Group income protection

Helping you understand our policy

Technical guide 05/25

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

For GIP 05/25, PGIP 05/25 and FLEX GIP 08/25 Policies

Using this document

What is a technical guide?

The Financial Conduct Authority is a financial services regulator. It requires us, L&G, to give you important information to help you to decide whether our 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 on page 36 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 we'll fix these at the start of the **policy**. You'll only be able to change these if we agree.

Where we refer to 'we', 'our' or 'us' this should be read as Legal and General Assurance Society Ltd.

We can provide cover for equity partners and members of a Limited Liability Partnership (LLP) as well as your employees. Where we've referred to 'employees' this should be read to include equity partners and members of a LLP. Where we refer to 'employer' or 'employment', this should be read to include partnerships and LLPs and the duties of an equity partner or LLP member.

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 contains information that 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 give 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 for financial advisers:

- Explains the intended target market for each of our Group Protection products.
- Provides information to help them complete their own fair value assessment.
- Describes how we regularly review our Group Protection products for appropriateness under our Product Lifecycle Management processes **group-protection.legalandgeneral.com/adviser/adviser-toolkit/product-governance/**

About Legal & General

L&G is a leading UK financial services group and major global investor. We've been safeguarding people's financial futures since 1836, and strive to build a better society, while improving the lives of our customers and creating value for shareholders. We are one of the world's largest asset managers with £1.2 trillion of assets under management at 31 December 2025. We're a leading provider of Group Protection cover in the UK with over 90 years of expertise and knowledge. We looked after almost 10,700 group protection policies and provided protection to 2.3 million employees at the end of 2025.

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 by searching for 'Legal & General Group PLC' at: **group.legalandgeneral.com/reporting-hub/**

Contents

4 **Aims, commitments and risks**

4 Its aims

4 Your commitment

5 Risks

6 **How the policy works**

7 **Your questions answered**

8 **1.0 What should we consider when deciding what benefits to provide?**

9 1.1 Who can the **policy** cover?

9 1.2 When can we include employees after the **policy** starts?

10 1.3 Can you cover **members** who are temporarily absent?

10 1.4 When can cover for a **member** change?

11 1.5 When will cover end?

12 1.6 What types of cover are available?

14 1.7 What is the maximum benefit you will cover?

14 1.8 How do you define incapacity?

15 1.9 When will you start benefit payments?

16 1.10 How long can you pay benefit for?

16 1.11 Can you pay a lump sum?

16 1.12 Can benefits being paid be protected from inflation?

17 **2.0 How do we set up a policy and when do we need to give you medical evidence?**

17 2.1 What do you need to set up the **policy**?

17 2.2 What medical evidence will you need before you'll cover the **members**?

18 2.3 If you have **medically underwritten** a **member**, when will they next need to give you medical evidence?

19 2.4 What are your terms if we're switching the insurance to you from another insurer?

21 2.5 What are your **actively at work** requirements?

22 2.6 What medical evidence do you need for employees who want cover before or after they are eligible?

24 2.7 What happens if we need to make a claim before you've finished your medical underwriting?

25 **3.0 What premiums will you charge for the cover?**

25 3.1 How will you work out the premiums?

25 3.2 Will there be any unexpected extra premiums?

25 3.3 How much commission will you pay our adviser?

25 3.4 Is there a discount for a good claims history?

26 **4.0 How does the accounting work?**

26 4.1 What information do you need for accounting?

27 4.2 How do you adjust premiums for **members** who join, leave or have benefit increases during the **policy year**?

27 4.3 If you or we cancel the **policy** mid year, will we lose any premiums we have paid in advance?

28 **5.0 How do we make a claim?**

28 5.1 When can we make a claim?

29 5.2 When do you need to know about a **member** who we may make a claim for?

29 5.3 Who pays for medical evidence?

29 5.4 Does other income the **member** receives affect the amount you pay out under this **policy**?

29 5.5 How long will you pay benefit for?

30 5.6 What happens if a **member's** illness or injury means that they can work part-time or in a reduced capacity?

30 5.7 After a **member** returns to work, can we make another claim for that **member**?

31 5.8 What happens to claims if you or we cancel the **policy**?

32 **6.0 What don't you cover?**

32 **7.0 Can you cover an employee who is not based in the UK?**

33 **8.0 What tax rules apply?**

33 **9.0 Can members continue their cover if they leave my employment?**

34 **Further information**

36 **Glossary**

39 **Contact details**

Aims, commitments and risks

Its aims

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

- Provide insurance to pay income protection benefit to **members** 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 **members** 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 and any material facts in line with the Insurance Act 2015 when you apply for a **policy** and at **annual renewal dates**. We can change or cancel the **policy** if you don't give us this information and this could affect claim payment. Please see question 4.1 for more details.
- Tell us about any new entrants, discretionary entrants, early entrants, late entrants you would like us to cover and leavers. We will need more information about early, discretionary and late entrants before we consider cover for them. Please see question 2.6 for more details.
- Give us all the information we ask for to support any claims and tell us about a claim within the time limits set out in question 5.2. Without this we won't be able to pay the claim or support a **member's** return to work. 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 **member's** condition following a claim, 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 **members** 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 **member**, or cover their increased benefit, if they aren't **actively at work**. We'll start or increase their cover when they are next able to meet our **actively at work** requirements. We define and give details of **actively at work** in question 2.5.
- The premiums may go up or down depending on changes in the **total scheme earnings** or **total benefit** we cover. We'll usually guarantee the **unit rate** until at least the second **annual renewal date**. We will then review it, following which we will usually guarantee the new **unit rate** for at least the next two years. We'll confirm the first guarantee period in our quote.
- The premiums and the **unit rate** may go up or down if, at an **annual renewal date**, 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**. Please see question 3.1 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 **member'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.
- You may need to pay an additional premium depending on the type of accounting we use. Please see question 4.2 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 1.12 for more details.
- 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 35 for more details

