Macquarie Life Active

Macquarie Life

Product Disclosure Statement jointly issued by:
Macquarie Life Limited ABN 56 003 963 773 AFSL 237 497
Macquarie Investment Management Limited ABN 66 002 867 003 AFSL 237 492
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FORWARD thinking

Important Information

This Product Disclosure Statement (PDS) contains important information about:
– an insurance product (an Active policy) issued by Macquarie Life Limited (Macquarie Life), and
– a superannuation interest issued by the trustee of the Macquarie Superannuation Plan (ABN 65 508 799 106), Macquarie Investment Management Limited (Trustee or MIML).

Both Macquarie Life and the Trustee take full responsibility for the whole PDS.

Macquarie Life and the Trustee are not authorised deposit-taking institutions for the purposes of the Banking Act 1959 (Cth), and their respective obligations do not represent deposits or other liabilities of Macquarie Bank Limited ABN 46 008 583 542. Macquarie Bank Limited does not guarantee or otherwise provide assurance in respect of the obligations of Macquarie Life or the Trustee.

Information contained in this PDS can change from time to time. If the change is not materially adverse, the updated information will be available on our website, macquarielife.com.au. A paper copy of any updated information will be given to you on request without charge.

An application for:
– an Active policy, or
– to join the insurance-only division of the Macquarie Superannuation Plan,

can be made via the electronic application available through Macquarie Life's online insurance platform or a current paper application form. It is important that you consider this PDS before completing the application form.

This PDS has been prepared by Macquarie Life and the Trustee and does not take into account your objectives, financial situation or needs. Before acting on this PDS you should consider whether it is appropriate to your objectives, financial situation and needs. We recommend you obtain financial, legal and taxation advice before making any financial investment decision.

Terminology used in this document

It is important to remember the following information and terminology when reading this document.

You may be covered under an Active policy that is owned by:
– a person or company (that is not a trustee of a superannuation fund),
– a person or company that is a trustee of a self managed superannuation fund, or
– Macquarie Investment Management Limited (MIML) as trustee of a superannuation fund.

Different terminology applies depending on how you are covered under an Active policy:

Policy owner	The person who is insured under the policy (insured person)	Terminology used in this document		
		"we", "our" or "us"	"you" or "your"	Policy is referred to as:
A person or company (that is not a trustee of a superannuation fund).	Either: – same person as the policy owner, or – a different person.	Macquarie Life	The policy owner (or, if the policy owner and the insured person are not the same, the insured person in relation to the person covered by the policy[1]).	Either: – being held outside superannuation, or – a non-superannuation policy.
A person or company who is a trustee of a self managed superannuation fund.	A member of the relevant self managed superannuation fund.	Macquarie Life	The policy owner (or member of the relevant self managed superannuation fund in relation to the person covered by the policy[1]).	Either: – being held within (or issued through) superannuation, or – a superannuation policy.
Macquarie Investment Management Limited (MIML) as trustee of a superannuation fund.	A member of an *eligible superannuation plan.*	In relation to the policy – Macquarie Life In relation to your membership of a superannuation plan – MIML.	The member of the *eligible superannuation plan* or insurance-only division of the Macquarie Superannuation Plan.	
	A member of the insurance-only division of the Macquarie Superannuation Plan.			

There are also some terms used which have a special meaning. These terms are shown in *italics* and are explained in the Glossary at the end of this PDS.

[1] For example, for Optional Income Cover, references to income are for the insured person's income.

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Active cover overview

The importance of insurance

Your life is full of promise and potential. All your hard work is building towards a bigger and brighter future for you and your family. It's a future that's worth protecting.

Life insurance helps you protect against the financial consequences of losing your most valuable asset – your health. It gives you the security of knowing that even if you get seriously ill or injured, you will have financial support to help you still achieve your long-term plans.

Why Active cover?

Active cover is a new style of life insurance that replaces a number of the traditional types of life insurance cover – allowing you to get more of the cover you need in one convenient package. And when you're insured by Active cover, you're covered 24 hours a day, anywhere in the world.

Unlike many other insurance policies, Active cover allows you to make multiple claims over the life of the policy. It also gives you broad coverage for a range of *Health Events,* and even if you suffer a medical condition that is not listed, you may be entitled to claim if the condition leads to a physical or mental impairment.

With a commonsense claims approach that's based on how serious your health or medical condition is, not on 'all or nothing' definitions, Active cover makes it easier for you to receive a benefit. Because that's what insurance should be all about.

The types of cover available are:

Types of available cover		For more detail see page:
Health Events	We will pay a lump sum on the occurrence of covered *Health Events*, such as heart attack, stroke, cancer, digestive conditions, psychiatric conditions and many others. The amount you receive depends on how serious the condition is. An important aspect of this cover is that we will pay a benefit if the *Health Event* meets the specific criteria set out under the policy and falls into one of the benefit categories. These benefit categories are found on page 43.	4 to 11
Death and terminal illness	We will pay a lump sum on diagnosis of a *terminal illness* or death.	4 to 11
Income Cover (optional)	We will pay a monthly amount for loss of work due to *illness* or injury that results in *disability* longer than the selected waiting period.	13 to 21
Child Cover (optional)	We will pay a lump sum if the insured child dies, is diagnosed with a *terminal illness* or suffers one of the covered *Child Cover Conditions.*	12

Choose the cover that suits you

Cover for *Health Events, terminal illness* and death are automatically included in your Active cover. You simply choose an *Initial Amount of Cover* based on how much insurance you need.

Income Cover and Child Cover are optional. You can indicate whether you want to include these in your Active cover when you apply.

A claims approach that makes sense

If you make a claim for a *Health Event* under your Active cover, the severity of your sickness or injury will determine how much we pay.

The more serious the *Health Event,* the larger the benefit, and if your health deteriorates further following a claim we may pay you another benefit.

The following tables provide a summary of the key features of Active cover.

Summary of the key features of Active cover	
When you can apply	You can apply for Active cover if you (or the insured person, if different) are aged between 15 and 65 (60 for some benefits) and for optional Income Cover if you (or the insured person, if different) are aged between 19 and 60. If you are applying for Child Cover, you can do this at any time while the child is between the ages of 2 and 14.
How long cover lasts	As long as you keep paying premiums, you can keep your cover to the following ages (of the insured person): ■ for life in respect of the death and *terminal illness* cover ■ age 99 for *Health Events* cover (although the definition of what is covered changes at age 70) ■ age 65 or 70 (depending on cover type) for Income Cover ■ Child Cover may be converted to a full policy prior to the child turning 21, otherwise cover will cease at 21
How much you can apply for	You can choose an *Initial Amount of Cover* to meet your needs, subject to the following limits: ■ for *Health Events* the cover can be from $100,000 to $3,000,000 ■ for death and *terminal illness* the minimum amount is equal to the amount of *Health Events* cover you have selected, however you can choose an amount higher than your *Health Events* cover with no maximum ■ for optional Income Cover the minimum is $1,250 per month and the maximum can be up to $40,000 per month for the first 2 years of the selected benefit period and $30,000 per month for the remainder of the benefit period ■ for optional Child Cover you can choose any amount between $10,000 and $250,000 for each child
Included features	As well as the benefits detailed above, your Active cover will automatically include the following features: ■ Claim Protector (*Health Events*) – protects your *Health Events* cover so that an amount of cover is left for future *Health Event* claims irrespective of past *Health Event* claims, subject to specified limits ■ Funeral Assistance – an advance payment of part of your death benefit to help meet funeral costs and other immediate expenses is made within two business days of us receiving the death certificate ■ Future Increases – allowing you to increase your cover, without the need for further medical questions or tests, after specified events occur that can impact your financial position (eg marriage or birth of a child) ■ Indexation Increases – your cover amount can automatically increase each year so it retains its value in line with inflation ■ Financial Planning – for some claims we will help fund financial advice so that you or your family can determine how to best structure your finances
Multiple claims	Your Active cover will not cease after a *Health Event* claim and will remain in place, allowing you to claim multiple times over the policy term subject to specified limits (see Claim Protector on page 9). For subsequent claims we will pay: ■ the difference in benefit severity for a deterioration of a condition for which a claim has been paid (see *Progressive Conditions* on page 7) ■ the difference in benefit severity for unrelated conditions that occur within the 12 month *Limited Claim Period* (see *Limited Claim Period* on page 8), or ■ the full benefit for unrelated conditions that occur outside the *Limited Claim Period* (see Subsequent claims under the policy on page 7)

How Active cover works

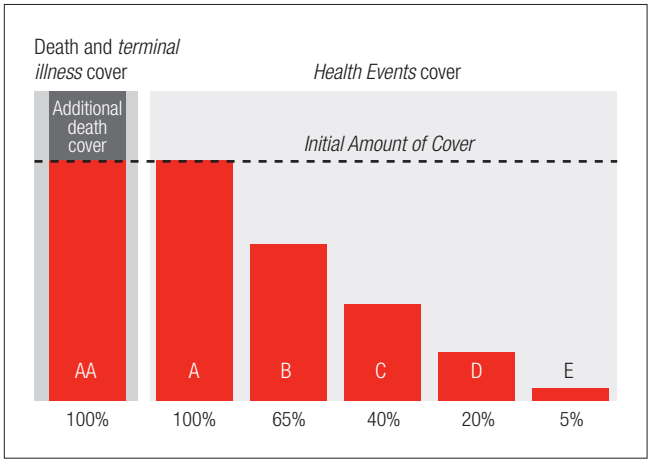
Health Events, terminal illness and death cover

When you apply for Active cover, you select the *Initial Amount of Cover* you want plus any optional additional death cover you need.

If you make a claim, the amount we will pay depends on the benefit category that your claim falls into, which is determined according to how serious the condition or event is.

The highest benefit category is for death and *terminal illness* (benefit category AA) and the cover is based on the *Initial Amount of Cover* plus any additional death cover that you choose to include. After that, the *Health Event* benefit categories range from A through to E (from most serious to least serious), with the cover based on a percentage of the *Initial Amount of Cover*, as shown in the table below.

Benefit category	Type of cover	Percentage of the *Initial Amount of Cover*
AA	Death and *terminal illness*	100%, plus any additional death cover purchased
A	*Health Events*	100% *(Initial Amount of Cover)*
B		65%
C		40%
D		20%
E		5%[1]



The amount we will pay may be reduced if it is not the first claim under the policy. See the section on "How we calculate the amount we will pay" on page 6.

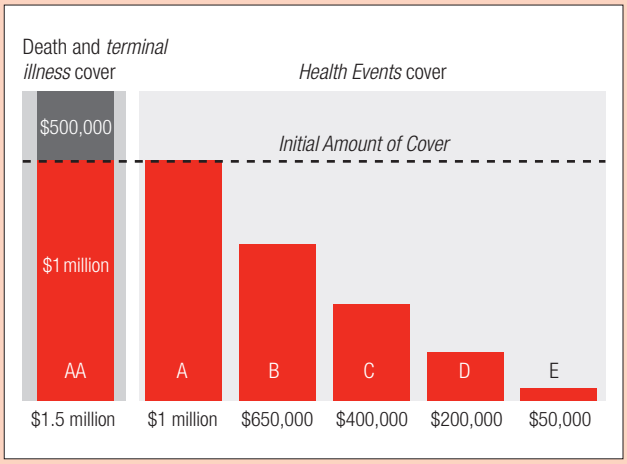
Examples

Throughout the PDS we will provide examples to show how Active cover works.

All examples are based on Active cover held by Michael, who is a 38 year old male.

Michael applied for an *Initial Amount of Cover* of $1 million plus $500,000 of additional death cover, which when issued provides the following levels of cover per benefit category:

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,500,000
A	*Health Events*	$1,000,000 *(Initial Amount of Cover)*
B		$650,000
C		$400,000
D		$200,000
E		$50,000



In the examples throughout the PDS, cover has been assumed not to have been increased due to *indexation*.

[1] If the *Initial Amount of Cover* is less than $200,000, benefit category E will be $10,000 and the percentage for benefit category E will be adjusted accordingly.

Health Events covered under the policy

The *Health Events* covered under the policy are summarised in the table below. We will pay a benefit if the *Health Event* meets the specific criteria set out under one of the benefit categories. If you suffer a medical condition that is not named in the list of *Health Events* your claim may be assessed under the *Health Event* category for the inability to perform activities of daily living. For the full list of *Health Events* and the benefit category that each *Health Event* falls within please refer to the *Health Events* section starting on page 43.

Body system	*Health Event* categories
Cancer	■ solid tumour cancers ■ lymphomas ■ brain tumours ■ leukaemias ■ other cancers (eg aplastic anaemia, multiple myeloma)
Heart and artery	■ heart attack ■ cardiomyopathy ■ other heart and artery conditions (eg severe congestive cardiac failure, severe peripheral vascular disease) ■ heart transplant ■ surgical procedures (eg coronary artery bypass graft, heart valve repair, endovascular iliac or femoral artery aneurysm repair)
Brain and nerves	■ stroke ■ cognitive conditions (eg diagnosis of dementia including Alzheimer's disease) ■ coma ■ surgical procedures and events (eg endovascular treatment of a cerebral aneurysm, stereotactic brain surgery) ■ other brain and nerve conditions (eg psychiatric conditions, severe epilepsy, multiple sclerosis)
Digestive system	■ transplants ■ surgical procedures (eg colostomy/ileostomy, surgical repair of tracheo-oesophageal fistula) ■ other digestive conditions (eg gastrointestinal disease, Crohn's disease, portal vein thrombosis) ■ liver conditions
Kidneys and urogenital tract	■ renal failure ■ kidney transplant ■ surgical procedures (eg nephrectomy)
Lungs	■ diseases of the lung ■ surgical procedures (eg lobectomy) ■ lung transplant ■ other lung conditions (eg lung abscess)
Musculoskeletal system	■ burns ■ back, limb and whole person impairment
Ear	■ loss of hearing ■ surgical procedures (eg inner ear or middle ear surgery)
Eye	■ loss of sight ■ surgical procedures (eg surgical repair of detached retina, corneal transplant)
HIV/AIDS	■ HIV/AIDS
General	■ hospital admission ■ inability to perform activities of daily living

A 90 day exclusion applies to some *Health Events*, see the *Health Events* section starting on page 43.

How we calculate the amount we will pay

First claim under the policy

For a *Health Event*, the amount we will pay for the first claim under the policy is calculated in the following way:

1. **Determine the benefit category and percentage that applies for the *Health Event***
2. **Multiply the percentage by the *Initial Amount of Cover***

For death or *terminal illness*, we will pay the *Initial Amount of Cover* plus any additional death cover under benefit category AA.

Initial Amount of Cover

The *Initial Amount of Cover* is the amount originally issued, adjusted for Indexation Increases over time, plus any subsequent increases or decreases to the cover that you apply for and we accept. Refer to Indexation Increases on page 11 for more information.

Remaining Amount of Cover

When your policy starts, the *Remaining Amount of Cover* under the policy is equal to the *Initial Amount of Cover*. When a *Health Event* claim is paid under the policy, the *Remaining Amount of Cover* under the policy is reduced by the amount paid for any *Health Event*.

Once the *Remaining Amount of Cover* has reduced to nil under the policy, there is no cover for *terminal illness* or death, unless additional death cover, which is not reduced by *Health Event* claims, has been included.

The Claim Protector feature included in your policy limits the extent to which the *Remaining Amount of Cover* for *Health Events* under benefit categories A to E will reduce. Refer to the Claim Protector section on page 9 for more information.

The *Remaining Amount of Cover* is adjusted for Indexation Increases in line with the *indexation* of the *Initial Amount of Cover*. Refer to Indexation Increases on page 11 for more information.

If you request a change to the *Initial Amount of Cover* under your policy, the *Remaining Amount of Cover* will be adjusted so that it retains the same proportion to the *Initial Amount of Cover* as it did before the requested change.

Maximum Amount Payable

The *Maximum Amount Payable* for each of the *Health Event* benefit categories A to E is calculated as the lesser of:

- the *Initial Amount of Cover* multiplied by the applicable percentage for the relevant benefit category, and
- the *Remaining Amount of Cover* under the policy.

If the *Initial Amount of Cover* is less than $200,000, the *Maximum Amount Payable* for benefit category E will be $10,000 and the percentage for benefit category E will be adjusted accordingly.

The *Maximum Amount Payable* for *terminal illness* and death under benefit category AA is the *Remaining Amount of Cover* under the policy plus any additional death cover.

Example: first claim

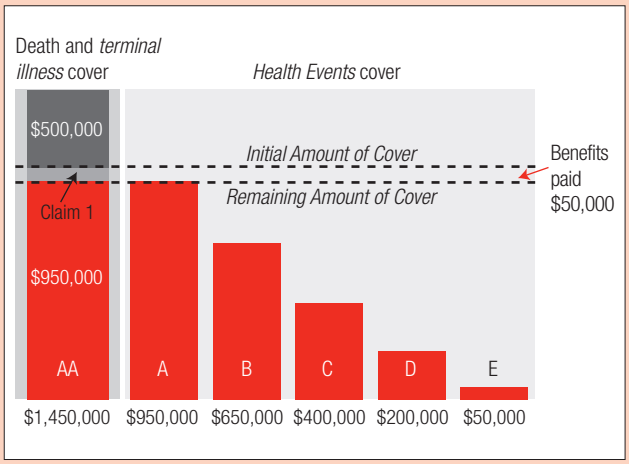
Michael is diagnosed with an early stage melanoma.

The depth and stage of the melanoma falls into the defined criteria for benefit category E under the *Health Event* category for solid tumour cancers, see the Cancer body system on page 43. For this claim, an amount of $50,000 is paid to Michael.

Following this claim, the *Remaining Amount of Cover* under the policy is reduced, resulting in the *Maximum Amount Payable* for each benefit category as shown below.

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,450,000
A	*Health Events*	$950,000
B		$650,000
C		$400,000
D		$200,000
E		$50,000

In the example, the claim for $50,000 reduces the *Maximum Amount Payable* for benefit categories AA and A as the *Remaining Amount of Cover* is less than the *Initial Amount of Cover* for these categories. For *Health Event* categories B to E there is no impact on the *Maximum Amount Payable.*



Subsequent claims under the policy

Multiple claims can be paid under the policy. Any claims that are paid reduce the *Remaining Amount of Cover* available for subsequent claims.

For a subsequent *Health Event* claim, we will pay the *Maximum Amount Payable* applicable to the relevant benefit category for the claim, unless it is a *Progressive Condition* (see below) or falls within the *Limited Claim Period* (see page 8), in which case the amount we pay will be reduced.

For a subsequent claim under the policy that is for death or *terminal illness*, we will pay the *Maximum Amount Payable* under benefit category AA (which is based on the *Remaining Amount of Cover* plus any additional death cover).

Progressive Conditions

There are a number of medical conditions that we will treat as a progression of a prior condition when calculating how much we will pay.

A *Progressive Condition* is any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. For full details of *Health Events* we consider to be *Progressive Conditions*, refer to page 51.

If the condition has progressed in severity, we will pay the difference between the benefit category applicable to the current *Health Event* and the highest benefit category previously paid for the *Progressive Condition(s)*. If the benefit category for the current *Health Event* is the same as the highest benefit category previously paid for the *Progressive Condition(s)*, no benefit is payable.

The amount we will pay for a *Health Event* due to a condition that is a *Progressive Condition* to a claim that has previously been paid is calculated in the following way:

1. **Determine the benefit category and percentage that applies for the *Health Event***
2. **Deduct the percentage applicable to the benefit category paid for the prior claim that was the *Progressive Condition*[1]**
3. **Multiply the resulting percentage by the *Initial Amount of Cover***
4. **The amount we will pay will be the lesser of the amount calculated above and the *Maximum Amount Payable* for the benefit category applicable to the *Health Event* being claimed**

Example: claim 2 – Progressive Condition

18 months after Michael's initial diagnosis of early stage melanoma, despite treatment, it has recurred and has been detected at a higher stage.

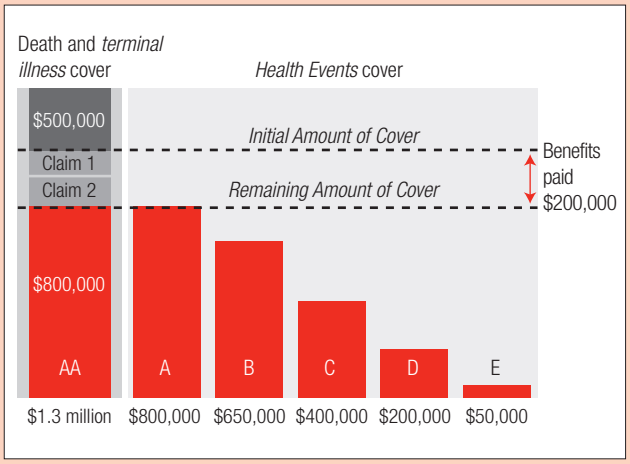
It now meets the defined criteria for benefit category D under the *Health Event* category for solid tumour cancers (see the Cancer body system on page 43).

As this recurrence of the melanoma is a *Progressive Condition* to the previous claim, we will pay the difference between the percentage payable for benefit category of the current claim and that of the previous claim.

In this case, the current benefit category of D provides a benefit of 20%, whilst the previous claim under benefit category E provided a benefit of 5%, therefore the amount payable is 15% of the *Initial Amount of Cover*, which is $150,000. This is the amount that will be paid, as it is not greater than the *Maximum Amount Payable* for benefit category D ($200,000). For this claim, an amount of $150,000 is paid to Michael.

Following this claim, the *Remaining Amount of Cover* under the policy is reduced, resulting in the *Maximum Amount Payable* for each benefit category as shown below.

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,300,000
A	*Health Events*	$800,000
B		$650,000
C		$400,000
D		$200,000
E		$50,000



[1] The relevant percentage for the prior claim (ie the actual amount paid for the claim as a percentage of the *Initial Amount of Cover*) will be used if the prior claim was for the *Health Event* angioplasty or the benefit category E amount was set at $10,000 because the *Initial Amount of Cover* was less than $200,000.

Limited Claim Period

As complications from a medical condition, or its treatment, often arise within the months following a condition and it can be difficult to identify all of these complications, a *Limited Claim Period* applies for 12 months following a *Health Event* claim.

When a claim for a *Health Event* occurs, a *Limited Claim Period* starts and lasts for 12 months. If a subsequent *Health Event* occurs during this *Limited Claim Period*, any amounts already paid during the current *Limited Claim Period* will be deducted from the amount we will pay for the current claim. This may result in no benefit being payable for a subsequent condition that falls within the *Limited Claim Period.*

We will not deduct amounts paid for a prior claim for a *Health Event* within the *Limited Claim Period* where either the current claim or the prior claim is/was for a *Health Event* that is the result of *accident*, unless the *Health Events* are directly or indirectly due to the same underlying cause or event.

Any *Health Event* that occurs during an existing *Limited Claim Period* will not start a new 12 month period. However, the next *Health Event* that occurs outside of a *Limited Claim Period* will start a new *Limited Claim Period*.

The 12 month period is based on the occurrence of each of the *Health Events* and not when the claim for that *Health Event* is paid.

The amount we will pay for a *Health Event* that falls during a *Limited Claim Period* is calculated in the following way:

1. **Determine the benefit category and percentage that applies for the *Health Event***

   If it is a *Progressive Condition* to a claim that occurred prior to the current *Limited Claim Period* apply the *Progressive Condition* reduction (see page 7)

2. **Multiply the percentage by the *Initial Amount of Cover***
3. **Deduct all amounts that have been paid during the current *Limited Claim Period***
4. **The amount we will pay will be the lesser of the amount calculated above and the *Maximum Amount Payable* for the benefit category applicable to the *Health Event* being claimed**

Example: claim 3 – Limited Claim Period

Six months following his second claim, Michael has a heart attack.

