MetLife

Group Income Protection Insurance

Supplementary Product Disclosure Statement

Preparation Date: 1 July 2019

The Supplementary Product Disclosure Statement ('SPDS') supplements information contained in the Combined Product Disclosure Statement and Policy Document ('PDS'), date issued 4 September 2017. This SPDS (prepared on 1 July 2019) is issued by MetLife Insurance Limited (MetLife) (ABN 75 004 274 882, AFSL No 238096), who is the issuer of the life insurance policy referable to Group Income Protection Insurance. MetLife takes full responsibility for the entirety of this SPDS. This SPDS must be read in conjunction with the PDS.

This SPDS has been issued to inform you of the following important amendments to the PDS as a result of replacing FOS with the Australian Financial Complaints Authority, and replacing Department of Immigration and Citizenship with Department of Home Affairs. This SPDS will apply to the Group Income Protection Insurance policies issued on or after the date of this SPDS.

1. Replace FOS with the Australian Financial Complaints Authority

1.1 In the section **"Our Contact details"** on page 6, replace the section headed **"Complaints resolution"** with the following:

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: auservices@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.

1.2 Replace section **"15. Complaints"** with the following:

"*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

GPO Box 3,
Melbourne VIC 3001
Phone: 1800 931 678

Email: info@afca.org.au
Online: www.afca.org.au

2. Replace Department of Immigration and Citizenship with Department of Home Affairs

2.1 In the table under section **"9.1 When cover will end for an insured person"**, row 11 (not including the header row) of the table is deleted and the following is inserted in the table in its place:

ceases to hold temporary work visa approved by the Department of Home Affairs (or any department that replaces it) and approved by *us*	the date the visa expires.

2.2 Replace section **"16. Definitions – Australian resident"** with the following:

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 Department of Home Affairs (or any department that replaces it); or b) is a citizen of New Zealand and the holder of a *Special Category Visa* while residing in Australia indefinitely.

Important contact information

Should you have any questions or concerns about your policy, please contact MetLife on 1300 555 625.

Group Income Protection Insurance

Combined Product Disclosure Statement and Policy Document

Issue Date: 4 September 2017

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

MetLife

Navigating life together

About MetLife

MetLife provides group insurance and individual life insurance products.

In Australia, MetLife is a specialist provider of life and income protection insurance. Since its entry into the Australian market in 2005, MetLife has grown its group insurance market share, doubling the size of its group business. This product is issued and underwritten by MetLife Insurance Limited.

The other members of the MetLife Group do not issue, guarantee or underwrite this product.

Globally, the MetLife companies reach more than 90 million customers throughout Asia-Pacific, the Americas and Europe. The MetLife companies include the number one life insurer in the United States (based on policies inforce), with close to 150 years of experience and relationships with more than 90 of the top 100 FORTUNE 500® companies in the United States.

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 Product Disclosure Statements (for non-superannuation policies) in deciding whether to acquire these other products.

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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* 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,
- *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 terms and conditions to understand the insurance provided (including the terms, exclusions and limitations that may apply to *your* cover).

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 by calling *us* on 1300 555 625.

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

About this document

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 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.

The booklet does not 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.

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 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, following assessment of any information that *we* may reasonable require, including medical information such as doctor's reports, mandatory blood tests and/or medical examinations.

When *we* underwrite a person for cover, *we* may 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.

For formula based cover and 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.

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.

Forward underwriting limits

We may offer *forward underwriting limits* 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* 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.

General information

Your duty of disclosure

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.

Our Privacy Statement

We collect, use and retain personal information in accordance with the Australian Privacy Principles and 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.

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, 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.

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*.

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.

However, *you* cannot return the product if *you* have exercised rights or powers under the product (for example, if *you* have made a claim). If *you* cancel the policy within the cooling off period *we* will refund *your* premiums less:

- the reasonable administrative and transaction costs (including taxes and duties) *we* have incurred in setting up the policy; and
- that proportion of the premium which relates to cover provided before *we* received *your* notice.

If *you* cancel the policy after the cooling off period, *we* will retain the portion of premium which relates to the cover that was provided before *we* received *your* written notice.

