GROUP SALARY CONTINUANCE INSURANCE

Supplementary Product Disclosure Statement (SPDS)

5 June 2023

HEALTHIER, LONGER, BETTER LIVES

This Group Salary Continuance Insurance SPDS is used to supplement and advise of any changes to the Group Salary Continuance Insurance Combined Product Disclosure Statement and Policy Document ('Group SC Insurance PDS') issued 1 March 2022.

This SPDS is issued by AIA Australia Limited (ABN 79 004 837 861 AFS Licence No. 230043), who is the insurer of the Group Salary Continuance Insurance product.

AIA Australia takes full responsibility for the entirety of this SPDS. This SPDS must be read together with the Group SC Insurance PDS issued 1 March 2022.

Section 5. Benefits

Section 5.3.2 'What we'll pay' is deleted and replaced with the following:

(Page 20 of the Group SC Insurance PDS)

5.3.2 What we'll pay

If an **Insured Person** becomes **Partially Disabled**, we'll calculate the **Monthly Benefit** using this formula:

$$\frac{A - B}{A} \times C$$

where:

*A = is the **Insured Person's Pre-Disability Income***

*B = the **Insured Person's Current Income** for the month for which they are claiming **Partial Disability***

*C = is the **Insured Person's Monthly Benefit** (i.e. if they were **Totally Disabled**)*

If we do not consider the **Insured Person** to be working to their capacity for reasons other than injury or sickness, "B" also includes any income they could reasonably be expected to earn if they were working to the extent of their capability in either their usual occupation or in any occupation. In determining this, we will consider all available medical evidence and any other relevant matters.

Where applicable and stated in the **Policy Schedule**, the **Partial Disability** benefit also includes the **SC Benefit** which we calculate using this formula:

$$\frac{A - B}{A} \times D$$

where:

*A = is the **Insured Person's Pre-Disability Income***

*B = the **Insured Person's Current Income** for the month for which they are claiming **Partial Disability***

*D = is the **Insured Person's SC Benefit***

The **Monthly Benefit** is payable monthly in arrears and stops at the earliest of the events described under Section 5.4.

Section 13. Meanings of words in this PDS

Section 13.1 'General Definitions' the definition 'Current Income' on page 37 of the Group SC Insurance PDS is deleted and replaced with the following:

Current Income	Means the income earned, by an **Insured Person** from personal exertion while **Partially Disabled** whether the income is from their usual occupation or any occupation. If the **Insured Person** takes annual leave or long service leave during the period of **Partial Disability**, this will be included in the income the **Insured Person** would have earned had they not taken such leave.

AIA Australia Limited (ABN 79 004 837 861 AFSL 230043) | 05/23 – GI7491

HEALTHIER, LONGER, BETTER LIVES

CORPORATE COVER

Group Salary Continuance Combined Product Disclosure Statement and Policy Document (PDS)

Issue Date: 1 March 2022

aia.com.au

Important Information

About this PDS

This Group Salary Continuance Combined Product Disclosure Statement and Policy Document (PDS) describes the main features and terms of AIA Australia's Group Salary Continuance Insurance product, which is issued by AIA Australia Limited ABN 79 004 837 861, AFSL 230043, (AIA Australia).

The product described in this PDS is only available to persons applying in Australia. Applications from outside Australia will not be accepted.

The PDS has been prepared with the intention of providing you with important information about AIA Australia's Group Salary Continuance Insurance product. Any information contained in this PDS is of a general nature only and has been prepared without taking into account your objectives, financial situation or needs. Therefore, before making any decision, you should consider the appropriateness of the advice, having regard to your objectives, financial situation and needs. If you are deciding whether to acquire this product, you should read this PDS before making your decision. Anyone making this PDS available to another person must provide them with the entire electronic file or printout. We will also provide a paper copy of the PDS on request without charge.

The information in this PDS is current as at the issue date of the PDS and may change from time to time. Where changes are made to the PDS (including changes that are materially adverse, or otherwise required by law) we will replace this PDS or issue a Supplementary PDS, and give you notice as required or permitted by law.

Taxation considerations are general and based on present taxation laws and may be subject to change. You should seek independent, professional tax advice before making any decision based on this information.

Defined terms

Certain terms in this PDS have been capitalised and bolded. Unless the context requires otherwise, these terms are defined in Section 13 of the PDS.

Throughout this PDS, any reference to:

- '**AIA Australia**', '**we**' '**us**', and '**our**' means AIA Australia Limited (ABN 79 004 837 861, AFSL 230043).
- '**you**' or '**your**' means the **Policy Owner**.
- '**your Policy**', '**a Policy**', '**the Policy**' means the documents that make up your policy issued by us to you
- '**PDS**' means this document which comprises the Group Salary Continuance Combined Product Disclosure Statement and Policy Document

Understanding this document

In this PDS:

- headings are used as a guide only,
- singular and plural nouns may be used interchangeably depending on the context, and
- reference to monetary amounts are in Australian dollars.

Contacting us

If you need to contact us you can do so at:

Level 6, 509 St Kilda Road
Melbourne VIC 3004
Phone: 1800 333 613 between 8 am and 6 pm (AEST/AEDT), Monday to Friday.

About AIA Australia

The best in life

AIA Australia is a leading life insurance specialist with 50 years' experience. We offer a range of products and services that protect and enhance the lives of more than 3.8 million Australians. We have a dream to champion Australia to be the healthiest and best protected nation in the world. We do that with AIA Vitality – the world's leading science-based health and wellbeing program, AIA health – A new kind of health insurance, and our Wellbeing Ecosystem we help our customers to live healthier, longer, better lives.

AIA Australia has been recognised with multiple awards, including Super Review Awards - Best Insurer of the Year (2018, 2019), FSC Life Insurance Awards - Innovation in Group Life Insurance (2021), iSelect Partner Awards - Insurer of the Year (2019), Insurance Asia International Life Insurer of the Year (Australia, 2020), Shared Value Awards Project of the year - Mental health support during COVID (2021), Shared Value Awards - Corporate Organisation Leading Through Shared Value (2019), Shared Value Awards - Organisation of the Year (2020) and the Women in Finance Employer of the Year Award (2018, 2019).

AIA Australia is wholly owned by the AIA Group, the largest independent publicly listed pan-Asian life insurance group with a presence in 18 markets across the Asia-Pacific region.

Further information can be found at aia.com.au

About AIA

AIA Group Limited and its subsidiaries (collectively "AIA" or the "Group") comprise the largest independent publicly listed pan-Asian life insurance group. It has a presence in 18 markets across the Asia-Pacific region - wholly-owned branches and subsidiaries in Hong Kong SAR, Thailand, Singapore, Malaysia, Mainland China, South Korea, the Philippines, Australia, Indonesia, Taiwan (China), Vietnam, New Zealand, Macau SAR, Brunei, Cambodia, Myanmar, and a 49 per cent joint venture in India.

The business that is now AIA was first established in Shanghai a century ago in 1919. It is a market leader in the Asia-Pacific region (ex-Japan) based on life insurance premiums and holds leading positions across the majority of its markets. It had total assets of US$326 billion as of 31 December 2020.

AIA meets the long-term savings and protection needs of individuals by offering a range of products and services including life insurance, accident and health insurance and savings plans. The Group also provides employee benefits, credit life and pension services to corporate clients. Through an extensive network of agents, partners and employees across Asia-Pacific, AIA serves the holders of more than 38 million individual policies and over 16 million participating members of group insurance schemes.

AIA Group Limited is listed on the Main Board of The Stock Exchange of Hong Kong Limited under the stock code "1299" with American Depositary Receipts (Level 1) traded on the over-the-counter market (ticker symbol: "AAGIY").

Partnering specialists

AIA Australia understands that the need of every client is different. That's why AIA Australia offers a flexible approach to life insurance. We can combine different types of cover within a single policy, tailoring specific solutions to deliver the most effective level of protection for our clients' needs. Our fresh and intelligent approach can add value, efficiency and a competitive advantage to our clients' business.

- We are one of Australia's largest group life insurers.
- We provide solutions to some of Australia's major financial institutions and corporate partners.
- We also offer retail insurance products through financial advisers and a valued network of affinity partners.
- We care for the health, insurance and rehabilitation needs of more than 3.8 million Australians.
- AIA Australia employs almost 2,325 staff across Australia.

Committed to the community

The AIA Australia philosophy is simple – helping people when they need it most. We want people to have adequate life insurance. We pay the claims that should be paid. We have the knowledge and experience to engage in controlled risk taking rather than risk avoidance. We are constantly reviewing our underwriting tools, such as non-medical limits, to minimise inconvenience to our clients and ultimately the lives insured.

We adopt a professional and positive approach to claims assessment to ensure claims are paid promptly.

Entrepreneurial culture

Our aim is to set industry standards in both product and service through our experienced and approachable team and by providing comprehensive, flexible group insurance solutions.

AIA Australia's employees work as a team to deliver some of the industry's most innovative life insurance solutions, with the aim of providing a worry free future to our customers.

We are passionately committed to providing an efficient and sensitive claims service that will help our customers when they need it most.

Experienced and proactive team

Our Business Development Team brings with them years of experience and insight in group insurance. We understand the specific needs of Australian group insurance clients and have superannuation fund and employer owned policy group insurance experience. The Business Development Team is supported by some of the industry's best group claims, actuarial, underwriting, administration and account management personnel from a myriad of backgrounds including superannuation, financial planning, consulting and administration to name a few. We also provide all the technical and communication support required by our clients.

Our commitment to you is a long term one. We build open and rewarding relationships through which we can continuously improve our product offering, as well as the way we work together, to create as much value as possible for you and your clients.

AIA Australia supports the FSC Life Insurance Code of Practice (Code)

The Code sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest. It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers.

The Code covers many aspects of a customer's relationship with their insurer, from buying insurance to making a claim, to providing options for those experiencing financial hardship or requiring additional support.

If you believe we have not acted within the spirit of the Code or are unhappy with your experience with us, you can access our complaints process by contacting us. You can find more information on the Code at fsc.org.au.

Contents

1. Policy Overview

1.1 About this Document

This is a Combined Product Disclosure Statement and Policy Document (PDS) issued by AIA Australia Limited (ABN 79 004 837 861, AFSL 230043)("AIA Australia"), which describes the main features and benefits of AIA Australia's Group Salary Continuance Insurance product.

This PDS is designed to help you understand AIA Australia's Corporate Cover product, which can be held inside superannuation, or as part of an employee benefit plan, outside of superannuation.

It provides important information about the features, benefits, costs and risks associated with the Corporate Cover product.

1.2 Implementing a Policy

AIA Australia provides group insurance to organisations such as employers or superannuation funds, where those organisations have 200 or more lives to be insured on a consistent basis.

In some cases, AIA Australia will provide **Cover** to Australian organisations with less than 200 lives where those organisations, usually employers, operate and have offices in multiple countries.

After consultation with you, AIA Australia will provide a quotation summary which should be considered in conjunction with this PDS.

In order to implement an AIA Australia group insurance Policy, we require the following:

- acceptance by email from you of our terms and the time and date you would like us to assume risk from (we will then confirm we are on risk by return email, issue an invoice and a partially completed group insurance Proposal Form),
- a fully completed group insurance Proposal Form, and
- payment of the required Deposit Premium.

Once all documentation is received, we will assist you in completely installing the group insurance Policy and underwriting **Eligible Persons** where necessary.

Cover for **Eligible Persons** does not commence until either AIA Australia notifies you in writing that the risk has been accepted or by the issuance of a Policy.

1.3 What documents make up your Policy?

Your Policy is a contract of insurance between AIA Australia(us) and you (the **Policy Owner**). It's made up of the following:

- sections 2 through to 13 of this PDS,
- the **Policy Schedule** issued to you and signed by us, and
- any riders or endorsements issued to you and signed by us.

1.4 About the Policy

This Policy:

- will be written in the AIA Australia Statutory Fund No 1,
- doesn't participate in our profits,
- doesn't acquire a surrender value,
- is subject to, and governed by, the laws of the Commonwealth of Australia, and
- is only available to **Policy Owners** in Australia.

This Policy can be assigned in accordance with the *Life Insurance Act 1995* (Cth) with our prior written consent. If we allow the assignment, the assignee will be recorded as the new **Policy Owner** with all the rights, powers, duties, obligations and privileges of the original **Policy Owner**.

All payments made in connection with this Policy, whether to us or by us, must be made in Australia and in Australian dollars.

1.5 Policy Owner

All benefits payable under the Policy are paid to the **Policy Owner** unless otherwise instructed by the **Policy Owner**.

The Policy can be issued as an ordinary Policy to an **Employer** as an **Employee** benefit, or it can be issued as a superannuation Policy to the trustee of a superannuation fund. This will be set out under the **Policy Type** in the **Policy Schedule** issued by us.

1.6 Inside Superannuation

Some of the terms and conditions of the benefits differ where the **Policy Owner** is a superannuation fund. The terms and conditions of all benefits are set out in this PDS and the **Policy Schedule**.

Where a trustee of a superannuation fund is the **Policy Owner**, all benefit payments due under the Policy will be made to or as directed by the **Policy Owner** and their release will be subject to restrictions under the relevant fund's trust deed and superannuation law.

1.7 Duty of Disclosure for Policy Owners

If you are the **Policy Owner**, you have a duty to tell us anything that you know, or could reasonably be expected to know, which may affect our decision to insure you and any other **Insured Person** and on what terms.

You have this duty until we agree to insure you, and also before you extend, vary or reinstate the Policy.

You do not need to tell us anything that:

- reduces our risk,
- is common knowledge,
- we know or should know as an insurer, or
- we waive your duty to tell us about.

If you do not tell us something

We may apply the following rights separately to each type of cover that we consider could form a separate Policy.

If you do not tell us something that you know, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms, this may be treated as a failure by the person entering into the contract to tell us something that they must tell us.

If you are the **Policy Owner**, and you do not tell us anything you are required to, and we would not have insured you if you had told us, we may avoid the contract within three years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount you or the **Insured Person** have been insured for. This would be worked out using a formula that takes into account the premium that would have been payable if you had told us everything you should have.

If we choose not to avoid the contract or reduce the amount you or the **Insured Person** have been insured for, we may, at any time vary the contract in a way that places us in the same position we would have been in if you had told us everything you should have.

If your failure to tell us is fraudulent, we may refuse to pay a claim and treat the contract as if it never existed. We may apply these rights separately to each type of cover that we consider could form a separate Policy.

1.8 Duty to Take Reasonable Care for Insured Persons

Before an **Insured Person** enters into a life insurance contract, they have a legal duty to take reasonable care not to make a misrepresentation to the insurer before the contract of insurance is entered into.

A misrepresentation is a false answer, an answer that is only partially true, or an answer which does not fairly reflect the truth.

This duty applies to a new contract of insurance and also applies when extending or making changes to existing insurance, and reinstating insurance.