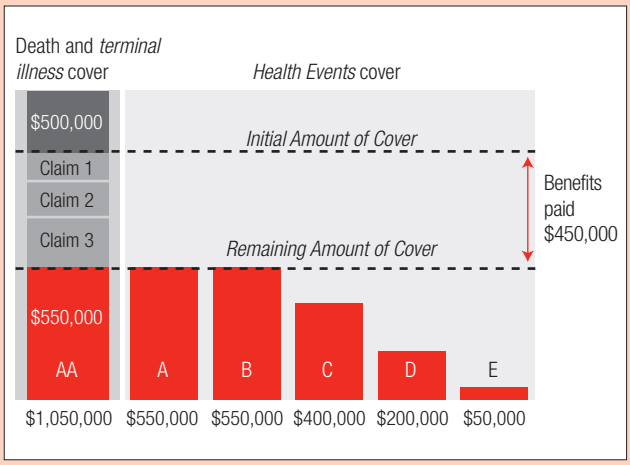
The severity of the heart attack meets the defined criteria for benefit category C under the *Health Event* category for heart attack, see the Heart and artery body system on page 45.

As this claim falls within the *Limited Claim Period* following the previous claim, we will only pay the difference between the amount payable for the current claim and the total of all other amounts paid during the current *Limited Claim Period*. This is calculated as $400,000 for the current benefit category C claim less the $150,000 already paid during the *Limited Claim Period*.

For this claim, an amount of $250,000 is paid to Michael.

Following this claim, the *Remaining Amount of Cover* under the policy is reduced, resulting in the *Maximum Amount Payable* for each benefit category as shown below.

Benefit category	Type of cover	*Maximum Amount Payable*
AA	Death and *terminal illness*	$1,050,000
A	*Health Events*	$550,000
B		$550,000
C		$400,000
D		$200,000
E		$50,000



Michael received a benefit in this case because the heart attack fell within a higher benefit category than the previous melanoma claim that was paid in the same *Limited Claim Period*. Had there been two claims within the *Limited Claim Period* that were within the same benefit category, no further benefit would have been paid.

Benefits and options

Your Active cover includes a number of built-in features plus additional options that are available for an extra premium.

Built-in features	Description	For more detail see page:
Claim Protector (*Health Events*)	Protects your *Health Events* cover so that an amount of cover is left for future *Health Event* claims irrespective of past *Health Event* claims, subject to specified limits.	9
Financial Planning benefit	We will reimburse the cost, to a maximum of $1,000, of engaging a qualified financial adviser to prepare a financial plan following payment of a claim under benefit category AA, A or B.	10
Funeral Assistance benefit	An advance payment of up to $15,000 of your death benefit to help meet funeral costs and other immediate expenses is made within 2 business days of receiving the death certificate.	11
Indexation Increases	We will increase your cover for benefit categories AA to E by the *indexation* rate on each cover anniversary before age 65, allowing your cover to increase in line with inflation.	11
Future Increases	After certain events (the birth or adoption of a child, a new or increased mortgage or an *income* increase of at least 15% in a 12 month period) you can apply to increase the *Initial Amount of Cover* (subject to certain limits) and we will accept the increase without the need for medical underwriting.	11

Additional options	Description	For more detail see page:
Additional death cover	You can purchase an amount of additional death cover that will be paid in addition to the *Remaining Amount of Cover* on diagnosis of a *terminal illness* or death.	10
Child Cover	Provides a benefit payment if the insured child suffers a *Child Cover Condition* for which they are covered, is diagnosed with a *terminal illness* or dies.	12
Income Cover	You can choose to include Income Cover to pay a monthly amount for loss of work due to *illness* or injury that results in *disability* longer than the selected waiting period.	13

Claim Protector (Health Events)

The Claim Protector feature is an important part of your Active cover that applies up to age 65 to ensure that you will have cover for subsequent *Health Events* available, up to the maximums shown in the table on the right. Under this feature, 25% of the *Initial Amount of Cover* is protected (called the Protected Amount).

For the first 14 days following the occurrence of a *Health Event* for which a claim is paid, the Claim Protector will not apply and the *Maximum Amount Payable* will be limited to the *Remaining Amount of Cover* under the policy. 14 days after a *Health Event* claim, if the *Maximum Amount Payable* is less than the Protected Amount, the *Maximum Amount Payable* for benefit categories A to E is increased to the lesser of:

- the Protected Amount, and
- the *Initial Amount of Cover* multiplied by the applicable percentage for the relevant benefit category (refer to page 4 for the percentages that apply),

provided the total amount claimed for *Health Events* under your Active cover does not exceed the limits shown in the table on the right.

Highest benefit category for which a claim has been paid	Maximum combined total payable for claims that are *Progressive Conditions*	Maximum combined total payable for all *Health Event* claims
A	$3 million	$5 million
B to E	$2 million	$4 million

The Claim Protector feature does not apply to *terminal illness* or death cover provided under the policy, therefore your death and *terminal illness* cover under the policy may reduce to nil unless additional death cover is included.

Increases to the *Maximum Amount Payable* under the Claim Protector feature are not available:

- after age 65, or
- if a claim for a *terminal illness* under benefit category AA or a *Health Event* that is a *terminal illness* under benefit categories A to E has been paid.

The Protected Amount is adjusted for Indexation Increases in line with *indexation* of the *Initial Amount of Cover*. Refer to Indexation Increases on page 11.

Example: claim 4 – Claim Protector

Five years later, Michael is in a car accident and suffers a back injury.

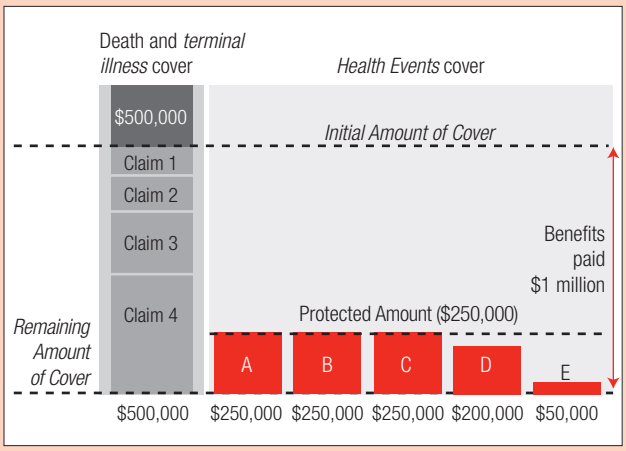
This injury meets the defined criteria for benefit category B under the *Health Event* category for back, limb and whole person impairment, see the Musculoskeletal body system on page 49.

This Health Event is not a *Progressive Condition* of any prior claim, nor has it fallen within a *Limited Claim Period*. Due to the previous claims paid under the policy, the *Maximum Amount Payable* for benefit category B is now $550,000 and this amount is paid to Michael. In total, $1 million has been paid to Michael for his *Health Events* claims.

This last claim has resulted in the *Remaining Amount of Cover* for the policy reducing to nil, making it less than the Protected Amount of $250,000 (25% of the *Initial Amount of Cover*). 14 days following the claim the Claim Protector applies and the *Maximum Amount Payable* for benefit categories A to D is increased as shown in the table below:

Benefit category	*Maximum Amount Payable* in the 14 days following the claim	*Maximum Amount Payable* 14 days after the claim
AA	$500,000	$500,000
A	$0	**$250,000**
B	$0	**$250,000**
C	$0	**$250,000**
D	$0	**$200,000**
E	$0	**$50,000**

Benefit categories A to C are increased to the Protected Amount. Benefit category D is increased to $200,000 based on 20% of the *Initial Amount of Cover* and benefit category E is increased to $50,000 based on 5% of the *Initial Amount of Cover.*



The automatic cover for *terminal illness* and death under Michael's policy has reduced to nil. However, because he chose to purchase additional death cover, he has $500,000 of cover remaining for death or *terminal illness.* The additional death cover is not reduced by claims for *Health Events* so will be available despite any future *Health Event* claims.

Additional death cover option

This is an option for which an additional premium is charged. You can purchase an amount of additional death cover that will be paid if you are diagnosed with a *terminal illness* or die. The additional death cover is added to the *Remaining Amount of Cover* to derive the *Maximum Amount Payable* under benefit category AA.

This option ensures you have an amount of death cover, separate from your *Health Events* cover, that is not affected by other claims under the policy.

Financial Planning benefit

Under this feature, we will reimburse the cost of engaging a qualified financial adviser to prepare a financial plan following payment of a claim for *terminal illness,* death or a *Health Event* that falls within benefit category A or B.

The total amount payable under this benefit is the lesser of the actual fee paid for the financial planning advice (excluding any commissions received by the adviser) and $1,000. It is payable on receipt of evidence of:

- the financial advice provided,
- the qualifications of the financial adviser, and
- the payment made for that advice.

This evidence must be received by us within 12 months of payment of the claim.

The benefit is payable to the person who receives the claim proceeds. If the claim proceeds are paid to more than one person, the maximum amount payable to each beneficiary for reimbursement of financial planning costs incurred by them will be split proportionally in line with the split of the benefit payment. The benefit is only payable once for the insured person across all cover with us. The financial adviser whose services are being reimbursed must be qualified and operating under an Australian Financial Services License.

Funeral Assistance benefit

Under this feature, part of the claim payment for death will be paid in advance so that immediate expenses can be met following your death. The amount payable is the lesser of $15,000 and 10% of the *Maximum Amount Payable* for benefit category AA. The maximum amount we will pay under the Funeral Assistance (or similar) benefit is $15,000 inclusive of all cover held with us for the insured person. In order to pay this benefit, we require medical evidence as to the cause and date of death. This benefit is not payable if death is the result of suicide within 13 months of *cover commencement*, is the result of anything that is excluded under the policy or if there is reasonable doubt about whether the death claim will become payable.

If we agree this benefit is payable, it will be paid to the nominated beneficiary, the policy owner if different to the insured person or the legal personal representative of the policy owner, within 2 business days of receipt all of the required documents. The claim payment for death will be reduced by the amount paid under the Funeral Assistance benefit.

The payment of the Funeral Assistance benefit is not an admission of liability and we reserve the right to recover the amount paid under the Funeral Assistance benefit if the death claim is subsequently denied.

Indexation Increases

We will increase the *Initial Amount of Cover*, *Remaining Amount of Cover,* additional death cover and Protected Amount for benefit categories AA to E by the *indexation* rate on each cover anniversary before age 65, so that the policy retains its value over time in line with inflation.

We will tell you the proposed *indexation* increase before it applies and you can choose to decline the increase. If you decline an increase it will not affect future increase offers. To decline an increase, we must receive your notice of decline before the applicable cover anniversary. If you decline an *indexation* increase on the *Initial Amount of Cover*, the *Remaining Amount of Cover* and Protected Amount will also not be increased.

Under the Indexation Increases feature, the *Initial Amount of Cover* can increase above the maximum allowed at application.

Future Increases

Under this feature, after certain events for the insured person, you can apply to increase the *Initial Amount of Cover* until age 55, and we will accept the increase without the need for medical underwriting. However, satisfactory evidence of the event for which the increase is sought will be required. The application for an increase under this feature must be made on the appropriate form. The increase only takes effect from when we approve the application for the increase. The following table sets out the events and the maximum amounts by which you can apply to increase the *Initial Amount of Cover*.

Events	Maximum increase
Marriage	The lesser of: ■ 25% of the *Initial Amount of Cover* when your policy started, and ■ $200,000.
Birth or adoption	
New mortgage or increase on existing mortgage (excluding refinance or draw down)	The lowest of: ■ 25% of the *Initial Amount of Cover* when your policy started, ■ $200,000, and ■ the increase in the size of the mortgage.
Increase in *income* by 15% or more in a 12 month period	The lowest of: ■ 25% of the *Initial Amount of Cover* when your policy started, ■ $200,000, and ■ five times the increase in *income.*

The minimum increase to the *Initial Amount of Cover* under the Future Increases feature is $10,000. An increase under this feature cannot be made until 12 months after the cover start date for the applicable insurance cover.

The increase in cover must be requested within six months of the event and only one increase may be applied for in any 12 month period under this feature. The maximum amount by which the *Initial Amount of Cover* can be increased under this feature is $1 million.

The *Initial Amount of Cover* cannot be increased above the maximum amounts allowable, as stated on page 3. These maximum limits apply inclusive of all lump sum cover held with us or another insurer for the insured person.

Any premium adjustments, exclusions or special conditions which applied to the original cover will also apply to any increases made under this feature.

This feature is not available if:

- the policy was issued with a premium adjustment in the form of a medical loading of 75% or more, or
- a claim has been or can be made by you for lump sum cover under any policy provided by us.

If an event or condition giving rise to a claim occurs (or for a *Health Event*, the symptoms leading to the condition occurring or being diagnosed first became apparent) during the first six months after an increase in the *Initial Amount of Cover* under this feature, we will only pay a claim in respect of the increased cover if:

- the condition for which the claim is being made is due to an *accident,* and
- the *accident* occurs after the date of the increase.

If you increase your *Initial Amount of Cover,* you can also increase your additional death cover proportionately.

Optional Child Cover

This is an option for which an additional premium is charged. Child Cover is available if you have, or are applying for Active cover. The child to be insured must be your natural, step or adopted child or grandchild.

When you apply for Child Cover, you select the Amount of Cover of between $10,000 and $250,000 that you want and this applies for each insured child under the policy.

The full Amount of Cover is payable if, during the period of cover, an insured child:

- dies,
- is diagnosed with a *terminal illness*, or
- suffers one of the *Child Cover Conditions* listed in the table.

We will only pay the Amount of Cover once under the policy for each insured child. Any amount we pay for Child Cover does not reduce the *Remaining Amount of Cover* under your Active cover.

The *Child Cover Conditions* are listed in the table below.

Child Cover Conditions	
Cancer of any body system	■ *cancer*[#] ■ *aplastic anaemia*
Heart and artery	■ *cardiomyopathy* ■ *heart attack*[#] ■ *open heart surgery*[#] ■ *out of hospital cardiac arrest*[#]
Brain and nerve	■ *bacterial meningitis or meningococcal septicaemia* ■ *benign brain tumour* ■ *brain damage* ■ *coma* ■ *encephalitis* ■ *major head trauma* ■ *muscular dystrophy with impairment level* ■ *paralysis* ■ *stroke*[#]
Lungs	■ *chronic lung disease* ■ *primary pulmonary hypertension*
Kidneys	■ *chronic kidney failure*
Ear, nose and throat	■ *loss of hearing* ■ *loss of speech or total aphasia*
Eye	■ *loss of sight*
Musculoskeletal	■ *loss of limbs* ■ *severe burns*
Digestive system	■ *chronic liver disease*
Other	■ *child's loss of independent existence* ■ *intensive care* ■ *major organ transplant* ■ *medically acquired HIV*

The definitions for all the *Child Cover Conditions* can be found in the Glossary at the end of this PDS. Any references to the 'insured person' include references to the 'insured child', where applicable.

A Child Cover claim will not be payable if we have not received consent to obtain the medical records, past and present, of the insured child.

Indexation Increases

We will increase the Amount of Cover, by the *indexation* rate on each cover anniversary before Child Cover ends, so that it retains its value over time in line with inflation.

We will tell you the proposed *indexation* increase before it applies and you can choose to decline the increase. If you decline an increase it will not affect future increase offers. To decline an increase, we must receive your notice of decline before the applicable cover anniversary.

Under the Indexation Increases feature, the Amount of Cover can increase above the maximum allowed at application.

Continuation of cover

This feature allows you or the insured child to commence a policy for the same or lesser amount as the Amount of Cover for the insured child under Child Cover, on any cover anniversary for the Child Cover that falls when the insured child is aged 15 to 21 inclusive, without the need for medical underwriting. Additional information from the insured child may be required at the time of conversion to establish the premium rate that will apply to the insurance.

Once this election is made, the Child Cover for that insured child is cancelled. The continuation of cover feature is not available if a claim has been paid or is payable for the insured child under any cover with us.

[#] if the *Child Cover Condition* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the 90 days of the *application date* or the date any cover is reinstated for the Child Cover, a benefit will not be paid for the *Child Cover Condition* at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Optional Income Cover

If you choose to include Income Cover, we will pay a monthly amount for loss of work due to *illness* or injury. You decide:

- the type of cover,
- the time period you have to wait after *disability* until we start paying you a benefit, and
- how long a benefit is payable to you.

You also decide the amount of cover you want, which is called the Monthly Amount of Cover. Generally this can be up to 75% of your annual *income.*

If your annual *income* is greater than $320,000, the maximum monthly amount you can apply for is the lesser of:

- $40,000 if the benefit period is 2 years, or $30,000 for other benefit periods (plus an additional $10,000 for the first two years of the benefit period),
- the monthly equivalent of 75% of the first $320,000, 50% of the next $240,000 and 20% of the balance of your annual *income.*

Income Cover Plus

In addition to the standard features and benefits available through Income Cover, you can also choose to take Income Cover Plus, which provides additional terms for the *Total Disability* benefit and the Premium Waiver feature.

Income Cover Plus is only available to certain occupations.

Type of cover

The type of cover that you choose will determine the benefit payable in the event of a claim:

i) **Income at claim**

The benefit payable is based on *income* over the three years prior to *disability*, but cannot be more than the Monthly Amount of Cover.

Financial evidence confirming the insured person's *income* over the period prior to claim must be provided at time of claim.

The benefit payable may therefore be less than the Monthly Amount of Cover that you are insured for if your *income* has reduced since the time of application.

ii) **Income at application**

The benefit payable is based on *income* over the three years prior to application.

The benefit is fixed and will not be reduced if there has been a fall in your *income* since application.

You can choose to provide the financial evidence supporting your *income* either at the same time as you apply (and your policy will therefore be referred to as 'endorsed'), or at time of claim.

The benefit payable may be reduced if you elect to provide the financial evidence at time of claim and it does not support the Monthly Amount of Cover you have selected. It may also be reduced if you are receiving income because you can still work in some capacity or are receiving income from another source, as explained on page 15.

Income

Income is defined as income earned through personal exertion calculated:

- after the deduction of expenses incurred in producing that income, and
- before the deduction of income tax.

It is based on the total remuneration package and includes salary, wages, packaged fringe benefits, regular commissions, regular bonuses, regular overtime payments and pre-tax superannuation contributions.

For the self-employed it also includes that share of net income of the business directly generated by personal exertion after deduction of all business expenses but before the deduction of tax.

Income does not include:

- income that the insured person would continue to receive from his or her business even if unable to work, including any ongoing profit generated by other employees of the business, or
- other unearned income such as dividends, interest or rental income.

Waiting period

The majority of benefits under Income Cover are subject to a waiting period before the benefits become payable. The following waiting periods are available:

- 30 days
- 60 days
- 90 days
- 1 year
- 2 years

The 2 year waiting period is only available if a benefit period of to age 65 or to age 70 is selected.

The waiting period begins the day you are *disabled* due to *illness* or injury and have been examined by a *medical practitioner.*

If medical and other evidence is provided that is acceptable to us, we will reduce the waiting period by the number of continuous days (up to a maximum of seven days) for which the insured person was absent from *gainful employment* due to *illness* or injury prior to first being examined by a *medical practitioner* in relation to their *disability*.

Where a waiting period applies to a benefit under Income Cover, the benefit is payable after the end of the waiting period and is not back dated to the beginning of the waiting period.

Return to work during the waiting period

You can return to work (and not be *disabled*) during the waiting period for up to:

- five consecutive days if your waiting period is 30 days,
- 10 consecutive days if your waiting period is 60 days, 90 days, 1 year or 2 years, or
- six consecutive months if your waiting period is 2 years and the insured person is also covered by a type of disability income insurance with a benefit period of two years provided through membership of a regulated and complying superannuation fund in Australia,

before we will restart the waiting period.

The waiting period will be extended by the number of days worked while the insured person is not *disabled.*

Waiting period reduction

If you select a 2 year waiting period, it can be reduced without medical underwriting to 1 year or 90 days if you also have salary continuance cover provided through your employer and that cover terminates because you leave your employer. This is not available if:

- you elect to take up any continuation of cover option on the salary continuance cover,
- you are on claim, or eligible to claim, at the time of applying to reduce the waiting period, or
- you are not engaged in *gainful employment* of at least 20 hours per week with a new employer.

You must apply to change the waiting period within 30 days of ceasing employment with the employer through which the salary continuance cover was provided. Evidence of the cover, cessation of your employment and other information necessary to assess your eligibility is required at the time of applying to reduce the waiting period.

The premium will be adjusted accordingly for any change made to the waiting period under this feature.

Benefit period

The benefit period is the maximum period for which a claim for a *disability* is payable after the end of the waiting period.

The following benefit periods are available:

- 2 years
- 5 years
- To age 65
- To age 70

The 'to age 70' benefit period is only available to people in some occupations. For some occupations, the maximum benefit period available may be 5 years.

The benefit period for an individual claim starts at the end of the waiting period and continues until the earlier of:

- the end of the selected benefit period (if the benefit period selected is 'to age 65' or 'to age 70', the benefit period ends at the cover anniversary when the insured person is aged 65 or 70, respectively), and
- the date when cover ends (see the section, "When cover ends" on page 34).

If the 'to age 70' benefit period has been selected, the *monthly benefit* will be determined on the basis of the 'income at claim' approach for any new claim where the waiting period commences on or after the cover anniversary when the insured person is 65.

Recurrent disability

If you select a to age 65 or to age 70 benefit period, any claim for a *disability* arising from the same or a related cause as a previous claim within 12 months of the previous claim ending will be treated as a continuation of the previous claim and the waiting period will be waived. If the claim is made more than 12 months after the previous claim ended it will be treated as a new claim and a new waiting period will apply.

If you select a 2 year or 5 year benefit period, or your cover is extended beyond age 65 under Cover Extension (see page 19), any claim for a *disability* arising from the same or a related cause as a previous claim that was made within six months of the previous claim ending, will be treated as a continuation of the previous claim and the waiting period will be waived. If the claim is made more than six months after the previous claim ended a new waiting period will apply. A new benefit period will apply only if the insured person made a successful return to *gainful employment* of at least 20 hours per week for a continuous period of six months.

Monthly benefit

The amount we will pay while you are *disabled* during the benefit period is all or part of the monthly benefit depending on whether you are *totally disabled* or *partially disabled*.

Total disability

A benefit will be payable for *total disability* if:

- you:
  - have been continuously *disabled* during the waiting period and are *totally disabled* for at least five consecutive days during that time, or
  - have Income Cover Plus and you have been continuously *disabled* during the waiting period, and
- are *totally disabled* after the end of the waiting period, or after a period during which a benefit for *partial disability* has been paid for the same *disability.*

The *total disability* benefit payable is the *monthly benefit,* adjusted to take into account any:

- reductions which apply, as explained in the "When the *monthly benefit* is reduced" section on this page, and
- increases under the Claims Escalation option, if it applies, as explained on page 19.

The *monthly benefit* for *total disability* is payable monthly in arrears for each day of *total disability* after the end of the waiting period (1/30th of the *monthly benefit* per day if the benefit is only payable for part of a month), but not beyond the end of the benefit period for that *disability.*

Partial disability

A benefit will be payable for *partial disability* if you:

- have been continuously *disabled* during the waiting period, and
- are *partially disabled* after the end of the waiting period, or after a period during which a benefit for *total disability* has been paid for the same *disability*.

The *partial disability* benefit payable is a proportion of the *monthly benefit,* calculated as follows:

$$\frac{\textit{pre-disability income} - \textit{post-disability income}}{\textit{pre-disability income}} \times \textit{monthly benefit}$$

adjusted to take into account any:

- reductions which apply, as explained in the "When the *monthly benefit* is reduced" section on this page, and
- increases under the Claims Escalation option, if it applies, as explained on page 19.

The *monthly benefit* for *partial disability* is payable monthly in arrears for each day of *partial disability* after the end of the waiting period (1/30th of the *monthly benefit* for *partial disability* per day if the benefit is only for part of a month) but not beyond the end of the benefit period for that *disability.*

When the *monthly benefit* is reduced

The *monthly benefit* payable for *total disability* or *partial disability* may be reduced if you receive any of the following payments:

- legislated compensation schemes and Workers Compensation (this reduction does not apply to some white collar, sedentary occupations), and
- any other insurance that provides income payments due to sickness or injury, which commenced prior to the commencement of the Income Cover unless we have expressly agreed not to apply a reduction.

