrest - with insertion of a defibrillator	Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness, requiring resuscitation and resulting in either of the following devices being surgically implanted: • implantable cardioverter-defibrillator (ICD); or • cardiac resynchronisation therapy with defibrillator (CRT-D). For the above definition, the following are not covered: • insertion of a pacemaker; • insertion of a defibrillator without cardiac arrest. • cardiac arrest secondary to illegal drug intake.
Cardiomyopathy - of specified severity	A definite diagnosis of cardiomyopathy by a consultant cardiologist. There must be clinical impairment of heart function resulting in the **permanent** loss of ability to perform physical activities to at least Class 3 of the New York Heart Association's classification of functional capacity*. For the above definition, the following aren't covered: • cardiomyopathy secondary to alcohol or drug intake;

Condition	Definition
	• all other forms of heart disease, heart enlargement and myocarditis. *NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.
Coma – with associated **permanent** symptoms	A state of unconsciousness with no reaction to external stimuli or internal needs which: • requires the use of life support systems; and • has associated **permanent neurological deficit with persisting clinical symptoms**. For the above definition, the following are not covered: • medically induced coma; • coma secondary to alcohol or drug intake.
Coronary artery by-pass grafts – with surgery to divide the breastbone or thoracotomy	The undergoing of surgery to divide the breastbone (median sternotomy) or thoracotomy on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts. For the above definition, the following is not covered: • any other surgical procedure or treatment.
Creutzfeldt-Jakob disease (CJD) – resulting in **permanent** symptoms	A definite diagnosis of Creutzfeldt-Jakob disease by a consultant neurologist. There must be **permanent** clinical loss of the ability in mental and social functioning to the extent that **permanent** supervision or assistance by a third party is required.
Deafness - **permanent** and **irreversible**	**Permanent** and **irreversible** loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram.
Dementia including Alzheimer's disease - of specified severity	A definite diagnosis of Dementia, including Alzheimer's disease by a consultant geriatrician, neurologist, neuropsychologist or psychiatrist supported by evidence including **neuropsychometric testing**. There must be permanent cognitive dysfunction with progressive deterioration in the ability to do all of the following: • remember; • reason; and • to perceive, understand, express and give effect to ideas. For the above definition, the following are not covered: • **mild cognitive impairment (MCI).**
Encephalitis - resulting in **permanent** symptoms	A definite diagnosis of encephalitis by a consultant neurologist resulting in **permanent neurological deficit with persisting clinical symptoms**.

Condition	Definition
Heart attack - of specified severity	A definite diagnosis of acute myocardial infarction with death of heart muscle as evidenced by all of the following: • new characteristic electrocardiographic changes or **new diagnostic imaging changes**; and • the characteristic rise of biochemical cardiac specific markers such as troponins or enzymes. The evidence must show a definite acute myocardial infarction. For the above definition, the following are not covered: • **myocardial injury** without infarction. • angina without myocardial infarction.
Heart valve replacement or repair - with surgery	The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.
Kidney failure - requiring **permanent** dialysis	Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is **permanently** required.
Liver failure - of advanced stage	Liver failure due to cirrhosis and resulting in all of the following: • **permanent** jaundice; • ascites and • encephalopathy. For the above definition, the following is not covered: • liver disease secondary to alcohol or drug intake.
Loss of hand or foot - **permanent** physical severance	**Permanent** physical severance of either a hand or foot at or above the wrist or ankle joints.
Loss of speech - total **permanent** and **irreversible**	Total **permanent** and **irreversible** loss of the ability to speak as a result of physical injury or disease.
Major organ transplant - from another donor	The undergoing as a recipient of a transplant from another donor, of bone marrow or of a complete heart, kidney, lung, pancreas, liver or lobe of the liver, or inclusion on an official UK, Channel Islands or Isle of Man waiting list for such a procedure. For the above definition, the following is not covered: • transplant of any other organs, parts of organs, tissues or cells.
Motor neurone disease - resulting in **permanent** symptoms	A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist: • amyotrophic lateral sclerosis (ALS); • primary lateral sclerosis (PLS); • progressive bulbar palsy (PBP); • progressive muscular atrophy (PMA); or

