Group critical illness cover

Helping you understand our policy

Technical guide

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

For CIC 04/26 and Flex CIC 04/26 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 Critical Illness Cover 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 aimed to use plain language throughout, to help make the technical guide easy to understand. You'll find explanations of any technical terms we use in the glossary, which is at the rear of this document. Where terms covered in the glossary appear in the main text, we've highlighted them in bold, **like this**.

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

We can also provide cover for equity partners or members of a Limited Liability Partnership (LLP). If the partnership is a LLP, 'equity partners' and 'partners' will mean 'members of an LLP'.

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

Other documents

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

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

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

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

Target market and fair value assessment information for financial advisers

Our product governance webpage 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 L&G

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 at:

group.legalandgeneral.com/reporting-hub/reports

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Aims, commitments and risks

Its aims

Our Critical Illness Cover **policy** aims to:

- Provide insurance to pay a lump sum benefit to an **insured employee** who is diagnosed with a condition they're insured for and survives for a set period of time.

  Please see question 1.7 for the full list of the conditions we cover and question 5.0 for the periods of time.

- Provide cover for only the illnesses defined in your **policy** and no others.
- Automatically include cover for the **children** of an **insured employee** at no extra cost, to pay a lump sum benefit if they're diagnosed with a condition they're insured for and survive for a set period of time.
- Offer cover to the **spouse** or **registered civil partner** of the **insured employee**, to pay a lump sum benefit if they're diagnosed with a condition they're insured for and survive for a set period of time. This will increase the premium.

Offer a choice of cover for these benefits.

Your commitment

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

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

  Please see question 4.1 for more details.

- Tell us about any individuals that we should cover that haven't been included already or when they no longer require cover, often described as new entrants, discretionary entrants, early entrants, late entrants and leavers.

  Please see question 2.8 for more details.

- Tell us of a claim within the time limits set out in question 5.0 and give us all the information we ask for to support the claims. Without this information, we won't be able to pay the claim.
- Pay the premiums by the dates we ask for them.
- Keep to all the conditions set out in the **policy**.

Risks

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

- We won't pay a claim if an **insured person** has a pre-existing condition.

  Please see question 2.5 for more details of pre-existing conditions.

- We may not pay a claim for an **insured person** because of a related medical condition.

  Please see question 2.6 for more details of related conditions.

- The premiums may go up or down depending on changes in the amount of **benefit** we cover. We'll usually guarantee the **unit rate** until the second **annual renewal date**. We'll then review it and usually guarantee the new **unit rate** for the next two years.
- 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 members' benefit** we've used to work out the **unit rate**.

  Please see question 3.1 for more details.

- You may need to pay an additional premium depending on the type of accounting we use.

  Please see question 4.2 for more details.

- We will stop cover if you stop paying premiums. We'll tell you in writing 14 days before we do this.
- 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 27 for more details.

How the policy works

- To start the **policy** we need a minimum of 10 **insured employees**. We can cancel or change the terms of the **policy** if **membership** falls to less than five **insured employees**. If we do this, we'll write to you at least 30 days before we cancel or make changes to the **policy**. Sometimes we'll start a **policy** with less than 10 **insured employees**. For example, if you have two or more **policies** linked together.
- You pay the cost of the cover.
- 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.
- You must include all employees, or equity partners, for cover under the **policy** as soon as they are eligible.
- We won't pay a claim if the person is not eligible for cover.