When an **Insured Person** applies for life insurance, we conduct a process called underwriting. It's how we decide whether we can cover an **Insured Person**, and if so, on what terms and at what cost.

We will ask questions we need to know the answers to. These will be about the **Insured Person's** personal circumstances, such as health and medical history, occupation, income, lifestyle, pastimes, and current and past insurance. The information the **Insured Person** gives us in response to our questions is vital to our decision.

If the Insured Person does not meet the duty

If the **Insured Person** does not meet their legal duty, this can have serious impacts on their insurance. There are different remedies that may be available to us. These are set out in the *Insurance Contracts Act 1984* (Cth) and are intended to put us in the position we would have been in if the duty had been met.

The **Insured Person's Cover** could be avoided (treated as if it never existed), or its terms may be varied. This may also result in a claim being declined or a benefit being reduced.

Please note there may be circumstances where we later investigate whether the information given to us was true. For example, we may do this when a claim is made.

Before we exercise any of these remedies, we will explain our reasons and what the **Insured Person** can do if they disagree.

We may apply these remedies separately to each type of cover that we consider could form a separate Policy.

Guidance for answering our questions

The **Insured Person** is responsible for the information provided to us. When answering our questions, the **Insured Person** is required to:

- Think carefully about each question before they answer. If they are unsure of the meaning of any question, they should ask us before responding.

- Answer every question.
- Answer truthfully, accurately and completely. If they are unsure about whether they should include information, they should include it.
- Review their application carefully before it is submitted. If someone else helped prepare their application (for example, an adviser), they should check every answer (and if necessary, make any corrections) before the application is submitted.

Changes before Cover starts

Before the **Insured Person's Cover** starts, we may ask about any changes that mean they would now answer our questions differently. As any changes might require further assessment or investigation, it could save time if they let us know about any changes when they happen.

If the Insured Person needs help

It's important that the **Insured Person** understands this information and the questions we ask. They should ask us or a person they trust, such as their adviser for help if they are having difficulty understanding the process of buying insurance or answering our questions.

If they're having difficulty due to a disability, understanding English or for any other reason, we're here to help. If required, the **Insured Person** can have a support person they trust with them.

Notifying the insurer

If, after the **Cover** starts, and the **Insured Person** thinks they may not have met their duty, please contact us immediately and we'll let them know whether it has any impact on the **Cover**.

1.9 Prohibition of certain transactions

Despite anything to the contrary, there is no **Cover** under this Policy and AIA Australia is not obliged to make any payments or to provide any services or benefits in relation to this Policy if:

- such **Cover**, payments, services or benefits, or
- **Cover**, payments, services or benefits provided by a third party in relation to, or arising from the Policy (including by a reinsurer of AIA Australia to AIA Australia),

would contravene any:

- United Nations resolutions,
- prohibitions or restrictions on trade or economic sanctions, or
- laws, government policy, regulatory guidance or regulator requests (including in relation to trade or economic sanctions) in Australia, the European Union or in any other jurisdiction,

applicable to the **Cover**, payments, services or benefits by AIA Australia or the third party.

2. Product features at a glance

The information in this section is a summary only and should be read in conjunction with the information provided in the Policy.

2.1 What options are available?

AIA Australia's Corporate Cover product has been designed to offer employers and superannuation funds the flexibility to tailor **Cover** to meet the needs of their employees and members. The following table outlines the different product design options available.

Product design feature	Options available
Benefit Period	2 year, 5 year, 10 year, To Age 60 and To Age 65
Cover Expiry Age	60, 65, and 70
Waiting Period	30 days, 60 days, and 90 days
Superannuation Contributions Benefit (SC Benefit)	Up to 15%
Insured Percentage	70% 70% reducing to 60% after 24 months 75% 75% reducing to 60% after 24 months
Disability definitions^	Definition 1 of **Disability**: assessed against 'usual occupation' for the entirety of the **Benefit Period** Definition 2 of **Disability**: for any **Benefit Period** exceeding 24 months, the definition will change to an 'any occupation' definition

^ Where an **Insured Person** is working on average less than 15 hours per week in the three months prior to the commencement of the **Waiting Period**, Definition 3 will apply which is an 'any occupation' definition.

2.2 Built-in benefits and features summary

The following table outlines the standard Built-in features of the Corporate Cover product. The brief descriptions given in the table are a summary only, please refer to the relevant page shown in the table for more detail.

Feature	Available in Superannuation?	Refer to page
Total Disability Pays a benefit if the **Insured Person** is not working due to injury or sickness and can't perform an Important Duty of their usual occupation.	✓	20
Partial Disability Pays a benefit if the **Insured Person** is working, or able to work, in a reduced capacity due to injury or sickness.	✓	20
Maximum Monthly Benefit $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.	✓	39
Death Benefit Pays an additional lump sum benefit if an **Insured Person** dies whilst entitled to a **Disability** benefit.	✓	23
Rehabilitation Incentive Benefit Pays a lump sum benefit if an **Insured Person** returns to work performing their full pre-disability duties and hours for 12 consecutive months after attending a rehabilitation program approved by us.	✗	24
Rehabilitation Expenses Benefit Covers the cost of the **Insured Person** participating in a pre-approved rehabilitation program or occupational services required to allow for a return to work.	✓	23

Feature	Available in Superannuation?	Refer to page
Recurrent Disability No further **Waiting Period** will apply if an **Insured Person** has a relapse of the same injury or sickness within 12 months of receiving a **Disability** benefit.	✓	23
Claims Escalation In the event of a claim, the **Monthly Benefit** will be increased annually provided there have been 12 continuous months of **Disability** benefits paid.	✓	22
Waiver of Premium Premiums are waived whilst an **Insured Person** is on claim.	✓	23
Automatic Uplift to new AAL We may apply an increased **AAL** to some **Insured Persons** including those who have previously been restricted due to non-receipt of underwriting, had an exclusion or a loading applied when taking over an existing group insurance policy.	✓	15
Interim Accident Cover We may pay up to $15,000 per month whilst an **Insured Person** is being underwritten.	✓	16
Cover while on leave without pay **Cover** will continue for a maximum period of up to 24 consecutive months while on approved leave.	✓	17
Cover while overseas **Cover** is provided 24 hours a day, all year round while the **Insured Person** is working or travelling overseas.	✓	17
Extended Cover **Cover** will continue for a maximum period of 60 consecutive days after the **Insured Person** ceases to be an **Employee** of the **Employer**.	✓	18
Return to Work during the Waiting Period An **Insured Person** is permitted to return to work once, performing their usual duties and hours for up to a certain number of days without the **Waiting Period** restarting again.	✓	23
Waiver of Underwriting Loadings Where a Policy has more than 100 **Insured Persons**, we will waive underwriting loadings for any formula driven, underwritten **Cover**.	✓	16

2.3 Optional benefits and features summary

AIA Australia offers a range of additional Optional features under the Corporate Cover product. If any Optional features are available, they will be stated in the **Policy Schedule**. The brief descriptions given in the table are a summary only, please refer to the relevant page shown in the table for more detail.

Feature	Available in Superannuation?	Refer to page
Continuation Option An **Insured Person** may be able to continue their **Cover** once their employment ceases with their **Employer**.	✓	18
Cover beyond age 65 Provides **Cover** beyond age 65 up to a maximum age of 70. Conditions apply.	✓	22
Superannuation Contribution Benefit (SC Benefit) Provides a benefit to cover the cost of employer superannuation guarantee contributions whilst an **Insured Person** is receiving a **Disability** benefit.	✓	22

Feature	Available in Superannuation?	Refer to page
Accommodation benefit Reimburses accommodation costs for an immediate family member if an **Insured Person** is **Totally Disabled** and confined to a bed or hospitalised more than 100 km from home.	✕	26
Family Care benefit Pays a benefit if an **Insured Person** is totally dependent on an immediate family member for their essential everyday needs and as a result their monthly income is reduced.	✕	26
Home Care benefit Reimburses home care expenses (up to a limit) if the **Insured Person** is **Totally Disabled** and confined to or near a bed and totally dependent on professional home care.	✕	26
Nursing Care benefit Pays a benefit for each day during the **Waiting Period** an **Insured Person** is **Totally Disabled** and confined to bed or hospitalised, and requires the full-time care of a registered nurse.	✕	26
Overseas Assistance benefit Reimburses the cost of a single standard economy airfare to Australia (up to a limit) for an **Insured Person** who has been **Totally Disabled** in excess of 90 days whilst outside Australia.	✕	26
Specific Injury benefit Pays a benefit for a specified period if the **Insured Person** suffers one of the listed specific injuries.	✕	27
Trauma benefit Pays a lump sum benefit if an **Insured Person** suffers one of the listed Trauma Events.	✕	27

3. Eligibility and Cover

3.1 Who's eligible for Cover?

An **Eligible Person** under this Policy is a person who:

- is an **Employee** of the **Employer**,
- is at least 15 years old,
- is younger than the **Maximum Entry Age**,
- is an **Australian Resident** or holder of a **Visa**, and
- meets any other additional eligibility criteria as set out in the **Policy Schedule**.

Inside Superannuation

In addition to the above:

- is a member of a complying superannuation fund, and
- meets the **PMIF Requirements** or is a **PMIF Exempt Member**.

3.2 When does Cover start?

Cover will commence for an **Eligible Person** in one of the following ways:

- by Automatic Acceptance, where **Cover** is granted automatically up to the **Automatic Acceptance Limit (AAL)**,
- after underwriting or through **Voluntary Cover**, the date we advise you in writing the **Insured Person's Cover** has been accepted, or
- through Takeover Terms, the date the Policy commences with AIA Australia.

Automatic Acceptance **Cover** for an **Eligible Person** will start on the latest of:

- the **Policy Commencement Date**, or
- the date the person first meets the eligibility criteria.

Where the **Policy Owner** is a superannuation fund, **Cover** will commence as follows.

If:		Then:
The person submits a **PMIF Election**^ within 120 days of the **Welcome Letter**	**Yes**	The date the **Policy Owner** receives a **PMIF Election**
	No	• the date the person meets the **PMIF Requirements** provided an SG contribution is received in the previous 120 day period, or • the date the **Policy Owner** receives an SG contribution after the person first meets the **PMIF Requirements**
The person is a **PMIF Exempt Member**		The date the person first meets the eligibility criteria

^ Where a **PMIF Election** is received more than 120 days after the **Welcome Letter**, **Cover** may only be provided through the underwriting process.

3.3 When will New Events Cover apply?

When **New Events Cover** applies, we will only pay a benefit if an injury or sickness first becomes apparent or first occurs on or after the date **Cover** commences for an **Insured Person**, or from the date **Cover** was reinstated or increased.

The following tables show how **New Events Cover** will apply in different circumstances. **New Events Cover** does not apply to underwritten cover.

Ordinary Non-Superannuation

If:	Then:
The **Insured Person** isn't **At Work** on the date **Cover** commences	We will only provide **New Events Cover** until they are **At Work** for 30 consecutive days

Inside Superannuation

If:	Then:
The **Insured Person** submits a **PMIF Election** within 120 days of their **Welcome Letter** or meets the **PMIF Requirements**	We will only provide **New Events Cover** from the date **Cover** commences until they are **At Work** for 30 consecutive days
The **Insured Person** is a **PMIF Exempt Member** (other than where a **PMIF Election** is made) and isn't **At Work** on the date **Cover** commences	We will only provide **New Events Cover** from the date **Cover** commences until they are **At Work** for 30 consecutive days

3.4 Automatic Acceptance

Automatic Acceptance means we'll automatically provide **Cover** to an **Eligible Person** in accordance with the benefit design as set out in the **Policy Schedule** up to the **AAL** without the need for underwriting subject to the following conditions:

- the **AAL** shown in the **Policy Schedule** is for an amount other than nil,
- the eligibility criteria in the **Policy Schedule** must clearly define who can obtain **Cover** under the Policy,
- the **Sum Insured** for each **Eligible Person** is provided in accordance with the benefit design as set out in the **Policy Schedule**, and
- any other terms that we specify in writing must be met.

Inside Superannuation

The Policy is the default superannuation fund of the **Employer**.

The applicable **AAL** will be set out in the **Policy Schedule**.

We reserve the right to change the conditions for Automatic Acceptance and/or the **AAL** under the Policy at the end of the **Rate Guarantee Period** if the above requirements aren't met.

3.5 Automatic variation of Cover

The **Sum Insured** will automatically increase or decrease in line with the benefit design as set out in the **Policy Schedule**. Any automatic increase in the **Sum Insured** will occur up to the higher of the **AAL** (if any) and the **Forward Underwriting Limit (FUL)**.

For Policies with less than 50 lives, any automatic increases will be limited to a maximum increase of 30% in total within a given 12 month period.

The premium will be adjusted to take into account the variation in the **Sum Insured** in respect of an **Insured Person**.

3.6 Changes to the AAL

The **AAL** will apply for the duration of the **Rate Guarantee Period**, however, if the number of **Insured Persons** changes by more than 25% (compared with the number of **Insured Persons** at the start of the latest **Rate Guarantee Period**), we reserve the right to vary the **AAL** by providing at least two months' prior written notice.

When an **AAL** decreases, the lower **AAL** will apply to all **Insured Persons** after that date with the exception of existing **Insured Persons** whose **Sum Insured** is higher than the lower **AAL**, in which case they will maintain their existing **Sum Insured**.

When an **AAL** increases, the higher **AAL** may apply to some existing **Insured Persons** above the previous lower **AAL**. This includes members who have previously been restricted due to non-receipt of underwriting, had an exclusion or a loading applied. Any loading, limitation or exclusion that previously applied to **Cover** above the lower **AAL** will also apply to **Cover** above the new higher **AAL**. The higher **AAL** does not apply to any **Insured Person** who has previously been declined.

3.7 Automatic uplift to the new AAL

If stated in the **Policy Schedule** when taking over an existing group insurance policy, if we have offered an **AAL** which is more competitive than the level under the previous policy, we may apply the new **AAL** to some members. This includes members who have been previously restricted due to non-receipt of underwriting or had an exclusion or a loading applied. Members declined for underwritten cover under the previous policy will be restricted to the lower **AAL** or **FUL** (as applicable).

Any loading, limitation or exclusion that previously applied to **Cover** above the lower **AAL** will also apply to **Cover** above the new higher **AAL**. We will advise you in writing if we agree to do this. Any **Insured Person** who has been previously underwritten above our **AAL**, will continue to be covered up to the level provided under the previous policy.

3.8 Underwriting

3.8.1 When is Underwriting required?

An **Eligible Person** who:

- doesn't meet the conditions of Automatic Acceptance,
- seeks **Cover** above the **AAL** or **FUL** (as applicable),
- seeks **Voluntary Cover**,
- has **Cover** with an annual increase above 30% (for Policies with less than 50 lives),
- has a **PMIF Election** which is received more than 120 days after receiving their **Welcome Letter**, or
- for any other reason outlined within the Policy,

may be provided **Cover** through the underwriting process.