Condition	Definition
	• spinal muscular atrophy (SMA). There must be **permanent** clinical impairment of motor function.
Multiple sclerosis - where there have been symptoms	A definite diagnosis of multiple sclerosis by a consultant neurologist. There must have been clinical impairment of motor or sensory function caused by multiple sclerosis.
Multiple system atrophy – resulting in **permanent** symptoms	A definite diagnosis of multiple system atrophy by a consultant neurologist. There must be evidence of **permanent** clinical impairment of either: • motor function with associated rigidity of movement; or • the ability to coordinate muscle movement; or • bladder control and postural hypotension.
Open heart surgery – with median sternotomy	The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiologist to correct any structural abnormality of the heart.
Paralysis of limb – total and **irreversible**	Total and **irreversible** loss of muscle function to the whole of any limb.
Parkinson's disease - resulting in **permanent** symptoms	A definite diagnosis of Parkinson's disease by a consultant neurologist or consultant geriatrician. There must be **permanent** clinical impairment of motor function with associated tremor or muscle rigidity. For the above definition, the following are not covered: • Other Parkinsonian syndromes; • Parkinsonism.
Primary pulmonary hypertension - of specified severity	A definite diagnosis of pulmonary hypertension. There must be clinical impairment of heart function resulting in the **permanent** loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classifications of functional capacity*. For the above definition, the following is not covered: • pulmonary hypertension secondary to any other known cause i.e. not primary. *NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.
Progressive supranuclear palsy – resulting in **permanent** symptoms	A definite diagnosis of progressive supranuclear palsy by a consultant neurologist. There must be **permanent** clinical impairment of eye movements and motor function.

Condition	Definition
Removal of an eyeball – due to injury or disease	Surgical removal of an eyeball as a result of injury or disease. For the above definition, the following are not covered: • self inflicted injuries.
Respiratory failure - of advanced stage	Advanced stage emphysema or other chronic lung disease, resulting in all of the following: • The need for regular oxygen treatment on a **permanent** basis; and • The **permanent** impairment of lung function tests as follows: – Forced Vital Capacity (FVC) and Forced Expiratory Volume at 1 second (FEV1)being less than 50% of normal.
Spinal stroke - resulting in symptoms lasting at least 24 hours	Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal canal resulting in **neurological deficit with persisting clinical symptoms** lasting at least 24 hours.
Stroke - resulting in symptoms lasting at least 24 hours	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in **neurological deficit with persisting clinical symptoms** lasting at least 24 hours. For the above definition, the following aren't covered: • transient ischaemic attack. • death of tissue of the optic nerve or retina/eye stroke.
Systemic lupus erythematosus – with severe complications	A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following: • **permanent neurological deficit with persisting clinical symptoms**; or • the permanent impairment of kidney function tests as follows: – Glomerular Filtration Rate (GFR) below 30 ml/min.
Third degree burns - covering 20% of the surface area of the body or 20% of the face or head	Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or covering 20% of the area of the face or head.

Condition	Definition
Total and Permanent Disability* - of specified severity (Own occupation)	**Total and Permanent Disability** – unable to do your own occupation ever again before your 70th birthday. Loss of the physical or mental ability through an illness or injury to the extent that the **life insured** is unable to do the material and substantial duties of their own occupation ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of the **life insured**'s own occupation that cannot reasonably be omitted or modified. 'Own occupation' means your trade, profession or type of work you do for profit or pay. It is not a specific job with any particular employer and is irrespective of location and availability. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the **life insured** expects to retire. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered. The definition of a clear prognosis is where a relevant specialist is able to provide the likely outcome of the illness, condition or disease. If the **life insured** is not in paid employment at the time of a claim, your claim will be assessed under the Specified Work Tasks definition described in the definition headed 'Total and Permanent Disability (Specified Work Tasks)'. Total and Permanent Disability will end when the oldest person covered reaches the policy end date, or 70th birthday, whichever is earlier. This benefit will be removed when you reach your 70th birthday and your premium will be reduced. We will contact you to let you know about the change in your premium and cover.

