Group critical illness cover A voluntary plan

Helping you understand our policy

Technical guide

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

VOL CIC 08/23

Legal & General

Using this document

What is a technical guide?

The Financial Conduct Authority is a financial services regulator. It requires us, Legal & General, to give you important information to help you to decide whether our 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). Unless shown otherwise 'employee' will also mean 'equity partner' and 'LLP member'.

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

Other documents

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

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

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

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

Target market and fair value assessment information for financial advisers

Our product governance webpage:

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

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

About Legal & General

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

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

Solvency and financial condition report (SFCR)

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

legalandgeneralgroup.com/investors/library

Contents

Aims, commitments and risks

Its aims

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

- Provide insurance to pay a lump sum benefit for an **insured person** who is diagnosed with an insured condition 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 a **member** at no extra cost.

  Please see the glossary for our definition of a child.
- Offer cover to the **spouse**, **registered civil partner** or **unmarried partner** of the **member**. This will increase the premium.

Offer a choice of cover for these benefits.

The levels of benefit are normally expressed in **units**. **Units** have a monetary value such as £10,000 or £25,000.

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 **monthly accounting dates** and **annual renewal dates**. We can cancel the **policy** if you don't give us this information.

  Please see question 4.1 for more details.
- Set up or adapt an administration system to help:
  - provide information to your employees;
  - help employees select their benefit;
  - work out premiums; and
  - send the payment and benefit selection details to us.

You may want to integrate this with your payroll system to help deduct the premiums from the **members'** earnings.

- 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 **membership** and the amount of benefit. For new **plans** we normally guarantee premium rates until the next **annual renewal date** when we'll review them. Once the **plan** is established we'll usually guarantee the rates for up to two years. We'll tell you the date the rates expire in our quotation and when we complete a review.
- You may need to pay us an additional premium if the value of all premiums from one **annual renewal date** to the next is less than the minimum premium. We'll proportion the minimum premium if cover for the **plan** doesn't start or stop on an **annual renewal date**. We'll tell you the minimum premium in our quote.
- We will stop cover if you don't keep to the **policy** conditions or stop paying premiums. We'll tell you in writing 14 days before we do this.
- We won't pay a claim if the person was not eligible for cover.

  Please see question 1.1 for more details about eligibility.

How the policy works

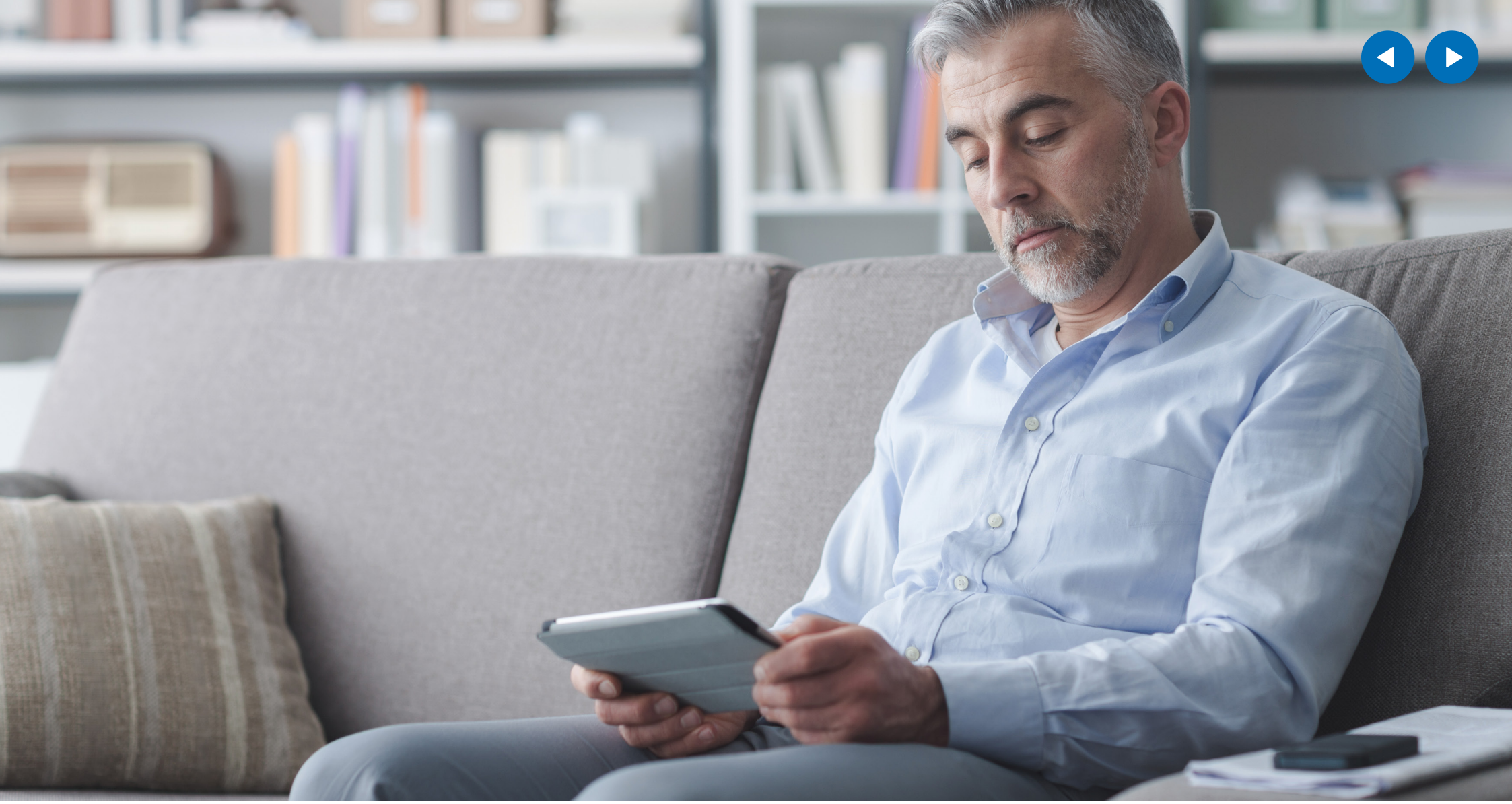
- If you currently insure the **plan** elsewhere, we normally need a minimum **membership** of 100.