If underwriting is required, they'll need to complete and send us AIA Australia's personal health statement in addition to any medical or other information we require.

We will consider the underwriting application and decide whether to:

- accept the **Cover** for the person under this Policy,

- offer **Cover** to the person under this Policy but with specific terms, conditions, exclusions, restrictions, or premium loadings, or
- refuse to **Cover** the person under this Policy for anymore **Cover** than they had before applying.

Where a Policy has more than 100 lives, we will waive underwriting loadings for any formula driven, underwritten **Cover**. Loadings may be applied for any element of **Voluntary Cover** depending on the circumstances.

As a result of the underwriting process, we will still record and advise of underwriting loadings for two reasons:

- if at some point in the future the Policy is terminated with AIA Australia and transferred to another insurer that does apply loadings, these loadings can be applied, or
- should a member exercise a Continuation Option, the correct retail premium can be charged.

3.8.2 Underwriting information access

AIA Australia practices open communication with our intermediary clients and **Insured Persons**. Any party related to the Policy is welcome to contact AIA Australia's underwriting staff for explanations on non-standard decisions, opinions and assistance with their life insurance application.

3.8.3 Costs of underwriting

We will pay all reasonable costs for providing the information we require for underwriting of an **Eligible Person**. Any costs incurred outside Australia in connection with the underwriting of an **Eligible Person** must be paid by the **Eligible Person**. We may reimburse these costs at our discretion.

3.8.4 Interim Accident Cover

If an **Eligible Person** submits an application for underwritten cover, we'll provide Interim Accident Cover during the underwriting process from the date we receive the application for an **Eligible Person**. It ends on the earliest of:

- the date we either accept or reject the application in writing,
- the date the **Eligible Person** cancels or withdraws the application in writing,
- 90 days elapsing from the date we received the application, and
- the date **Cover** would have otherwise ceased under the Policy.

A benefit will only be paid in the event of **Accidental Injury** resulting in **Disability**.

The maximum benefit we will pay is the lesser of the amount of cover applied for and $15,000 per month. Where an **AAL** or **FUL** applies, the amount applied for is the amount of **Cover** above the relevant **AAL** or **FUL**.

No benefit for Interim Accident Cover is payable if:

- bodily injury to the person is caused by engaging in any sport or pastime that would not normally be covered under our occupation and pastime guidelines, or
- if the person lodges a claim for an excluded event under our Policy (as described under Section 7).

The **Benefit Period** and **Waiting Period** that applies to an **Insured Person** as set out in the **Policy Schedule** will apply for Interim Accident Cover.

Interim Accident Cover does not cover the **Insured Person** for any built-in or Optional benefits under the Policy.

3.9 Takeover Terms (if applicable)

In some cases, we may take over a group insurance policy from another insurer. If this happens, the proposed **Cover** must be comparable with the existing cover, and the existing cover must cease for every person.

The question of whether AIA Australia or the previous insurer under the previous policy carries the risk of an **Insured Person's** claim will be determined in accordance with **FSC Guidance Note 11**. If applicable, this will be stated in the **Policy Schedule**.

Insured Persons will be covered for benefits on underwriting terms no less favourable than those provided by the previous insurer, including forward underwriting limits, premium loadings, restrictions, exclusions and any limitations imposed on an **Insured Person** by the previous insurer.

We require details of previous acceptance terms for **Insured Persons** who have underwritten cover, **Voluntary Cover** and/or cover in excess of the previous insurer's automatic acceptance limit within 90 days of the takeover date, unless otherwise agreed in writing.

We reserve the right to request proof that a person under a previous group insurance policy has been satisfactorily underwritten for takeover of **Cover** to apply.

If underwriting exclusions or loadings do apply, these will be carried forward and applied above our **AAL** or the previous insurer's automatic acceptance limit (as applicable) to form part of the Takeover Terms.

If alternative Takeover Terms are agreed to by us, these will be stated in the **Policy Schedule**.

In the event the Policy is terminated and transferred to another Australian life insurer, we will comply with **FSC Guidance Note 11**.

3.10 Overseas Cover

If an **Insured Person** travels overseas on a temporary basis (including whilst travelling or holidaying), **Cover** will apply 24 hours a day seven days a week.

An **Insured Person's Cover** will continue if they are required to live outside Australia for employment with their **Employer**. The details regarding the whereabouts of **Insured Persons** overseas must be provided to us when requested and when providing us with membership data.

If a claim is made, **Disability** benefits may continue for up to 12 months after which time the **Insured Person** may be required to return to Australia (at their own expense) for further assessment in order for **Disability** benefits to continue.

3.11 Cover while on Leave Without Pay

If an **Insured Person** is on Leave Without Pay and there is a documented 'return to work' date, their **Cover** will continue for a maximum period of up to 24 consecutive months after the commencement of leave, provided premiums continue to be paid.

An **Insured Person** may apply to extend **Cover** beyond the 24 month period by applying to us in writing before the 24 month period ends. Any extension will be at our discretion.

Cover for an **Insured Person** who is on Leave Without Pay will cease at the earliest of:

- 30 days after an **Insured Person** does not return on the documented 'return to work' date,
- Leave Without Pay exceeding 24 months, or any extended period we have agreed in writing, or
- **Cover** otherwise ending under this Policy (as described in Section 4.1)

If an **Insured Person** becomes **Disabled** whilst on Leave Without Pay, benefits won't start to accrue until the documented 'return to work' date (provided they have also served the **Waiting Period**).

Any requests for reinstatement of **Cover** will require underwriting.

3.12 Cover while on paid leave

Provided premiums continue to be paid, **Cover** will continue for an **Insured Person** while on paid leave approved by their **Employer**.

4. When Cover ends and benefits cease

4.1 When does Cover end

An **Insured Person's Cover** ends when the first of the following events occur:

- the date an **Insured Person** dies,
- the date an **Insured Person** reaches the **Cover Expiry Age**,
- the date the Policy is terminated,
- the date the **Insured Person** ceases to be an **Employee** of the **Employer**,
- the date the **Insured Person** ceases to be an **Eligible Person**,
- 60 days after premium payments cease in respect of the **Insured Person**,
- the date the **Insured Person** no longer meets the conditions for continuation of **Cover** during Leave Without Pay,
- the date AIA Australia accepts or declines the **Insured Person's** Continuation Option application (where applicable), and
- the date the **Insured Person** who is not an **Australian Resident**:
  - is no longer permanently in Australia, or
  - not eligible to work in Australia.

Inside Superannuation

In addition to the above:

- the end of the period for which premiums have been paid after an **Insured Person's** account becomes **Inactive**, and
- the date the **Insured Person** is no longer a **PMIF Exempt Member** and does not meet the **PMIF Requirements**.

4.2 Extended Cover

If **Cover** ends for an **Insured Person** because they cease to be an **Employee** of the **Employer**, we will continue **Cover** under the Policy for a maximum period of 60 consecutive days after they cease to be an **Eligible Person**.

Extended Cover will end for an **Insured Person** on the earliest of:

- the date the **Insured Person** reaches the **Cover Expiry Age**,
- 60 days after the date the **Insured Person** ceases to be an **Employee** of the **Employer**,
- the date we accept or decline an **Insured Person's** Continuation Option (if applicable), and
- the date **Cover** would otherwise have ended under the Policy in accordance with Section 4.1.

Cover will continue at the same **Sum Insured** and subject to the same premium loadings and exclusions that applied to the **Insured Person** immediately prior to their **Cover** ceasing.

We will pay a benefit if:

- they become **Disabled** within the Extended Cover period,
- they remain **Disabled** after the end of the **Waiting Period**, and
- the benefit would have been payable if their **Cover** hadn't ended.

The maximum period a **Monthly Benefit** is payable for Extended Cover is limited to 24 months while the person remains **Disabled**.

4.3 Reinstatement of Cover (inside superannuation only)

If an **Insured Person's Cover** ended under the Policy because their account is **Inactive**, their **Cover** will be reinstated if within 60 days of **Cover** ending, they have notified you of their request to reinstate their **Cover** despite their account being **Inactive**.

Cover will automatically be reinstated from the date **Cover** ended, provided backdated premiums are received by you. For the avoidance of doubt, any premium loadings, exclusions, special conditions or restrictions (including if their **Cover** was **New Events Cover**) which applied prior to their **Cover** ending, will continue to apply to their reinstated cover.

We will continue to provide **Cover** during the 60 day reinstatement period provided **Cover** would not have otherwise ended under the Policy in accordance with Section 4.1. The maximum period a **Monthly Benefit** is payable during this period is limited to 24 months while the person remains **Disabled**.

In all other cases, **Cover** that has ceased can only be reinstated subject to underwriting and our agreement in writing.

4.4 Continuation Option – optional

Where the **Policy Schedule** states that a Continuation Option is available, if an **Insured Person's Cover** has ended under your Policy, they can ask us to provide cover under a new individual policy as long as:

- their **Cover** has ended under the Policy as a result of ceasing to be eligible for **Cover**, for reasons other than injury or sickness,
- their **Cover** has not ended because the Policy is terminated,
- they were under the age of 60 when their **Cover** ended,
- the application for a Continuation Option is received within 60 days of ceasing employment, with no individual consideration made for applications made after this date,
- they are commencing new employment on a permanent basis for at least 15 hours per week in an occupation acceptable under our individual policy within 90 days of ceasing employment,
- the person is not eligible to receive, or must have not previously been paid a benefit payment(s) under the Policy, or any other benefits have or are being paid under any life insurance policy (including TPD or terminal illness benefits),
- our minimum policy issue requirements for the individual policy are met,
- we receive a satisfactory Australian citizen or Permanent Residency and Smoker declaration, and
- the person is **At Work** performing their full and normal duties on the date immediately prior to ceasing to be eligible under your Policy.

Where the above conditions have been met, we'll issue an individual policy to the person.

The individual policy is subject to the following conditions:

- we will offer benefits that are no greater than those provided to the person under your Policy,
- the amount of cover available and provided under the individual policy is no more than the **Sum Insured** that applied when their **Cover** ended under your Policy,
- where the equivalent waiting period is not available under our individual policy, the next longer waiting period will apply,
- where the equivalent benefit period is not available under our individual policy, then the next shortest benefit period will apply,
- it will reflect the terms, conditions and premium rates available under our individual policy at the time the individual policy is issued to the person,
- does not include any optional policy features under your Policy, and
- it will carry the same exclusions and/or loadings that applied to the person's cover under your Policy when their **Cover** ended.

Where the **Cover Expiry Age** under your Policy is 70, the maximum cover expiry age that is allowable under the individual policy will apply.

If an **Insured Person's Cover** has ended because the Policy is terminated by the **Employer**, by AIA Australia or in circumstances where an **Insured Person** is no longer eligible to hold **Cover** under the Policy as a result of business activities (such as acquisition, takeover, merger activity, restructure, divestment) and the **Insured Person** continues to be employed, they will not be eligible for a Continuation Option.

For more information on AIA Australia's individual Income Protection policy, please refer to the Priority Protection Product Disclosure Statement and Policy Document available at aia.com.au.

A person applying for a Continuation Option must complete a group insurance Continuation Application form (available upon request from the AIA Group Administration team at AU.GroupInsurance@aia.com).

5. Benefits

5.1 Disability definitions

The **Disability** definition that will apply in the event of a claim will depend on the average number of hours worked per week by the **Insured Person** immediately prior to the commencement of the **Waiting Period**.

Insured Person	Definition
Worked on average 15 hours or more per week in the three months immediately prior to the commencement of the **Waiting Period**^#	Definition 1 or Definition 2 of **Disability** (as set out in the **Policy Schedule**)
Worked on average less than 15 hours per week in the three months immediately prior to the commencement of the **Waiting Period**^#	Definition 3 of **Disability**

^ If the **Insured Person** has been **Employed** with the **Employer** for less than three months immediately prior to the commencement of the **Waiting Period**, their weekly working hours will be averaged over their period of employment.

\# If an **Insured Person** becomes **Disabled** whilst on Leave Without Pay, the **Disability** definition used to assess the **Insured Person** will be that which would have applied to the **Insured Person** immediately prior to the commencement of Leave Without Pay.

The **Disability** definition which applies to an **Insured Person** may differ to the **Disability** definition which applied at the time **Cover** commenced.

5.2 Total Disability benefit

5.2.1 When we'll pay

If an **Insured Person** is:

- **Totally Disabled** for at least 7 out of 12 consecutive days during the **Waiting Period**, and
- continuously **Disabled** for the balance of the **Waiting Period**, and
- continues to be **Totally Disabled** after the expiry of the **Waiting Period** or after receiving a **Partial Disability** benefit is **Totally Disabled** immediately after ceasing to be **Partially Disabled** for the same or related condition,

a **Total Disability** benefit is payable provided the **Insured Person** meets the **Total Disability** definition that applies to them at the end of the **Waiting Period**.

5.2.2 What we'll pay

We'll pay the **Monthly Benefit** applicable to the **Insured Person** subject to the **Maximum Monthly Benefit**, less any Benefit Offsets.

The **Total Disability** benefit starts to accrue from the day after the **Waiting Period** ends and is paid at the end of the month in which the **Insured Person** is **Totally Disabled**. We'll pay 1/30th of the benefit for each day the **Insured Person** is entitled to the benefit for partial months of **Total Disability**.

The **Monthly Benefit** is payable monthly in arrears and stops at the earliest of the events described under Section 5.4.

5.3 Partial Disability benefit

5.3.1 When we'll pay

If an **Insured Person** is:

- **Totally Disabled** for at least 7 out of 12 consecutive days during the **Waiting Period**, and
- continuously **Disabled** for the balance of the **Waiting Period**, and
- **Partially Disabled** after the expiry of the **Waiting Period** or after receiving a **Total Disability** benefit is **Partially Disabled** immediately after ceasing to be **Totally Disabled** for the same or related condition,

a **Partial Disability** benefit is payable provided the **Insured Person** meets the **Partial Disability** definition that applies to them.

5.3.2 What we'll pay

If an **Insured Person** becomes **Partially Disabled**, we'll calculate the **Monthly Benefit** using this formula:

$$\frac{A - B}{A} \times C$$

where:

*A = is the **Insured Person's Pre-Disability Income***

*B = the **Insured Person's Current Income** for the month for which they are claiming **Partial Disability***

*C = is the **Insured Person's Monthly Benefit** (i.e. if they were **Totally Disabled**)*

If we do not consider the **Insured Person** to be working to their capacity for reasons other than injury or sickness, "B" also includes any income they could reasonably be expected to earn if they were working to the extent of their capability in either their usual occupation or in any occupation where Definition 2 or Definition 3 applies. In determining this, we will consider all available medical evidence and any other relevant matters.

Where applicable and stated in the **Policy Schedule**, the **Partial Disability** benefit also includes the **SC Benefit** which we calculate using this formula:

$$\frac{A - B}{A} \times D$$

where:

*A = is the **Insured Person's Pre-Disability Income***

*B = the **Insured Person's Current Income** for the month for which they are claiming **Partial Disability***

*D = is the **Insured Person's SC Benefit***

The **Monthly Benefit** is payable monthly in arrears and stops at the earliest of the events described under Section 5.4.