Condition	Definition
Total and Permanent Disability* - of specified severity (Specified work tasks)	**Total and Permanent Disability** – unable to do three Specified Work Tasks ever again before your 70th birthday. Loss of the physical ability through an illness or injury to do at least three of the six work tasks listed below ever again. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the life insured expects to retire. The **life insured** must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. The Specified Work Tasks are: **Walking:** The ability to walk more than 200 metres on a level surface. **Climbing:** The ability to climb up a flight of 12 stairs and down again, using the handrail if needed. **Lifting:** The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table. **Bending:** The ability to bend or kneel to touch the floor and straighten up again. **Getting in and out of a car:** The ability to get into a standard saloon car, and out again. **Writing:** The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered. The definition of a clear prognosis is where a relevant specialist is able to provide the likely outcome of the illness, condition or disease. Total and Permanent Disability will end when the oldest person covered reaches the policy end date, or 70th birthday, whichever is earlier. This benefit will be removed when you reach your 70th birthday and your premium will be reduced. We will contact you to let you know about the change in your premium and cover.
Traumatic brain injury – resulting in permanent symptoms	Death of brain tissue due to traumatic injury resulting in **permanent neurological deficit with persisting clinical symptoms**.

*If you have Total and Permanent Disability it will be shown in your Policy Terms and Conditions and Policy Schedule that you receive after you take out your policy. The definition applied will depend on your personal circumstances both at application and at the point of claim.

Additional cover included for Critical Illness Cover

If you choose Critical Illness Cover, you'll have additional cover for the conditions listed in this section.

Claims paid under additional cover won't reduce your amount of cover or change your premiums.

If the life insured has a condition that's covered by additional cover, the diagnosis must come from a verified UK medical consultant whose specialism we consider appropriate to the relevant condition.

If the life insured meets one of the definitions listed below we will pay the lower of:

- 25% of the amount of cover at the time our definition is met, or
- £25,000

You can claim once per condition defined in the table below. Once we've accepted a claim for a condition, you won't be covered for it again. If you have a joint life policy, each person can claim once per condition.

Condition	Definition
Carcinoma in situ of the breast - treated by surgery	The undergoing of surgery on the advice of a hospital consultant to remove a tumour following the diagnosis of carcinoma in situ of the breast. For the above definition the following is not covered: • Any other type of treatment.
Low grade prostate cancer - requiring treatment	The undergoing of treatment on the advice of a hospital consultant following diagnosis of a malignant tumour of the prostate positively diagnosed and having a Gleason score of between 2 and 6 inclusive and has progressed to at least clinical TNM classification T1N0M0. For the above definition, the following are not covered: • prostatic intraepithelial neoplasia (PIN); • observation or surveillance; or • surgical biopsy.

We won't pay a claim under additional cover if:

- there's more than one diagnosis in the same time period of investigation and treatment and
- you're eligible to make a full claim for a critical illness.

We've explained Terms used in Critical Illness Cover definitions later in this document.

Children's Critical Illness Cover

How Children's Critical Illness Cover works

Children's Critical Illness Cover is included as part of Critical Illness Cover.

We will pay this cover if a **relevant child** is diagnosed with any of the following during the period of cover:

- Any condition as defined in the section headed 'Critical Illness Cover Definitions', apart from Total and Permanent Disability;
- 'Additional cover included for Critical Illness Cover'.

The amount payable per **relevant child** under the policy will be the lower of:

- 50% of the amount of cover at the time our definition is met; or
- £25,000

When you can make a claim for Children's Critical Illness Cover

We will pay one claim per **relevant child** (to a maximum of two **relevant children**) covered under the policy. After the second claim has been paid, the Children's Critical Illness Cover will end. If the **relevant child** is covered by more than one policy with us, we'll pay you a maximum of £50,000 for that child across all policies.

Claims paid under Children's Critical Illness Cover won't reduce your amount of cover or change your premiums.

To make a claim, your **relevant child** needs to be diagnosed or meet the relevant definition on or before the policy expiry date. We'll pay a claim if the child is between 30 days old and inclusive of the **relevant child's** 18th birthday, or 21st birthday if in full-time education when the relevant definition is met, and lives for at least 14 days from the date of diagnosis. We'll still pay your claim if your child's 18th birthday, or 21st birthday if in full time education, passes, or your policy expires in this 14 day period.