  For a new voluntary **plan** which isn't currently insured, we usually require a minimum potential **membership** of 2,500. We can reduce this to 500 if it's linked to another group protection policy with a compulsory level of cover.

  We may be able to insure lower levels of **membership**. However, it increases the chances of you paying a shortfall if the total premiums paid by the **members** are less than our minimum premium.
- You set up a **plan** to provide the benefit to your employees. The **plan** benefits can then be insured under a **policy** issued to you. The **policy** will continue indefinitely as long as you meet its conditions, including paying premiums when they're due. Whether you're setting up a **plan** for the first time or switching cover to us from another insurer; we can prepare a specimen explanatory leaflet that you can use to explain the benefits to your employees.
- 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.
- Please tell us if you'd like to start a **policy** so we can agree the start date with you. We'll provide cover on the basis set out in our quotation. You'll need to allow plenty of time before the **policy** start date so you can tell your employees about the new **plan**, or any changes to an existing **plan**.
- You, as the policyholder, need to collect premiums due for each **insured person** as necessary, paying them in full to us each month.
- On the **monthly accounting date** you'll need to send us your premium calculation, and the premium payment.

  Please see question 4.0 for more details.
- You'll need to tell us if you want to change the insured basis in any way, for example, include another employer in the **plan** increasing the number of potential **members**. We'll need to assess if we can agree to the change and we may also need to set new terms and change the premium rates.
- We can change the **policy** terms at the end of any guarantee period. If we do this, we'll write to you at least 30 days before we change the terms. This won't apply to premium rate changes where we'll tell you at least three months before the **annual renewal date**. We'll give you more detail about this in the **policy**.
- 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 about these in the **policy**.
- You must give us all the information we need when you make a claim.
- If you make a valid claim, we'll pay the insured benefit directly to the **member** by direct credit.

  Please see question 5.0 for more details.



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?

A **member** can choose benefit in whole **units** up to a maximum number of **units**. A **unit** is an amount of cover, usually £10,000 or £25,000. We'll tell you the agreed **unit** size and maximum number of **units** in our quote.

Please see question 1.6 for more details about our other benefit limits.

1.1 Who can be covered?

We'll assume **membership** of the **plan** is open to all your employees who are normally working and resident in the United Kingdom. Please tell us if this isn't the case. For example, you may also want to offer **membership** to your equity partners or LLP members.