If a lump sum is received from any of the above sources, we will convert that lump sum to a monthly payment at the rate of 1% of the lump sum paid per month for the first 100 months that a benefit is paid.

The benefit we will pay will only be reduced to ensure that, when combined with the payments from any of the above sources, it does not exceed the monthly equivalent of:

- 75% of *pre-disability income* for *total disability*
- 100% of *pre-disability income* for *partial disability*, or
- 100% of *pre-disability income* while the *monthly benefit* is increased under the Booster option (see page 20).

Benefits and options

Under Income Cover, other benefits may become payable in addition to, or instead of, the *total disability* or *partial disability* benefit. These benefits are summarised in the table below.

Benefit	Description	For more detail see page:
Built-in benefits and features		
Specific Injury benefit	If you suffer one of the defined specific injuries, we will pay the *monthly benefit* for a certain number of months depending on the injury, regardless of whether you are *totally disabled.*	17
Death benefit	We will pay up to four times the Monthly Amount of Cover, to a maximum of $75,000, if you die during the period of cover.	17
Indexation Increases	The Monthly Amount of Cover is increased by the *indexation* rate on each cover anniversary before age 65, allowing your cover to increase in line with inflation, unless you choose not to accept the increase.	17
Premium Waiver	We will waive the premium payable for Income Cover while a benefit is payable under Income Cover (and during the waiting period if you have Income Cover Plus).	17
Involuntary Unemployment Premium Waiver	We will waive the premium payable for Income Cover for up to three months while you are *involuntarily unemployed* and registered with a recognised employment agency.	17
Extra Benefits option		
Health Event benefit	If you suffer a *Health Event* that meets benefit category A or B, we will pay the *monthly benefit* for six months, regardless of whether you are *totally disabled*. A 90 day exclusion applies to some *Health Events*.	18
Bed Confinement benefit	If you are confined to bed and are under the care of a registered nurse for 72 hours or more, we will pay the *monthly benefit* during the waiting period.	18
Home Care benefit	If you are confined to bed as a result of continuing *total disability,* we will pay an additional amount to cover: ■ the forgone *income* of an *immediate family member* who has ceased work to care for you, or ■ the cost of employing a registered nurse or housekeeper, up to a monthly amount that is the lesser of $5,000 or the *monthly benefit* for up to six months.	18
Rehabilitation Expenses benefit	We will pay an additional amount to cover all or part of any expenses or costs, up to 12 times the *monthly benefit,* associated with a rehabilitation programme for you if a benefit for *total disability* is payable.	18
Accommodation benefit	We will pay an additional amount to cover the costs of accommodation up to $250 a day for a maximum of 30 days in any 12 month period, if an *immediate family member* requires accommodation at a location more than 100km from their home to be closer to you while you are *totally disabled* and confined to bed.	18
Future Increases	Allows you to increase your Monthly Amount of Cover by up to 15% on each cover anniversary to match a corresponding increase in *income* without the need for medical underwriting.	18
Cover Extension	If the 'to age 65' benefit period has been selected, Income Cover (on modified terms) can continue beyond the cover expiry at age 65 for some occupations.	19
Other available options		
Claims Escalation option	While a benefit for *total disability* or *partial disability* is being paid, we will increase the Monthly Amount of Cover by the *indexation* rate at the cover anniversary.	19
Accident option	We will pay the *total disability* benefit during the waiting period if the insured person is *totally disabled* for at least four consecutive days due to an *accident.*	19
Superannuation Cover option	Generally the Monthly Amount of Cover can be up to 75% of your *income* however with this option you can insure up to 80% of your *income* so that in the event of *disability* you can make a level of contribution into superannuation. Part of the *monthly benefit* will be paid to you and part must be paid to the trustee of a nominated superannuation fund.	19
Booster option	Under this option, if the insured person suffers a *Health Event* that meets benefit category A, we will increase the *monthly benefit* by 33% for a maximum of two years for a claim under *total disability,* the Specific Injury benefit or *Health Event* benefit.	20

Specific Injury benefit

If you suffer one of the injuries listed below, we will pay the *monthly benefit* for the number of months indicated, regardless of whether you are *totally disabled*. Payments will be made during the waiting period.

Specific Injury	Payment period
The total and irreversible loss of the use of two limbs, where a limb is defined as the shoulder down to the hand or the hip down to the foot	60 months*
Total and permanent loss of any two of: ■ the use of a foot from the ankle joint ■ the use of a hand from the wrist ■ the sight in an eye that is irreversible	24 months
Total and permanent loss of any one of: ■ the use of a foot from the ankle joint ■ the use of a hand from the wrist ■ the sight in an eye that is irreversible	12 months
Total and complete severance of the thumb and index finger from the phalangeal joint of the same hand	6 months
Fracture of thigh or pelvis	3 months
Fracture of the leg (between the knee and foot) or knee cap	2 months
Fracture of the upper arm (including elbow and shoulder bone)	2 months
Fracture of the skull (except bones of the nose or face)	2 months
Fracture of the lower arm (including wrist, but excluding elbow, hands or fingers)	1 month
Fracture of the jaw or collarbone	1 month

* If the benefit period is two years, the payment period for loss of the use of two limbs under this feature is 24 months.

If the benefit period is two or five years, the benefit period for a *disability* due or related to an injury for which we have paid the Specific Injury benefit is reduced by the number of months for which we have paid the Specific Injury benefit.

If you suffer more than one specific injury at the same time, we will only pay for one specific injury, being the one with the longest payment period.

If we are paying benefits under the Specific Injury benefit, payments will cease if Income Cover ends, explained in the section titled "When cover ends" on page 34.

Death benefit

If you die during the period of cover, we will pay an amount equal to four times the Monthly Amount of Cover, to a maximum of $75,000, on receipt of the death certificate.

Indexation Increases

The Monthly Amount of Cover may be increased by the *indexation* rate on each cover anniversary before you reach age 65, so that it retains its value over time in line with inflation.

If the *indexation* rate is zero or negative, the Monthly Amount of Cover will not change.

We will tell you the proposed *indexation* increase before it applies and you can choose to decline the increase. If you decline an increase it will not affect future *indexation* increase offers. To decline an increase, we must receive your notice of decline before the applicable cover anniversary.

Under the Indexation Increases feature, the Monthly Amount of Cover can increase above the maximum allowed at application.

If you have selected the '*income* at claim' type of cover, you should consider whether, by accepting an increase, your Monthly Amount of Cover will exceed the *monthly benefit.* For the '*income* at application' type of cover, the *indexation* increase applied to the Monthly Amount of Cover will not need to be financially verified at time of claim.

Premium Waiver

We will waive the premium payable for your Income Cover while an Income Cover benefit is payable.

If you have Income Cover Plus, the premium will also be waived during the waiting period if a benefit becomes payable under the policy.

Involuntary Unemployment Premium Waiver

If your Income Cover has been continuously in force for the six months preceding *involuntary unemployment* of at least ten consecutive working days, we will waive the premium payable for Income Cover for up to three months at a time for the period while you are *involuntarily unemployed* and registered with a recognised employment agency.

The premium will be waived due to *involuntary unemployment* for a maximum of three months in any 12 month period and a total maximum of six months inclusive of all cover held with us for you over the life of the policy. If you pay your premium on an annual basis, we will provide a pro rata refund of the premium that has already been paid for each month that you are eligible for the Involuntary Unemployment Premium Waiver.

Extra Benefits option

This is an optional package of additional income benefits and features for which an additional premium is charged.

The Extra Benefits option includes the following income benefits and features:

- Health Event benefit
- Bed Confinement benefit
- Home Care benefit
- Rehabilitation Expenses benefit
- Accommodation benefit
- Future Increases
- Cover Extension

Health Event benefit

If you suffer a *Health Event* that meets benefit category A or B, we will pay the *monthly benefit* for six months, regardless of whether you are *totally disabled*. Payments will be made during the waiting period.

For some *Health Events*, a 90 day exclusion applies, as explained in the *Health Events* section on page 43.

We will only pay once for each *Health Event* (and *Progressive Condition*) under this benefit.

If the benefit period is 'two years' or 'five years', the benefit period for a *disability* due or related to a condition for which we have paid the Health Event benefit is reduced by number of months for which we have paid the Health Event benefit.

If you suffer more than one *Health Event*, we will only pay for one *Health Event* at a time.

If we are paying benefits under the Health Event benefit, payments will cease if Income Cover ends, explained in the section titled "When cover ends" on page 34.

Bed Confinement benefit

If you are *totally disabled*, confined to bed, as confirmed by a *medical practitioner,* and are under the care of a registered nurse for 72 hours or more during the waiting period, we will pay 1/30th of the *monthly benefit* for each day of such bed confinement during the waiting period. The Bed Confinement benefit is payable for a maximum of 90 days.

Home Care benefit

If a benefit for *total disability* has been paid for at least 30 days, and you are confined to bed as a result of continuing *total disability*, as confirmed by a *medical practitioner*, we will increase the amount we will pay in a month to cover either:

- the amount of *income* foregone in the month by an *immediate family member* who provides satisfactory evidence to us that they were *gainfully employed* for at least 20 hours per week prior to you suffering the *disability* and have ceased to be *gainfully employed* to care for you, or
- the cost of employing a registered nurse or housekeeper.

The additional amount we will pay each month is limited to the lesser of $5000 and an amount equal to the *monthly benefit*. We will pay this benefit for a maximum of six months. This benefit starts to accrue on the first day that all of the above requirements are met and is paid monthly in arrears.

This benefit is in addition to any benefit payable for *total disability.*

Rehabilitation Expenses benefit

If a benefit for *total disability* is payable, we will increase the amount we will pay in a month to cover all or part of any rehabilitation expenses or costs associated with a rehabilitation programme for you that we have approved in advance. A maximum payment of 12 times the *monthly benefit* applies under this benefit. This benefit is in addition to any benefit payable for *total disability* or *partial disability*.

Accommodation benefit

If you are *totally disabled* and confined to bed, as confirmed by a *medical practitioner*, and an *immediate family member* requires accommodation at a location more than 100km from their home to be closer to you, we will increase the amount we will pay in a month to cover the costs of accommodation up to $250 per day for a maximum of 30 days in any 12 month period.

The Accommodation benefit is payable during the waiting period. This benefit is in addition to any benefit payable for *total disability*.

Future Increases

Under this feature you can apply to increase your Monthly Amount of Cover by up to 15% on each cover anniversary to match a corresponding increase in *income* until you turn 55, and we will accept the increase without the need for medical underwriting.

Only increases to the Monthly Amount of Cover above $500 are eligible for applications under the Future Increases feature.

The Monthly Amount of Cover cannot be increased under the Future Increases feature:

- by more than 15% at any cover anniversary, or
- above the maximum amounts allowable, explained on page 13.

The combined total of all increases to the Monthly Amount of Cover cannot exceed the Monthly Amount of Cover originally issued.

Financial evidence may be required to establish that your *income* supports the increase to the Monthly Amount of Cover in line with the maximum limits for Income Cover.

The increase in cover must be requested within 30 days of the applicable cover anniversary and must be made on the appropriate form. The increase only takes effect from when we approve the application for the increase.

Any premium adjustments, exclusions or special conditions which applied to the original cover will also apply to any increases made under this feature.

This feature is not available if:

- the policy was issued with a premium adjustment in the form of a medical loading of 75% or more, or
- a claim has been or can be made by you under any income replacement policy provided by us.

Cover Extension

This feature only applies to some occupations. It is only available with the 'to age 65' benefit period.

Under this feature we will offer to continue Income Cover beyond the cover anniversary when you are aged 65, if you are employed in an occupation which we insure under our standard underwriting guidelines at the time the offer is made.

The policy owner must accept the offer within 30 days of the cover anniversary when the insured person is age 65.

This offer will not apply if:

- we originally offered cover with a limitation on the term of the policy so that cover expires earlier than the cover anniversary when you are aged 65,
- we originally offered cover with a premium adjustment due to medical reasons, or
- you were eligible to receive a *disability* claim in the preceding 12 month period.

Cover under this feature will be provided on the following modified terms:

- on an 'income at claim' basis,
- a benefit period of 12 months,
- benefits will only be payable for *total disability*, *partial disability* and the Death benefit,
- the Extra Benefits option, Claims Escalation option, Accident option, Superannuation Cover and Booster options will not apply,
- Indexation Increases will not apply, and
- the maximum *monthly benefit* we will pay is $15,000.

Cover can continue on the modified basis until the earlier of:

- the cover anniversary when you are aged 70, and
- you not having been in *gainful employment* of at least 20 hours a week for six consecutive months.

Claims Escalation option

This is an option for which an additional premium is charged.

While a benefit for *total disability* or *partial disability* is being paid before the cover anniversary when you are age 65, we will increase the Monthly Amount of Cover by the *indexation* rate at the cover anniversary.

Accident option

This is an option for which an additional premium is charged.

It is only available if a 30 day waiting period applies. For some occupations, the Accident option may not be available.

If you are *totally disabled* for at least four consecutive days within 30 days of suffering an *accident,* the *monthly benefit* for *total disability* will be payable during the waiting period.

The *monthly benefit* is payable in arrears for each day of *total disability* including the first four consecutive days (1/30th of the *monthly benefit* per day if the benefit is only payable for part of the month), but not beyond the end of the waiting period for that *disability.*

Superannuation Cover option

This option allows you to have a higher Monthly Amount of Cover than is usually available under Income Cover so that in the event of *disability* you can make a level of contribution into superannuation. Generally, the Monthly Amount of Cover can be up to 75% of your *income,* however this option allows you to insure up to 80% of your *income*. Part of the *monthly benefit* will be paid to you and part must be paid to the trustee of a nominated superannuation fund.

The amount you can insure is up to the monthly equivalent of the sum of:

- the annual *income* that you contribute to superannuation, to a maximum of 20% of annual *income* (the Superannuation Cover amount), and
- the percentage of the remainder of *income* (that is, annual *income* less the Superannuation Cover amount determined above), as follows:
  - 75% of the first $320,000,
  - 50% of the next $240,000,
  - and 20% of the balance

subject to the following limits:

- $40,000 per month if the benefit period is 2 years, or
- $30,000 per month for other benefit periods (plus an additional $10,000 per month for the first two years of the benefit period).

For example, for an applicant who earns an annual salary of $100,000 and has superannuation guarantee contributions of $9,000 made on their behalf each year, their annual *income* is $109,000 which can be insured as follows:

	Superannuation Cover amount	Remainder of *income*	Monthly Amount of Cover
Without Superannuation Cover option	0	75% x 109,000	
	0	= 81,750/12	
		$6,813	**$6,813**
With Superannuation Cover option	100% x 9,000	75% x 100,000	
	9,000/12	= 75,000/12	
	$750	**$6,250**	**$7,000**

The Superannuation Cover Percentage is the proportion of the *monthly benefit* that will be paid to your nominated superannuation fund (after any adjustment for tax – see below) while we are paying you a *monthly benefit* under Income Cover.

The Superannuation Cover Percentage is calculated at the time of application and is calculated as the Superannuation Cover amount divided by the Monthly Amount of Cover. In the example above, the Superannuation Cover Percentage is worked out as $750 (the Superannuation Cover amount) divided by $7,000 (the Monthly Amount of Cover) which equals 10.71%.

The *monthly benefit*, inclusive of any Superannuation Cover amount, is included in your assessable income for tax purposes. We will adjust the Superannuation Cover amount for the potential tax liability that may apply to this amount based on the marginal rate of tax that would otherwise have applied to the last dollar of the insured person's *pre-disability income*. The tax adjustment amount will be paid directly to you and the Superannuation Cover amount reduced by this tax adjustment amount before it is paid to your nominated superannuation fund.

By applying for this option, you agree to provide us with the name and details of the trustee of your nominated superannuation fund to which the Superannuation Cover amount of your *monthly benefit* is to be paid. If you do not provide us with a direction at time of claim, we may not be able to pay the Superannuation Cover amount.

If the fund you nominate does not accept the Superannuation Cover amount from us, we will pay it to you subject to proof that the amount is subsequently forwarded to a superannuation provider for the insured person's benefit.

The amount that we pay to your nominated superannuation fund is paid on your behalf as a personal contribution and subject to the standard superannuation rules relating to preservation, contributions and tax.

Booster option

This is an option for which an additional premium is charged. It is only available with a benefit period of 'to age 65' or 'to age 70' and where the Monthly Amount of Cover applied for at application, inclusive of any Superannuation Cover amount, is $30,000 per month or less.

Under this option, if you are eligible for a *Health Event* claim under benefit category A, we will increase the *monthly benefit* by 33% under *total disability*, the Specific Injury benefit or the *Health Event* benefit for a maximum of two years for a claim for any *disability* arising from the same or a related cause.

Any benefits payable after the cover anniversary when you are age 65 will not be subject to increases under this option. The Booster option does not apply to a claim under *partial disability*, the Death benefit, Bed Confinement benefit, Home Care benefit, Rehabilitation benefit, Accommodation benefit or benefits payable under the Accident option.

Indexation Increases and the Claims Escalation option will continue to apply.

If the Superannuation Cover option applies, the Superannuation Cover Percentage will be applied to the increased *monthly benefit* to determine the amount payable to the trustee of your nominated superannuation fund.

Medical professionals feature

If a medical professional contracts HIV or Hepatitis B or C, professional guidelines may restrict their ability to perform certain procedures and result in a reduction of income, well before the illness results in a physical inability to perform the duties of their occupation.

Under Income Cover, Macquarie Life will consider that a medical professional has satisfied the occupational duties component of the *total disability* or *partial disability* definition if the following apply:

- the occupation class shown on your policy is 1M,
- the insured person becomes infected with HIV, Hepatitis B or Hepatitis C as confirmed by documented proof of the infection,
- at the time of infection, exposure prone procedures, as defined by the relevant professional governing body, are at least one of the duties of the insured person's *usual occupation* necessary to produce income, and
- due to the insured person's HIV, Hepatitis B or Hepatitis C status, the insured person is required to cease performing exposure prone procedures as a result of the guidelines of the professional governing body in their state.

The other components of *total disability* and *partial disability*, as applicable, must also be satisfied in order for a claim to be admitted.

The Medical Professionals feature will not apply if:

- a treatment is available which renders the HIV or Hepatitis B or C virus inactive and non-infectious, or
- the insured person has elected not to take a relevant vaccine that is recommended by the relevant professional governing body and which is available prior to the event which causes infection.

If more than one benefit is payable

If you are eligible for one or more of the *monthly benefit* for *total disability*, *monthly benefit* for *partial disability*, Specific Injury benefit, *Health Event* benefit, Bed Confinement benefit or the Accident option at the same time, only one benefit is payable, being the one which provides the highest payment.

When portions of the Monthly Amount of Cover are subject to different terms

Where we agree, your Income Cover policy may be set up so that separate portions of the Monthly Amount of Cover are subject to different waiting periods, benefit periods, types of cover and/or options. Details of each portion of the Monthly Amount of Cover, and the waiting periods, benefit periods, types of cover and options that apply to each portion, will be shown in the policy issued to you.

In determining the *monthly benefit* to be used as the basis for the payment of any benefit(s) under the policy in any given month, we will consider the sum of only those portions of the Monthly Amount of Cover for which the particular benefit is payable, having regard to the waiting period, benefit period, type of cover and options that are applicable.

Important information

When we won't pay

We will not pay a benefit under your Active cover if any of the following apply:

Death and *terminal illness* (benefit category AA)

- if your *terminal illness* or death occurs directly or indirectly by an intentional self inflicted act within 13 months of *cover commencement.* This exclusion will not apply if the *replacement cover waiver – death and terminal illness* applies.

***Health Events* (benefit categories A to E)**

- if the *Health Event* is caused directly or indirectly by an intentional self inflicted act at any time,
- if the *Health Event* has a specified exclusion (see *Health Events* section starting on page 43), or
- if the *Health Event* occurs within 90 days of the *application date* or the date any cover is reinstated and the *Health Event* has a 90 day exclusion specified (see *Health Events* section starting on page 43). This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Child Cover

Where the *Child Cover Condition* (or where the condition involves surgery or a procedure, the disease or condition for which the surgery or procedure is undertaken):

- is a congenital condition,
- is caused by the intentional act or intentional omission of the policy owner or the insured child's parent, guardian or a person acting in a regular de facto role as a parent, or
- occurs within 90 days of the *application date* or the date any cover is reinstated and the *Child Cover Condition* has a 90 day exclusion specified (see Child Cover section on page 12). This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Income Cover

- if the *disability* is caused directly or indirectly by:
  - an intentional self inflicted act at any time,
  - normal or uncomplicated pregnancy or childbirth,
  - war or an act of war, or
  - elective surgery that occurs within six months of *cover commencement,*
- for claims payable under the Health Events benefit on page 18, if the *Health Event* occurs within 90 days of the *application date* or the date any cover is reinstated and the *Health Event* has a 90 day exclusion specified (see *Health Events* section on page 43),
- any period while the insured person is in jail,
- any period beyond three months while the insured person is outside of Australia. Upon return to Australia, benefits can continue if otherwise payable, or
- if the insured person unreasonably refuses to undergo the medical treatment including rehabilitation to treat their *disability* as recommended by their *medical practitioner.*

We may, when lawfully entitled to do so, avoid or adjust your cover if you have breached your duty of disclosure (see page 29) or you or the person to be insured have made a misrepresentation (see page 34) in your application for Active cover or when applying for an increase in cover.

When cover or the amount payable is reduced

Cover provided under the policy will be reduced if you request a decrease in your Active cover.

If you request a change to the *Initial Amount of Cover* for *Health Events*, *terminal illness* and death cover under your policy, the *Remaining Amount of Cover* and the Protected Amount will be adjusted so that it retains the same proportion to the *Initial Amount of Cover* as it did before the requested change.

The amount we will pay for a *Health Event*, *terminal illness* or death claim may be reduced if it is not the first claim under your policy. Refer to the "How we calculate the amount we will pay" section on page 6.

For Income Cover, the amount payable may be reduced if you are able to continue to work in a reduced capacity, or are receiving *income* from other sources. See page 13 for information about Income Cover.

Changes to definitions

From the cover anniversary when the insured person is age 70, cover for all *Health Events* ceases and cover is only provided for:

- *loss of independent existence.* This will be treated as benefit category A, and
- death and *terminal illness* under benefit category AA.

From the cover anniversary when the insured person is age 99, cover for *loss of independent existence* ceases and cover is only provided for death and *terminal illness* under benefit category AA criteria.

Things to consider

The type of insurance cover and amount of cover you select may not be adequate for your objectives, financial situation and needs. This is why we suggest that you consult a financial adviser (who holds an Australian Financial Services Licence) before you apply for Active cover.

Superannuation policies

If your Active cover is held within superannuation, it is important to remember that the governing rules of the relevant superannuation fund, and superannuation and other laws may restrict (depending on your circumstances):

- the contributions that can be made to the relevant superannuation fund (that may be required by the trustee to pay the premiums for the Active policy), and
- the benefits that can be paid from the relevant superannuation fund (following receipt by the trustee of the relevant superannuation fund of a benefit paid under the Active policy).

The premium

How the premium is calculated

The premium you pay for your Active cover is calculated as at the cover start date and at each subsequent cover anniversary, by applying our Active cover premium rates to the amount of cover for each benefit.

For *Health Events*, *terminal illness* and death cover, the premium is based on the *Initial Amount of Cover* throughout the life of the policy.

The factors on which the premium will depend include how much cover you have selected, the options which apply, the premium payment frequency, the premium type and your (or the insured person's, if different):

- age (premiums generally increase with age),
- gender,
- general health,
- smoking status (premiums are higher for smokers),
- recreational pursuits,
- occupation, and
- state of residence.

The premiums for each type of insurance also depend on:

- whether the policy is structured under the Superannuation Optimiser structure (see page 26),
- for Income Cover, the waiting period, benefit period and whether the cover is provided on an '*income* at claim' or '*income* at application' basis.

Generally, there are two premium types to choose from:

- **'Stepped' premium** – generally, the premium increases each year based on the insured person's age.
- **'Level' premium** – the premium remains the same until the cover anniversary when the insured person is aged 65, except for:
  - increases to your Active cover, including those made under Indexation Increases and Future Increases, and
  - increases we make to the underlying rates as explained on this page under "Changes to the premium".