5.4 How long we'll pay

The **Benefit Period** will be set out in the **Policy Schedule** and is the maximum length of time we'll pay **Disability** benefits.

We'll pay **Disability** benefits until the earliest of the following events:

- the **Insured Person** is no longer **Disabled**,
- the **Benefit Period** ends, or 2 years for a **Casual** or **Fixed Term Employee** with a minimum contract period of 12 months or less,
- the **Insured Person** reaches the **Cover Expiry Age**,
- the **Insured Person** dies,
- for an **Insured Person** who is not an **Australian Resident**, the date the **Insured Person** is no longer permanently in Australia or not eligible to work in Australia, and
- 24 months of **Disability** benefits have been paid (where the **Insured Person** has a **Cover Expiry Age** of 70) and the **Waiting Period** commences on or after the **Insured Person's** 65th birthday.

5.5 Benefit Offsets

The **Disability** benefit payable to an **Insured Person** will be reduced by:

- all benefits or other payments (whether lump sum, periodic or otherwise) which are paid or required to be paid, in relation to the injury or sickness of the **Insured Person**, under any:
  - Workers' Compensation, Motor Accident Compensation or similar legislation or scheme,
  - Social Security or similar legislation,
  - statute, or damages under common law (whether or not modified by statute), for loss of income, loss of earning capacity or any other economic loss (including any benefits or payments received for work injury damages), or
  - disability income type insurance policy (other than a lump sum TPD benefit received under any insurance policy),
- any other loss of income, loss of earning capacity or other economic loss component of a lump sum payment paid or required to be paid in relation to the injury or sickness of the **Insured Person**,
- any paid parental leave received by the **Insured Person** where an **Insured Person** continues to suffer a **Disability** during a period of paid parental leave, or
- any paid sick leave received by the **Insured Person**.

Where a **Disability** benefit is payable, we will also reduce the **Disability** benefit payable to an **Insured Person** by any remuneration component used in determining the **Insured Person's Sum Insured** that is paid to the **Insured Person** from an employer while being paid a **Disability** benefit.

The **Disability** benefit will not however be reduced by income earned from investments, annual leave, long service leave or any termination (redundancy) payments.

An **Insured Person's Disability** benefit will only be reduced to the extent required to ensure the **Disability** benefit when added together with any other payments from other sources does not exceed:

- for **Total Disability** benefits, the **Insured Percentage** of the **Insured Person's Pre-Disability Income**, or
- for **Partial Disability** benefits, 100% of the **Insured Person's Pre-Disability Income**.

In the case of Benefit Offsets paid or payable as a lump sum (including by way of settlement or commutation):

- the **Insured Person** must provide us, as soon as reasonably practicable, a breakdown of the lump sum including the portion of the lump sum relating to loss of income, loss of earning capacity or any other economic loss, the amount claimed in respect of each head of damage or loss (to the extent applicable) and any other information we reasonably require in relation to the lump sum,
- we will only reduce what we pay the **Insured Person** by the portion of the lump sum relating to loss of income, loss of earning capacity or any other economic loss for the same period, as determined at our discretion,
- the portion of the lump sum relating to loss of income identified above will be converted by us to a monthly amount at the rate of 1/60th per month over a period of 60 months for the purposes of calculating the amount to be offset, and
- where the **Insured Person** does not provide sufficient particulars to reasonably allow us to make a determination of the portion of the lump sum relating to loss of income, loss of earning capacity or any other economic loss for the same period, we will convert the entirety of the lump sum to a monthly amount at a rate of 1/60th per month over

a period of 60 months for the purposes of calculating the amount to be offset.

5.6 Insuring Superannuation Contributions

The **Policy Owner** has two ways to include superannuation contributions under the Policy:

- Superannuation Contributions Benefit (**SC Benefit**), or
- Mandated super contributions where included in the **Income** definition.

Where either of the above apply, it will be stated in the **Policy Schedule**.

Where an **Insured Person's Cover** is restricted to the **AAL** or **FUL**, any portion of the **Monthly Benefit** relating to the **SC Benefit** or mandated superannuation contributions will be reduced, and in some circumstances may be reduced to nil.

5.6.1 Superannuation Contributions Benefit (SC Benefit)

Under the **SC Benefit**, an **Insured Person** will be provided with a benefit, whilst a **Disability** benefit is also payable, to cover compulsory **Employer** superannuation contributions. The **SC Benefit** must be paid directly to a complying superannuation fund by the **Policy Owner** and will also be subject to any conditions of release under superannuation law. The **SC Benefit** cannot be paid to superannuation funds outside of Australia.

The maximum amount of the **SC Benefit** paid to the **Insured Person** for a **Disability** benefit will be the lesser of the following:

- applying the **SC Benefit** percentage stated in the **Policy Schedule** to the **Pre-Disability Income**, and
- 100% of the monthly **Maximum Super Contribution Base** for the applicable income year.

In the case of **Partial Disability**, the **SC Benefit** is to be calculated in accordance with the formula under Section 5.3.2.

The **SC Benefit** will be reduced, and in some circumstances may be reduced to nil, where the total benefit payable would exceed the **Maximum Monthly Benefit**.

5.6.2 Mandated Super contributions

An **Insured Person** will be provided with a benefit, in the event of **Disability**, to cover mandated superannuation contributions paid to them by their **Employer**.

The amount payable will be in line with the **Insured Percentage** nominated in the **Monthly Benefit** definition within the **Policy Schedule** (as an example, if the **Monthly Benefit** is 75% of **Pre-Disability Income** and mandated super contribution applies then the amount payable will be 75% of base salary + 75% of the mandated super contributions) up to the maximum terms of the Policy.

Any mandated super contribution benefit must be paid into the **Insured Person's** nominated superannuation account by the **Policy Owner** or the **Insured Person** as applicable.

5.7 Claims Escalation benefit

The **Monthly Benefit** will be increased by the lesser of the percentage increase in the Consumer Price Index (CPI) and 5% each year.

This will apply at each anniversary, from the date when benefits first commenced provided there has been 12 continuous months of **Disability** benefit payments.

The Claims Escalation benefit may apply to the 2 year **Benefit Period** if stated in the **Policy Schedule**.

Where the **Monthly Benefit** reduces after the first 24 months of the **Benefit Period**, the increase will apply to the reduced **Monthly Benefit**.

5.8 Cover Beyond Age 65 (optional)

This section will apply where the **Cover Expiry Age** in the **Policy Schedule** is 70.

For all cover beyond age 65, the **Disability** benefit cannot exceed $10,000 per month (inclusive of the **SC Benefit** if applicable) for benefits that are paid on or after the **Insured Person's** 65th birthday.

5.8.1 2-year, 5-year or 10-year Benefit Period

Age at disability	Condition
If the **Waiting Period** commences before the **Insured Person's** 65th Birthday	We will pay **Disability** benefits based on the **Benefit Period** that applied to the **Insured Person** or age 70, if earlier.
If the **Waiting Period** commenced on or after the **Insured Person's** 65th Birthday	We will pay **Disability** benefits until the earliest of: • two years, or • the **Insured Person** reaching age 70

5.8.2 To Age 65 benefit period – Top Up

Age at disability	Condition
If the **Waiting Period** commences before the **Insured Person's** 63rd birthday	We will pay **Disability** benefits until the **Insured Person** turns age 65.
If the **Waiting Period** commenced on or after the **Insured Person's** 63rd Birthday	We will pay **Disability** benefits until the earliest of: • two years, or • the **Insured Person** reaching age 70

5.9 Waiver of Premiums benefit

While an **Insured Person** is being paid a **Monthly Benefit** as a result of **Disability**, we will waive premiums related to the period the **Insured Person** is entitled to be paid a **Monthly Benefit**.

5.10 Death benefit

If an **Insured Person** dies while they're entitled to a **Disability** benefit, we will pay an additional lump sum benefit equal to three times the **Monthly Benefit** applicable to the **Insured Person** at the date of death.

We will limit the **Monthly Benefit** used to calculate this benefit to a maximum of $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.

Where an **Insured Person's Monthly Benefit** has been reduced after the first 24 months of the **Benefit Period**, the **Monthly Benefit** used to calculate the Death benefit will be the reduced **Monthly Benefit** at the date of death.

5.11 Recurrent Disability benefit

5.11.1 Recurrence within 12 months:

We will waive the **Waiting Period** and recommence **Disability** benefits immediately if the **Insured Person**:

- returns to paid, full pre-disability duties and hours, after payment of a **Disability** benefit under this Policy, and
- suffers **Disability** for the same or a related injury or sickness within 12 months of returning to paid, full pre-disability duties and hours.

The claim will be treated as a continuation of the most recent claim and will be payable for up to the remaining balance of the **Benefit Period**.

Where Definition 2 of **Disability** is stated in the **Policy Schedule**, irrespective of the number of times a claim is assessed under this condition the **Insured Person** will only be eligible to receive **Disability** benefits for a cumulative period of 24 months under a usual occupation definition of **Disability**.

Where the **Monthly Benefit** reduces after the first 24 months of the **Benefit Period**, irrespective of the number of times a claim is assessed under this condition the **Insured Person** will only be eligible for **Disability** benefits with reference to 70% or 75% (as appliable) of their **Pre-Disability Income** for a total and cumulative period of 24 months.

5.11.2 Recurrence after 12 months:

Any recurrence of **Disability** occurring more than 12 months after returning to paid, full pre-disability duties and hours, will be treated as a new claim and be subject to a new **Waiting Period** and a new **Benefit Period**.

5.12 Concurrent Disability benefit

We will only pay **Disability** benefits for an **Insured Person** for one injury or sickness at a time.

5.13 Return to Work during the Waiting Period

An **Insured Person** is permitted to return to work once, performing their usual duties and hours for up to:

- 10 consecutive days during the **Waiting Period**, where the **Waiting Period** is 60 days or more, or
- five consecutive days during the **Waiting Period**, where the **Waiting Period** is less than 60 days.

Where the **Insured Person** does return to work during the **Waiting Period** for up to five or 10 consecutive days (as applicable), the **Waiting Period** will be extended by the total number of days the **Insured Person** attempted to return to work.

Where the **Insured Person** returns to work during the **Waiting Period** more than once or for more than five or 10 consecutive days (as applicable), the **Waiting Period** starts again.

5.14 Rehabilitation Expense benefit

As a result of a claim under this Policy, we will pay the costs of the **Insured Person's** participation in a rehabilitation program approved by us that is part of a structured return to work program and is necessary to assist in the **Insured Person's** rehabilitation back to work, following their injury or sickness.

We will pay this benefit for the following types of programs:

- graded exercise programs,
- wellness programs,

- business coaching,
- graded return-to-work programs,
- modification of work environments,
- work-related counselling,
- career advice and redirection,
- re-skilling or retraining,
- the supply of ergonomic equipment, or
- other types of programs which we approve from time to time.

However, we will not reimburse costs of participating in any program where the relevant program:

- provides ongoing services that do not have the specific and stated objective of leading to an increase in function,
- does not have the primary purpose of returning the **Insured Person** to paid employment,
- does not have goals incorporated into the plan that can be measured,
- is of a type ordinarily engaged in for general health and wellbeing, or
- involves costs that, if paid, cause us to infringe the *National Health Act 1953* (Cth), *Health Insurance Act 1973* (Cth), *Private Health Insurance Act 2007* (Cth), *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) or any similar legislation or regulation in connection with health insurance, as amended from time to time.

The **Insured Person** is required to seek our approval of the program prior to their participation otherwise there is the risk that the **Insured Person** will be out of pocket for the costs incurred. We won't unreasonably delay letting the **Insured Person** know whether or not we'll reimburse them for the proposed rehabilitation program.

This benefit also covers the reimbursement of pre-approved occupational rehabilitation services, equipment and/or modifications that are considered necessary as part of a structured return to work program.

For any workplace modifications, the maximum payment is three times the **Monthly Benefit** and a payment will only be made once in respect of an **Insured Person**.

This benefit is payable in addition to any other benefit paid.

We will not pay this benefit for expenses that are reimbursed from any other source.

5.15 Rehabilitation Incentive benefit

We will pay the **Insured Person** a benefit equal to three times the **Monthly Benefit** or $20,000 (whichever is lesser) if the **Insured Person** returns to paid full pre-disability duties and hours with their **Employer** for twelve consecutive months after attending a rehabilitation program approved by us.

The rehabilitation program is required to be part of a structured return to work program that is reasonably necessary to assist in the **Insured Person's** rehabilitation back to work following a period of injury or sickness.

We will only pay this benefit if the **Insured Person** has received a **Disability** benefit under this Policy and their **Cover** remains in force at the end of the twelve consecutive month period.

This benefit is only payable once in respect of an **Insured Person**.

The **Monthly Benefit** used to calculate this benefit will be the **Monthly Benefit** that applied on the final day the **Disability** benefit was paid under this Policy (including where the **Monthly Benefit** has reduced after 24 months) prior to the **Insured Person's** return to work at full pre-disability duties and hours.

We will pay this benefit where the **Insured Person** participated in the following types of programs:

- graded exercise programs,
- wellness programs,
- business coaching,
- graded return-to-work programs,
- modification of work environments,
- work-related counselling,
- career advice and redirection,
- re-skilling or retraining,
- the supply of ergonomic equipment, or
- other types of programs which we approve from time to time.

However, we will not pay this benefit where the relevant program:

- provides ongoing services that do not have the specific and stated objective of leading to an increase in function,
- does not have the primary purpose of returning the **Insured Person** to paid employment,
- does not have goals incorporated into the plan that can be measured,
- is of a type ordinarily engaged in for general health and wellbeing, or

- involves costs that, if paid, cause us to infringe the *National Health Act 1953* (Cth), *Health Insurance Act 1973* (Cth), *Private Health Insurance Act 2007* (Cth), *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) or any similar legislation or regulation in connection with health insurance, as amended from time to time.

We require the **Insured Person** to seek our approval of the program prior to their participation otherwise there is the risk that we will not pay this benefit. We won't unreasonably delay letting the **Insured Person** know whether or not we approve the program for the purpose of this benefit.

This benefit is not available to superannuation owned policies.

6. Optional benefits

The following Optional benefits are available at an additional cost. These benefits are payable in the circumstances described in the Policy. Any Optional benefits that apply will be stated in the Policy Schedule.

Optional benefits are not available for superannuation owned policies.

6.1 Accommodation benefit

The Accommodation benefit will assist an immediate family member with the costs of accommodation for each night the immediate family member is required to stay away from home to be near the **Insured Person** provided they are confined to a bed or hospitalised due to sickness or injury.