The eligibility conditions you choose will need to include entry ages and any service qualification. If **membership** of the **plan** is restricted to certain group of employees, you'll also need to give us a description of the group that will be eligible. You should also consider any laws on discrimination or unfair treatment. For example those about age, equal treatment of men and women, and the treatment of part-time, fixed-term and disabled employees.

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

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

We'll automatically include cover for the **children** of all the **members** 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 question 2.4 for more details of switch terms.

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?

Membership of the **policy** is offered at the following times:

- The **policy** start date and at each of the next three **monthly accounting dates**.
- After the **policy** start date employees can join from the **monthly accounting date** at, or immediately following, the start of their employment. If they don't join then they'll also have an opportunity at any of the next three **monthly accounting dates**.
- At each **annual renewal date**.
- Where you have asked us and we've agreed to allow for **lifestyle events**, there's a further opportunity to join. In these circumstances we'll let eligible employees join from either of the two **monthly accounting dates** immediately following a **lifestyle event**.

Lifestyle events are an optional feature, which if included, allows your employees to change, or join for benefit following specified events. We usually define **lifestyle events** as:

- the employee's marriage or the civil partnership registration.
- the birth of the employee's **child**.
- the adoption of a **child** by the employee.
- the death of an employee's dependant.
- the employee's divorce or dissolution of their **registered civil partnership**.

We'll consider variations to the above events. Please contact us to discuss your requirements.

When eligible to be covered, an employee will need to tell you the number of **units** of cover they have chosen. Our quote will tell you about the limits on cover, and if the employee needs to meet any conditions relating to medical evidence. Our pre-existing and related conditions exclusions will also apply when anyone joins the **plan**.

1.3 When can members change their cover?

Members can increase their chosen cover in whole **units** at the following times:

- At an **annual renewal date**.
- If the **policy** allows for **lifestyle event** changes, at one of the next two **monthly accounting dates** following a **lifestyle event**.

If we've included **lifestyle event** changes, we'll limit the number of times a **member** can increase their cover during a single **policy** year. We'll tell you these limits in our quote.

We'll apply the pre-existing and related conditions exclusions to each increase. The previous terms and exclusions, if any apply, will remain for the previous level of benefit.

Members can decrease their benefit by any number of **units** at any time. We'll reduce the benefit at the next **monthly accounting date** after they tell you of their decision. If a **member** has increased cover at different times, the pre-existing and related conditions exclusions will apply from different dates. When cover is reduced, we'll remove the **units**, terms and exclusions relating to the most recent increases first.

Members can choose to cancel benefit at any time. The change will take place at the next **monthly accounting date** after they tell you of their decision, unless the cover has been terminated for any other reason.

Eligible employees can restart their cover after leaving the **plan** or decreasing benefit. We'll treat restarted cover as a cover increase. This means an employee can only restart cover when the **policy** allows increases.

1.4 Will cover continue for a member who is temporarily absent?

Yes, we'll continue to provide cover for temporary absence or maternity, paternity, adoption or shared parental leave for up to one year from the **monthly accounting date** immediately before the start of the absence provided:

- premiums continue to be paid to us; and
- the **member** continues to be entitled to benefit under the terms and conditions of their employment.

We'll consider other periods of temporary absence. Please contact us if you would like a different option.

A **member** can't increase cover during temporary absence from work.

The temporary absence cover doesn't apply to equity partners or members of a LLP. However, they'll be covered while they remain equity partners or members of a LLP and entitled to a share of the profits, whether they are at work or not. Premiums must continue to be paid to us for the cover to continue.

1.5 When will cover end?

a) Under normal circumstances

We will stop covering an **insured person**:

- the day before the next **monthly accounting date** following a **member's** decision to cancel the **insured person's** cover;
- the day before the next **monthly accounting date** when the **member** leaves your employment;
- when the **member** reaches the benefit termination date we show in the **policy**. This is the day our cover ends and is usually their **state pension age**;
- if the **insured person** no longer meets the eligibility conditions;
- if we stop receiving premiums;
- if the **member** retires early;
- if the **member** reaches the end of a period of temporary absence cover; or
- if they die before we're due to pay benefit.

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

If you become subject to an effective winding up resolution, or cease to carry on business, cover for all **insured persons** will end at the end of the monthly accounting period for which premiums have been paid.

If an **insured person**:

- is diagnosed with;
- has undergone; or
- is in a duration period included in the definition of:

an insured condition before cover is cancelled, we'll pay benefit in accordance with the **policy** terms.