  At the cover anniversary when the insured person is aged 65, the 'level' premium automatically converts to a 'stepped' premium.

If you request an increase or decrease in your Active cover, the premium will reflect the change. Before each cover anniversary, we will notify you of the premium for the period to the next cover anniversary.

As part of the application process, an indicative premium will be provided to you. You can also request a copy of our Active cover premium rates. The actual premium could increase if the person to be insured has a birthday after the indicative premium is provided and before the cover start date. We may also only be able to offer you cover if you agree to a higher premium.

Payment of the premium

Your premium is calculated on an annual basis and can be paid yearly or monthly in advance. If you choose to pay it yearly in advance, a discount of 6% will apply.

If you are a member of an *eligible superannuation plan* your premium will automatically be deducted in advance from your account, otherwise the premium can be paid from the following sources:

- credit card,
- direct debit from an Australian bank account,
- an *eligible wrap service* held in the same name, or
- Macquarie Cash Management Account (CMA).

You, or your adviser acting as your agent, must provide us with a valid premium deduction authority to enable us to deduct the premium when due for payment.

The premium payable for the first year is shown in the policy. If you pay annually, we will deduct the premium on the cover anniversary each year or another date to which we agree.

If you pay monthly, we will deduct the premium every month on the same day of the month as the cover anniversary or another day of the month to which we agree. If the date shown falls on a weekend or public holiday, the premium will be deducted on the next business day following the due date.

All payments to us must be in Australian dollars.

Non-payment of premium

If a premium payment is not made, we will notify you advising the date on which the policy will end if the amount due is not paid. If a payment sufficient to meet the amount due is not made by that date, we will cancel the policy.

We will give at least 20 business days notice before the policy is cancelled because of non-payment of premiums.

Changes to the premium

We can change the Active cover premium rates but only if we do this for all policies in a defined risk group.

Any changes to premium rates will come into effect for your policy on the next cover anniversary after we make the change.

If we increase premium rates we will usually provide 30 days prior notice of your new premium.

We reserve the right to pass on any government taxes and charges which may be introduced or increased during the life of your policy.

Surrender value

Your Active cover does not have a surrender value.

A pro-rata refund will be made where a premium is paid annually and cover is cancelled prior to the next cover anniversary.

Insurance-only division of Macquarie Superannuation Plan

If you have Active cover as a member of the insurance-only division of the Macquarie Superannuation Plan, MIML will use your contributions to the insurance-only division to pay the premium for the policy on your life. For further information on the insurance-only division of the Macquarie Superannuation Plan, see pages 36 to 39.

Direct Debit Service Agreement

Where you have elected to have your Active cover premium deducted from your account by direct debit, you agree to the terms detailed below.

1. I/we have requested Macquarie Life Limited, ABN 56 003 963 773 AFSL No. 237497, (User ID 145096) to deduct my nominated account with:
   - any amounts that become payable in relation to my Active cover, or
   - any amount needed to cover contributions to Active cover held in the insurance-only division of the Macquarie Superannuation Plan,

   through the BECS (Bulk Electronic Clearing System).
2. The financial institution may, in its absolute discretion, at any time by notice in writing to me terminate this request as to future debits.
3. Macquarie Life may, by notifying me within 14 days, vary the timing of future debits.
4. Where the due date does not fall on a business day and I am uncertain whether sufficient cleared funds will be available to meet the direct debit, I will contact my financial institution directly and ensure that sufficient cleared funds are available.
5. I can modify or defer this regular Direct Debit Request at any time by giving Macquarie Life 14 days notice.
6. I can stop or cancel the regular Direct Debit Request at any time by giving Macquarie Life or my financial institution 14 days notice.
7. If at any time I feel that a direct debit against my nominated account is inappropriate or wrong it is my responsibility to notify Macquarie Life or my financial institution as soon as possible.
8. If I believe there has been an error in debiting my account, I will notify Macquarie Life or my financial institution and confirm that notice in writing with Macquarie Life as soon as possible.
9. Direct debiting through BECS is not available on all accounts. I can check my account details against a regular statement or check with my financial institution as to whether I can request a direct debit from my account.
10. It is my responsibility to ensure that there are sufficient cleared funds in my nominated account to honour the Direct Debit Request. I understand that the Direct Debit Request will be automatically cancelled if two debit payments are dishonoured because of insufficient funds. Macquarie Life will give me 14 days notice in writing if they intend to cancel my Direct Debit Request.

    Macquarie Life will also charge the cost of dishonoured direct debits against my account. Macquarie Life may cancel my Active cover if the Direct Debit Request is cancelled because of dishonours.
11. It is my responsibility to ensure that the authorisation given to debit the nominated account is identical to the account signing instruction held by the financial institution where the account is held.
12. Macquarie Life may need to pass on details of my direct debit request to their sponsor bank in BECS to assist with the checking of any incorrect or wrongful debits to my nominated account.

Policy ownership

Ownership of your Active cover is an important consideration as it may affect the following aspects of your insurance cover:

- how cover will be issued,
- who receives any benefit that becomes payable,
- types of cover and options available,
- benefits included in a policy eg some benefits are not available when cover is held through superannuation,
- access to any benefit that becomes payable, and
- the tax treatment of the premium paid and benefits received.

The first five aspects are covered in this section. For information on tax, see page 40.

To maximise the efficiency of your insurance arrangements, Active cover allows a number of ownership structures as shown in the table below.

Policy owner	The person who is insured under the policy (insured person)	Type of cover available
Non-superannuation		
A person or company (that is not a trustee of superannuation fund).	Either: ■ the same person as the policy owner, or ■ a different person.	All types of cover are available under a non-superannuation policy: ■ death and *terminal illness,* ■ *Health Events,* ■ Income Cover (including Extra Benefits option), and ■ Child Cover.
Within superannuation		
A person or company who is a trustee of a self managed superannuation fund.	A member of the relevant self managed superannuation fund.	The types of cover available under a superannuation policy are limited to: ■ death and *terminal illness,* ■ *Health Events* (meeting the SIS permanent incapacity definition), and ■ Income Cover (not available through the insurance-only division of the Macquarie Superannuation Plan).
Macquarie Investment Management Limited (MIML) as trustee of a superannuation fund.	A member of an *eligible superannuation plan.* A member of the insurance-only division of the Macquarie Superannuation Plan.	

Non-superannuation

When you apply for Active cover outside of superannuation, the policy is issued directly to you as policy owner. Any of the types of cover under Active cover can be held under a non-superannuation policy.

Where there are multiple owners of a single policy who are individual persons, each will own the policy as joint tenants (ie on the death of one of the policy owners, their share passes to the surviving joint tenants), unless they own the policy as trustees or we agree to a different arrangement which we will note on the policy.

If you hold an *eligible wrap service* in the same name, you can link your Active cover to it and the premiums will be deducted from your account.

If a benefit becomes payable, the benefit is generally paid to the policy owner. If the insured person and policy owner are the same, the amount payable on the death of the insured person will be paid to the legal personal representative, unless any beneficiaries have been nominated under the policy, in which case it will be paid to the nominated beneficiaries.

Nominating a beneficiary for death cover

If the policy owner is the same as the insured person, up to five beneficiaries can be nominated to receive the benefit payment if the insured person dies. If you do not nominate a beneficiary, the benefit will be paid to your legal personal representative or other person we are permitted to pay under the Life Insurance Act 1995 (Cth).

Each beneficiary you nominate must be a person, a company or a legally recognised charity. You can change or cancel these nominations at any time in writing. A change in a nomination only takes effect when received by us. At time of claim, if part of a nomination is invalid or one of the nominated beneficiaries has predeceased the insured person, the proceeds in relation to that invalid part or predeceased nominated beneficiary will be paid to your legal personal representative.

If a nominated beneficiary is a minor, we will pay the proceeds in relation to that nominated beneficiary to their legal guardian or into a trust for which that minor is a beneficiary.

All nominations will automatically cease if ownership of the policy is transferred (see page 28).

Within superannuation

When you apply for cover within superannuation, the trustee of the relevant superannuation fund applies to Macquarie Life for cover in respect of the relevant member's life and the policy is issued to the trustee as policy owner.

We do not allow some parts of the Active cover to be held within superannuation. If you choose to hold part of your Active cover within superannuation, two policies will be issued under a structure called Superannuation Optimiser:

- a superannuation policy which will be owned by the trustee of a superannuation fund, and
- a separate non-superannuation policy which will provide the cover that cannot be issued under a superannuation policy.

Superannuation Optimiser

The policy issued to the trustee of a superannuation fund will hold the cover for death and *terminal illness* and part of the cover for *Health Events.* The *Health Events* which are included are those covered under benefit category A and which also meet the Superannuation Industry (Supervision) Act 1993 (Cth) (SIS) definition of permanent incapacity (as amended from time to time and applied as if we were the trustee of the relevant superannuation fund). We refer to this policy as the 'superannuation policy'.

The balance of the cover for *Health Events* not included under the superannuation policy will be held under a separate policy which we refer to as the 'non-superannuation policy'. The two policies will be linked together in a Superannuation Optimiser structure so that claims that are paid under one policy will reduce the *Remaining Amount of Cover* available under both policies. The effect of this structure is that the same amount of cover is provided, but split between two separate policies.

Superannuation policy	Non-superannuation policy
■ Death ■ *Terminal illness* ■ *Health Events* covered under benefit category A (meeting SIS definition of permanent incapacity)	■ *Health Events* covered under benefit category A (not meeting SIS definition of permanent incapacity) ■ *Health Events* covered under benefit category B, C, D and E

Claims under the superannuation policy

Claims for death and *terminal illness* will be paid under the superannuation policy to the trustee as policy owner. Claims for *Health Events* will first be assessed under the superannuation policy to determine if the following requirements are satisfied:

- the definition of a *Health Event* covered under benefit category A, and
- the Superannuation Industry (Supervision) Act 1993 (Cth) (SIS) definition of permanent incapacity (as amended from time to time and applied as if we were the trustee of the relevant superannuation fund).

If both requirements are satisfied and a benefit is payable under the superannuation policy, the benefit will be paid to the trustee. The release of the benefit from the superannuation fund to the member or beneficiaries will then be subject to the governing rules of the superannuation fund and superannuation and related taxation laws current at the time of payment.

Claims under the non-superannuation policy

If no benefit is payable under the superannuation policy, the claim will then be assessed under the non-superannuation policy. If a benefit is payable under the non-superannuation policy, the benefit is paid to the policy owner of the non-superannuation policy (and hence is not subject to superannuation laws).

Other conditions that apply to Superannuation Optimiser policies

The *Initial Amount of Cover* under each of the policies must always be the same. If you request a decrease to the *Initial Amount of Cover*, it will be applied to both policies. Similarly, if you apply to increase the *Initial Amount of Cover*, you must apply to increase both policies. In the event that the cover is cancelled under one of the policies, the cover under the other policy will immediately end.

We will take into account prior claims under both policies when determining whether a claim under either policy is for a *Progressive Condition* or is subject to a *Limited Claim Period.*

In the event of a *Health Event* claim, the premium payable under the superannuation policy is reduced in the same proportion as the reduction applied to the *Remaining Amount of Cover,* while the premium payable under the non-superannuation policy is increased by a corresponding amount so that the total premium payable across the two policies is unchanged (excluding other changes to the policies or indexation or age related increases). For more information on how we calculate premiums see The Premium section on page 23.

Other conditions on holding cover within superannuation

Child Cover cannot be held within superannuation. The Funeral Assistance benefit is not available if you choose to hold part of your cover within superannuation. If you choose to hold part of your cover within superannuation, the Financial Planning benefit (see page 10) will only apply to the non-superannuation policy.

As explained in the section titled "Changes to definitions" on page 22, the cover for *Health Events* changes at the cover anniversary when the insured person is aged 70 and this cover will be held under the superannuation policy. The cover under the non-superannuation policy will end at the cover anniversary when the insured person is aged 70.

Income Cover

Income Cover cannot be held within the insurance-only division of the Macquarie Superannuation Plan. Income Cover with an 'income at application' cover type is not available within *eligible superannuation plans.*

If you choose to hold Income Cover within superannuation and select the Extra Benefits option, two policies will be issued: a superannuation policy which will be owned by the trustee of a superannuation fund and a separate non-superannuation policy to hold the Extra Benefits cover.

Superannuation policy	Non-superannuation policy
■ Income Cover	■ Income Cover Extra Benefits

Any benefit that becomes payable in respect of the Extra Benefits cover is paid to the policy owner of the non-superannuation policy and is not subject to superannuation law.

The Extra Benefits cover is only available with a current Income Cover policy and the Monthly Amount of Cover under both policies must be the same. If the Monthly Amount of Cover under the Income Cover is altered, the Extra Benefits cover will be similarly altered and the premium adjusted accordingly. If the Income Cover is cancelled, the Extra Benefits cover will also be cancelled. The terms and conditions of "When we won't pay" as explained on page 22 and "When cover ends" as explained on page 34 that apply to Income Cover also apply to the Extra Benefits cover.

If you choose to hold your Income Cover within superannuation, the Specific Injury benefit will only apply if you select the Extra Benefits option (refer to page 18). In this case, the Specific Injury benefit will be included in the Extra Benefits policy issued.

The Superannuation Cover option is not available if Income Cover is held within superannuation. Income Cover Plus is not available if you choose to hold Income Cover as a member of an *eligible superannuation plan*.

Benefit payments

If a benefit becomes payable under Active cover held within superannuation, it will be paid to the trustee, who must distribute the benefit in accordance with the governing rules of the superannuation plan and superannuation laws current at the time of payment. There may be circumstances in which the trustee will receive a benefit under an Active policy but is unable to release all or part of a benefit from the superannuation fund at that time. For example, super law constraints may prevent a trustee from paying a benefit it receives under Income Cover in relation to:

- certain features and benefits that apply without a requirement for the insured person to have ceased an arrangement of gainful employment or to have been on unpaid leave for at least some duration, and
- cover provided on an 'income at application' basis.

There may also be circumstances where the benefit paid from Macquarie Life to the trustee is included in the superannuation fund's assessable income for tax purposes, in which case, the benefit paid from the fund will be net of any tax payable by the fund.

We recommend you seek advice before you apply if you are considering taking this insurance cover within superannuation.

Self managed superannuation funds

If you are the trustee of a self managed superannuation fund, you can apply for Active cover as the trustee in respect of a member or members of your self managed superannuation fund. It is your responsibility as trustee to consider the appropriateness of providing each type of insurance cover within superannuation and superannuation law that operates to limit when benefits received by you as trustee can be paid to a member of your fund.

If, as trustee of a self managed superannuation fund, you have an *eligible wrap service*, you can link the Active cover to that account and premiums will be deducted from the account. We will make any claim payments to you in your capacity as trustee of the fund.

Members of a superannuation plan for which MIML is trustee

You can apply for Active cover through superannuation if you are a member of an *eligible superannuation plan* or by becoming a member of the insurance-only division of the Macquarie Superannuation Plan.

If you are a member of an *eligible superannuation plan*, you can link the Active cover to your accumulation account and premiums will automatically be deducted from the account. We will make any claim payments to MIML, as trustee of the *eligible superannuation plan*.

Insurance-only division of Macquarie Superannuation Plan

Important information about applying for Active within superannuation by becoming a member of the insurance-only division of the Macquarie Superannuation Plan can be found on page 36.

Transferring ownership

If your Active cover is held under a non-superannuation policy, you can transfer ownership of your policy to another non-superannuation ownership arrangement by completing a Memorandum of Transfer, which must be signed by both you and the transferee, and sending it to us with your original policy for registration. The transferee must have an insurable interest in the insured person that is satisfactory to us.

If you have existing cover under a non-superannuation policy and want the cover to be held within superannuation, the trustee of the superannuation fund can apply for a new policy in respect of cover on your life and your existing cover can be cancelled and issued under a new policy owned by the trustee, subject to superannuation laws.

If the trustee of a superannuation plan holds the policy on your life, you can request the trustee to transfer the policy to you subject to superannuation laws and the governing rules of the fund.

All transfers between policy owners and to new policies must be like for like cover, otherwise a full application and usual underwriting assessment will be required.

How to apply

Your adviser

This product is available through licensed intermediaries, who we refer to as 'your adviser'. This includes licensed financial advisers, who can assist you with advice in considering Active cover and help you determine the amount and type of cover you require considering your personal objectives, financial situation and needs. It also includes licensed distributors who may promote the product and make it available to you or assist you with an application.

Your adviser may act as your agent and lodge your application with us on your behalf.

Your adviser is your main point of contact for your insurance so please talk to them if you have any questions about your Active cover.

If your application for Active cover is accepted, Macquarie Life may pay your adviser a commission for selling this product. The commission is paid by us and does not affect your premium. You can obtain details from your adviser of any commission paid.

How to apply

To apply for cover, you need to lodge an application with us, which your adviser can help you with. We will accept a paper application signed by you, or an online application lodged electronically by a financial adviser, where the adviser lodges the application as your agent. Generally the application will include an application for Active cover, a detailed personal statement and a number of declarations we will rely on in deciding whether or not to issue (and the terms on which we issue) the insurance being applied for, and to administer any policies we issue.

If your adviser lodges an online application on your behalf, the adviser is required to confirm that he or she has your authorisation to act as your agent and that you have made a number of declarations and authorisations. It is your responsibility to ensure that the information provided to us by your adviser is accurate and complete. We will rely on the accuracy of the information provided to us via the online application, as we would if a paper application was signed and submitted by you. We may contact you to verify that the information we have received from your adviser is accurate and complete.

If you are the policy owner, but are not also the insured person under the policy we issue, it will be necessary for personal and health information to be collected from the insured person. This can be provided on a paper application submitted to us, and signed by the insured person. Alternatively, it may be supplied to us via the online application process described above. In these cases, the adviser will also be acting as the agent of the person to be insured in submitting the information.

After an online application is lodged electronically by you or your adviser, you will receive a copy of the completed application relied upon by us in assessing the application. You must carefully review the information provided to ensure it is accurate and complete and notify us as soon as possible if any corrections are required. If a policy has already been issued and the corrected information would have been relevant in our assessment of the application, we may seek to enforce our remedies for non-disclosure and cancel or vary the insurance to take into account the corrected information.

If the person to be insured has a birthday after the application is submitted and before cover commences, the premium will be adjusted to reflect the rate applicable for your age at *cover commencement*. In these cases the premium may differ from any indicative quotes provided to you prior to the issue of the policy.

Your duty of disclosure

Before entering into a contract with us you have a duty, under the Insurance Contracts Act 1984 (Cth), to disclose to us every matter you know, or could reasonably be expected to know, that is relevant to our decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to us before your cover is extended, varied or reinstated. Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by us,
- that is of common knowledge,
- that we know or, in the ordinary course of our business, ought to know, or
- as to which compliance with your duty is waived by us.

Non-disclosure

If you fail to comply with your duty of disclosure and we would not have entered into the contract on any terms if the failure had not occurred, we may avoid the contract within 3 years of entering into it. If your non-disclosure is fraudulent, we may avoid the contract at any time.

If we are entitled to avoid a contract of life insurance, we may, within 3 years of entering into it, elect not to avoid it but reduce the amount that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to us.

Please note, your duty of disclosure continues until a written contract of insurance has been issued by us.

Underwriting

We will promptly notify you or your adviser of any additional information needed to underwrite your application.

We may contact you for additional information about your medical and financial circumstances, as well as any hazardous pursuits or pastimes, occupational duties and other information that may assist with assessment of your application.

We may ask you to undergo a medical examination and/or blood tests. This will usually be arranged through our nominated pathology provider, who may be able to arrange the services to be undertaken at your workplace or home or at medical centres across Australia. On request, we can send the medical examination and blood test results to a doctor nominated by you. We will cover the associated costs of any tests required.

The tests and requirements may vary depending on your age and occupation and the amount and type of cover applied for.

The application

In accepting an application of insurance, we will be relying on declarations and authorisations made by you, either directly or via your agent, relating to the following matters:

Your adviser

- you have appointed your adviser to act on your behalf in relation to this insurance and, if we receive online applications lodged by your adviser, you have appointed your adviser as your agent to complete and lodge an application for insurance as your agent,
- you have received an Active cover PDS and agree to be bound by it.

Disclosure obligations

- you and the person to be insured (if different) have read and understood the duty of disclosure as explained in this PDS and understand the duty continues until we have issued a contract of insurance,
- you and the person to be insured (if different) confirm the information supplied in connection with the application is true and correct and no information material to the application has been withheld,
- you acknowledge that we are entitled to rely on the information provided in the application, including online applications lodged on your behalf, in determining an application and assessing future claims, and that we may be entitled to vary or avoid the insurance if there has been non-disclosure, misrepresentation or fraud, and
- you and the person to be insured (if different) agree that you will review the information provided on an online application and agree to inform us immediately if there are any errors or omissions and understand that we may seek to vary or avoid the insurance if errors or omissions are identified.

Authorisations

- you and the person to be insured (if different) authorise and consent to the collection of medical information and its use by us, and
- you authorise the collection of premiums from the account designated in the application.

Other declarations

- you acknowledge that the terms and conditions of the Active policy we issue are available online at macquarielife.com.au and that a copy will be sent to you upon request,
- you and the person to be insured (if different) have read the Privacy Statement contained in the PDS,
- you have read the anti-money laundering terms and conditions in the PDS,
- if applying for membership of the insurance-only division of the Macquarie Superannuation Plan, you are eligible to contribute to superannuation under superannuation laws, and
- you acknowledge that Macquarie Bank Limited has no obligations in respect of Active cover issued by us.

Who should authorise the application

Both you as the policy owner and the person to be insured (if different) must authorise the application, payment authority and various other declarations and authorisations that are required to be completed for an application. As noted above, where an online application is lodged by your adviser electronically these authorisations will be provided to us by the adviser acting as your agent.

Cooling-off period

You have a 21 day cooling-off period after your Active cover commences during which time you can cancel your policy if you decide that the insurance cover does not meet your needs. You will be entitled to a refund of the premium that you have paid (if you applied for cover within superannuation, superannuation regulations may require your refund to be preserved within the superannuation system). If you wish to use the cooling-off period, you must not have made a claim and must notify us within 21 days of the earlier of:

- the date you receive your policy, or
- the end of the fifth business day after we issue the policy.

Privacy

Your privacy is important to us and the Trustee. This statement explains how personal information can be used or disclosed and provides information about your privacy rights.

By completing the application you and the person to be insured agree to allow us (and, if you are a member of a plan for which MIML is trustee, the Trustee) to use the personal information of you and the person to be insured to:

- assess and process the application for insurance,
- communicate with you and your nominated adviser about the application and any cover we supply to you, monitor, audit, evaluate and otherwise administer your policy, and
- assess, process and investigate any claims.

Other than for the purposes set out in this document, we will not share sensitive, health or financial information. However, we, or other Macquarie companies, may contact you to offer you other products or services which may be of interest to you. If you do not wish that to occur please let us know by contacting us.

If you, or the person to be insured, do not supply us and the Trustee with the personal information requested, we may not be able to provide the cover or benefit applied for.

Health information

The references in this Privacy Statement to personal information include sensitive information such as your medical and health related details. If required to assess your application, administer your policy or process any claims, we (and, if you are a member of a plan for which MIML is trustee, the Trustee) may seek further information from any medical attendant consulted by you.

Disclosure of personal information

You and the person to be insured also agree that other companies in the Macquarie Group and our external service providers (including for example, reinsurers and mailing houses) may access personal information when appropriate to assess your application, verify your identity, administer your policy or process any claims.

We and the Trustee may also disclose the personal information of you and the person to be insured:

- if acting in good faith, we believe that the law requires or permits us to do so,
- if you or the person to be insured consent, or
- to the doctor identified in the application of the person to be insured if any medical tests that we have requested return an abnormal result.

The personal information will also be provided to your adviser in connection with the application for insurance and on going management of your policy. This excludes the release of any reports sourced by Macquarie Life from any outside parties. You can instruct us not to supply your adviser with any medical information received by us in the declaration that forms part of your application, or by writing to us.