What is not covered?

We will not pay a claim if:

- your **relevant child's** condition was present at birth
- your **relevant child's** symptoms started before your cover started
- The **relevant child** dies within 14 days of the date of diagnosis;
- it is for Total and Permanent Disability;

Child Funeral Benefit

We want to support you during this difficult time. On the death of a **relevant child**, we'll contribute £4,000 towards their funeral. You can make claims for Child Funeral Benefit for up to a maximum of two **relevant children**.

What is not covered?

We won't pay claims if:

- your **relevant child's** condition was present at birth
- the cause of death first arose before the **relevant child** was covered
- we've already paid a claim for Children's Critical Illness Cover for the same child.

If you or your child need to go to hospital

Accident Hospitalisation Benefit, Family Accommodation Benefit and Childcare Benefit are included with our Critical Illness Cover.

Accident Hospitalisation benefit

We'll pay £5,000 if the life insured or **relevant child** is admitted to hospital with physical injuries for a minimum of 28 consecutive days immediately following an accident. Physical injury must have resulted solely and directly from unforeseen, external, violent and visible means and must be independent from any other cause.

We'll only pay one claim in respect of each life insured. This benefit is not payable if a valid claim has been made for:

- A critical illness.

For Child Accident Hospitalisation Benefit, we'll only pay this benefit if the accident doesn't result in us paying out under:

- Children's Critical Illness Cover as described in the section headed 'Children's Critical Illness Cover'.

We will pay one claim per **relevant child**, up to a maximum of two **relevant children** for Children's Critical Illness Cover.

If the same **relevant child** is covered by more than one policy issued by us, we will pay a maximum of £10,000 for that relevant child under this benefit.

Family accommodation benefit

With Children's Critical Illness Cover, for every night a **relevant child** spends in hospital in the three months immediately following diagnosis of one of the critical illnesses covered in the section headed 'Children's Critical Illness Cover', we will pay you £100 per night up to a maximum of £1,000.

Childcare Benefit - If you need someone to look after your child while you're critically ill

Childcare Benefit is included as an additional benefit with our Critical Illness Cover. We've added this benefit to your policy to help with childcare costs so you can focus on getting better.

If you choose:

- Critical Illness Cover and we pay a claim under the policy due to the diagnosis of the life insured with any condition as defined in 'Critical Illness Cover Definitions' and 'Additional cover included for Critical Illness Cover' sections of this document.

We will:

- pay up to £1,000 towards childcare with a registered childminder if you have a natural child, legally adopted child, or stepchild under 5 years old at the time of your diagnosis.
- only pay the childcare benefit when we have received receipts or proof of payment from the registered childminder. This benefit covers childcare that takes place in the 18 months following the life insured's diagnosis.

Paying for your policy

Premiums can be paid monthly or annually.

If you miss a payment

Your policy will be cancelled if your premium isn't paid. We won't refund any premiums you've already paid.

If your premium remains unpaid for any reason 60 days after the due date of any missed payment, your policy will be deemed cancelled and cover will automatically end.

Choosing your cover type

If you choose to add Critical Illness Cover alongside your Life Insurance as a separate policy (also referred to as Additional or Independent Critical Illness Cover), you may be able to select different premium and cover type options for each, depending on what is available when you apply.

Level

Level cover if you want your cover to stay the same

The amount of cover will stay the same unless you change it using the options available in the section headed 'Making changes to your policy' during the period of cover.

What happens to premiums?

You can choose to have:

- guaranteed premiums - which means they'll stay the same unless you make changes to your policy.

Making changes to your policy

Increasing your cover

If certain life events happen, you may be able to increase your amount of cover without having to give us any more medical information. You can only do this if the policy started before the life insured's 55th birthday. Your Policy Schedule (which you'll receive when your policy starts) will say if you have this option.

You can increase your amount of cover if one of the following happens:

- the life insured gets married or enters into a registered civil partnership
- the life insured gets divorced or dissolves a registered civil partnership
- the birth of a life insured's child
- the life insured legally adopts a child
- the life insured's income increases if they get a promotion or new job
- the life insured's mortgage increases because they move house or are carrying out major home improvements.

