Issue Date: 15 May 2017

ZURICH®

Zurich Active

Product Disclosure Statement including policy conditions

This PDS

This PDS contains information about the Zurich Active policies, as well as the policy conditions.

The Zurich Active policies are:

- Zurich Active Cover
- Zurich Child Cover
- Zurich Income Protector.

Defined terms

In this PDS, all terms appearing in italics are defined terms with special meanings which are explained in the Definitions section of the PDS. Policy features are capitalised for ease of identification.

'Zurich', 'us', 'our', and 'we' means Zurich Australia Limited. Unless specified, 'You' means the person making the insurance decisions and applying for cover ie. generally the policy owner (including trustees of a self-managed superannuation fund). Where you are taking out insurance as a member of any other superannuation fund, 'you' will be the life insured. See the section 'Policy ownership' on page 2.

A reference to 'Zurich Income Protector' refers to both levels of cover: Zurich Income Protector and Zurich Income Protector Plus, except where separate provisions are specifically stated as only applying to Zurich Income Protector Plus.

Policy conditions

This PDS includes the policy conditions which will apply to your cover once your application has been accepted. It is important that you read them carefully and keep this document in a safe place.

Important notes

The Zurich worldwide group of companies has obligations under various Australian and foreign laws. Despite anything to the contrary in this PDS or any other document related to the policies described in this PDS, the policies' terms will operate subject to all laws with which a Zurich worldwide company considers it must comply.

This offer is available only to persons receiving it (including electronically) within Australia. We cannot accept cash or applications signed and mailed from outside Australia.

Cover is available to Australian residents (including people who are in the process of applying for permanent residency) who are living in Australia. All parties to any policy issued must be Australian residents, including policy owners, lives insured, payors and beneficiaries nominated. The policies are designed for Australian residents, and their operation and your rights may be restricted if you or the life insured become a resident of another country.

General information only

The information contained in this PDS is general information only. It does not take into account your individual objectives, financial situation or particular needs. You should consider the appropriateness of each policy having regard to your objectives, financial situation and needs.

We recommend you seek professional financial and taxation advice before making any decisions regarding these policies.

Up to date information

The information in this PDS is up to date at the date it is prepared. Certain information in this PDS may change from time to time. Where the change is not materially adverse, we will update such information on our website, www.zurich.com.au. A paper copy of the updated information will be available free of charge upon request by contacting us (see the inside back cover of this PDS for details).

Issuer information

This PDS and the life insurance products described in it are issued by Zurich Australia Limited ABN 92 000 010 195, AFSL 232510. Our contact details appear on the inside back cover of this PDS.

If you take out Zurich Active policies via a superannuation fund, Zurich issues life insurance policies to the trustee.

Preparation date: 20 April 2017

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Introduction

Zurich Active allows you to select a combination of life insurances and ownership structures to meet your needs as determined by you and your adviser.

The primary benefits provided under these insurances are summarised in this table. You will find the terms and conditions applying to each type of insurance in the next sections of this PDS.

Zurich Active Cover

Health events, terminal illness & death cover	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), *terminal illness* and death. The amount payable for a *health event* 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 set out on page 8.

Zurich Child Cover

Child cover	Child cover provides a lump sum payment if the insured child suffers one of the insured trauma conditions. It also includes death, terminal illness and carer benefits.

Zurich Income Protector

Income protection cover	Income protection provides a monthly benefit that contributes towards a replacement income if the life insured is unable to work and is disabled, in most cases, for longer than the specified waiting period.

Cooling off period

After we send you a policy schedule, you have 21 days to check that your policy meets your needs. Within this time you may cancel the policy and receive a full refund of any premiums paid, provided you have not exercised any rights under it. Your request can be in writing or by phone (see the section 'How to contact us' on the inside back cover of this PDS).

If your policy has superannuation ownership, any refund is subject to preservation requirements. You may be required to nominate a complying superannuation fund for any refund.

If you exercise any rights in relation to your policy (for example, you make a claim) before the 21 day period has elapsed, your option to cancel your policy and receive a refund will be forfeited.

Worldwide cover

You are covered under any Zurich Active policy 24 hours a day, seven days a week, worldwide.

If you are claiming income protection benefits while overseas, we will require you to have a medical examination every 12 months for benefits to continue.