1.6 What is the maximum benefit you will cover?

The maximum benefit we will cover is:

Members – the lower of

- five times their **P60 earnings**; and
- £250,000.

Spouses, registered civil partners and unmarried partners – a cash amount of £150,000.

We will still insure benefit for a **spouse**, **registered civil partner** or **unmarried partner** if the employee's benefit isn't insured.

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

- an amount equal to 25% of the **member's benefit**; and
- £20,000.

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

Children's cover is dependent on the employee being a **member**.

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

We'll tell you in our quote which conditions 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 questions 2.5, 2.6 and 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	with surgery to divide the breastbone
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 persisting symptoms
Parkinson's Disease	resulting in permanent symptoms
Progressive Supranuclear Palsy	resulting in permanent symptoms
Stroke	resulting in symptoms lasting at least 24 hours

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	
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)	
Angioplasty	to treat specific conditions of specified severity
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 either surgical removal or permanent symptoms
Blindness	permanent and irreversible
Cardiomyopathy	of specified severity
Coma	resulting in permanent symptoms
Deafness	permanent and irreversible
Encephalitis	resulting in permanent neurological deficit
Heart Surgery	with surgery to divide the breastbone
Heart Valve Replacement Or Repair	with surgery to divide the breastbone
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
Pulmonary Artery Surgery	to excise and replace with a graft
Respiratory Failure	of advanced stage
Rheumatoid Arthritis	of specified severity
Terminal Illness	before the **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	permanent, irreversible and before the greater of age 65 or **state pension age**
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 need. You'll need to fill in a proposal form and we'll need the first premium within 14 days of the date we agree to provide cover. Where it isn't possible for you to tell us what the first month's premium will be within 14 days, we'll ask for a nominal deposit premium instead. The nominal deposit premium will be based on the information you've already provided us for the quote.

You'll also need to allow some time before the **policy** starts to let your employees know about a new **plan** or any changes to your existing **plan**.

Please also check if any **members** 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?

Usually an **insured person** will get cover without needing to give us medical evidence. Medical evidence is information about their health and pastimes. We'll tell you in the quote if evidence is needed.

We have a pre-existing and related condition exclusion. This means we won't pay a claim for any condition the **insured person** had 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.

If a **member** needs to give us medical evidence, they will need to fill in a member's declaration form. We call our assessment of this evidence, **medical underwriting**.

To help the **member** fill in the member's declaration form, we offer a tele-interview service allowing the form to be filled in 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/workplacebenefits. 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 having these carried 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 and we'll give you details about this at the time.

If we accept **medically underwritten** cover:

- Any **special terms** we set will apply to all the **member's benefit**. This includes any previously accepted cover.
- We will no longer apply the pre-existing and related conditions exclusions up to the **medically underwritten** level of **member's benefit**.
- If you're not happy with any **special terms** we've set, you'll have 30 days to write us and cancel the cover the **special terms** relate to. If you do we'll reinstate the pre-existing and related conditions to the **member's benefit**.

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

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

If we **medically underwrite** a **member** we may ask for more medical evidence for increases in benefit. This will depend on the amount of the increase and any existing **special terms**. We'll write to you to let you know our requirements.

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

Terms for an eligible person's cover that starts at the switch date

We'll apply our pre-existing and related condition exclusion.

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

Switch terms for an insured person previously insured

We'll usually provide cover for an **insured person** at the same level and on the same terms as the previous insurer. However we'll apply our pre-existing and related conditions exclusion in place of the previous insurer's exclusions, and the cost of cover may be different.
To do this:

- the previous insurer will have accepted cover for all the benefit levels chosen for them at any time;
- the cover with the previous insurer was not subject to any **special terms**;
- if they were **medically underwritten** by the previous insurer, the last acceptance terms were issued within the five years immediately before the switch; and
- their cover doesn't exceed the maximum benefit in our quotation.

Terms for an insured person who doesn't meet our switch terms

We're happy to consider and negotiate terms to insure any **member** who doesn't meet the switch terms conditions. If you give us their full details, we'll consider if we can cover them. If we can then set terms, you'll need to accept them 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 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 **member's benefit** level we've **medically underwritten**.

See question 2.2 for more details about removing the pre-existing and related conditions exclusion.

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

- had or has or undergone before they join the **plan**.
- is already in a qualifying period for an insured condition when they join the **plan**. 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 **plan**.

The above exclusion will apply even if a diagnosis has not been made before cover for the **insured person** starts.