Our contact details

How to contact us

MetLife Insurance Limited
Level 9, 2 Park Street, Sydney NSW 2000
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: auservices@metlife.com

or write to:

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

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

Telephone: 1800 367 287
Email: info@fos.org.au

or write to:

The General Manager
Financial Ombudsman Service
GPO Box 3, MELBOURNE VIC 3001

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*	50*
Who can obtain cover?	Generally *Australian residents* or holders of a temporary work visa approved by *us* aged up to 64. The person will also need to satisfy any other eligibility conditions chosen by *you* and agreed to by *us*.
Minimum entry age	15
Maximum entry age	64
Maximum insurable age	70**
Waiting period options	30, 60 and 90 days
Benefit period options	2 years, 5 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 12 consecutive months or less, and • *casual employees*.
Maximum monthly benefit	$30,000 (75% of first $480,000 of annual income inclusive of the *Superannuation contribution benefit*)*** 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 of 3%)
Minimum premium (excluding any adviser remuneration and Government charges, taxes and levies)	$10,000 per annum
Insured percentage	Up to 75%
Superannuation contribution benefit (SCB)***	Up to 10%
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.

**We* have the discretion to accept a lower number

**As agreed by *us*

***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.	3
Increasing benefits (Escalation benefit)	*We* may increase the *disability benefits* paid to an *insured person* to keep up with inflation every 12 months.	3
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*.	8
24 hour worldwide cover	*We'll* provide cover for an *insured person* 24 hours a day while they are overseas. Some conditions apply.	11
Cover while on leave without pay (Leave of absence)	*We'll* continue to provide cover while an *insured person* is on approved leave.	11
Interim accident cover	Provides interim cover for up to 90 days while an *insured person* or *eligible person* is being underwritten.	14
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.	16
Waiver of premium	Premiums are waived while an *insured person* is receiving a benefit.	17
Guaranteed renewable	*We'll* guarantee to renew the policy each year provided the premiums are paid and the terms and conditions of the policy are met.	19
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.	25
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 to formula based cover and where the policy covers 50 or more *insured persons*.	

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*.	4
Crisis benefit	Provides a lump sum benefit if an *insured person* suffers one of the 35 listed *crisis benefit medical conditions*.	4
Specific injury benefit	Provides a benefit if an *insured person* suffers one of the *specific injury events*.	6
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*.	6
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*.	6
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*.	6
Cover beyond age 65	Provides cover beyond age 65 up to a maximum age of 70. Some conditions apply.	12
Continuation option	An *insured person* may be able to continue their cover once their employment ceases with *you*.	13

Disability definitions

There are two types of *total disability* definitions that can apply. The *total disability* definition that will apply in the event of a claim will depend on the average number of hours worked per week by the *insured person* prior to the *date of disablement* as shown in the table below.

Insured Person	Definition
Worked on average a minimum of 15 hours in a normal working week in the three months immediately prior to the *date of disablement**	*Total disability standard definition*
Worked on average less than 15 hours in a normal working week in the three months immediately prior to the *date of disablement**	*Total disability restricted definition*

*Where the *insured person* has been *employed* for less than 3 months, their weekly working hours will be averaged over their period of *employment*

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Group Income Protection Insurance (Ordinary)

Policy Document

MetLife

Navigating life together

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 "**How to read this policy**" that contains some rules that explain how the policy is intended to be read.

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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*.	*We'll* pay *you* a benefit if an *insured person* is *partially disabled*.

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*, less any amount of *other disability income*. 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* but only to the extent that it exceeds 75% of the *insured person's pre-disability income*.
Partial disability benefit	*We'll* pay *you* the amount determined by the formula below, less any amount of *other disability income*. $\frac{\textit{pre-disability income} - \textit{return to employment income}}{\textit{pre-disability income}} \times \textit{monthly benefit}$ The *partial disability benefit* will be reduced by *other disability income* if: • the benefit payable, plus • the *other disability income*, plus • the *return to employment income*, exceeds 100% of the *insured person's pre-disability income* but only to the extent that it exceeds 100% of the *insured person's pre-disability income*.

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 1/30th of the *monthly benefit* for each day the benefit is 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*,
- death of the *insured person*,
- *insured person* reaches the *maximum insurable 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 **6.4 Cover beyond age 65** if the *insured person's maximum insurable 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*.

1.5 Recurrent disability

If *disability* recurs within six months from the date the *insured person* ceased to be *disabled* 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.

1.6 Death benefit

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

- *disability benefit*,
- *nursing care benefit*,
- *crisis benefit* except if the date of death is within three months of a *crisis benefit* being payable, or
- *specific injury 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 after their 65th birthday, this benefit cannot exceed $30,000.

1.7 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,
- 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* approve.

1.8 Escalation benefit

We may increase the *disability 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* 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.

1.9 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*, and
- *accommodation 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:

- not exceed the *maximum monthly benefit* when combined with the *disability benefit*,
- 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*.