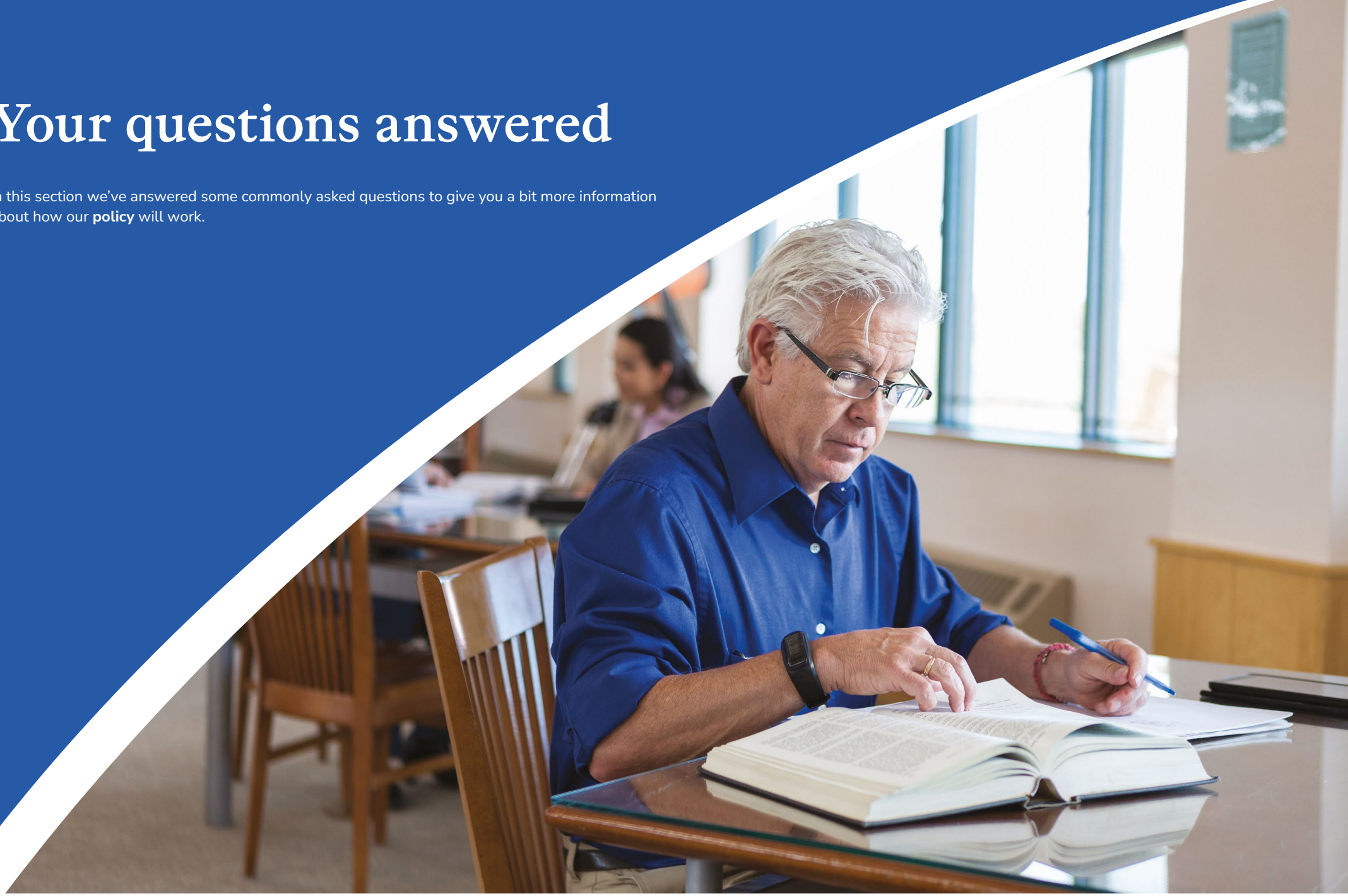
  Please see question 1.1 for more details about eligibility.
- You must give us all the information we need when you make a claim.
- If you make a valid claim, we'll usually pay the insured benefit directly to the **member** by direct credit.

  Please see question 5.0 for more details.
- We'll need up-to-date information from you at each **annual renewal date** so we can calculate 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 rate guarantee period. If we do this, we'll write to you at least 30 days before we change the terms.
- 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, which affect the **policy**. We'll give you more details of these in the **policy**. This includes any benefit payments in respect of the **member's spouse, civil partner** or **child**.

Your questions answered

In this section we've answered some commonly asked questions to give you a bit more information about how our **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 **insured employees**. We can insure benefit as an amount of money, or a multiple of **scheme earnings**.

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

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

We can insure any number of categories, but it's important we know which **insured employees** 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' 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 part or all the benefit you want to pay to your employees.

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

For example, if you promise to pay a benefit of four times their earnings but only insure three times their earnings, you would have to pay the remainder yourself.

Check our quote

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

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

1.1 Who can the policy cover?

The **policy** can cover employees and equity partners. Equity partners are partners who have an equity share in the firm and whose income from the firm is taxed as trading profits.

For an extra premium, we can also cover **spouse** or **registered civil partners** of the **insured employees**. Please ask us if you'd like to include this cover.

We'll automatically include cover for the **children** of all the **insured employees** at no extra cost.

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 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 questions 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.

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 agreement and any terms we may apply.

For information on when we can cover employees before or after they're first eligible, see question 2.8.

The agreed eligibility conditions will include a description of the employees eligible for each category, the entry ages, any service qualification and details of any link to your pension scheme **membership**.

We will not pay a claim if an **insured person** has a pre-existing condition.

Please see question 2.5 for more details of pre-existing conditions.

We may not pay a claim if an **insured person** has a related medical condition.

Please see question 2.6 for more details of related conditions.

1.2 When can you cover new employees under the policy?

The 'entry date' is when we'll start covering new employees under the **policy**.

The entry date can be:

Yearly	Monthly	Daily
We only include new employees once a year at the **annual renewal date**.	Cover for new employees starts at a specified date each month.	We include new employees on the first day they meet the eligibility conditions.

Our quote and **policy** will show the entry date. All new employees must meet the **policy** eligibility before we will start their cover.

We may be able to cover employees before the first entry date as early entrants if they meet the eligibility. 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 2.8 for more details of our requirements for employees who want cover before or after they are eligible.

If an **insured employee** becomes eligible to change to a different benefit category, we'll cover the new benefit level immediately as long as any other requirements we've set are met.

1.3 When can cover for an insured employee change?

A 'benefit increase' is when we'll start covering increases in an **insured person's** cover, for example, after a pay rise.