How the policy works

- A Group Income Protection quote and **policy** can be arranged online through our digital service called ONIX. ONIX access is only available where your cover is arranged for you by a financial adviser. Our online quote and **policy** can't be used if you want cover for a flexible benefits **policy**. Policies set up using the efficiencies of ONIX will have this benefit reflected in the **unit rate** or terms. Where the criteria allows, use of ONIX for annual accounting and rate reviews will continue to benefit from the terms applicable.
- If you've chosen to appoint a financial adviser who uses ONIX (our online administration service) to maintain your **policy**, we may recognise this in our ongoing terms for cover. For example, offering a reduced **unit rate** or enhancing the **free limit**. If your financial adviser stops using the available services on ONIX to maintain your **policy**, we may remove these enhancements when the **unit rate** guarantee ends.
- We'll need a minimum of 3 **members** to start a **policy** using ONIX, and at least 10 **members** to start a **policy** if ONIX hasn't been used. There isn't a maximum number of **members** we can insure.
- We can cancel or change the terms of:
  - A Group Income Protection **policy** if membership falls to less than three **members**. We'll send written confirmation at least six months in advance if we do.
  - A Flexible Group Income Protection **policy** if the membership falls to less than five **members**. We'll send written confirmation at least three months in advance if we do.
- You pay us the cost of the cover. You will need to collect the premium from equity partners or members of a LLP covered.
- 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 **member** doesn't meet the **policy** definition of incapacity. Please see questions 1.8 and 5.1 for more details.
- You must include all eligible employees for cover under the **policy** as soon as they are eligible.
- We won't pay a claim if the employee 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 **member** at the end of the month it's due. Where you receive the benefit you will be responsible for paying the benefit to the **member** after deducting any applicable Income Tax and National Insurance contributions. Equity partners and LLP members will be paid direct where they have a UK bank account.
- We can reduce the benefit payments under the **policy** if the **member** is receiving any other regular income because of their illness or injury. Please see question 5.4 for more details
- If we're paying benefit for a **member**, we won't charge premiums for them.
- We'll stop paying benefit for a **member** 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'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 **member** 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 or regulation or **state benefits** which affect group income protection policies. We'll give you more details of these in the **policy**.
- We'll give you full details of our cancellation rights 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 simple as possible, ideally having the same basis for all **members**.

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

You should also consider any laws on discrimination or unfair treatment. For example, those about age, equal treatment of men and women, and the treatment of part-time, fixed-term and disabled employees.

It's important we know which **members** 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 directors', 'all equity partners' or 'all employees'.

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 all, or part, of the benefit you want to pay to the **members**.

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

For example, if your **scheme** promises to pay a benefit of 50% of earnings but you 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 our terms, **unit rate** and premium.

1.1 Who can the policy cover?

We will only start cover for each employee, 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.

An employee 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. There's an explanation of when we can cover employees before or after they are first eligible in question 2.6. If you wish to include an employee 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 stop. We call this the **benefit termination date**.

This can be the greater of the **member** reaching age 65, or their **state pension age**.

We are also able to offer the option to continue to pay benefits until the **member** 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 **members** in a particular category.

1.2 When can we include employees after the policy starts?

All **employees** 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'll only include new employees once a year at the **annual renewal date**, provided they've met the **policy** eligibility conditions.	Cover for new employees starts at a specified date each month, provided they've met the **policy** eligibility conditions. Unless we tell you otherwise, this will be the same day of the month the **annual renewal date** falls on.	We include new employees on the first day they meet the **policy** eligibility conditions.

We may be able to cover new employees before the first entry date as early entrants if they meet the eligibility conditions. If the eligibility is linked to membership of your pension scheme, we may also be able to cover employees who join the pension **scheme** after their first opportunity as late entrants. Please see question 2.6 for more details of our requirements for employees who want cover before or after they are eligible.

If a **member** becomes eligible to change to a different category, we'll cover them in that category immediately as long as any other requirements we've set are met.

1.3 Can you cover members who are temporarily absent?

Unless we tell you otherwise, if a **member** is temporarily off work for any reason other than illness or injury, we'll provide temporary absence cover as long as:

- the period of the absence is fixed before it starts, and is not longer than one year;
- the **member** has a written right to return to the same job when their absence ends; and
- you tell us about the absence, in writing, within one month of it starting.

If the **member** becomes ill or is injured during their temporary absence, the **deferred period** will start from the day they become incapacitated. However, benefit payments will not become payable until the later of:

- the end of the **deferred period**; or
- the end of the agreed period of temporary absence. Please see question 1.9 for more details about **deferred periods**.

If a **member** is on maternity, paternity, shared parental or adoption leave, we'll continue to provide cover as long as they remain entitled to the benefit under the terms and conditions of their employment.

We'll keep a **member's** cover the same as it was on the day before their temporary absence starts.

1.4 When can cover for a member change?

Our quote and **policy** will show the benefit increase date. A 'benefit increase' is when we'll start covering increases or decreases to a **member's** cover, for example, after a pay review.

If we work out the benefit for a **member** using a multiple of **scheme earnings**, benefit increases can be:

Yearly	Monthly	Daily
We only change a **member's** cover once a year at the **annual renewal date**. This means, if you make a claim, we'll use the **member's** earnings at the last **annual renewal date** to work out their benefit, even if their earnings have changed since.	We'll start covering changes for **members** at a specified date each month. Unless we tell you otherwise, this will be the same day of the month the **annual renewal date** falls on.	We change the cover for **members** on the first day their **scheme earnings** change.

If the benefit is a fixed sum, for example £20,000, in total, per 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.