Guaranteed upgrade of benefits

We may improve the terms of the benefits described in this PDS. If we do so, without any change in the standard premium rates, we will incorporate the improvement in your policy. Any medical condition existing at the time the improvement is offered or any injuries sustained prior will be excluded from being eligible for payment under the improved terms.

Guaranteed renewable

Provided you pay premiums as required, these policies are guaranteed to be renewable up until the expiry date of the benefit(s) you have chosen regardless of any changes in your health or pastimes.

Cover that keeps up with you

These policies have been designed with long-term, flexible cover in mind, and include automatic yearly increases in sums insured to protect cover against the impact of inflation.

Life insurance code of practice

As a member of the Financial Services Council of Australia (the FSC), we will be bound by the Life Insurance Code of Practice with effect from 1 July 2017. The code outlines the standards that we are committed to in providing life insurance services to you. The Code can be found at www.fsc.org.au.

Significant risks

There are certain risks associated with holding a Zurich Active policy:

- the insurance you have chosen might be inadequate to fully protect your financial needs based on your circumstances now or in the future
- if premiums are not paid when due, the policy will lapse, the life insured will no longer be covered and you cannot make a claim
- if you do not comply with your duty of disclosure, we may not pay your claim, pay only a portion of your claim, vary your cover or cancel your cover.

The duty of disclosure is explained on page 36.

Policy ownership

To maximise the efficiency of your insurance cover, you can tailor a Zurich Active policy to suit your individual needs.

Two important considerations are policy ownership and whether or not to structure ownership of any of your insurance cover in superannuation – through your own self-managed superannuation fund (SMSF) or as a member of an *eligible superannuation fund*. Some benefits are not available or are restricted when cover is held in superannuation but this structure allows premiums to be funded by superannuation investments and contributions.

Zurich allows a number of ownership structures to suit individual circumstances, as summarised in the table below.

If you wish to hold as much of your cover as possible in super, but still wish to access benefits which cannot be held in superannuation, Zurich's superannuation optimiser could be the solution. More information about superannuation optimiser can be found on page 41.

Your financial adviser can provide you with more information on policy structures for your individual situation.

	Policy owner	Policies available	Life insured	Benefits payable to
Outside of super	**You** as an individual (can be via a platform)	Zurich Active Cover Zurich Child Cover Zurich Income Protector/Plus	**You** or another individual	**You** or Nominated beneficiary (for death benefits if you are the sole policy owner and life insured)
	You as a corporation		Individual	Policy owner
In super (superannuation ownership)	**You** as SMSF trustee/s (individual or corporation) (can be via a platform)	Zurich Active Cover Zurich Income Protector/Plus (benefits adjusted to comply with superannuation laws)	SMSF member	SMSF trustee/s
	Trustee of an eligible superannuation fund (can be via a platform)	Zurich Active Cover Zurich Income Protector/Plus (benefits adjusted to comply with superannuation laws)	**You** (applying for cover through your superannuation fund)	Policy owner

Benefits under Zurich Active policies are usually payable on an event (eg. death or injury) happening to the life insured but payable to the policy owner. You can have a single policy owner or joint policy owners (eg. husband and wife, family trust trustees, business partners or individual SMSF trustees).

With superannuation ownership, the trustee may release benefits to you upon meeting a superannuation condition of release under superannuation law and in accordance with the trust deed.

Zurich Active at a glance

Zurich Active Cover

Health events, terminal illness & death cover
Provides a lump sum payment if the life insured suffers a covered *health event*, is diagnosed with a *terminal illness* or dies

Entry ages	15 – 65	
Expiry age	99 Limited Health events cover applies from age 70 (only *loss of independent existence*)	
Minimum sum insured	$100,000	
Maximum sum insured	Health events cover: $4,000,000 This includes any cover provided under the Extended care option (being an additional 50% of the *initial amount of cover*) at time of application. Death & terminal illness cover: no maximum (depends on individual needs)	
Increasing cover after the policy begins (in addition to Inflation protection increases)	Cover can be increased until the policy anniversary following the life insured's 69th birthday. The minimum increase amount is $50,000.	
Included benefits	• Health events benefit* • Death & terminal illness benefit • Claim protector • Advancement for funeral expenses*	page 7 page 7 page 12 page 14
Included features	• Inflation protection • Future insurability • Financial planning advice* • Interim cover • Premium holiday#	page 14 page 14 page 15 page 37 page 47
Available options	• Additional death cover option • Extended care option	page 16 page 16

* These in-built benefits and optional benefits are not available in superannuation, but can be accessed via superannuation optimiser. In this structure, the only *health events* covered under the superannuation policy are those covered under benefit category A and which also meet the definition of *permanent incapacity*.