You'll need to let us know within six months of the above happening to be able to use this option. We might ask for some documents relating to the life event. For example, we might ask to see a copy of the life insured's marriage certificate if they get married.

Limits to increases in cover

Your amount of cover can be increased by the lower of:

- 100% of the original amount of cover; or
- £200,000; or
- If your pay increases due to a promotion or new job, the original amount of cover multiplied by the percentage increase in your earnings; or
- If your mortgage increases due to moving house or undertaking major home improvements, the amount of increase in the mortgage.

You can apply to increase your cover multiple times. However, the total amount you can increase your cover by can't be more than the lower of £200,000 or 100% of the original cover amount, across all changes applied.

If you increase your cover this way, we'll set up an additional policy that takes the increase into account. This will:

- mean you can't increase your cover on the new policy without further medical evidence
- end at your 65th birthday, or one year after the policy expiry date, whichever comes first
- be subject to the premiums, and terms and conditions at the time the new policy is issued.

If we can't offer you what you ask for when you apply to increase your cover when using this option, we'll offer you a reasonable alternative.

When this option is not available

You won't be able to increase your cover:

- after the life insured's 55th birthday (if two people are covered by this policy, this applies when the eldest person covered reaches 55)
- if you've been diagnosed with, have had or are receiving medical treatment for our definition of any illnesses or conditions covered under this policy
- if you have symptoms or are having tests for a condition covered by this policy.

In these circumstances, this option will only be available to the life insured where the test results confirm that the life insured does not have a condition covered by the policy.

Joint life policy separation

If you take out a joint life policy, you can separate it if you get divorced or you dissolve your registered civil partnership. You can also separate the policy if one of you takes over an existing mortgage in one name or takes out a new mortgage in one name.

You must make the request within six months of the event being finalised.

We'll then cancel this policy and start a new single life policy for each life insured.

You can't separate a Joint life policy if either of the lives insured has had a valid claim for a critical illness listed under the sections headed 'Additional cover included with Critical Illness Cover'.

What we need to process your request

To separate your policy, we'll need evidence such as:

- A decree absolute if you get divorced; or
- A final order for the dissolution of your registered civil partnership; or
- Proof of ownership of the relevant mortgage.

We'll also need consent of both lives insured by completing and returning an amendment form issued by us. This will include a short questionnaire about the life insured's health, medical history, residency and leisure activities.

If either life insured answers 'yes' to any of the questions in the amendment form, we'll need you to complete a full application form in order to set up a single life policy. Where we undertake a full medical and lifestyle assessment, depending on the answers there may be circumstances where we may not be able to offer cover to both of the lives insured.

How we'll provide cover after separation

The new single life policies will include the same cover as the original policy. We won't change the cover in any other way, other than making it a single life policy.

The new single life policies will be subject to premiums, terms and conditions available at the time you make the change.

Your new policy will cover either £1,000,000 or your original amount of cover - whichever is lower.

Your new policy will end on your 75th birthday or one year after your original policy expires - whichever comes first.

Replacing a joint life policy – if one of you makes a claim

If one of you makes a valid claim for a critical illness, you can request to continue cover for the other life insured as a new single life policy.

You need to ask us to set this up within six months of a valid claim being paid. We can't create a new policy if you've made a claim for 'Additional cover included with Critical Illness Cover'.

What we need to process your request

For us to set up the new policy for you (the person who hasn't made a claim), we'll need you to give your consent and complete a replacement cover form. It asks some questions about your health, medical history, leisure activities you take part in and where you live. If you answer 'yes' to any of the questions, you'll need to fill out a full application.

Your premiums and terms and conditions might change. They will be explained in your new policy documents.

Where we undertake a full medical and lifestyle assessment, there may be circumstances where we may not be able to offer cover to the life insured.

How we'll provide your replacement cover

The new single life policy will include the same amount of cover as the original policy. We won't change the cover in any other way, other than making it a single life policy.

Your new policy will end on the life insured's 75th birthday or one year after your original policy expires - whichever comes first.

The new single life policy will be subject to premiums, terms and conditions available at the time you make the change.