Sometimes a **member** might become eligible to change to a different category with a different benefit basis, for example, because of a promotion. If this happens, we'll cover them for the new benefit basis immediately as long as any other requirements we've set are met. If the new category allows for daily increases, we'll also consider any change in the **member's** earnings at the same time. If it doesn't allow for daily increases, we won't cover the increase until the next date for benefit increases in that category.

1.5 When will cover end?

a) Under normal circumstances

We will stop covering a **member**:

- When they leave your employment or no longer meet the eligibility conditions.
- When they reach the **benefit termination date** set out in the **policy**. This can be the greater of the **member** reaching age 65, their **state pension age** at the point they become a **disabled member** or their **dynamic state pension age**. Alternatively you can choose an age up to 70.
- If they retire early.
- When their period of temporary absence cover ends.
- If the **member** dies.

b) If you, or we, cancel the cover

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

- We'll continue your cover as long as you meet the conditions we show in 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 35 for further details about our approach to **financial crime** risks.

We'll give you full details of our cancellation terms in the **policy**.

1.6 What types of cover are available?

There are two types of benefit we can pay. They are called **member's benefit** and **additional benefit**.

	Member's benefit	Additional benefit
What does this mean?	This is the benefit we'll pay you to pass on to the **member** after making the necessary deductions, such as income tax, when they're long-term absent because of illness or injury.	You can cover your continuing liability to pay pension contributions to an occupational or personal pension **scheme** for the **member**. You can cover some of the **member's** own pension contribution. You also can cover your liability to pay National Insurance contributions on the **member's benefit**.
How it works	Usually we'll cover a set percentage of **scheme earnings** for all **members** or all **members** as required in a particular category. If the **member's benefit** includes a deduction for a fixed monetary value or components of the **employment support allowance**, **members** with low **scheme earnings** may not receive benefit. • We can cover a percentage of the **member's scheme earnings**. • We can cover a percentage of the **member's scheme earnings** less a fixed monetary value. • We can cover a percentage of the **member's scheme earnings** less an amount equivalent to **employment and support allowance**. The components of the **employment and support allowance** we deduct will be agreed in the quote and will be deducted for the duration of the claim. We will deduct this amount even if the **member** doesn't receive **employment and support allowance**. When calculating benefit we will use the rates of **employment and support allowance** applying at the start of the **deferred period**. Continues	If we agree to cover different levels of pension contributions for **members** within the same category; – you'll need to confirm the contribution level at each **annual renewal date**; – changes to these levels apply from the date of change subject to **actively at work** criteria being met; and – we'll fix the percentage of pension contributions at the start of the **deferred period** for the duration of a claim. The total cover for both yours and the **member's** pension contributions must stay within the maximum benefit limits.

Member's benefit Continued

How it works

- We can cover a percentage of the **member's scheme earnings** less an amount equivalent to **basic allowance** for the first 52 weeks of claim payment. The value of the **basic allowance** we deduct will be shown in the quote. After benefit has been paid for 52 weeks this amount will no longer be deducted. We call this an integrated **policy**.

Usually we'll cover a set percentage of **scheme earnings** for all **members** or all **members** as required in a particular category. If the **member's benefit** includes a deduction for a fixed monetary value or components of the **employment support allowance**, **members** with low **scheme earnings** may not receive benefit.

In practice this amount can either:

- be deducted if the **member** applies for and receives the **basic allowance**,
- be deducted if the **member** does not apply for the **basic allowance,** or
- not be deducted if the **member** applies for but does not qualify for the **basic allowance**.

Initially we'll calculate **member's benefit** assuming the **member** will receive the **basic allowance**. If the **member** applies for but does not qualify for the **basic allowance** we'll amend the benefit and backdate the adjustment from the first claim payment.

Under the integrated **policy** the maximum **benefit termination date** is limited to the higher of the **member's state pension age** or age 65 and the only **deferred periods** available are 26 and 28 weeks. A minimum of 50 **members** is needed for an integrated **policy**.

The **member's benefit** cannot be more than the maximum benefit.

We can cover different basis of benefit for different categories of **members**.

Please see question 1.7 for details of the maximum benefit limits.

Scheme earnings are often based on the **member's** basic annual salary, but we can include other income from employment, such as cash dividends (not those reinvested), partnership drawings, bonuses or commission. If we do this, we will average these amounts over the last three years. We'll tell you in the quote if you need to average any part of the **scheme earnings**. We cannot include director's fees as part of the **scheme earnings**.

1.7 What is the maximum benefit you will cover?

We will restrict benefits to the following limits:

- The **member's benefit** must not exceed £350,000 in total, per year.
- The total of your pension contributions and the **member's** own pension contributions must not exceed £75,000 in total, per year.
- In respect of PAYE employees the total of **member's benefit** and the **member's** own pension contributions must not exceed 80% of their **scheme earnings**.
- In respect of equity partners and members of a LLP the **member's benefit** must not exceed 50% of the average yearly earnings over the last three years for which accounts have been produced.

Please see question 5.4 for details of how other income affects the benefit in the event of a claim

1.8 How do you define incapacity?

We assess a claim to see if the **member's** illness or injury means they meet the incapacity definition set out in the **policy**.

We have three different incapacity definitions; **own occupation**, **suited occupation**, and **progressive**. We can also quote for an **own occupation** definition applying for a set number of months of benefit payment and a **suited occupation** definition applying after that. We can quote a different incapacity definition for different categories of **members**, or negotiate an alternative definition with you.

Our quote will tell you which incapacity definition we've used.

Own occupation definition

A **member** 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, other than one which results in payment of a partial benefit. Please see question 5.6 for more details about partial benefit.

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 **member** 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 **member** 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 **member** 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 **member** and their employer.

