MetLife

Life, inspired by you.

Group Income Protection Insurance

Combined Product Disclosure Statement and Policy Document

Issue Date: 1 November 2023

Group Income Protection Insurance
is issued by MetLife Insurance Limited
(MetLife)
ABN 75 004 274 882 AFSL No. 238096

About MetLife

In Australia, MetLife provides group insurance and individual life insurance products, specialising in death, total and permanent disability, and income protection insurance. Since its entry into the Australian market in 2005, MetLife has grown its group insurance market share significantly through partnering with superannuation funds, employers, brokers and advisers.

With over 150 years of experience, MetLife globally has established a strong presence in more than 40 markets reaching nearly 100 million customers.

This product is issued and underwritten by MetLife Insurance Limited.

The other companies within the MetLife group do not issue, guarantee or underwrite this product.

Which group insurance products are described in this document?

This booklet only covers MetLife Group Income Protection Insurance for ordinary (non-superannuation) arrangements. This booklet will not apply to *you* if *you* are the trustee of a superannuation fund and are looking to provide insurance for *your* members.

There are separate booklets containing the Product Disclosure Statements and/or policy documents for the following group insurance products issued by MetLife:

- MetLife Income Protection Insurance for superannuation arrangements (for policy documents only)
- MetLife Group Life Insurance for ordinary (non-superannuation) arrangements
- MetLife Group Life Insurance for superannuation arrangements (for policy documents only)

You can contact *us* on 1300 555 625 for a copy of these documents. *You* should consider these documents in deciding whether to acquire these other products.

MetLife 360Health - Virtual Care

When *you* purchase the policy, all *insured persons* under the policy will automatically have access to MetLife 360Health including the Virtual Care program.

MetLife 360Health Virtual Care is a service that gives an *insured person*, their partner and their children access to expert medical support and guidance from the comfort of their own home.

When someone is facing a health problem they need clear, definitive answers and reassurance that the support they are getting is the best available. *We* help where there is uncertainty by providing an *insured person* (and their partner and children) with easy access to general practitioners, specialists, mental health clinicians, dietitians and exercise physiologists via Virtual Care which is provided through our partner Teladoc Health.

The services available include Mental Health Assist, Expert Medical Opinion, Ask a Clinician, Fitness and Recovery and Nutrition Consultation. These services are designed to provide support for the *insured person* (and their partner and children) and are confidential.

For more information on this service, including instructions on how to access the service, please visit www.metlife.com.au/insurance-solutions/personal-insurance/360health/metlife-360health-corporate/

Contents

About this document

How to read this booklet

This booklet contains the Product Disclosure Statement (PDS) and the policy document for MetLife Group Income Protection Insurance for ordinary (non-superannuation) arrangements.

In this booklet:

- *we*, *our*, *us* and *MetLife* refer to MetLife Insurance Limited,
- *you*, *your* and *policy owner* refer to the applicant for this product and, if a policy is issued, the *policy owner* as set out in the *policy schedule*,
- headings are intended as a guide only and are not to be used to interpret the policy conditions, and
- as the context allows, plurals can be read as the singular and the singular as plurals.

What documents make up your policy?

The documents issued by *us* that make up *your* contract of insurance with *MetLife* (policy) are:

- the policy document section of this booklet,
- the *policy schedule* issued and signed by *us*, and
- any addendums issued and signed by *us*.

Please keep these documents in a safe place.

What is MetLife Group Income Protection Insurance Ordinary?

MetLife Group Income Protection Insurance Ordinary (Non-Superannuation) provides income protection cover in relation to a group of people who share a commonality, such as employees of the same employer. As a result, there will be a single MetLife Group Income Protection Insurance policy between *you* and *us*, but the policy provides cover in relation to a group of *eligible persons*.

As the insurance is provided on a group basis, *we* will pay the insured benefits to *you* (except where *your* policy expressly states otherwise such as in the case of a *superannuation contribution benefit* or a *retraining expenses benefit*) and *you* will pay the premiums collectively to *us*.

Understanding your insurance

Insurance can be complex, but it's important that *you* can understand how *your* insurance works. So *we've* tried to keep the language in this document as clear and straightforward as possible but some expressions that are used in this booklet do have a special meaning. Where these expressions are used they appear in italics. The meaning of all the defined terms are above (see **How to read this booklet**) and in the section headed **16. Definitions** in the policy document section of this booklet.

This booklet is only available to persons receiving the offer and making an application in Australia. It is not an offer, invitation or recommendation by *MetLife*. Applications from outside Australia will not be accepted. *MetLife* is also not bound to accept any application.

This booklet has been designed to help *you* decide if MetLife Group Income Protection insurance is right for *you*. Any advice given in the booklet is general advice only and does not take into account *your* objectives, financial situation or needs. As a result, before acting on this information, *you* should consider the appropriateness of the information having regard to *your* objectives, financial situation and needs.

This booklet contains important information about:

- significant features and benefits of this product,
- *your* Duty of Disclosure when applying for this product,
- the Duty to Take Reasonable Care for any *insured person* that applies for *underwritten cover*,
- *our* internal and external dispute resolution procedures, and
- *your* cooling off rights when purchasing this product.

Please note that, in addition to the summary of the significant features and benefits of this product, *you* must also read the policy document (which forms part of this booklet) as it contains the specific terms and conditions to understand the insurance provided (including the terms, exclusions and limitations that may apply to *your* cover). You should also refer to the MetLife Target Market Determination for MetLife ordinary (non-superannuation) Group Life and Group Income Protection available at www.metlife.com.au/partnerships/corporate/ before making a decision about acquiring, retaining or disposing of these products.

About this document

Updating this PDS

The information contained in this PDS is current at the time of issue. From time to time *we* may change or update information that is not materially adverse by providing a notice of changes on *our* website www.metlife.com.au. *You* can also obtain a paper copy of the updated information without charge by calling *us* on 1300 555 625.

If there is a materially significant change or omission to this PDS which affects your policy, *we* will issue *you* with a notice of the changes.

Applying for cover

After consultation with *you*, *we* will provide a quote summary which should be considered in conjunction with this booklet. If *you* would like to go ahead with the application for cover, *we* would require *you* or *your* adviser to accept the quote summary by email and to advise us of the date *you* would like *us* to assume risk from. When *we* receive this information *we* will assist *you* in the application process which will include the completion of an application form. Please note, *we* do not generally assume risk that commences from a date before *you* accept the quote, unless *we* specifically agree to do so.

Neither this booklet nor the quote summary constitute a legally binding contract of insurance with *MetLife*. A contract is only formed when:

- *we* accept *your* application for this product and issue a *policy schedule* to *you* which confirms *your* cover and contains the specific benefits that apply to *your* policy. *We* may also require *you* to accept the policy by signing the *policy schedule* or by another means agreed by *us*,
- *we* issue an 'on-risk' letter confirming the issue of the policy and
- *you* have paid the premium *we* advise *you* is due and payable for the cover.

If *we* agree to change any of the terms or conditions of the policy, *we* will do this by adding an addendum to *your* policy.

Other information

Automatic acceptance

We may offer *standard cover* up to an agreed amount (referred to as an *automatic acceptance limit*) without the need for medical or other evidence, if the following criteria are satisfied:

- at least 75% of the people that meet the *eligibility conditions* become an *insured person*, and
- the conditions that *you* set for people to be covered under this policy does not allow them to directly or indirectly choose their own level of cover outside of those conditions without *our* consent. For example, the amount of cover a person can obtain is based on a set formula which applies to all persons who meet the conditions, and
- at each *annual review date*, *you* provide *us* with the relevant details of every person who satisfies the *eligibility conditions* as at the *annual review date*. If a person satisfies the *eligibility conditions*, but *you* do not provide their details at the next *annual review date* after they become an *eligible person*, *we* may require that person to apply for cover and their application will be subject to acceptance by *us*. Unless *we* agree otherwise with *you*, *we* will require medical or other evidence as per *our* normal underwriting process as part of the person's application.

Underwriting

Underwriting is the process of assessing a person's insurability by obtaining information about their personal and family medical history, occupation, pastimes and any other information *we* may reasonably require that is considered relevant.

There may be situations where the *insured person* must obtain cover through underwriting. For example, an *insured person* is seeking cover above the *automatic acceptance limit*. Where underwriting is required *we* will need the *insured person* to complete a personal statement (application form) provided by *us* so *we* can assess their request. This means that acceptance for cover will be at *our* discretion and on such terms and conditions *we* determine, which will be based on *our* assessment of any information that *we* may reasonably require, including medical information such as doctors' reports, blood tests and/or medical examinations.

When *we* underwrite a person for cover and *we* have received all the information *we* reasonably require, *we* will decide to:

(a) accept on standard terms,

(b) accept with an exclusion (e.g. of a specific condition),

(c) accept with a loading (e.g. +50% of the standard premium),

(d) accept with a combination of an exclusion and a loading, or

(e) decline cover.

Where the policy covers 50 or more *insured persons*, any loading will be recorded but not charged by *us* unless the *insured person* chooses to continue cover under a continuation option (if applicable).

We will only ask for personal information that *we* are permitted to ask for by law and *our* relevant industry Code of Practice, and which *we* believe is necessary for *our* underwriting purposes.

Duty to take reasonable care not to make a misrepresentation - Persons being underwritten

Care must be taken to answer all questions *we* ask as part of an *eligible person's* insurance application honestly and accurately.

Otherwise, the *eligible person* may not be able to rely on the insurance when it's needed most.

When an *eligible person* applies for life insurance, *we* will ask them a number of questions.

Our questions will be clear and specific. They will be about things such as the *eligible person's* health and medical history, occupation, income, lifestyle, pastimes, and other insurance.

The answers given in response to *our* questions are very important. *We* use them to decide if *we* can provide cover to the *eligible person* and, if *we* can, the terms of the cover and the premium *we* will charge.

The duty to take reasonable care

When applying for insurance, there is a duty to take reasonable care not to make a misrepresentation. A misrepresentation could be made if an answer is given that is false, only partially true, or that does not fairly reflect the truth.

This means when answering *our* questions, the *eligible person* should respond fully, honesty and accurately.

The duty to take reasonable care not to make a misrepresentation applies any time an *eligible person* answers *our* questions as part of an initial application for insurance, an application to extend or make changes to existing insurance, or an application to reinstate insurance.

The *eligible person* is responsible for all answers given, even if someone assists them with their application. *We* may later investigate the answers given in the *eligible person's* application, including at the time of a claim.

Other information

Consequences of not complying with the duty

If there is a failure to comply with the duty to take reasonable care not to make a misrepresentation, it can have serious consequences for the *eligible person's* insurance, such as those explained below:

Potential consequences	Additional explanation	Impact on claims
The cover being avoided	This means the *eligible person's* cover will be treated as if it never existed	Any claim that has been made will not be payable
The amount of cover being changed	The *eligible person's* cover level could be reduced	If a claim has been made, a lower benefit may be payable
The terms of the cover being changed	*We* could, for example, add an exclusion to the *eligible person's* cover meaning claims for certain events will not be payable	If a claim has been made for an event that is now excluded, it will not be payable

If *we* believe there has been a breach of the duty to take reasonable care not to make a misrepresentation, *we* will let the *eligible person* know *our* reasons and the information *we* rely on and give the *eligible person* an opportunity to provide an explanation.

In determining if there has been a breach of the duty, *we* will consider all relevant circumstances.

The rights *we* have if there has been a failure to comply with the duty will depend on factors such as what *we* would have done had a misrepresentation not been made during the *eligible person's* application process and whether or not the misrepresentation was fraudulently made.

If *we* decide to take some action on the *eligible person's* cover, *we* will advise *you* or the *eligible person* of *our* decision and the process to have this reviewed or make a complaint if *you* or the *eligible person* disagree with *our* decision.

Guidance for answering *our* questions

When answering *our* questions, the *eligible person* should:

- Think carefully about each question before they answer. If they are unsure of the meaning of any question, they should ask *us* before they respond,
- Answer every question that *we* ask,
- Not assume that *we* will contact the *eligible person's* doctor for any medical information,
- Answer truthfully, accurately and completely. If they are unsure about whether they should include information, they should include it or check with *us*,
- Review their application carefully. If someone else helped prepare their application (for example, their adviser), they should check every answer (and make corrections if needed) before the application is submitted.

Other important information

An *eligible person's* application for cover will be treated as if they are applying for an individual 'consumer insurance contract'. For this reason, the duty to take reasonable care not to make a misrepresentation applies.

Before the *eligible 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 the *eligible person* lets *us* know about any changes when they happen.

If after the cover starts, the *eligible person* thinks they may not have met their duty, they should contact *us* immediately and *we'll* let them know whether it has any impact on the cover.

Forward underwriting limits

When *we* accept a person's application after being underwritten, *we* may offer a *forward underwriting limit* for cover above the *automatic acceptance limit*. The amount of an *insured person's forward underwriting limit* will be advised by *us*. A *forward underwriting limit* will only be available where the policy has a standard formula for calculating the *insured cover* and may require the provision of additional mandatory information such as doctor's reports, blood tests and/or medical examinations.

Premiums and charges

The amount of the premium is the total cost of cover for all *insured persons* during the relevant period based on the *premium rates* (which may include an admin fee and broker commission) for that period including any premium loadings. The premium amount also includes any government levies, taxes or charges not included in the *premium rates*. Further information on premiums can be found in the section titled **11. Premiums** of the policy document.

Your premium rate will mainly depend on factors impacting on the level of insurance risk such as:

(a) the amount and type of cover that will be provided;

(b) the demographics of the *insured persons* (e.g. age, occupation, and gender distributions); and

(c) *your* history of claims.

General information

Your duty of disclosure - Applying for this policy

This section applies only to the *policy owner*. Persons being underwritten should refer to "Duty to take reasonable care not to make a misrepresentation – Persons being underwritten" on page 4 of this PDS.

Before *you* enter into a life insurance contract, *you* have a duty to tell *us* anything that *you* know, or could reasonably be expected to know, that may affect *our* decision to insure *you* and on what terms. *You* have this duty until *we* agree to insure *you*.

You have the same duty before *you* extend, vary or reinstate the contract.

You do not need to tell *us* anything that:

- reduces the risk *we* insure *you* for,
- is common knowledge,
- *we* know or should know as an insurer, or
- *we* waive *your* duty to tell *us* about.

If the insurance is for the life of another person and that person does not tell *us* everything he or she should have, this may be treated as a failure by *you* to tell *us* something that *you* must tell *us*.

If you do not tell us something

In exercising the following rights, *we* may consider whether different types of cover can constitute separate contracts of life insurance. If they do, *we* may apply the following rights separately to each type of cover.

If *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 3 years of entering into it.

If *we* choose not to avoid the contract, *we* may, at any time, reduce the amount *you* 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. However, if the contract has a surrender value, or provides cover on death, *we* may only exercise this right within 3 years of entering into the contract.

If *we* choose not to avoid the contract or reduce the amount *you* 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. However, this right does not apply if the contract has a surrender value or provides cover on death.

If *your* failure to tell *us* is fraudulent, *we* may refuse to pay a claim and treat the contract as if it never existed.

For the avoidance of doubt, if between the date of quotation and the *commencement date*, the number of persons who will be eligible for cover changes by more than 25% from the number of *eligible persons* declared for the purposes of quoting, this is considered a matter relevant to *our* decision whether to accept the risk and, if so, on what terms.

Previous Representations and Information – existing cover that was not provided automatically

Please note that subject to the terms and conditions of the policy, the insurer *(MetLife)* in accepting the risk of insuring *your* existing cover (i.e. cover that was not provided to *you* automatically) will be doing so on the basis of the cover being valid because *you*, or the *insured person*, complied with *your/* their duty of disclosure or duty to take reasonable care not to make a misrepresentation under the Insurance Contracts Act 1984 (Cth) (whichever duty applied at the time of *your*, or the *insured person's,* application for the cover) when applying for cover with any previous insurer.