Your rights and responsibilities

If you do not supply all of the personal information requested, we may not be able to provide you with the cover for which you apply. You also have a duty of disclosure (explained on page 29) under the Insurance Contracts Act 1984 (Cth).

Under the Privacy Act 1988 (Cth), you may request access to your personal information held by us (and, if you have applied for membership of the insurance-only division of the Macquarie Superannuation Plan, the Trustee).

You can contact us to make such a request or for any other reason relating to the privacy of your personal information.

Contact details are shown in the section titled “Contact information” on page 42.

Anti-money laundering (AML)

1. You undertake that you will not knowingly do anything to put us in breach of the Anti-Money Laundering and Counter-Terrorism Financing Act 2006, rules and other subordinate instruments (“AML/CTF Laws”), and to notify us if you are aware of anything that would put Macquarie in breach of AML/CTF Laws.
2. You undertake that you are not aware and have no reason to suspect that the money used to fund your insurance is derived from or related to money laundering, terrorism financing or similar activities (“Illegal Activities”) or that the proceeds of your insurance will fund Illegal Activities.
3. You acknowledge that we are subject to AML/CTF Laws. In making this application you consent to us disclosing in connection with AML/CTF Laws any of your Personal Information as defined in the Privacy Act 1988 (Cth).
4. You acknowledge that in certain circumstances we may be obliged to freeze or block an account where it is used in connection with Illegal Activities or suspected Illegal Activities. Freezing or blocking can arise as a result of the account monitoring that is required by AML/CTF Laws. If this occurs, we are not liable to you for any consequences or losses whatsoever and you agree to indemnify us if we are found liable to a third party in connection with the freezing or blocking of your account.
5. You acknowledge that we retain the right not to provide services or issue products to any applicant that we decide, in our sole discretion, that we do not wish to supply.

Interim cover

While your application for Active cover is being assessed, we provide you with interim cover for *accidental* injury or death, except where the insurance applied for will replace existing insurance in place with us or with another insurer.

The person to be insured will be covered for *Health Events*, *terminal illness* and death that fall within benefit categories AA, A and B as the result of an *accident*, where the *accident* occurs during the period of interim cover and the condition occurs within three months of the *accident.* Only one benefit across the benefit categories AA, A and B will be payable during interim cover, being the one which pays the highest benefit.

If Income Cover is included in the application for cover, you will be covered for:

- the interim benefit for *total disability* from the end of the waiting period applied for in the application, for up to a maximum of six months, if you are *totally disabled* as the result of an *accident* that occurs during the period of interim cover and *total disability* due to the *accident* starts within three months of the *accident,* and
- the interim death benefit, if you die as the result of an *accident* that occurs during the period of interim cover and death occurs within three months of the *accident.*

If Child Cover is included in the application, the child to be insured will be covered for death as the result of an *accident* and the *Child Cover Conditions* listed below as the result of an *accident,* where the *accident* occurs during the period of interim cover and the condition occurs within 3 months of the *accident:*

- *coma*
- *paralysis*
- *loss of hearing*
- *loss of limbs*
- *loss of sight*
- *major head trauma*
- *severe burns*

When interim cover starts

Interim cover starts on the date an authorised application is received by us.

When interim cover ends

Interim cover will end on the earlier of:

- your application for cover is accepted and cover commences,
- your application for cover is cancelled or withdrawn by you,
- insurance cover commences under another contract of insurance (whether or not it is an interim contract of insurance) between you and Macquarie Life or another insurer,
- your interim cover is cancelled by us by providing you with at least 20 business days written notice, or
- 90 days from the date the interim cover started.

When interim cover is not payable

Nothing will be payable if the condition or event giving rise to the claim under interim cover was caused directly or indirectly by:

- an *accident* or injury that first occurred before interim cover started,
- an intentional self-inflicted act,
- consumption of alcohol or drugs,
- for Child Cover, an intentional act or intentional omission of the policy owner or the insured child's parent, guardian or a person acting in a regular de facto role as a parent, or
- the person to be insured engaging in any sport, pastime or occupation that we would not normally cover at standard rates.

When lawfully entitled to do so, we may avoid or adjust your interim cover if you have breached your duty of disclosure or you or the insured person have made a misrepresentation when applying for cover.

What we will pay

The maximum interim cover benefit that we will pay for each type of cover across all applications for the person to be insured is set out below:

In the case of interim cover for death, *terminal illness* and *Health Events*, the lesser of:

- the *Initial Amount of Cover* applied for to a maximum of:
  - Benefit category AA: $1 million,
  - Benefit category A: $500,000,
  - Benefit category B: $325,000,
- the *Initial Amount of Cover* that we would offer under our usual underwriting rules based on the proposed premium.

In the case of interim cover for *total disability* under Income Cover, the lesser of:

- the Monthly Amount of Cover applied for,
- $5,000 per month,
- the monthly equivalent of 75% of first $320,000, 50% of the next $240,000 and 20% of the balance of the person to be insured's *pre-disability income*, adjusted for any reductions which apply, as explained in the section titled "When the *monthly benefit* is reduced" on page 15, and
- the Monthly Amount of Cover that we would offer under our usual underwriting rules based on the proposed premium.

In the case of the interim death benefit under Income Cover, the lesser of:

- four times the Monthly Amount of Cover applied for,
- $20,000,
- four times the monthly equivalent of 75% of the first $320,000, 50% of the next $240,000 and 20% of the balance of the person to be insured's *pre-application income*, and
- four times the Monthly Amount of Cover that we would offer under our usual underwriting rules based on the proposed premium.

In the case of interim Child Cover, the lesser of:

- the Amount of Cover applied for, subject to a maximum of $50,000, and
- the Amount of Cover that we would offer under our usual underwriting rules based on the proposed premium.

If multiple policies for the same person to be insured are applied for, and the maximum interim cover benefit payable for the person to be insured is less than the total of all amounts applied for, we will reduce the maximum interim cover benefit across the multiple applications in the same proportion.

If interim cover benefits are paid for the person to be insured by other insurers for an *accident,* we will reduce the amount we will pay for the same *accident* under the same or similar type of insurance so that the total paid across all insurers is no more than the maximum amount we otherwise would have paid.

We will only pay one amount under interim cover for *Health Events*, *terminal illness* and death cover, being whichever provides the greatest benefit.

Your policy

When cover starts

Your Active cover starts from the Cover start date shown in the policy schedule that will be sent to you, subject to any special conditions that apply, or any other date applying under *cover commencement.*

As explained in the "Important information" section on page 22, qualifying periods may continue to apply for a period after *cover commencement* for some claims.

Active cover is referable to our No. 4 Statutory Fund and any claims paid under the policy will be paid from this fund.

Two documents make up your Active cover, the policy schedule and the Active policy terms and conditions. We will send you the policy schedule for your Active cover. A copy of the Active policy terms and conditions that apply to the Active cover are available online at macquarielife.com.au. Alternatively, you may call one of our service consultants who can arrange to send you a paper copy of the policy terms free of charge. We recommend you keep your Macquarie Life Active policy schedule in a safe place with the Active policy terms and conditions.

The policy schedule

If we accept your application, we will issue a policy (or policies) detailing:

- policy owner(s),
- insured person,
- details of the insured person (such as gender, date of birth, occupation class and smoker status),
- type of cover provided,
- whether the policy is linked to another policy through Superannuation Optimiser structuring,
- amount of cover for the insurance(s) provided,
- if Income Cover is included, whether the cover is provided on an '*income* at claim' or '*income* at application' basis, the waiting period and the benefit period,
- any options that apply,
- cover start date,
- *application date,*
- cover anniversary,
- any premium adjustments which apply,
- any special conditions which apply, and
- the premium payable for the first year and when it is payable.

We may, when lawfully entitled to do so, avoid or adjust your cover if you have breached your duty of disclosure or you or the insured person have made a misrepresentation in your application for Active cover or when applying for an increase in cover.

When cover ends

Insurance cover provided under Active cover ends on the earliest of:

- the cover anniversary following the expiry age shown in the table following,
- your death,
- the *Maximum Amount Payable* under benefit category AA reduces to nil (only in respect of cover for *terminal illness* and death),
- before age 65, the maximum combined total payable for all *Health Events* claims has been reached, as explained under the Claim Protector feature, see page 9 (only in respect of cover for *Health Events*),
- after age 65, the *Maximum Amount Payable* under benefit categories A to E reduces to nil (only in respect of cover for *Health Events*),
- cancellation of the cover upon written request of the policy owner,
- cancellation of the cover by us due to non-payment of the premium when due,
- any other date applied under a special condition shown in the policy schedule, or
- if you are a member of an *eligible superannuation plan,* 30 days after the insured person has left the *eligible superannuation plan* or becomes ineligible for membership of the *eligible superannuation plan* under law.

Cover type	Expiry age
Death and *terminal illness*	No expiry
Health Events	99[1]
Child Cover	21[2]
Income Cover with the following benefit periods: ■ 2 year ■ 5 year ■ to age 65	65[3]
Income Cover with a to age 70 benefit period	70

[1] The cover provided for *Health Events* changes at age 70. See page 22.
[2] Child Cover ends only in respect of the insured child for whom the expiry event has occurred.
[3] Income Cover may be extended beyond the cover anniversary when you are aged 65 subject to the terms of the Cover Extension feature. See page 19.

Guaranteed upgrades

We will automatically provide you with any future improvements we make to the Active cover that you hold when they do not result in an increase in the premium rates. Where they do result in an increase in the premium rates, you will have the option to take up the offer of the upgrade.

Improvements will not apply to a claim resulting from an *illness* which first occurs (or symptoms leading to the condition occurring or being diagnosed first became reasonably apparent), or an injury or event which occurred, before these improvements took effect.

Keeping us informed

To ensure that our records are kept up to date and correct, we request that you advise us:

- of a change in your address or contact details, or
- of a change in banking or credit card details (that are relevant for the payment of premiums).

Making a claim

Notifying us of a claim

Please contact us on insuranceclaims@macquarie.com or 1800 208 130 if you think you are eligible to make a claim, or are unsure and would like some assistance. It is important that you notify us as soon as possible after any event that may lead to a claim. We will send you claim forms and explain in detail what the next steps are. If you do not notify us within 30 days of an event, we may be able to adjust the benefit payable if we have been prejudiced by the delay.

Assessing a claim

We will pay a benefit only after all of our claim requirements have been met and we admit liability. To assess the claim, and ongoing payments in the case of Income Cover, we will require some or all of the following (to be provided at your expense), in a form that is satisfactory to us:

- a completed claim form,
- your policy,
- proof of age (unless previously provided),
- a certified copy of the death certificate (for death claims only),
- evidence of *terminal illness*, the *Health Event* or *disability,* whichever is applicable for the claim being made, including test results and medical attendant statements (which we will send separately to your treating medical specialist),
- financial evidence including evidence of other insurance cover,
- evidence of *pre-disability income* and *post-disability income* and any other payments also received while Income Cover benefits are being paid by us, and
- evidence of *income* at time of application (and, if we have accepted an application for an increase in cover, your *income* at the time you applied for the increase in cover) if Income Cover is provided on an 'income at application' basis, unless it has already been supplied.

We may also require further medical and occupational assessments and other information where relevant to assess or finalise payment of the claim. This may include assessment by a *medical practitioner* nominated by us. Reasonable co-operation from you and/or the claimant is required.

All claim payments may be subject to an appropriate specialist physician approved by us verifying the diagnosis.

Where we request an examination, assessment or financial audit by a person we nominate, we will meet the cost. Otherwise you must meet the cost of satisfying our claim requirements.

If the insured person dies while a *Health Event* or *terminal illness* claim is being assessed, we will finalise assessment of the claim in progress if we have sufficient evidence at the time of death to establish whether the insured person met the definition for which the original claim was being assessed. If we do not have sufficient evidence at that time to finalise assessment of the claim in progress, the claim will be assessed under the policy terms relating to death.

Health Event claims

An appropriate medical specialist will be required to confirm the diagnosis of the condition for any *Health Event* claim made under your Active cover.

In conjunction with the evidence provided and information from the treating medical specialist, we will determine the benefit category that applies to the condition for which you are making a claim. You cannot elect to have the claim assessed or paid under a lower benefit category.

Payment of a claim

We will pay the claim as soon as possible once it has been approved.

All claims will be paid in Australian dollars.

We understand that at the time of claim it is not only financial support that is needed and so for severe claims, up to three free counselling sessions may be available for the claimant and/or their immediate family.

Insurance-only division of Macquarie Superannuation Plan

This section is applicable if you want to apply for Active cover within superannuation by becoming a member of the insurance-only division of the Macquarie Superannuation Plan. We do not allow some parts of the Active cover to be held through superannuation and a separate non-superannuation policy will be set up to hold these parts under the Superannuation Optimiser structure (see page 26).

The Macquarie Superannuation Plan is a resident, complying and regulated superannuation fund within the meaning of the Superannuation Industry (Supervision) Act 1993 (Cth).

The Macquarie Superannuation Plan is not subject to a direction from the Australian Prudential Regulation Authority under Section 63 of that Act, not to accept any contributions, made to the Plan by an employer sponsor.

Who can apply

You can apply to become a member of the insurance-only division of the Macquarie Superannuation Plan if you are eligible to make superannuation contributions or have them made on your behalf.

Generally, you are eligible to contribute to superannuation (or have contributions made on your behalf) if you are either:

- under age 65, or
- aged 65 to 74 and have worked at least 40 hours in a period of not more than 30 consecutive days in the financial year in which contributions are made.

Membership of the insurance-only division of the Macquarie Superannuation Plan is solely for the purpose of the provision of insurance cover within superannuation.

The Trustee will only accept your application for membership of the insurance-only division of the Macquarie Superannuation Plan if your application for insurance is accepted by Macquarie Life.

The insurance-only division of the Macquarie Superannuation Plan does not offer a superannuation savings facility. The only amounts that the Trustee will accept are contributions that are made for the purpose of paying the premiums for your Active cover.

The Trustee will not accept other amounts, including contributions that are made for a purpose other than the payment of a premiums, rollovers, transfers or Government co-contributions.

Benefit payments

If you suffer a *Health Event*, are diagnosed with a *terminal illness* or die and we pay a benefit to the Trustee, the Trustee can only pay a benefit from the insurance-only division of the Macquarie Superannuation Plan if:

- it receives a benefit from us in respect of a Active cover under which you are covered, and
- the Trustee is able to pay the benefit in accordance with superannuation laws current at the time of payment and the governing rules of the fund.

The current conditions of release for superannuation benefits are outlined below.

Death

In the event of your death, any benefit paid to the Trustee will be paid from the fund to either your legal personal representative (estate) or one or more of your dependants as defined under superannuation law (see the section titled "Death benefits" on page 37).

However, the benefit may be paid to another individual if the Trustee has not been able to find a legal personal representative or a dependant of yours after making reasonable enquiries.

Terminal medical condition

In order for the Trustee to release a benefit due to a terminal medical condition, the following conditions must be met:

- two registered *medical practitioners* have certified that you suffer from an illness or have incurred an injury that is likely to result in your death within a period that ends not more than 12 months after the date of the certificate,
- at least one of the registered *medical practitioners* is a specialist practising in an area related to the illness or injury suffered by you, and
- the period stated in each of the certificates has not ended.

Permanent incapacity

In order for the Trustee to release a benefit due to permanent incapacity, the following condition must be met:

- the Trustee is reasonably satisfied that you are unlikely, because of ill-health, to engage in gainful employment in a capacity for which you are reasonably qualified because of education, training or experience.

Other conditions

The other conditions prescribed under superannuation law under which the Trustee may release a benefit from the fund include:

- where you have reached the age of 65,
- where you have reached the age of 60 and you have ceased an arrangement of gainful employment on or after reaching the age of 60,
- where you have reached your preservation age (see below), you have ceased an arrangement of gainful employment and the Trustee is reasonably satisfied that you intend to never again become gainfully employed for at least 10 hours per week,
- where you are in severe financial hardship (as defined in superannuation legislation),

- where you are granted access on compassionate grounds approved by the Australian Prudential Regulation Authority (APRA).

Your preservation age depends on when you were born as set out in the table below:

Date of birth	Preservation age
Before 1 July 1960	55
1 July 1960 – 30 June 1961	56
1 July 1961 – 30 June 1962	57
1 July 1962 – 30 June 1963	58
1 July 1963 – 30 June 1964	59
After 30 June 1964	60

If the Trustee is unable to release all or part of a benefit at the time of claim, your entitlement (or part of it) will remain in the superannuation system in a cash account and will be released to you when you satisfy the relevant benefit payment criteria under superannuation law or, on your instructions, transferred to another division of the Macquarie Superannuation Plan or another superannuation fund after allowance for any fund tax liability.

Death benefits

You are given a number of options for nominating to whom a death benefit payable from the insurance-only division of the Macquarie Superannuation Plan will be paid.

No nomination – if you do not nominate a beneficiary, your benefit will be paid as a lump sum to your legal personal representative (your estate) unless the trustee has not been able to find a legal personal representative after making reasonable enquiries, in which case payment may be made to another individual.

Non-lapsing death benefit nomination – where the Trustee has consented to your nomination, your benefit will be paid as a lump sum to the person that you have nominated as long as your nomination:

- is valid, and
- has been made in the prescribed manner.

A non-lapsing nomination can only be made by you. The Trustee will not accept a non-lapsing nomination made by an attorney or any other agent.

The Trustee can only consent to a nomination in respect of one or more of your dependants (explained on this page) or legal personal representative. To remain a valid nomination, a nominated beneficiary must still be a dependant at the time of death.

If the Trustee has consented to your nomination to pay one or more dependants and that nomination, or a part of it, is no longer valid at the time of payment, the Trustee will pay the non-valid portion of your death benefit to your legal personal representative. The Trustee will pay the valid portion of your death benefit in accordance with that part of your nomination which is valid.

It is very important that you periodically review your nomination to ensure you still wish for the Trustee to pay the person(s) you have nominated, because:

- unlike a Will, your non-lapsing nomination will not automatically become invalid in the event of marriage, divorce or any other life-changing event, and
- a non-lapsing nomination will not become invalid after a period of time. We will send you regular reminders with the details of your nomination.

The Trustee can only consent to a nomination if it is made in writing and signed by you in the presence of two witnesses who are over 18 years of age and not named as beneficiaries in your nomination. To make a nomination simply complete the death benefit nomination section of the application, or complete a death benefit nomination form and send it to us.

A nomination applies across all death benefits with regard to your Active interest in the insurance-only division of the Macquarie Superannuation Plan. Any subsequent nomination revokes a prior nomination and applies across all death benefits with regard to your Active interest in the insurance-only division of the Macquarie Superannuation Plan.

You may revoke or change your nomination at any time by completing and sending to us a new non-lapsing death benefit nomination form. It will come into effect once the Trustee has consented to it.

Because there are special rules regarding how benefits can be paid from a superannuation fund in the event of your death, care should be taken when making your nomination as you may need to consider the impact it could have on your overall estate planning. You may want to seek legal or financial advice.

In some cases, upon special request, the Trustee will consent to nominations which are not catered for on the non-lapsing death benefit nomination form (eg because they are complex or because payment is contingent upon certain events occurring). If you wish to make a more detailed nomination, please speak to your financial adviser or contact us.

Who is a dependant?

Under current superannuation law a dependant includes:

- your spouse (including an opposite or same-sex de facto partner with whom you live on a genuine domestic basis as a couple or a person (whether of the same sex or a different sex) with whom you are in a prescribed kind of relationship that is registered under a State or Territory law prescribed for the purposes of the Acts Interpretation Act 1901),
- a child of yours (including an adopted child, a step-child, an ex nuptial child, a child of your spouse and a child within the meaning of the Family Law Act 1975),
- a person with whom you have an interdependency relationship, and
- a person who is otherwise your dependant (such as someone who is financially dependent on you).

Two people will typically have an interdependency relationship if:

- they have a close personal relationship,
- they live together,
- one of each of them provides the other with financial support, and
- one or each of them provides the other with domestic support and personal care.

Also, if two people have a close personal relationship but do not satisfy the conditions referred to above because either or both of them suffer from a physical, intellectual or psychiatric disability, they may nevertheless have an interdependency relationship.

Tax file number collection

Collection of tax file numbers (TFNs) is authorised under the Superannuation Industry (Supervision) Act 1993 (Cth). The Trustee will only use your TFN for purposes authorised by superannuation and taxation laws.

The purposes currently authorised include:

- taxing benefit payments at lower rates than may otherwise apply,
- passing your TFN to the Australian Taxation Office, and
- allowing the Trustee to provide your TFN to the trustee of another superannuation fund or Retirement Savings Account (RSA) if your benefit is transferred to that fund. However, the Trustee will not do so if you advise us in writing that you do not want us to pass it on.

Declining to quote your TFN is not an offence, however, if you do not give your superannuation fund your TFN, either now or later:

- the Trustee cannot accept contributions made by you or someone on your behalf (other than your employer),
- certain concessional contributions and other amounts may be subject to an additional TFN tax at the rate of 31.5%,
- you may pay more tax on your superannuation benefits than you have to (you may get this back in your income tax assessment), and
- it may be more difficult to find your superannuation benefits if you lose contact with your superannuation fund.

As a consequence, the Trustee will not accept your application for membership of the insurance-only division of the Macquarie Superannuation Plan until you provide your TFN.

The lawful purpose for which your TFN can be used and the consequences of not quoting your TFN may change in future, as a result of legislative amendments.

Refunds

The insurance-only division of the Macquarie Superannuation Plan has been established purely for the purpose of providing insurance cover inside the superannuation environment and is not an accumulation based superannuation fund.

Premiums paid under Active cover are funded by superannuation contributions which are subject to superannuation preservation rules and therefore are generally not refundable directly back to the member or contributor. In the case of insurance cover being cancelled and a premium refund being due (for example, part refund of an annual insurance premium), the refund will need to be paid to another complying superannuation fund (the 'other fund') by way of a rollover, rather than as a direct payment back to the contributor.

When money is paid as a rollover to the other fund, contributions tax that would otherwise have been offset by a tax deduction for insurance premiums may become payable by the fund. In these cases, the amount of the tax payable will be deducted from the amount refunded and the balance transferred to the other fund.

If the member does not provide details of the other fund to which they would like the rollover to be paid within 30 days, the Trustee may transfer the money to an Eligible Rollover Fund (ERF). The ERF chosen for this purpose is called the Super Safeguard Eligible Rollover Fund.

The Super Safeguard Eligible Rollover Fund

APRA has approved the Super Safeguard Eligible Rollover Fund to operate as an ERF. The trustee is Trust Company Superannuation Services Limited ABN 49 006 421 638 AFSL 235 153. Trust Company Superannuation Services Limited will provide some protection for your benefits from erosion due to fees and charges under member benefit protection rules. Should your superannuation benefit be transferred to the Super Safeguard Eligible Rollover Fund all subsequent enquiries relating to your benefit should be directed to:

Super Safeguard Eligible Rollover Fund
GPO Box 3426
Melbourne, Victoria 3001
Phone: 1300 135 181
Fax: 1300 135 191
Email: supersafeguard@primary.com.au
Website: supersafeguard.com.au

Should your superannuation benefit be transferred to the Super Safeguard Eligible Rollover Fund:

- your interest in (and membership of) the Macquarie Superannuation Plan, including your insurance cover, will cease,
- you will become a member of the Super Safeguard Eligible Rollover Fund and will be subject to its governing rules,
- your account will be invested according to the investment strategy of the Super Safeguard Eligible Rollover Fund,
- the Super Safeguard Eligible Rollover Fund may charge fees to your account, and
- you may not be offered insurance cover.

You should refer to the Product Disclosure Statement for the Super Safeguard Eligible Rollover Fund for more information.

The Trustee reserves the right to change the chosen ERF without prior notice to you.

Regular reports

An annual report about the management and financial condition of the Macquarie Superannuation Plan for the period to 30 June is prepared each year. This annual report is available free of charge from us, at macquarie.com.au or as a hard copy. If you do not elect to receive a hard copy annual report we will assume you wish to view the annual report online and we will not send you a copy.