If we work out the benefit using a multiple of an **insured employee's** earnings, benefit increases can be:

Yearly	Monthly	Daily
We only increase an **insured employee's** cover once a year at the **annual renewal date**. This means, if you make a claim, we'll use the **insured employee's** earnings at the last **annual renewal date** to work out their benefit, even if their earnings have increased since.	We'll start covering increases for **insured employees** at a specified date each month.	We increase the cover for **insured employees** immediately when they change.

Our quote and **policy** will show the benefit increase date.

If an **insured employee** becomes eligible for a different category with a different benefit basis for example because of a promotion, we'll start covering the new benefit basis immediately as long as any other requirements we have set are met. If the new category allows for daily changes, we'll also consider any increase in the **insured employee's** earnings at the same time. Otherwise the changes to their earnings will not take effect until the next normal date for benefit changes in that category.

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

1.4 Can you cover an insured employee who is temporarily absent?

Yes, we'll continue to provide cover for temporary absence up to the **benefit termination age** if the **insured employee** is off work because of illness or injury, or up to three years for absence because of any other reason. This is our standard temporary absence cover. Please ask us if you'd like other options.

If we work out the benefit using a multiple of an **insured employee's** earnings, we'll continue that cover. If you reduce their earnings while they are off work, we'll continue to cover the same benefit as before the reduction.

The temporary absence cover doesn't apply to equity partners. However, even if they are off work, we'll still cover them as long as they are still equity partners and are entitled to a share of the profits.

We'll continue to provide cover if an **insured employee** is on maternity, paternity, adoption or shared parental leave as long as they remain entitled to the benefit under the terms and conditions of their employment.

1.5 When will cover end?

a) Under normal circumstances

We will stop covering an **insured person** when the **insured employee**:

- leaves your employment or no longer meets the eligibility conditions;
- reaches the benefit termination date we show in the **policy**. This is the day our cover ends and is usually their **state pension age**;
- retires early;
- reaches the end of a period of temporary absence cover without returning to work; or
- dies before we're due to pay benefit.

We'll stop covering a **spouse**, **registered civil partner** or **child**, if they no longer qualify for benefit or die. We won't cover **spouse** or **registered civil partners** beyond age 70.

Apart from eligible **children**, who are covered from birth to age 21 years, we can provide cover to age 70. We will not provide Terminal Illness and Total and Permanent Disability cover for a person who has reached their **state pension age**.

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 notice in writing.
- We'll give you at least 14 days' notice in writing if we have to cancel the **policy** because you haven't met its conditions.

1.6 What is the maximum benefit you will cover?

The maximum benefit we will cover is:

Insured employees – the lower of:

- five times their **scheme earnings**; and
- £500,000.

Spouse and registered civil partners – the lower of:

- £250,000; or
- another amount we've agreed.

Children's benefit (we provide this cover automatically at no extra cost) – the lower of:

- an amount equal to 25% of the **insured employee's** benefit; and
- £25,000.

This is for each **child** and there's no limit to the number of **children** we'll cover.

1.7 What types of cover are available?

There are two types of cover available, Core and Additional. The Additional cover also includes cover for the core conditions.

For Additional cover we can:

- cover Total And Permanent Disability on a 'own occupation basis'; or
- cover Total And Permanent Disability on a 'suited occupation basis'; or
- cover Total And Permanent Disability on a 'any occupation basis'; or
- exclude cover for Total And Permanent Disability and Terminal Illness.

We'll tell you in our quote which one we're covering.

These headings are only a guide as to what we cover. The full definitions of the conditions are in the **policy**. We'll also include them with our quote. These typically use medical terms to describe the conditions, and in some cases the cover may be limited. For example:

- Some types of cancer are not covered.
- To make a claim for some conditions, the **insured person** needs to have permanent symptoms.

Please see question 6.0 for details about our exclusions.

The cover for **children** will be aligned to what you choose for the **insured employee**. If you've chosen just Core, the **child** of the **insured employee** will be covered by the conditions under:

- Core conditions; and
- Core child conditions.

If you've chosen Core and Additional, the **child** of the **insured employee** will be covered by the conditions under:

- Core conditions; and
- Additional conditions; and
- Core child conditions.

CORE – CONDITIONS COVERED	
Cancer (including Hodgkin's Disease)	excluding less advanced cases
Cancer Second and Subsequent	new and unrelated cancer
Cardiac Arrest	with insertion of a defibrillator
Coronary Artery Bypass Grafts	
Creutzfeldt-Jakob Disease (CJD)	resulting in permanent symptoms
Dementia (including Alzheimer's Disease)	of specified severity
Heart Attack	of specified severity
Kidney Failure	requiring dialysis
Major Organ Transplant	from another donor
Motor Neurone Disease	resulting in permanent symptoms
Multiple Sclerosis	with current clinical impairment
Parkinson's Disease	resulting in permanent symptoms
Progressive Supranuclear Palsy	resulting in permanent symptoms
Stroke	resulting in symptoms lasting at least 24 hours
Systemic lupus erythematosus	resulting in permanent symptoms

Please ask us if you would like to see a list of the full definitions before we give you a quote.