We will pay the lesser of:

- the actual accommodation cost, and
- $250 a day

for up to 30 days (including during the **Waiting Period**) in any 12 month period if the **Insured Person** is:

- **Totally Disabled**, and
- more than 100 kilometres from home, or on the advice of a **Medical Practitioner**, is required to travel to a place more than 100 kilometres from home.

6.2 Family Care benefit

We will pay this benefit if as a result of **Total Disability**:

- the **Insured Person** is totally dependent on an immediate family member for their essential everyday needs such as feeding, dressing, and bathing, and
- the immediate family member's monthly income through personal exertion is reduced as a result of looking after the **Insured Person**.

We will pay the lesser of:

- the immediate family member's reduction in pre-tax monthly income, and
- 50% of the **Monthly Benefit**,

for up to 90 days, starting from the end of the **Waiting Period**.

We will limit the **Monthly Benefit** used to calculate this benefit to a maximum of $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.

6.3 Home Care benefit

We will pay this benefit if after the **Waiting Period**, the **Insured Person** is:

- **Totally Disabled**,
- confined to or near a bed other than in a hospital or a similar institution that provides nursing care, and
- totally dependent on a paid professional home carer (excluding relatives and immediate family members).

We will reimburse the lesser of:

- $150 a day, and
- 100% of the **Monthly Benefit**,

for up to six months, to help cover the cost provided the **Insured Person** remains totally dependent upon the professional home carer.

This benefit will not be paid if the **Insured Person** is already receiving the Family Care benefit, Accommodation benefit, or Nursing Care benefit.

We will limit the **Monthly Benefit** used to calculate this benefit to a maximum of $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.

6.4 Nursing Care benefit

We will pay the **Insured Person** 1/30th of the **Monthly Benefit** for each day during the **Waiting Period** they are **Totally Disabled** and require nursing care by a registered nurse or hospitalisation at least once a day and remain in or near a bed for a substantial part of each day.

We will pay the benefit after the **Insured Person** has been confined to a bed or hospitalised for more than two consecutive days until the end of the **Waiting Period** up to a maximum of 90 days.

The **Medical Practitioner** and the registered nurse cannot be the **Insured Person**, a family member, a business partner, or an employee or employer of the **Insured Person**.

We will limit the **Monthly Benefit** used to calculate this benefit to a maximum of $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.

6.5 Overseas Assistance benefit

If the **Insured Person** becomes **Totally Disabled** for a period in excess of three consecutive months while travelling or residing outside of Australia, we will reimburse the lesser of:

- the cost of a single standard economy airfare to Australia via the most direct route available, and
- three times the **Monthly Benefit**.

The amount of this benefit will be reduced by any other reimbursements the **Insured Person** is entitled to in respect of their transportation, such as benefits provided by private medical and health insurance and travel insurance.

This is subject to there being no more than 10% of **Insured Persons** working overseas at any time and clarification of countries and term of assignment of all **Insured Persons** overseas by the **Employer** being provided to AIA Australia on an annual basis as part of the annual review process.

6.6 Specific Injury benefit

The Specific Injury benefit is payable if an **Insured Person** suffers one of the listed events set out in the table below as a result of an Injury^^. We will pay the **Monthly Benefit** for the Payment Period applicable to the relevant listed event, set out in the table below. The Payment Period commences on the date of Injury, even if the **Insured Person** is not **Disabled** and applies irrespective of the **Waiting Period**.

Payment of the Specific Injury benefit is payable until the earlier of:

- the expiry of the Specific Injury benefit Payment Period set out in the table below,
- the expiry of the **Benefit Period** specified in the **Policy Schedule**,
- the date the Policy is terminated,
- the date the **Insured Person** dies, and
- the date the **Insured Person** reaches the **Cover Expiry Age**.

The Specific Injury benefit is paid instead of any other benefits under this Policy.

If we pay the Specific Injury benefit and the **Insured Person** becomes **Disabled** as a result of the same listed event, **Disability** benefits will be paid from the later of the end of the:

- Specific Injury Payment Period, and
- **Waiting Period**.

Where the **Insured Person** is entitled to a Trauma benefit under the Policy at the same time as a Specific Injury benefit, we will only pay for the benefit with the longest Payment Period.

If the **Insured Person** suffers another listed event during the Payment Period, we will continue to pay for the balance of the original Payment Period or the new Payment Period, whichever is longer, and no other benefit will be paid in respect of that period.

We will limit the **Monthly Benefit** used to calculate this benefit to a maximum of $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.

Specific Injury^^	Payment Period
Paralysis (diplegia, hemiplegia, paraplegia, quadriplegia)	60 months*
Loss^ of use of both feet, both hands or the sight of both eyes	24 months*
Loss^ of use of a hand and a foot, a hand and an eye, or a foot and an eye	24 months*
Loss^ of use of an arm or a leg	18 months
Loss^ of use of a foot, or a hand, or the sight in one eye	12 months
Loss^ of use of the thumb and the index finger on the same hand	6 months
Fracture# of the thigh (femur) above the knee, or the pelvis. Benefits will not be payable for fractures involving the knee joint or hip joint.	3 months
Fracture# of the upper arm (humerus) or the shoulder blade (scapula). Benefits will not be payable for fractures involving the elbow joint or shoulder joint.	2 months
Fracture# of the jaw (mandible or maxilla)	1.5 months
Fracture# of the collarbone (clavicle)	1.5 months

* If the **Insured Person** has a 2 year **Benefit Period**, claim payments will cease at the end of the **Benefit Period**, for example, payments for an Injury that resulted in Paralysis would end after 24 months, not 60 months as shown in the table above.

^ "Loss" means the total and permanent loss of:

- use of the hand from the wrist or the foot from the ankle joint,
- use of the arm from the elbow or the leg from the knee joint,
- use of the thumb and index finger from the first phalange joint, or
- sight (to the extent of 6/60 or less) in the eye.

^^ "Injury" means physical bodily injury caused solely and directly by violent, external and visible means and is independent of any existing medical condition or other cause. Sickness directly resulting from medical or surgical treatment rendered necessary by the physical injury will not constitute an "Injury".

"Fracture" means any fracture that requires a pin, traction, a plaster cast or other immobilising structure but does not include a fracture which occurs as a result of, or during, surgical or medical treatment.

6.7 Trauma benefit

The Trauma benefit is payable if the **Insured Person** is diagnosed with a Trauma Event as set out in the table below and survives for 14 days following that diagnosis. The Trauma benefit payment is in the form of a lump sum equal to three times the **Monthly Benefit**.

The benefit will be paid even if the **Insured Person** is not **Disabled** and applies irrespective of the **Waiting Period**.

If selected, the Trauma benefit will be in addition to any other benefit insured under the Policy with the exception of the Specific Injury benefit.

If the **Insured Person** is eligible to claim a Specific Injury benefit at the same time as a Trauma benefit, we will only pay the benefit with the longest Payment Period.

If we pay the Trauma benefit and the **Insured Person** continues to be **Disabled** at the end of the **Waiting Period**, any further benefit payments will be determined in accordance with the terms and conditions of the Policy.

We will limit the **Monthly Benefit** used to calculate this benefit to a maximum of $30,000 per month or $10,000 per month on or after the **Insured Person's** 65th birthday.

Trauma Events covered

- Accidental HIV Infection^
- Alzheimer's Disease
- Aplastic Anaemia
- Bacterial Meningitis
- Benign Brain Tumour^
- Blindness
- Cancer^
- Cardiomyopathy
- Chronic Liver Disease
- Chronic Lung Disease
- Coma
- Coronary Artery By-pass Surgery^
- Dementia
- Diplegia
- Heart Attack^
- Heart Valve Surgery^
- Hemiplegia
- Kidney Failure
- Loss of Hearing
- Loss of Independence
- Loss of Limbs and Sight of One Eye
- Loss of Speech
- Major Burns
- Major Head Trauma
- Major Organ Transplant^
- Motor Neurone Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Occupationally Acquired Hepatitis B or Hepatitis C Infection^
- Other Serious Coronary Artery Disease^
- Paraplegia
- Parkinson's Disease
- Pneumonectomy
- Pulmonary Arterial Hypertension (primary)^
- Quadriplegia
- Rheumatoid Arthritis
- Stroke^
- Surgery to Aorta^
- Terminal Illness^
- Encephalitis

^ 90-day Qualifying Period applies.

Please refer to Section 13.2 for all Trauma definitions.

6.7.1 Qualifying period

For **Cover** that was not obtained under Automatic Acceptance, a Trauma benefit is not payable if the Trauma Event first occurs or is first diagnosed or investigated, or the symptoms are reasonably apparent within 90 days after **Cover** commences, is reinstated or increased (but only in relation to the increased amount). The Trauma Event with this Qualifying Period are noted with an (^) symbol in the table above.

The 90 day Qualifying Period will be waived where this Policy is a replacement policy from a previous insurer and the full Qualifying Period has already been served under the previous policy.

6.7.2 Proof of positive diagnosis required

We must receive written confirmation of the diagnosis of a Trauma Event from a **Medical Practitioner** (specialising in the relevant field) and/or legally qualified pathologist to enable us to pay the Trauma benefit.

6.7.3 Limitations

The Trauma benefit is payable once only in respect of the **Insured Person**.

If the **Insured Person** suffers more than one Trauma Event at the same time, we will only pay for one Trauma Event.

The Trauma benefit does not cover any disease, sickness or incapacity other than the Trauma Events listed in the table above and defined in Section 13.2.

7. When won't we pay?

Type of exclusion	We won't pay a benefit if
War and Active Service	The condition for which the **Insured Person** is claiming is caused by: • an act or activity of **War** which occurs after their **Cover** started, increased or was reinstated, • active service or participation in the armed forces of any country, territory or, foreign or international organisation in Australia or any foreign country after their **Cover** started, increased or was reinstated, or • engagement in (including planning or preparing for) any hostile activity or conflict in Australia or any foreign country. In the case of an **Insured Person** who is engaged lawfully serving within the Australian Defence Forces Reserve, the active service exclusion only applies where the **Insured Person** has been called up for active service in the armed forces of Australia or any other country.
Pregnancy	The **Insured Person's Disability** is the result of a normal pregnancy, uncomplicated childbirth or miscarriage.
Self-inflicted acts or suicide	The **Insured Person's Disability** is the result of an attempted suicide or self-inflicted injury.
Criminal Activity	**Disability** is due directly or indirectly to the **Insured Person's** participation in criminal activity or resulting from incarceration. For avoidance of doubt, we will not pay a benefit for any period the **Insured Person** is incarcerated arising from their participation in criminal activity.
Other	Any other exclusions imposed by AIA Australia on an **Insured Person**.

8. Making a Claim

AIA Australia is passionately committed to providing an efficient and sensitive claims service that will help our customers when they need it most.

8.1 Notifying us of a claim

AIA Australia should be notified of an **Insured Person's Disability** which gives rise to a claim, within a reasonable period of time of such occurrence. Once AIA Australia has been notified of a claim, we will provide the necessary claim forms as soon as is reasonably possible.

If a claim arises during a period where no premiums have been received by AIA Australia but is nevertheless within the **Grace Period**, no **Disability** benefit in respect of such claim will be admitted until all premiums owing are paid.

8.2 What we'll need to assess a claim

Different types of claims require different claims assessment processes. AIA Australia may ask for the **Insured Person** to undergo further medical or other examinations or ask for additional information to support their claim.

Aside from any medical examinations or other assessments or enquiries that AIA Australia arranges, the **Insured Person** needs to provide, at no expense to us, any evidence that we reasonably consider necessary to satisfy us of our liability to pay a claim including any reports from **Medical Practitioners** who have treated the **Insured Person**.

8.3 Overseas claims

AIA Australia will, wherever possible, use our network of overseas life insurance companies to gather the information necessary to assess claims overseas, however, AIA Australia reserves the right to require that an **Insured Person** returns to Australia (at the **Insured Person's** expense) for claims assessment and medical examination prior to the payment or continued payment of any **Disability** benefit. AIA Australia may not pay a **Disability** benefit where an **Insured Person** does not return to Australia.

9. Profit Share and Multinational Pooling

AIA Australia can generally offer participation in a number of different Profit Sharing arrangements.

If Profit Share or Multinational Pooling applies, it will be stated in the **Policy Schedule**.

9.1 Self-Experience

For larger policies with at least 1,000 insured lives, we may offer a Self-Experience Profit Sharing formula.

Consideration of a rebate will be based upon the experience of a client's individual group insurance arrangements.

A premium loading may apply for participation in this arrangement.

9.2 Multinational Pooling

For Corporate Multinational clients, AIA Australia offers access to the following pooling solutions, allowing AIA to further enhance its services to multinational companies:

- AIA Pool offered by AIA Asia Benefits Network (AABN), a regional solution specifically designed for clients with Asia Pacific presence or with a mandate to manage employee benefit programs within the region.
- ZGEBS Pool offered by Zurich Group Employee Benefit Solutions (ZGEBS), a global solution for clients with international needs.
- AGB Pool offered by Alliance Global Benefits (AGB), a global solution to clients with international needs.

Operating in 16 countries and with our partnership with the above named pooling partners, AIA will develop group insurance solutions for multinational companies through the creation, marketing and successful delivery of employee benefit programs.

AIA will pool the experience of multiple group insurance policies (or other eligible policies such as Corporate Medical) where the common link is the parent company and, depending on the needs and suitability based on the current situation of multinational companies, either a regional solution by AABN or a global solution offered in conjunction with ZGEBS or AGB will be recommended.

Generally, better benefits are obtainable under Multinational Pooling arrangements when compared to locally managed policies, due to economies of regional or global scale.

AIA Australia would be pleased to work with you in terms of facilitating the design, installation and operation of a Multinational Pooling plan and has the local and regional expertise internally to ensure this is promptly achieved.

10. How premiums work

10.1 Calculation of premiums

The cost of your premium is the total cost of cover for all **Insured Persons** during the relevant period. The premium amount also includes any government levies, taxes or charges not included in the **Premium Rates**. Premiums are calculated by applying the relevant **Premium Rate** as set out in the **Policy Schedule** to the amount of cover held by the **Insured Person** and will include any loadings for premiums paid more frequently than yearly.

The cost of your **Premium Rates** will be set out in the **Policy Schedule**.

10.2 Frequency of premiums

Premiums can be paid either:

- monthly in advance or in arrears,
- quarterly in advance, or
- annually in advance.

10.2.1 Quotation Premium

When pricing a group insurance Policy, we will provide you with a quotation based on our best interpretation of the information provided by you. The quotation should be considered in conjunction with all terms and conditions contained in this PDS.

The rating factors considered when setting the **Premium Rates** include important factors like the occupations and profiles of the people to be insured. Some of the factors that may cause your **Premium Rates** to go up or down include:

Rating Factors	How it may affect the cost of your cover
Age	Premiums generally increase as the average age of the insured group increases.
Gender	Premiums vary depending on the percentage of females and males in the insured group.
Occupation	Premiums are generally higher if the insured group's occupation is more dangerous
Benefit Design	The type and amount of cover, monthly income of the insured group, the waiting period and benefit period all affect the premium.
Optional benefits	Optional benefits provide additional cover or benefits for the insured group at an extra cost.
Claims Experience	Premiums are generally higher if more claims have been made by the insured group.