MetLife will also be relying on the representations *you*, or the *insured person*, made and the information *you/*they provided in relation to any existing cover which was not provided to *you* automatically, as though the representations made and the information provided was true, accurate and complete, and as if those representations were made, and the information was provided, directly to *MetLife*.

In the event that *you*/they did not comply with *your*/their duty of disclosure (or otherwise made misrepresentations) or *your*/their duty to take reasonable care not to make a misrepresentation (as applicable), *you* understand that *MetLife* may have remedies under the Insurance Contracts Act 1984 (Cth) in relation to *your* existing cover, including avoiding the cover (i.e. treating it as though it never started), as though the breach of duty and/or misrepresentation occurred directly with and/or to *MetLife*.

Our Privacy Statement

We collect, use and retain personal information in accordance with the Privacy Act 1988 (Cth). *We* collect, use, process and store personal information and, in some cases, sensitive information (including health information) about *you* and the individuals covered under *your* policy, in order to comply with *our* legal obligations, to assess *your* application for insurance cover, to administer the insurance cover provided, to enhance customer service or products and to manage claims. If *you* do not agree to provide *us* with the information, *we* may not be able to process *your* application, administer *your* cover or assess *your* claims.

General information

In dealing with *us*, *you* agree to *us* using and disclosing *your* personal information as set out in this section and in *our* Privacy Policy.

For further information about how *we* handle *your* personal information, the entities *we* often disclose personal information to (including overseas recipients), details of how *you* can access or correct the information *we* hold about *you* or make a complaint, *you* can access *our* Privacy Policy at www.metlife.com.au/privacy or contact *us* on 1300 555 625.

Tax and stamp duty

Goods and Services Tax (GST) currently does not apply to life insurance premiums. Premiums are inclusive of stamp duty where applicable. The rate of duty will differ depending on which state or territory the *insured person* resides in and that rate may also vary from time to time.

This information is based on *our* current interpretation of the tax laws. Should changes in the law result in any new or additional taxes, duties or charges in relation to this policy, these amounts may be added to the premium or charged to the *policy owner*.

The way *your* insurance benefits and premiums are taxed will depend on *your* individual circumstances. *We* recommend that *you* consult a professional tax adviser for advice regarding *your* circumstances.

Commissions

When *you* purchase a group insurance policy from *us*, the premium is paid to *us*. When an adviser is involved, they may request that a commission be applied to the premium for their services. This commission rate, which can be up to 30% of the annual premium plus GST, will be added to the premiums due to *us* under the policy and *we* will then pay the commission to the adviser. It is the responsibility of the adviser to advise *you* if there is any commission being applied under the policy for their service. Any commissions will be included in the cost of the premiums that *you* pay.

Commissions cannot be applied to a policy where the *policy owner* is a trustee of a complying superannuation fund.

Cooling off period

You have 14 days after *your* cover commences to cancel the policy. This is known as the cooling off period. The 14 days commences on the earlier of:

- 5 days after *we* issue the policy to *you*, and
- the date *you* receive *our* 'on-risk letter' confirming the issue of the policy.

If *you* cancel the policy within the cooling off period *we* will:

- refund any premium *you* have paid; and
- terminate the policy effective from the *commencement date*. Note, this means that *we* will not pay any benefits under the policy.

If *you* cancel the policy after the cooling off period or if *you* have exercised rights or powers under the policy (for example, if *you* have made a claim), *we* will retain the portion of premium which relates to the cover that was provided before *we* received *your* written notice.

Life Insurance Code of Practice

MetLife is proud to have adopted the Life Insurance Code of Practice – a code developed by the life insurance industry to ensure a consistently high level of product and service standards for all Australians. You can find information about the Code at the Life Insurance Code of Practice link at the bottom of each page on our website **www.metlife.com.au**

Our contact details

How to contact us

MetLife Insurance Limited
GPO Box 3319, Sydney NSW 2001
Telephone: 1300 555 625 Monday to Friday (except public holidays) 8:00 am to 5:00 pm (AEST)
Email: auservices@metlife.com
Website: www.metlife.com.au

Complaints resolution

It is *our* commitment that *we* will always attempt to satisfactorily answer any questions and resolve any problems or complaints *you* may have regarding the policy or *our* services.

If *you* wish to make a complaint about this product or *our* services, please contact *us* on:

Telephone: 1300 555 625
Email: aucomplaints@metlife.com

or write to:

Dispute Resolution Officer
MetLife Insurance Limited
Reply Paid 3319, SYDNEY NSW 2001

You may contact the Australian Financial Complaints Authority (AFCA) if *you* are not satisfied with how *we* respond to *your* complaint. AFCA is an independent body whose services are available to *you* at no cost. They can be contacted by:

Telephone: 1800 931 678
Email: info@afca.org.au

or write to:

Australian Financial Complaints Authority
GPO Box 3, MELBOURNE VIC 3001

Time limits may apply for *you* to take *your* complaint to AFCA. *You* should consult the AFCA website (www.afca.org.au) to find out the time limit that applies to *your* complaint.

Group Income Protection Insurance: a snapshot

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

Features at a glance: benefits and options

MetLife Group Income Protection Insurance pays *you* a benefit if an *insured person* is *partially disabled* or *totally disabled* subject to the terms and conditions of *your* policy.

Cover and limitations

Minimum number of *insured persons*	25
Who can own the policy?	*You* must be an Australian entity* to be the *policy owner.*
Who can obtain cover?	Generally *Australian residents* or holders of a *valid temporary visa* aged up to 64**. The person will also need to be *employed* by an Australian entity* and satisfy any other *eligibility conditions* chosen by *you* and agreed to by *us*.
Minimum entry age	15
Maximum entry age	64
Maximum *cover cessation age*	70***
Waiting period options	30, 60 and 90 days.
Benefit period options	2 years, 5 years, 10 years and To Age 65. 2 year top up benefit expiry option (only available with the To Age 65 *benefit period*). The following persons can only have a 2 year *benefit period*: • *contractors* engaged by the *employer* for a period of less than 12 consecutive months, and • *casual employees*.
Maximum monthly benefit (includes the *superannuation contribution benefit*, if applicable)****	$30,000 (equivalent to 75% of first $480,000 of annual income) Where an *insured person* is 65 or older, the *maximum monthly benefit we'll* pay will not exceed $10,000.
Premium frequency	Yearly unless other frequency requested (at additional cost).
Minimum premium (excluding any commissions, third party administration fees and government charges, taxes and levies)	$10,000 per annum. *We* may change the minimum premium amount (increase or decrease) at the end of the *premium guarantee period*.
Insured percentage	Up to 75% of *income*.
Superannuation contribution benefit (SCB)****	Up to 15% of *income*. Percentages in excess of the "charge percentage" identified in section 19 of the Superannuation Guarantee (Administration) Act 1992 (or any legislation that replaces it) are only available to employees that receive contributions above the "charge percentage" as at: • for a new policy, both the date of quotation and the *commencement date*, or • for an existing policy, both the date a quote is issued to add the *superannuation contribution benefit*, and the effective date the *superannuation contribution benefit* is added to the policy.
Exclusions	Exclusions and limitations apply which means that there will be situations where *we* will not pay a benefit. Refer to the terms in the policy document for further information.

*Entity as defined under s64A of the Corporations Act 2001 (Cth)

** Where the policy has a cessation age of 70, persons aged up to 69 who held cover under the *previous policy* immediately before the *commencement date* may be able to obtain *takeover cover* subject to **3.5 Takeover cover**.

***As agreed by *us*. *Cover cessation age* applicable to *your* policy may be lower. ****The SCB is an optional benefit.

Standard features

Feature/Benefit	Description	Policy Document Page
Total disability benefit	Provides a benefit if an *insured person* is *totally disabled*.	2
Partial disability benefit	Provides a benefit if an *insured person* is *partially disabled*.	2
Death benefit	Provides an additional lump sum benefit if an *insured person* dies while *we* are paying them a *disability benefit*.	3
Retraining expense benefit	*We* may cover the cost incurred by the *insured person* while receiving a *disability benefit* if they undergo a retraining program that *we* have approved.	4
Increasing benefits (Escalation benefit)	*We* may increase the *disability benefits* paid to an *insured person* to keep up with inflation every 12 months.	4
Recurrent disability	No further *waiting period* will apply if an *insured person* has a relapse of the same sickness or injury within 6 months of receiving a *disability benefit**.	3
Standard cover	Available to all persons who satisfy the *eligibility conditions* chosen by *you* and agreed to by *us*. To get *standard cover* each person must be disclosed to *us* within 30 days of the next *annual review date* after they first satisfy the *eligibility conditions*.	11
24-hour worldwide cover	*We'll* provide cover for an *insured person* 24 hours a day while they are overseas. Some conditions apply.	16
Cover while on leave without pay	*We'll* continue to provide cover while an *insured person* is on approved leave.	16
Interim accident cover	Provides interim cover for up to 90 days while an *insured person* or *eligible person* is being underwritten.	19
Extended cover	Provides cover for up to 60 days where an *insured person* leaves *your employment* and ceases to be eligible for cover under the policy.	21
Waiver of premium	Premiums are waived while an *insured person* is receiving a benefit.	23
Return to work during the waiting period	For *total disability*, an *insured person* is permitted to return to work once, performing their usual duties without the *waiting period* restarting again.	34
Bundled policy discount	*We* may provide a discount when *you* take out both a Group Life Policy and Group Income Protection Policy with *us*. When *we* provide a discount, it will apply to the policy with the lowest premium.	23
Waiver of underwriting loadings	Where a premium loading is recorded for an *insured person*, *we* will not charge the extra premium for the loading except if the *insured person* exercises a continuation option. This is only applicable where the policy covers 50 or more *insured persons*.	
Guaranteed renewable	*We'll* guarantee to renew the policy each year provided the premiums are paid in accordance with the terms and conditions of the policy.	

*Only one *benefit period* will apply for all recurrent *disabilities*.

Optional features at an additional cost

Feature/Benefit	Description	Page
Superannuation contribution benefit	Provides a benefit to cover the cost of employer superannuation guarantee contributions while an *insured person* is receiving a *disability benefit*.	5
Crisis benefit	Provides a lump sum benefit if an *insured person* suffers one of the listed *crisis benefit medical conditions*.	6
Specific injury benefit	Provides a benefit if an *insured person* suffers one of the *specific injury events*.	7
Nursing care benefit	Provides a benefit to help with nursing expenses where the *insured person* requires the continuous full-time care of a *registered nurse*.	8
Family care benefit	Provides a benefit to help cover some of the lost income of an *insured person's direct family member* who has stopped working to care for the *insured person*.	8
Accommodation benefit	Provides a benefit to help cover some of the cost of accommodation for an *insured person's direct family member* while the *insured person* requires the continuous full-time care of a *registered nurse*.	9
Return to work benefit	Provides a benefit when an *insured person* returns to work performing their pre-*disability* hours after completing a *return to work program*, and they remain at work for 6 consecutive months.	9
Life recovery benefit	Provides a benefit to help with the recovery of an *insured person* who is *totally disabled* and has an unplanned emergency hospital admission.	9
Enhanced death benefit	Provides a lump sum benefit if an *insured person* dies or becomes *terminally ill* while they are insured under the policy even if *we* are not paying them a *disability benefit*.	10
Relocation benefit	Provides a benefit to assist with the costs of returning to Australia when an *insured person* becomes eligible for a *disability benefit* when overseas.	10
Cover beyond age 65	Provides cover beyond age 65 up to a maximum age of 70. Some conditions apply.	17
Continuation option	An *insured person* may be able to continue their cover once their *employment* ceases with *you*.	18
Profit sharing	Larger policies with at least 1,000 insured lives may be entitled to participate in profits that are based on self-experience profit sharing, by way of repayment of premiums.	23

Disability definitions

There are two *total disability* (and *partial disability*) definitions available under the policy for *you* to choose from. The definitions are as follows:

Definition 1	"Own occupation" definition applicable for the entire duration of the *benefit period*.
Definition 2	"Own occupation" definition applicable for the first 2 years of the *benefit period*. "Any occupation" definition applicable for each month of the *benefit period* after 2 years.

Definition 2 is generally cheaper than Definition 1 where the *benefit period* that applies to *your* policy (or a particular category of *insured persons* under the policy) is greater than 2 years.

The definition that applies to *your* policy will be stated in *your policy schedule*.

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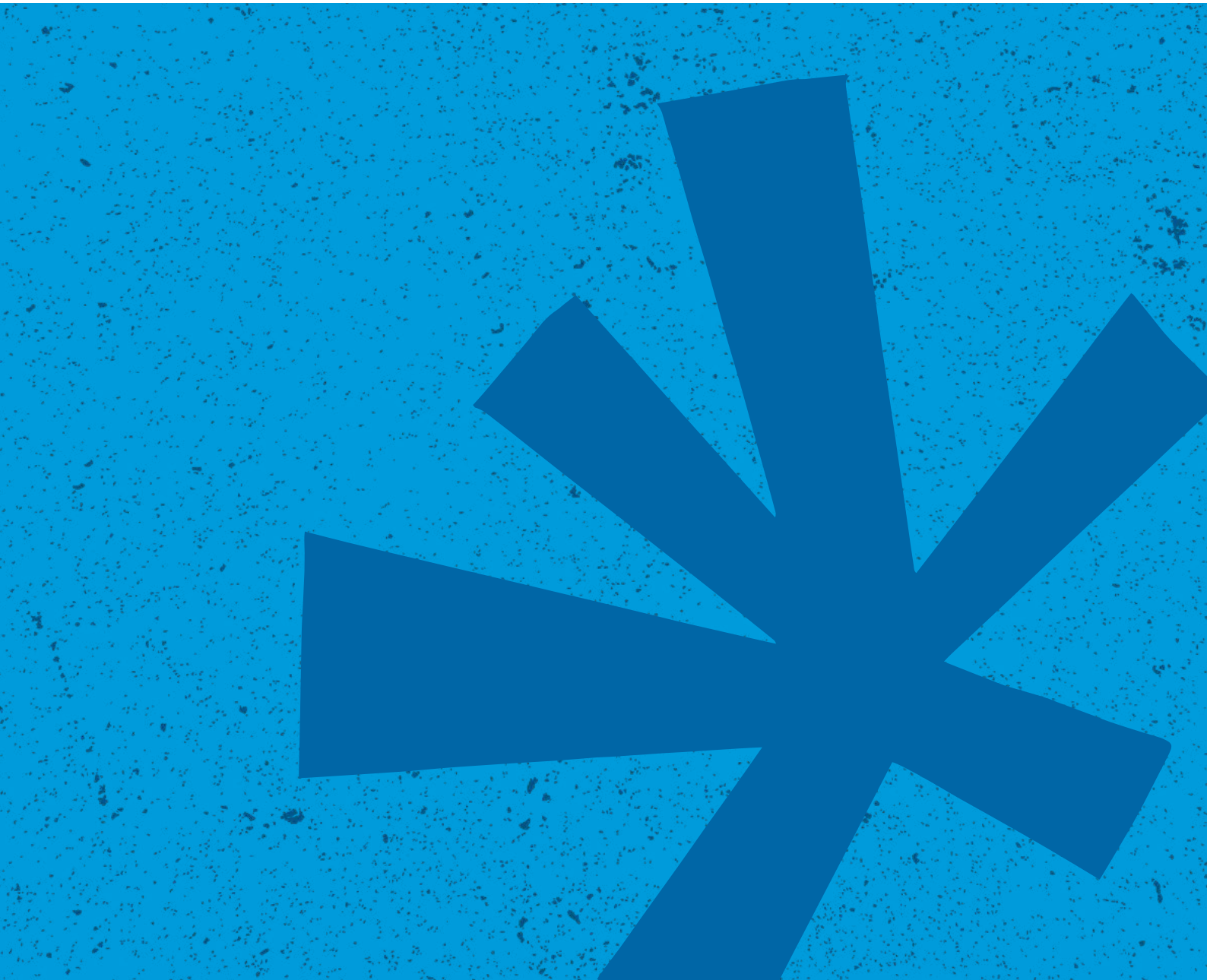
Group Income Protection Insurance (Ordinary)

Policy Document



About this policy document

This is *your* Group Income Protection Policy Document, which sets out the details of the cover provided to *insured persons*.