Premium holiday is not available on policies set up in a platform arrangement.

Zurich Child Cover

Child cover
Provides death, *terminal illness* and limited trauma benefits for children, as well as a carer benefit for parents

Entry ages	2 – 17	
Expiry age	18	
Minimum sum insured	$10,000	
Maximum sum insured	$500,000 Maximum applies to all child trauma cover combined across all insurers. Death & terminal illness benefit is capped at $200,000.	
Increasing cover after the policy begins (in addition to Inflation protection increases)	Cover can be increased until the policy anniversary following the life insured's 17th birthday. The minimum increase amount is $10,000.	
Included benefits	• Trauma benefit • Injury advancement benefit • Carer benefit • Death & terminal illness benefit	page 18 page 18 page 18 page 18
Included features	• Inflation protection • Cover increase provision • Continuation of cover • Interim cover • Premium holiday#	page 19 page 19 page 19 page 37 page 47

Premium holiday is not available on policies set up in a platform arrangement.

Zurich Income Protector

Income protection cover
Provides a monthly benefit if the life insured is unable to work due to a *sickness* or *injury* and is *totally disabled* or *partially disabled*, in most cases, for longer than the specified waiting period

Entry ages	19 – 60	
Expiry age	65 70 (with age 70 benefit period)	
Eligibility	The life insured must be working in *full-time paid employment*	
Minimum insured amount	$1,500 per month	
Maximum insured amount	$30,000 per month, plus an additional $30,000 per month restricted to a one or two year benefit period.	
Increasing cover after the policy begins (in addition to Inflation protection increases)	Cover can be increased until the policy ends. The minimum increase amount is $500 per month.	
Choice of cover	• Zurich Income Protector Plus • Zurich Income Protector	
Benefit type	• Indemnity • Agreed value • Endorsed agreed value	
Waiting periods available	• 14, 30, 60, 90, 180 days • 1 or 2 years	
Benefit periods available	• 1 year • 2 years • 5 years • to age 65 • to age 70 (A1, A1L, A1M, A2, A3)	
Included benefits	• Total disability benefit • Partial disability benefit • Specified injury benefit* • Rehabilitation benefit* • Funeral benefit • Confined to bed benefit (Plus only)	page 24 page 25 page 26 page 27 page 27 page 27
Included features	• Inflation protection • Waiver of premium • Medical professionals feature • Waiting period reduction feature • Involuntary unemployment • Interim cover • Premium holiday#	page 28 page 28 page 29 page 29 page 30 page 37 page 47
Optional benefits	• Increasing claims option • Super contributions option • Day 4 accident option • Family care option* • Home support option* • Future insurability option • Lump sum accident option* • Trauma advancement option* • Needlestick cover option^*	page 30 page 30 page 31 page 31 page 31 page 32 page 32 page 33 page 33

* These in-built benefits and optional benefits are not available in superannuation, but can be accessed via superannuation optimiser.

\# Premium holiday is not available on policies set up in a platform arrangement.

^ The Needlestick cover option can be applied for up to age 65 and expires at age 75. The maximum sum insured for Needlestick cover under all Zurich policies is $1,000,000. The Needlestick cover sum insured does not increase under Inflation protection.

Income protection cover restrictions for SR occupations
Some restrictions apply to occupations which we classify as 'special risk', as follows:

Entry ages	19 – 53	
Expiry age	60	
Unemployment	Cover terminates after you are no longer in *full-time paid employment* for 12 months	
Choice of cover	Zurich Income Protector Plus is not available	
Waiting periods available	• 30, 60, 90 days	
Benefit periods available	• 1, 2, 5 years	
Maximum insured amount	$10,000 per month	
Optional benefits	• Increasing claims option • Family care option* • Home support option* • Needlestick cover option^*	page 30 page 31 page 31 page 33

Zurich Active Cover

The Zurich Active Cover policy pays a lump sum if the life insured suffers a specified health event or in the event of the life insured's terminal illness or death.

Health events, terminal illness & death cover

This package of cover will provide a lump sum payment if the life insured suffers one of the listed *health events* or is diagnosed with a *terminal illness*. It can also provide a lump sum payment to your estate or nominated beneficiary if the life insured dies.