Management fees and charges

The Trustee applies no management fees or costs to members or their benefits. The only amounts paid by members are contributions to meet the premium for the Active cover.

The Trust Deed

The Trust Deed and Rules of the insurance-only division of the Macquarie Superannuation Plan sets out the powers and duties of the Trustee and the rights and obligations of the members of the Macquarie Superannuation Plan. Members are bound by (and the Trustee must comply with) the Trust Deed and Rules (as amended from time to time) for the Macquarie Superannuation Plan. The Trustee is also subject to duties under the law, including to:

- act honestly,
- exercise care and diligence, and
- exercise its powers in the best interests of members of the Macquarie Superannuation Plan (as a whole).

The Trust Deed and Rules and superannuation law also limit the Trustee's liabilities in relation to the Macquarie Superannuation Plan. Generally the Trustee can be indemnified for its costs and expenses in acting as the trustee of the Macquarie Superannuation Plan out of the assets of the Macquarie Superannuation Plan. The Trustee can (without your consent) amend the Trust Deed and Rules, terminate the Macquarie Superannuation Plan or transfer your interest to another superannuation fund.

A copy of the Trust Deed and Rules is available on request.

Tax

The information provided in this section is a general guide only and we recommend you speak to your tax adviser regarding the tax consequences of insurance cover and policy ownership.

Where you are the policy owner

Any reference to 'you' in this section is in respect of your capacity as the policy owner (including circumstances in which you own the policy in your capacity as trustee of a self-managed superannuation fund).

Tax treatment of premiums

Non-superannuation

The premiums that you pay for a non-superannuation policy in respect of death, *terminal illness*, *Health Events* or Child Cover are generally not tax deductible to you. However, there are some circumstances where the premium, or part of the premium, may be claimed as a tax deduction. For example, this may be relevant in situations where an employer owns the policy or pays the premiums. There may be other tax consequences associated with this situation such as fringe benefits tax. We recommend you consult your tax adviser to discuss your particular circumstances.

The premiums that you pay for Income Cover are typically a tax deductible expense to you.

Within superannuation (as trustee of a self managed superannuation fund)

The premium payable for a superannuation policy in respect of death, *terminal illness* and *Health Events* is generally tax deductible to you. This is partly a result of the design of the policy terms that apply to the Superannuation Optimiser structure.

Premiums for Income Cover held within superannuation may also be an allowable deduction (in full or in part) to you if certain conditions are met. The inclusion of certain features under Income Cover means that a premium paid for a policy held inside super may not be fully deductible. We recommend you seek professional tax advice.

Tax treatment of benefits

Non-superannuation

The tax treatment of a benefit payable for death, *terminal illness*, *Health Events* or Child Cover can vary depending on the policy owner. There may be some cases where the benefit is taxable, such as where an employer owns the policy, and we recommend you discuss your particular circumstances with your tax adviser.

Benefits that are payable under Income Cover (including any Superannuation Cover and the Extra Benefits cover) are generally included in your assessable income and will be subject to tax at your marginal tax rate.

Within superannuation (as trustee of a self managed superannuation fund)

If you own Active cover as the trustee of a self managed superannuation fund, the gross amount of any benefit that is payable under the cover will be paid by us to you in your capacity as the trustee. You are responsible for determining any tax liability in respect of an Active cover benefit that you receive or distribute from your self managed superannuation fund. We recommend you seek professional tax advice.

Where you are a member of a superannuation plan for which MIML is trustee

Any reference to 'you' in this section is in respect of your capacity as a member of an *eligible superannuation plan* or the insurance-only division of the Macquarie Superannuation Plan.

We recommend you consult your tax adviser regarding the tax treatment of premiums and the overall tax effectiveness of insurance obtained through superannuation.

Tax treatment of premiums

Your contributions are used by the Trustee to pay the premiums due on your policy held through the superannuation plan.

When contributing to superannuation, it is important to be mindful of contribution caps which operate to limit the amount of contributions that can be made tax effectively to superannuation. The caps generally apply to all contributions paid into the superannuation system for you during the course of a financial year, whether they are made to one or more superannuation funds.

It is your responsibility to ensure you do not exceed these caps. Significant tax penalties apply where these caps are exceeded.

In some circumstances, you may be entitled to claim a tax deduction in respect of the personal contributions you make to the superannuation plan. To claim a tax deduction, you must meet a number of conditions including a requirement to submit a notice to the Trustee in an ATO approved format within certain time limits. We suggest you obtain professional tax advice if you are considering claiming a tax deduction for your contributions.

Generally the Trustee is required to pay tax of 15% on all employer contributions and personal contributions that you advise us you intend to claim as a tax deduction. However, this tax may be offset by a tax deduction on the premiums.

The policy premiums may be tax deductible to the Trustee. The premium payable for the superannuation policy in respect of death, *terminal illness* and *Health Events* is generally tax deductible to the Trustee. This is partly a result of the design of the policy terms that apply to the Superannuation Optimiser structure.

Premiums for Income Cover held within superannuation may also be an allowable deduction (in full or part) to the Trustee if certain conditions are met. The inclusion of certain features under Income Cover means that a premium paid for a policy held inside super may not be fully deductible.

Where your Active cover is linked to an *eligible superannuation plan,* the account from which the premium was deducted will be credited for the tax effect of any tax deduction that is able to be claimed by the fund in respect of those insurance premiums.

For cover held within the insurance-only division of the Macquarie Superannuation Plan, tax deductions, where applicable, can be used by the Trustee to offset the effect of the 15% tax on any taxable contributions. In situations where the contributions are not taxable (for example, where you or your spouse has made non-concessional contributions) the tax effect of a deduction available to the Trustee in relation to policy premiums is not credited to your Active cover.

Tax treatment of benefits

If an insured benefit becomes payable, Macquarie Life pays the insurance proceeds to the Trustee, who in turn is responsible for paying the benefit in accordance with the governing rules of the fund and superannuation laws.

Any insurance benefit that is payable through the superannuation plan is paid after allowance for any fund tax liability. Special tax treatment may apply to payments made from an *eligible superannuation plan* or the insurance-only division of the Macquarie Superannuation Plan in the event of your death, diagnosis of a terminal medical condition or permanent disablement. This treatment is determined independently of the basis for which the original insurance claim was paid to the trustee.

A lump sum benefit paid from an *eligible superannuation plan* or the insurance-only division of the Macquarie Superannuation Plan after your death is tax free when it is paid to one or more of your tax dependants (either directly or via the estate). For tax purposes, a dependant includes:

- your spouse (including an opposite or same-sex de facto partner with whom you live on a genuine domestic basis as a couple or a person, (whether of the same sex or a different sex), with whom the you are in a prescribed kind of relationship that is registered under a State or Territory law prescribed for the purposes of the Acts Interpretation Act 1901),
- your former spouse,
- a child of yours under the age of 18 (including an adopted child, a stepchild or an ex nuptial child, a child of your spouse and child within the meaning of the Family Law Act 1975),
- a person with whom you have an interdependency relationship, and
- a person who is otherwise your dependant (such as someone who is financially dependent on you).

In other circumstances, part or all of the death benefit may not be tax free. The level of tax applicable will depend on a number of factors.

A lump sum benefit paid from an *eligible superannuation plan* or the insurance-only division of the Macquarie Superannuation Plan in the event you suffer a from a terminal medical condition may be tax free in certain circumstances.

A lump sum benefit paid from an *eligible superannuation plan* or the insurance-only division of the Macquarie Superannuation Plan because of your permanent disablement may be a taxable superannuation benefit. In some cases, special tax treatment may apply to the payment.

If a benefit becomes payable under Income Cover, typically any regular payments made by the Trustee to you will be assessable income for tax purposes and the Trustee will be required to withhold PAYG tax.

The tax information contained in this PDS is based on our understanding of the tax laws that were current at the date of this PDS. These laws can change, so you should consult your tax adviser to discuss the tax effect of arranging your insurance cover through the member of an *eligible superannuation plan* or the insurance-only division of the Macquarie Superannuation Plan.

Contact information

Macquarie Life and Macquarie Investment Management Limited

We are here to help with any questions you have about your cover. The contact details for Macquarie Life and Macquarie Investment Management Limited are:

General enquiries

Contact: Insurance consultant
Telephone: 1800 005 057
Fax: 1800 812 175
Email: insurance@macquarie.com
Post: Macquarie Life
GPO Box 5216
Brisbane QLD 4001

Claims

Telephone: 1800 208 130
Email: insuranceclaims@macquarie.com

You should be aware that we record all of our telephone conversations with you or your adviser relating to your policy.

What to do if you have a complaint

Policy owners of Active cover (either directly or as the member or trustee of a self managed superannuation fund)

We have procedures in place to properly consider and deal with your enquiries and complaints within 45 days of a complaint being made. If you have a complaint you may contact the Complaints Officer of Macquarie Life on the contact details shown above.

If your complaint is not resolved to your satisfaction within 45 days you may refer it to the Financial Ombudsman Service Limited which has the following contact details:

Telephone: 1300 780 808
Email: info@fos.org.au
Website: fos.org.au

Members of a superannuation plan for which MIML is trustee

If you are a member of Macquarie Superannuation Plan, superannuation law requires the Trustee to take all reasonable steps to ensure that complaints are properly considered and dealt with within 90 days.

Complaints may be made to the Complaints Officer of the Trustee on the contact details shown above. If you are not satisfied with the resolution of the complaint, you may refer the complaint to the Superannuation Complaints Tribunal which has the following contact details:

Telephone: 1300 780 808
Email: info@sct.gov.au
Website: sct.gov.au

Health Events

Benefit categories for Health Events

Benefit category	Health Events
Body system: Cancer	
Health Event category: Solid tumour cancers	
A	Any metastatic *cancer* classified as Stage III or above based on TNM classification where all treatment modalities have failed and been exhausted and where no other therapies are available and where progression of the cancer can be identified
B	Advanced *cancer* classified as Stage III or above based on TNM classification
C	Advanced *cancer* classified as Stage II based on TNM classification
D	*Cancer*
	Total mastectomy for *carcinoma in situ of breast* where the procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment
	Prostate cancer requiring radical prostatectomy where the procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment
	Prostate cancer where the tumour is described histologically as TNM Classification T1 and has a Gleason score greater than 6
E	*Carcinoma in situ of the breast* (excluding mastectomy)
	Carcinoma in situ of the cervix
	Carcinoma in situ of the ovary
	Carcinoma in situ of the fallopian tube
	Carcinoma in situ of the vagina
	Carcinoma in situ of the vulva
	One or more melanomas which are both less than 1.5mm Breslow thickness and less than Clark level 3 depth of invasion, confirmed histologically by biopsy
	Prostate Cancer where the tumour is described histologically as TNM Classification T1 and has a Gleason score of 6 or less

The following are excluded under the 'solid tumour cancers' category:

- All hyperkeratoses, basal cell carcinomas, and squamous cell carcinomas of skin unless there has been a spread to other organs,
- pTa bladder tumours, and
- Stage 0 bowel cancer.

Health Event category: Lymphomas	
A	Advanced lymphoma classified as Ann-Arbor stage III or above where all treatment modalities have failed and been exhausted and where no other therapies are available and where progression of the cancer with resultant ongoing and continuous symptomatology can be identified
B	Hodgkin's Lymphoma classified as Ann-Arbor Stage III or above
	Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage III or above
C	Hodgkin's Lymphoma classified as Ann-Arbor Stage II
	Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage II
D	Hodgkin's Lymphoma classified as Ann-Arbor Stage I
	Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage I

Benefit category	Health Events
Body system: Cancer	
Health Event category: Brain tumours	
A	Malignant brain tumour classified as Grade III or above based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system where all treatment modalities have failed and been exhausted and where no other therapies are available and where progression of the cancer can be identified
B	Malignant brain tumour classified as Grade III or above based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system
C	Malignant brain tumour classified as Grade II based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system
D	Malignant brain tumour classified as Grade I based on the WHO grading system for malignant neuroepithelial tumours of the central nervous system
Health Event category: Leukaemias	
A	Leukaemia where all treatment modalities have failed and been exhausted and where no other therapies are available, where progression of the cancer can be identified and where there is resultant ongoing and continuous symptomatology
B	Acute myeloid leukaemia
	Advanced chronic lymphocytic leukaemia classified as RAI Stage 3 or above
	Chronic myeloid leukaemia
	Acute lymphoblastic leukaemia
C	Chronic lymphocytic leukaemia classified as RAI Stage 2
D	Chronic lymphocytic leukaemia classified as RAI Stage 1
Health Event category: Other cancers	
B	*Aplastic anaemia*
	Bone marrow or stem cell transplant specifically to treat cancer
	Transplant waiting list for the transplant of bone marrow specifically to treat cancer
	Multiple myeloma classified as stage 3 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
C	Multiple myeloma classified as stage 2 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
D	Multiple myeloma classified as stage 1 on the Durie Salmon scale or New ISS, requiring chemotherapy or radiotherapy
E	Confirmed diagnosis of myelodysplastic syndrome requiring continuing and ongoing supportive care with regular transfusion of blood products, chemotherapy, or other equivalent treatments
	Bone marrow or stem cell transplant to treat a disease other than cancer

The following are excluded under the *'Cancer'* body system:

- any myeloproliferative diseases including polycythaemia rubera vera, essential thrombocytosis and myelofibrosis,
- chronic lymphocytic leukaemia classified as RAI Stage 0,
- if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the 90 days of the *application date* or the date any cover is reinstated, a benefit will not be paid for the *Health Event* (or *Progressive Condition*) at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Benefit category	Health Events
Body system: Heart and Artery	
Health Event category: Heart attack	
A	*Heart attack* resulting in permanent* and irreversible left ventricular ejection fraction of less than 30% whilst on ongoing optimal therapy for a minimum of 6 months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
B	*Heart attack* resulting in permanent* and irreversible left ventricular ejection fraction of 30 to 40% whilst on ongoing optimal therapy for a minimum of 6 months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
C	*Heart attack*
Health Event category: Cardiomyopathy	
A	*Cardiomyopathy* resulting in permanent* and irreversible left ventricular ejection fraction of less than 30% whilst on ongoing optimal therapy for a minimum of 6 months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment.
B	*Cardiomyopathy* resulting in permanent* and irreversible left ventricular ejection fraction of 30 to 40% whilst on ongoing optimal therapy for a minimum of 6 months, and significant and irreversible physical impairment to the degree of at least Class III of the *New York Heart Association Functional Classification System* of cardiac impairment
Health Event category: Other heart and artery conditions	
A	*Severe congestive cardiac failure* with a permanent* BNP level of greater than 500ng/l, whilst on ongoing optimal therapy for a minimum of 6 months where BNP lowering is specifically targeted as a treatment outcome measure (Equivalent levels of proBNP will be accepted.)
	Severe peripheral vascular disease resulting in amputation of the leg below the knee or higher
C	*Severe peripheral vascular disease* with gangrene and amputation of more than one toe
Health Event category: Heart transplant	
B	*Heart or heart and lung transplant*
	Transplant waiting list for the transplant of a heart or a heart and lung transplant
Health Event category: Surgical procedures	
C	*Coronary artery bypass graft*
	Open aortic graft surgery – abdominal or thoracic
	Open iliac or femoral artery aneurysm grafting
	Surgical repair to correct structural lesions of the heart
	Heart valve replacement or repair
	Total pericardiectomy for constrictive pericarditis
E	*Percutaneous coronary angioplasty***
	Endovascular heart valve repair or replacement
	Endovascular or open carotid artery stenosis repair
	Endovascular repair of an aortic aneurysm
	Endovascular repair to correct structural lesions of the heart
	Endovascular iliac or femoral artery aneurysm repair
	Permanent cardiac defibrillator insertion

* Permanency to be established by 3 readings, 3 months apart. ** The maximum benefit payment per claim is $40,000.

The following are excluded under the 'Heart and artery' body system:

- if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the 90 days of the *application date* or the date any cover is reinstated, a benefit will not be paid for the *Health Event* (or *Progressive Condition*) at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Benefit category	Health Events
Body system: Brain and Nerves	
Health Event category: Stroke	
A	Any *stroke* causing *permanent* and irreversible inability to perform 4 out 6 *activities of daily living*
B	Any *stroke* causing *permanent* and irreversible inability to perform 3 out 6 *activities of daily living*
C	Any *stroke* causing *permanent* and irreversible inability to perform 2 out 6 *activities of daily living*
E	*Stroke*

The following are excluded under the 'Stroke' category:

- if the *Health Event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent within the 90 days of the *application date* or the date any cover is reinstated, a benefit will not be paid for the *Health Event* (or *Progressive Condition*) at any time under the policy. This exclusion will not apply if the *replacement cover waiver – Health Events and Child Cover* applies.

Health Event category: Cognitive conditions	
A	*Severe cognitive impairment*
D	*Diagnosis of dementia including Alzheimer's disease*
Health Event category: Coma	
E	*Coma*
Health Event category: Surgical procedures and events	
C	Craniotomy to treat a cerebral arteriovenous malformation
	Craniotomy to treat a cerebral aneurysm
	Craniotomy to remove a *benign brain tumour*
E	Endovascular treatment of a cerebral arteriovenous malformation
	Endovascular treatment of a cerebral aneurysm
	Endovascular treatment of a subarachnoid haemorrhage
	Stereotactic brain surgery used for ablation, stimulation, implantation or radiotherapy
	Shunt insertion for hydrocephalus

The following are excluded under the 'surgical procedures and events' category:

- Cysts, granulomas, abcesses, haematomas, trans-sphenoidal hypophysectomy and biopsy procedures.

Health Event category: Other brain and nerve conditions	
A	Any chronic neurological disease causing *permanent* and irreversible inability to perform 4 out 6 *activities of daily living*
	Permanent vegetative state
	Quadriplegia
	Severe epilepsy
	Psychiatric condition resulting in: ■ *Permanent* and irreversible inability to perform 4 out 6 *activities of daily living*, or ■ *Permanently* placed under public guardianship by the Guardianship Board due to concern for their own safety or safety of others, or ■ *Total lack of social interaction*
	Permanent total aphasia
B	Any chronic neurological disease causing *permanent* and irreversible inability to perform 3 out 6 *activities of daily living*
	Diagnosis of motor neurone disease
	Paraplegia
C	Any chronic neurological disease causing *permanent* and irreversible inability to perform 2 out 6 *activities of daily living*
	Diagnosis of bilateral hemianopia
D	*Psychiatric condition*

Benefit category	Health Events
Body system: Brain and Nerves	
Health Event category: Other brain and nerve conditions (continued)	
E	*Diagnosis of multiple sclerosis*
	Diagnosis of Parkinson's disease
	Diagnosis of muscular dystrophy
	Diagnosis of myasthenia gravis
	Diagnosis of cavernous sinus thrombosis

The following are excluded under the 'Brain and nerves' body system:
- any psychiatric condition as a result of drug or alcohol intake.

Body system: Digestive System	
Health Event category: Transplants	
B	*Liver transplant*
	Total pancreas transplant
	Small bowel transplant
	Transplant waiting list for the transplant of the liver, total pancreas or small bowel
Health Event category: Surgical procedures	
C	*Colectomy*
	Colostomy/Ileostomy
E	Surgical repair of a tracheo-oesophageal fistula
	Chronic anal fistula requiring three or more in-patient surgical procedures
Health Event category: Other digestive conditions	
A	Objective evidence of *gastrointestinal disease* with all of the following: ■ persistent disturbance of bowel function at rest with severe persistent pain, ■ complete limitation of activity with continued restriction of the diet and no response to medical therapy, ■ constitutional symptoms – fever, weight loss or anaemia where there is no prolonged remission, and ■ there have been at least 4 hospital admissions in a 12 month period
	Permanent and ongoing inability to swallow requiring *permanent* extraneous feeding methods
B	Objective evidence of *gastrointestinal disease* with all of the following: ■ severe exacerbations of bowel dysfunction with disturbance of bowel function with continual pain, ■ restriction of activity with continued restriction of the diet and no response to medical therapy, ■ constitutional symptoms – fever, weight loss or anaemia, and ■ there have been at least 2 hospital admissions in a 12 month period
C	*Severe Crohn's disease*
E	*Portal vein thrombosis*
	Severe ulcerative colitis
	Crohn's disease
Health Event category: Liver conditions	
A	*End stage liver disease*
C	Chronic inflammatory hepatitis resulting in a Knodell score of at least 13 out of 22, and showing abnormal LFT's including ALT, AST and GGT of more than 3 times the normal range continuously for at least one year (tested at least three times over this period)
E	Partial hepatectomy (donors and liver biopsies excluded)

The following are excluded under the 'Digestive system' body system:
- any liver condition as a result of drug or alcohol intake.

Benefit category	Health Events
Body system: Kidneys and Urogenital Tract	
Health Event category: Renal failure	
A	*Chronic renal failure* where a renal physician has confirmed that on the basis of the insured person's medical condition, the insured person is *permanently* excluded from access to renal transplantation
B	*Chronic renal failure*
E	*Acute renal failure*
Health Event category: Kidney transplant	
B	*Renal transplant*
	Transplant waiting list for the transplant of a kidney
Health Event category: Surgical procedures	
C	Total cystectomy requiring a urinary conduit
E	Nephrectomy (donors excluded)
	Bilateral orchidectomy due to disease
	Bladder fistula requiring a surgical procedure for closure of the fistula
	Vesico/recto-vaginal fistula requiring a surgical procedure for closure of the fistula

The following are excluded under the 'Kidneys and urogenital tract' body system:

- acute renal failure as a result of drug or alcohol intake,
- transgender surgery.

Body system: Lungs	
Health Event category: Diseases of the lung	
A	End stage lung disease requiring *permanent* and continuous oxygen therapy (according to current Thoracic Society of Australia and New Zealand treatment guidelines) as prescribed by an appropriate registered *medical practitioner*
B	*Chronic lung disease*
Health Event category: Surgical procedures	
C	*Pneumonectomy* (excluding donors)
D	Lobectomy (excluding biopsy procedures and donors)
Health Event category: Lung transplant	
B	*Lung or heart and lung transplant.*
	Transplant waiting list for the transplant of a lung or a heart and lung transplant
Health Event category: Other lung conditions	
E	Lung abscess requiring surgical drainage through an open thoracotomy (simple percutaneous drainage procedures excluded)
	Chronic bronchopleural fistula requiring a surgical procedure for closure of the fistula through an open thoracotomy
	Chronic bronchiectasis requiring daily physiotherapy or postural drainage on instruction of a lung specialist for a period of more than 3 months and under the continuous care of a respiratory physician
	Multiple episodes of recurrent pulmonary emboli separated by a period of 6 months requiring insertion of a veno-caval filter

Benefit category	Health Events
Body system: Musculoskeletal System	
Health Event category: Burns	
B	*Severe burns* where the third degree burns cover at least 20% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
C	*Severe burns* where the third degree burns cover at least 15% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
D	*Severe burns* where the third degree burns cover at least 10% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
E	*Severe burns* where the third degree burns cover at least 5% of the body surface area as measured by the Rule of Nines or the Lund and Browder Body Surface Chart
Health Event category: Back, limb and whole person impairment	
A	*loss of musculoskeletal function,* that even with the use of appropriate assistive devices and workplace modifications, results in the *permanent* inability to: ■ perform 2 or more *occupational core duties*, where these duties require the use of the specific musculoskeletal function to complete at least 80% of the insured person's average weekly work hours, and ■ earn an *income* in any occupation which provides at least 75% of the insured person's *income* in the most recent 12 month period in which they were *gainfully employed*
B	*Permanent* and irreversible *loss of the use of two limbs*
	Permanent and irreversible *WPI* of at least 60%
C	*Permanent* and irreversible *WPI* of at least 40%
D	*Permanent* and irreversible *loss of use of one upper limb*
	Permanent and irreversible *WPI* of at least 25%
E	*Permanent* and irreversible *loss of use of one lower limb*
	Le Fort III facial reconstruction surgery
	Amputation of 2 or more fingers at the PIP or MCP joint, one of which must be either the index finger or thumb (must be due to either disease or *accident)*
	Severe osteoporosis

Body system: Ear	
Health Event category: Loss of hearing	
A	*Complete loss of hearing*
B	*Severe loss of binaural hearing*
E	*Complete loss of hearing in one ear*
Health Event category: Surgical procedures	
E	*Inner ear or middle ear surgery*
	Radical or modified radical mastoidectomy where considered the appropriate and necessary treatment by a medical specialist

Benefit category	Health Events
Body system: Eye	
Health Event category: Loss of sight	
A	*Permanent* and irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that eyesight is reduced in both eyes to 6/60 or less of central visual acuity on the Snellen test chart
	Permanent and irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that the degree of vision is less than or equal to 20 degrees of arc from the centre of the horizontal plane of the visual field
C	*Permanent* and irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that eyesight is reduced in both eyes to 6/18 or less of central visual acuity on the Snellen test chart
E	*Permanent* and irrecoverable loss of sight in one eye, with and without the use of an appropriate aid, to the extent that eyesight is reduced in that eye to 6/60 or less of central visual acuity on the Snellen test chart
Health Event category: Surgical procedures	
E	Surgical repair of a detached retina (laser surgery excluded)
	Corneal transplant

Body system: HIV/AIDS	
A	*Advanced AIDS*
B	*Accidental HIV infection*

The following are excluded under the 'HIV/AIDS' body system:

- HIV infection caused by any means other than those described in the definitions of these *Health Events*, including recreational intravenous drug use and sexual activity, other than assault as described, or
- If a treatment is developed and approved which renders the HIV virus inactive and non-infectious, or
- If the insured person has elected not to take an approved vaccine that is recommended by the relevant government body for use in the insured person's occupation and is available prior to the event which causes infection.

