



Part A is to be completed by the employer.

Part B is to be completed by the member with help from the employer. The member will need to sign Part B in two places. If the member's incapacity stops them from signing, the person who helped them complete Part B should sign on their behalf.

If available, please put copies of medical reports in a sealed envelope with this form and send them to Group Protection Benefits Team, Legal & General Assurance Society Limited, Four Central Square, Cardiff, CF10 1FS

Part A

Scheme name

Employer name

Policy number

Employer contact name

Employer contact address

Postcode

Telephone number

Email address

1 About the member

Title: Mr/Mrs/Miss/Ms/Other

Surname

Forename

Address

Postcode

Telephone – mobile or landline

Email address

National Insurance number

Date of birth

2 About the job

2.1 What date did your employee:

Job title

Start employment?

Become a member of the pension scheme?

First become incapacitated?

Last work?

2.2 Did your employee join the pension scheme at the first opportunity?

What date has ill health early retirement been awarded from?

What is the proposed early retirement date?

(DD/MM/YYYY)

(DD/MM/YYYY)

(DD/MM/YYYY)

(DD/MM/YYYY)

Yes

No

(DD/MM/YYYY)

(DD/MM/YYYY)

3 Occupational health details

If yes, please provide us with the:

Have you requested occupational health (OH) advice relating to this ill health early retirement?

Name of the occupational health adviser (OHA)

Contact name at the OHA

Telephone number

Email address

Copies of their full OH record. (Please tick to confirm if OH information has been attached.)

Yes

No

Yes

No

If occupational health advice has not been sought please confirm what medical evidence has been requested to assist in making the decision to grant ill health early retirement.

4 Financial details

Please state the amount claimed or strain cost calculation (Claim Amount) that you are requesting.

What was the member's basic annual salary at the date of leaving service?

What was the member's contractual weekly working hours at the date of leaving service?

Had the number of hours been contractually reduced in the last 12 months?

If so, please confirm the previous contractual weekly working hours.

Yes

No

5 Policyholder's bank details for claim payment

Account number

Sort code

Bank or building society

Address

Postcode

[illegible]

6 Employer's declaration

We declare that the above statements are accurate and complete and that the above member is eligible, in accordance with the terms and conditions of the policy issued by Legal & General Assurance Society Limited (L&G).

We confirm we have the member's explicit consent, or have other legal basis, to provide L&G the information contained in this form and any further information (including medical or health information) that is required.

Signed

Name

Job title

Date

____ (DD/MM/YYYY)

(DD/MM/YYYY)

Part B

1 About you



To be completed by the member. Please check the information in Part A:1 is correct.

2 About your condition

2.1 Please tell us about the condition that prevents you from working

Please describe the symptoms of this condition

2.2 When were these symptoms first experienced?

Please tell us the name and address of your GP

Name

Address

Postcode

(DD/MM/YYYY)

- Please tell us the name and address of the consultants seen about this condition along with the date of your last visit

Name

Address

Postcode

Date

Name

Address

Postcode
- 2.3 What part of your occupation can't you do?

2.4 How are you restricted by these symptoms and how long do they last?

2.5 Have you received any treatment for your incapacity?

2.6 What medication are you currently taking? Please state the dosage and if you suffer from any side effects

2.7 Please indicate the number of hours each day you're able to do the following activities

2.8 What weight can you lift or pull?

2.9 By using the scale of functional ability, please tell us how you can perform these tasks

Scale of functional ability

- 5 = No reduction
- 4 = Slightly reduced
- 3 = Moderately reduced function
- 2 = Very reduced function
- 1 = No function at all

(DD/MM/YYYY)

(DD/MM/YYYY)

Walking

hrs

Sitting

hrs

Standing

hrs

Climbing (stairs/ladders)

hrs

Bending and lifting

hrs

Driving

hrs

kg

Right shoulder

Kneeling

Climbing stairs

Reaching above shoulders

Right arm

Vision

Climbing ladders

Exposure to cold

Right hand

Standing

Lifting/ carrying

Working with heights

Left shoulder

Hearing

Bending

Sitting for a long time

Left arm

Walking

Driving

Outdoor work in all weather conditions

Left hand

Speech

Mental function

Exposure to heat



It is important that you read and accept all of the following paragraphs. If you are unsure of anything or have any queries please contact us. Our details are at the end of this form.

Access to medical reports

Notice of your Statutory Rights under the Access to Medical Reports Act 1988, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, and the Isle of Man Access to Health Records and Reports Act 1993.

L&G may need to get medical reports to support your absence from work. Before they can ask any doctor that you have consulted to provide a report they need your permission under the above Acts.

This permission is requested below. Your legal rights are as follows:

- You do not need to give your permission, but if you do not L&G may not be able to assess your incapacity and this may affect entitlement to benefit. This does not prevent you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it, in which case please tick the box under Medical Consent. If you do this the doctor can see that you require access and can keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time the doctor will send the report to L&G.
- If you choose not to see the report at this stage you may ask the doctor for a copy within six months of it being sent. L&G can send a copy of the report to the doctor if you ask to see it at a later date.
- If you think that any part of the report is not correct or is misleading you may ask the doctor to amend it. If the doctor refuses to make the amendments you may ask him or her to attach a statement outlining your views, which will then accompany the report.
- The doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor provides tells us about your current health, any care, medication or treatment you are currently receiving. It also tells us the results of any referrals or tests.

If you have any questions about your rights under the Act or questions relating to the process of getting, assessing or storing medical information, please write to:

Benefits and Governance Director, Group Protection, Legal & General Assurance Society Limited, Four Central Square, Cardiff, CF10 1FS

Medical Consent

If L&G decide they need to obtain a report from my doctor, I agree to them asking any doctor I have consulted about my physical or mental health to provide medical information so that they may assess entitlement to benefit.