In this policy:

- *we*, *us* and *our* refer to MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096,
- *you* and *your* refer to the *policy owner*.

Understanding your policy

Insurance can be complex, but it's important that *you* and the people that are insured under this policy can understand how *your* insurance works. *We* have tried to keep the language in this document as clear and straightforward as possible but some expressions that are used in the policy do have a special meaning.

Where these expressions are used they appear in italics. The meaning of all the defined terms is in section **16 Definitions**.

There is also a section **14.10 Interpretation** that contains some rules that explain how the policy is intended to be read.

Contents

1. Benefits

1.1 Main benefits

There are two main benefits available under this policy. These benefits are payable in the circumstances described in the policy:

Total Disability Benefit	Partial Disability Benefit
We'll pay *you* a benefit if an *insured person* is *totally disabled*, provided their *date of disablement* occurs whilst they are an *insured person*.	*We'll* pay *you* a benefit if an *insured person* is *partially disabled,* provided their *date of disablement* occurs whilst they are an *insured person*.

1.2 What we pay

The amount of the benefit *we'll* pay *you* is as follows.

Benefit type	Amount we pay
Total disability benefit	*We'll* pay *you* the amount of the *insured person's monthly benefit*. The amount *we* pay will be reduced by any amount of *other disability income* in accordance with section **1.5 When we reduce benefits**.
Partial disability benefit	*We'll* pay *you* the amount determined by the formula below: $\frac{\textit{pre-disability income} - \textit{return to employment income}}{\textit{pre-disability income}}$ *x monthly benefit* The amount *we* pay will be reduced by any amount of *other disability income* in accordance with section **1.5 When we reduce benefits**.

1.3 When we pay

Disability benefits will begin to accrue from the day after the *waiting period* has ended. Unless *we* agree otherwise, benefits will be paid monthly in arrears, immediately following the month they relate to, until *we* cease to be liable. If a *disability benefit* is payable for less than a whole month, *we* will pay a portion of the *monthly benefit* based on the number of days in the month in which the benefit is payable. For example, if the *monthly benefit* starts to accrue on 16th February (outside of a leap year), we will pay 13/28th of the *monthly benefit* for February representing the 13 days of the month of February where benefits are payable.

1.4 When we stop paying

We will pay *disability benefits* until the earliest of the:

- end of the *benefit period* that applies*,
- date the *insured person* is no longer *disabled*,
- date the *insured person* is no longer under the *regular care* of a *medical practitioner*,
- death of the *insured person*,
- date the *insured person* reaches the *cover cessation age*,
- date the *insured person* is not an *Australian resident*, is no longer permanently in Australia or not eligible to work in Australia, and
- date benefits stop under section **6.3 Cover beyond age 65** if the *insured person's cover cessation age* is greater than age 65.

We may also cease to pay *disability benefits* where the *insured person* refuses to undergo or continue a *return to work program* as reasonably required by *us*.

Important Note: *Benefit period* for *contractors* and *casual employees
Contractors engaged by the *employer* for a period of less than 12 consecutive months and *casual employees* will have a two year *benefit period.*

1.5 When we reduce benefits

Total disability benefit

The *monthly benefit* will be reduced by *other disability income* if:

- the *monthly benefit*, plus
- the *other disability income*,

exceeds 75% of the *insured person's pre-disability income* (which includes any indexation to the *pre-disability income* figure as described in this section 1.5) but only to the extent that it exceeds 75% of that *pre-disability income* figure.

Partial disability benefit

The *partial disability benefit* will be reduced by *other disability income* if:

- the *partial disability benefit* payable, plus
- the *other disability income*, plus
- the *return to employment income*,

exceeds 100% of the *insured person's pre-disability income* (which includes any indexation to the *pre-disability income* figure as described in this section 1.5) but only to the extent that it exceeds 100% of that *pre-disability income* figure.

Indexation of pre-disability income

For the purpose of calculating the reduction under this section 1.5 (and the reduction under section **2.1 Superannuation contribution benefit**, if applicable), the *pre-disability income* figure *we* use will be increased by the lower of 5% and the most recently published *consumer price index (CPI)* increase. *We* will only do this where *we* have been paying the *disability benefit* for an *insured person* for a continuous 12 month period. If an increase is applicable, it will be applied at the end of each continuous 12 month period.

> For the avoidance of doubt, indexation to the *pre-disability income* (as described above) will only occur for the purpose of calculating the reduction that applies under this section 1.5 (and the reduction under section **2.1 Superannuation contribution benefit**, if applicable), and does **not** apply when calculating the *disability benefit*. See section **1.9 Escalation benefit** for details on increases to the *disability benefit*.

1.6 Recurrent disability

If *disability* recurs within six months from the date the *insured person* ceased to be *disabled,* and eligible for a *disability benefit,* from the same or related illness or injury, *we* will treat the recurrent *disability* as a continuation of the original claim.

This means *we* will:

- not apply a *waiting period* for the recurrent *disability*, and
- add together all periods of *disability* in determining when the *benefit period* ends.

If *total disability* or *partial disability* recurs six months or greater from the date the *insured person* ceased to be *disabled* from the same or related illness or injury, and cover has not otherwise ceased, *we* will still add together all periods of *disability* in determining when the *benefit period* ends. *We* will also apply a *waiting period* for the recurrent *disability*.

Maximum benefit per disability

The maximum period *we* will pay for a *disability* due to the same or related illness or injury is the *benefit period*. This is regardless of how often the *insured person* is *disabled* due to this illness or injury. For example, if an *insured person* with a 2 year *benefit period* is paid for 16 months for a back injury, returns to work for several years and then suffers the same or related injury again, the most *we* will pay for the second claim is 8 months.

1.7 Death benefit

If an *insured person* dies while entitled to receive a:

- *disability benefit*,
- *nursing care benefit*,

- *specific injury benefit*, or
- *life recovery benefit*

we'll pay *you* a one off amount of three times the *insured person's monthly benefit* and *superannuation contribution monthly benefit* (if it applies). If the *insured person's* death is on or after their 65th birthday, this benefit cannot exceed $30,000.

Exclusions – when we will not pay a death benefit

We will not pay this benefit if:

- the *insured person* dies within 3 months of a *crisis benefit* being payable, or
- a benefit is paid or payable under section **2.9 Enhanced death benefit**.

1.8 Retraining expense benefit

When an *insured person* is *disabled*, and not required to participate in a *return to work program* by *us*, however a *medical practitioner* certifies that a rehabilitation program (other than an *excluded rehabilitation program*) would assist in their return to work, *we* will pay the costs for this, provided that:

- *we* approve the expenditure in writing before they are incurred (for which approval must not be unreasonably withheld),
- the expenses are incurred to directly assist the *insured person* to return to work in a gainful occupation or to undertake a vocational retraining program,
- *we* pay the costs directly to the provider of the applicable service, and
- the maximum amount *we* will pay for any one *disability* is the lesser of the:
  - expenses, and
  - amount *we* pre-approve.

We will not pay any expenses incurred for non-attendance or non-participation during the rehabilitation program by the *insured person*.

1.9 Escalation benefit

We will increase the *disability benefit* or *specific injury benefit* payable to an *insured person* by the lower of 5% and the most recently published *consumer price index* (*CPI*) increase. *We* will only do this where *we* have been paying the *disability benefit* or *specific injury benefit* for an *insured person* for a continuous 12 month period. If an increase is applicable, it will be applied at the end of each continuous 12 month period.

Where the *consumer price index (CPI)* is less than 0% *we* will apply a rate of 0%.

Any increase to the *disability benefit* or *specific injury benefit* cannot exceed the *maximum monthly benefit*.

1.10 Reduced or nil payments

If the *insured person* is *disabled* but the amount of *disability benefit* payable by *us* for a period is reduced or becomes zero under any condition of this policy, *we* will still consider that *we* have made a benefit payment for that period and count that period as part of the *benefit period*.

2. Optional benefits

The following optional benefits are also available under this policy:

- *superannuation contribution benefit*,
- *crisis benefit*,
- *specific injury benefit*,
- *nursing care benefit*,
- *family care benefit*,
- *accommodation benefit*,
- *return to work benefit,*
- *life recovery benefit,*
- *enhanced death benefit, and*
- *relocation benefit.*

These benefits are payable in the circumstances described in the policy only when the *policy schedule* specifies that the benefit applies.

2.1 Superannuation contribution benefit

Where *we* are paying *you* a *disability benefit* for an *insured person*, *we'll* pay an amount equal to the *superannuation contribution monthly benefit* or *superannuation contribution partial monthly benefit* (as applicable).

Payment of this benefit will:

- be paid monthly in arrears and into the *insured person's* complying superannuation fund, and
- stop when the *insured person* ceases to be entitled to a *disability benefit*.

Reductions and limitations

The benefit payable under this section will be reduced by the amounts below:

- the amount of any *employer* superannuation contributions paid to an *insured person's* superannuation account for any period of *disability* (this does not include *employer* superannuation contributions paid to an *insured person's* superannuation account that relates to *return to employment income*), and
- the amount of any benefits payable under any other income protection policy where that benefit payable is designed to replace in whole or in part the compulsory employer superannuation entitlements the *insured person* would have benefited from if they were not *disabled,*

but only if the amounts above, when combined with the *superannuation contribution benefit*, exceeds the *superannuation contribution insured percentage* multiplied by the *pre-disability income*. The reduction will only apply to the extent that the combined amount exceeds the *superannuation contribution insured percentage* multiplied by the *pre-disability income*.

The *pre-disability income* figure *we* use for the above reduction will be increased in accordance with the terms outlined at section **1.5 When we reduce benefits** "Indexation of pre-disability income".

We can refuse to make a *superannuation contribution benefit* to anyone other than the trustee of a complying superannuation fund of which the *insured person* is a member at the time of payment.

Option - Converting monthly benefit to superannuation contribution monthly benefit

If the *superannuation contribution monthly benefit* payable is less than the *superannuation contribution insured percentage* multiplied by the *pre-disability income*, the *insured person* can choose to have a portion of their *monthly benefit* paid as a *superannuation contribution monthly benefit* instead. The *insured person* must tell *us* in writing before the relevant *disability benefit* is paid if they wish to exercise this option.

The total amount of *superannuation contribution monthly benefit* cannot exceed an amount equal to the *superannuation contribution insured percentage* multiplied by the *pre-disability income*.

2.2 Crisis benefit

How the crisis benefit works

We will pay this benefit if the *insured person* first satisfies one of the *crisis benefit medical conditions* while covered under this policy. The *crisis benefit medical conditions* are listed in the table below.

How you are paid for a crisis benefit

The amount *we* pay varies with age, and will be:

- if the *insured person* is under age 65, three times the *monthly benefit* plus the *superannuation contribution monthly benefit* (if applicable)
- if the *insured person* is age 65 or over, three times the lesser of:
  - the *monthly benefit*, plus the *superannuation contribution monthly benefit* (if applicable), and
  - $10,000 per month.

The medical conditions we cover

The table below lists the medical conditions covered. The specific definition of each medical condition that an *insured person* needs to satisfy can be found in Appendix B. The definitions use medical terms because they are necessary to describe the precise symptoms, procedures and/or diagnosis.

Crisis Benefit Medical Condition	
Angioplasty – Triple Vessel	Loss of Speech
Aplastic Anaemia	Major Head Trauma
Bacterial Meningitis	Motor Neurone Disease
Benign Brain Tumour*	Multiple Sclerosis
Blindness	Muscular Dystrophy
Cancer*	Occupationally Acquired Hepatitis B or Hepatitis C Infection*
Cardiomyopathy	Parkinson's Disease
Coma	Pneumonectomy (Removal of the lung)
Coronary Artery Bypass Surgery*	Primary Pulmonary Hypertension*
Dementia including Alzheimer's	Severe Burns
Heart Attack*	Stroke*
Heart Valve Surgery*	Surgery to Aorta*
Loss of Hearing	Terminal Illness*
Loss of Independence	Viral Encephalitis
Loss of Limbs	Vital Organ or Digestive System Disorder – end stage
Loss of Limbs and Sight of One Eye	

*the *insured person* is not covered for that condition if it occurs in the first 90 days after the *insured person's* cover starts, is increased or reinstated.

Exclusions – when we will not pay a crisis benefit

We will not pay this benefit if the *insured person*:

- had symptoms directly related to, or had been diagnosed with, the condition that they are claiming before crisis benefit cover started for them under this policy. Where this is a surgical condition, this exclusion applies where the *insured person* experienced symptoms directly related to, or had been diagnosed with, the condition that resulted in the need for surgery, prior to when crisis benefit cover started for them under this policy. However, if the *insured person* is claiming under *takeover cover*, we will not apply this exclusion where a "crisis benefit" (or a similar benefit payable for

specified medical conditions) would have been payable in relation to them under the *previous policy* if that policy had remained in force,

- suffers the condition identified with an * in the above table in the first 90 days after crisis benefit cover starts for them under this policy. However, if the *insured person* is claiming under *takeover cover*, we will not apply this exclusion where a "crisis benefit" (or a similar benefit payable for specified medical conditions) would have been payable in relation to them under the *previous policy* if that policy had remained in force,
- has been paid a *crisis benefit* within the previous 12 months while covered under this policy,
- has been paid two *crisis benefits* while covered under this policy or any other policy issued by *us* for which this policy is a replacement,
- is receiving the *specific injury benefit* for the same period, or
- dies within 14 days of satisfying the *crisis benefit medical condition*.

A *crisis benefit* is only payable once per *crisis benefit medical condition*.

2.3 Specific injury benefit

If an *insured person* suffers one of the events listed below as a result of an *accident* that first occurs on or after the start of an *insured person's* cover, *we* will pay a benefit for the period identified in the "Payment Period" column. *We* will only pay this benefit once under this policy for each *insured person*.

Specific Injury Event Payment Period	Payment Period
Paraplegia	60 months
Quadriplegia	60 months
Total and permanent loss of use of:	
Both hands or both feet or sight in both eyes	24 months
One hand and one foot	24 months
One hand and sight in one eye	24 months
One foot and sight in one eye	24 months
One arm or one leg	18 months
One hand or one foot or sight in one eye	12 months
Thumb and index finger from the same hand	6 months

Fracture requiring a plaster cast or other immobilising device of the following bones:	Payment Period
Thigh (shaft)	3 Months
Pelvis (except coccyx)*	3 Months
Skull (except bones of the face or nose)*	2 Months
Arm, between elbow and shoulder (shaft only)	2 Months
Shoulder blade	2 Months
Leg (above the foot)	2 Months
Kneecap	2 Months
Elbow	2 Months
Forearm, between wrist and elbow (shaft only)	2 Months
Collarbone	1.5 Months

*plaster cast or other immobilising device not required for these fractures.

The amount of the *specific injury benefit* will be equal to the sum of the *total disability benefit* and the *superannuation contribution monthly benefit* (if applicable). It is also paid from the date the *specific injury event* occurs (as certified by a *medical practitioner*), can be paid during the *waiting period* and is paid monthly in arrears unless *we* agree otherwise. The amount *we* pay will be reduced by any amount of *other disability income* in accordance with section **1.5 When we reduce benefits** and in accordance with the reductions and limitations that apply as per section **2.1 Superannuation contribution benefit**.

