Partners' group income protection

For a partnership or a limited liability partnership.

Helping you understand our policy

Technical guide 09/23

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

For PGIP 04-22 Policies

Legal & General

Using this document

What is a technical guide?

The Financial Conduct Authority is a financial services regulator. It requires us, Legal & General, to give you important information to help you to decide whether our Partners' Group Income Protection is right for you. You should read this document carefully so that you understand what you are buying, and then keep it safe for future reference.

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

Before you start reading

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

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

If the partnership is a Limited Liability Partnership (LLP), 'equity partners' and '**partners**' will mean 'members of an LLP'.

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

Other documents

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

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

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

See question 2.1 to find out what we need to set up your **policy**.

Target market and fair value assessment information for financial advisers

Our product governance webpage:

- Explains the intended target market for each of our Group Protection products
- Provides information to help financial advisers complete their own fair value assessment
- Describes how we regularly review our Group Protection products for appropriateness under our Product Lifecycle Management processes

https://www.legalandgeneral.com/adviser/workplace-benefits/group-protection/products/insurance-distribution-directive/

About Legal & General

Established in 1836, Legal & General is one of the UK's leading financial services groups and a major global investor, with over £1.2 trillion in total assets under management at 31 December 2022 of which a third is international. We also provides powerful asset origination capabilities. Together, these underpin our leading retirement and protection solutions: we are a leading international player in pension risk transfer, in UK and US life insurance, and in UK workplace pensions and retirement income. Through inclusive capitalism, we aim to build a better society by investing in long-term assets that benefit everyone.

We're a leading provider of Group Protection cover in the UK with over 90 years of expertise and knowledge. We looked after over 6,000 group protection policies and provided protection to almost 1.8 million employees at the end of 2022.

Solvency and financial condition report (SFCR)

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

Contents

Aims, commitments and risks

Its aims

Our Partners' Group Income Protection **policy** aims to:

- Provide insurance to pay income protection benefit for **partners** of a firm who cannot work because of long-term illness or injury which meets the policy definition of incapacity.

  Offer a choice of cover for these benefits.

- Let us work with you, when appropriate, to provide early intervention and rehabilitation for **partners** who are absent from work because of long-term illness or injury.

Your commitment

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

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

  Please see question 4.1 for more details.

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

  Please see question 2.6 for more details.

- Give us all the information we ask for to support any claims, and tell us of a claim within the time limits set out in question 5.2. Without this we won't be able to pay the claim or provide rehabilitation.

  Please see question 5.0 for more details.

- Pay the premiums on the dates we ask for them.
- Keep to all the conditions set out in the **policy**.
- Keep us informed of a **partner's** condition, so we can stop paying benefit if they no longer meet the **policy** definition of incapacity.

Risks

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

- We'll need **partners** to be **actively at work** before we can start their cover. We'll also need them to be **actively at work** before we start covering any increases to their cover. This means we won't cover a **partner**, or cover their increased benefit, if they weren't **actively at work**. We'll start their cover when they are next able to meet our **actively at work** requirements.

  We define and give full details of actively at work in question 2.5.

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

  Please see question 3.1 for more details.

- If you choose not to protect benefit payments against the effect of inflation, the value, but not the amount of benefit we pay, could reduce over time.

  Please see question 1.9 for more details.

- We will stop cover if you stop paying premiums. We'll tell you in writing 14 days before we do this. We'll still pay valid claims if the **partner's** absence started before cover ended and all premiums have been paid.
- We will not pay benefit for a new claim if you haven't paid premiums due for the accounting period in which the **deferred period** starts.
- If we identify a **financial crime** risk we might cancel the **policy**, withdraw a guaranteed quote or take any other reasonable action.

  Please see 'Further Information' section on page 26 for more details

How the policy works

- To start the **policy** we need a minimum of 10 **partners**. We can cancel or change the terms of the **policy** if membership falls to less than five **partners**. If we do this, we'll write to you at least 30 days before we cancel the **policy**. Sometimes we'll start a **policy** with less than 10 **partners**. For example, if you have two **policies** linked together.
- Each **partner** pays the cost for their own cover. You will need to collect the premium for each **partner** and pay us a combined premium.
- We'll give you the specific terms and conditions in the quote. We'll guarantee the quote for three months unless we tell you otherwise.
- There are **policy** options you can choose which affect how much you pay. We'll fix your chosen options, including the eligibility, cover and terms at the start of the **policy**. You'll need to tell us if you want to change these as we need to assess if we can agree the change. We may also need to set new terms and change the **unit rate** and the premium we charge you.
- We won't pay a claim if the **partner** doesn't meet the policy definition of incapacity.

  Please see question 5.1 for more details.

- You must include all **partners** for cover under the **policy** as soon as they are eligible.
- We won't pay a claim if the **partner** is not eligible for cover.

  Please see question 1.0 for more details about eligibility.

- You must give us all the information we need when you make a claim.
- If you make a valid claim, we'll pay the benefit for the **partner** at the end of the month it's due. We will normally pay benefit to the **partner** if they have a UK bank account. If they don't we will pay you the benefit to pass onto them.
- If we're paying benefit to a **partner**, we won't charge premiums for them.
- We'll stop paying benefit for a **partner** if they no longer meet the policy definition of incapacity.

  Please see question 5.5 for more details about when we'll stop paying benefit.