The quotation will be based on the assumption that the specifications, data and advice provided to AIA Australia are accurate and complete. If found this is not the case, we reserve the right to alter the quoted **Premium Rates** or withdraw the quotation.

We reserve the right to adjust the quoted **Premium Rates** at the **Policy Commencement Date** where the details at the **Policy Commencement Date** differ from the details upon which the quotation was based.

10.2.2 Deposit Premium

The Deposit Premium is one of the requirements needed to implement an AIA Australia group insurance Policy and is payable prior to the **Policy Commencement Date** and will initially be calculated at the quotation stage. Upon commencement of the Policy, an adjusted premium will be calculated and be reduced by the Deposit Premium received.

10.2.3 Annual Review Premium

At the Policy **Renewal Date**, the premiums will be re-calculated and an **Adjustment Premium** calculated to reflect changes in the Policy membership including variations to the **Insured Person's Sum Insured** or **Insured Persons** joining or exiting the Policy since the last **Renewal Date**. Prior to the annual **Renewal Date**, a Deposit Premium will be requested by us. Upon receipt of updated membership data as at the annual **Renewal Date**, the annual review premium will be calculated and reduced by the Deposit Premium received. Any **Adjustment Premium** must be remitted to us within 30 days of the calculation.

10.3 Minimum annual premium

The **Minimum Annual Premium** payable for the Policy is set out in the **Policy Schedule**. This excludes any external brokerage or administration fees, Goods and Services Tax (GST) or Stamp Duty.

10.4 Tax on premiums

Where we become liable for any tax or other imposts levied by any Commonwealth or State government, authority or body in connection with the Policy, we may reduce, vary or otherwise adjust any amounts (including but not limited to **Premium Rates**, charges and benefits) under the Policy in the manner and to the extent we determine to be appropriate, to take account of the tax or impost.

10.5 If you don't pay premiums

In the event that premiums are not paid within the **Grace Period**, we will give you written notice of our intention to terminate the Policy. If the overdue premiums have not been paid within a further 30 days of that written notice, the Policy will terminate and all **Cover** will cease. If the event giving rise to a claim occurs within any period for which no premiums have been remitted to AIA Australia, no benefit in respect of such claim will be paid until all premiums due for that Policy have been remitted to AIA Australia.

10.6 When we will refund premiums (inside superannuation only)

10.6.1 Multiple Cover

Where, upon receipt of a claim, we identify the **Insured Person** has multiple Automatic Acceptance insurance cover and no benefit is payable because they have already received a benefit under another income protection policy (in accordance with Section 5.5), we will give the **Insured Person** the option to cancel their **Cover** and receive a premium refund for the period where multiple insurance cover was held, up to a maximum of six years.

10.6.2 Ineligible Cover

Where we identify the **Insured Person** would not be eligible to claim on the Automatic Acceptance **Cover** provided, premiums will be refunded for the period the **Insured Person** was ineligible. Refunds will not be provided if the **Insured Person** has an injury or sickness that means they are not covered due to **New Events Cover** or an exclusion or limitation, because they may still be eligible for cover for any new or other injuries or sicknesses.

11. Changes to your Policy

11.1 When can we change the Policy?

This Policy may be changed by written agreement between you and us.

11.2 Guarantee of Premium

We will guarantee the quoted **Premium Rates** for a period as set out in the **Policy Schedule** for **Cover** provided:

- the number of **Insured Persons** does not fluctuate by more than 30% in any 12 month period,
- no more than 10% of the **Insured Persons** are outside of Australia, and
- the benefit design as set out in the **Policy Schedule** does not change.

11.3 Variation of Policy

During the **Rate Guarantee Period**, we will not vary any of the terms and conditions of the Policy, including without limitation the **Premium Rates** and/or **AAL**^ in the **Policy Schedule**, unless:

- there is an actual or anticipated change to the insurance arrangements (including without limitation changes to benefit design and/or eligibility for Automatic Cover) and as a result there is or could be expected to be a material impact on the Policy, as determined by us acting reasonably, including without limitation where the **Premium Rates** no longer accurately reflect the risk under the Policy,
- any business activities (such as acquisition, takeover, merger activity, restructure, divestment) results in unusual changes to the membership of the **Employer** which requires a restructure of the current **Employer** arrangements and there is or could be a material impact to the insurance arrangements,
- in the event of **War** on Australia's shores or any act of invasion on Australian shores,
- there is an actual or anticipated change to the law or relevant industry codes and as a result:
  - there is or could be a material impact on the Policy, as determined by us acting reasonably, including without limitation where the **Premium Rates** no longer accurately reflect the risk under the Policy,
  - it is or could become impossible or impractical for us to carry out our obligations under the Policy,
  - government taxes or levies are or could be imposed or changed, or
  - the provisions of the Policy would otherwise become inconsistent with the law or relevant industry codes to the extent of such inconsistency.
- our right to vary the terms and conditions of the Policy does not apply to the extent that it would prevent the Policy from being treated as a life insurance business under the *Life Insurance Act 1995* (Cth) (or any legislation that replaces it).

If we change the Policy for one of these reasons outlined above, we'll give you 90 days' written notice.

^ Changes to the **AAL** are also subject to Section 3.6.

11.4 Termination of Policy

The **Policy Owner** may terminate the Policy at any time by giving prior written notice. We will refund any premium for any period of unexpired risk and where applicable the **Policy Owner** must pay all outstanding premiums up to the date the Policy is terminated.

If the number of **Insured Persons** fall below the **Minimum Insured Lives** as set out in the **Policy Schedule** or the annual premium falls below the **Minimum Annual Premium** as set out in the **Policy Schedule**, we may issue a written notice to terminate the Policy.

We will give the **Policy Owner** 30 day's written notice of our intention to terminate the Policy.

12. AIA Australia Privacy Policy Summary

12.1 Privacy

This section summarises key information about how the AIA Australia Group handles personal information including sensitive information. More information can be found in the full version of the AIA Australia Group Privacy Policy at aia.com.au/privacy.

Your privacy is important to us and AIA Australia is bound by the Privacy Act, and other laws which protect your privacy. The AIA Australia Group consists of AIA Australia Limited, AIA Financial Services Pty Limited, CMLA Services Pty Ltd, Jacques Martin Pty Ltd, Jacques Martin Administration and Consulting Pty Ltd (together referred to as "**AIA Australia Group**", "**we**", "**us**" and "**our**"). Together, we provide you the following notification and information about our Privacy Policy and your rights.

12.1.1 Why we collect your personal information

We collect, use and disclose personal and sensitive information ("**Personal Information**") for multiple purposes including:

- to process applications for our products and services (including products we distribute),
- to assist with enquiries and requests in relation to our products and services (including products we distribute),
- for underwriting and reinsurance purposes,
- to administer, assess and manage your products and services, including claims,
- to understand your needs, interests and behaviour and to personalise dealings with you,
- to provide, manage and improve our products and services,
- to provide you with financial advice,
- to maintain and update our records,
- to verify your identity and/or authority to act on behalf of a customer,
- to detect, manage and deal with improper conduct and commercial risks,
- for research, reporting and marketing purposes,
- to comply with applicable laws and regulatory obligations, and
- for any other purposes as outlined in the Privacy Policy.

The reasons why we collect, use and disclose Personal Information may vary depending on the product, service, or other circumstances in which you have engaged with AIA Australia Group.

Full details of the purposes for our collection of Personal Information are set out in our full Privacy Policy.

12.1.2 How we collect, use and disclose your personal information

Personal Information may be collected from various sources, including:

- forms you submit,
- our records about your use of our products and services,
- our records from your dealings with us, including telephone, email or online interactions (including webchat), and
- public sources, social media, and third parties described in our Privacy Policy.

Further, we will collect and use Personal Information as and when it is required or authorised by law. These obligations are detailed further in our Privacy Policy.

Where you provide us with Personal Information about someone else you must have their consent to provide their Personal Information to us in the manner described in our Privacy Policy.

We may provide, collect and exchange your Personal Information with third parties, including:

- members of the AIA Group,
- the **Insured Person**, **Policy Owner,** or beneficiaries of an insurance policy,
- service providers and contractors,
- your intermediaries, including your financial adviser, the distributor of your insurance policy and the trustee or administrator of your superannuation fund, your employer, your treating doctor or your legal representatives, or anyone acting on your behalf (together, your "**Representatives**"),
- your employer, bank, medical professionals or health providers,
- partners used in our activities or business initiatives (including, if relevant to your policy, the Commonwealth Bank of Australia),
- our distributors, clients, and reinsurers,
- other financial services organisations involved in providing, managing or administering products or services recommended as part of any financial advice we provide to you,
- AIA Health Insurance Pty Ltd,

- other insurers (including worker's compensation insurers, authorities, other private health insurers) and their contractors and agents,
- other super funds, trustees of those super funds and their agents,
- regulatory and law enforcement agencies,
- other bodies that administer applicable industry codes, and
- other parties described in our Privacy Policy.

Where we provide your Personal Information to a third party, the third party may collect, use and disclose your Personal Information in accordance with their own privacy policy and procedures. These may be different to those of the AIA Australia Group.

Parties to whom we disclose Personal Information to may be located in Australia, South Africa, the United States, the United Kingdom, Europe, Asia and other countries including those set out in our Privacy Policy. If the Financial Services Council Life Code of Practice ("**Code**") applies to the insurance cover we provide you, we will comply with the Code when we collect, use and disclose your Personal Information.

12.1.3 Other important information

By providing information to us or your Representatives, the trustee or administrator of a superannuation fund, submitting or continuing with a form or claim, or otherwise interacting or continuing your relationship with us, you confirm that you agree and consent to the collection, use (including holding and storage), disclosure and handling of Personal Information as described in the Privacy Policy on our website and that you have been notified of the matters set out in this summary and the AIA Australia Group Privacy Policy. You agree that we may not issue a separate notice each time Personal Information is collected.

You must obtain and read the most up to date version of the AIA Australia Group Privacy Policy via aia.com.au/privacy, or by contacting us on 1800 333 613 for AIA or AIA Financial Wellbeing on 1800 434 044 to obtain a copy.

You have the right to access the Personal Information we hold about you, and can request the correction of your Personal Information if it is inaccurate, incomplete or out of date. Requests for access or correction can be directed to us using the details in the 'Contact us' section below.

Our full Privacy Policy provides more detail about our collection, use (including handling and storage), disclosure of Personal Information and how you can access and correct your Personal Information, make a privacy related complaint and how we will deal with that complaint, and your opt-out rights. Always ensure you are reviewing the most up-to-date version of the Privacy Policy as published at aia.com.au/privacy.

For avoidance of doubt, the Privacy Policy applicable to the management and handling of Personal Information will be the most current version published at aia.com.au/privacy, which shall supersede and replace all previous Privacy Policies and/or Privacy Statements and privacy summaries that you may receive or access, including but not limited to those contained in or referred to in any telephone recordings and calls, websites and applications, underwriting and claim forms, Product Disclosure Statements and other insurance and disclosure statements and documentation.

12.1.4 Contact us

If you have any questions or concerns about your Personal Information, please contact us as set out below:

AIA Australia Limited
PO Box 6111
Melbourne, VIC 3004
Phone: 1800 333 613

AIA Financial Services Pty Limited, trading as AIA Financial Wellbeing
PO Box 6051
Melbourne, VIC 3004
Phone: 1800 434 044

12.2 If there's a problem

If you have any questions or concerns about your Policy, please contact us directly on 1800 333 613 and we will promptly investigate your enquiry, referring it if necessary, to our Internal Disputes Resolution Committee (IDRC).

Internal complaints are normally resolved within 30 days, or 45 days for Policies inside superannuation. In special circumstances, we may take longer. If this is the case, we will advise you.

If you are not satisfied with the response provided, you may complain to the independent Australian Financial Complaints Authority (AFCA).

Details are as follows:

Australian Financial Complaints Authority (AFCA)
GPO Box 3
MELBOURNE VIC 3001
Telephone: 1800 931 678
Email: info@afca.org.au
Online: www.afca.org.au

13. Meanings of words in this PDS

13.1 General Definitions

Definition	Meaning
Accident or Accidental Injury	Means a physical injury which occurs while the Policy is in force that is caused solely and directly by violent, visible, external and unexpected means that would have occurred in the absence of any mental or physical health condition which the **Insured Person** was subject to, at or prior to the relevant accident event.
Adjustment Premium	As set out in the **Policy Schedule**.
At Work	Means the person is: • engaged in their normal duties, without limitation or restriction due to injury or sickness, and working their usual hours on the applicable date, • not restricted by injury or sickness from being capable of performing their full and normal duties on a full time basis (for at least 30 hours per week) even though their actual employment can be on a full-time, part-time, contract or casual basis, and • not in receipt of and/or entitled to claim any income support benefits from any source including workers' compensation benefits, statutory transport accident benefits and disability income benefits. The person will be considered **At Work** if on the applicable date, as the context requires, the person is on **Employer** approved leave for reasons other than injury or sickness, and not taking into account the leave, is able to meet the **At Work** definition. A person who does not meet these requirements is considered not **At Work**.
Australian Resident	Means: • a person who resides in Australia and is either an Australian citizen or a holder of an Australian Permanent Resident visa, or • a person who is a New Zealand citizen and is the holder of a **Special Category visa** while residing in Australia indefinitely.
Automatic Acceptance Limit (AAL)	Means the amount of cover that applies to an **Insured Person** without underwriting. The **AAL** is as set out in the **Policy Schedule**.
Benefit Period	Means the maximum period as set out in the **Policy Schedule** for which the **Monthly Benefit** will be paid in respect of an **Insured Person** for any one period of **Disability**.
Casual(s)	Means a person who is not a **Permanent Employee** and is employed with an **Employer** on a casual basis and whose **Employer** is making superannuation guarantee contributions in respect of the **Casual Employee**. The **Benefit Period** for **Casual Employees** will be limited to two years and the **Insured Person's Pre-Disability Income** from the **Employer** will be measured over the three months immediately prior to the commencement of the **Waiting Period**.
Cover	Means Salary Continuance Insurance cover provided to an **Insured Person** pursuant to Section 3.2.
Cover Expiry Age	Means the age at which **Cover** ceases as set out in the **Policy Schedule**.
Current Income	Means the income earned, by an **Insured Person** from personal exertion while **Partially Disabled** whether the income is from their usual occupation or any occupation where Definition 2 or Definition 3 of **Partial Disability** applies. If the **Insured Person** takes annual leave or long service leave during the period of **Partial Disability**, this will be included in the income the **Insured Person** would have earned had they not taken such leave.
Disability or Disabled	Means **Total Disability** or **Partial Disability** as applicable.
Eligible Person	Means a person who meets the eligibility criteria as described under Section 3.1.
Employee(s)	Means a person engaged by the **Employer** under a contract of employment to undertake identifiable duties.
Employer(s)	Means the **Employer** as set out in the **Policy Schedule**.