CORE – CHILD CONDITIONS COVERED	
Cerebral Palsy	
Children's intensive care benefit	
Child Loss of Independent Existence	
Cystic Fibrosis	
Hydrocephalus	treated with insertion of a shunt
Muscular Dystrophy	
Spina Bifida	

ADDITIONAL – CONDITIONS COVERED (INCLUDES CORE CONDITIONS ALSO)	
Aorta Graft Surgery	requiring surgical replacement
Aplastic Anaemia	with permanent bone marrow failure
Bacterial Meningitis	resulting in permanent neurological deficit
Balloon Valvuloplasty	to relieve heart valvular abnormalities
Benign Brain Tumour	resulting in permanent symptoms or undergoing defined treatments
Benign spinal cord tumour	resulting in permanent symptoms or undergoing defined treatments
Blindness	permanent and irreversible
Cardiomyopathy	of specified severity
Coma	resulting in permanent symptoms
Coronary angioplasty	to treat specific conditions of specified severity
Deafness	permanent and irreversible
Encephalitis	resulting in permanent neurological deficit
Heart Surgery	with surgery to divide the breastbone
Heart Valve Replacement Or Repair	requiring surgery
HIV Infection	caught in a specified country from a blood transfusion, a physical assault or at work in an eligible occupation (see opposite #)
Liver Failure	of advanced stage

ADDITIONAL – CONDITIONS COVERED (INCLUDES CORE CONDITIONS ALSO) – continued	
Loss Of Hand or Foot	permanent physical severance
Loss Of Independent Existence (including Muscular Dystrophy)	permanent and irreversible
Loss Of Speech	permanent and irreversible
Paralysis Of Limb	total and irreversible
Primary pulmonary arterial hypertension	of specified severity
Pulmonary Artery Surgery	to excise and replace with a graft
Respiratory Failure	of advanced stage
Rheumatoid Arthritis	of specified severity
Terminal Illness	before **state pension age** where death is expected within 12 months
Third-Degree Burns	covering 20% of the surface area of the body or 20% of the face or head.
Total And Permanent Disability	before **state pension age** and of specified severity
Traumatic Head Injury	resulting in permanent symptoms

The specified countries for HIV infection are the United Kingdom, Australia, Canada, the Channel Islands, a European Union country, the Isle of Man, Japan, Hong Kong, New Zealand and USA

The eligible occupations for HIV infection caught at work are:

- Emergency services – police, fire and ambulance.
- Medical profession – including administrators, cleaners, dentists, doctors, nurses and porters.
- Armed forces.

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

2.1 What do you need to set up the policy?

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

You'll also need to:

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

  Please see questions 4.0 and 4.1 for more details.

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

  Please see question 2.2 for more details about medical evidence.

To protect you and us from **financial crime**, we may need to confirm your identity. We may do this by using reference agencies to search sources of information about you (an identity search). This will not affect your credit rating. If this identity search fails, we may ask you for documents to confirm your identity.

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

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

a) 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 **insured employees** needing to give us medical evidence. Medical evidence is information about their health and pastimes. We'll tell you the **free limit** in the quote.

We also have a pre-existing condition exclusion for cover up to the **free limit**. This means we won't pay a claim for any condition the **insured person** has, at or before, the start of their cover. We also won't pay claims for conditions occurring within two years of their cover starting which are related to a condition which existed at, or before, the start of their cover.

Please see questions 2.5 and 2.6 for more details about these exclusions.

b) Cover above the free limit

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

Depending on the information an **insured employee** 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 **insured employee** will have the choice of carrying these out at home or at work by a qualified 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.

If we accept cover above the **free limit**:

- Any **special terms** we set will apply to all the **insured employee's** cover. This includes their cover below the **free limit**.
- The pre-existing and related conditions exclusions will no longer apply to the cover we've agreed to.

- If you're not happy with any **special terms** we've set, you'll have 30 days to write to us and cancel the cover above the **free limit**. If you do, we'll re-instate the pre-existing and related conditions exclusions for cover below the **free limit**.

We will not need any medical evidence for **spouses'**, **registered civil partners'** or **children** when their cover starts. However we'll always apply the pre-existing and related conditions exclusions to their cover.

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

We'll give you full details of our **policy** requirements for medical evidence when we start cover.

Once we **medically underwrite** an **insured employee** 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** an **insured employee**, and agree cover at ordinary rates, they won't normally need to give us more medical evidence and we won't apply our exclusions for pre-existing and related conditions for an increase until:

- It's been five years since we last **medically underwrote** them.
- The **insured employee's** benefit increases by more than 15% above their benefit 12 months earlier in those five years.
- Total increases in benefit during the five-year period add up to more than £50,000.
- If our terms for a change to the **policy** ask for medical evidence.

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

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

We'll give you full details of our **policy** requirements for medical evidence when we start cover.

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

We'll apply our pre-existing and related condition exclusions. We'll need medical evidence for the portion of their cover which is above our **free limit**.

Switch terms for insured members previously medically underwritten

We'll usually provide cover for these **members** at the same level and on the same terms (but not necessarily at the same cost) as the previous insurer.