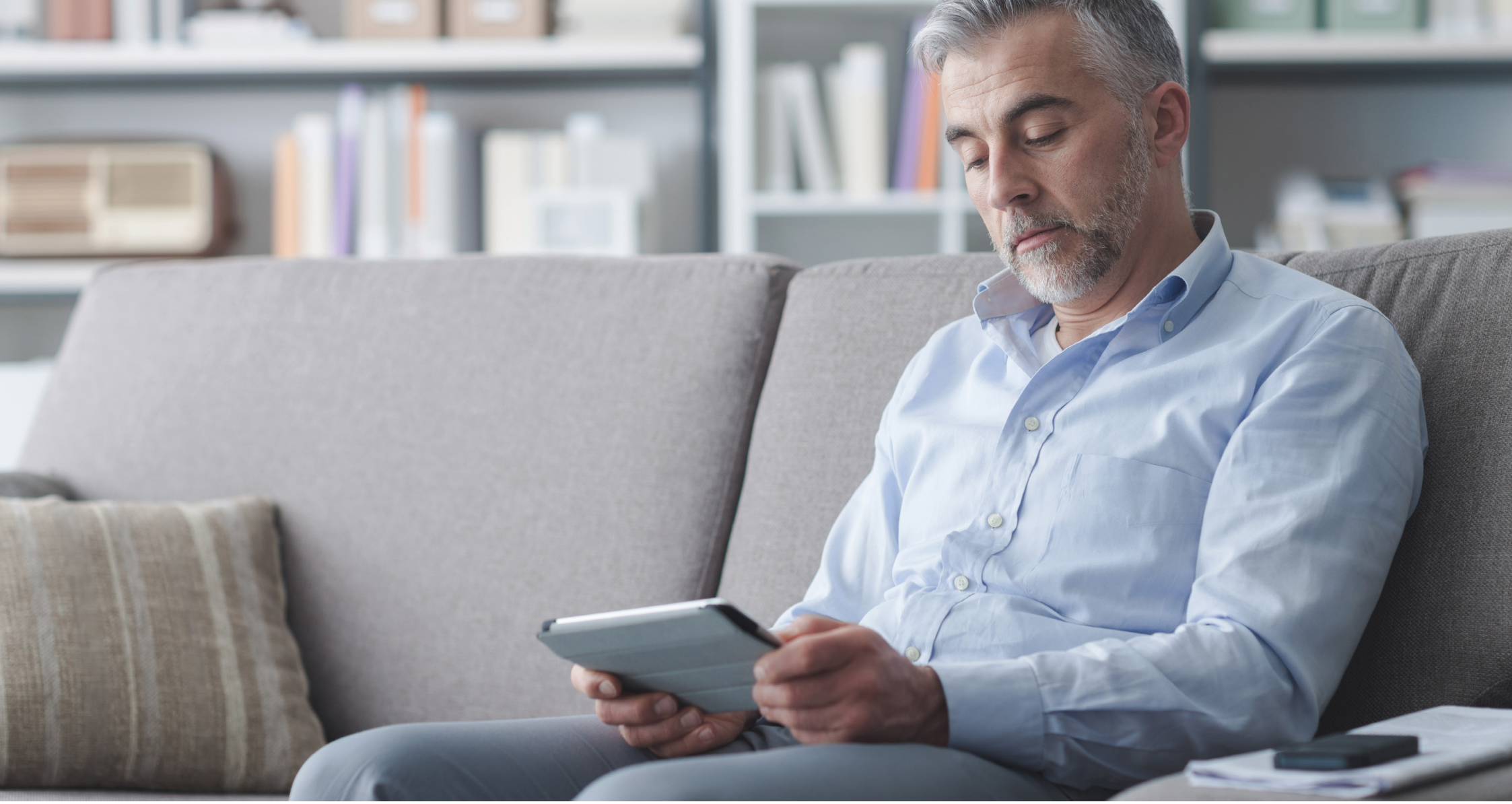
- We can reduce the benefit payments under the **policy** if the **partner** is receiving any other regular income because of their illness or injury.

  Please see question 5.4 for more details.

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

  Please see question 4.1 for more details.

- We can change the **policy** terms at the end of any **unit rate** guarantee period. If we do this, we'll write to you at least 30 days before we change the terms.
- The terms and conditions applying to an incapacitated **partner** will be those in force at the date they first became incapacitated.
- The **policy** will continue indefinitely as long as you meet its conditions, including paying premiums when we ask for them.
- We can change or cancel the **policy** if there are changes to legislation, regulation or **state benefits** which affect income protection policies. We'll give you more details of these in the **policy**.



Your questions answered

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

1.0 What should we consider when deciding what benefits to provide?

Different benefit categories

We suggest you keep the benefit as simpleas possible, ideally having the same basis forall **partners**.

You can group the **partners** into separate categories and can have different amounts of cover between categories. All **partners** in the same category must have the same benefit basis. As this is a group **policy**, it must cover all your eligible **partners**.

We can insure any number of categories, but it's important we know which **partners** are in which category. We must therefore agree the eligibility conditions for each category at the start of the **policy**. Examples of a category eligibility could be 'all equity partners' or 'all equity partners based in London'.

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

How much to insure

You can choose to take out an insurance **policy** to insure part or all the benefit you want to pay to the **partners**.

If you only insure part of the benefit you may have to pay the difference yourself.

For example, if you promise to pay a benefit of 50% of earnings but only insure 30% of earnings, you would have to pay the remaining 20% of earnings yourself.

Check our quote

Please check that our quote matches what you'd like us to insure.

If you'd like us to change the options we've used, please tell us so we can change the quote. We'll tell you how any changes will affect the **unit rate** and premium.

1.1 Who can the policy cover?

The **policy** can cover **partners** with an equity share in the firm and whose income from the firm is taxed as trading profits. We will only start cover for each **partner** when they meet:

- the eligibility conditions;

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

- our **actively at work** requirements;

  Please see question 2.5 for more details of actively at work.

- our medical evidence requirements; and

  Please see question 2.2 for more details of medical evidence.

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

  Please see question 2.4 for more details of switch terms.

A **partner** must be included for cover under the **policy** on the date they first meet the eligibility conditions.