We will cease to pay this benefit for the *insured person* if:

- it has been paid for the payment period corresponding to the *specific injury event*,
- they reach the *cover cessation age*, or
- they die.

This benefit will:

- not be paid where the *insured person* is also receiving a *crisis benefit* for the same period, and
- be paid instead of, and not in addition to, any *disability benefit* for the same period.

If an *accident* results in more than one *specific injury event*, *we* will only pay one *specific injury benefit* and it will be for the *specific injury event* with the longest payment period.

2.4 Nursing care benefit

We will pay a benefit if an *insured person* is *confined to bed* for three or more consecutive days during the *waiting period*.

This benefit starts after the *insured person* has been *confined to bed* for three successive days and will be paid for each successive day that the *insured person* is *confined to bed* for a maximum of 30 days. The benefit is paid monthly in arrears.

The daily amount of this benefit will be equal to the lesser of:

- 1/30 of the *total disability benefit* and the *superannuation contribution benefit*; and
- $150.00.

We will cease to pay this benefit for an *insured person* if:

- it has been paid for 30 days or they have completed the *waiting period* (whichever happens first),
- they are no longer *confined to bed*,
- they reach the *cover cessation age*, or
- they die.

This benefit will not be paid where the *insured person* is also receiving the *disability benefit*, *accommodation benefit*, *specific injury benefit*, *family care benefit* or *life recovery benefit* for the same period.

2.5 Family care benefit

We will pay a benefit if an *insured person* is *totally disabled* and is receiving *family care* for at least three consecutive days.

This benefit starts after the *insured person* has received *family care* for three consecutive days and will continue to be paid each day that they are *totally disabled* and receiving *family care* for up to a maximum period of six months.

The monthly amount of this benefit will be equal to the lesser of:

- $2,000,
- 50% of the *total disability benefit* and the *superannuation contribution benefit*, and
- the amount *we* consider is the monthly income lost by the *direct family member* directly resulting from the *direct family member's* provision of *family care*.

We will cease to pay this benefit for an *insured person* if:

- they are no longer *totally disabled*,
- a *medical practitioner* no longer certifies the *insured person* requires *family care*,
- it has been paid for six months,
- they reach the *cover cessation age*, or
- they die.

This benefit will not be paid where the *insured person* is also receiving the *specific injury benefit* or *nursing care benefit* for the same period.

2.6 Accommodation benefit

We will pay a benefit where a *direct family member* has chosen to stay at a place near where the *insured person* is c*onfined to bed* (other than the *insured person's* home of residence) provided the *insured person*:

- is *totally disabled*,
- is c*onfined to bed* due to an injury or illness, and
- on the advice of a *medical practitioner* has been relocated to a place more than 100 kilometres from the *insured persons* place of residence.

The amount *we* will pay for this benefit will be the lesser of:

- the actual accommodation costs, and
- $250 a day.

This benefit is payable once for up to 30 days in any 12 month period.

This benefit will not be paid where the *insured person* is also receiving the *nursing care benefit* or *specific injury benefit* for the same period.

2.7 Return to work benefit

We will pay a benefit if an *insured person* engages in a *return to work program* that *we* have requested whilst the *insured person* is *disabled*, and:

- *we* provide *you* or the *insured person* with confirmation in writing at the start of the r*eturn to work program* that the program is a *qualifying program* for the purpose of the *return to work benefit*,
- either during, or immediately after completing the *return to work program*, the *insured person*:
  - ceases to be *disabled*, and
  - returns to work with their *employer*, and
  - returns to working at least the same hours they were performing immediately before their *date of disablement*, and
- the *insured person* continuously performs their full hours, and does not become *disabled* again, for 6 consecutive months.

When the *benefit period* applicable to an *insured person* is 2 years, the amount *we* will pay for this benefit will be the lesser of:

- the *monthly benefit* plus *superannuation contribution monthly benefit* (if applicable), and
- $10,000

When the *benefit period* applicable to an *insured person* is greater than 2 years, the amount *we* will pay for this benefit will be the lesser of:

- three times *monthly benefit* plus *superannuation contribution monthly benefit* (if applicable), and
- $20,000

This benefit is only payable once for an *insured person*.

2.8 Life recovery benefit

We will pay a benefit if an *insured person* is *totally disabled* and has an *unplanned hospital admission* during the *waiting period*.

This benefit starts after the *insured person* becomes *totally disabled* and has an *unplanned hospital admission* where the *insured person* is required to spend at least 24 hours in hospital. This benefit will be paid for each consecutive calendar day that the *insured person* remains in hospital up to a maximum of 5 calendar days.

The daily amount of this benefit will be $300.

We will cease to pay this benefit for the *insured person* if:

- it has been paid for 5 days or they have completed the *waiting period* (whichever happens first),
- they are no longer *totally disabled*,
- they are discharged from hospital,
- they reach the *cover cessation age*, or
- they die.

This benefit will not be paid where the *insured person* is also receiving the *disability benefit, nursing care benefit, specific injury benefit* or *family care benefit* for the same period.

2.9 Enhanced death benefit

We will pay a benefit if an *insured person* dies or suffers a *terminal illness* whilst they are an *insured person*. This benefit will be paid regardless of whether the *insured person* is *disabled* at the date they become *terminally ill* or die.

The amount *we* will pay for this benefit will be three times the *monthly benefit* plus *superannuation contribution monthly benefit* (if applicable).

We will only pay this benefit once for an *insured person*. This means if *we* pay this benefit because the *insured person* suffers a *terminal illness*, *we* will not pay a second benefit when the person dies.

2.10 Relocation benefit

We will pay a benefit if an *insured person* becomes *disabled* whilst outside Australia and qualifies for a *disability benefit* at the end of the *waiting period*.

The amount payable will be the lesser of:

- the cost of a single standard economy airfare back to Australia via the most direct route available,
- the cost of changing previously made flight arrangements, and
- three times the *monthly benefit*.

This benefit is:

- payable as a once off lump sum payment,
- only payable once for the same or related illness or injury,
- subject to the *policy owner* providing details of all *insured persons* outside Australia as per section **14.3 Record keeping**.

3. Getting cover

3.1 Eligibility

To be eligible for cover under this policy, a person must satisfy the *eligibility conditions* in the *policy schedule*.

Once a person receives cover under this policy, they will continue to hold that cover until it ends under the terms of the policy (see section **9.1 When cover will end for an insured person**).

3.2 Automatic acceptance

Automatic acceptance means that *we* will accept an *eligible person* for *insured cover* up to the *automatic acceptance limit* without the need for underwriting, subject to the terms of section **3.3 Standard cover.**

To be eligible for automatic acceptance at least 75% of the people that meet the *eligibility conditions* must be *insured persons*. If this condition is not met at any time, *we* may reduce the *automatic acceptance limits* and/or withdraw automatic acceptance for future *eligible persons*.

3.3 Standard cover

Where an *automatic acceptance limit* applies, a person who:

- is an *eligible person*,
- is at least 15 years of age and no older than the *maximum entry age*,
- has been notified to *us*, including all relevant details *we* require, within 30 days of the next *annual review date* after they first satisfy the *eligibility conditions* (or by another date *we* have agreed with *you*)*, and
- is not subject to *takeover cover*,

will have *standard cover* apply to them subject to the terms of this policy. There are circumstances where the cover an *insured person* obtains through automatic acceptance will be subject to *limited cover conditions*. See section **4.2 Limited cover** for details.

*If a benefit becomes payable under this policy for an *eligible person* after they have satisfied the *eligibility conditions*, but before the date that *you* are required to notify *us* of the *eligible person's* details, *we* will deem that *eligible person* to have been notified to *us* in accordance with this section 3.3.

3.4 Underwritten cover

An *eligible person* who:

- is not eligible for *standard cover* under automatic acceptance or *takeover cover*,
- seeks cover above the *standard cover* they obtained under automatic acceptance or *takeover cover*, or
- seeks to have their cover increase in line with their *insured cover* formula above the limits under section **5.2 Automatic changes to cover**,

must obtain cover through underwriting.

In order to consider the *eligible person's* application, *we* may require additional information on them, including medical and lifestyle information. *We* will only ask for personal information that *we* are permitted to ask for by law and *our* relevant industry Code of Practice, and which *we* believe is necessary for *our* underwriting purposes.

After considering an application for cover where *we* have received all the information *we* require, *we* will make one of the following decisions:

Accept cover	Accept with conditions	Refuse cover
Accept the *eligible person* for cover under this policy.	Accept the *eligible person* for cover on the conditions *we* consider appropriate. For example, placing an exclusion on the cover.	Refuse to provide cover under this policy.

Where *we* accept the application with conditions, or refuse the application, this will not affect any existing cover the *eligible person* may have. So if the *eligible person* already has *standard cover* under automatic acceptance the amount and conditions of that cover will not be changed by *our* underwriting decision.

3.5 Takeover cover

Where some or all of the cover available under this policy was held under a *previous policy* on the day before the *commencement date* (or a later date *we* have agreed with *you*), and *we* agree to takeover that cover, *we* will do so on the following basis:

- the *benefit period* that applies under the *previous policy* will continue to apply under this policy (unless *we* agree otherwise with *you*). If the same *benefit period* is not available under this policy, the *benefit period* that applies will be the next shortest *benefit period* available under this policy,
- where the *benefit period* was the same or longer under the *previous policy*, *we* will provide cover and determine *our* liability for claims made in respect of that person by applying *FSC Guidance Note 11* (or equivalent industry replacement guidance) as the "incoming insurer." If there is any inconsistency between the terms and conditions of this policy and *FSC Guidance Note 11* (or equivalent industry replacement guidance), the policy terms and conditions prevail to the extent of the inconsistency,
- where the *benefit period* was shorter under the *previous policy*, *we* will only apply *FSC Guidance Note 11* (or equivalent industry replacement guidance) as the "incoming insurer" if *we* specifically agree to do so with the *policy owner*. If *we* do not agree to apply the terms of *FSC Guidance Note 11* (or equivalent industry replacement guidance), *we* may agree to apply alternative takeover terms,
- the *waiting period* that applied under the *previous policy* will continue to apply under this policy (unless *we* agree otherwise with *you*). If the same *waiting period* is not available under this policy, the *waiting period* that applies will be the next longest *waiting period* available under this policy,
- where the *automatic acceptance limit* under this policy is higher than the automatic acceptance limit that applied under the *previous policy*, *we* will uplift all *insured persons* to the new *automatic acceptance limit*. For *insured persons* who held underwritten cover under the *previous policy*, those who held a forward underwriting limit below the new *automatic acceptance limit* will be uplifted to the new *automatic acceptance limit*. Those who held a forward underwriting limit higher than the new *automatic acceptance limit* will retain that amount as a *forward underwriting limit*, with any restrictions, loadings and/or conditions that applied under the *previous policy* applicable to the amount above the new *automatic acceptance limit*,
- where the *automatic acceptance limit* under this policy is lower than the automatic acceptance limit that applied under the *previous policy*, the new lower *automatic acceptance limit* will apply to all existing *insured persons*, with the following exceptions:
  - *insured persons* who held *standard cover* under the *previous policy* greater than *MetLife's automatic acceptance limit* will retain their cover as a *forward underwriting limit*. Any automatic changes to cover as per section **5.2 Automatic changes to cover** will be capped at this *forward underwriting limit*, and
  - *insured persons* who held cover with a forward underwriting limit will retain that amount as a *forward underwriting limit*. Any exclusions, restrictions or loadings that had applied to the *insured person's* cover will continue to apply to the cover above the automatic acceptance limit of the *previous policy*,
- where *takeover cover* applies and the *insured person* receives an increase in cover, *limited cover conditions* may apply as per section **4.2 Limited cover**,
- any individual conditions, exclusions or restrictions that applied to a person's transferred cover under the *previous policy* on the day before the *commencement date* will continue to apply until they expire according to their terms. This includes any limited cover and exclusions. Similarly, if a person had no cover under the *previous policy* (because they had

previously opted out, had cover cancelled or they were not eligible for cover after they joined the *employer*), they will not be provided cover under this policy, unless *we* agree otherwise with *you*, and

- *we* are accepting the *insured person's takeover cover* based on their representations that the information provided to the insurer of the *previous policy* was true, accurate and complete and that they complied with their 'Duty of Disclosure' or 'Duty to take reasonable care not to make a misrepresentation' (as applicable at the time they applied for their cover under the *previous policy*).

  We may reduce the amount of insurance provided to an *insured person*, or treat the *takeover cover* for that person as not having commenced with *us*, if the person breached their 'Duty of Disclosure', or 'Duty to take reasonable care not to make a misrepresentation' (as applicable at the time they applied for their cover under the *previous policy*), or made misrepresentations in a way which would enable an insurer to exercise a remedy under the Insurance Contracts Act 1984 (Cth).

Before *we* provide *takeover cover*, *we* will require that all relevant information from the *previous policy*, including formulas, automatic acceptance limits and the details of any specific conditions that apply to a person, be supplied to *us*. Where *we* do not receive such information, *we* will not provide terms for taking over cover.

4. When cover starts and its conditions

4.1 When cover starts

The date cover starts will depend on the type of cover.

Cover type	Cover starts...
Standard cover	For a person who obtains *standard cover* by way of automatic acceptance, cover starts from the: • date they first become an *eligible person* if this happens on or after the *commencement date*, or • *commencement date* if they first became an *eligible person* before the *commencement date* and remain so on the *commencement date*.
Underwritten cover	For a person who obtains *underwritten cover*, cover starts when *we* accept the *eligible person* for cover.
Takeover cover	For a person who obtains *takeover cover*, cover starts on the *commencement date,* or on a later date *we* have agreed with *you* and this is specified in the *policy schedule*.

4.2 Limited cover

What's limited cover?

When the *limited cover conditions* apply, *we* will only pay a benefit for an illness or injury if it first becomes apparent or first occurs on or after the date the *insured person's* cover started or increased.

An illness or injury is considered to have first become apparent on the earlier of the day the *insured person*:

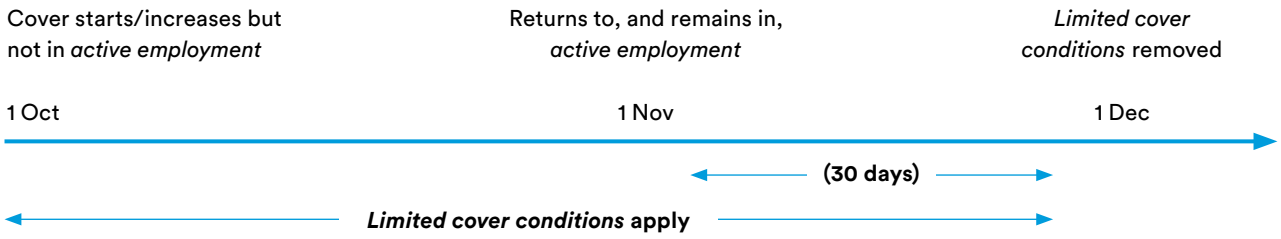
- is first given advice, care or treatment or recommended that they seek advice, care or treatment for the illness or injury, by a *medical practitioner*, and
- first had any symptom of the illness or injury for which a reasonable person in the same circumstances would have sought advice, care or treatment from a *medical practitioner*.