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.

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*
- if the *insured person* is over age 65, the lesser of:
  - the *monthly benefit*, 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 A. The definitions use medical terms because they are necessary to describe the precise symptoms, procedures and/or diagnosis.

Crisis Benefit Medical Condition	
Accidental HIV Infection*	Loss of Limbs
Alzheimer's Disease	Loss of Limbs and Sight of One Eye
Aplastic Anaemia	Loss of Speech
Bacterial Meningitis	Major Head Trauma
Benign Brain Tumour*	Major Organ Transplant*
Blindness	Motor Neurone Disease
Cancer*	Multiple Sclerosis
Cardiomyopathy	Muscular Dystrophy
Chronic Liver Failure	Occupationally Acquired Hepatitis B or Hepatitis C Infection*
Chronic Renal Failure	Parkinson's Disease
Chronic Respiratory Failure	Pneumonectomy (Removal of the lung)
Coma	Primary Pulmonary Hypertension *
Coronary Artery Angioplasty Multiple Vessel* (or Triple Vessel Coronary Artery Angioplasty)	Severe Burns
Coronary Artery By pass Surgery*	Stroke*
Heart Attack*	Surgery to Aorta*
Heart Valve Surgery*	Terminal Illness*
Loss of Hearing	Viral Encephalitis
Loss of Independence	

*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 or had been diagnosed for the condition that they are claiming before cover started for them under this policy,
- suffers the condition identified with an * in the above table in the first 90 days after cover starts for them under this policy except where *we* agree otherwise as part of *our* takeover cover terms,
- 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.

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)	2 Months
Shoulder blade	2 Months
Leg (above the foot)	2 Months
Kneecap	2 Months
Elbow	2 Months
Forearm, between wrist and elbow (shaft)	2 Months
Collarbone	1.5 Months

The amount of the benefit will be equal to the sum of the *total disability benefit* and the *superannuation contribution benefit*. It is also paid from the date the *specific injury event* occurs and can be paid during the *waiting period*.

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 *maximum insurable 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 *maximum insurable 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* or *family care 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 *maximum insurable 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 *confined to bed* (other than the *insured person's* home of residence) provided the *insured person*:

- is *totally disabled*,
- is *confined 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.

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 subject to the terms of the policy.

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.

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*,
- at least 15 years of age and under the *maximum entry age*, and
- not entitled to receive *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.

3.4 Underwritten cover

An *eligible person* who:

- is not eligible for cover under automatic acceptance, or
- seeks cover above the cover they obtained under automatic acceptance,

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, *we* may:

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 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*, 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. 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 shorter 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* as the "incoming insurer." If there is any inconsistency between the terms and conditions of this policy and *FSC Guidance Note 11*, the policy terms and conditions prevail to the extent of the inconsistency,
- where the *benefit period* was longer under the *previous policy* or *we* are unable to provide an equivalent *waiting period* that was provided under the *previous policy*, *we* will only apply *FSC Guidance Note 11* 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*, *we* may agree to apply alternative takeover terms,
- the *waiting period* that applied under the *previous policy* will continue to apply under this policy. 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, and
- any individual conditions, exclusions or restrictions that applied to the 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.

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 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*.

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*:

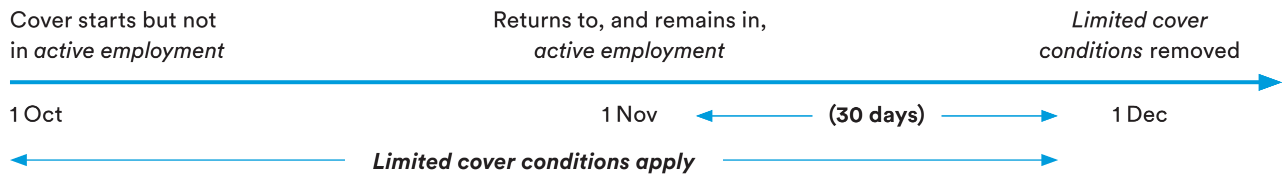
- is first given advice, care or treatment or recommended that they seek advice, care or treatment for the illness or injury, by a *medical practitioner*, and
- first had any symptom of the illness or injury for which a reasonable person in the same circumstances would have sought advice, care or treatment 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 or the date their *standard cover* increases due to a change in the benefit design.	*Limited cover conditions* apply 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* for *standard cover* and the *automatic acceptance limit*.
Underwritten cover	The amount of cover that has been accepted.
Takeover cover	The nearest amount of cover that which applied under the *previous policy* (unless the *policy schedule* states otherwise), but not exceeding the maximum 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*.