Fixed Term Employee(s)	Means a person who is employed under a written contract with an **Employer** for a fixed term of at least six months and whose **Employer**: • requires the person to perform identifiable duties for a regular number of hours each week, • provides the person with annual leave and sick leave entitlements, and • is making superannuation guarantee contributions in respect of the person. Where a **Fixed Term Employee** is employed on a minimum contract period of 12 months or less, the **Benefit Period** will be limited to two years and the **Insured Person's Pre-Disability Income** from the **Employer** will be measured over the three months immediately prior to the commencement of the **Waiting Period**.
Forward Underwriting Limit (FUL)	Means the amount, determined by us, which an **Insured Person's Cover** may increase to in line with the benefit design without the need for further underwriting.
FSC Guidance Note 11	Means FSC Guidance Note No. 11 Group Insurance Takeover Terms as amended from time to time (the current version of which is dated 9 May 2013).
Grace Period	Means 30 days of grace shall be allowed for the payment of each premium. If a claim arises within that period, no benefit amount will become payable under the Policy in respect of such claim until the outstanding premium amount is paid to us in full.
Inactive	Means the **Policy Owner** has not received a contribution or rollover in respect of the **Insured Person** for a continuous period of 16 months. An account will not be considered **Inactive** for an **Insured Person**: • who is a defined benefit member, • who is an ADF Super member (within the meaning of the *Australian Defence Force Superannuation Act 2015* (Cth)) or would have been an ADF Super member if they did not choose their own superannuation fund, • whose **Employer** pays the full cost of the **Insured Person's** premiums to the **Policy Owner** each quarter. Quarter means a period of 3 months beginning on 1 January, 1 April, 1 July or 1 October, or • who has provided a written election to the **Policy Owner** to maintain their **Cover**.
Income	Unless other otherwise stated in the **Policy Schedule**, **Income** means: **Definition A –** where the **Insured Person** is **Employed** excluding bonuses The pre-tax remuneration package paid by the **Employer** to the **Insured Person** whilst they are an **Insured Person**, including base salary and fees, regular overtime earnings and regular commissions (but excluding superannuation guarantee contributions, allowances, irregular overtime earnings and irregular commissions and unearned income such as investment or interest earnings)*. Regular overtime earnings and regular commissions will be calculated based on the average of the last three years' (or where the **Insured Person** has been employed for less than 3 years, averaged over the **Insured Person's** period of employment) regular overtime earnings and regular commissions received by the **Insured Person** whilst they are an **Insured Person**, from the **Employer**. **Definition B –** where the **Insured Person** is **Employed** including bonuses The pre-tax remuneration package paid by the **Employer** to the **Insured Person** whilst they are an **Insured Person**, including base salary and fees, regular bonuses, regular overtime earnings and regular commissions (but excluding superannuation guarantee contributions, allowances, irregular bonuses, irregular overtime earnings and irregular commissions and unearned income such as investment or interest earnings)*. Regular bonuses, regular overtime earnings and regular commissions will be calculated based on the average of the last three years' (or where the **Insured Person** has been employed for less than 3 years, averaged over the **Insured Person's** period of employment) regular bonuses, regular overtime earnings and regular commissions received by the **Insured Person** whilst they are an **Insured Person**, from the **Employer**. **Definition C –** where the **Insured Person** is self-employed Where the **Insured Person** directly or indirectly owns all or part of the business, including all or part ownership through another legal entity, from which they earn their usual **Income**, the gross amount earned by the business in the 12 months immediately prior to the relevant period, as a direct result of the **Insured Person's** personal exertion or activities through their usual occupation after allowing for the costs and expenses incurred in deriving that **Income**. **Income** from the business will not include investment income, profit distributions or similar payments that may continue in the event of **Disability**. * The **Income** advised by the **Employer** to determine an **Insured Person's Sum Insured** may not always be the same as the remuneration the **Insured Person** receives from their **Employer**.
Insured Percentage	Means the **Insured Percentage** as set out in the **Policy Schedule** used to calculate the **Monthly Benefit**.

Insured Person	Means an **Eligible Person** who has **Cover** in force under the Policy, other than Interim Accident Cover.
Maximum Entry Age	Age 59 where the 'To Age 60' **Benefit Period** applies. Age 64 for all other **Benefit Periods**.
Maximum Monthly Benefit	$30,000 per month (inclusive of **SC Benefit**). $10,000 per month (inclusive of **SC Benefit**) where an **Insured Person** is aged 65 and over.
Maximum Super Contribution Base	Means the maximum limit on an **Employee's** income that the superannuation guarantee (SG) rate is applied against. The **Maximum Super Contribution Base** is a quarterly amount set by the Australian Tax Office and indexed every income year.
Medical Practitioner(s)	Means a legally qualified and registered doctor of medicine, other than the **Insured Person**, or a family member, business partner, **Employee**, work colleague or **Employer** of the **Insured Person**. We may accept a similarly qualified person who is registered and practicing as a medical practitioner in another country with a similar standard of medical care as that in Australia, and who has a formal qualification that is generally equivalent to that required to practice in Australia. We may seek an opinion from a qualified registered medical practitioner in Australia to review such overseas medical evidence.
Minimum Annual Premium	As set out in the **Policy Schedule**.
Minimum Insured Lives	As set out in the **Policy Schedule**.
Monthly Benefit	Means the amount calculated in accordance with the formula (including the **Insured Percentage**) as set out in the **Policy Schedule**.
New Events Cover	Means the **Insured Person** is only covered for claims arising from a sickness which first became apparent or an injury which first occurred on or after the date the **Insured Person's Cover** commenced or most recently commenced under this Policy and is not related to a sickness or injury that occurred before the applicable date.
Partial Disability or Partially Disabled	As set out in the **Policy Schedule** subject to Section 5.1, the available definitions are as follows: **Definition 1** Means solely as a result of injury or sickness the **Insured Person** is: • unable to work in their usual occupation at full capacity after becoming **Totally Disabled**, • working in their usual occupation in a reduced capacity or working in an alternative occupation; • earning an income which is less than their **Pre-Disability Income**, and • under the regular care of, and following the advice of, a **Medical Practitioner** in relation to that injury or sickness. **Definition 2** Means solely as a result of injury or sickness, in the first 24 months of the **Benefit Period** the **Insured Person** is: • unable to work in their usual occupation at full capacity after becoming **Totally Disabled**, • working in their usual occupation in a reduced capacity or working in an alternative occupation, • earning an income which is less than their **Pre-Disability Income**, and • under the regular care of, and following the advice of, a **Medical Practitioner** in relation to that injury or sickness. After the expiry of the first 24 months and for the balance of the **Benefit Period**, solely due to the same injury or sickness the **Insured Person** is: • unable to perform any occupation for which they are reasonably suited by education, training or experience, but has returned to work in their usual occupation in a reduced capacity or an alternative occupation, • earning an income which is less than their **Pre-Disability Income**, and • under the regular care of, and following the advice of, a **Medical Practitioner** in relation to that injury or sickness.

Partial Disability or Partially Disabled (continued)	**Definition 3** Means solely as a result of injury or sickness the **Insured Person** is: • unable to perform any occupation for which they are reasonably suited by education, training or experience, but has returned to work in their usual occupation in a reduced capacity or an alternative occupation, • earning an income which is less than their **Pre-Disability Income**, and • under the regular care of, and following the advice of, a **Medical Practitioner** in relation to that injury or sickness.
Permanent Employee	Means a person who accepts an offer of employment where the **Employer** and the person have agreed to continuing and indefinite work and whose **Employer**: • requires the person to perform identifiable duties for a regular number of hours each week, • provides the person with annual leave and sick leave entitlements, and • is making superannuation guarantee contributions in respect of the person.
PMIF Election	Means the notification provided to the **Policy Owner** by an **Eligible Person**, of their election to be provided with **Cover** by the **Policy Owner** despite being under age 25 or their account balance being less than $6,000 in accordance with section 68AAB or section 68AAC of the *Superannuation Industry (Supervision) Act 1993* (Cth).
PMIF Exempt Member	Means a person that a superannuation fund is permitted under the *Superannuation Industry (Supervision) Act 1993* (Cth) to provide insurance cover to despite the person being under age 25 or having an account balance within the **Employer's** default superannuation fund of less than $6,000 (as applicable) due to any of the following: • the person has made a written election to take out or maintain cover (**PMIF Election**) despite their account balance being less than $6,000 in accordance with section 68AAB(2) of the *Superannuation Industry (Supervision) Act 1993* (Cth), • the person has made a written election to take out or maintain cover (**PMIF Election**) despite being under the age of 25 years in accordance with section 68AAC(2) of the *Superannuation Industry (Supervision) Act 1993* (Cth), • the person is a defined benefit member, • the person qualifies for the dangerous occupation exception under section 68AAF of the *Superannuation Industry (Supervision) Act 1993* (Cth), • the person is an ADF Super member (within the meaning of the *Australian Defence Force Superannuation Act 2015* (Cth)) or would have been an ADF Super member if they did not choose their own superannuation fund, or • the person's **Employer** pays the full cost of premiums in respect of the **Insured Person** and the Employer-Sponsor Contribution Exception applies in accordance with section 68AAE of the *Superannuation Industry (Supervision) Act 1993* (Cth).
PMIF Requirements	Means the person is not a **PMIF Exempt Member** and is aged 25 years or over and has an account balance within their **Employer's** default superannuation fund of $6,000 or more.
Policy Commencement Date	Means the date the Policy commences, as set out in the **Policy Schedule**.
Policy Owner	Means the owner of the Policy, as set out in the **Policy Schedule**.
Policy Schedule	Means the document that accompanies this Policy issued by us to you, outlining the details of the benefit design and terms including any Non-Standard Terms and Conditions agreed by us that apply.
Policy Type	Means either ordinary non-superannuation or superannuation business as set out in the **Policy Schedule**.

Pre-Disability Income	Means one of the following: • for **Casuals** or **Fixed Term Employees** with a minimum contract period of 12 months or less, the average gross monthly **Income** earned by the **Insured Person** in the three months immediately prior to the commencement of the **Waiting Period** or if working less than three months, the average gross monthly **Income** earned over the **Insured Person's** period of employment, or • where the above does not apply, the gross monthly **Income** earned by the **Insured Person** immediately prior to the commencement of the **Waiting Period**. For **Insured Persons** that become **Disabled** during a period of Leave Without Pay (including maternity or paternity leave), the **Sum Insured** will be based on the level of the **Insured Person's Pre-Disability Income** at the date immediately prior to the commencement of Leave Without Pay. If the **Insured Person** takes a period of paid leave at a reduced **Income** prior to commencing Leave Without Pay, in the event of a claim, **Pre-Disability Income** will be calculated based on their **Income** immediately prior to such a reduction.
Premium Rate(s)	As set out in the **Policy Schedule**.
Rate Guarantee Period	As set out in the **Policy Schedule**.
Renewal Date	As set out in the **Policy Schedule**.
Special Category visa (SCV)	As per the guidelines provided under the Department of Immigration and Border Protection, a **Special Category visa** (subclass 444) is a temporary visa that allows a person to stay and work in Australia as long as that person remains a New Zealand citizen. For avoidance of doubt, a New Zealand citizen who holds a **SCV** while residing in Australia and departs temporarily overseas will be treated the same as an **Australian Resident**. They will be entitled to the same provisions, **Cover** terms and conditions as an **Australian Resident** under this Policy.
Sum Insured	Means the amount of insured **Cover** that we will provide under the Policy in accordance with the benefit design as set out in the **Policy Schedule**.
Super Contributions Benefit (SC Benefit)	As set out in the **Policy Schedule** and described under Section 5.6 of this Policy.
Total Disability or Totally Disabled	As set out in the **Policy Schedule** subject to Section 5.1, the available definitions are as follows: **Definition 1** Means solely as a result of injury or sickness the **Insured Person** is: • unable to perform at least one Important Duty^ of their usual occupation, • under the regular care of, and following the advice and treatment of a **Medical Practitioner** in relation to that injury or sickness, and • not working in any occupation (whether paid or unpaid). Where the Policy is provided within superannuation, the injury or sickness must cause the **Insured Person** to cease gainful employment. **Definition 2** Means solely as a result of injury or sickness, in the first 24 months of the **Benefit Period**, the **Insured Person** is: • unable to perform at least one Important Duty^ of their usual occupation, • under the regular care of, and following the advice and treatment of a **Medical Practitioner** in relation to that injury or sickness, and • not working in any occupation (whether paid or unpaid). After the expiry of the first 24 months and for the balance of the **Benefit Period**, solely due to the same injury or sickness the **Insured Person** is: • unable to perform any occupation for which they are reasonably suited by education, training or experience, • under the regular care of, and following the advice and treatment of a **Medical Practitioner** in relation to that injury or sickness, and • not working in any occupation (whether paid or unpaid). Where the Policy is provided within superannuation, the injury or sickness must cause the **Insured Person** to cease gainful employment.

Total Disability or Totally Disabled (continued)	**Definition 3** Means the **Insured Person** solely as a result of injury or sickness is: • unable to perform any occupation for which they are reasonably suited by education, training or experience, • under the regular care of, and following the advice and treatment of a **Medical Practitioner** in relation to that injury or sickness, and • not working in any occupation (whether paid or unpaid). Where the Policy is provided within superannuation, the injury or sickness must cause the **Insured Person** to cease gainful employment. ^ Important Duty means a duty that involves 20% or more of the **Insured Person's** overall occupational tasks.
Visa	Means a current and valid visa issued in accordance with the *Migration Act 1958* (Cth) or any amending or replacing Act which enables an **Eligible Person** or **Insured Person** to work in Australia.
Voluntary Cover	If stated as being provided in the **Policy Schedule**, **Voluntary Cover** means the discretionary **Cover**, which is not based on the benefit design and which the **Insured Person** may elect, subject to underwriting and acceptance by us.
Waiting Period	Means the **Waiting Period** is the initial length of time an **Insured Person** must be **Disabled** before the **Monthly Benefit** begins to accrue. It will be set out in the **Policy Schedule**. The **Waiting Period** starts on the later of: • the date a **Medical Practitioner** examines the **Insured Person** and certifies they're **Totally Disabled** provided the **Insured Person** has ceased working solely as a result of that injury or sickness, and • the date the **Insured Person** ceased work due to that injury or sickness. If an **Insured Person** consults a **Medical Practitioner** within seven days of ceasing work due to the injury or sickness, the **Waiting Period** will commence on the date after the **Insured Person** ceased work.
War	Includes but is not limited to war (declared or undeclared) or war related activities, revolution, invasion or rebellion or civil unrest.
Welcome Letter	Means the initial notification sent by a superannuation fund to a person as a result of them joining the **Employer** and which we agree with the **Policy Owner** constitutes the **Welcome Letter**.