Body system: General	
Health Event category: Hospital admission	
D	*Intensive care unit (ICU)* admission for at least 5 weeks where ongoing assisted mechanical ventilation is required for at least 3 weeks
E	Hospital admission for at least 4 weeks after spending at least 1 week in *ICU.* Ongoing medical treatment is required in an acute healthcare setting or rehabilitation facility throughout this entire hospital admission period (ie over the minimum 5 week period)
Health Event category: Inability to perform Activities of Daily Living (ADL)*	
A	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 4 out 6 *activities of daily living*
B	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 3 out 6 *activities of daily living*
C	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 2 out 6 *activities of daily living*

* Unless specifically stated as a measurement tool for a *Health Event*, the use of the 'Activities of daily living' category will only be applied to a condition that cannot be evaluated under a specific *Health Event* and cannot be described elsewhere.

The following are excluded under the 'General' body system:

- *Intensive care unit (ICU)* admission as a result of drug or alcohol intake.

Progressive Conditions

A *Progressive Condition* is any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. This includes any condition that is a recognised outcome and/or complication of a prior claim or a recognised complication of any treatment that might be administered in relation to the prior claim event.

Any two medical conditions that are both *Progressive Conditions* of a third medical condition, will be treated as *Progressive Conditions* to each other for calculating the amount payable.

The table below sets out the additional circumstances in which we will treat a condition as a *Progressive Condition.* This is relevant for determining the amount payable for any *Health Event* claim under the Active cover.

The terms used below are used in the broader medical meaning of the condition and not the defined *Health Events* as found in the *Health Events* tables in this section or in the defined terms in the glossary.

Condition for which a claim has been paid:	Conditions which are considered to be *Progressive Conditions* to the condition for which a claim has been paid:
Any arthritis, osteoporosis	Any arthritis, osteoporosis.
Cancer	Cancer of the same cell type, including any treatment or disease for cancer of the same cell type.
Cognitive conditions	Coma, Parkinson's disease, stroke.
Multiple sclerosis	Any cognitive conditions.
Muscular dystrophy	Cardiomyopathy.
Parkinson's disease	Any cognitive conditions.
Stroke	Cognitive conditions, Parkinson's disease.
Any psychiatric condition	Any psychiatric condition.
Brain and neurological conditions, epilepsy	Brain and neurological conditions, coma, stroke, epilepsy.
Any other condition described by a neurologist to be a chronic neurological disease including but not limited to the following: permanent vegetative state, profound short term memory loss, multiple sclerosis, dementia, epilepsy, myasthenia gravis, Alzheimer's disease, muscular dystrophy, motor neurone disease.	Any other condition described by a neurologist to be a chronic neurological disease including but not limited to the following: permanent vegetative state, profound short term memory loss, multiple sclerosis, dementia, epilepsy, myasthenia gravis, Alzheimer's disease, muscular dystrophy, motor neurone disease.
Progressive systemic sclerosis, systemic lupus erythematosis, sarcoidosis, polyarteritis nodosa, giant cell arteritis, polymyositis, Wegener's granulomatosis, rheumatoid arthritis.	Progressive systemic sclerosis, systemic lupus erythematosis, sarcoidosis, polyarteritis nodosa, giant cell arteritis, polymyositis, Wegener's granulomatosis, rheumatoid arthritis.
Any cardiac condition or procedure	Any cardiac condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim.
Any lung condition or procedure	Any lung condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim.
Any kidney or urogenital tract condition or procedure	Any kidney or urogenital tract condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim.
Any eye condition or procedure	Any eye condition or procedure.
Any ear condition or procedure	Any ear condition or procedure.
Any gastrointestinal disease or procedure	Any gastrointestinal disease or procedure.
Any liver disease or procedure	Any liver disease or procedure.
Diabetes, diabetes progression, complications of diabetes	Stroke, pancreas transplant, loss of vision, heart attack, cardiac bypass, cardiomyopathy, angioplasty, peripheral vascular disease, renal failure, kidney transplant.
Any condition which is assessed on the basis of an inability to perform *activities of daily living*	Any condition which is assessed on the inability to perform *activities of daily living.*

Glossary

Health Events

***Health Events* defined terms**	
permanent	Irreversible and present for a minimum of 6 months, while on optimal therapy, if appropriate (unless the *Health Event* specifically references an alternate timeframe over which the permanency will be measured).
transplant waiting list	Inclusion on an official transplant Australian waiting list, approved by us. The inclusion must be upon the advice of an appropriate medical specialist.
Body system: Cancer	
cancer	The presence of one or more malignant tumours, positively diagnosed with histological confirmation that are characterised by the uncontrolled growth of malignant cells and invasion and destruction of normal tissue. Any tumour described as early stage cancer, carcinoma in situ, premalignant, borderline malignant, non invasive, or of low malignant potential is excluded.
carcinoma in situ of breast	Localised cancer characterised by a focal autonomous new growth of cancer cells, which has not yet infiltrated or destroyed normal tissue, and where there is a confirmed histopathological diagnosis carcinoma in situ without evidence of invasive cancer.
carcinoma in situ of the cervix	High grade dysplasia of the cervix at CIN III or above, confirmed histologically by biopsy.
carcinoma in situ of the fallopian tube	A focal autonomous new growth of carcinomatous cells within the fallopian tube which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be limited to the tubal mucosa and classified as Tis according to the TNM staging method or *FIGO* Stage 0.
carcinoma in situ of the ovary	A focal autonomous new growth of carcinomatous cells within the ovary which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method or *FIGO* Stage 0.
carcinoma in situ of the vagina	A focal autonomous new growth of carcinomatous cells within the vagina which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method or *FIGO* Stage 0.
carcinoma in situ of the vulva	A focal autonomous new growth of carcinomatous cells within the vulva which has not yet resulted in the invasion of normal tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The tumour must be classified as Tis according to the TNM staging method or *FIGO* Stage 0.
prostate cancer	Localised prostate cancer characterised by focal autonomous new growth of cancer cells.
aplastic anaemia	Severe *permanent* and irrecoverable aplasia of bone marrow which results in anaemia, neutropenia and thrombocytopenia requiring at least one of the following treatments: ■ immunosuppressive agents, ■ bone marrow transplant, or ■ peripheral blood stem cell transplant.
bone marrow or stem cell transplant	The insured person is the recipient of a bone marrow or stem cell transplant, where the transplant is considered the appropriate and necessary treatment.
FIGO	The staging method of the International Federation of Gynaecology and Obstetrics.
Body system: Heart and Artery	
heart attack	Myocardial infarction, characterised by death of a portion of heart muscle due to inadequate blood supply. The following clinical features must be present (and not be caused by medical intervention): ■ new ECG changes, and ■ elevation of cardiac enzymes, troponins or other biochemical markers above generally accepted laboratory levels of normal. If the above is inconclusive then we will consider a claim based on conclusive evidence that myocardial infarction has occurred, resulting in either one of the following: ■ new pathological Q-waves, ■ a permanent left ventricular ejection fraction of 50% or less, measured six weeks or more after the event, provided the date of the event is able to be established.

Health Events defined terms	
New York Heart Association functional classification system	A scale used to assess cardiac impairment. I. No symptoms and no limitation in ordinary physical activity. II. Mild symptoms and slight limitation during ordinary activity and comfortable at rest. III. Marked limitation in activity due to symptoms, even during less-than-ordinary activity and comfortable only at rest. IV. Severe limitations and experiences symptoms even while at rest.
cardiomyopathy	Disease of the heart muscle causing it to enlarge and become weaker.
severe congestive cardiac failure	Failure of the functioning of the ventricles of the heart with poor cardiac output and congestion of the lungs or systemic veins.
severe peripheral vascular disease	Severe arterial insufficiency in vessels resulting in ischaemia of the limbs as a consequence of atherosclerosis.
heart or heart and lung transplant	The insured person is the recipient of a heart or heart and lung transplant, where the transplant is considered the appropriate and necessary treatment.
coronary artery bypass graft	The undergoing of coronary artery bypass grafting for the treatment of coronary artery disease that is considered the appropriate and necessary treatment. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
open aortic graft surgery – abdominal or thoracic	Open surgery with aortic grafting that is considered the appropriate and necessary treatment to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
open iliac or femoral artery aneurysm grafting	Open surgery for the purposes of grafting the iliac or femoral artery vessels for the treatment of an aneurysm. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
surgical repair to correct structural lesions of the heart	The undergoing of a thoracotomy that is considered necessary to repair a structural lesion of the heart. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
heart valve replacement or repair	The undergoing of a thoracotomy that is considered necessary to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.
total pericardiectomy for constrictive pericarditis	The undergoing of a thoracotomy with a total pericardiectomy for constrictive pericarditis.
percutaneous coronary angioplasty	The undergoing of percutaneous balloon dilatation, atherectomy or stent placement to correct a narrowing or blockage that is considered the appropriate and necessary treatment on the basis of angiographic evidence.
endovascular heart valve repair or replacement	Heart valve repair or replacement via percutaneous intravascular techniques not involving open thoracotomy.
endovascular or open carotid artery stenosis repair	The undergoing of percutaneous or open carotid artery stenosis repair.
endovascular repair of an aortic aneurysm	Abdominal or thoracic aneurysm repair or replacement via percutaneous techniques.
endovascular repair to correct structural lesions of the heart	Repair to correct structural lesions of the heart via percutaneous techniques.
endovascular iliac or femoral artery aneurysm repair	Iliac or femoral artery aneurysm repair or replacement via percutaneous techniques.
permanent cardiac defibrillator insertion	The insured person has a *permanent* cardiac defibrillator inserted. Cardiac pacemakers are specifically excluded.

Health Events defined terms	
Body system: Brain and nerves	
Stroke	A neurological event caused by a cerebrovascular incident. The stroke must: ■ be confirmed by an appropriate medical specialist, and ■ be evidenced by neuro-imaging. Transient ischaemic attacks, cerebral events due to reversible neurological deficits and migraine are excluded.
severe cognitive impairment	Total and permanent deterioration or loss of intellectual capacity (supported by a score of 15 or less out of 30 in a Mini Mental State Examination or evidence from other neuropsychometric testing that is acceptable to us) that has required the insured person to be under continuous care and supervision by another person as certified by an appropriate medical specialist for at least 3 consecutive months and at the end of that 3 month period, the insured person requires ongoing continuous care and supervision by another person.
diagnosis of dementia including Alzheimer's disease	Diagnosis of dementia by neurological assessment confirming that the insured person requires continuous care and supervision by another person as certified by an appropriate medical specialist as the result of cognitive impairment characterised by a Mini Mental State Examination score of 24 or less out of 30 or assessed by at least two neuropsychometric tests performed 9 months apart with a battery of tests which clearly define the severity of the impairment.
Coma	A state of total unconsciousness and unresponsiveness to all external stimuli, resulting in a score of 8 or less on the Glasgow Coma Scale, as outlined below, for a continuous period of at least three days. Glasgow Coma Scale is a scoring system used to measure the level of consciousness following traumatic brain injury. It is composed of three parameters as given below: **Best Eye Response (4)** 1. No eye opening 2. Eye opening to pain 3. Eye opening to verbal command 4. Eyes open spontaneously **Best Verbal Response (5)** 1. No verbal response 2. Incomprehensible sounds 3. Inappropriate words 4. Confused 5. Orientated **Best Motor Response (6)** 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localising pain 6. Obeys Commands A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 a moderate injury and 8 or less a severe brain injury.
benign brain tumour	A non-malignant tumour in the brain or pituitary gland, including tumours of the brain itself, meningiomas, cranial nerve tumours and pituitary tumours treated by non-transphenoidal techniques. The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI.
permanent vegetative state	Persistent state of complete unresponsiveness to external stimuli associated with an incapacity to communicate or manage bodily functions for a continuous period of at least 3 months with no hope of recovery as confirmed by a medical specialist.
quadriplegia	total, *permanent* and irreversible loss of the use of all four limbs as a consequence of *illness* or injury, where a limb is defined as the shoulder down to the hand or the hip down to the foot.
severe epilepsy	Averaging more than 2 witnessed grand mal (tonic clonic) epileptic attacks per week over a six month period as documented by a neurologist despite optimal stabilised therapy, and under the control of a neurologist
total lack of social interaction	There is a *permanent* inability to carry out all of the following: ■ answering the telephone ■ holding a face to face conversation for at least five minutes and ■ travelling 50 metres outside using all available aids.

Health Events defined terms	
paraplegia	Total, *permanent* and irreversible loss of the use of two limbs as a consequence of illness or injury, where a limb is defined as the shoulder down to the hand or the hip down to the foot.
permanent total aphasia	Total and irreversible loss of speech with no intelligible vocalisation possible and incapacity to communicate in order to manage day-to-day activities. The loss must be confirmed to be total and irreversible at least three months after speech was first lost. Loss of speech due to psychological reasons and hysterical loss of speech are excluded.
psychiatric condition	A psychiatric condition resulting in ongoing medical treatment from a psychiatrist for more than two years and more than two-in patient admissions, each greater than one week, over a two year period.
diagnosis of motor neurone disease	Unequivocal diagnosis of motor neurone disease.
diagnosis of multiple sclerosis	Unequivocal diagnosis of multiple sclerosis, and evidenced by appropriate neuro-imaging and spinal fluid abnormalities.
diagnosis of Parkinson's disease	Unequivocal diagnosis of Parkinson's disease. Parkinson's disease as a result of medication or drugs is excluded.
diagnosis of muscular dystrophy	Unequivocal diagnosis of muscular dystrophy, which causes progressive and selective degeneration and weakness of voluntary muscles.
diagnosis of myasthenia gravis	Unequivocal diagnosis of myasthenia gravis.
diagnosis of cavernous sinus thrombosis	Unequivocal diagnosis of cavernous sinus thrombosis by a medical specialist via an MRI scan.
diagnosis of bilateral hemianopia	Unequivocal diagnosis of complete and *permanent* bilateral hemianopia as diagnosed by an appropriate medical specialist.
Body system: Digestive system	
liver transplant	The insured person is the recipient of a liver, where the transplant is considered the appropriate and necessary treatment.
total pancreas transplant	The insured person is the recipient of a total pancreas, where the transplant is considered the appropriate and necessary treatment.
small bowel transplant	The insured person is the recipient of a small bowel, where the transplant is considered the appropriate and necessary treatment.
colectomy	Total colectomy requiring *permanent* colostomy or resulting in ileorectal anastomosis.
colostomy/ileostomy	The creation of a *permanent* non-reversible opening, linking the colon and/or ileum to the external surface of the body.
gastrointestinal disease	Disease of the gastrointestinal system evidenced by organic pathology obtained by biopsy and present continuously for at least 12 months.
portal vein thrombosis	Isolated thrombosis of the portal vein.
severe Crohn's disease	Diagnosis of Crohn's disease with stricture formation, fistula formation and resection of the small bowel, that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.
Crohn's disease	Diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.
severe ulcerative colitis	Diagnosis of ulcerative colitis that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.
end stage liver disease	End stage liver failure defined by irreversible loss of liver biosynthetic function of the liver accompanied by a persistent coagulopathy and *permanent* jaundice, resulting in at least one of the following: ■ diuretic resistant refractory ascites, ■ recurrent portal hypertensive bleeding, ■ recurrent portal systemic encephalopathy, ■ recurrent spontaneous bacterial peritonitis, ■ listing for liver transplantation.

Health Events defined terms	
Body system: Kidneys and urogenital tract	
chronic renal failure	Chronic irreversible failure of the function of both kidneys requiring *permanent* and ongoing haemodialysis or peritoneal dialysis. The insured person must be under the continuous care of a renal physician.
acute renal failure	Acute reversible failure of the function of both kidneys requiring admission to an ICU* or renal dialysis unit for temporary haemodialysis or haemofiltration treatment. *ICU must be an accredited Intensive Care Unit by the Australian Council on Healthcare Standards (ACHS)
renal transplant	The insured person is the recipient of a kidney transplant, where the transplant is considered the appropriate and necessary treatment.
Body system: Lungs	
chronic lung disease	End stage lung disease requiring a persistent FEV1 less than 30% predicted or DLCO less than 40% predicted (according to current Thoracic Society of Australia and New Zealand treatment guidelines) measured on at least three separate occasions more than three months apart whilst on optimal therapy.
pneumonectomy	Removal of an entire lung.
lung or heart and lung transplant	The insured person is the recipient of a lung or heart and lung transplant, where the transplant is considered the appropriate and necessary treatment.
Body system: Musculoskeletal system	
severe burns	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns.
loss of musculoskeletal function	A condition affecting musculoskeletal function resulting in: a) loss of hand function where there is: ■ total and irreversible loss of muscle power resulting in the inability to grip any tool, utensil or assistive device, or ■ total and irreversible loss of the ability to use the hands and fingers with precision to perform activities such as picking up or manipulating small objects, manually operating a range of equipment or communicating through writing or typing, b) at least 80% *impairment of the upper limb*, c) at least 50% *impairment of the lower limb*, or d) at least 60% WPI The condition must be *permanent* and supported by appropriate radiological evidence.
impairment of the upper limb	*Permanent* and irreversible impairment of the hand based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols.
impairment of the lower limb	*Permanent* and irreversible impairment of the foot based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols.
occupational core duties	The primary *income* generating tasks being performed by the insured person in the occupation, business or employment in which they were *gainfully employed* at the time of the injury or *illness* (or if not *gainfully employed* at that time, the occupation, business or employment in which the insured person was most recently *gainfully employed*).
loss of the use of two limbs	The *permanent* and irreversible total loss of the use of two limbs, where 'limb' means the whole hand or whole foot.
loss of use of one upper limb	The *permanent* and irreversible total loss of the use of one whole hand.
loss of use of one lower limb	The *permanent* and irreversible total loss of the use of one whole foot.
whole person impairment (WPI)	Whole Person Impairment based on the American Medical Association Guides to the Evaluation of Permanent Medical Impairment, 5th edition – the examining doctor will be provided with specific evaluating protocols
severe osteoporosis	Before the age of 50, the insured person: ■ suffers at least two vertebral body fractures or a fracture of the neck or the femur, due to osteoporosis, and ■ has a bone mineral density reading with a T-score of less than -2.5 (ie 2.5 standard deviations below the young adult mean for bone density). This must be measured in at least two sites by dual energy x-ray absorptiometry (DEXA).

Health Events defined terms	
Body system: Ear	
complete loss of hearing	The total and irreversible loss of more than 90% of binaural hearing as per the American Medical Association Guides to the Evaluation of Permanent Medical Impairment: 4th edition, with and without the use of an appropriate aid.
severe loss of binaural hearing	Total and irreversible loss of more than 75% of binaural hearing as per the American Medical Association Guides to the Evaluation of Permanent Medical Impairment: 4th edition, with and without the use of an appropriate aid.
complete loss of hearing in one ear	The total and irreversible loss of hearing in one ear, with and without the use of an appropriate aid.
inner ear or middle ear surgery	Surgery to the cochlear or middle ear bones, where the surgery is considered the appropriate and necessary treatment by a medical specialist.
radical or modified radical mastoidectomy	Removal of the mastoid bone and bones of the middle ear due to chronic disease.
Body system: Eye	
corneal transplant	The insured person is the recipient of a cornea, where the transplant is considered the appropriate and necessary treatment.
Body system: HIV/AIDS	
advanced AIDS	HIV infection with a persistent CD4 cell count of less than 200/ul despite appropriate continuous antiretroviral therapy. There must be an associated AIDS defining illness with AIDS resulting in at least one of the following: ■ Kaposi's Sarcoma or Lymphoma ■ Pneumocystis Carinii infection, cryptoccal infection or any other opportunistic infection of the lungs or nervous system ■ Tuberculosis or other mycobacterium infection at any site ■ Progressive Multifocal Leukoencephalopathy ■ HIV Encephalopathy ■ HIV Wasting Syndrome characterised by more than 10% weight loss, chronic intractable diarrhoea and chronic candidiasis of the respiratory tract or gastrointestinal tract.
accidental HIV infection	*Accidental* infection with Human Immunodeficiency Virus (HIV) as the result of: ■ Transfusion of blood or blood products*, ■ Organ transplantation*, ■ *Accidental* incident occurring during the course of performing normal professional duties of the insured person's regular occupation with the requirement that appropriate care is being exercised**, or ■ Physical or sexual assault – a criminal case must be opened in addition to the insured person starting antiviral therapy**. The *accident* causing infection with HIV must have occurred after the date of policy commencement, or reinstatement, whichever is latest. The incident must be reported to us within seven days of occurrence and we must be given access to test all blood tests and blood samples used. * The procedure must have been performed by a registered health professional and have occurred in Australia. We require a statement from the appropriate Statutory Health Authority that provides documented proof of the incident and confirms that the infection is medically acquired. ** The incident must be reported to the appropriate authority and be supported by a negative HIV antibody test performed after the incident. The production and detection of HIV antibodies (sero-conversion) must be subsequently confirmed by way of a positive HIV antibody test within six months of the incident.
Body system: General	
intensive care unit (ICU)	An accredited Intensive Care Unit by the Australian Council on Healthcare Standards (ACHS)

Health Events defined terms

activities of daily living (ADL)

There are six main categories of ADLs. Each category is made up of a list of specific tasks. If the stated number of the specific tasks within a category cannot be done, the whole category is scored as an inability to perform that ADL category.

The ability to perform Activities of Daily Living must be assessed by a medical specialist, appropriate to the medical condition causing the impairment, using the Activities of Daily Living scoresheet provided by us. Supporting objective medical evidence or investigations for each *activity of daily living* scored must be provided.

All Activities of Daily Living should be measured with assistive devices where applicable.

The ADL categories, specific tasks and required scores in order to be considered unable to perform the ADL category are detailed in the table below.