Please see question 1.2 for more details of entry dates.

Please see question 2.6 for information on when we can cover **partners** before they are first eligible.

If you wish to include a **partner** at any other time we must be told in advance and all cover will be subject to our prior agreement and any terms we may apply.

You will also need to fix the date on which cover and benefit payment stops (we call this the **benefit termination date**). This can be the greater of the **partner** reaching age 65, or their **state pension age**.

We are also able to offer the option to continue to pay benefits until the **partner** reaches their **state pension age** even if this changes after they become incapacitated. This option is known as **dynamic state pension age**.

Alternatively you can choose an age up to 70. The **benefit termination date** must be the same for all **partners** in the same category.

We'll continue to provide cover if a **partner** is on maternity, paternity, adoption or shared parental leave as long as they remain a **partner** of the firm and you pay the premiums when they are due.

If you have any **partners** who you pay a salary and who don't have an equity share in the firm, we cannot cover them under this **policy**. However, we may be able to cover them under a separate **policy** for employees. Please ask us if you'd like to know more about this.

1.2 When can we include partners after the policy starts?

All **partners** must meet the **policy's** eligibility conditions. Once they do, we'll start covering them from the 'entry date'. Our quote and **policy** will show the entry date.

The entry date can be:

Yearly	Monthly	Daily
We only include new **partners** once a year at the **annual renewal date**, provided they've met the **policy** eligibility conditions.	Cover for new **partners** starts at a specified date each month, provided they've met the **policy** eligibility conditions.	We include new **partners** on the first day they meet the **policy** eligibility conditions.

If you have new **partners** who don't meet the eligibility we've agreed on, we may be able to cover them as early entrants.

Please see question 2.6 for more details of our requirements for partners who want cover before they are eligible.

1.3 When can partners increase their cover?

If we work out the benefit using earnings, as long as they are **actively at work**, we'll start covering increases for existing **partners** at each **annual renewal date**. This means, if you make a claim, we'll use the **partner's** earnings at the **policy** start date, or if later, the last **annual renewal date** to work out their benefit, even if their earnings have increased since.

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

1.4 When will cover end?

a) Under normal circumstances

We will stop covering a **partner**:

- when they are no longer a **partner** of the firm or no longer meet the eligibility conditions;
- on the **benefit termination date** we show in the **policy**. This can be the greater of the **partner** reaching age 65, their **state pension age** at the point they become a **disabled partner** or their **dynamic state pension age**.
- if they retire early; or
- if they die.

b) If you, or we, cancel the cover

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

- You can cancel the **policy** by giving us notice in writing.
- We'll give you 14 days' notice in writing if we have to cancel the **policy** because you haven't met its conditions.
- We can cancel the policy immediately if we identify a financial crime risk.

Please see page 26 for further details about our approach to **financial crime** risks.

We'll continue your cover as long as you meet the conditions we show in the **policy**.

1.5 What is the maximum benefit you will cover?

The benefit we pay for a **partner** is called 'member's benefit'.

Member's benefit can be either a fixed amount or a percentage of the **partner's** average yearly earnings over the last three years for which accounts have been produced. Whichever you choose, it must apply to all the **partners** covered by the **policy**, or all the **partners** in a particular category.

The maximum benefit we will cover is the lower of:

- 50% of their average yearly earnings over the last three years for which accounts have been produced; and
- £350,000 in total, per year.

1.6 How do you define incapacity?

We assess a claim to see if the **partner's** illness or injury means they meet the incapacity definition set out in the **policy**. This can be an 'own occupation' or 'suited occupation' incapacity definition. Our quote will confirm the agreed incapacity definition.

- Own occupation definition

  A **partner** is incapacitated if:

  – an illness or injury prevents them from performing the essential duties required of their occupation; and

  – they are not conducting any other role, than one which results in payment of a partial benefit.

  We describe partial benefit in question 5.6.

  This is the more expensive option.

  We'll pay benefit if medical evidence supports that they can't carry out the essential duties of their occupation because of illness or injury.

  When we assess a claim under this definition, we'll compare what a **partner** can and can't do (we call these their functional capabilities) against the essential duties of their occupation. In our assessment we'll also consider if a **partner** is able to carry out the essential duties of their occupation with a different organisation.

We won't pay benefit if there are other non-medical reasons preventing the **partner** returning to the essential duties of their occupation. For example a non-medical reason might be a lifestyle choice, or a breakdown in the relationship between the **partner** and their firm.

- Suited occupation definition

  A **partner** is incapacitated if:

  – an illness or injury prevents them from doing all jobs which are appropriate to their experience, training or education; and

  – they are not conducting any other role, other than one which results in payment of a partial benefit.

  We describe partial benefit in question 5.6.

Alternatively, we can quote a combination of these incapacity definitions. For example, an 'own occupation' definition applying for the first two years of benefit payment and a 'suited occupation' definition applying after that. We can also quote a different incapacity definition for different categories of **partners**, or negotiate an alternative definition with you.

1.7 When will you start benefit payments?

We will start paying benefit from the end of the **deferred period** if, after assessing all the medical evidence, the **partner** meets the **policy** definition of incapacity. As long as the **partner** still meets the **policy** definition of incapacity, we'll continue to pay the benefit at the end of each month it's due.

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

If a **partner** goes back to work during the **deferred period**, but becomes unable to work again because of their injury or illness, we'll link the whole of each previous period of absence together as long as:

- each absence is for at least five consecutive working days;
- each absence is because of the same or a related injury or illness; and
- the last day of any previous period of absence is within 52 weeks of the first day of the latest period of absence.

We'll stop linking absences for the **deferred period** if the **policy** ends.

The longer the **deferred period**, the lower the cost of the insurance. This is because it's more likely that **partners** will go back to work before the end of the **deferred period** so we're less likely to pay benefit.