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 acceptance letters are not provided we may ask for evidence in the event of a claim.

We'll normally provide cover at the same level for **members**, as long as cover with the previous insurer was:

- for their full **benefit entitlement**;
- not subject to any **special terms**, or for which an extra premium of no more than 100% of the normal premium was charged and paid;
- the acceptance terms were issued within the five years immediately before the transfer; and
- the total value of benefit for the **member** doesn't exceed the lower of our **free limit** or £250,000

Switch terms for insured members not previously medically underwritten

If the **member** has not been medically underwritten and their previous cover was subject to a pre-existing conditions exclusion, we'll normally accept cover up to the lower of our **free limit** or £500,000 subject to our pre-existing and related conditions exclusions.

We give more information about pre-exisiting and related conditions in questions 2.5 and 2.6.

We'll 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'll need to give this to us when the **policy** starts or we won't be able to pay a claim for these **members**.

We'll need medical evidence for a **member** meeting the above switch terms, whose cover:

- is over our **free limit**; or
- was accepted by the previous insurer with **special terms** attached.

Terms for any members who do not meet our switch terms

We're happy to consider and negotiate terms to insure any **members** who don't meet the switch terms conditions. If you give us their full details, we'll consider if we can cover them. If we can, you'll need to accept in writing any terms we set, before we start covering them. To avoid a break in cover, you'll need to give us these details before the switch date.

2.5 What is your pre-existing conditions exclusion?

For a new insured person

We apply a pre-existing conditions exclusion to all benefit. If we **medically underwrite** a **member** and accept their cover we'll usually remove the exclusion applying up to the benefit level we've **medically underwritten**.

The pre-existing conditions exclusion means, we won't pay benefit for any insured condition which the **insured person**:

- had or has undergone before they were first covered by the **scheme**.
- is already in a qualifying period for an insured condition when they were first covered by the **scheme**. Any qualifying periods that apply are shown within the insured condition definition. For example to meet the qualification for multiple sclerosis, the specified symptoms must persist for six months. We include full details of the insured condition definitions in our quote appendix and the **policy** terms.
- has previously received benefit for that insured condition.
- has experienced symptoms of, taken medical advice on, been treated for, or investigated for, before they were first covered by the **scheme**.

The above exclusion will apply even if a diagnosis or the qualifying requirements for an insured condition were not met before cover for the **insured person** starts.

For this purpose, we'll consider the following to be the same condition:

Aorta Graft Surgery	requiring surgical replacement
Balloon Valvuloplasty	to relieve heart valvular abnormalities
Cardiac Arrest	with insertion of a defibrillator
Cardiomyopathy	of specified severity
Coronary angioplasty	to treat specific conditions of specified severity
Coronary Artery Bypass Grafts	
Heart Attack	of specified severity
Heart Surgery	with surgery to divide the breastbone
Heart Transplant	with reference to Major Organ Transplant
Heart Valve Replacement Or Repair	requiring surgery
Primary pulmonary arterial hypertension	of specified severity
Pulmonary Artery Surgery	to excise and replace with a graft
Stroke	resulting in symptoms lasting at least 24 hours

For the condition Heart Transplant, this includes Major Organ Transplant where the **insured person** has undergone a complete heart transplant as a recipient or has been included on an official United Kingdom, Channel Islands or Isle of Man transplant waiting list to receive a complete heart.

Bone Marrow;

- Aplastic Anaemia
- Undergoing a bone marrow transplant as a recipient (with reference to Major Organ Transplant)
- The inclusion on an official United Kingdom, Channel Islands or Isle of Man transplant waiting list to receive bone marrow (with reference to Major Organ Transplant)

Kidneys;

- Kidney Failure – requiring dialysis
- A Complete Kidney Transplant – with reference to Major Organ Transplant
- The inclusion on an official United Kingdom, Channel Islands or the Isle of Man transplant waiting list to receive a complete kidney (with reference to Major Organ Transplant)

Liver;

- Liver Failure – of advanced stage
- A Complete Liver, Or A Lobe Of Liver, Transplant
- The inclusion on an official United Kingdom, Channel Islands or the Isle of Man transplant waiting list to receive a complete liver, or lobe of liver (with reference to Major Organ Transplant)

Lungs;

- Respiratory Failure – of advanced stage
- A Complete Lung Transplant – with reference to Major Organ Transplant
- The inclusion on an official United Kingdom, Channel Islands or the Isle of Man transplant waiting list to receive a complete lung (with reference to Major Organ Transplant)
- Cystic Fibrosis

Lupus;

- Systemic Lupus Erythematosus with severe complications
- Antiphospholipid Syndrome (Hughes Syndrome)
- Sjogren's Syndrome
- Any autoimmune condition directly and causally associated with the development or progression of systemic lupus erythematosus.

Also, where an **insured person** has had any malignant tumours, defined as Cancer, we won't pay benefit for any subsequent Cancer. For this purpose the subsequent cancer has to be connected to, or associated with, the earlier diagnosis of cancer. If the cancer is new and unrelated it may be covered by Cancer second and subsequent.