ADL category	Specific tasks	Scores required in order to be considered unable to perform the ADL category:
1. Self-care	■ Bathing ■ Grooming ■ Dressing ■ Eating and feeding ■ Bowel and bladder function ■ Mobility	■ 'cannot' in at least one specific task, or ■ 'with help' in at least two specific tasks.
2. Communication	■ Speaking ■ Reading ■ Writing ■ Keyboard use	■ 'cannot' in at least one specific task, or ■ 'minimal' in at least two specific tasks.
3. Physical activity	**Intrinsic** ■ Standing ■ Sitting ■ Reclining ■ Walking ■ Stooping ■ Squatting ■ Kneeling ■ Reaching ■ Bending ■ Twisting **Functional** ■ Carrying ■ Lifting ■ Pushing ■ Pulling ■ Climbing ■ Exercising	■ 'cannot' in at least three specific tasks, or ■ 'with help' in at least six specific tasks.
4. Sensory function	■ Hearing ■ Seeing ■ Tactile sensation ■ Tasting ■ Smelling	■ 'cannot' in at least one specific task, or ■ 'minimal' in at least two specific tasks.
5. Hand functions	■ Grasping ■ Holding ■ Pinching ■ Percussive movements ■ Sensory discrimination	■ 'cannot' in at least one specific task, or ■ 'minimal' in at least two specific tasks.
6. Advanced functions	■ Travel (riding, driving) ■ Sexual function ■ Social interaction ■ Understand concepts ■ Memory ■ Problem solving ■ Stress adaptation ■ Sleep pattern ■ Recreational/ social activities	■ 'cannot' or 'poor' in at least four specific tasks.

ADL Scoring

The following scoring method is used to score the ADL Score Sheet:

- If a person is independent in performing that task, he is regarded as able to do that task (can), (normal) or (good).
- If a person makes use of assistive devices, or requires the supervision of another person in performing that task, he is regarded as requiring assistance to do the task (with help), (minimal) or (average). Examples of assistive devices are walking frames, raised toilet seats, shower or bath benches.
  Please note that glasses and hearing aids are not classified as assistive devices.
- If a person is completely dependent on another person(s) to perform a task, he is regarded as unable to do that task (cannot) or (poor). Poor means a rating of poor or below average as measured and evaluated by the relevant and appropriate neuropsychometric test(s).

Child Cover

Child Cover Conditions defined terms	
Child activities of daily living	1. Bathing and showering 2. Dressing and undressing 3. Eating and drinking 4. Using the toilet to maintain personal hygiene 5. Moving from place to place by walking, wheelchair or with assistance of a walking aid or getting in and out of bed, a chair or wheelchair.
Cancer	
cancer	The presence of one or more malignant tumours, including lymphoma (including Hodgkin's and non-Hodgkin's disease), leukaemia, multiple myeloma and malignant bone marrow disorders, that are characterised by the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue. The following cancers are excluded: ■ tumours which are histologically described as premalignant or show the malignant changes of carcinoma in situ (including cervical dysplasia CIN-III and lower). Carcinoma in situ of the breast is covered if it results directly in the removal of the entire breast. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment, ■ melanomas which are both less than 1.5mm Breslow thickness and less than Clark level 3 depth of invasion, ■ all hyperkeratoses and basal cell carcinomas, and squamous cell carcinomas of skin unless it has spread to other organs, ■ chronic lymphocytic leukaemia less than Rai stage 1, and ■ prostatic cancers which are TNM Classification T1 or less and have a Gleason score of 6 or less. Prostatic cancer which is TNM classification T1 or less and which has a Gleason score of 6 or less is covered if it results in the entire removal of the prostate. This procedure must be performed specifically to arrest the spread of malignancy and be considered the appropriate and necessary treatment.
aplastic anaemia	Severe aplasia of bone marrow which results in anaemia, neutropenia and thrombocytopenia requiring one of the following treatments: ■ immunosuppressive agents, ■ bone marrow transplant, or ■ peripheral blood stem cell transplant.
Heart and artery	
cardiomyopathy	Disease of the heart muscle causing it to enlarge and become weaker, resulting in significant cardiac impairment to the degree of at least Class III of the *New York Heart Association functional classification system.*
heart attack	Myocardial infarction, characterised by death of a portion of heart muscle due to inadequate blood supply. The following clinical features must be present (and not caused by medical intervention): ■ new ECG changes, and ■ elevation of cardiac biomarkers with CK-MB above the upper limit of normal or Troponin I greater than 2.0 ug/L or Troponin T greater than 0.6ug/L. ■ If the above is inconclusive then we will consider a claim based on conclusive evidence that myocardial infarction has occurred, resulting in either one of the following: ■ new pathological Q-waves, ■ a permanent left ventricular ejection fraction of 50% or less, measured six weeks or more after the event.
open heart surgery	The undergoing of a thoracotomy for treatment of cardiac defect(s), cardiac aneurysm or benign cardiac tumour(s).
out of hospital cardiac arrest	Cardiac arrest that occurs outside of a hospital due to cardiac asystole or ventricular fibrillation with or without ventricular tachycardia. The cardiac arrest must not be related to any medical procedure and must be documented by an electrocardiogram.

Child Cover Conditions defined terms	
Brains and nerves	
bacterial meningitis or meningococcal septicaemia	Bacterial meningitis or meningococcal septicaemia resulting in: ■ a permanent impairment of at least 25% whole person function, or ■ total and irreversible inability to perform at least one of the numbered *child activities of daily living.*
benign brain tumour	Non-malignant tumour in the brain, pituitary gland or spine, resulting in a neurological deficit causing: ■ a permanent impairment of at least 25% whole person function, or total and irreversible inability to perform at least one of the numbered *child activities of daily living.* The presence of the tumour must be confirmed by imaging studies such as CT scan or MRI. Cysts, granulomas, aneurysms in or of the arteries or veins of the brain and haematomas are not covered.
brain damage	Brain damage, as confirmed by a *medical practitioner* who is a consultant neurologist, which results in a neurological deficit causing a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 5th edition, or an equivalent impairment approved by us.
coma	A state of total unconsciousness and unresponsiveness to all external stimuli, resulting in a score of 8 or less on the Glasgow Coma Scale, as outlined below, for a continuous period of at least three days. Glasgow Coma Scale is a scoring system used to measure the level of consciousness following traumatic brain injury. It is composed of three parameters as given below: **Best Eye Response (4)** 1. No eye opening 2. Eye opening to pain 3. Eye opening to verbal command 4. Eyes open spontaneously **Best Verbal Response (5)** 1. No verbal response 2. Incomprehensible sounds 3. Inappropriate words 4. Confused 5. Orientated **Best Motor Response (6)** 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localising pain 6. Obeys commands A Coma Score of 13 or higher correlates with a mild brain injury, 9 to 12 a moderate injury and 8 or less a severe brain injury.
encephalitis	Acute inflammation of the brain caused by viral infection resulting in neurological deficit and leading to: ■ permanent impairment of at least 25% whole person function, or ■ total and irreversible inability to perform at least one of the numbered *child activities of daily living.*
major head trauma	*Accidental* head injury, leading to neurological deficit causing: ■ permanent impairment of at least 25% whole person function, or ■ total and irreversible inability to perform at least one of the numbered *child activities of daily living.*
muscular dystrophy with impairment level	Unequivocal diagnosis of muscular dystrophy, which causes progressive and selective degeneration and weakness of voluntary muscles resulting in: ■ permanent impairment of at least 25% whole person function, or ■ total and irreversible inability to perform at least one of the numbered *child activities of daily living.*

Child Cover Conditions defined terms	
paralysis	The total and irreversible loss of the use of two limbs, where a limb is defined as the shoulder down to the hand or the hip down to the foot.
stroke	A neurological event caused by a cerebrovascular incident. The stroke must: ■ be confirmed by an appropriate medical specialist, and ■ be evidenced by neuro-imaging. Transient ischaemic attacks, cerebral events due to reversible neurological deficits, migraine, hypoxia or trauma, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.
Lungs	
chronic lung disease	End stage lung disease requiring permanent and continuous oxygen therapy, a persistent FEV1 less than 30% predicted or DLCO less than 40% predicted (American Thoracic Society 2004).
primary pulmonary hypertension	Primary pulmonary hypertension characterised by enlargement of the right ventricle as a result of high pulmonary artery pressure. It must have resulted in significant cardiac and respiratory impairment leading to impairment equivalent to at least Class III of the *New York Heart Association functional classification system.*
Kidneys	
chronic kidney failure	Chronic irreversible failure of the function of both kidneys requiring either regular renal dialysis or renal transplantation.
Ear, nose and throat	
loss of hearing	The total and irreversible loss of hearing in both ears with and without the use of an appropriate aid.
loss of speech or total aphasia	Total and irreversible loss of speech. The loss must be confirmed to be total and irreversible at least three months after speech was first lost. Loss of speech or total aphasia due to psychological reasons is excluded.
Eye	
loss of sight	The irrecoverable loss of sight, with and without the use of an appropriate aid, to the extent that eyesight is reduced in both eyes to 6/60 or less of central visual acuity on the Snellen test chart or the degree of vision is less than or equal to 20 degrees of arc.
Musculoskeletal	
loss of limbs	The total and irreversible loss of the use of: ■ two limbs, or ■ sight in both eyes *(loss of sight),* ■ or the sight in one eye and one limb, where 'limb' means whole hand or whole foot and loss of sight in one eye means the irrecoverable loss of sight in one eye, with and without the use of an appropriate aid, to the extent that eyesight is reduced in that eye to 6/60 or less of central visual acuity on the Snellen test chart.
severe burns	Tissue injury caused by thermal, electrical or chemical agents causing third degree burns to at least: ■ 20% of body surface as measured by the Rule of Nines or the Lund and Browder Body Surface Chart, ■ the whole of both hands, requiring surgical debridement and/or grafting, or ■ the whole of the face, requiring surgical debridement and/or grafting.

Child Cover Conditions defined terms	
Digestive system	
chronic liver disease	End stage liver failure resulting in permanent jaundice, bleeding varices, ascites or encephalopathy.
Other	
child's loss of independent existence	After reaching seven years of age, the total and irreversible inability to perform at least two of the numbered *child activities of daily living* without the assistance of another person.
intensive care	A sickness or injury has resulted in the insured person requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hrs per day) or more in an authorised intensive care unit of an acute care hospital. No benefit shall be payable where the sickness or injury is as a result of drug or alcohol intake or other self-inflicted means.
major organ transplant	The insured person is the recipient of an organ transplant of one of the following organs: ■ heart, ■ kidney, ■ liver, ■ lung, ■ pancreas, ■ small bowel, or ■ the transplantation of bone marrow. The transplant must be considered the appropriate and necessary treatment.
medically acquired HIV	The *accidental* infection with Human Immunodeficiency Virus (HIV), which on the balance of probabilities arose from one of the following medical procedures: ■ transfusion of blood or blood products, ■ organ transplant, ■ assisted reproduction techniques, or ■ other medical procedure or operation performed by a doctor or at a registered medical facility. The procedure must have been performed by a registered health professional and have occurred in Australia. We require a statement from the appropriate Statutory Health Authority that provides documented proof of the incident and confirms that the infection is medically acquired. A claim for medically acquired HIV will not be payable if: ■ HIV infection is caused by any other means, including sexual activity or recreational intravenous drug use, or ■ a treatment is developed and approved which renders the HIV virus inactive and non-infectious.

Other

Other defined terms	
accident/accidental	A fortuitous and unforeseen event, resulting in an injury, which is not caused, or contributed to, by an intentional act of the insured person.
application date	The application date shown on your policy, which is the Macquarie Life date stamp recorded on a paper application received by Macquarie Life or the date an electronic application is authorised via Macquarie's online website for: ■ a new type of cover with Macquarie Life, or ■ an increase to existing cover (but only in respect of the increase).
Child Cover Condition	An injury, *illness* or treatment for an injury or *illness*, meeting the criteria as defined in the Child Cover Condition section on page 59. The date of occurrence of the Child Cover Condition is: ■ for an injury, the date the injury occurs, ■ for an *illness*, the date a *medical practitioner* confirms diagnosis, or ■ for treatment, the date the insured person undergoes the treatment. In order to be eligible to claim, the occurrence of the Child Cover Condition as described above must occur after *cover commencement* and before cover ends.
cover commencement	The latest of: ■ cover start date shown in your policy schedule, ■ the date cover is reinstated (but only in respect of the reinstated cover), or ■ the date cover commences for any increases in cover that you applied for (but only in respect of the increase).
disability/disabled	*Total disability* or *partial disability*.
eligible superannuation plans	■ Macquarie Super Consolidator, Macquarie Super Accumulator, Macquarie Super Manager or Macquarie SuperOptions, or ■ any other superannuation plan for which MIML acts as trustee (excluding the insurance-only division of the Macquarie Superannuation Plan).
eligible wrap service	■ Macquarie Investment Consolidator, Macquarie Investment Accumulator or Macquarie Investment Manager, or ■ a client branded version of one of the above products.
fracture	Any break in the bone that requires a pin, traction, plaster or other immobilising structure.
gainful employment/ gainfully employed	The insured person is engaged in an occupation, business or employment for remuneration or reward.
Health Event	An injury, *illness* or treatment for an injury or *illness*, meeting the criteria as defined in the *Health Events* section starting on page 43. The date of occurrence of the Health Event is: ■ for an injury, the date the injury occurs, ■ for an *illness,* the date a *medical practitioner* confirms diagnosis, or ■ for treatment, the date the insured person undergoes the treatment. In order to be eligible to claim, the occurrence of the Health Event as described above must occur after *cover commencement* and before cover ends.
illness	A pathologicial condition evidenced by medically recognised signs and symptoms.
immediate family member	A married or de facto partner, child, brother, sister or parent.

Other defined terms	
income	Income earned through personal exertion calculated: ■ after the deduction of expenses incurred in producing that income, and ■ before the deduction of income tax. It is based on the total remuneration package and includes salary, wages, packaged fringe benefits, regular commissions, regular bonuses, regular overtime payments and pre-tax superannuation contributions. For the self-employed it also includes that share of net income of the business directly generated by personal exertion after deduction of all business expenses but before the deduction of tax. Income does not include: ■ income that the insured person would continue to receive from his or her business even if unable to work, including any ongoing profit generated by other employees of the business, or ■ other unearned income such as dividends, interest or rental income.
Indexation	The increase in consumer price index. For *Health Events, terminal illness* and death cover and Child Cover, the minimum indexation rate that will apply is 3%. The consumer price index is the weighted average of the eight Australian capital cities combined, published by the Australian Bureau of Statistics or any body which succeeds it, in respect of the 12 month period finishing on or prior to 30th September. It will be determined at 31 December each year and applied at the cover anniversary on or following 1 March in the next year.
Initial Amount of Cover	The Initial Amount of Cover is the amount originally issued, adjusted for Indexation Increases over time, plus any subsequent increases or decreases to the cover that you apply for and are accepted by us. Refer to page 11 for information about Indexation Increases.
involuntary unemployment/ involuntarily unemployed	A period during which the insured person is: ■ not working, ■ is actively seeking employment, and ■ is registered with Centrelink or other government approved job placement agencies as a job seeker, and where becoming unemployed was a result of: – the termination of the insured person's *gainful employment* by their employer without the consent of the insured person, or – the insured person being made redundant from *gainful employment* by their employer. It does not include unemployment as a result of: ■ the insured person ceasing *gainful employment* of a casual, seasonal or temporary nature, ■ the expiration of a fixed term employment contract or other specified period of work, or ■ the deliberate or serious misconduct of the insured person.
Limited Claim Period	As complications from a medical condition, or its treatment, often arise within the months following a condition and it can be difficult to identify all of these complications, a *Limited Claim Period* applies for 12 months following a Health Event claim. When a claim for a *Health Event* occurs, a *Limited Claim Period* starts and lasts for 12 months. If a subsequent *Health Event* occurs during this *Limited Claim Period*, any amounts already paid during the current *Limited Claim Period* will be deducted from the amount we will pay for the current claim. We will not deduct amounts paid for a prior claim for a *Health Event* within the *Limited Claim Period* where either the current claim or the prior claim is/was for a *Health Event* that is the result of *accident*, unless the *Health Events* are directly or indirectly due to the same underlying cause or event.
loss of independent existence	The total and irreversible inability to perform at least two of the tasks under the Self-care category of Activities of Daily Living. In order to be considered unable to perform two of the Self-care tasks, the person must score 'cannot' for at least two of the Self-care tasks.
Maximum Amount Payable	The Maximum Amount Payable for each of the *Health Event* benefit categories A to E is calculated as the lesser of: ■ the *Initial Amount of Cover* multiplied by the applicable percentage for the relevant benefit category, and ■ the *Remaining Amount of Cover* under the policy. If the *Initial Amount of Cover* is less than $200,000, the Maximum Amount Payable for benefit category E will be $10,000 and the percentage for benefit category E will be adjusted accordingly. The *Maximum Amount Payable* for *terminal illness* and death under benefit category AA is the *Remaining Amount of Cover* under the policy plus any additional death cover.
medical practitioner	A doctor who is legally qualified and registered to practise in Australia (or if outside Australia, has equivalent qualifications and registration) not being you, the insured person, or a business partner or *immediate family member* of you or the insured person.

Other defined terms	
monthly benefit	■ In relation to Income Cover provided on an 'income at claim' basis and without the Superannuation Cover option selected, the lesser of: – the Monthly Amount of Cover, and – the monthly equivalent of 75% of the first $320,000, 50% of the next $240,000 and 20% of the balance of the insured person's *pre-disability income*, ■ In relation to Income Cover provided on an 'income at claim' basis and with the Superannuation Cover option selected, the lesser of: – the Monthly Amount of Cover, and – the monthly equivalent of 100% of the insured person's *pre-disability income* contributed to superannuation (up to a maximum of 20% of *pre-disability income* but no more than the proportion of *pre-application income* contributed to superannuation) plus 75% of the next $320,000 of *pre-disability income*, 50% of the next $240,000 and 20% of the balance, ■ In relation to Income Cover provided on an 'income at application' basis and without the Superannuation Cover option selected, the lesser of: – the Monthly Amount of Cover, and – the monthly equivalent of 75% of the first $320,000, 50% of the next $240,000 and 20% of the balance of the insured person's *pre-application income*, ■ In relation to Income Cover provided on an 'income at application' basis and with the Superannuation Cover option selected, the lesser of: – the Monthly Amount of Cover, and – the monthly equivalent of 100% of the insured person's *pre-application income* contributed to superannuation (up to a maximum of 20% of *pre-application income*), 75% of the next $320,000 of *pre-application income*, 50% of the next $240,000 and 20% of the balance, ■ In relation to Income Cover provided on an 'endorsed income at application' basis, the Monthly Amount of Cover, ■ In relation to Income Cover where portions of the Monthly Amount of Cover are each provided with different types of cover (on either an 'income at claim' basis or an 'income at application' basis), the greater of: – the portion of the Monthly Amount of Cover provided on an 'income at application' basis, and – the *monthly benefit* otherwise calculated on an 'income at claim' basis using the combined total of the portions of the Monthly Amount of Cover provided on an 'income at application' basis and an 'income at claim' basis. In determining the *monthly benefit* to be used as the basis for the payment of any benefit(s) under the policy in any given month, we will consider the sum of only those portions of the Monthly Amount of Cover for which the particular benefit is payable, having regard to the waiting period, benefit period, type of cover and options that are applicable.
partial disability/ partially disabled	The insured person is, solely as a result of injury or *illness:* ■ unable to perform at full capacity one or more of the duties of their *usual occupation* necessary to produce income as confirmed by a *medical practitioner*, and ■ is *gainfully employed* but their *post-disability income* is less than *pre-disability income*, and is under the regular care and following the advice of a *medical practitioner*.
pre-application income	The insured person's annual *income* at the time you applied for the cover or, if you have applied to increase the Monthly Amount of Cover which we accepted, at the time you applied for the increase.
pre-disability income	If Income Cover is provided on an: ■ 'income at application' basis, the highest average monthly *income* of the insured person for 12 consecutive months between two years before the cover start date and the start of the waiting period applying to the claim, ■ 'income at claim' basis, the highest average monthly *income* of the insured person for 12 consecutive months in the three years preceding the start of the waiting period applying to the claim. *Pre-disability income* will be increased by the *indexation* rate at each cover anniversary while the insured person remains on claim.
Progressive Condition	There are a number of medical conditions that we will treat as a progression of a prior condition when calculating how much we will pay. A *Progressive Condition* is any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim. For full details of *Health Events* we consider to be *Progressive Conditions,* refer to page 51.

Other defined terms	
post-disability income	The average *income* earned in the month by the insured person from personal exertion following injury or *illness* while *partially disabled.*
Remaining Amount of Cover	When your policy starts, the *Remaining Amount of Cover* under the policy is equal to the *Initial Amount of Cover*. When a *Health Event* claim is paid under the policy, the *Remaining Amount of Cover* under the policy is reduced by the amount paid for the *Health Event*. Once the *Remaining Amount of Cover* has reduced to nil under the policy, there is no cover for t*erminal illness* or death, unless additional death cover, which is not reduced by *Health Event* claims, has been included.
replacement cover waiver – death and terminal illness	The specified exclusion will be waived and does not apply if the policy issued by us replaces other similar insurance under a policy or policies issued by us or another insurer (the other policy), and we agreed to issue this policy on the basis that it replaced the other policy (as shown in your policy) and the following conditions are also met: ■ the *Initial Amount of Cover* plus any additional death cover being issued by us is the same amount or less than that under the other policy. If the death and *terminal illness* cover (being the *Initial Amount of Cover* plus any additional death cover) under the policy being issued by us is higher than that under the other policy, the exclusion will not apply only in respect of the amount of death and *terminal illness* cover that replaces cover under the other policy, ■ the other policy was continuously in force for 13 months immediately prior to the issue of this policy, ■ the other policy was cancelled immediately after the issue of this policy, and ■ no claim is pending or payable under the other policy.
replacement cover waiver – Health Events and Child Cover	The specified exclusion does not apply to a *Health Event* or *Child Cover Condition*, as relevant, if the policy issued by us replaces other similar insurance under a policy or policies issued by us or another insurer (the other policy) and we agreed to issue this policy on the basis that it replaced the other policy (as shown in your policy) and the following conditions are also met: ■ the *Initial Amount of Cover* being issued for *Health Events* (or the Amount of Cover for Child Cover) by us is the same amount or less than that under the other policy. If the *Initial Amount of Cover* (or Amount of Cover) under the policy being issued by us is higher than that under the other policy, the exclusion will not apply only in respect of the amount of the *Initial Amount of Cover* (or Amount of Cover) that replaces cover under the other policy, ■ the other policy was continuously in force for 90 days immediately prior to the issue of this policy, ■ the other policy provided similar cover for the *Health Event* (or the *Child Cover Condition*), ■ the other policy was cancelled immediately after the issue of this policy, and ■ no claim is pending or payable under the other policy.
terminal illness	The insured person is diagnosed with an *illness,* which reduces life expectancy to less than 12 months from the date of claim, as confirmed by two *medical practitioners*, one of whom is a medical specialist approved by Macquarie Life.
total disability/totally disabled	The insured person is, solely as a result of injury or *illness:* ■ unable to perform one or more of the duties of their *usual occupation* necessary to produce income as confirmed by a *medical practitioner*, and ■ not *gainfully employed* in any capacity, and is under the regular care and following the advice of a *medical practitioner*. If you have Income Cover Plus, for a maximum of twelve monthly payments per claim, we will also consider the insured person to be *totally disabled* if the insured person: ■ is unable to work more than 10 hours* per week in their *usual occupation*, and ■ has a *post-disability income* that is less than 25% of their *pre-disability income* and is under the regular care and following the advice of a *medical practitioner* *If the insured person was working less than 20 hours per week in their usual occupation in the 12 months immediately prior to disability, the insured person must be unable to work more than 5 hours per week in their usual occupation.
usual occupation	The occupation in which the insured person is regularly engaged, except: ■ if your policy shows that we classified the occupation of the insured person as occupation class 4, after three years of claim, usual occupation means any occupation which the insured person is reasonably capable of performing having regard to their education, training or experience, ■ if the insured person has been unemployed or on maternity, paternity or sabbatical leave for greater than 12 months at the time of *disability,* then usual occupation means any occupation which the insured person is reasonably capable of performing having regard to their education, training or experience.

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How to contact Macquarie Life and Macquarie Investment Management Limited

Existing Clients

Your adviser is your main point of contact for your insurance cover, so if you have any questions about your cover, please talk to your financial adviser.

1800 005 057

GPO Box 5216
Brisbane QLD 4001

insurance@macquarie.com

macquarielife.com.au

Claims

1800 208 130

insuranceclaims@macquarie.com

FORWARD thinking

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