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

Angioplasty	to treat specific conditions of specified severity
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 Artery Bypass Grafts	with surgery to divide the breastbone
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	with surgery to divide the breastbone
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.

We will consider the following to be the same condition

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

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 covered through the **plan**:

- Loss Of Independent Existence (including Muscular Dystrophy) – permanent and irreversible
- 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), Paralysis Of limb, Terminal Illness, or Total And Permanent Disability, if:

- the **insured person** has at any time, been diagnosed with 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 through the **plan**.

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 **plan**, even if the insured condition hasn't been formally diagnosed.

For increases

Each time an **insured person's** benefit increases we'll apply a new pre-existing conditions exclusion to that increase. For this purpose, wherever the exclusion refers to the date of being covered through the **plan** or cover starting, it should be read as the day of the benefit increase.

If cover for a **child** starts after the **member** is covered under the **plan**, we'll apply the pre-existing conditions exclusion from the day the **child** is included for cover.

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** a **member** and accept their cover we'll usually remove the exclusion applying up to the **member's benefit** level we've **medically underwritten**.

See question 2.2 for more details about removing the pre-existing and related conditions exclusion.

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 **plan** 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 **plan**:

- 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 tell you the related conditions in our quote and **policy**.

For increases

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 **plan** or cover starting, it should be read as the day of the benefit increase.

If cover for a **child** starts after the **member** is covered by the **plan**, we'll apply the related conditions exclusion from the day the **child** is included for cover.

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

When a claim is made 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.

2.8 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.

3.0 What premiums will you charge for the cover?

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

- amount of cover;
- age of each **member**;
- type of work of **membership** as a whole;
- work locations;
- If we're also covering **spouses, registered civil partners**, or **unmarried partners**; and
- claims history, if the **plan** was previously insured or self-insured.

Please read question 3.4 for more details about claims history.

A minimum premium will apply. This means if the value of all premiums calculated using the premium rate table from one **annual renewal date** to the next is less than the minimum premium, we'll ask you to pay the difference. We'll proportion the minimum premium if cover for the **plan** doesn't start or stop on an **annual renewal date.** We'll tell you the minimum premium in our quote.

3.1 How will you work out the premiums?

You will calculate the premium each month using the table of rates we'll provide and the **plan** membership data at each **monthly accounting date**. The table of rates will refer to the ages and the cost of the **units**. We'll periodically check your calculation when you send us the premium and supporting data.

The premium rates on the table are age related and increase with age. For ease, the ages referred to for the calculation of premiums are those attained at the **policy** start date or preceding **annual renewal date** if later.

At each **annual renewal date** you'll need to total the premiums paid for the preceding year and compare them against the minimum premium. If there is a shortfall, you'll need to pay us the difference up to the minimum premium straight away.

3.2 Will there be any unexpected extra premiums?

If a **member** has given us medical evidence, following our assessment, we may charge an extra premium. We'll write to you to let you know how much this extra premium is. It reflects the **member's** state of health or dangerous pastimes. The extra premium will be effective immediately, as will the additional benefit. If the **member** decides that they don't want to pay the extra premium, please tell us in writing within 30 days of our letter to you. We'll then remove the extra premium and the additional benefit.

We may charge a minimum premium.

Please read question 3.0 and 3.1 for more details about our minimum premium.

3.3 How much commission will you pay our adviser?

We may pay commission to your 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 for our **policy**, and any previous policies, when we work out our table of rates. 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?

The **policy** has a monthly accounting period with premiums becoming due at each **monthly accounting date**. At each **monthly accounting date** you'll need to calculate the required premiums due for each **insured person**, collect them, and pay them to us in full.

We can accept premium payments from you by the Bankers' Automated Clearing System (BACS).

4.1 What information do you need for accounting?

At each **monthly accounting date** we'll need for each **member**, their:

- name;
- gender;
- date of birth;
- age attained at the last **annual renewal date**, or the **policy** start date if the first **annual renewal date** hasn't been reached;
- benefit; and
- amount of calculated premium.

If we're also covering **spouses**, **registered civil partners**, or **unmarried partners** you'll also need to include the same information for them alongside each **member's** details.

When we review the table of rates ahead of an **annual renewal date** we'll also ask you to supply information about the occupation categories and geographical distribution of all **members**.

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** or **unmarried partner**, who you should have included on the membership list, we won't pay a claim for them.