If L&G need to obtain a report from my doctor:

- **I do not want** to see the report before it is sent to L&G ☐
- **I do want** to see the report before it is sent to L&G ☐

I consent to:

- L&G gathering information from other insurance companies about other applications for life, critical illness, sickness, disability, accident or private medical insurance that I or my employer have made.
- L&G obtaining medical information about me from my employer, any professional medical adviser appointed by my employer or any agent my employer may have used to medically assess me at any time.

I authorise those asked to provide medical information to do so when they see a copy of this consent form.

I confirm that I have read and accepted this Consent. I also confirm I have read my rights under the Access to Medical Reports Act.

By signing this Consent I agree to all of the contents.

Signature

X

Date

(DD/MM/YYYY)

If your incapacity means you can't sign this Consent yourself, the person who helped you to complete this form should sign it on your behalf in the space provided below.

Signed on behalf of the member

X

Date

(DD/MM/YYYY)

Name of signatory

Relationship to member

Reason for signing on behalf of the member

4 Fraud prevention

The personal information L&G collects from you and/or your employer will be shared with fraud prevention agencies who will use it to prevent fraud and money laundering and to verify your identity.

If false or inaccurate information is provided and fraud is identified, details will be passed to fraud prevention agencies. Law enforcement agencies may access and use this information. We may also share information about you with other organisations and public bodies, including the police and we may check and/or file your details with fraud prevention agencies and databases.

If fraud is detected, you could be refused certain services, finance or employment. Further details of how your information will be used by us and these fraud prevention agencies can be found by accessing this link, www.cifas.org.uk/fpn

L&G and other organisations may also access and use this information to prevent fraud and money laundering, for example, when:

- Checking details on applications for credit and credit related or other facilities.
- Managing credit and credit related accounts or facilities.
- Recovering debt.
- Checking details on proposals and claims for all types of insurance.
- Checking details of job applicants and employees.
- Checking sources of income and tax details.

L&G and other organisations may access and use from other countries the information recorded by fraud prevention agencies. Please contact our Group Financial Crime department if you wish to receive the relevant details of the fraud prevention agencies:

Group Protection, Legal & General Assurance Society Limited, Four Central Square, Cardiff, CF10 1FS

L&G may also check the details of other parties related to your contract, including verification of identity. This includes beneficiaries, trustees, settlors, third party premium payers, executors or administrators of your estate, parties with power of attorney and any other beneficial owner.

5 Declaration and Consent to use your information

Protecting your personal information is extremely important to L&G. This policy tells you how we collect and process your personal information. Please take a few minutes to read it. <http://www.legalandgeneral.com/privacy-policy/>

Please contact us if you'd like us to post you a copy of our Privacy Policy.

You must **read carefully the answers you have given to the questions** before accepting the following Declaration.

- Please remember that all the items of information asked for in this form are taken into account when assessing the payment of benefit. Please also remember that if you do not answer the questions fully and accurately, benefit may not be paid. If necessary, please return to the questions and amend your answer in the appropriate place.
- L&G will try to rely on the information you provide and **you must not assume that they will always clarify that information with your doctors.**
- To protect you and us from financial crime, we may need to confirm your identity from time to time. We may do this by using reference agencies to search sources of information about you (an identity search). This will not affect your credit rating. If this identity search fails, we may ask you for documents to confirm your identity.



It is important that you read and accept all of the following paragraphs. If you are unsure of anything or have any queries, please contact us. Our details are at the end of this form.

I understand that insurers share information to prevent fraudulent claims via an Association of British Insurers (ABI) register. I also understand that some of the information that I supply on this form could be placed on the register and made available to participating insurers, a list of which is available on request from the ABI.

I understand that all items of information requested in this form are taken into account when assessing incapacity and entitlement to benefit. I understand that the issue of this form is not an admission of liability.

I understand that a copy of this form is available on request.

I declare that to the best of my knowledge and belief all the statements made in this form are true and complete and have been recorded accurately on this form.

I agree that these statements will be used for this application for benefit and any other assessment or review of entitlement to benefit.

I understand that if I do not give all the requested information truthfully, completely and accurately benefit may not be paid.

I agree that this information can also be used to maintain management information for business analysis.

I agree to:

- L&G sharing medical information (and other information collected via this form) about me with their reinsurers, their third-party service providers, my own doctor or any doctor that L&G uses for the purposes of assessing and reviewing entitlement to benefit and administering policies.
- L&G and any organisation acting on L&G's behalf sharing medical information (and other information collected via this form) about me with my employer, my employer's intermediary and any professional medical adviser appointed by my employer for the purposes of assessing and reviewing entitlement to benefit, and administering policies.
- L&G sharing medical information with other insurance companies when requested to do so, for the purposes of assessing and reviewing entitlement to benefit and administering policies.

By signing below I consent to L&G processing my medical and health information that I have provided so they can assess this benefit claim and administer policies in line with L&G's [Privacy Policy](#). I also consent to L&G sharing this information, where necessary, with the reinsurers referenced in the Privacy Policy.

Please check you have also read and signed Section 3.
Sections 3 and 4 must be signed before we can process this claim for benefit.

Signed

X

Date

(DD/MM/YYYY)

If your incapacity prevents you from signing this consent yourself, the person who helped you to complete this form should sign it on your behalf in the space provided below.

Signed on behalf of member

X

Date

(DD/MM/YYYY)

Name of signatory

Relationship to member

Reason for signing on behalf of the member

Contact us



0345 026 0094

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



groupprotection.benefitsmanagement@landg.com



www.legalandgeneral.com/employer/group-protection



**Group Protection, Legal & General Assurance Society Limited
Four Central Square, Cardiff, CF10 1FS**