1.8 How long can you pay benefit for?

We will stop paying benefit at the earliest of:

- The **partner** stops meeting the incapacity definition in the **policy**. We'll regularly review the **partner's** illness or injury so we can assess this.
- The **partner** reaches their **benefit termination date**. This cannot be later than their 70th birthday.
- The date the **partner** dies.

We'll tell you the agreed **benefit termination date** in the quote.

There are more details of when we will stop paying benefit in question 5.5.

1.9 Can we protect benefit payments from inflation?

You can choose to help towards protecting against the value of the benefit payments reducing over time because of inflation. We call this the benefit increase rate.

We can increase the benefit we pay each year by a fixed rate of your choice. The maximum is 5%. Alternatively, we can increase the benefit at the rate of inflation, as measured by the Retail Prices Index (RPI), by up to 5%. If RPI is less than 0%, we won't reduce the benefit we pay.

Unless we agree otherwise, we'll increase the benefit on the anniversary of the date we made the first monthly payment. Other options we can consider are increasing the benefit on the anniversary of the **partner's** first absence and increasing the benefit at an agreed date each year.

We'll tell you in our quote if we've allowed for benefit increases and if so, at what date and amount.

2.0 How do we set up a policy and when do we need to give you medical evidence?

2.1 What do you need to set up the policy?

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

You'll also need to:

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

  Please see questions 4.0 and 4.1 for more details.

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

  Please see question 2.2 for more details about medical evidence.

- Check if all the **partners** are **actively at work**.

  We give more information about actively at work in question 2.5.

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

2.2 What medical evidence will you need before you'll cover the partners?

a) Cover up the free limit

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

b) Cover above the free limit

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

To help **partners** fill in the member's declaration form, we offer a tele-interview service allowing them to fill in the form over the phone.

If they prefer to fill in the form themselves, you can find the member's declaration form in the literature section on our website

legalandgeneral.com/adviser/workplacebenefits/group-protection/literature-and-forms/. Alternatively, you can ask us for a copy.

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

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

We'll write to you to explain any **special terms**. If this includes an **extra premium loading** and you decide you don't want to pay this, you can cancel the cover the **extra premium loading** is for by telling us in writing within 30 days.

Unless we tell you otherwise, the **special terms** will not affect the cover below the **free limit** or any cover we've previously accepted.

2.3 If you have medically underwritten a partner, when will they next need to give you medical evidence?

We have two types of medical underwriting, forward underwriting and ONEderwriting. The one we will use depends on the number of **partners** we cover under the **policy**. We'll give full details of our requirements for medical evidence in the **policy**. A summary of when we next need medical evidence is below:

Less than 20 partners

Forward underwriting

This means, once we **medically underwrite** a **partner** they won't normally need to give us more medical evidence for increases in benefit for another five years.

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

If we **medically underwrite** a **partner**, and agree cover on any of the following terms:

- ordinary rates;
- an **extra premium loading** of 150% or less that you are paying;

- an exclusion for hazardous pursuits;
- an exclusion for a medical condition;

they won't normally need to give us more medical evidence for an increase until the earliest of:

- it's been five years since we last **medically underwrote** them;
- the **partner's** benefit increases by more than 15% above their benefit 12 months earlier in those five years; and
- if our terms for a change to the **policy** ask for medical evidence, the date you ask us to make the change from.

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

20 Partners or more

Onederwriting

ONEderwriting is our way of keeping our **medical underwriting** as simple as possible. It means we'll **medically underwrite** a **partner** once and usually, we won't need any more medical evidence for increases in their benefit.

Unless we tell you otherwise, our standard approach for ONEderwriting will be:

We will not need more medical evidence if we've previously accepted cover for a **partner**:

- at ordinary rates;
- with an **extra premium loading** that you are paying; or
- with an exclusion.

As long as their benefit is below our maximum benefit (see question 1.5), we'll provide cover on the same terms and will not need more medical evidence for:

- normal increases in their earnings; and
- if we agree to change the insured basis at a future date for all **partners**.

If you're paying an **extra premium loading**, you must tell us before the date of the increase and the amount of all increases. This is because we'll need to add the **extra premium loading** to each increase. If you change your mind and you don't want us to cover the increase, you can tell us within 30 days after the date of the increase. If you decide not to increase cover at this time, we will stop using ONEderwriting for that **partner**.

We will need medical evidence for the next increase in cover when previous medically underwritten cover applied for was subject to any of the following:

- restriction;
- declinature;
- postponement;
- not proceeded with;
- subject to other terms;
- restriction or declinature because the **partner** didn't provide medical evidence; or
- you choosing not to pay an **extra premium loading**.

2.4 What are your terms if we're switching the insurance to you from another insurer?

We'll normally accept a high level of cover without needing medical evidence, as long as **partners** meet our switch terms and our **actively at work** requirements. This is even if the previous insurer added a premium loading.

We give more information about actively at work in question 2.5.

Terms for partners who are eligible for cover for the first time at the switch date

We'll need medical evidence for the portion of their benefit which is above our **free limit**.

Switch terms for existing partners previously insured

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

(a) We'll normally accept existing cover for **partners** whose cover with the previous insurer was:

- for their full **benefit entitlement**;
- not subject to any **special terms**;
- never subject to medical evidence;

as long as they meet our **actively at work** requirements.

We give more information about our actively at work requirements in question 2.5.

We'll need medical evidence when a **partner's** cover first exceeds our **free limit**.

(b) For other existing **partners** we'll normally accept their existing cover without medical evidence if:

- their benefit is not more than £200,000 in total, per year and any premium loading is not more than 300%; or
- their benefit is above £200,000 in total, per year (but not above our maximum benefit limit) and any premium loading is not more than 150%;

as long as:

- their cover with the previous insurer was for their full **benefit entitlement**; and
- they meet our **actively at work** requirements.