When limited cover applies

Limited cover conditions apply as follows:

Cover type	Scenario	Limited cover conditions
Standard cover	The *insured person* is not in *active employment* on the date *standard cover* commences.	*Limited cover conditions* apply until they have returned to *active employment* for 30 consecutive days as also shown in the diagram below.
Standard cover	The *insured person* is not in *active employment* on the date their *standard cover* increases, and this increase occurs purely as a result of any change to the policy terms and/or benefit design, including an increase to the *automatic acceptance limit*, an increase in the *benefit period* and/or a change in the *insured cover* formula.	*Limited cover conditions* apply to the increased portion of cover until they have returned to *active employment* for 30 consecutive days as also shown in the diagram below.
Takeover cover	The *insured person* obtains *takeover cover*, is not in *active employment* on the *commencement date*, and receives an increase in cover purely as a result of any change to the policy terms and/or benefit design compared to the *previous policy*, including an increase to the *automatic acceptance limit*, an increase in the *benefit period* and/or a change in the *insured cover formula*.	*Limited cover conditions* apply to the increased portion of cover until they have returned to *active employment* for 30 consecutive days as also shown in the diagram below.

Example



5. Cover amounts

5.1 Amount of cover

The amount of income protection cover that applies to an *eligible person* will be determined as follows:

Cover type	Cover amount
Standard cover	The lesser of the *insured cover* and the *automatic acceptance limit*.
Underwritten cover	The amount of cover that has been accepted.
Takeover cover	The nearest amount of cover to the cover that applied under the *previous policy* (unless the *policy schedule* states otherwise), but not exceeding the *maximum monthly benefit.*

5.2 Automatic changes to cover

The amount of cover that applies to an *insured person* will automatically change (increase or decrease) in line with changes to an *insured person's monthly income* up to the amount of the cover that does not require written acceptance by *us*.

If there were less than 100 *insured persons* at the latest *annual review date*, any such change in cover cannot result in the amount of cover increasing for the *insured person* by more than the greater of:

- 25%, or
- $1,000 per month,

since the last *annual review date*.

Any changes cannot increase cover above the *maximum monthly benefit*.

5.3 Reducing or cancelling cover

An *insured person* can apply to reduce or cancel their cover at any time, subject to the *insured cover* formula in the *policy schedule*.

The reduction or cancellation will take effect from the date *you* notify *us* in writing.

5.4 Changes to automatic acceptance limits

Increases in the automatic acceptance limit

Where there is a change in benefit design and the *automatic acceptance limit increases*, the higher *automatic acceptance limit* will apply to all existing *insured persons* who hold cover immediately prior to the date of the increase, unless the *insured person* has a capped cover amount accepted by *us* or a *forward underwriting limit* applicable to them which is greater than the new *automatic acceptance limit*, in which case the higher capped cover amount or *forward underwriting limit* will continue to apply.

Any exclusions, restrictions and/or loadings that had applied to the *insured person's* cover immediately prior to the date the *automatic acceptance limit* is increased will continue to apply, but only on the cover that is above the new higher *automatic acceptance limit*.

Limited cover conditions shall apply to any increase in cover as a result of increases in the *automatic acceptance limit*, see section **4.2 Limited cover**.

Decreases in the automatic acceptance limit

Where there is a change in benefit design and the *automatic acceptance limit* decreases, the lower *automatic acceptance limit* will apply to all existing *insured persons* who hold cover immediately prior to the date of the decrease, with the following exceptions:

- *Insured persons* who held *standard cover* greater than the new *automatic acceptance limit* immediately prior to the decrease will retain their cover as a *forward underwriting limit*. Any automatic changes to cover as per section **5.2 Automatic changes to cover** will be capped at this *forward underwriting limit*.
- *Insured persons* who held a capped cover amount accepted by us or a *forward underwriting limit* immediately prior to the decrease will retain that capped cover amount or *forward underwriting limit*. Any exclusions, restrictions and/or loadings that had applied to the *insured person's* cover immediately prior to the date the *automatic acceptance limit* is decreased will continue to apply to the cover above the previous *automatic acceptance limit*.

6. Extent of cover

6.1 Worldwide cover

Cover for an *insured person* applies worldwide. However, if an *insured person*:

- is not an *Australian Resident*,
- holds a *valid temporary visa*, and
- is temporarily overseas for reasons other than *employment*,

they will only have cover for a maximum of 90 days from the date they leave Australia.

If an *insured person*:

- is not an *Australian Resident*,
- holds a *valid temporary visa*, and
- is temporarily *employed* overseas,

cover will continue to the earliest of 2 years or the expiration date of the *valid temporary visa*, provided premiums continue to be paid by *you*.

Where an *insured person* who is an *Australian Resident* is temporarily overseas, cover will continue provided premiums continue to be paid by *you*.

An *insured person* may, where reasonably required by *us* for the purposes of the assessment of their claim, be required to return to Australia at their own expense. There is also a maximum period for which *we* will pay benefits under this policy for an *insured person* who is overseas. The maximum periods are as follows:

- *We* will, subject to all policy terms, pay a benefit if an *insured person* becomes *disabled* while they are outside Australia for a maximum period of 12 months.
- If the *insured person* is receiving benefits when they leave Australia, subject to all policy terms, any ongoing entitlement to benefits is limited to 12 months from the date they leave Australia.

If an *insured person* returns to Australia and they are still *disabled*, benefits may be reinstated effective from the date they return subject to the other terms of this policy.

6.2 Leave without pay

If an *insured person* is given *unpaid leave*, *we* will continue to cover them for a period up to 24 months after the commencement of the leave if:

- the *employer* approves the period of *unpaid leave* in writing before the *insured person* goes on leave, and
- premiums continue to be paid for the *insured person* during their *unpaid leave*.

If the *insured person* will be on *unpaid leave* beyond the initial 24 month period, *you* may 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, exercised reasonably and based on consideration of relevant factors including but not limited to for how long the *insured person* will be on leave beyond the 24 month period and the reason(s) for the *unpaid leave*.

Cover for an *insured person* who is on *unpaid leave* will cease at the earliest of when the *insured person's*:

- *unpaid leave* ceases and they do not return to their *employment*,
- *unpaid leave* exceeds 24 months, or any extended period *we* have agreed to in writing, or
- cover otherwise ceases under this policy.

If an *insured person* is on *unpaid leave* and becomes eligible for a *disability benefit we* will pay this benefit at the later of the:

- date that has been agreed and documented by the *employer* and *insured person*, as the date the *insured person* will be returning to their *employment*, and
- day after the *waiting period* has ended.

6.3 Cover beyond age 65

If the *cover cessation age* stated in the *policy schedule* is greater than 65 years, the following will apply.

For a 2 year or a 5 year Benefit Period

Where the *cover cessation age* is greater than 65, an *insured person* with a *benefit period* of 2 years or 5 years will have their cover continue after they turn age 65 up to the *cover cessation age* on the following basis:

Age at Disability	Cover conditions
If the *date of disablement* is before the *insured person's* 65th birthday	The *disability benefit* will be paid for a period not exceeding the *benefit period* that applies to the *insured person*.* The *disability benefit* plus *superannuation contribution benefit* (if applicable) that accrue and become payable after the *insured person's* 65th birthday cannot exceed $10,000 per month.
If the *date of disablement* is on or after the *insured person's* 65th birthday	The *disability benefit* will be paid until the earliest of: • 2 years, or • the *insured person* reaching the *cover cessation age** The *disability benefit* plus *superannuation contribution benefit* (if applicable) cannot exceed $10,000 per month.

* Benefits may stop earlier under section **1.4 When we stop paying**.

For a 10 year Benefit Period

Where the *cover cessation age* is greater than 65, an *insured person* with a *benefit period* of 10 years will have their cover continue after they turn age 65 up to the *cover cessation age* on the following basis:

Age at Disability	Cover conditions
If the *date of disablement* is before the *insured person's* 63rd birthday	The *disability benefit* will be paid until the earliest of: • 10 years, or • the *insured person* reaching their 65th birthday*.
If the *date of disablement* is on or after the *insured person's* 63rd birthday	The *disability benefit* will be paid until the earliest of: • 2 years, or • the *insured person* reaching the *cover cessation age** The *disability benefit* plus *superannuation contribution benefit* (if applicable) that accrue and become payable after the *insured person's* 65th birthday cannot exceed $10,000 per month.

* Benefits may stop earlier under section **1.4 When we stop paying**.

To Age 65 benefit period – Top up

An *insured person* with a To Age 65 *benefit period* will have their cover continue after they turn age 65 with a *benefit period* of 2 years if they have not previously claimed under this policy before their 63rd birthday. Cover will continue on the following basis:

Age at Disability	Cover conditions
If the *date of disablement* is before the *insured person's* 63rd birthday	The *disability benefit* will be paid until the *insured person* turns age 65.* Note, cover will cease on the *insured person's* 65th birthday (or earlier, subject to section **9.1 When cover will end for an insured person)**
If the *date of disablement* is on or after the *insured person's* 63rd birthday	The *disability benefit* will be paid until the earliest of: • 2 years, or • the *insured person* reaching the *cover cessation age*.* The *disability benefit* plus *superannuation contribution benefit* (if applicable) that accrue and become payable after the *insured person's* 65th birthday cannot exceed $10,000 per month.

* Benefits may stop earlier under section **1.4 When we stop paying**.

7. Continuation option

If the *policy schedule* states that *your* policy has a Continuation Option and an *insured person's* cover ends under this policy because they cease to be engaged by the *employer*, they may apply to continue their cover with *us* through a new individual policy without having to provide medical evidence. To do so all the following requirements must be met.

The person must:

- be under age 60 when they apply for the Continuation Option,
- be an *Australian Resident* with a residential address in Australia,
- no longer be *employed* or engaged by the *employer*,
- not be leaving *employment* either directly or indirectly due to illness or injury,
- have been *employed* as either a *permanent employee,* a *franchisee* or a partner, and *at work* on the last day before their cover ends,
- not be joining any military forces (other than the Australian Armed Forces Reserve and is not on active duty outside Australia),
- not have ever claimed, or be entitled to claim, any benefit under any life policy for illness or injury,
- meet *our* standard minimum requirements for a new individual policy at that time, and
- provide *us*, within 60 days of cover ending under this policy, with the application for the Continuation Option and the correct premium for the cover being applied for.

In addition, this policy must still be in force and all premiums due for the person's cover under this policy must be up to date.

Where the above conditions are met, *we* will issue an individual policy to the person, subject to:

- satisfactory completion of the application for Continuation Option form,
- the *waiting period* not being shorter, and the *benefit period* not being longer than those that applied when their cover ceased under this policy. Where the same *waiting period* is not available under the individual policy, the *waiting period* that applies will be the next longest *waiting period* available under the individual policy. Where the same *benefit period* is not available, the *benefit period* that applies will be the next shortest *benefit period* available under the individual policy,
- the amount of cover under the individual policy is no more than the cover that applied when their cover ceased under this policy, and
- the individual policy having the same exclusions and loadings that applied when their cover ceased under this policy.

The person's cover will then be subject to the terms and conditions (including premium rates) applicable to the individual policy.

8. Interim accident cover

8.1 What is interim accident cover?

If an *eligible person* applies for *underwritten cover*, *we* will provide them with *interim accident cover*.

We will pay a *disability benefit* and a *superannuation contribution benefit* (if it applies) if the person suffers *disability* as a direct result of an *accident* that occurs during the *interim accident cover* period defined in section **8.2 When interim accident cover starts and stops.** The *accident* and the resulting *date of disablement* must occur during the *interim accident cover* period for this benefit to be paid.

8.2 When interim accident cover starts and stops

Interim accident cover starts on the date *we* receive the *eligible person's* application for *underwritten cover* and ends on the earliest of the date:

- the application is withdrawn,
- *we* accept the application,
- *we* reject the application,
- an *interim accident benefit* becomes payable,
- 90 days from the date *we* receive the application, and
- cover would otherwise cease under this policy for the person.

8.3 What we'll pay

If *we* pay a benefit for *interim accident cover*, the total benefit *we'll* pay for *interim accident cover* and any other cover available under this policy will be the lesser of:

- the total amount of cover the *eligible person* would have if their application for cover was accepted, subject to a maximum of $20,000 per month above the existing cover,
- the *insured percentage* of the person's *pre-disability income* plus *superannuation contribution benefit* (if applicable), and
- the *maximum monthly benefit*,

less any amount of *other disability income* (as described in section **1.5 When we reduce benefits**) and *return to employment income* (as described in **1.2 What we pay**). The *benefit period* and *waiting period* that applies will be that specified in the *policy schedule*.

8.4 What happens if we pay an interim accident benefit?

If *we* pay an *interim accident benefit*, the application for *underwritten cover* will be cancelled.

9. Ending and reinstating cover

9.1 When cover will end for an insured person

Cover for an *insured person* under this policy will end on the earlier of the following:

When the *insured person*...	Cover ends on...
reaches the *cover cessation age*	the date they reach the *cover cessation age.*
commences duty with the military services (other than the Australian Armed Forces Reserve and is not on active duty outside Australia) of any country	the date they commence duty with the military services.
dies	the date of death.
has their cover cancelled by the *policy owner*	the date determined under section **5.3 Reducing or cancelling cover**.
is no longer an *insured person* because the policy is terminated	the date the policy is terminated subject to section **9.2 What happens if this policy ends?**
is no longer an *Australian Resident* and does not hold a *valid temporary visa*, is no longer permanently in Australia or is not eligible to work in Australia	the date the person is no longer an *Australian Resident* or no longer permanently in Australia or eligible to work in Australia.
ceases to be engaged by the *employer*	for an employee, the date they cease to be *employed* by the *employer.* for anyone else, the date they cease to be engaged by the *employer.* *We* will however extend cover from this date for up to 60 days (see section **9.4 Extended cover**).
ceases to meet the *eligibility conditions* (excludes ceasing to meet the *maximum entry age* if lower than the *cover cessation age*)	the date they cease to meet the *eligibility conditions.*
no longer meets the conditions under section **6.1 Worldwide cover** for cover while temporarily overseas	the date the person no longer meets the conditions for cover to continue while overseas under section **6.1 Worldwide cover**.
no longer meets the conditions under section **6.2 Leave without pay** for cover during *unpaid leave*	the date the person no longer meets the conditions for cover to continue when on *unpaid leave* under section **6.2 Leave without pay**.
has not had the outstanding premium owing for their cover paid to *us* within 30 days of the *premium due date*	the date premiums have been paid up to for the *insured person's* cover.
ceases to hold a *valid temporary visa* and is not an *Australian Resident*	the date the visa expires.
is accepted or rejected for a continuation option (for Extended Cover only)	the date the application for a continuation option is either accepted or rejected.

9.2 What happens if this policy ends?

Cover for all *insured persons* will end on the date this policy ends.

If *you* take out a policy with another insurer when this policy ends, *we* will use *FSC Guidance Note 11* (or equivalent industry replacement guidance) to transfer the cover of all *insured persons* to the new policy. Where there are inconsistencies between *FSC Guidance Note 11* (or equivalent industry replacement guidance) and this policy, this policy will prevail to the extent of the inconsistency.

9.3 Reinstating cover

If *you* wish to reinstate cover that has ceased for an *insured person*, please contact *us* to discuss the circumstances under which cover can be reinstated.

9.4 Extended cover

If cover ends because the *insured person* ceases to be engaged by an *employer*, *we* will extend cover for up to 60 days from the date the cover ceased for that person. Premiums are not payable for this extension of cover.

The extended cover period ceases on the earlier of the following:

- 60 consecutive days have elapsed since their cover ceased,
- the date that an application for a continuation option has been accepted or declined by *us*,
- the date the person obtains insurance for the same or similar benefit provided under this policy with any other insurer as reasonably determined by *us*, or
- the date that cover would otherwise cease in accordance with any other condition in section **9.1 When cover will end for an insured person** (excluding when the person ceases to meet the *eligibility conditions*).

10. Claims

10.1 When to tell us about a claim

You must tell *us* as soon as reasonably practicable if *you* become aware of a claim or potential claim. If *you* or the *insured person* unreasonably delay telling *us* and that delay causes *us* to be unable to reasonably assess and determine a claim, *we* may refuse to pay the claim.