In-built benefits

Benefit name	Description
Health events, terminal illness & Death cover	Provides a lump sum payment if the life insured suffers one of the listed *health events*, is diagnosed with a *terminal illness* or in the event of the life insured's death.
Advancement for funeral expenses	Advances a small portion of the *initial amount of cover* so that immediate expenses can be met following the death of the life insured.

In-built policy provisions

Benefit name	Description
Inflation protection	Cover will increase every year, unless declined by you, without health assessment.
Claim protector	Ensures 25% of the *initial amount of cover* is retained on the policy so that funds will be available in the event that the life insured suffers more than one claim for *health events* over the life of the policy.
Future insurability	Allows an increase in cover without underwriting on certain life events eg. marriage or birth of a child.
Financial planning advice	Reimburses the cost of advice up to $1,000.
Interim cover	Puts some accident cover in place as soon as cover is applied for, as set out in the Interim cover terms on page 37.
Premium holiday (not available under platform)	Allows a break in cover (max 12 months over the life of the policy) to ease financial pressure.

Optional benefits

Optional benefits can be added after policy commencement but they then cannot be exercised if an insured event occurs or is apparent within 90 days after the option is added.

Option name	Description
Additional death cover option	Pays an additional lump sum if the life insured is diagnosed with a *terminal illness* or in the event of the life insured's death.
Extended care option	Pays an additional benefit amount if the life insured suffers a category A *health event* that meets at least either 4 of the 6 *activities of daily living* or 60% *whole person impairment*.

The terms and conditions which apply to Zurich Active Cover are set out on page 7.

A claims approach to health events that makes sense

If you are eligible to claim for a *health event* under your Zurich Active Cover policy, the severity of your *sickness* or *injury* will determine how much we pay. Generally 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.

Your policy will not cease after a Health event claim and will remain in place at a reduced level, allowing you to claim multiple times over the life of the policy, subject to specified limits (see 'Claim protector' on page 12).

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 10)
- the difference in benefit severity for unrelated conditions that occur within the 12 month *limited claim period* (see 'Limited claim period' on page 11) or
- the full amount of the applicable benefit for unrelated conditions that occur outside the *limited claim period*, subject to remaining levels of cover (see 'Subsequent claims under the policy' on page 10).

Active Cover also includes the *safety net categories* by which we can assess your functional capacity against the criteria in these *safety net categories* in the event that you do not meet the criteria of any other *health event* category.

Active cover in superannuation

If you choose to hold your cover within superannuation, superannuation optimiser will apply.

Superannuation optimiser allows you to split your cover so that it is held across two policies. One policy is issued to a trustee of a superannuation fund while the other is issued to the life insured (or other entity who is not a trustee of a superannuation fund). This enables you to hold those benefits that comply with a superannuation condition of release within superannuation and the remainder outside of superannuation.

For more information about superannuation optimiser, see page 41.

Zurich Active Cover terms and conditions

The information provided below forms part of the Zurich Active terms and conditions. Words or expressions shown in *italics* have their meaning explained in the Definitions sections at the end of this PDS.

Upon acceptance of your application, we will issue you with a policy schedule. The policy schedule shows the life insured covered under this policy and shows the Health events benefit amount and the Death & terminal illness benefit amount. It also shows any optional benefits provided.

If the policy is one of two related policies issued under superannuation optimiser, it will show whether the policy is the superannuation policy or the non-superannuation policy. If the superannuation optimiser applies, see the section 'Superannuation optimiser – health events, terminal illness & death cover' on page 41 for important information and terms, including how payments are made from the two related policies under which the benefits are provided.

The life insured is only covered for the benefits and for the amounts as shown on the policy schedule until the applicable benefit expiry dates. Benefits are only 'in force' from the applicable start date until the applicable benefit is terminated.

You have the option to make changes to your policy. Additional optional benefits or increases to the benefit amounts may be applied for after policy commencement, but will be effective only if we accept the application after considering the life insured's personal circumstances including health, occupation and pastimes.

The benefits provided by the Zurich Active policy are set out below. Optional benefits are described in the Optional benefits section on page 16.

Some benefits do not form part of the policy if the policy is issued to the trustee of a superannuation fund – these are clearly indicated.