Although our quotation may show **own occupation** for a category, we'll use a different definition for **members** whose occupation needs a special certificate or licence such as pilots, offshore workers or lorry drivers. We'll cover these **members** using our **suited occupation** definition instead.

Suited occupation definition

A **member** 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. Please see question 5.6 for more details about partial benefit.

Progressive

A progressive definition combines the definitions described previously. From the end of the **deferred period**:

- Year one and two are assessed on an **own occupation** definition.
- Year three and four are assessed on a **suited occupation** definition.
- Year five and beyond are assessed on an activities of daily working definition.

For **members** whose occupation needs a special certificate or licence such as pilots, offshore workers or lorry drivers. We'll cover these **members** using our **suited occupation** definition for the first four years. Thereafter, they'll be assessed on an activities of daily working definition.

Activities of daily working

A **member** is incapacitated if an illness or injury means they meet (with or without aids or adaptations):

- at least three of the criteria in Section 1; or
- one of the criteria in Section 2:

Section 1

a) **Walking:** they cannot walk more than 200 metres on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body.

   A claim under this section should be supported by evidence that they have been prescribed and are taking appropriate medication.

b) **Rising/Sitting:** they are unable to rise and sit using a raised chair with arms without the help of another person.

c) **Dexterity:** they are unable to write legibly with a pen or pencil or use a keyboard with either hand.

d) **Communication:** they cannot:

   - clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room in their first language; or
   - understand simple messages in their first language; or
   - speak with sufficient clarity to be clearly understood in their first language.

e) **Eyesight:** their visual ability is reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.

Section 2

a) **Severe mental illness** means the diagnosis by a Specialist Consultant Psychiatrist of one of the following:

   - Schizophrenia, bipolar affective disorder, paranoid (delusional) psychosis, schizo-affective disorder or
   - Severe depressive illness which:
     - has chronic unremitting symptoms; and
     - has not responded to comprehensive management and treatment which the individual has complied with for a period of greater than 12 months; and
     - has resulted in an inpatient admission to a psychiatric ward for more than seven consecutive nights.

   The **member's** ability to think, communicate and behave appropriately must be so impaired as to significantly interfere with their ability to deal with the ordinary demands of life.

b) **Organic brain disease or injury:** they suffer from chronic organic brain disease or brain injury (confirmed by neurological investigation or imaging techniques) affecting their ability to reason and understand. This is to the extent that they require continual supervision by another person 24 hours a day.

1.9 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 **member** meets our **policy** definition of incapacity. As long as the **member** still meets our **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 may also be any other number of weeks in this range. We'll tell you the agreed **deferred period** in the quote.

If a **member** 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 absence for the **deferred period** if the **policy** ends.

The longer the **deferred period**, the lower the cost of the insurance. This is because there's more time for **members** to recover and be able to go back to work before the end of the **deferred period**, so we're less likely to pay benefit.

1.10 How long can you pay benefit for?

We will stop paying benefit at the earliest of:

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

We also have the right to stop payment of benefit if the **member** leaves your service. See question 5.5 for more details.

For some occupations, for example, pilots or lorry drivers, we will use an earlier **benefit termination date**.

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.

As a cost saving option, you can choose an option where the benefit payment term is limited to 24, 36 or 60 months. We call this a **limited term**. This option can be varied:

- We can continue to pay benefit for a **member** who is permanently disabled.
- We can pay a lump sum after the end of the **limited term**. See question 1.11 for more details.

1.11 Can you pay a lump sum?

We can pay a lump sum benefit for a **member** still meeting the **incapacity definition** at the end of the **limited term**. We can also pay a lump sum after four years of benefit payments under the progressive incapacity definition.

Our quote will confirm if a lump sum could be paid following a claim and what it'll be. This lump sum will be subject to a maximum equal to the total value of the monthly **member's benefit** payments had they been paid from the end of the **limited term** up to the age shown in the **benefit termination date**.

If the lump sum is based on **scheme earnings** we'll use the same value of **scheme earnings** to work out the lump sum as we did for the first year's **member's benefit**.

1.12 Can benefits being paid be protected from inflation?

You can choose to help towards protecting the value of the benefit payments reducing over time because of inflation. We have different options you can choose from. We call this the **benefit increase rate**.

We can increase the **member's benefit** and **additional benefit** we pay by a fixed rate of your choice. The maximum is 5%.

Alternatively, we can increase the **member's benefit** and **additional benefit** we pay by the rate of inflation, as measured by the Retail Prices Index (RPI) or the Consumer Price Index (CPI), by up to 5%. If the index used 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 **member'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 usually need to fill in an onboarding form and must pay the first premium within 14 days of the date we agree to provide cover.

If your financial adviser used our online service, ONIX, to obtain the quote you wish go ahead with, they'll accept the quote on your behalf using the same service. Depending on the **policy** options you've chosen, you may not need to fill in an onboarding form.

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 **members** need to give us medical evidence. Please see question 2.2 for more details about medical evidence.
- Check if all the **members** 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 that 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 members?

a) Cover up to 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 **members** needing to give us medical evidence. Medical evidence is information about their health and hobbies. Our **free limit** will depend on the total number of **members** and the amount of cover.

It will also depend on whether the eligibility conditions you set, is based on employees joining your pension **scheme**, where membership is voluntary. If we don't know this when we produce our quote, we'll assume that at least 75% of eligible employees will have joined your pension **scheme** at the start date of the **policy**. We'll reduce the **free limit** we quoted if this isn't the case.

We'll tell you the **free limit** in the quote.

b) Cover above the free limit

If the benefit for a **member** is above the **free limit** and they wish to have full cover, 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 **members** 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/workplace-benefits/group-protection/literature-and-forms/**. Alternatively, you can ask us for a copy.