Where we use 'cancer', please remember this excludes less advanced cases.

Please ask us if you would like to see a list of the full definitions before we give you a quote.

We will not pay benefit for the following conditions if the disablement or illness started before the **insured person** was first covered by the **scheme**:

- Child loss of independent existence
- Loss Of Independent Existence (including Muscular Dystrophy) – permanent and irreversible
- Rheumatoid arthritis – of specified severity
- Terminal Illness – before state pension age where death is expected within 12 months
- Total And Permanent Disability – before state pension age and of specified severity

We won't pay benefit for the insured conditions of Loss Of Independent Existence (including Muscular Dystrophy), Child loss of independent existence, Paralysis Of Limb, Terminal Illness, Total And Permanent Disability, or Rheumatoid arthritis, if:

- the **insured person** has at any time, had or undergone any of the insured conditions; or
- a medical adviser chosen by us, believes it has resulted from any condition which the **insured person** was known to have, at or before, being covered by the **scheme**.

As long as a later diagnosis confirms this, we'll consider an **insured person** to have:

- had
- undergone, or
- been in a duration period included in the definition of,

an insured condition before they were included for benefits under the **scheme**, even if the insured condition hasn't been formally diagnosed.

For increases in cover for the insured person

Each time an **insured person's** benefit increases (except benefit increases as a result of scheme earnings increases which are in-line with standard company pay awards and limited to a maximum of 7% per **policy** year.) we'll apply a new pre-existing conditions exclusion to that increase. For this purpose, wherever the exclusion refers to the date of joining the **scheme** or cover starting, it should be read as the day of the benefit increase.

If cover for a **child**, **spouse** or **registered civil partner** starts after the **insured employee** was first covered by the **scheme**, we'll apply the pre-existing conditions exclusion from the day the **child**, **spouse** or **registered civil partner** are also covered.

2.6 What is your related conditions exclusion?

For a new insured person

We apply a related conditions exclusion to all benefit. If we **medically underwrite** an **insured employee** and accept their cover we'll usually remove the exclusion applying up to the **insured employee's** benefit level we've **medically underwritten**.

The related conditions exclusion means we won't pay benefit for any insured condition occurring within two years of an **insured person** being covered by the **scheme** that resulted from any related condition. Related conditions include those for which the **insured person**, on or before the date they were covered by the **scheme**:

- has received treatment;
- has had symptoms of;
- has sought advice on; or
- was aware of.

For this exclusion, the insured condition may have directly or indirectly resulted from a related condition. The decision as to whether a condition is a related condition will be based on the opinion of a medical adviser chosen by us.

We'll confirm the related conditions in our quote and **policy**.

For increases in cover for the insured person

Each time an **insured person's** benefit increases we'll apply a new related conditions exclusion to the increased amount. For this purpose, wherever the exclusion refers to the date of being covered by the **scheme** or cover starting, it should be read as the day of the benefit increase.

If cover for a **child**, **spouse** or **registered civil partner** starts after the **insured employee** was first covered by the **scheme**, we'll apply the related conditions exclusion from the day the **child**, **spouse** or **registered civil partner** is included for cover.

2.7 What happens to a pre-existing and related condition exclusion following a claim?

When a lump sum is paid following a claim for an insured condition, a new pre-existing and related condition exclusion will apply in respect of later claims.

The new pre-existing and related condition exclusion will apply to all benefit, at the date the **insured person** last met an insured condition.

See questions 2.5 and 2.6 for more details.

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

	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.	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**. Our exclusions for pre-existing and related conditions will apply. See questions 2.5 and 2.6 for more details.	If you want to include an employee as a late entrant, we'll agree cover for them up to the **free limit** without any medical evidence. Our exclusions for pre-existing and related conditions will apply. See questions 2.5 and 2.6 for more details.

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

Early entrants

What if an early entrant doesn't meet the above requirements?

All other early entrants will need 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 accident cover for up to 90 days while we assess medical evidence. See question 2.9 for more details.

We still can consider cover for an employee 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.

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

We'll give employees temporary accident cover, starting from the later of:

- the date cover is needed from; or
- the date we know they need to provide their medical evidence.

Our temporary accident cover will end at the earliest of the date we finish our assessment or the end of 90 days. However, there are some limits for temporary accident cover:

- We'll only pay a claim if the accident happens during the period of temporary accident cover.
- An accident is an unforeseen and unintended casualty or mishap caused by violent accidental external and visible means during the temporary accident cover period and is the exclusive and immediate cause of the insured condition.

Temporary accident cover excludes:

- Claims caused directly or indirectly in whole or in part by alcoholic intoxication, the influence of narcotics or drugs and medical or surgical treatment (except if necessary because of the accident).
- Claims caused by, or happening through, suicide, attempted suicide or intentional self-injury.

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

Our exclusions for pre-existing and related conditions will apply.

See questions 2.5 and 2.6 for more details.

3.0 What premiums will you charge for the cover?

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

- amount of cover;
- age and gender of the **insured employees**;
- type of work;
- work locations;
- If we're also covering **spouses** or, **registered civil partners** and
- claims history, if the **policy** was previously insured or self-insured.