When a benefit is payable

A benefit is payable if, while the cover for Health events, terminal illness & death cover is in force, the life insured:

- dies
- is diagnosed with a *terminal illness* or
- suffers a *health event* covered under the policy, and the *maximum amount payable* for the benefit category under which the benefit is payable is not nil.

Whenever a Health events benefit is paid and the policy has not ended, we will issue you with a replacement policy schedule which will state the *remaining amount of cover* and *maximum amounts payable* for each benefit category.

Where we do not accept your application for Health events cover, we may issue a policy with Death & terminal illness cover only. In this situation, your policy schedule will show the *maximum amount payable* for Health events benefit categories as zero. Refer to the section 'Benefit categories' on the next page.

You may request the removal of the Health events benefit from your policy. In which case we will reduce the *initial amount of cover* on the corresponding benefit categories to zero. We will issue you with a replacement policy schedule, which will reflect the changes.

Where your policy schedule indicates that superannuation optimiser applies, your cover will be held over two related policies with a payment available under only one of these policies for any one *health event*. Refer to the 'Superannuation optimiser – health events, terminal illness & death cover' section on page 41 for further information.

When cover changes

From the policy anniversary following the life insured's 65th birthday, cover for *occupational impairment* and cover under the Extended care option, if applicable, ceases. From the policy anniversary following the life insured's 70th birthday, cover for all *health events* ceases and cover is only provided for:

- *loss of independent existence* (under benefit category A), and
- *death* & *terminal illness* (under benefit category AA).

Health event categories

The *health events* are grouped into different Health event categories, as set out on page 57.

Health event claims will first be assessed against the definitions under the Health event benefit category relevant to the affected body system, eg. heart and artery. The 'Inability to perform Activities of Daily Living (ADL)' and 'Occupational impairment' *safety net categories* will only apply if, in our opinion, you do not meet the definition under any of the other Health event categories.

Benefit categories

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

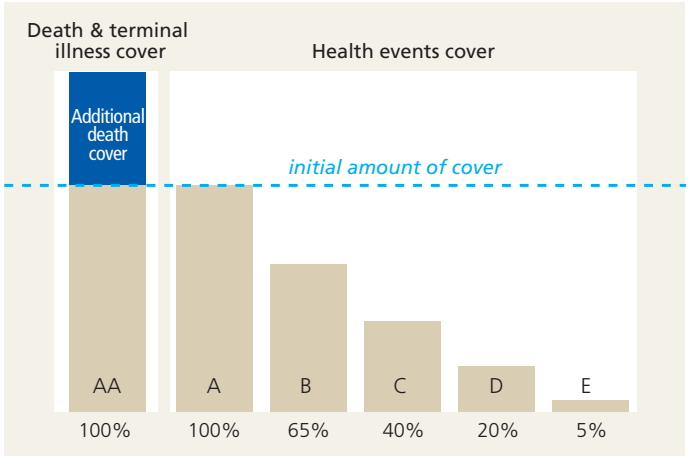
The highest benefit category is for Death & *terminal illness* (benefit category AA) and the cover is based on the *initial amount of cover* plus any Additional death cover that you choose to include. After that, the Health event benefit categories range from A through to E (from most serious to least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

The list of *health events* covered by your policy and their corresponding benefit categories can be found in the section 'Health events' on page 57.

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 the next page.

Benefit category	Type of cover	Percentage of the *initial amount of cover*
AA	Death & terminal illness	100%, plus any Additional death cover purchased
A	Health events	100% (*initial amount of cover*)
B	Health events	65%
C	Health events	40%
D	Health events	20%
E	Health events	5%[1]

[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.



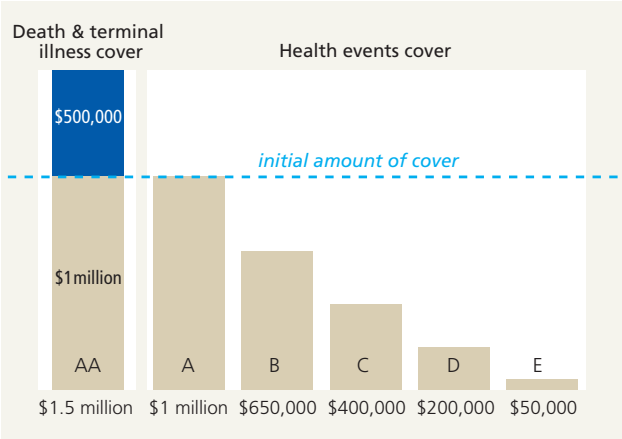
Examples

Throughout the PDS we will provide examples to show how the cover works. These do not form part of your Zurich Active Cover policy terms and conditions.