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.

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

6. Extent of cover

6.1 Disability definitions

There are two types of *total disability* definitions that can apply. The *total disability* definition that will apply in the event of a claim will depend on the average number of hours worked per week by the *insured person* prior to the *date of disablement* as shown in the table below.

Insured Person	TPD Definition
Worked on average a minimum of 15 hours in a normal working week in the three months immediately prior to the *date of disablement**	*Total disability standard definition*
Worked on average less than 15 hours in a normal working week in the three months immediately prior to the *date of disablement**	*Total disability restricted definition*

*Where the *insured person* has been *employed* for less than 3 months, their weekly working hours will be averaged over their period of *employment*.

Example

The *total disability* definition may change when an *insured person's* hours change. For example, if a person's average hours worked in a normal week over a three month period changes from more than 15 hours to less than 15 hours they will no longer be eligible for the *total disability standard definition* and will only be able to claim under the *total disability restricted definition*.

6.2 Worldwide cover

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

- is not an *Australian Resident*, (including a holder of a temporary work visa approved by *us*), and
- is temporarily *employed* overseas,

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

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

We may require an *insured person* to return to Australia at their expense for assessment of a claim. 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, at our discretion, 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, 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.

6.3 Leave without pay

If an *insured person* is given a *leave of absence*, *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 leave in writing before the *insured person* goes on leave, and
- premiums continue to be paid for the *insured person* during their *leave of absence*.

If the *insured person* will be on *leave of absence* 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.

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

- *leave of absence* ceases and they do not return to their *employment*,
- *leave of absence* 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 *leave of absence* and becomes eligible for a 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.

6.4 Cover beyond age 65

If the *maximum insurable* age stated in the *policy schedule* is greater than age 65, the following will apply.

2 year or 5 year Benefit Period

Where the *maximum insurable* age is greater than 65, an *insured person* with a *benefit period* of 2 years or 5 years will have their cover continue from age 65 up to the *maximum insurable age* if they have not previously claimed under this policy or any other life insurance policy on the following basis:

Age at Disability	Cover conditions
If the *date of disablement* is before 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* cannot exceed $10,000 per month for benefits that are paid after the *insured person's* 65th birthday.
If the *date of disablement* is on or after 65th birthday	The *disability benefit* will be paid until the earliest of: • 2 years, or • the *insured person* turning age 70.* The *disability benefit* 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 from age 65 with a *benefit period* of 2 years if they have not previously claimed under this policy or any other life insurance policy on the following basis:

Age at Disability	Cover conditions
If the *date of disablement* is before 63rd birthday	The *disability benefit* will be paid until the *insured person* turns age 65.*
If the *date of disablement* is on or after 63rd birthday	The *disability benefit* will be paid until the earliest of: • 2 years, or • the *insured person* turning age 70.* The *disability benefit* 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, then when an *insured person's* cover under this policy ends 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:

- have been covered under this policy,
- be under age 60 when they apply for the Continuation Option,
- be an *Australian Resident*,
- no longer be *employed* or engaged by the *employer*,
- not be leaving *employment* 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 ending,
- not be joining any military forces (other than the Australian Armed Forces Reserve and is not on active duty outside Australia),
- not be entitled to any benefit under this policy or another policy issued by *us*,
- meet *our* standard minimum requirements for a new individual policy at that time including *our* occupation and pastimes underwriting requirements, 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:

- the *waiting period* not being shorter, and the *benefit period* not being longer than those that applied when they ceased cover under this policy,
- the amount of cover under the individual policy is no more than the cover that applied when they ceased cover under this policy, and
- the individual policy having the same exclusions and loadings that applied when they ceased cover 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 cover* 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, and
- the *insured percentage* of the person's *pre-disability income* plus *superannuation contribution benefit* (if applicable),

less any amount of *other disability income* and *return to employment income* as described in section **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 when:

The *insured person*…	Cover ends on…
reaches the *maximum insurable age*	the date they reach the *maximum insurable 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.
tells *you* in writing that they want to cancel their cover	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 temporary work visa approved by *us*, 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**).
no longer meets the conditions under section **6.2 Worldwide cover** for cover while temporarily *employed* overseas	the date the person no longer meets the conditions for cover to continue while *employed* overseas under section **6.2 Worldwide cover**.
no longer meets the conditions under section **6.3 Leave without pay** for cover during *leave of absence*	the date the person no longer meets the conditions for cover to continue when on leave without pay under section **6.3 Leave without pay**.
where premiums have not been paid within 30 days of the *premium due date*	30 days after the *premium due date*.
ceases to hold a temporary work visa approved by the Department of Immigration and Citizenship and approved by *us*	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* to transfer the cover of all *insured persons* to the new policy. Where there are inconsistencies between *FSC Guidance Note 11* and this policy, this policy will be used.