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

Less than 20 members

Forward Underwriting

This means, once we **medically underwrite** a **member** 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 **member**, and agree cover on any of the following terms:

- ordinary rates;
- an additional **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 **member's benefit** increases by more than 15% above their benefit within any 12 month period starting on or after the day we finished their **medical underwriting**; and
- if our terms for a change to the **policy** ask for medical evidence, the date you ask us to make the change from.

Where we allow for future increases after we've medically underwritten a **member**, we'll apply the last **medical underwriting** terms to each increase. If you're paying an **extra premium loading**, you must tell us before the date of the increase and the amount of all increases as 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 that you no longer need it. If you do, we will stop using forward underwriting for that **member**.

If we **medically underwrite** a **member** 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 Members or more

ONEderwriting

ONEderwriting is our way of keeping our **medical underwriting** as simple as possible. It means we'll **medically underwrite** a **member** 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:

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

- at ordinary rates;
- an **extra premium loading** that you are paying;
- an exclusion for hazardous pursuits; or
- an exclusion for a medical condition;

as long as their benefit is below our maximum benefit (see question 1.7), they won't normally need to give us more medical evidence for:

- normal increases in benefit resulting from **scheme earnings** increases; and
- an increase affecting all **members**, or all **members** in a category of more than five **members**, resulting from an agreed future change to the insured basis.

Where we allow for future increases after we've **medically underwritten** a **member**, we'll apply the last **medical underwriting** terms to each increase. If you're paying an **extra premium loading**, you must tell us before the date of the increase and the amount of all increases as 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 that you no longer need it. If you do, we will stop using ONEderwriting for that **member**.

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 **member** 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 the employees meet our switch terms. This is even if the previous insurer charged a premium loading. We give more information about **actively at work** in question 2.5.

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

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

Switch terms for existing employees previously insured

For both (a) and (b) below we'll usually provide cover for these employees 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 employees 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 **actively at work** in question 2.5.

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

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

- their cover is not more than £200,000 in total, per year and any additional premium loading is not more than 300%; or
- their cover is above £200,000 in total, per year (but not above our maximum benefit limit) and any additional 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 usually need you to give us a copy of the previous insurer's latest letter of acceptance or fill in a Declaration – switch terms form. You must give us all the required details of previous cover when the **policy** starts or we may not be able to pay a claim for these **members**. Where details about previous cover is not provided, we may ask for the information in the event of a claim.

For these employees 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'll use our ONEderwriting terms for benefit increases.

Cover cannot be increased during the **deferred period** and cannot be more than our maximum benefit. We give more information about **deferred periods** in question 1.9 and our maximum benefit in question 1.7.

(ii) If the previous insurer accepted cover on a forward underwriting basis with an additional 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 **member** 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.

Cover cannot be increased during the **deferred period** and cannot be more than our maximum benefit. We give more information about **deferred periods** in question 1.9 and our maximum benefit in question 1.7.

(iii) For all other **members**;

- 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 employees who do not meet our switch terms

We're happy to consider and negotiate terms to insure any employees who don't meet our 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 that 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 employees 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 employee must be in full active employment, physically and mentally able to perform all the duties associated with their normal job on the day the cover is going to start or increase. Zero-hour contract employees will not be considered to be **actively at work** if they were suffering from a medical condition which would have prevented them from working on the day the **actively at work** condition applied.
How it works	**New policies and existing schemes being insured for the first time** We'll need employees to be **actively at work** on the day we start cover. **If you're switching the insurance of an existing policy to us** **Employees covered under the previous policy** For benefits up to the previously insured level we'll need employees to be **actively at work** on the day before we start cover. We'll need them to be **actively at work** before we'll cover any benefit increases for them. **Employees joining at the policy start date** We'll need all new employees 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'll need all new employees you include to be **actively at work**. We'll need **members** to be **actively at work** before we'll cover any benefit increases for them after the start of the **policy.** **Cover for employees who are not actively at work** If an employee isn't **actively at work**, we won't start cover for them, or increase their cover, until they are next **actively at work**.

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

We can cover employees before or after they are first eligible. We've given more details in the table below:

	Early entrants	Late entrants
What does this mean?	An early entrant is an employee you want us to cover before they complete the qualifying service or reach the first entry date. See question 1.2 for more details about entry dates.	Where all, or extra, benefit is limited to employees who join your pension **scheme**, a late entrant is an employee who joins your pension **scheme** after they are first eligible to join.
When can an employee's cover start?	If you want to include an employee as an early entrant within three months after their employment starting, we'll agree cover for them up to the **free limit** as long as they are **actively at work**.	**Joining up to six months late** If you want to include an employee who joins your pension **scheme** within six months after the date they were first eligible to join, as long as they are **actively at work**, we'll cover them up to the **free limit**. **Joining late at an auto-enrolment event** An auto-enrolment event is the day you start pension **scheme** auto-enrolment. It's also the day every three years when you automatically re-enrol the employees to the pension **scheme** who had previously decided to opt out. If you want to include an employee as a late entrant at an auto-enrolment event, as long as they are **actively at work**, we'll cover them up to the **free limit.** **Joining late at any other time** For all other employees you want to include as a late entrant, as long as they are **actively at work** we'll agree cover for them up to the lower of: • the **free limit**; and • £50,000 annual benefit.

What if an early or late entrant doesn't meet the above requirements for cover?	We'll need the employee 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 apply **special terms** or **extra premium loadings**. 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.

We still can consider cover for a person who:

- doesn't meet all the eligibility conditions;
- isn't an early entrant; and
- isn't a late entrant.

You'll need to tell us about the individual, and we'll tell you if we are able to cover them. We'll tell you any terms, such as **medical underwriting**, that will apply.
90 days temporary cover will apply where terms include **medical underwriting** unless our terms tell you otherwise.