10.2 What we need to be told

Before *we* will pay a claim *we* will need *you* or the *insured person* to provide any evidence *we* reasonably believe necessary to make a decision about the claim. This may include regular monthly reports from the *insured person's* treating *medical practitioner* in *our* chosen form as well as documentary evidence of the *insured person's income*.

Apart from any medical examinations, *return to work programs* and non-invasive tests that *we* may arrange, *we* will not pay for any costs incurred in providing evidence to support the claim, including any reports submitted to *you* from *medical practitioners* who have treated the *insured person*. Where *we* arrange for the *insured person* to undergo medical examinations, a *return to work program* or non-invasive tests that *we* reasonably believe are necessary, *we*:

- will appoint a *medical practitioner* or other health professional, and
- will pay the fees and the costs of those examinations, programs and tests. However, unless *we* agree otherwise in writing, *we* won't pay any other costs related to the *insured person's* attendance for these investigations and programs, including costs of travelling to an appointment or for non-attendance at an appointment.

We, or someone else on *our* behalf, may investigate an *insured person's* financial affairs where they are relevant to a claim. In this case, *you* and the *insured person* must cooperate fully in the investigation and provide access to all the evidence *we* reasonably consider necessary to the investigation.

10.3 Claims evidence

All evidence must be clear, able to be understood and if in writing, legible.

Where reasonable, *we* may require *you* to have foreign language evidence translated into English, and appropriately certified to be a true copy of the original. Where this is required, *we* will ensure appropriate and reasonable support is provided to any *insured persons* who do not speak English as a first language.

10.4 Confidentiality requirements

If *we* give *you* information that *we* obtain in the course of assessing a claim:

- *you* must deal with that information in accordance with the Privacy Act 1988, and keep that information confidential at all times, unless *you* have a legal obligation to disclose it, and
- any person *you* appoint to assist *you* to manage or assess claims must agree to be bound by these same confidentiality obligations.

10.5 Repayment of overpaid benefits

If *we* pay benefits that are more than the *insured person* is entitled to be paid under the terms of this policy, and the overpayment is as a result of a misrepresentation made by *you* or the *insured person*, *you* will repay to *us* the benefit amount that *you* received which was more than the correct benefit amount. *We* may reduce the benefit amount by any amount *we* deem reasonably necessary until the overpaid amount has been repaid in full.

11. Premiums

11.1 Amount and calculation of premiums

The amount of the 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* (which may include commission and third party administration fees) as stated in the *policy schedule* to the amount of cover held by the *insured person*, and will include any loadings that apply to that *insured person*.

11.2 Adjustments in premiums

There are two methods available for adjustments in premiums. The method that applies to *your* policy will be stated in the *policy schedule*.

Method 1

Any adjustment premium for the previous year will be determined at each *annual review date* by taking:

- a pro rata increase or decrease of the premium for any increase or decrease in an *insured person's* amount of cover from the date of the increase or decrease to the current *annual review date*,
- a pro rata premium for new *insured persons* joining this policy during the previous year from the date of membership to the current *annual review date*, and
- a pro rata refund of the premium for *insured persons* leaving this policy during the previous year from the date of cessation of membership to the current *annual review date*.

Example

The annual review date is 1 January 2025 and a new employee joins on 1 December 2024. They are covered for 31 days out of 365. Therefore the amount of premium charged for the 2024 calendar year will be (31/365) x the annual premium.

Method 2

Any adjustment premium for the previous year shall be determined at each *annual review date* by application of the formula:

$$\text{Adjustment Premium} = 1/2P \times \frac{(S2 - S1)}{S1}$$

When:

P is the total premium at the previous *annual review date*.

S1 is the amount of cover for all *insured persons* at the previous *annual review date*.

S2 is the amount of cover for all *insured persons* at the current *annual review date*.

Adjustment premiums shall be paid by or to *us* within 30 days of the completion of the annual review.

11.3 When premiums are due

Insurance premiums are payable to *us* annually in advance except where *we* agree to accept premiums by instalments. When premiums are payable by instalments an additional premium, as notified by *us*, will be payable.

If *we* do not receive the full premium for all *insured persons*, including any premium adjustments, within 30 days of the premium being due, *we* can give *you* written notice to terminate the policy. If a benefit is payable to *you* for a claim that occurs during a period where premiums are overdue, *we* will not pay the benefit until *you* pay *us* the overdue premium in full for all *insured persons*.

11.4 Minimum annual premium amount

We reserve the right to apply a minimum annual premium amount. If a minimum annual premium amount applies, this will be stated in the *policy schedule*. *We* may change the minimum annual premium amount by giving *you* 30 days written notice. Such minimum annual premium will become payable from the end of the *premium guarantee period* until *we* advise it is no longer payable.

11.5 Premium audit

From time to time *we* may audit *your* membership records to ensure the correct premium is being calculated and paid to *us*. *We* will give *you* reasonable notice if *we* propose to conduct an audit, and will only conduct an audit in normal office hours.

11.6 Premium corrections

If the age of an *insured person* has been incorrectly stated, *you* must advise *us* of the correct age as soon as it is reasonable for *you* to do so. *We* will retrospectively and prospectively adjust the premium and/or amount of cover for that *insured person*, as appropriate, based on the correct age.

11.7 Waiver of premiums while disabled

Premiums will be waived for an *insured person* whilst *we* are paying a benefit under this policy for them.

11.8 Premium discount for bundled policies

If the *policy owner* has an active Group Life Policy with *us*, *we* may provide a discount on whichever policy (either this policy or the Group Life Policy) has the lowest gross annual premium.

Where a discount is provided this will be detailed in the *policy schedule*, including the percentage amount of the discount. The discount will be applied to the final premium calculation at the *annual review date*.

If the *policy owner* cancels the Group Life Policy with *us*, *we* will stop providing the discount.

11.9 Profit sharing

Larger policies with at least 1,000 insured lives may be entitled to participate in profits that are based on self-experience profit sharing by way of repayment of premiums.

If *you* are eligible and have elected to participate in self-experience profit sharing, all details will be specified in *your policy schedule*.

12. Varying the policy

This policy may be varied by written agreement between *you* and *us*. It may also be varied in the following circumstances.

If *we* vary the policy it must not prevent the policy from being treated as life insurance business under the Life Insurance Act 1995 (or any legislation that replaces it).

12.1 When we can vary the policy

We have the right to vary the *premium rates* or *automatic acceptance limit* at any time after the end of the *premium guarantee period*. *We* will give *you* 60 days written notice before *we* do this.

We may vary the terms and conditions (including the *premium rates*) with immediate effect and confirm that change in writing, even before the end of the *premium guarantee period*, if:

- the number of *insured persons* covered under this policy changes by more than 25% from the number of *insured persons* at the commencement of the previous *premium guarantee period*,
- the number of *insured persons* covered under this policy becomes less than 75% of *eligible persons*, or
- *your* business activity results in unusual changes in the number of *insured persons* (such as due to mergers or takeovers) which leads, in *our* appointed actuary's opinion, to an increase in the *premium rates* by 5% or more.

12.2 Changes in the law and its interpretation

If there is a change to a law or the way a law is interpreted, *we* may also vary any of the terms and conditions of this policy (including the *premium rates*), with immediate effect, even before the end of a *premium guarantee period*.

We can do this when a change to a law or its interpretation means:

- it becomes impossible or impractical for *us* to carry out *our* obligations under the policy,
- how *we* or the policy is taxed changes,
- government charges, taxes or levies are imposed or changed, or
- the terms of the policy would become inconsistent with the law.

In this section, a "law" includes an industry code of practice that *we* are under a legal or contractual obligation to comply with.

12.3 War in Australia

If there is a *war* within Australia, *we* may vary the *premium rates* with immediate effect.

13. Exclusions

13.1 Acts of war

We will not pay a benefit for an *insured person* if their *disability* is caused directly or indirectly by an act of *war*.

13.2 Self-inflicted injury or attempted suicide

We will not pay a benefit in respect of an *insured person* if an illness, injury or medical condition is directly or indirectly caused by intentional self-inflicted injury or infection, suicide or attempt at suicide.

13.3 Normal pregnancy

We will not pay a benefit in respect of an *insured person* if their *disability* is directly or indirectly caused by normal and uncomplicated pregnancy, caesarean birth, threatened miscarriage, participating in in-vitro fertilisation or other medically assisted fertilisation techniques and normal discomforts of pregnancy, such as morning sickness, back ache, varicose veins, ankle swelling and bladder problems.

13.4 Health legislation

We will not make a payment under this policy if the payment would cause *us* to infringe any legislation in connection with health insurance, including the Private Health Insurance Act 2007 (Cth), Private Health Insurance (Prudential Supervision) Act 2015 (Cth), Health Insurance Act 1973 (Cth) or the National Health Act 1953 (Cth) or any succeeding legislation in connection with health insurance.

13.5 Sanctions

No benefit will be payable where the payment would expose *us*, *you* or the *insured person* (or an entity related to *us* or *you*) to any sanction, prohibition or restriction under the United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, Australia or United States of America.

13.6 Concurrent disabilities

We will only pay a *disability benefit* for an *insured person* for one *disability* at a time.

If a *disability benefit* is payable for a particular illness or injury, and the person subsequently suffers an unrelated illness or injury which also independently causes them to be *disabled* for the same period:

- no separate *disability benefit* will be payable for the subsequent illness or injury while a *disability benefit* is payable for the first illness or injury, and
- if the subsequent illness or injury becomes the sole condition causing *disability*, then that illness or injury will be treated as being "related" to the first illness or injury such that both periods of *disability* will be added together for the purposes of determining when the *benefit period* ends (see section **1.6 Recurrent disability**).

13.7 Criminal activity

We will not pay a benefit for an *insured person* if their *disability* is caused directly from the *insured person's* participation in criminal activity.

14. Policy owner information

14.1 Policy term

This policy commences on the *commencement date* and will end on the earliest of:

- the date *we* receive *your* written request to cancel this policy,
- a date *we* agree to in writing with *you*,
- the date cover ends for all *insured persons*, or
- a date *we* give *you* in writing if a premium is more than 30 days overdue. See section **11.3 When premiums are due**.

14.2 Payment of benefits

All payments connected to this policy will be paid to *you*, or a person nominated by *you* in writing, unless the terms of this policy specifically state otherwise.

14.3 Record keeping

You must keep accurate records necessary for the effective operation of this policy, in a format that is reasonably accessible by *us*.

The information *you* must provide includes information relevant to each claim including:

- salary,
- leave records, and
- *employment* duties.

Additionally, *you* must provide any records *we* are entitled to access under this policy to investigate the premiums owed to *us* during a relevant period, and the person's eligibility to be covered under this policy.

For *insured persons* who are overseas for a period exceeding 90 days for any reason, *you* must provide *us* with the following at each *annual review date*:

- visa expiration date if not an *Australian Resident*,
- location(s),
- start date of period overseas, and
- anticipated end date of period overseas.

14.4 Currency

All payments connected to this policy, whether to *us* or by *us*, must be made in Australia and in Australian currency.

14.5 Audit

We may conduct an audit of:

- the performance of any obligation under this policy, or
- records *you* (or any person on *your* behalf) have,

which are connected with this policy.

We will give *you* reasonable notice if *we* propose to conduct an audit, and will only conduct an audit in normal office hours.

14.6 Notices

Notices must be in writing. *We* will send all notices to *you* at the address *you* last gave *us*, and *you* must send notices to *us* at the address *we* last gave *you*.

A notice which is delivered personally, by facsimile or email is treated as being given on the day it was received and a notice which is posted is treated as being given three days from the date of posting.

14.7 Waivers

If *we* do not exercise a power or right *we* have under this policy (or delay exercising it) this does not operate as a waiver of that power or right. *We* waive a power or right only where *we* say so in writing.

14.8 Non-assignment of policy

You may not assign this policy, unless *we* have previously given *our* written consent.

14.9 Statutory fund and surrender value

This policy:

- is issued in *our* No. 1 Statutory Fund,
- does not participate in *our* profits, and
- does not acquire a surrender value.

14.10 Interpretation

How to read this policy:

- headings are intended as a guide only and are not to be used to interpret the policy conditions, and
- as the context allows, plurals can be read as the singular and the singular read as plurals.

14.11 Governing law

This policy is subject to and governed by the laws of the Commonwealth of Australia and the laws of the State of New South Wales.

15. Complaints

We will try to resolve any complaints and disputes promptly through *our* internal disputes resolution process.

But if *we* are unable to resolve a dispute to the *insured person's* satisfaction, the *insured person* may contact the Australian Financial Complaints Authority for help.

Australian Financial Complaints Authority
Phone: 1800 931 678
Write to: GPO Box 3, MELBOURNE VIC 3001
Email: info@afca.org.au
Online: www.afca.org.au

16. Definitions

Words or expressions in italics throughout the policy document have meanings set out below:

accident	Bodily injury caused solely and directly by accidental, external and visible means, independent of any other cause.
accommodation benefit	A benefit payable as described in section **2.6 Accommodation benefit**.
active employment	A person who, based on the balance of available evidence, is capable of performing their identifiable duties, without restriction by any illness or injury, for at least 35 hours per week (whether or not they are actually working those hours).
annual review date	The "Annual Review Date" stated in the *policy schedule*.
at work	Actively performing all the duties of their *occupation*, working their usual hours free from any limitation due to illness or injury and not entitled to or receiving income support benefits of any kind.
Australian Resident	A person who (a) resides in Australia and is either an Australian citizen or the holder of a permanent visa as identified by the Australian Government; or (b) is a citizen of New Zealand and the holder of a *Special Category Visa* while residing in Australia indefinitely. This includes a citizen of New Zealand who held a *Special Category Visa* whilst residing in Australia and has departed overseas temporarily, but who remains a citizen of New Zealand whilst overseas and eligible to reside and work in Australia under the *Special Category Visa*.
automatic acceptance limit	The maximum amount determined by *us* and notified to *you* from time to time as stated in the *policy schedule* for which *we* may accept a person for *insured cover* without underwriting.
benefit period	The maximum period for which *disability benefits* may be payable due to the same or related illness or injury and is identified in the *policy schedule*. The following persons can only have a 2 year *benefit period*: • *contractors* engaged by the *employer* for a period of less than 12 consecutive months, • *casual employees*.
casual employee	A person being engaged in *employment* of a temporary nature where: • continuity of *employment* is not guaranteed by the *employer*, regardless of hours worked or the period of *employment*, and • the person is not entitled to annual leave or sick leave.
commencement date	The "Commencement Date" stated in the *policy schedule*.
confined to bed	An *insured person* is *disabled* and a *medical practitioner* has certified that they require the continuous full time care of a *registered nurse*.
consumer price index or CPI	The consumer price index (weighted average of 8 capital cities combined) as published by the Australian Bureau of Statistics or its successor. If the Index is not published the increase shall be calculated by reference to such other retail price index which in *our* opinion most closely replaces it.
contractor	A person who is contracted for a fixed period of *employment* determined at the commencement of their *employment* and where that person is entitled to have benefits such as superannuation contributions and sick leave.
cover cessation age	The age at which a person's *insured cover* will cease, and they are no longer eligible for cover under this policy. The *cover cessation age* is shown in the *policy schedule*.
crisis benefit	A benefit payable as described in section **2.2 Crisis benefit**.
crisis benefit medical condition	A condition listed in Appendix B of this policy.
date of certification	The most recent date that two *medical practitioners*, one of whom is a *medical specialist* in the *insured person's* illness, certify that the illness will lead to the *insured person's* death within 12 months.
date of disablement	The later of, the: • first date on which an *insured person* is unable to work due to illness or injury, and • date a *medical practitioner* certifies that an *insured person* is *totally disabled*.