We don't charge a minimum premium.

Please read question 3.4 for more details about claims history.

3.1 How will you work out the premiums?

We'll use either a **unit rate** or an exact cost to work out the premiums. We'll tell you which one we'll use in our quote.

Unit rate – For policies with 10 or more insured employees

We'll work out the cost for each £100 of **total members' benefit** or **total scheme earnings**. We call this cost the **unit rate**. We'll multiply the **unit rate** by the **total members' benefit** or **total scheme earnings**, as appropriate for your policy at the start of each **policy** year to work out a year's premium.

If the **membership** falls below 10, we'll change the way we work out premiums to exact cost. We'll tell you before we do this.

Please read question 4.2 for more details.

Exact cost – For policies with nine or less insured employees

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

Please read question 4.2 for more details.

If the **membership** increases to 10 or more, we'll change the way we work out premiums to **unit rate**. We'll tell you before we do this.

3.2 Will there be any unexpected extra premiums?

We'll usually fix the **unit rate** or the age related premium rates until 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 another two years. However, we can change a **unit rate** during this period if there is a change of more than 25% in the **membership** or the **total members' benefit** (or **total scheme earnings**) covered by the **policy**. If this happens, we can change the **unit rate** from an **annual renewal date**. This means the premiums and the **unit rate** may go up or down.

If an **insured employee** has given us medical evidence, you may need to pay us an extra premium because of their health or dangerous pastimes. Although the extra premium applies immediately, we won't ask you to pay it straight away. Instead we'll wait and add it to your next account. You need to 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 read 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** or the **total members' 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 financial adviser?

We may pay commission to your financial adviser. The standard rate is 12% of the premium you pay. We can pay different levels of commission although this will affect the premium we charge. Our quote will show the commission level 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**. We'll adjust the premiums for a good or bad claims history. A good claims history is where there are fewer claims, this usually means the premiums will be lower than for a bad claims history.

4.0 How does the accounting work?

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

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

You can pay yearly premiums by cheque or Bankers' Automated Clearing System (BACS). You can only pay monthly premiums by direct debit.

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

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

You'll 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 won't update the final account, if new data is provided, 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 an **insured employee'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.

For unit rate policies

At the start of the **policy**, and at each rate review date, for each current **insured employee** you will need to give us their:

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

If we're also covering **spouses** or **registered civil partners** you'll also need to include their name, gender, date of birth and benefit level alongside each **insured employee's** details.

At other **annual renewal dates**, as long as there isn't a change of more than 25% in the data totals since the last **annual renewal date**, you'll only need to send us:

- the total number of **insured employees**; and
- the **total members' benefit**.

If the **policy** is set up on sweep up accounting we'll also need to know the **total members' 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.

It's important we get this renewal 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 **insured employee**, or if insured, a **spouse** or **registered civil partner**, 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.

For exact cost policies

At the start of the **policy** and at each **annual renewal date** we'll need a list showing each current **insured employee's**:

- name;
- gender;
- date of birth;
- **scheme earnings**;
- benefit;
- eligibility category (if there's more than one);
- date of joining for employees whose cover started between **annual renewal dates**;
- date of leaving for employees whose cover ended between **annual renewal dates**; and
- if the **policy** allows, the amount and date of any changes to benefit since the last **annual renewal date**.

If we're also covering **spouse** or **registered civil partners** you'll also need to include their name, gender, date of birth and benefit level alongside each **insured employee's** details.

It's important we get this renewal 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 **insured employee**, or if insured, a **spouse** or **registered civil partner**, 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 employees who join, leave or have benefit increases during the policy year?

We'll normally use exact cost accounting for **policies** with nine or less **insured employees**, and for all others either sweep-up or no change accounting. 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. 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 premium 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 **insured employee**. 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 have to pay us any premiums you owe immediately.

5.0 How do we make a claim?

For most insured conditions we'll pay the lump sum if the **insured person** survives for 14 days after meeting the definition for the insured condition. Firstly, we'll need you to send us a claim form within 30 days of the **insured person** meeting the definition of an insured condition. If we receive the claim form more than two years after the end of the survival period, we have the right not to pay the claim.

We'll assess the information on the claim form to check if the **insured person** is eligible for cover. We'll also need medical information to help us check the claim against the insured condition definition as well as our pre-existing and related conditions exclusions. This medical information could be a report from the **insured person's** doctor or medical consultant. We'll pay the cost of any medical reports we ask for.

If a claim is valid, we'll pay benefit to the relevant **member**. This includes any benefit payments in respect of the **member's spouse**, **registered civil partner** or **child**.

We also have some other requirements for a few specific insured conditions as follows:

Terminal illness claims

We'll only pay claims for terminal illness if you send us the claim form before the **insured person** reaches their **state pension age**.

You must also send us the claim form before the **insured person** dies.

Total and permanent disability claims

You should tell us about a potential claim after three months of continuous disability.

We'll only pay claims for Total And Permanent Disability before the **insured person** reaches their **state pension age**. The **insured person** must also have been continuously disabled for six months.