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

We'll give employees temporary cover in respect of the benefit subject to **medical underwriting**, starting from the date we know they need to provide their medical evidence. However, there are some limits:

- We will not pay the benefit which is subject to **medical underwriting** for an employee whose injury or illness is caused by any medical condition that they were diagnosed with or displaying symptoms of within the five years before temporary cover starts.
- We won't give temporary cover to any employee whose cover has been refused, restricted or already has **special terms** attached.
- We won't give temporary cover to any employee 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 the end of the 90 days from when we know that the employee will need to provide medical evidence. We won't pay claims for accidental disability caused by:

- alcohol abuse;
- the influence of drugs;
- medical treatment or surgical treatment (except treatment that is needed because of the accident);
- criminal acts;
- attempted suicide; or
- intentional self-injury.

Our temporary cover or accident 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 employee will need to provide medical evidence.

We'll restrict temporary cover or accident cover so that **member's benefit** and **additional benefit** are not more than the maximum benefit in question 1.7.

3.0 What premiums will you charge for the cover?

The premiums we charge are dependent on many things, including the:

- amount of cover;
- age and gender of the **members**;
- 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 see 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 usually use a **unit rate** to work out premiums. We may use our **exact cost** basis instead if the **policy** is very small, or the cover of one or two employees disproportionately affects the overall **policy** premium. We'll tell you which basis we'll use in our quote.

Unit rate

We'll work out the cost for each £100 of the **total scheme earnings** or **total benefit**. We call this cost the **unit rate**. We'll multiply the **unit rate** with the **total scheme earnings** or **total benefit** at the start of each **policy year** to work out that year's premium.

Exact cost

We'll work out a premium for each **member** from age related premium rates. We'll multiply the amount of cover to these rates at the beginning of each **policy year**.

3.2 Will there be any unexpected extra premiums?

We'll usually fix the **unit rate** or the age related premium rates until at least the end of the second **policy year**. We will then review them, following which we will usually fix the **unit rate** or the age related premium rates for at least another two years. We'll confirm the first guarantee period in our quote.

However we can change the **unit rate** from any **annual renewal date** if the:

- membership;
- **total benefit**; or
- **total scheme earnings**

has changed by more than 25% from the total we used to work out the **unit rate**. This means the premiums and the **unit rate** may go up or down.

If you've chosen to appoint a financial adviser who uses our ONIX online services to maintain your **policy**, we may offer a reduced **unit rate**. If your financial adviser stops using ONIX, we may remove this reduction when we next work out a new **unit rate**.

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

The premiums may also change at the start of the **policy** when we work out accurate premiums. Please see question 4.0 for more details.

If eligibility for some, or all, cover is dependent on pension membership, we'll adjust our account when you start auto-enrolment or re-enrolment if:

- the **policy** uses no change accounting (see question 4.2 for more details); and
- the number of **members**, the **total scheme earnings**, or **total benefit** increases by more than 25% because of auto-enrolment or re-enrolment.

You'll need to tell us if this happens. We'll charge an extra premium based on the **unit rate**, the extra cover and the number of days to the next **annual renewal date**.

3.3 How much commission will you pay our adviser?

We'll pay commission to your financial 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 commission rate we've allowed for.

3.4 Is there a discount for a 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 than we statistically expect, this usually means the premiums will be lower than for a bad or average 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.

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 the membership list used for the quote may be up to one year old by the time the **policy** starts. If the membership list has changed, we'll ask you for an updated list that's accurate on the day the **policy** starts. We'll use the new 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.

For all **policies**, at each **annual renewal date**, we'll ask you to pay 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?

For all **policies** you must tell us about anyone who needs to give us medical evidence before we can consider their full cover. This will include:

- When a **member's** cover goes over the **free limit** for the first time.
- Anyone who needs cover before or after they are first eligible and our terms say medical evidence is needed.
- If our terms say we need medical evidence for cover.

We suggest you regularly check if medical evidence is needed and not leave it to the **annual renewal date**. Regular checks will help you make sure you have the cover you need.

Information we will always need.

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

- Name,
- Gender,
- date of birth,
- benefit,
- **scheme earnings** (if applicable),
- eligibility category (if there's more than one),
- job title, and
- work postcode.

At the start of the **policy**, and at each rate review we will also require details of:

- anyone who is not, due to ill health/injury, currently carrying out either their full role or are working less than their contracted hours, and have not done so for at least three months; and
- any information or material facts—such as known serious or terminal illnesses (such as cancer), overseas business travel, use of non-schedule airlines, private/charter helicopter use, offshore work or hazardous activities—that are relevant to the cover we're providing, in accordance with the Insurance Act 2015.

Unit rated policies

If the **policy** is set up on sweep up accounting, we'll also need to know the **total scheme earnings** (or **total benefit** if rate is linked to benefit) at the day before each **annual renewal date**. We use this to work out the end of year adjustment.

Please read question 4.2 for more details about the sweep up accounting adjustment.

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 **member** 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 **members** 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 **member'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 **members** who wouldn't fulfil 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 **members** who may reach the **benefit termination date** within their relevant **deferred period**.

When a **member** 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.

For exact cost policies

At each **annual renewal date** you will need to give us a membership list showing each current **member's**: :

- date of joining for employees whose cover started since the previous **annual renewal dates**;
- date of leaving for employees whose cover ended since the previous **annual renewal dates**;
- if the **policy** allows, the amount and date of any changes to benefit since the last **annual renewal date**.

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 an employee who you should have included on the membership list at the start of the **policy** or the **annual renewal date**, we won't pay a claim for them.

4.2 How do you adjust premiums for members who join, leave or have benefit increases during the policy year?

We'll tell you in our quote which accounting we'll use.