9.3 Reinstating cover

Cover which has ceased can only be reinstated if *we* agree to reinstate the cover in writing.

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 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**.

10. Claims

10.1 When to tell us about a claim

You must tell *us* as soon as possible if *you* become aware of a claim or potential claim. If *you* or the *insured person* delay telling *us* and that prejudices *our* interests, *we* may reduce the benefit or not pay the claim. *Our* interests include the ability to obtain the evidence *we* require or would have obtained for the period of the illness or injury.

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* 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 program* 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 or non-invasive tests that *we* believe are necessary, *we*:

- have the discretion to appoint a *medical practitioner* or other health professional of *our* choosing, 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, 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 Illegible and foreign language evidence

We require all evidence to be legible and in English.

Therefore, *we* may require *you* to have evidence:

- transcribed into a form in which can be comprehended in English, and
- appropriately certified to be a true copy of the original.

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.

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* 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 options available for adjustments in premiums. The option that applies to *your* policy will be stated in the *policy schedule*.

Option 1

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

- a proportion 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 proportion of the premium for new *insured persons* joining this policy during the previous year from the date of membership to the current *annual review date*.
- a proportion 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*.

Option 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 person's* at the previous *annual review date*.

S2 is the amount of cover for all *insured person's* 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, 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.

11.4 Minimum annual premium amount

We reserve the right to apply a minimum annual premium amount by giving *you* 30 days written notice. Such minimum annual premium will become payable from the next *annual review date* 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 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.

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* opinion, to a major change in the risk insured by this policy.

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.

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 or attempt at suicide.

13.3 Normal pregnancy

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 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

Despite anything else in this policy, neither *you* nor *us* will be required to provide any premium, benefit, cover or payment under this policy where doing so would violate any laws or regulations.

14. Policy owner information

14.1 Policy term

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

- two months after *we* receive *your* written request to cancel this policy, but no sooner than the end of the *premium guarantee period*,
- 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.

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.

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:

- any transaction,
- 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 within 45 days, the *insured person* may contact the Financial Ombudsman Service for help.

Financial Ombudsman Service
Phone: 1800 367 287 **or** (03) 9613 7366
Write to: GPO Box 3, MELBOURNE VIC 3001

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 in *our* opinion 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 Department of Immigration and Citizenship; or (b) is a citizen of New Zealand and the holder of a *Special Category Visa* while residing in Australia indefinitely.
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.
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 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 **1.6 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*.
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**.
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*.
insured percentage	The "Insured Percentage" stated under "Insured Cover" in the *policy schedule*.
insured person	An *eligible 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.
leave of absence	Any period of absence by the *insured person*, unpaid, that has been approved by the *employer* in writing prior to such absence.

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*.
maximum insurable age	The maximum age for which a person can hold *insured cover*. The *maximum insurable age* is shown in the *policy schedule*.
maximum monthly benefit	The maximum amount payable each month inclusive of any superannuation contribution and any indexation, as identified in the *policy schedule* or otherwise stated in this policy.
medical practitioner	A person, accepted by *us*, 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 or sibling.
medical specialist	A *medical practitioner* with a qualification awarded by, or which equates to that awarded by, the relevant specialist professional college in Australia to treat certain conditions.
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 (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*, • any amounts payable: – through workers compensation or any similar legislation or any settlement under common law, – sick leave, – in respect of loss of income (whether legislated or otherwise), – under any statutory accident compensation scheme, – any *disability*, injury or illness policy (other than lump sum TPD). 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	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 – working in another occupation, • is earning a *return to employment income* which is less than their *pre-disability income*, and • is under the regular care and following the advice 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 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*. This will not include any *income*, or portion of *income*, that continues while the *insured person is disabled*.
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.
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.
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 expenses benefit	A benefit payable as described in section **1.7 Retraining expense benefit**.
return to employment income	The amount of **income** the *insured person* has received during the month that *we* are paying a *partial disability 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 or • *employment* assistance. The cost of any *return to work program we* require an *insured person* to undertake will be met by *us*.
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 actual average monthly compulsory *employer* superannuation entitlement the *insured person* benefited from in the 12 month period prior to the *date of disablement*.
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**.
totally disabled/total disability	**Standard Definition** For an *insured person* who has been working on average a minimum of 15 hours in a normal working week in the three months (or where the *insured person* has been employed for less than three months, over their period of *employment*) immediately prior to the *date of disablement*: *Total disability* means 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 and following the advice of a *medical practitioner*, and • not working in any *occupation*, whether paid or unpaid.