We'll need you to give us a copy of the previous insurer's latest letter of acceptance or a completed Declaration – switch terms form. You'll need to give this to us when the **policy** starts or we won't be able to pay a claim for these **partners**.

For the **partners** who meet our switch terms without needing to send us medical evidence, we may need medical evidence for future increases in cover. We've described when we need medical evidence for their increases below:

(i) If the previous insurer accepted cover under a ONEderwriting (see ONEderwriting in question 2.3) type approach, in most cases we won't need any more medical evidence for:

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

Benefit cannot be increased during the **deferred period** and cannot be more than our maximum benefit.

We give more information about deferred periods in question 1.7 and our maximum benefit in question 1.5.

(ii) If the previous insurer accepted cover on a forward underwriting basis with a premium loading of not more than 150%, we will next need medical evidence at the earliest of:

- Five years from the date they were last underwritten by a previous insurer. This could be the switch date if cover is increased at that date and they were **medically underwritten** more than five years ago.
- When the **benefit entitlement** of a **partner** increases by more than 15% within any 12 month period starting on or after the **policy's** start date.
- If cover is below our **free limit**, the first time it goes over.

Benefit cannot be increased during the **deferred period** and cannot be more than our maximum benefit.

We give more information about deferred periods in question 1.7 and our maximum benefit in question 1.5.

(iii) For all other **partners**:

- If their existing cover with the previous insurer is more than our **free limit**, we'll need medical evidence on the next increase in cover. This could be at the switch date if cover is increased at that date.
- If their existing cover with the previous insurer is less than our **free limit**, we'll need medical evidence when their benefit first goes above our **free limit**.

Terms for any partners who do not meet our switch terms

We're happy to consider and negotiate terms to insure any **partners** who don't meet the conditions under (a) and (b) of the switch terms even if they had some benefit declined by the previous insurer. If you give us their full details, we'll consider if we can cover them. We can then set terms which you'll need to accept in writing before we will start their cover. To avoid a break in cover, you'll need to give us these details before the switch date.

2.5 What are your actively at work requirements?

We'll need **partners** to be **actively at work** before we can start their cover. We'll also need them to be **actively at work** before we start covering any increases.

Actively at work	
What does this mean?	This means the **partner** must be in full active employment, physically and mentally able to perform all the duties associated with their normal occupation as a **partner** on the day the cover is going to start.
How it works	**New policies** We'll need **partners** to be **actively at work** on the date we start or increase cover. **If you're switching the insurance of an existing policy to us** • Partners covered under the previous policy For benefits up to the previously insured level we'll need **partners** to be **actively at work** on the day before we start cover. We'll need **partners** to be **actively at work** before we'll cover any benefit increases for them. • Partners joining at the policy start date We'll need all new **partners** you include to be **actively at work** on the day we start cover. Please also see question 2.4 for our other terms for switching insurance. **After the policy start date** We will need **partners** to be **actively at work** if they are included for cover after the **policy** start date, and for all benefit increases. **Cover for partners who are not actively at work** If a **partner** is not **actively at work**, we will not cover them, or increase their cover, until they are next **actively at work**.

2.6 What medical evidence do you need for partners who want cover before they are first eligible?

We still can consider cover for a **partner** who doesn't meet all the eligibility conditions and isn't an early entrant. You'll need to tell us about that **partner** before we can consider our terms for cover.

Early entrants	
What does this mean?	An early entrant is a **partner** you want us to cover before they complete the qualifying service or reach the first entry date. See question 1.2 for more detail about entry dates.
When can an early entrant's cover start?	If you want to include a **partner** as an early entrant within the three months after they join the firm, we'll agree cover for them up to the **free limit** as long as they are **actively at work**.
What if an early entrant doesn't meet the above requirements for cover?	We'll need the **partner** to fill in and send us a 'discretionary entrants' application for cover form'. This will allow us to assess if we can provide cover, if we need medical evidence, and if we need to give them **special terms** or ask for extra premiums. We'll need medical evidence before we can consider cover over the **free limit**. See question 2.2 for more details. We'll give temporary or accident cover for up to 90 days while we assess medical evidence. See question 2.7 for more details. You can find the Discretionary Entrants Application for Cover Form in the literature section on our website **legalandgeneral.com/adviser/workplacebenefits/group-protection/literature-and-forms/**. Alternatively, you can ask us for a copy.

2.7 What happens if we need to make a claim before you've finished your medical assessment?

We'll give **partners** temporary cover, starting from the date we know they need to provide their medical evidence. However, there are some limits for temporary cover:

- We will not pay benefit for a **partner** whose injury or illness is caused by any medical condition that they were diagnosed with or were displaying symptoms of within the previous five years.
- Our temporary cover will end at the earliest of the date we finish our assessment or the end of the 90 days from when we know that the **partner** will need to provide medical evidence.
- We'll restrict temporary cover so the **partner's** benefit is not more than the maximum benefit. See question 1.5 for our maximum benefit.
- We won't give temporary cover to any **partner** whose cover has been refused, is restricted or already has **special terms** attached.
- We won't give temporary cover to any **partner** who has refused to give medical evidence, either now or in the past.

When we can't provide temporary cover, we'll provide 'accident cover'. This will end at the earliest of the date we finish our assessment or at the end of the 90 days from when we know that the **partner** will need to provide medical evidence. We won't pay claims for accidental disability caused by:

- alcohol abuse;
- the influence of drugs;
- medical treatment (except for treatment they need because of the accident);
- surgical treatment (except for treatment they need because of the accident);
- attempted suicide;
- criminal acts; and
- intentional self-injury.