Other changes you can make to your policy

You might be able to ask us to:

- change the amount of cover
- change the length of your policy
- remove one person from the policy (if you chose a joint policy)
- change the frequency of your premiums between annually and monthly

We'll need some information from you to make these changes:

- Consent to make the changes
- You'll have to fill out and send an amendment form to us. It asks some questions about your health, medical history, residency and leisure activities. If you answer 'yes' to any of the questions, you'll need to fill out a full application.
- Any documents reasonably required by us to support what you're asking us to change

We might ask you to fill out a new application. This might include having a medical and lifestyle assessment.

We'll let you know whether we can make the changes or not.

Making changes to your policy might change your premiums. We'll confirm if the change you've requested means the original policy has to be cancelled and a new policy issued, which may have different terms and conditions.

When we can make changes to your policy

During the application process we will ask you questions about your personal circumstances and we may request additional information from you in order to make an assessment and offer you a policy. The life insured is required to answer all of our questions honestly and accurately.

- If you (or an agent acting on your behalf) deliberately or recklessly provide inaccurate information we are entitled to cancel the policy and refuse to pay the amount of cover. In these circumstances we may not refund any premiums you have already paid.
- If you (or an agent acting on your behalf) provide inaccurate information through carelessness, we are entitled to amend the policy to reflect the terms that would have been offered had the accurate information been known. In these circumstances:
    i. if we would not have issued the policy had the accurate information been provided, we are entitled to cancel the policy, however we will refund any premiums you have already paid;
    ii. if we would have issued the policy on different terms and conditions (other than those relating to premiums) had the accurate information been provided, we may make changes to the policy terms and conditions and treat the policy as if it had been issued on the different terms and conditions;

iii. in addition, if we would have issued the policy with higher premiums had the accurate information been provided, we may reduce the amount of cover to reflect the higher premiums that would have applied had the accurate information been provided. The following formula will be used in these circumstances:

$$\textbf{New amount of cover} = \frac{\text{Premium actually charged} \times \text{Original amount of cover}}{\text{Higher premium}}$$

How to cancel your policy

You can cancel your policy at any time. Once your policy starts, we'll let you know about your right to cancel.

You can cancel your policy within 30 days of receiving your welcome pack. In this case, we'll refund any premiums you've paid.

If you cancel your policy after 30 days of receiving your welcome pack, and pay monthly premiums, we won't refund any premiums you've paid. If you pay annually, you will receive a proportionate refund of your annual premium.

If you cancel your policy your cover will end and no further premiums will be payable.

When we can cancel your policy

We can cancel your policy, deny a claim or take reasonable action to comply with laws, regulations, sanctions regimes, international guidance and/or demands from any authorities, relating to Financial Crime Risk Management Activity.

If you, or someone acting on your behalf, gives us incorrect information, we retain the right to cancel your policy, even where we may have been able to offer alternative terms. If we do this, we won't pay claims, and may not refund the premiums paid to that point.

How to make a complaint

Our number one priority is to provide you with the highest level of customer service, but we know that sometimes things can go wrong. We'll try to find a solution as quickly as possible.

We can usually sort out most issues straightaway. If it takes longer, we'll contact you to let you know who will be dealing with it and what the next steps are.

After looking into your complaint we'll respond as quickly as possible. We'll keep in touch with you until your complaint has been resolved. If you disagree with our decision, feel we have misunderstood anything or you would like to give us more information please let us know.

You can contact us by phone, letter or email using the details in the section headed 'How to get in touch with us'.

You can also contact us by secure message if you have access to your online account.

If you're unhappy with our final response to your complaint, the Financial Ombudsman Service may be able to help.

You can find out more about the Financial Ombudsman Service at www.financial-ombudsman.org.uk or you can contact them:

Making a complaint will not affect your legal rights.

By phone	By email	By post
Call 0800 023 4567 or 0300 123 9123	complaint.info@financial-ombudsman.org.uk	The Financial Ombudsman Service Exchange Tower London E14 9SR

Additional information and general conditions

We may make changes to the policy terms and conditions that we reasonably consider are appropriate due to a change in any applicable legislation, regulation or taxation. In such circumstances, we will notify you in advance of any changes being made.

We have the right by notifying you to:

- cancel this policy; and
- not pay a claim on this policy; and
- take other reasonable action

In order to comply with laws, regulations, sanctions regimes, international guidance and/or demands from any authorities, relating to Financial Crime Risk Management Activity.