totally disabled/total disability / continued

Restricted Definition

For an *insured person* who has been working on average less than 15 hours in a normal working week in the three months (or where the *insured person* has been employed for less than three months, over their period of employment) immediately prior to the *date of disablement*:

Total disability means the *insured person* solely as a result of illness or injury occurring while the policy is in force is:

- under the regular care and following the advice of a *medical practitioner*,
- not working in any *occupation*, whether paid or unpaid, and
- in *our* opinion, is totally unable to perform (with or without aids or adaptations) at least 2 of the following activities of daily working:
  - **Walking**: they cannot walk more than 200 metres on a level surface without stopping due to breathlessness, angina or severe pain elsewhere in the body,
  - **Rising/Sitting**: they are unable to rise and sit using a raised chair with arms without the help of another person,
  - **Dexterity**: they are unable to write legibly with a pen or pencil or use a keyboard with either hand
  - **Communication**: they cannot
    (i) clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room in their first language, or
    (ii) understand simple messages in their first language, or
    (iii) speak with sufficient clarity to be clearly understood in their first language;
  - **Eyesight**: their visual ability is reduced to the extent that functional abilities are affected and independent functioning without physical assistance from another person in a workplace is impossible, even with the use of assistive devices.

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.

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:

- the *insured person* must be *totally disabled* for at least 7 out of 12 consecutive days of the waiting period to qualify for a *disability benefit*,
- if the *insured person* returns to work at full capacity during the *waiting period*:
  - 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, otherwise the waiting period starts again.

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 Level 9, 2 Park Street, Sydney, New South Wales.

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. *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 if less, 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* over the previous 12 months prior because of the personal exertion of the *insured person*. Income will not include investment income, profit distributions 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
Accidental HIV Infection	Infection with the Human Immunodeficiency Virus (HIV) where it was acquired as a result of an accident and seroconversion to HIV infection occurs within six months of the accident. Any accident giving rise to a potential claim must be reported to *us* and supported by a negative HIV Antibody test taken after the accident. This does not include any disease or injury associated with AIDS or HIV virus acquired as a result of sexual activity or recreational intravenous drug use.
Alzheimer's Disease	The unequivocal diagnosis of Alzheimer's (pre-senile dementia) Disease by a consultant neurologist confirming Alzheimer's due to failure of brain function with significant cognitive impairment for which no other recognisable cause has been identified. Significant cognitive impairment means deterioration in the *insured person's* mini mental state examination, or equivalent thereof, scores to 20 or less, with the test administered or confirmed by neurologist or appropriate specialist.
Aplastic Anaemia	Acquired permanent bone marrow failure that results in anaemia, neutropenia and thrombocytopenia requiring treatment by at least one of the following: • blood production transfusion, • marrow stimulating agents, • immunosuppressive agents, or • bone marrow transplantation.
Bacterial Meningitis	The diagnosis of the *insured person* with Bacterial Meningitis. The meningitis must produce neurological deficit causing permanent and significant functional impairment. Significant means at least a 25% impairment of whole person function as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Diagnosis must be confirmed by a consultant neurologist. Bacterial Meningitis in the presence of HIV is excluded. All other forms of meningitis including viral, are excluded.
Benign Brain Tumour	The diagnosis of a non-malignant tumour of the brain or spinal cord. Confirmed by appropriate specialist (neurologist or neurosurgeon) and imaging studies such as CT or MRI scans. Resulting in permanent symptoms or signs leading to at least 25% impairment of whole person function as defined in Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Cysts, granulomas, cholesteatomas, malfunctions in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are excluded.
Blindness	As a result of disease or accident the permanent loss of the sight in both eyes such that the: a) visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes, or b) field of vision is constricted to 20 degrees or less of arc around central fixation in the better eye irrespective of corrected visual activity (equivalent to 1/100 white test object), or c) combination of visual defects results in the same degree of vision impairment as that occurring in (a) or (b) above.
Cancer	The presence of one or more malignant tumours including Hodgkin's disease, leukaemia and other malignant bone marrow disorders, and is characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue of different histological type. The following classifications are not covered under this definition: • pre-malignant, • non-invasive, • high-grade dysplasia, • carcinoma in situ, • having borderline malignancy or low potential, or • any other skin cancer.