death benefit	The benefit payable for death as described in section **1.7 Death benefit**.
direct family member	An *insured person's*: • spouse or de-facto spouse, • parent or parent-in-law, • child who is at least 18 years of age, or • sibling who is at least 18 years of age.
disabled/disability	Either *partially disabled* or *totally disabled* as the context requires.
disability benefit	A benefit payable under this policy as a result of an *insured person* suffering *total disability* or *partial disability* (as applicable).
eligibility conditions	"Eligibility Conditions" stated in the *policy schedule* that detail how a person can become eligible for *insured cover*.
eligible person	A person who meets the "Eligibility Conditions" stated in the *policy schedule*.
employed or employment	A person being engaged by the *employer*: • under a contract of employment and includes a: – *permanent employee* – *casual employee* – *contractor*, or • as a *franchisee*, or • as a partner (if the *employer* is a partnership).
employer	The "Employer" named in the *policy schedule* and any associated entity agreed to by *us*.
enhanced death benefit	A benefit payable as described in section **2.9 Enhanced death benefit**.
excluded rehabilitation program	Any program providing 'hospital treatment' or 'general treatment' within the meaning of the Private Health Insurance Act 2007 or any other program which might cause this policy to cease to be exempt from the National Health Act 1953, Health Insurance Act 1973 or Private Health Insurance Act 2007, Private Health Insurance (Prudential Supervision) Act 2015 or any succeeding legislation in connection with health insurance.
family care	Care provided by a *direct family member* to an *insured person* when: • a *medical practitioner* certifies that an *insured person* is *totally disabled* and requires care at home for 7 or more hours per day; • the *insured person* is not performing any work, • the *direct family member* providing the care was engaged in paid employment on a permanent basis for a minimum of 30 hours per week on the date the *insured person* became *totally disabled*, and • the *direct family member* can demonstrate to *our* satisfaction a reduction in their income as a result of providing this care to the *insured person*.
family care benefit	A benefit payable as described in section **2.5 Family care benefit.**
forward underwriting limits	The amount, determined by *us*, which an *insured person's insured cover* may increase to, in line with the calculation for *insured cover*, without the need for additional underwriting. This is only available where the policy has a standard formula for calculating the *insured cover*.
franchisee	An individual who has entered into a *franchise agreement* with *you*.
franchise agreement	Has the meaning given to it in the Competition and Consumer (Industry Codes Franchising) Regulation 2014 (or any legislation that replaces it).
FSC Guidance Note 11	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).
income	(a) As set out in **Appendix A** and the definition which applies will depend on the *insured person's employment* status and is stated in the *policy schedule*, and (b) any other component agreed to by *us* that would not otherwise be considered as income under **Appendix A**. The following rules apply: • Where the person is on *unpaid leave*, and *we* continue to provide cover in respect of that *insured person* pursuant to section **6.2 Leave without pay**, *income* is the amount defined in (a) and (b), immediately before the start of the *unpaid leave*.

income (continued)	• Where the person takes a period of paid leave at a reduced income prior to commencing *unpaid leave*, and *we* continue to provide cover in respect of that *insured person* pursuant to section **6.2 Leave without pay**, *income* is the amount defined in (a) and (b) immediately before the start of the period of paid leave at a reduced income. • Where extended cover applies as per section **9.4 Extended cover**, *income* is the amount defined in (a) and (b) immediately before the date of *employment* cessation.
income producing duty	A duty of the *insured person's occupation* that generates at least 20% of the *insured person's pre-disability income*.
insured cover	The "Insured Cover" stated in the *policy schedule* which details the calculation of insurance cover for an *insured person*, plus the *superannuation contribution benefit* (if applicable).
insured percentage	The "Insured Percentage" stated under "Insured Cover" in the *policy schedule*.
insured person	A person who has cover in force under this policy, other than *interim accident cover*.
interim accident benefit	The benefit payable for *interim accident cover* as described in section **8 Interim accident cover**.
interim accident cover	The cover provided under section **8 Interim accident cover** while a person is being assessed by *us* for additional cover that is not accepted under automatic acceptance.
life recovery benefit	A benefit payable as described in section **2.8 Life recovery benefit.**
limited cover conditions	The limitations on an *insured person's* cover as described in section **4.2 Limited cover**.
maximum entry age	The maximum age a person can be to be eligible for *standard cover* as stated in the *policy schedule*. For the avoidance of doubt, *maximum entry age* is counted in whole years. Therefore for a *maximum entry age* of 64, *we* will consider a person to be aged 64 until the day before their 65th birthday.
maximum monthly benefit	The maximum amount payable each month inclusive of any *superannuation contribution benefit* and any indexation, as identified in the *policy schedule* or otherwise stated in this policy.
medical practitioner	A person who is registered and practising as a medical practitioner in Australia other than the: • *insured person*, or • *insured person's* spouse or partner, parent, child, sibling or business partner. *We* may accept a similarly qualified person who is registered and practising as a medical practitioner in another country, on the basis their credentials are recognised by the Australian Medical Board.
medical specialist	A *medical practitioner* who is registered as a Specialist with the Australian Health Practitioner Regulation Agency (or any other body which replaces it).
monthly benefit	The lesser of the: • *insured percentage* multiplied by the *insured person's pre-disability income*, • *automatic acceptance limit* or *forward underwriting limit* (as applicable to the *insured person*), and • *maximum monthly benefit*, subject to section **5.2 Automatic changes to cover.**
monthly income	The *income* earned by the *insured person* in one calendar month.
nursing care benefit	A benefit payable as described in section **2.4 Nursing care benefit**.
occupation	The *insured person's* regular occupation that could be performed at any place of work.
other disability income	In respect of a month, any of the following benefits or entitlements which were received by an *insured person* during the month or which, though not actually received, *we* reasonably apportion to them for the month in question being any of the following: • the amount of any *income* that continues to be paid or continues to accrue (and is payable at a later date) whilst the person is *disabled* (this does not include *return to employment income*), • the amount of any income (other than benefits received under this Policy) and the commutation of income paid or payable in respect of an *insured person* as a result of *total disability* or *partial disability* or *interim accident cover*, • paid sick leave, • paid annual leave or paid long service leave, but only amounts received more than 3 months from the date *disability benefits* first commence for the same or related injury or illness, • any amounts payable in relation to a *disability*, injury or illness policy (other than lump sum TPD, trauma/crisis benefit or terminal illness)

other disability income (continued)	• any amounts payable in respect of loss of income or loss of earning capacity (including an award of damages or a settlement of a claim for damages for personal injury under common law): – through workers compensation or any similar legislation (including any settlement under common law), or – under any statutory accident compensation scheme. Any amount which is in the form of a lump sum or is exchanged for a lump sum has a monthly income equivalent of 1/60th of the lump sum over a period of 60 months.
paraplegia	Total and permanent loss of the use of the lower limbs as a result of injury or disease.
partially disabled or partial disability	(refer to the *policy schedule* for the definition that applies to *your* policy) **Definition 1** An *insured person*, solely as a result of illness or injury, is: • unable to work in their *occupation* at full capacity but is: – working in their *occupation* in a reduced capacity, or – capable of working in that *occupation* in a reduced capacity (where such work is reasonably available), or – working in another occupation, • is earning or is reasonably capable of earning a *return to employment income* which is less than their *pre-disability income*, and • is under the *regular care* of a *medical practitioner*. **Definition 2** Own Occupation (applicable for the first 2 years of the *benefit period* only): An *insured person*, solely as a result of illness or injury, is: • unable to work in their *occupation* at full capacity but is: – working in their *occupation* in a reduced capacity, or – capable of working in that *occupation* in a reduced capacity (where such work is reasonably available), or – working in another occupation, • is earning or is reasonably capable of earning a *return to employment income* which is less than their *pre-disability income*, and • is under the *regular care* of a *medical practitioner*. Any occupation (applicable for each month of the *benefit period* after 2 years): An *insured person*, solely as a result of illness or injury, is: • unable to work at full capacity in their *occupation* or any other occupation they are suited to by reason of their education, training or experience but they are: – working in a reduced capacity in their *occupation* or another occupation they are suited to by education, training or experience, or – capable of working in a reduced capacity in their *occupation* or another occupation they are suited to by reason of education, training or experience (where such work is reasonably available), or – working in any other occupation, • is earning or is reasonably capable of earning a *return to employment income* which is less than their *pre-disability income*, and • is under the *regular care* of a *medical practitioner*.
partial disability benefit	A benefit payable as described in section **1.2 What we pay**.
permanent employee	Employment under an agreement or award in which a person works a minimum number of hours, has an employment contract of indefinite duration, and is entitled to conditions and benefits normally associated with permanent employment such as annual leave and sick leave.
policy owner	The "Policy Owner" named in the *policy schedule*.
policy schedule	Any document issued to *you* which contains the specific terms and conditions that apply to this policy.
pre-disability income	The *insured person's monthly income* immediately prior to their *date of disablement*.
premium due date	The "Premium Due Date" stated in the *policy schedule*.
premium guarantee period	The "Premium Guarantee Period" stated in the *policy schedule*.

premium rates	The rates stated in the *policy schedule* "Schedule 2".
previous policy	The "Previous Policy" named in the *policy schedule*.
quadriplegia	Total and permanent loss of the use of both arms and both legs as a result of injury or disease.
qualifying program	A *return to work program* that is: • a comprehensive *return to work program* comprising of a range of tailored services with a goal of returning the *insured person* to their full duties and hours, • supported by evidence, including but not limited to the opinion of *medical practitioners, medical specialists* and occupational rehabilitation reports, indicating that the *return to work program* is necessary to facilitate a safe and sustainable return to full duties and hours, • supported by a documented return to work plan, agreed to in writing by the *employer*, the *insured person* and their *medical practitioner*, that consists of: – the anticipated timeframe for the *insured person* to return to their full hours and duties, – actions required by the *employer*, the *insured person*, their *medical practitioner* and the occupational rehabilitation provider coordinating the *return to work program*, and – scheduled review points for the goals, anticipated timeframes and actions required. For a *return to work program* to be considered a qualifying program, for the purposes of the *return to work benefit*, both the *employer* and the *insured person* must consistently participate in the documented actions required as part of the above mentioned return to work plan. *Return to work programs* consisting of once-off single services such as health coaching, exercise programs and job seeking assistance are not considered to be qualifying programs for the purposes of the *return to work benefit*.
registered nurse	A person who is registered and practising as a nurse, other than: • the *insured person*; • an *insured person's* parent, child or sibling; • an *insured person's* spouse or partner, as determined by *us* in *our* absolute discretion; or • an *insured person's* business partner, associate or employee.
regular care	Following the advice of a treating *medical practitioner* in accordance with, as appropriate for the condition, an established management plan aligned to accepted clinical practice guidelines for the management of the *insured person's* medical condition(s) (guidelines must be recognised in Australia).
relocation benefit	A benefit payable as described in section **2.10 Relocation benefit**.
retraining expenses	The cost of a retraining program (other than a retraining program providing 'hospital treatment' or 'general treatment' within the meaning of the Private Health Insurance Act 2007 (Cth) or any other program which might cause this policy to cease to be exempt from any legislation in connection with health insurance) which *we* have approved in writing prior to incurring such costs.
retraining expense benefit	A benefit payable as described in section **1.8 Retraining expense benefit**.
return to employment income	The amount of income the *insured person* has received, or is capable of earning, during the month that *we* are paying a *partial disability benefit*.
return to work benefit	A benefit payable as described in section **2.7 Return to work benefit.**
return to work program	Any program or service which *we* reasonably consider would assist the *insured person* to carry out the duties of their *occupation* or any other occupation which may include (but not be limited to): • training and education, • work or other experience, • employment assistance, or • workplace equipment and/or modification directly related to the *insured person's* injury and reasonably necessary to assist them to return to work*. The cost of any *return to work program we* require an *insured person* to undertake will be met by *us*. *For the avoidance of doubt, *we* will not provide funding for any equipment that the *employer* is required to provide as per their relevant state/territory workplace health and safety legislation.
special category visa	Has the meaning given to it in section 32 of the Migration Act 1958 (Cth).
specific injury benefit	A benefit payable under the circumstances described in section **2.3 Specific injury benefit**.
specific injury event	An event listed in section **2.3 Specific injury benefit** for which a *specific injury benefit* will be payable for.

standard cover	The acceptance of *insured cover* by *us* without the need for underwriting for an amount up to the *automatic acceptance limit*.
superannuation contribution benefit	A benefit payable as described in section **2.1 Superannuation contribution benefit**.
superannuation contribution insured percentage	The "*Superannuation Contribution Insured Percentage*" stated in the *policy schedule.*
superannuation contribution monthly benefit	The lesser of: • the *superannuation contribution insured percentage* multiplied by *pre-disability income*; and • the *automatic acceptance limit* (or *forward underwriting limit*, if applicable) minus the *monthly benefit*.
superannuation contribution partial monthly benefit	A benefit payable in accordance with the following formula: ((*pre-disability income –return to employment income)/pre-disability income*) *x superannuation contribution monthly benefit*
takeover cover	The cover described in section **3.5 Takeover cover**.
Terminal illness/ terminally ill	(a) an *insured person* suffering from an illness that despite reasonable medical treatment will lead to the *insured person's* death within 12 months of the *date of certification*, and (b) *we* are satisfied, on medical or other evidence, that despite reasonable medical treatment the illness will lead to the *insured person's* death within 12 months of the *date of certification* referred to in paragraph (a). The *date of certification* must be made while the *insured person* is covered under this policy
totally disabled/total disability	(refer to the *policy schedule* for the definition that applies to *your* policy) **Definition 1** The *insured person* solely as a result of illness or injury occurring while the policy is in force is: • unable to perform at least one *income producing duty* of their *occupation*, • under the *regular care* of a *medical practitioner*, and • not working or capable of working in their *occupation* in a reduced capacity (where such work is reasonably available) and is not working in any other occupation, whether paid or unpaid. **Definition 2** <u>Own Occupation (applicable for the first 2 years of the *benefit period* only):</u> The *insured person* solely as a result of illness or injury occurring while the policy is in force is: • unable to perform at least one *income producing duty* of their *occupation*, • under the *regular care* of a *medical practitioner*, and • not working or capable of working in their *occupation* in a reduced capacity (where such work is reasonably available) and is not working in any other occupation, whether paid or unpaid. <u>Any occupation (applicable for each month of the *benefit period* after 2 years):</u> The *insured person* solely as a result of illness or injury occurring while the policy is in force is: • unable to perform at least one *income producing duty* of their *occupation* or any other occupation they are suited to by reason of their education, training or experience • under the *regular care* of a *medical practitioner*, and • not working or capable of working in a reduced capacity in their *occupation* or any other occupation they are suited to by reason of their education, training or experience (where such work is reasonably available), whether paid or unpaid.
total disability benefit	The benefit payable as described in section **1.2 What we pay.**
underwritten cover	Cover accepted by *our* underwriters following *our* assessment of any information that *we* may reasonably require, including information about the person's personal and family medical history.
unpaid leave	Any period of absence by the *insured person* from their *occupation*, unpaid by the *employer*, that has been approved by the *employer* in writing prior to such absence.
unplanned hospital admission	An *insured person* is under the care of, and following the advice of, a *medical practitioner* in hospital after an unplanned emergency admission.
valid temporary visa	A current and valid visa permitting residency (excluding a visa allowing permanent residency in Australia) and employment in Australia 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.

waiting period	The continuous period of days stated in the *policy schedule* starting from the *date of disablement* and during which an *insured person* has remained *totally disabled* or *partially disabled* in order to be entitled to a *disability benefit*. The following rules apply: (i) the *insured person* must be *totally disabled* for at least 7 out of the first 12 consecutive days of the *waiting period* to qualify for a *disability benefit*, (ii) if the *insured person* returns to work at full capacity during the *waiting period*, and is not participating in a *return to work program*: – where the *waiting period* is less than 60 days: if the *insured person* returns to work only once for a period of 5 consecutive days or less, the number of days worked will be added to the *waiting period*, or – where the *waiting period* is 60 days or more: if the *insured person* returns to work only once for a period of 10 consecutive days or less, the number of days worked will be added to the *waiting period*. Where either of the above criteria are not met, the *waiting period* starts again. (iii) if the *insured person*: – returns to work at full capacity during the *waiting period*, – receives assistance for this return to work via a *return to work program*, and – subsequently becomes *disabled* again before the end of the *waiting period*, the *waiting period* will be deemed to have commenced as at the first date the *insured person* became *totally disabled*, and the number of days worked will not be added to the *waiting period*.
war	Any act of war (whether declared or not), revolution, invasion, rebellion or civil unrest.
we/our/us	MetLife Insurance Limited ABN 75 004 274 882 AFSL No. 238096.
you/your	The *policy owner.*

Appendix A – Income Definitions

The definitions of *income* available in the policy will be based on the *insured person's employment* status as shown in the table below. The definition(s) which will apply to *your* policy will be stated in the *policy schedule*.