4.2 How do you adjust premiums for an insured person whose benefit changes during a policy year?

Premiums are calculated by reference to the **plan** membership at each **monthly accounting date**. Changes to the **membership** and benefit during the **policy** year will therefore be allowed for within each monthly account.

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 date the **policy** is cancelled. If an allowance needs to be made for a minimum premium in the final account, this will be proportioned to reflect the cover for part of a year. We will either send you a refund for any overpaid premiums, or you'll have to pay any premiums you owe us 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.

You can claim for more than one insured condition, however we'll only pay one valid claim if more than one insured condition arises from a single incident.

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**, **civil partner**, **unmarried 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 the **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 benefit for any insured condition occurring within two years of an **insured person** joining the **plan** that resulted from a related condition.

Please read question 2.6 for more details about related conditions.

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

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

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

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

We'll cover **members** who live and are employed in the United Kingdom while they are travelling overseas.

We'll usually cover **members** based overseas as long as they don't form the majority of the **membership**. 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, in the UK in sterling.
- For **medical underwriting** and assessing claims, we reserve the right for the **insured person** to be examined by a consultant and 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 conditions Angioplasty and HIV Infection to specified countries. We'll tell you these in our quote.

8.0 What tax rules apply?

Our understanding of the tax rules for this **policy** are:

- **Members** will not get tax relief on the premiums they pay.
- **Members** will not need to pay income tax on the lump sum we pay.

9.0 Can an insured person continue their cover if the member leaves my employment?

No, an **insured person** cannot continue cover at his or her own expense if the **member** stops working for you.

Further information

Providing insurance

This Voluntary Group Critical Illness Cover **policy** is provided by Legal & General Assurance Society Limited. Our principal office for the purpose of the **policy** is at:

Knox Court,
10 Fitzalan Place,
Cardiff
CF24 0TL

0345 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-policy

Questions and complaints

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

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

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

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

Compensation

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

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

- unmarried,
- a child of the **member**, or
- a step child of the **member** from a marriage or **registered civil partnership** entered into by the **member** who is financially dependent upon the **member**, or
- a child of an **unmarried partner** who is financially dependant on the **member**; or
- legally adopted by the **member**.

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.

Insured person
A person we're covering for benefit under the **policy**. This can be a **member** or their **spouse**, **registered civil partner**, **unmarried partner** or **child**.

Lifestyle event
Lifestyle events enable **members** to change, or join for benefit following specified events. Lifestyle events are usually ones which would change a **member's** way of life. The events you decide to include will need to be agreed by us before the **policy** starts.

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

Member
An employee, equity partner or LLP member we've agreed to cover for benefit under the **policy**.

Membership
The **members** covered by the **policy**.

Member's benefit
A **member's** cover under the **policy**. This cover amount doesn't include any benefit for any **children**, a **spouse**, a **registered civil partner** or an **unmarried partner**.

Monthly accounting date
The first day of each monthly accounting period. Normally this is the **annual renewal date** and the same day of every month afterwards.

Policy
The legal contract between you and us. You choose how much of the benefits to insure under the policy.

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

P60 earnings

If the **member** is an employee, it's their total earnings from the employer in the previous tax year excluding director's fees. We'll annualise the taxable earnings you have employed for less than a complete tax year.

If the **member** is an equity partner or an LLP member, it's their self-employed earnings from the firm averaged over the last three years for which accounts have been produced. If an equity partner or LLP member has been with the firm for less than three years, we'll work out the average annual earnings over the time they have been at the firm.

The tax year runs from the 6 April to the 5 April.

Registered civil partner

A person whom the **member** 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.

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 **member'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.

Unit

An amount of cover, usually £10,000 or £25,000. **Members** can choose cover in whole units.

Unmarried partner

A person:

- who is financially dependent on the **member** or with whom a financial dependency exists with the **member** which contributes to their joint standard of living, and
- is aged not less than 16 years but less than 70 years, and has the same residence as the **member**, and
- is not a **child** or a foster child or relative of the **member**.

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 settle 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 8.30am to 5.30pm Monday to Friday.	**0800 023 4567** or **0300 1239 123** (free for mobile phone user paying a monthly charge for calling phone numbers beginning with 01 or 02).	**020 7741 4100** or **0800 678 1100**
group.protection@landg.com **legalandgeneral.com/workplacebenefits**	**complaint.info@financial-ombudsman.org.uk** **financial-ombudsman.org.uk**	**enquiries@fscs.org.uk** **fscs.org.uk**

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