Cancer / continued	The following diagnoses are covered under this definition: • Malignant tumours of the prostate with any one of the following characteristics: – a Gleason score of at least 7, or – having progressed to at least TNM classification T2, or – having progressed to at least TNM classification T1 and where prostatectomy is considered medically necessary to arrest malignancy; • Carcinoma in situ of the breast where a mastectomy (removal of the entire breast with or without nipple and skin sparing surgery) is required and considered medically necessary; and • Malignant Melanoma having any one of the following characteristics: – Breslow thickness of at least 1.5mm, or – evidence of ulceration.
Cardiomyopathy	Permanent and irreversible impairment of ventricular function as confirmed by a cardiologist to the degree of the New York Heart Association classification Class III where there is an ejection fraction of <45%.
Chronic Liver Failure	End stage liver failure, together with two of the following conditions: • permanent jaundice, • ascites, or • hepatic encephalopathy.
Chronic Renal Failure	End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is instituted.
Chronic Respiratory Failure	End stage lung disease with a consistent pulmonary function test result of FEV1 less than 40% predicted and requiring permanent oxygen therapy.
Coma	A state of unconsciousness with no reaction to external stimuli or internal needs, 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 96 hours.
Coronary Artery Angioplasty Multiple Vessel (or Triple Vessel Coronary Artery Angioplasty)	Angioplasty of the coronary arteries (with or without the insertion of a stent, laser therapy or atherectomy) to three or more coronary arteries within the same surgical procedure or within two procedures done no more than two months apart. Angiographic evidence, indicating at least 50% obstruction of three or more coronary arteries, is required to confirm the need for this procedure. In the opinion of an appropriate consultant *medical specialist*, the treatment must be required on medical grounds and must be the most appropriate treatment.
Coronary Artery By Pass Surgery	Coronary artery bypass graft surgery performed in an open heart operation or by key-hole surgical technique for coronary artery disease causing inadequate myocardial blood supply but does not include laser therapy, angioplasty or any other intra-arterial procedure.
Heart Attack (Myocardial Infarction)	The death of a portion of the heart muscle as a result of inadequate blood supply. The diagnosis must be confirmed by a cardiologist and evidenced by typical rise and/or fall of cardiac biomarker blood test with at least one level above the 99th percentile of the upper reference limit plus any one of the following: • acute cardiac symptoms and signs consistent with myocardial infarction (e.g. chest pain); • new serial ECG changes with the development of any of the following: – ST elevation or depression, – T wave inversion, – pathological Q waves or – left bundle branch block (LBBB); or • imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. If the above is inconclusive then if three months after the heart attack is diagnosed the *insured person's* left ventricular ejection fraction is less than 50%, then the definition will be met. The following are not covered: • a rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease, and • other acute coronary syndromes including but not limited to angina pectoris.

<table>
<tr><td>Heart Valve Surgery</td><td>The actual undergoing of a procedure to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities occurring after the commencement date or last reinstatement date of your policy.
Valvotomy is specifically excluded.</td></tr>
<tr><td>Loss of Hearing</td><td>Complete and irrecoverable loss of hearing in both ears which cannot be corrected or improved with treatment or assistive devices, as a result of injury or sickness, as certified by an appropriate medical specialist with objective testing.</td></tr>
<tr><td>Loss of Independence</td><td>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**. The condition should be confirmed by a consultant physician.
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 protect himself or herself as measured by clinical evidence and standardised tests which reliably measure the impairment in the following areas:
• short or long term memory,
• orientation as to person (such as personal identity), place (such as location) and time (such as day, date and year), and
• deductive or abstract reasoning.
or
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.