Definition	Employment Status	Income Definition
1(a).	*Employed* – standard (excluding *casual employees*)	The total regular income received by the *insured person* from the *employer* for personal exertion for their occupation including salary sacrifice amounts, but excluding overtime payments, profit distributions, director's fees and any other non-regular payments.
1(b).	*Employed* – tailored components (excluding *casual employees*)	The total regular income received by the *insured person* from the *employer* for personal exertion for their occupation including salary sacrifice amounts, SG contributions*, regular commission*, regular bonus* (but excluding overtime payments, profit distributions, director's fees and any other non-regular payments). Where this income includes commission and bonuses, these components will be averaged over a three year period, unless otherwise specified in the *policy schedule*. *The component(s) that apply to *you* will be specified in the *policy schedule*.
2.	*Casual employee*	The average of the regular income received by the *insured person* from the *employer* over the previous 12 months or the actual period of *employment* if less than 12 months, subject to a minimum average period of 3 months.
3.	Partner	The total regular income received by the *insured person* (after deduction of their share of business expenses) from the *employer* because of the personal exertion of the *insured person,* averaged over the previous 12 months (or lesser period if *employed* for less than 12 months). Income may include profit distribution that is connected to personal exertion. Profit distribution will be averaged over the previous 2 years (or lesser period if *employed* for less than 2 years). When calculating the average *income*, if the *insured person* has been *employed* for a period of 6 months or less, *we* will average over 6 months. Income will not include investment income or similar payments that may continue in the event of *disability*.
4.	Shareholders (*employed* as a *permanent employee*)	The total regular income received by the *insured person* from the *employer* for personal exertion for their occupation, including any income distributed to a spouse/partner and/or a child/children, (also including salary sacrifice amounts but excluding overtime payments, profit distributions, director's fees and any other non-regular payments). Where this income includes commission and bonuses these components will be averaged over a three year period.
5.	*Franchisee*	Income is the Gross Total Receivables Package less Ongoing Franchise Expenses. "Gross Total Receivable Package" means the total income received from the operation of the franchise and includes, but is not limited to, the following items: • Franchise income from all regular jobs, • Franchise income from all irregular jobs, • Mandated superannuation contributions, • Depreciation* of business equipment and motor vehicle(s), • The proportionate value of the motor vehicle. "Ongoing Franchise Expenses" means the total expenses that is necessarily incurred in the operation of the franchise and includes, but is not limited to, the following items: • Franchise fees, • Insurance, • Equipment and motor vehicle(s) maintenance costs, • Fuel, • Office supplies. *The maximum depreciation amount to be added back is the lesser of the actual depreciation, and 20% of net profit.

6.	Self -employed (Executive Director)	For a self-employed person, or an executive director, and who owns (directly or indirectly) all or part of the business, including all or part ownership through another legal entity, the regular income earned in the 12 months immediately prior from the *insured person's* personal exertion after the deduction of their share of business expenses incurred in earning the income excluding investment income, profit distributions or similar payments that may continue in the event of disability.

Appendix B – Crisis Medical Conditions

Medical Condition	Definition
Angioplasty – Triple Vessel	Means undergoing an angioplasty on each of the three main coronary arteries (left anterior descending, left circumflex, right coronary), either in a single procedure, or multiple procedures within two months of the original procedure. The procedure must be considered the necessary and appropriate treatment by a *medical specialist*, and supported by angiographic evidence of coronary artery disease in each of the three main coronary arteries. It specifically excludes any other angioplasty, intra-arterial procedures and other non-surgical procedures.
Aplastic Anaemia	Means the *diagnosis* of aplastic anaemia that results in anaemia, neutropenia and thrombocytopenia and requires interventionist treatment, such as the use of immunosuppressive agents, marrow stimulating agents or a bone marrow transplant.
Bacterial Meningitis	Means the *diagnosis* of bacterial meningitis, causing *permanent neurological deficit*. It specifically excludes bacterial meningitis in the presence of HIV infection and all other forms of meningitis, including viral and other immunocompromised states.
Benign Brain Tumour	Benign Brain Tumour in the brain or spinal cord means a non cancerous tumour in the brain or spinal cord which produces *permanent neurological deficit*, resulting in: • neurological damage and functional impairment causing a total and irreversible inability to perform without the assistance of another person at least one of the '*Activities of Daily Living*'; or • the undergoing of a surgery to remove the tumour. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI and the impairment must be certified by a consultant neurologist. *We* do not cover any of the following: • cysts, granulomas and cerebral abscesses; • malformations in, or of, the arteries or veins of the brain; • haematomas; or • tumours in, or of, the pituitary gland.
Blindness	Means the permanent loss of sight in both eyes, whether aided or unaided, as a result of Injury or Illness such that visual acuity is reduced to 6/60 or less in both eyes, or such that the visual field is reduced to 20 degrees or less of arc.
Cancer	Means the *diagnosis* of a malignant cancer with histological or cytological confirmation and characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue. The term 'malignant cancer' includes carcinoma, leukaemia, sarcoma and lymphoma. It specifically excludes: • all tumours which are histologically classified as any of the following: – pre-malignant; – non-invasive; – high-grade dysplasia; or – having borderline malignancy or low malignant potential. • *carcinoma in situ*, except where it requires *major cancer treatment*; • all cancers of the prostate unless: – Diagnosed before age 55 and progressed to at least clinical stage T1a, T1b or T1c using the TNM clinical staging system; – progressed to at least clinical stage T1b or T1c on the TNM clinical staging system; – histologically classified as having a Gleason score of 7 or above; or – *major cancer treatment* is required.

Cancer continued	• cutaneous lymphoma (lymphoma confined to the skin) unless having progressed beyond Ann Arbor Stage I; • chronic lymphocytic leukaemia unless progressed to at least RAI Stage I; • squamous cell carcinoma of the skin unless there has been a spread to other organs (including bone or lymph nodes); • all hyperkeratosis or basal cell carcinomas of the skin; and • all melanoma skin cancers, unless the Breslow thickness is 1mm or more or ulceration is present.
Cardiomyopathy	Means the *diagnosis* of cardiomyopathy with permanently impaired ventricular function resulting in significant permanent physical impairment to the degree of Class 3 or more of the New York Heart Association or equivalent classification of cardiac impairment.
Coma	Means the total failure of cerebral function characterised by total unconsciousness and unresponsiveness to all external stimuli, resulting in a documented Glasgow Coma Scale of 6 or less with the use of a life support system, for a continuous period of at least 72 hours. It specifically excludes medically induced comas.
Coronary Artery Bypass Surgery	Means the undergoing of coronary artery bypass surgery to one or more coronary arteries as the necessary and appropriate treatment of coronary artery disease.
Dementia including Alzheimer's	Means the *diagnosis* of dementia or Alzheimer's disease resulting in a permanent loss of cognitive function, for which no other recognisable cause has been identified. A Mini-Mental State Examination score of 20 or less out of 30 is required.
Heart Attack	Means the *diagnosis* of myocardial infarction (death of a portion of the heart muscle) as a result of inadequate blood supply to the relevant area, as measured by the tests specified below. The *diagnosis* must be supported by a diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following: • symptoms of ischeamia consistent with myocardial infarction; • ECG changes indicative of new ischeamia (new ST-T changes or new left bundle branch block); • development of new pathological Q waves on the ECG; or • new regional wall motion abnormality persisting for at least six weeks and confirmed on cardiac imaging including echocardiogram, cardiac CT, cardiac MRI or cardiac radio nuclear scan. If the above tests are inconclusive or unable to be met, *we* will consider other appropriate and medically recognised tests. The above specifically excludes: • a rise in biological markers as a result of an elective keyhole procedure for coronary artery disease; • pulmonary embolisms; • viral myocarditis; and • other acute coronary syndromes including but not limited to angina pectoris.
Heart Valve Surgery	Means the undergoing of heart surgery using an endoscopic procedure, or via a catheter, or endovascular method, to treat a heart valve defect or heart valve abnormality.
Loss of Hearing	Complete and permanent loss of hearing in both ears which cannot be corrected or improved with treatment or assistive devices, as a result of injury or sickness the loss is at least 90 dB in both ears, averaged over frequencies of 500Hz, 1000Hz and 2000Hz, as certified by an appropriate *medical specialist*.
Loss of Independence	1. 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* without the assistance of another person. or 2. Cognitive impairment, meaning a deterioration or loss in the insured person's intellectual capacity which requires another person's assistance or verbal cueing to perform any of the *Activities of Daily Living*. or

Loss of Independence continued	3. Loss of Limb/s 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. The loss of independence should be confirmed by a consultant physician.
Loss of Limbs	Means the total and permanent loss of the use of two or more *limbs*, due to paralysis or physical loss.
Loss of Limb/s and Sight of One Eye	The total and irrecoverable loss by the *insured person* of the: • use of two *limbs*, or • use of one *limb* and the sight of one eye.
Loss of Speech	The total and permanent loss of the ability to produce intelligible speech, as a result of permanent damage to the larynx or its nerve supply or to the speech centres of the brain, whether caused by injury, tumour or sickness. The loss must be certified as being total and permanent by an appropriate *medical specialist*.
Major Head Trauma	As a result of an Accident, a traumatic brain injury resulting in *permanent neurological deficit*, causing either; • at least 25% impairment of whole person function (lasting more than six weeks from the date of the trauma) as defined in, at least, the 5th edition of the Guides to the Evaluation of Permanent Impairment, American Medical Association. Diagnosis must be certified by a consultant neurologist, or • totally and irreversibly unable to perform at least two of the five *Activities of Daily Living*. An Accident 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 is not traceable, even indirectly, to any pre-existing mental or physical condition.
Motor Neurone Disease	Means the *diagnosis* of a permanent and progressive form of motor neurone disease confirmed by neurological investigation.
Multiple Sclerosis	Means the *diagnosis* of a permanent and progressive form of multiple sclerosis.
Muscular Dystrophy	Means the *diagnosis* of a muscular dystrophy resulting in a *permanent neurological deficit*.
Occupationally Acquired Hepatitis B or Hepatitis C Infection	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 whilst the *insured person* is performing the usual duties of their normal occupation and involves contact with a bodily 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, • the *insured person* has a positive anti-HCV screening tests (enzyme immunoassay) 10 weeks after infection, • 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.
Parkinson's Disease	Means the *diagnosis* of permanent and progressive Parkinson's disease or Parkinsonisms.
Pneumonectomy (Removal of the lung)	Undergoing a surgical procedure in which an entire lung is removed due to underlying lung disease or disorder.

Primary Pulmonary Hypertension	Primary pulmonary hypertension with right ventricular enlargement established by investigations including cardiac catheterisation, resulting in a significant permanent physical impairment to the degree of at least Class III of the New York Heart Association classification of Cardiac Impairment.
Severe Burns	Means burns that involve damage or destruction of the skin to its full depth through to the underlying tissue.
Stroke	Means the *diagnosis* of a stroke with an acute onset of new objective neurological symptoms lasting more than 24 hours. The *diagnosis* must be supported by neuroimaging evidence of a lesion consistent with the neurological symptoms. It specifically excludes: • transient ischaemic attacks; • brain or spinal cord damage due to an accident, Injury, infection, or non-vasculitic inflammatory disease; • vascular disease affecting the eye or optic nerve; • ischaemic disorders of the vestibular system; • strokes caused by or related to illicit drug use or substance abuse; • migraine; and • hypoxic events.
Surgery to the Aorta	Surgical repair to the aorta to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta but does not include angioplasty, intra arterial procedures or other non surgical techniques.
Terminal Illness	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.
Viral Encephalitis	Means the *diagnosis* of viral encephalitis, causing *permanent neurological deficit*.
Vital Organ or Digestive System Disorder – end stage	Means: • the *diagnosis* of any of the following: – end stage liver failure with permanent jaundice and presenting with ascites or encephalopathy; – end stage renal failure with chronic irreversible failure of both kidneys that needs permanent dialysis or renal transplantation; – end stage lung disease requiring permanent supplementary oxygen, confirmed by a *medical specialist*; – end stage chronic obstructive pulmonary disease (COPD) with a persistent FEV1 less than 30% predicted or DLCO less than 40% predicted (according to current Thoracic Society of Australia and New Zealand treatment guidelines) measured on two separate occasions at least three months apart while on optimal therapy; or • being required to be placed on an Australian waiting list to receive a transplant of a heart, kidney, liver, lung, pancreas, small bowel, or bone marrow as confirmed by a *medical specialist*.

Appendix B – Term Definition

Appendix B Term	Definition
Activities of Daily Living	The Activities of Daily Living are: • bathing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means; • dressing – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances; • feeding – the ability to feed yourself when food has been prepared and made available; • toileting – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function; and • mobility – the ability to get out of bed into an upright chair or wheelchair and back again.
Carcinoma In Situ	Means a cancer *diagnosed* as carcinoma in situ or which is classified as FIGO Stage 0, or which has a TNM classification as Tis.
Diagnose, Diagnosed, Diagnosis, Diagnosing	Means unequivocal diagnosis by a suitable and appropriate *medical specialist*.
Limb, Limbs	Means an entire hand or an entire foot.
Health Professional	Means a recognised health professional registered with the Australian Health Practitioner Regulation Agency (or, a medical registration body in another country recognised as equivalent to the Australian Health Practitioner Regulation Agency).
Permanent Neurological Deficit	Means dysfunction of the nervous system that is present on clinical examination and the prognosis is that it will last throughout life. Examples of dysfunction include impairment to: • motor function (due to hemiplegia, monoplegia, hemiparesis, monoparesis, paralysis, lack of co-ordination, tremors, numbness or localised weakness); or • communication (due to dysarthria, aphasia, dysphagia). The following are excluded: • an abnormality seen on brain or other scans without definite related clinical symptoms; • neurological signs occurring without symptomatic abnormality, for example brisk reflexes without other symptoms; and • symptoms of psychological or psychiatric origin.
Major Cancer Treatment	Means any of the following as the necessary and appropriate treatment to arrest the spread of malignancy of a cancer: • surgery to remove the entire prostate to treat prostate cancer; • surgery to remove all breast tissue to treat breast cancer (including where performed with nipple and skin sparing surgery) to treat breast cancer; • breast conserving surgery accompanied by adjuvant therapy (such as radiotherapy and/or chemotherapy). The surgery and treatment must be undertaken specifically to arrest the spread of malignancy, and be considered the appropriate and necessary treatment as confirmed by an appropriate specialist doctor; • radiotherapy; or • chemotherapy.

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