Sweep-up accounting

We'll adjust premiums at the end of each **policy year** for changes in line with the agreed eligibility conditions and benefit basis. Our adjustment assumes all changes in membership and cover took place midway through the year. We'll charge an extra premium or pay you a refund at the beginning of the next **policy year**.

No change accounting

Our **unit rate** will allow for changes in membership and cover during the **policy year**. This means we don't need to adjust the premiums at the end of the **policy year** for changes that are in line with the agreed eligibility conditions and benefit basis.

Exact cost accounting (also known as single premium or current cost basis)

Exact cost means we'll adjust the premiums at the end of each **policy year** for the exact time and amount of cover we provide for each **member**. We'll charge an extra premium or pay you a refund at the beginning of the next **policy year**.

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 **member** meets the incapacity definition in the **policy**.

How incapacitated must the member be?

The **policy** will tell you which incapacity definition we will use. We give more information about our definitions of incapacity in question 1.8.

How will you assess a claim?

We will need suitable evidence of the **member'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, musculoskeletal condition or cancer	We need to be informed of all **members**, 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 **members**, who are continuously absent for eight weeks or more, by the tenth week of absence.

The Absence Notification Form gives us information about the **member**. 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 **member** 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 **member** may need to have an independent medical examination or assessment.

We can also consider any medical reports or extra information that you or the **member** 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 details we may not be able to pay the claim. For example, if the **member** 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 **member** cope with their changing lifestyle and encourage them to return to work as soon as possible. With our help, the **member** 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 **member** 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.

Under the Equalities Act, you may have to adapt the workplace to meet the needs of a disabled person. Some of the services we provide may help you to do this.

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

The earlier we start collecting information about a **member'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 **member** 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 reports, tests and examinations that we ask for.

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

The **policy** aims to give the **member** a lower income than they received whilst working. This aims to give 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;

- for PAYE employees: 90% of the **member's** total earnings just before the start of the **deferred period**.
- for equity partners and members of a LLP: 50% of the member'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 income from a pension, or income the **member** was already receiving before the start of the **deferred period**, for example, dividends from shares unless those dividends were insured, in which case they are included unless they cease before the date benefit is due to be paid.

5.5 How long will you pay benefit for?

We will pay benefit until the earliest of:

- the **benefit termination date** set out in the **policy**;
- the date the **member** no longer meets the **policy** definition of incapacity, even if they don't have a job to go back to;
- the end of the fixed term contract in place at the start of the **deferred period**;
- the date the **member** dies; or
- the end of a **limited term**.

What happens if the member's employment is terminated?

We have the right to stop payment of benefit if the **member** leaves your service. However, if we are asked to pay **member's benefit** directly to the **disabled member** in advance of them leaving service, we may at our discretion agree. This is subject to:

- the **member** having remained in employment for the whole of the **deferred period**; and
- benefit payments in respect of the incapacitated **member** having been made to you after the end of the **deferred period**.

Payment of **additional benefit** will stop when we begin to pay **member's benefit** to the former employee.

The agreement to continue payments to a **member** after their service has ended will be between you (the policyholder) and us.

Benefit payments will stop at the same time and in the same circumstances that would have applied if the **member** had remained in employment.

Where we agree to pay **member's benefit** directly to a **disabled member** after their employment has ended, we will deduct and account for any income tax due on the **member's benefit**.

Cover for the former employee will stop when their entitlement to **member's benefit** ends and no new claims will be considered for them. However, the **linked claim** provisions shown in question 5.7 will continue to apply. This means that if the former employee suffers a relapse from the same or a related condition within 52 weeks of the claim ending, then benefit payments will recommence immediately, subject to meeting the **policy** definition of incapacity that applied when their absence initially commenced.

What happens if our business goes into liquidation?

If we're paying a claim for the **member** and your business goes into liquidation, we'll pay the **member's benefit** direct to the **member.** Any **additional benefit** will stop.

Benefit payments will stop at the same time and in the same circumstances that would have applied if your business wasn't in liquidation.

What happens if an incapacitated member's contract of employment is transferred to another employer under a TUPE arrangement?

If an incapacitated **member** (including a **member** within the **deferred period**) is transferred to another employer under a **TUPE** arrangement, we will pay **member's benefit** and **additional benefit** to the new employer subject to:

- you requesting us to continue paying benefit; and
- the new employer taking over the responsibilities in relation to the claim, that would normally apply to the policyholder. Examples include but are not limited to meeting obligations under the Equalities Act 2010, providing requested information and supporting a return to work plan; and
- a written agreement being completed by you, the new employer and us.

5.6 What happens if a member'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 **member** works and their reduction in earnings. 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 **member'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 **member** having to complete a new **deferred period** if, within the next 52 weeks of the date they returned to work, 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 member returns to work, can we make another claim for that member?

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 **member** is off work again within 52 weeks of the date they returned to work, we will treat them as a **linked claim**. This means we'll start paying benefit again as soon as we receive suitable confirmation that the absence is through 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 **member** had not returned to work. We'll stop paying benefit at the normal end dates shown in question 5.5.

Where we limit payment to a certain number of months (a **limited term**), we'll start paying benefit again, as above. We'll extend the **limited term** to allow for the time the employee was back at work.

For **linked claims** under an integrated **policy** we'll continue to deduct the amount equivalent to the **basic allowance** until the claim has been paid for a total of 52 weeks. The amount equivalent to the **basic allowance** will not be deducted if the **member** applies for but does not qualify for the **basic allowance**.

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 **members** 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 follows:

- If, on returning to work, the **member** 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 **member** 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 **member** 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 **member** doesn't meet the **policy** definition of incapacity or if an employee is not eligible for cover.

For **members** 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 **members** based in certain overseas locations. We'll tell you if we've done this.

7.0 Can you cover an employee who is not based in the UK?

We will need full details of any overseas employees 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 employees until we've assessed their details and told you of any terms.