All examples are based on Health events, terminal illness & death cover held by Michael, who is a 38 year old male.

The examples throughout the PDS do not include indexation increases.

Michael applied for an *initial amount of cover* of $1,000,000 plus $500,000 of Additional death cover, which when issued, provides the following levels of cover per benefit category:



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 as follows:

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 'Inflation protection' on page 14.

Remaining amount of cover

When your policy starts, the *remaining amount of cover* under the policy is the same as the *initial amount of cover*. When a Health event benefit is paid under the policy, the *remaining amount of cover* is reduced by the amount paid.

Once the *remaining amount of cover* has reduced to nil, there is no cover for *terminal illness* or death, unless Additional death cover is included in the policy. Additional death cover is not reduced by the payment of a Health event benefit.

The Claim protector feature limits the extent to which the *remaining amount of cover* for *health events* under benefit categories A to E will reduce. Refer to 'Claim protector' on page 12.

The *remaining amount of cover* is adjusted for indexation increases in line with the indexation of the *initial amount of cover*. Refer to 'Inflation protection' on page 14.

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.

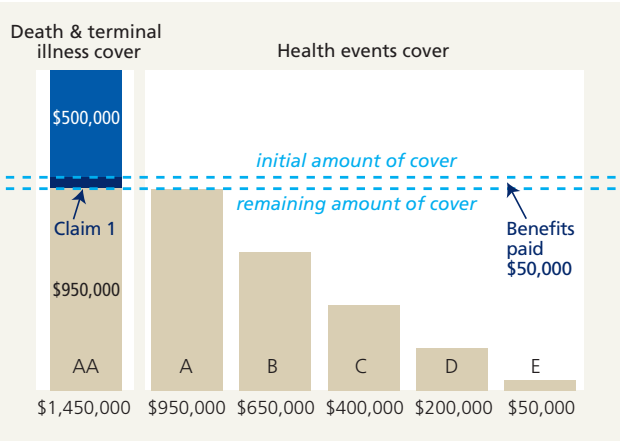
The depth and stage of the melanoma falls into the defined criteria for benefit category E (5%) under the Health event benefit category for solid tumour cancers (see Cancer body system on page 57). For this claim, an amount of $50,000 is paid to Michael.

Because the condition meets a definition under this Health event category, the claim is not assessed against the *safety net categories*.

Following this claim, the *remaining amount of cover* under the policy is reduced as follows:

Benefit category	Type of cover	*Maximum amount payable*
AA	Death & terminal illness	$1,450,000
A	Health events	$950,000
B	Health events	$650,000
C	Health events	$400,000
D	Health events	$200,000
E	Health events	$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 made 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 the next page), 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 'Health event progressive conditions' on page 66.

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

The amount we will pay for a *health event* due to a condition that is a *progressive condition* is calculated as follows:

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 of the *health event* being claimed.

[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 *angioplasty* or the benefit category E amount was set at $10,000 because the *initial amount of cover* was less than $200,000.

Example: second claim – 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 benefit category for solid tumour cancers (see Cancer body system on page 57).

Because the condition meets a definition under this Health event category, the claim is not assessed against the *safety net categories*.

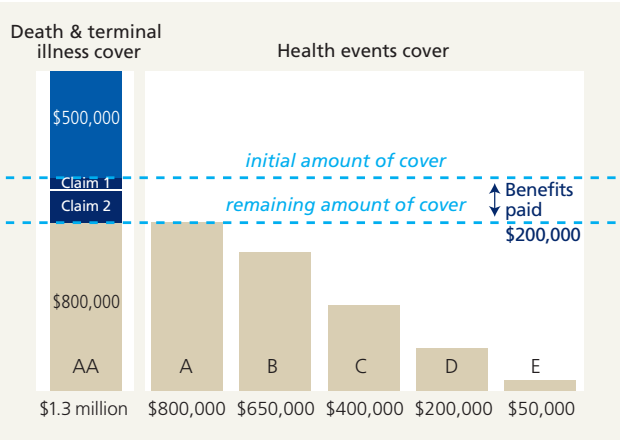
As this recurrence of melanoma is a *progressive condition*, we will pay the difference between the percentage payable for the benefit category of the current claim and that of the previous claim.