The right to exercise any option under the policy or to exercise any right conferred by the policy is limited to such as are allowed in the terms of the policy and as are compatible with the requirements of Paragraph 19(3) of Schedule 15 of the Income and Corporation Taxes Act 1988 for a qualifying policy.

The policy cannot be issued or assigned into a trust.

Terms used in Critical Illness Cover definitions

AFIP/Miettinen and Lasota classification – Air Forces Institute of Pathology (AFIP), Miettenen and Lasota refers a classification used by the medical profession relating specifically to gastrointestinal stromal tumours. It provides information from histological findings of how aggressive tumours are and likelihood of them progressing to become more serious.

Grade - In the context of describing tumours and cancer, grade describes how normal or abnormal cancer cells look under a microscope. The more normal the cells look, the less aggressive the tumour and the more slowly it grows and spreads, these are described as “low grade” and will be attributed a low number (normally 1). On the other hand, the more abnormal the cells look, the more aggressive the cancer and the faster it is likely to grow and spread with higher numbers allocated to the grade.

Irreversible - Cannot be reasonably improved upon by medical treatment and/or surgical procedures used by the National Health Service in the UK at the time of the claim.

Life/lives insured - The person or persons whose life is covered under this policy. If there is more than one life covered then this definition covers all lives insured.

Mild cognitive impairment (MCI) - A condition where mental abilities such as memory and thinking are impaired to a greater extent than would normally be expected according to age. Symptoms are mild enough to not interfere significantly with daily life and so are not defined as the more serious condition of dementia.

Myocardial Injury - A term used to describe where the sensitive “troponin” blood test is elevated suggestive there has been damage to heart tissue and is often but not always caused by myocardial infarction (heart attack).

Neuroendocrine tumours (NET) - Rare tumours that can develop in many different organs in the body. It affects nerve and gland cells that produce hormones (neuroendocrine cells). There is wide variation in prognosis with NETs, depending upon different characteristics including the “grading” of the tumour.

Neurological deficit with persisting clinical symptoms - Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last at least 24 hours. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

Neuropsychometric testing - A key diagnostic tool for the assessment of dementia and other neurological conditions.

New diagnostic imaging changes - In relation to heart attack, is where a scan of the heart indicates there has been damage to the heart muscle.

Permanent - Expected to last throughout the **life insured**’s life, irrespective of when the cover ends or the **life insured** retires.

Permanent neurological deficit with persisting clinical symptoms - Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the life insured's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

UICC/TNM stage – Union for International Cancer Control (UICC) and TNM is a globally recognised standard for classifying the extent of spread by cancer using a numeric staging system.

The Financial Services Compensation Scheme (FSCS)

The FSCS is designed to pay compensation if a firm is unable to pay claims, because it has stopped trading or been declared in default. So, if we run into financial difficulties, you may be able to claim via the FSCS, for any money you’ve lost.

However, before looking to pay compensation, the FSCS will first see if they can arrange for the continuity of your current policy. The FSCS may arrange for the policy to be transferred to another insurer or arrange for a new policy to be provided.

Most of our customers, including most individuals and small businesses, are covered by the FSCS. Whether or not you can claim, and the amount you could claim, will depend on the specific circumstances of your claim. The FSCS will pay 100% of the value of the claim.

You can find out more about the FSCS, including eligibility to claim, by visiting its website
www.fscs.org.uk
or calling
0800 678 1100.

Solvency and Financial Conditions Report (SFCR)

Legal & General are required to publish an annual Solvency and Financial Condition Report (SFCR) describing our Business and its Performance, our System of Governance, Risk Profiles, Valuation for Solvency Purposes and Capital Management. Our latest SFCR is available at: www.legalandgeneralgroup.com/investors/library.

Our Regulator

We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. We are registered on the Financial Services Register under number 117659. You can check this at register.fca.org.uk or telephone them on 0800 111 6768.

Alternative formats

If you would like a copy of this in large print, braille, PDF or in an audio format, call us on **0370 010 4080**. We may record and monitor calls. Call charges will vary.

legalandgeneral.com

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QGI14872 - 2026/01