We'll usually cover employees who work abroad as long as:

- they meet the eligibility conditions; and
- they have a contract of employment, or are an equity partner/LLP member, with a UK company covered under the **policy**; and
- most of the **members** covered under the **policy** work in the UK.

Please refer to our overseas bulletin for further information. All premiums must be paid in UK pounds sterling by the UK employer. We'll fix any currency conversion rates at each **annual renewal date**.

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 **member** may need to have an independent medical examination or assessment. If this happens, we will 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 UK pounds sterling to a UK bank account of the UK company.

Where we have agreed to pay benefit directly to a **member**, we will pay the benefit to the **member** in UK pounds sterling, and only into a UK bank account that is registered in the **member's** name.

8.0 What tax rules apply?

Our understanding of the current tax rules for group income protection **schemes**, which could change in the future, is as follows:

- The premiums you pay for employees who are not major shareholders in your company, equity partners or LLP members are tax-deductible and can be offset against your profits for tax purposes.
- Your premiums are not treated as a 'benefit in kind' for employees.
- The benefit we pay to you will be taxable as a trading receipt. However, when you pay the benefit to the **member** it will be deductible as a business expense for tax purposes.
- The amount you pay to a PAYE **member** under the rules of the **scheme** will be treated as earned income, on which Income Tax and National Insurance contributions are due in the same way as on the **member's** salary.
- If a lump sum option is selected, the tax treatment will depend on how you as the policyholder use it. We suggest you get legal advice before choosing a lump sum.

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

9.0 Can members continue their cover if they leave my employment?

No, a **member** cannot continue cover at their own expense if they stop working for you.

Further information

Providing insurance

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

Legal and General Assurance Society Limited
Four Central Square
Cardiff
CF10 1FS

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-notice/**

Questions and complaints

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

If you didn't use a financial adviser to arrange your **policy** or you still need to talk 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. You can find their contact details at the back of this technical guide.

Law

The **policy** is governed by English law.

Under our **policy**, **members** do not have any rights under the Contracts (Rights of Third Parties Act) 1999. This means they do not have to be involved in decisions about the insurance provided by the **policy**.

However, if we've paid a benefit direct to a **member** because you stop trading or are wound up, the **member** will have rights under the Act as far as the claim is concerned.

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

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

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, 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.

Glossary

Our terms explained

Actively at work
This means the employee must be in full active employment, physically and mentally able to perform all the duties associated with their normal job as an employee 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.

Additional benefit
Cover for contributions to a pension you've set up for your employees. It can also cover your liability to pay National Insurance contributions.

Annual renewal date
The anniversary date of when your **policy** starts or another yearly date that we've agreed with you.

Basic allowance
The annual basic rate of benefit payable by the Department for Work and Pensions after the assessment phase of the **Employment and support allowance**.

Benefit entitlement
This is the amount of benefit a **member** 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 increase rate
The yearly increase in **member's benefit** and/or **additional benefit**.

Benefit termination date
The last date to which we'll pay benefit, or provide cover, for a **member**.

Deferred period
The period of time before we start paying benefit. It starts on the date the **member** 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 member
Means an insured **member** 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 member**, then we will change the **benefit termination date** of such **disabled member** 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 member**, 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 member** is entitled to a UK state pension.

Employment and support allowance
One or more of the parts of the Employment and support allowance payable by the Department for Work and Pensions.

Exact cost

We'll work out the cost for each **member** using their age, gender and amount of cover. This is also known as single premium or current cost.

Extra premium loading

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

Financial Crime

Financial crime is defined as:

- 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.

Free limit

The maximum amount of cover we will provide to a **member** 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**.

Linked claim

A second, or subsequent, claim for the same **member** within 52 weeks after the first claim for them ended, where the absence is caused by the same or a related incapacity. For linked claims we'll waive the **deferred period** for the second or subsequent claim.

Medical underwriting

The process we use to assess the health and hobbies of an employee. At the end of the process we may apply **special terms**.

Member

Employees, equity partners and members of a Limited Liability Partnership (LLP) included for benefits within the **scheme** and insured under the **policy**.

Member's benefit

The basic benefit we pay to you to pass on to the **member**. This is usually calculated as a percentage of **scheme earnings**.

Own occupation

A **member** is incapacitated if an illness or injury prevents them from performing the essential duties required of their occupation.

Policy

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

Policy year	The day the **policy** starts until the day before the first **annual renewal date**. Thereafter 12-month period starting from the **annual renewal date** and ending the day before the next **annual renewal date**.
Scheme	The scheme you have set up to pay the benefits promised under the scheme to your employees.
Scheme earnings	The earnings we use to work out a **member'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 are part of the **Employment and support allowance** payable by the Department for Work and Pensions.
State pension age	The age at which a **member** begins to receive their United Kingdom state pension from the Government or the age at which they would have received it had they been eligible.
Suited occupation	A **member** is incapacitated if an illness or injury prevents them from doing all jobs which are considered to be appropriate to their experience, training or education.
Total benefit	The total benefit for all **members**.
Total scheme earnings	The total scheme earnings for all **members**.
TUPE	This means the Transfer of Undertakings (Protection of Employment) Regulations.
Unit rate	This is how we work out the cost of a **policy**. We'll work out 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 and General Assurance Society Limited Four Central Square Cardiff CF10 1FS	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 **group-protection.legalandgeneral.com/adviser**	**complaint.info@financial-ombudsman.org.uk** **financial-ombudsman.org.uk**	**enquiries@fscs.org.uk** **fscs.org.uk**

Legal and General Assurance Society Limited. Registered in England and Wales No. 166055.
Registered office: One Coleman Street, London EC2R 5AA

Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

BH1408 W8850 11/25

GIP Technical Guide 05/25