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.

Progressive

A progressive definition combines all of the three 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 licence, for example, pilots 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.

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, we can limit the benefit payment term 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 protect 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 need to fill in a proposal form and pay the first premium within 14 days of the date we agree to provide cover.

If your adviser used our online service 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 a proposal 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 pastimes. Our **free limit** will depend on the 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 a **member** 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**.

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 a year and any additional premium loading is not more than 300%; or
- their cover is above £200,000 a 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 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 employees.

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.
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 **members** 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 is not **actively at work**, we will not cover them, or increase their cover, until they are next **actively at work**.

2.6 What medical evidence do you need for 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 give them **special terms** or ask for extra premiums. We'll need medical evidence before we can consider cover over the **free limit**. See question 2.2 for more details. We'll give temporary or accident cover for up to 90 days while we assess medical evidence. See question 2.7 for more details.

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 that employee before we can consider our terms for cover.

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

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

- We will not pay benefit 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 90 days. 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 90 days.

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

Unit rate – For policies with 10 or more members

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.

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 members

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**.

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. Please read question 4.2 for more details

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 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 a **member** 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. If you tell us in writing within 30 days that you don't want this cover, we will not charge the extra premium.

The premiums may also change at the start of the **policy** when we work out accurate premiums. Please 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 adviser as a percentage of each premium you pay. The standard rate is 12%. We can pay different levels of commission although this will affect the premium we charge. Our quote will show the rate we've allowed for.

3.4 Is there a discount for 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, this usually means the premiums will be lower than for a bad claims history.

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 the **basic allowance** and any other regular income, the total is not more than 90% of the **member's** total earnings just before the start of the **deferred period**.

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.

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 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 in advance of the **member** leaving service we may, at our discretion, agree to pay **member's benefit** directly to the incapacitated **member** 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.

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**.

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

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