**Activities of Daily Living means:
• Bathing: the ability to wash themselves either in the bath or shower or by sponge bath without the assistance of another person. The insured person will be considered to be able to bathe themselves even if the above tasks can only be performed by using equipment or adaptive devices.
• Dressing: the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten and unfasten them without the assistance of another person. The insured person will be considered able to dress themselves even if the above tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.
• Eating: the ability to feed themselves once food has been prepared and made available, without the assistance of another person.
• Toileting: the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing without the assistance of another person. The insured person will be considered able to toilet themselves even if he or she has an ostomy pouch/bag and is able to empty it himself or herself, or if the insured person uses a commode, bedpan or urinal, and is able to empty and clean it without the assistance of another person.
• Transferring: the ability to move in and out of a chair or bed without the assistance of another person. The insured person will be considered able to transfer themselves even if equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorised devices are used.</td></tr>
<tr><td>Loss of Limbs</td><td>The total and permanent loss of the use of two limbs as a result of injury or disease.</td></tr>
<tr><td>Loss of Limb/s and Sight of One Eye</td><td>The total and irrecoverable loss by the insured person of the:
• use of both hands, or
• use of both feet, or
• use of one hand and one foot, or
• use of one hand and the sight of one eye, or
• use of one foot and the sight of one eye.</td></tr>
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<tr><td>Loss of Speech</td><td>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 not less than three months after the ability to speak was first lost.</td></tr>
<tr><td>Major Head Trauma</td><td>As a result of an Accident, a traumatic brain injury resulting in permanent neurological deficit, causing at least 25% impairment of whole person function (lasting more than six weeks from the date of the trauma) as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Diagnosis must be certified by a consultant neurologist.
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.</td></tr>
<tr><td>Major Organ Transplant</td><td>The human to human organ transplant from a donor to that person of one or more of the following organs:
• kidney,
• heart,
• lung,
• liver,
• pancreas,
• small bowel, or
• the transplantation of bone marrow.
This treatment must be considered medically necessary and the condition affecting the organ deemed untreatable by any other means other than organ transplant, as confirmed by a medical specialist.
The transplantation of any other organ, only part of an organ, or any other tissue transplants is excluded from this definition.</td></tr>
<tr><td>Motor Neurone Disease</td><td>The unequivocal diagnosis of Motor Neurone Disease, certified by a consultant neurologist, with significant persistent neurological deficit resulting in a permanent inability to perform two or more of the activities of daily living, bathing, dressing, toileting, eating and taking medication resulting in a requirement for continual supervision to protect the insured person suffering the disease or others.</td></tr>
<tr><td>Multiple Sclerosis</td><td>A disease characterised by demyelimination of nervous tissue. The diagnosis has to be made by a consultant neurologist confirming:
• more than one episode of well- defined neurological deficit with persisting neurological abnormalities, and
• with permanent impairment of at least 25% of function although the person suffering the disease need not necessarily be confined to a wheelchair.
The diagnosis will be based on confirmatory neurological investigations, e.g. lumbar puncture, evoked visual responses, evoked auditory responses and MRI (Magnetic Resonance Imaging) evidence of lesions of the central-nervous system.</td></tr>
<tr><td>Muscular Dystrophy</td><td>The unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist resulting in a permanent impairment.</td></tr>
<tr><td>Occupationally Acquired Hepatitis B or Hepatitis C Infection</td><td>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;</td></tr>
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Occupationally Acquired Hepatitis B or Hepatitis C Infection / continued	• 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	The unequivocal diagnosis by a consultant neurologist of idiopathic Parkinson's Disease (paralysis agitans) which is of a permanent nature and requires treatment with a dopamine precursor. All other types of Parkinsonism are excluded.
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 either a significant permanent physical impairment to the degree of at least Class III of the New York Heart Association classification of Cardiac Impairment or a pulmonary artery pressure of 25 mm Hg at rest or 30 mm Hg during physical activity.
Severe Burns	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns to any of the following: • 20% or more of the Body Surface as measured by the 'Rule of 9' or the Lund and Browder Body Surface Chart, • whole of both hands, requiring surgical debridement and/or grafting, or • whole of the head requiring surgical debridement and/or grafting.
Stroke	Death of brain tissue caused by one of the following: • ischaemic infarction of brain tissue, or • intracranial haemorrhage (cerebral, intraventricular or subarachnoid). The diagnosis must be supported by both of the following: • evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event, and • findings on MRI, CT or other reliable imaging evidence consistent with the diagnosis of a new stroke. The following are not covered: • transient ischaemic attacks, • cerebral symptoms due to migraine, and • vascular disease affecting the eye or optic nerve. Permanent neurological deficit with persisting symptoms means dysfunction in the nervous system that is present on clinical examiniation and expected to last throughout the *insured person's* life. It includes outcomes such as numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function. It does not mean: • an abnormality seen on brain or other scans without definite related clinical symptoms, • neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms, and • symptoms of psychological or psychiatric origin.
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	Severe inflammation of brain tissue which results in significant and permanent neurological impairment as certified by a consulting neurologist. Significant neurological impairment means at least 25% impairment of whole person function as defined in the Guides to the Evaluation of Permanent Impairment 5th edition, American Medical Association. Diagnosis as certified by a consultant neurologist. Encephalitis as a result of HIV infection is excluded.

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