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

3.0 What premiums will you charge for the cover?

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

- amount of cover;
- age and gender of the **partners**;
- type of work;
- work locations;
- rate benefit increases to help reduce the effect of inflation; and
- claims history, if the **policy** was previously insured or 'self-insured'.

Please read question 3.4 for more details about claims history.

We don't charge a minimum premium.

3.1 How will you work out the premiums?

We'll work out the cost for each £100 of **total benefit** or **total scheme earnings**. We call this cost the **unit rate**. We'll multiply the **unit rate** with the **total benefit** for the **policy** or **total scheme earnings**, at the start of each **policy year** to work out a year's premium. At the end of a **policy year** we'll adjust this premium to allow for membership changes. We'll also use the **unit rate** to work out these adjustments.

Please read question 4.2 for more details.

3.2 Will there be any unexpected extra premiums?

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

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

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

Please read question 4.0 for more details.

3.3 How much commission will you pay our adviser?

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

3.4 Is there a discount for good claims history?

Yes, we consider the past claims history of our **policy**, and any previous policies, when working out the **unit rate**. A good claims history is where there are fewer claims, this usually means the premiums will be lower than for a bad claims history.

4.0 How does the accounting work?

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

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

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

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

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

You'll also need to send us an up-to-date membership list if the **policy** is cancelled so we can work out the final account. If you don't give us this within 30 days of the policy cancelling we'll work out the final account based on the latest membership list you gave us. We'll not update the final account after it's sent to you.

4.1 What information do you need for accounting?

At the start of the **policy**, and at each **annual renewal date**, you will need to give us a membership list showing each current **partner's**:

- name;
- gender;
- date of birth;
- **scheme earnings** (if applicable); and
- eligibility category (if there's more than one).

To simplify and keep the accounting for the **policy** straightforward, where we calculate the premium by applying the **unit rate**, the **total scheme earnings** should include the **scheme earnings** for every eligible **partner** at the **annual renewal date**.

For accounting purposes, the **unit rate** will take into account the following factors: -

- The **policy** maximum benefit levels, and
- Any **partners** who may be close to the **benefit termination date** which could mean that no benefit will be paid as they would not fulfill the **deferred period**.

When supplying the **total scheme earnings**, there will be no need to apply a restriction to a **partner's scheme earnings** where an equivalent amount in benefit exceeds the policy's level of maximum benefit. You will also not need to provide the **scheme earnings** for the partners who wouldn't fulfill the **deferred period** if they couldn't work because of long-term illness or injury, despite meeting the **policy** definition of incapacity.

You should include the **scheme earnings** for any **partners** who may reach the **benefit termination date** within their relevant **deferred period**.

When a **partner** has been restricted to a level of benefit after undergoing medical underwriting, the amount of **scheme earnings** used for accounting purposes will be amended to reflect the underwriting decision made.

It's important we get this information quickly so we can work out the accurate premium and give you accurate accounts. If the information is not received within three months of an **annual renewal date** we can cancel the **policy** or change the terms and conditions of the **policy**.

It's also important that we know exactly who's covered under the **policy**. If you don't include a **partner** who you should have included on the membership list at the start of the **policy** or at the **annual renewal date**, we won't pay a claim for them.

4.2 How do you adjust premiums for partners who join or leave during the policy year?

We'll need to know when **partners** leave during the **policy** year.

If we start covering new **partners** daily or monthly you will also need to tell us when **partners** join during the **policy** year.

We give more information about daily and monthly entrants in question 1.2.

For new **partners**, we will charge a premium for the part of the **policy** year left to the next **annual renewal date**. We call this a proportionate premium.

For **partners** leaving, we will refund a proportion of the premium to the next date that premiums are due.

4.3 If you or we cancel the policy mid year, will we lose any premiums we have paid in advance?

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

5.0 How do we make a claim?

5.1 When can we make a claim?

Under what circumstances?

We will pay a claim if, at the end of the **deferred period**, the **partner** meets the incapacity definition in our **policy**.

How incapacitated must the partner be?

The **policy** will tell you which incapacity definition we will use.

We give more information about our definitions of incapacity in question 1.6.

How will you assess a claim?

We will need suitable evidence of the **partner's** incapacity to assess if they meet the incapacity definition in the **policy**. We do this in two main stages:

(a). You'll need to fill in and send us an Absence Notification Form within the following time limits:

Cause of absence	Notification requirement
Mental health condition, musculo-skeletal condition or cancer	We need to be informed of all **partners** we're covering, who are continuously absent for four weeks or more, by the sixth week of absence.
All other absences	We need to be informed of all **partners** we're covering, who are continuously absent for eight weeks or more, by the tenth week of absence.

The Absence Notification Form gives us information about the **partner**. It includes details of their earnings, the job they were doing and whether they could continue to do any part of that job.

(b). Medical assessment

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

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

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

It's important we have all the medical details to allow us to assess the claim. If we're not given all the relevant medical details we may not be able to pay the claim. For example if the **partner** refuses to go for an assessment, or if we're not given consent to access these details.

Can rehabilitation help?

From the early stages of their incapacity, where appropriate, we'll work with you to help the **partner** cope with their changing lifestyle and encourage them to return to work as soon as possible. With our help, the **partner** may be able to cope with, or overcome, their incapacity.

For example, we may be able to:

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

5.2 When do you need to know about a partner who we may make a claim for?

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

If you think the **partner** may be off work for longer than the **deferred period**, we would like to know within the time limits shown in the table in question 5.1 under **How will you assess a claim?**

If you tell us of their absence after the end of the **deferred period**, we will not backdate benefit payments to the end of the **deferred period**. If you don't tell us within 90 days after the end of the **deferred period**, we have the right not to pay the claim.