HIV infection

The definition of the insured condition must be met. A second blood test, within 12 months of the event, must confirm the presence of HIV or antibodies to that virus.

6.0 What don't you cover?

We won't pay a claim if the condition is not insured.

We include the full definitions of the conditions listed in question 1.7 with our quote and policy.

We won't pay a claim if the **insured person** doesn't meet the definition of the insured condition.

We won't pay a claim for Terminal Illness submitted to us after an **insured person's** death.

We won't pay a claim if the **insured person** had a pre-existing condition.

Please read question 2.5 for more details about pre-existing conditions.

We won't pay claim for any insured condition occurring within two years of an **insured person** being covered under the **scheme** that resulted from a related condition.

Please read question 2.6 for more details about related conditions.

We won't pay a claim for any person not eligible for cover.

For **insured employees** 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 **insured employees** 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'll cover **insured employees** who live and are employed in the United Kingdom while they are travelling overseas on company business.

We'll usually cover **insured employees** based overseas as long as they don't form the majority of your **insured employees**. We'll need their full details, as we may need to give you **special terms** for their cover. We won't start covering them until we've told you our terms.

In addition to any **special terms**, we'll also apply the following additional standard terms to an **insured person** while they are based outside the United Kingdom:

- You must pay all premiums, and we'll pay all benefit, from a UK bank account in UK pounds sterling.
- We'll fix any currency conversion rates at each **annual renewal date**.
- We reserve the right for a consultant to examine the **insured person** in a country of our choice. We define a consultant as: a recognised consulting doctor holding an appointment in a hospital in the United Kingdom or Republic of Ireland, or a recognised consulting doctor holding an appointment in a hospital in another country.
- If we need medical examinations and evidence when we assess a claim, we'll only pay the costs up to a similar level as if the claim had occurred in the United Kingdom.
- All diagnosis and medical reports must be in English.
- We limit the insured condition HIV Infection to specified countries, as stated on page 12 under question 1.7. We'll tell you these in our quote.

8.0 What tax rules apply?

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

- Premiums you pay for your employees are tax-deductible and can be offset against your profits for tax purposes.
- Your premiums will be treated as a benefit in kind for your employees. This means these employees will pay tax on the premiums you pay for them and their **spouse** or **registered civil partner** if covered.
- Your employees will not need to pay income tax on the lump sum we pay.
- Premiums which equity partners' pay for their own cover, as opposed to those paid for their employees, are not deductible for tax purposes. However, if we pay a lump sum following a claim, it will be paid tax-free.

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

No, an **insured person** cannot continue cover at their own expense if the **insured employee** stops working for you.

Further information

Providing insurance

This Group Critical Illness Cover **policy** is provided by Legal and 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 072 0751
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. Their contact details are at the end of this guide.

Law

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

Under our **policy**, an **insured person** does not have any rights under the Contracts (Rights of Third Party Act) 1999. This means you don't have to involve them in decisions about the insurance **policy** we provide.

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

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

Benefit entitlement
This is the amount of benefit an **insured person** 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.

Child/ Children
Any child, from birth but less than 21 years, who is:

- unmarried,
- a child of the **insured employee**, or
- a stepchild of the **insured employee** from a marriage or **registered civil partnership** entered into by the **insured employee** who is financially dependent upon the **insured employee**, or
- legally adopted by the **insured employee**.

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 an **insured person** 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**.

Insured employee
An employee or equity partner we've agreed to cover for benefit under the **policy**.

Insured person
A person we're covering for benefit under the **policy**. This can be an **insured employee** and their **spouse**, **registered civil partner** or **child**.

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

Member/ Membership
Employees included in the **scheme** in accordance with the eligibility terms.

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

Registered civil partner
A person whom the **insured employee** has registered a civil partnership with as defined in the Civil Partnerships Act 2004 which has not been dissolved or annulled and is less than age 70.

Scheme
The scheme you have set up to provide critical illness benefits to your employees. You decide how much of the benefits to insure under the **policy**.

Scheme earnings

These are the earnings we use to work out an **insured employee's** benefit if it's based on a multiple of earnings. Scheme earnings are usually the **insured employee's** basic annual salary, but you may use other earnings if this is more appropriate, for example, to allow for other income such as bonuses or commission. You cannot include directors' fees as part of scheme earnings. For equity partners, we'll usually base benefits on earnings averaged over the last three years for which accounts have been produced.

Special terms

Terms for cover that we cannot accept at ordinary rates. This can include an increase to the premium, exclusion, restriction, postponement or where cover has been declined.

Spouse

The **insured employee's** current or only husband or wife who is less than age 70.

State pension age

The age at which eligible people begin to receive their state pension from the Government.

Total members' benefit

The total insured benefit for all **insured employees**.

Total scheme earnings

The total **scheme earnings** for all **insured employees**.

Unit rate

This is one of the ways we calculate the cost of a **policy**. We'll calculate the cost for each £100 of cover and multiply this with the **total members' benefit** or **total scheme earnings** 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 072 0751 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**

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