13.2 Medical Conditions

Term	Meaning
Accidental HIV Infection	Means infection with the Human Immunodeficiency Virus (HIV) acquired by accident or violence during the course of the **Insured Person's** normal occupation or through the medium of a blood transfusion, transfusion of blood products, organ transplant, assisted reproduction technique or other medical procedure or operation performed by a doctor or at a recognised medical facility. Sero-conversion evidence of the HIV infection must occur within six months of the accident and must be verified by an appropriate **Medical Practitioner**. HIV infection transmitted by any other means, including but not limited to sexual activity or non-medical intravenous drug use, is not Accidental HIV Infection under the Policy. Any accident giving rise to a potential claim must be supported by a negative HIV antibody test taken within seven days after the accident. We must be given access to test independently all blood samples used, if we require. We retain the right to take further independent blood tests or other medically accepted HIV tests.
Activities of Daily Living	Means the following activities: **Bathing** The ability to wash themselves either in the bath or shower or by sponge bath without the assistance of another person. The **Insured Person** will be considered to be able to bathe themselves even if the above tasks can only be performed by using equipment or adaptive devices.

Activities of Daily Living (continued)	**Dressing** The ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten and unfasten them without the assistance of another person. The **Insured Person** will be considered able to dress themselves even if the above tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls. **Eating** The ability to feed themselves once food has been prepared and made available, without the assistance of another person. **Toileting** The ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing without the assistance of another person. The **Insured Person** will be considered able to toilet themselves even if he or she has an ostomy and is able to empty it themself, or if the **Insured Person** uses a commode, bedpan or urinal, and is able to empty and clean it without the assistance of another person. **Transferring** The ability to move in and out of a chair or bed without the assistance of another person. The **Insured Person** will be considered able to transfer themselves even if equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorised devices is used.
Alzheimer's Disease	Means the diagnosis of **Alzheimer's Disease** as confirmed by a consultant neurologist, psychiatrist or geriatrician resulting in significant cognitive impairment. Significant cognitive impairment means deterioration in the **Insured Person's** mini-mental state examination, or equivalent thereof, scores to 20 or less.
Aplastic Anaemia	Means a definite diagnosis of chronic persistent bone marrow failure, confirmed by a bone marrow biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring treatment by at least one of the following: • blood production transfusion, • marrow stimulating agents, • immunosuppressive agents, or • bone marrow transplantation.
Bacterial Meningitis	Means the diagnosis of the **Insured Person** with **Bacterial Meningitis**. The meningitis must produce neurological deficit causing permanent and significant functional impairment. 'Significant' shall mean at least a 25% impairment of whole person function as defined in the Guide to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Diagnosis must be confirmed by a consultant neurologist. **Bacterial Meningitis** in the presence of HIV is excluded. All other forms of meningitis including viral, are excluded.
Benign Brain Tumour	Means a non-cancerous tumour on the brain or spine giving rise to symptoms of permanent neurological deficit, resulting in the **Insured Person** either: • suffering at least 25% impairment of whole person function, attributable to the above condition, as defined in the Guide to the Evaluation of Permanent Impairment 5th edition, American Medical Association, or • being totally and permanently unable to perform any one of the **Activities of Daily Living**. The above requirement will be waived if the tumour is surgically removed regardless of whether or not the symptoms of permanent neurological deficit apply. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI (Magnetic Resonance Imaging). Cysts, granulomas, cholesteatomas, malfunctions in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland are not covered.
Blindness	Means as a result of disease or accident and certified by an ophthalmologist, the: • visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes, or the • field of vision is constricted to 20 degrees or less of arc around central fixation in the better eye irrespective of corrected visual activity (equivalent to 1/100 white test object), or the • combination of visual defects results in the same degree of vision impairment as that occurring in either of the above.

Cancer	Means the presence of one or more malignant tumours including Hodgkin's disease, leukaemia and other malignant bone marrow disorders, and characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue, but does not include the following: • tumours which are histologically described as premalignant or showing the changes of 'carcinoma in situ', • 'carcinoma in situ of the breast'^, • melanomas of less than 1mm thickness, without ulceration as determined by histological examination, • all hyperkeratoses or basal cell carcinomas of the skin, • cutaneous squamous cell carcinomas of T3N0M0 and below grade tumours, where the tumour is less than five cm in greatest diameter, • T1N0M0 papillary carcinoma of the thyroid less than one cm in diameter unless a total thyroidectomy has been undertaken and was considered by treating doctors to be appropriate and necessary treatment, • Polycythemia Rubra Vera requiring treatment by venesection alone, and • tumours treated by endoscopic procedures alone. ^ Carcinoma in situ of the breast is only covered if it results directly in the removal of the entire breast or requires surgery and adjuvant therapy specifically to arrest the spread of malignancy and this procedure is considered the appropriate and necessary treatment as confirmed by an appropriate specialist acceptable to us. Skin cancer – where diagnosed by an appropriate specialist acceptable to us, we will pay 100% of the **Sum Insured** for: • melanomas where the tumour is with ulceration or is diagnosed as 1 mm or greater in Breslow's depth of invasion, or • cutaneous squamous cell carcinomas where the tumour is diagnosed at greater than T3N0M0 or any TN1, 2 or 3 or metastases are present.
Cardiomyopathy	Means a condition of impaired ventricular function of variable aetiology (often not determined) resulting in permanent significant physical impairment i.e. Class III on the New York Heart Association classification of cardiac impairment. The New York Heart Association classifications are: • Class I – no limitation of physical activity, no symptoms with ordinary physical activity. • Class II – slight limitation of physical activity, symptoms occur with ordinary physical activity. • Class III – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity. • Class IV – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.
Chronic Liver Disease	Means end stage liver failure, together with two of the following conditions: • permanent jaundice, • ascites, or • hepatic encephalopathy. Such disease directly related to alcohol or drug abuse is excluded.
Chronic Lung Disease	Means end stage respiratory failure requiring continuous and permanent oxygen therapy and is confirmed by a medical specialist, excluding intermittent oxygen therapy.
Coma	Means a definite diagnosis of a state of unconsciousness with failure to respond normally to external stimuli or internal needs and requiring life support for a continuous period of at least 96 hours, for which period the Glasgow coma score must be 7 or less. Excluded from this definition is coma resulting from alcohol or drug abuse. The diagnosis of **Coma** must be made by an appropriate medical specialist.
Coronary Artery By-Pass Surgery	Means the actual undergoing of by-pass surgery (including saphenous vein or internal mammary graft(s) for the treatment of coronary artery disease). The operation must be for the treatment of one or more coronary arteries and angioplasty contra-indicated and must be considered necessary by a consultant cardiologist.
Dementia	Means the definitive diagnosis of **Dementia** as confirmed by a consultant neurologist, psychiatrist or geriatrician resulting in significant cognitive impairment. Significant cognitive impairment means deterioration in the **Insured Person's** mini-mental state examination or equivalent thereof, scores to 20 or less. Dementia as a result of alcohol or drug abuse is excluded.

Diplegia	Means the total and permanent loss of function of both sides of the body due to spinal cord injury or disease, or brain injury or disease.
Encephalitis	Means severe inflammation of the brain substance (cerebral hemisphere, brainstem or cerebellum) caused by infection resulting in the **Insured Person** either: • being totally and permanently unable to perform any one of the **Activities of Daily Living**, or • suffering at least a 25% impairment of whole person function, attributable to the above condition, as defined in the Guide to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Diagnosis must be confirmed by a consultant neurologist.
Heart Attack (myocardial infarction)	Means the death of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be confirmed by a cardiologist and evidenced by: • typical rise and fall of cardiac biomarker blood test (Troponin T, Troponin I or CK-MB) with at least one level above the 99th percentile of the upper reference limit, plus • acute cardiac symptoms and signs consistent with myocardial infarction (e.g. chest pain), or • new serial ECG changes with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or Left Bundle Branch Block (LBBB). If the above tests are inconclusive, we will consider other appropriate and medically recognised tests. Other acute coronary syndromes including but not limited to angina pectoris are excluded.
Heart Valve Surgery	Means the actual undergoing of a procedure to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities occurring after the **Policy Commencement Date** or last reinstatement date of the Policy. Valvotomy is specifically excluded.
Hemiplegia	Means the total and permanent loss of function of one side of the body due to spinal cord injury or disease, or brain injury or disease.
Kidney Failure	Means end stage renal failure, which presents as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation carried out.
Loss of Hearing	Means a definite diagnosis, by an appropriate medical specialist, of: • the total and irreversible loss of hearing in both ears, even with amplification, or • loss of hearing that has an average auditory threshold of 90 decibels or greater, even with amplification, calculated on the following frequencies: 500 hertz, 1000 hertz, 2000 hertz, 3,000 hertz and 4,000 hertz in the better ear.
Loss of Independence	Means: • a condition as a result of injury or sickness, where the **Insured Person** is totally and irreversibly unable to perform at least two of the five **Activities of Daily Living**. The condition should be confirmed by a consultant physician, or • cognitive impairment, meaning a deterioration or loss in the **Insured Person's** intellectual capacity which requires another person's assistance or verbal cueing to protect themselves as measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas: • short or long term memory, • orientation as to person (such as personal identity), place (such as location) and time (such as day, date and year), • deductive or abstract reasoning. or • **Loss of Limbs and Sight of One Eye.** The **Insured Person** would be required to be under continuous care and supervision by another adult person for at least six consecutive months. At the end of that six- month period, the **Insured Person** must, in our opinion on the basis of medical evidence, require ongoing continuous care and supervision by another adult person.

Loss of Limbs and Sight of One Eye	Means the total and irrecoverable loss by the **Insured Person** of any of the following: • use of both hands, • use of both feet, • use of one hand and one foot, • use of one hand and the sight of one eye, or • use of one foot and the sight of one eye.
Loss of Speech	Means the complete and irrecoverable loss of the ability to speak as a result of injury or sickness which must be established, and the diagnosis reaffirmed after a continuous period of three months of such loss by an appropriate medical specialist.
Major Burns	Means the **Insured Person** has suffered third degree burns to: • at least 20% of the body surface, • whole of both hands, requiring surgical debridement and/or grafting, or • whole of the head requiring surgical debridement and/or grafting.
Major Head Trauma	Means a head injury, as a result of an **Accident**, resulting in neurological deficit, as certified by a consultant neurologist acceptable to us, causing at least a permanent 25% impairment of whole person function as defined in the Guide to the Evaluation of Permanent Impairment 5th edition, American Medical Association.
Major Organ Transplant	Means having received, from a human donor, a medically necessary transplant involving one or more of the following organs: kidney, heart, liver, lung, bone marrow and pancreas.
Motor Neurone Disease	Means the unequivocal diagnosis of **Motor Neurone Disease** confirmed by a consultant neurologist.
Multiple Sclerosis	Means the unequivocal diagnosis of **Multiple Sclerosis** confirmed by a consultant neurologist, evidenced by: • more than one episode of well-defined neurological deficit, and • residual neurological impairment persisting for a continuous period of at least six months.
Muscular Dystrophy	Means the unequivocal diagnosis of **Muscular Dystrophy**, confirmed by a consultant neurologist.
Occupationally Acquired Hepatitis B or Hepatitis C Infection	Means the **Insured Person** is infected with Hepatitis B or Hepatitis C as a result of an Occupational Accident. An Occupational Accident means an accident that happens while the **Insured Person** is performing the usual duties of their normal occupation and involves contact with a body substance which puts the **Insured Person** at risk of transmission of the infections. This benefit will only be paid if all the following conditions for payment are satisfied. We require that: • the **Insured Person** reports the accident to us within 48 hours after it happens, • the **Insured Person** is tested for infections within 48 hours after the accident and the results are negative, • a **Medical Practitioner** diagnoses the **Insured Person** to be: - positive to Hepatitis C within 180 days after the accident, or - positive to Hepatitis B within 180 days after the accident and still be positive within 180 days after the first diagnosis, - the **Insured Person** complies with all infection control precautions that apply, - the **Insured Person** is vaccinated or immunised for the infections as required by us, and - all tests be carried out according to the procedures we specify.
Other Serious Coronary Artery Disease	Means the narrowing of the lumen of at least three coronary arteries by a minimum of 60%, as proven for the first time by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed.
Paraplegia	Means the total and permanent loss of function of the lower limbs due to spinal cord injury or disease, or brain injury or disease.
Parkinson's Disease	Means the unequivocal diagnosis of idiopathic **Parkinson's Disease** as confirmed by a consultant neurologist and requiring treatment. All other types of parkinsonism are excluded.
Pneumonectomy	Means undergoing a surgical procedure in which an entire lung is removed due to an underlying lung disease or disorder.

Pulmonary Arterial Hypertension (Primary)	Means primary pulmonary hypertension associated with right ventricular enlargement established by cardiac catheterisation, resulting in significant irreversible physical impairment of at least Class III of the New York Heart Association classification of cardiac impairment. Pulmonary Hypertension in association with chronic lung disease is specifically excluded. Other forms of hypertension (involving increased blood pressure) are specifically excluded. The New York Heart Association classifications are: • Class I – no limitation of physical activity, no symptoms with ordinary physical activity. • Class II – slight limitation of physical activity, symptoms occur with ordinary physical activity. • Class III – marked limitation of physical activity and comfortable at rest, symptoms occur with less than ordinary physical activity. • Class IV – symptoms with any physical activity and may occur at rest, symptoms increased in severity with any physical activity.
Quadriplegia	Means the total and permanent loss of function of the lower and upper limbs due to spinal cord injury or disease, or brain injury or disease.
Severe Rheumatoid Arthritis	Means the unequivocal diagnosis of rheumatoid arthritis by a rheumatologist that meets qualification for treatment by biological agents under PBS^ requirements after treatment with conventional disease-modifying anti-rheumatic drugs (DMARDs) having failed and has failed to respond to treatment with a biological DMARD. ^ Pharmaceutical Benefits Scheme – Rheumatoid Arthritis Initial PBS authority application.
Stroke	Means an acute neurological event caused by a cerebral or subarachnoid haemorrhage, cerebral embolism or cerebral thrombosis, where the following conditions are met: • there is an acute onset of objective and ongoing neurological signs that last more than 24 hours, and • findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques, demonstrate a lesion consistent with the acute haemorrhage, embolism or thrombosis. Excluded: • brain damage due to an accident, infection or hypoxia, • Transient Ischaemic Attack, • non-vasculitic inflammatory disease, • vascular disease affecting the eye, optic nerve or vestibular functions only.
Surgery to the Aorta	Means the surgical repair to the aorta to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta but does not include angioplasty or non-surgical techniques.
Terminal Illness	Means the diagnosis of the **Insured Person** with an illness which in the opinion of an appropriate medical specialist(s), approved by us, will result in the death of the **Insured Person** within 12 months of the diagnosis regardless of any treatment that may be undertaken.

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