5.3 Who pays for medical evidence?

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

5.4 Does other income the partner receives affect the amount you pay out under this policy?

The **policy** aims to give the **partner** a lower income than they received whilst working. This is to provide an incentive for them to return to work. We'll therefore reduce the benefit we pay so, when it's added to any other regular income, the total is not more than 50% of the **partner's** average earnings over the three years before the start of the **deferred period** for which accounts have been produced.

Other regular income includes payments from any other insurance policies. For example, loan protection policies. It doesn't include pension income or income the **partner** was already receiving before the start of their incapacity, for example dividends from shares, or any **state benefits** the **partner** is receiving.

5.5 How long will you pay benefit for?

We will pay benefit until the earliest of:

- the termination date set out in the **policy**;
- the date the **partner** no longer meets the **policy** definition of incapacity, even if they don't have a job to go back to; or
- the date the **partner** dies.

5.6 What happens if a partner's illness or injury means that they can work part-time or in a reduced capacity?

We will pay a partial benefit. This will allow for the reduction in the number of hours the **partner** works and their reduction in earnings. We'll also adjust the benefit for inflation. We don't need to pay a full claim before we'll consider a claim for partial benefit.

We'll adjust the partial benefit if the **partner's** earnings change. For example, if the number of hours they work increases. If the change results in no benefit being paid, the claim will end. However, we will consider reinstating the claim without the **partner** having to complete a new **deferred period** if, within the next 52 weeks, they suffer a relapse (see question 5.7). If a relapse occurs after 52 weeks we'll treat it as a new claim.

5.7 After a partner returns to work, can we make another claim for that partner?

Yes.

If their incapacity is from a different cause we'll treat them as a new claim. This means they'll have to meet the **policy** definition of incapacity and complete a new **deferred period** before we can pay benefit.

If their incapacity is from the same or a related cause and the **partner** is off work again within 52 weeks of the date they returned to work, we will treat them as a 'linked claim' You'll need to tell us their absence restarted within four weeks. We'll start paying benefit again as soon as we receive suitable confirmation that the absence is due to the same or a related cause and they meet the **policy** definition of incapacity. The amount we pay will be at the level we would have paid if the **partner** had not returned to work. We'll stop paying benefit at the normal end dates shown in question 5.5.

5.8 What happens to claims if you or we cancel the policy?

As long as premium payments are up-to-date when the **policy** is cancelled, we'll continue to pay benefit for any valid claims we were paying at the cancellation date. We'll stop paying benefit at the normal end dates shown in question 5.5.

We'll also pay any valid claims for **partners** whose absence started before cover ended and who are still in the **deferred period**. We will stop paying benefit at the normal end dates shown in question 5.5.

If you cancel the **policy** because you're switching the insurance to another insurer, we will treat linked claims (as described in question 5.7) as follows:

- If, on returning to work, the **partner** meets the new insurer's actively at work requirement, then the new policy will cover them. However, we will pay benefit for a linked claim, but only until the end of the **deferred period** under the new insurer's policy. From then on, the new insurer will be responsible for the claim under the terms of its own policy.
- If, on returning to work, the **partner** doesn't meet the new insurer's actively at work requirement, and so doesn't get cover under the new policy, we will continue to assess and pay the claim. We'll stop paying benefit at the normal end dates shown in question 5.5.

This means the **partner** will not lose the benefit of a linked claim because you're switching the insurance to another insurer.

6.0 What don't you cover?

We won't pay a claim if the **partner** doesn't meet the **policy** definition of incapacity or if the **partner** is not eligible for cover.

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

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

7.0 Can you cover a partner who is not based in the UK?

We will need full details of any overseas **partners** at the start of cover and at each **annual renewal date** as we need to assess if we can cover them and if we need to change our standard terms. We will not provide any cover for overseas **partners** until we've assessed their details and told you of any **special terms**.

We'll usually cover **partners** who work abroad as long as:

- they meet the eligibility conditions; and
- they are a **partner** in a UK firm covered under the policy; and
- most of the **partners** covered by the **policy** work in the UK.

All premiums must be paid in sterling by the UK employer.

We'll need satisfactory medical evidence in English to allow us to assess a claim. We will try to ask for as little information as possible, but the **partner** may need to have an independent medical examination or assessment. If this happens we will usually pay an amount towards the cost of the examination or assessment that is equivalent to the cost of a similar examination in the UK.

Benefits will be paid in sterling to a UK bank account. If the **partner** doesn't have a UK bank account, we will pay you the benefit to pass onto them.

8.0 What tax rules apply?

Our understanding of the current tax rules for this **policy**, which could change in the future, are:

- There is no tax relief on your premiums.
- The benefit we pay is not assessed as trading profits for income tax purposes.

You may want to get your own tax advice about the **policy**.

9.0 Can partners continue their cover if they leave the partnership?

No, **partners** cannot continue cover at their own expense if they leave the partnership.

Further information

Providing insurance

This Partners' Group Income Protection **policy** is provided by Legal & General Assurance Society Limited. Our principal office for the purpose of the **policy** is at:

Knox Court
10 Fitzalan Place
Cardiff
CF24 0TL

0345 026 0094
We may record and monitor calls. Call charges will vary.

Privacy policy

We're the sole data controller for the information we hold with respect to the **policy**, and solely responsible for its security.

To arrange and manage the **policy**, you'll need to send us personal information about your employees who are, or become, eligible for cover. This may include medical and health information. You need to satisfy yourself of a legal basis that allows you to send us these details, or consider seeking appropriate consent (explicit consent in the case of medical or health information).

Please share our full Privacy Policy with your employees so they understand what we do with the information we collect. Our full Privacy Policy is available at:
legalandgeneral.com/privacy-policy

Questions and complaints

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

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

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

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

Compensation

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

Law

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

Language

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

Insurance Act 2015

In the event that you breach your 'duty of fair presentation', we may at our discretion, agree to pay a claim in full if you agree to pay an additional premium. This is conditional on the breach not being 'deliberate' or 'reckless', and occurring in a situation where we can show that we would have charged a higher or additional premium had full disclosure occurred.

Industry regulation

We're authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority. Our Financial Services Register number is 117659. You can check this on the Financial Services Register by visiting the FCA's website:

fca.org.uk/register

or by contacting the FCA on:

0800 111 6768.

Further information (continue)

Financial Crime Risk Management

We are committed to protecting our customers and us from **financial crime** whilst meeting all our legal and regulatory obligations to complete checks on policyholders, equity parterns, LLP members, employees or potential beneficiaries, company directors and all beneficial owners.

If in our opinion, it becomes appropriate or necessary, in order to manage our exposure to the risk of **financial crime**, we might take one or more of the following steps:

- withdraw or make changes to a quote for cover;
- cancel a **policy** by giving written notice;
- where we consider it to be reasonable in light of the level of risk of **financial crime**, immediate cancellation of cover or any benefit payable under the **policy**; and/or
- take any other reasonable action that we deem necessary in all the circumstances.

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

Glossary

Our terms explained

Actively at work This means the **partner** must be in full active employment, physically and mentally able to perform all the duties associated with their normal occupation as a **partner** on the day the cover is due to start. We'll also need them to be **actively at work** before we start covering any increases to their cover.

Annual renewal date The anniversary of the start date of the **policy** or another yearly date that we've agreed with you.

Benefit entitlement This is the amount of benefit a **partner** is covered for under the **policy**. Sometimes this can be restricted. For example, if a portion of benefit is declined after **medical underwriting**. Their full benefit entitlement would therefore be the amount of benefit before any portions are restricted or declined.

Benefit termination date The last date to which we'll pay benefit for a **partner**.

Deferred period The period of time before we start paying benefit. It starts on the date the **partner** is:

- unable to work;
- only able to work reduced hours; or
- only able to work in reduced capacity;

because of their injury or illness.

Disabled partner Means an insured **partner** who at any time,

i. meets the policy definition of incapacity, and,

ii. is not engaged in any other occupation, other than one which causes payment of a partial benefit.

Dynamic state pension age If legislation extends the **state pension age** of a **disabled partner,** then we will change the **benefit termination date** of such **disabled partner** to the earlier of their:

new **state pension age,** end of a **limited term** or, 70th birthday.

If legislation removes the **state pension age** as a method of calculating when UK state pensions start for a **disabled partner**, we will fix the **benefit termination date** for them at the age that applied before it was removed.

The above terms will apply regardless of whether the disabled **partner** is entitled to a UK state pension.

Extra premium loading If **medical underwriting** shows a partner doesn't meet our standard criteria we may increase the premium for them. We call this increase an extra premium loading.

Financial Crime The contravention of or the risk of any other sanction, restriction, or adverse measure pursuant to any sanctions program;

- Money laundering and terrorist financing;
- Fraud (internal and external);
- Bribery and corruption;
- Facilitation of tax evasion; and Insider dealing and market abuse.

A sanctions program is any national or international sanctions laws and regulations enacted by the United Kingdom, United States of America, the European Union or the United Nations, and such other sanctions laws and regulations enacted by any other country or body that we consider, from time to time and at our absolute discretion, would exposes us to any risk beyond a level that we consider to be reasonable.

Glossary (continue)

Free limit The maximum amount of cover we will provide to an insured **partner** without the need for medical evidence or details of their hobbies. We'll tell you the free limit in our quote as a level of benefit or **scheme earnings**.

Limited term An option you can ask for under our **policy** that provides a maximum limit on the length of time we'll pay benefit for. We'll start the limited term on the day after the end of the **deferred period**.

Medical underwriting The process we use to assess the health and pastimes of a **partner**. At the end of the process we may apply **special terms**.

Partner An equity partner of a firm, or a member of a Limited Liability Partnership, who has an equity share in the firm and whose income from the firm is taxed as trading profit.

Policy The legal contract between you and us. You choose how much of the benefits you've promised to the **partners** that you want to insure under the policy.

Policy year The 12-month period starting from the **annual renewal date** and ending the day before the next **annual renewal date**.

Scheme earnings The earnings we use to work out a **partner's** benefit.

Special terms Terms for cover that we cannot accept at ordinary rates. This will include **extra premium loadings**, exclusions, restrictions, postponements or where cover has been declined.

State benefits These are benefits that form part of the Employment and Support Allowance payable by the Department for Work and Pensions.

State pension age The age at which an eligible **partner** could begin to receive their state pension from the Government, or would otherwise receive it if they were entitled.

Total benefit The total benefit for all **partners**.

Total scheme earnings The total **scheme earnings** for all insured **partners**.

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

Contact details

Group protection principal office Questions and complaints	Financial Ombudsman service	Financial Services Compensation Scheme
Managing Director, Group Protection Legal & General Assurance Society Limited Knox Court 10 Fitzalan Place Cardiff CF24 0TL	If we can't resolve a complaint, you may be able to refer it to: Financial Ombudsman Service Exchange Tower London E14 9SR	PO Box 300, Mitcheldean, GL17 1DY
0345 026 0094 We may record and monitor calls. Call charges will vary. Lines are open from 9am to 5pm Monday to Friday.	**0800 023 4567** or **0300 1239 123** (free for mobile phone user paying a monthly charge for calling phone numbers beginning with 01 or 02).	**020 7741 4100** or **0800 678 1100**
group.protection@landg.com **legalandgeneral.com/adviser/workplace-benefits/group-protection/**	**complaint.info@financial-ombudsman.org.uk** **financial-ombudsman.org.uk**	**enquiries@fscs.org.uk** **fscs.org.uk**

BH1404 W8853 09/23

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