In this case, the current benefit category of D provides a benefit of 20%, while the previous claim under benefit category E provided a benefit of 5%, so 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 as follows:

Benefit category	Type of cover	*Maximum amount payable*
AA	Death & terminal illness	$1,300,000
A	Health events	$800,000
B	Health events	$650,000
C	Health events	$400,000
D	Health events	$200,000
E	Health events	$50,000



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 *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 an *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 commences 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

The amount we will pay for a *health event* that falls during a *limited claim period* is calculated as follows:

1. determine the benefit category and percentage that applies for the *health event*.

If it is a *progressive condition* and the previous *health event* occurred prior to the current *limited claim period*, apply the *progressive condition* reduction (see previous page).

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 of the *health event* being claimed.

Example: third claim – 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 benefit category for heart attack, (see Heart and artery body system on page 59).

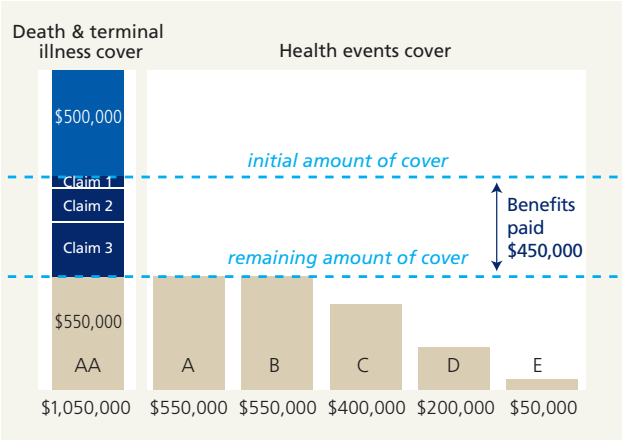
Because the condition meets a definition under this Health event category, the claim is not assessed against the *safety net categories*.

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 as follows:

Benefit category	Type of cover	*Maximum amount payable*
AA	Death & terminal illness	$1,050,000
A	Health events	$550,000
B	Health events	$550,000
C	Health events	$400,000
D	Health events	$200,000
E	Health events	$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.

Claim protector

The Claim protector is an important feature of your cover that applies up to the life insured's 65th birthday to ensure that you will have cover for subsequent *health events* available, up to the maximums shown in the table below. 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*, 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*, 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 8 for the percentages that apply), provided the total amount claimed for *health events* up to the limits shown in the table below.

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	$4,000,000	$6,600,000
B to E	$2,600,000	$5,200,000

* This includes any amounts paid under the Extended care option.

The Claim protector does not apply to *terminal illness* or death cover provided under the policy, which means your Death & *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 are not available:

- after the life insured's 65th birthday 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 'Inflation protection' on page 14.

Example: fourth claim – 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 Musculoskeletal body system on page 63).

Because the injury meets a definition under this Health event category, the claim is not assessed against the *safety net categories*.

This injury is not a *progressive condition*, 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, $1,000,000 has been paid to Michael for his *health events* claims.

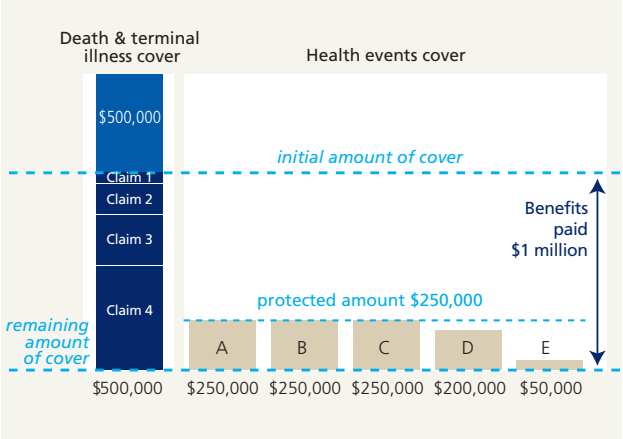
This claim has resulted in the *remaining amount of cover* for the policy reducing to nil, making it less than the protected amount of $250,000 (25% of the *initial amount of cover*).

14 days following the claim the Claim protector applies and the *maximum amount payable* for benefit categories A to D is increased as follows:

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.

Safety net

Zurich Active Cover is designed to pay a benefit if the life insured suffers a serious health condition. While the policy sets out an extensive list of specified conditions under each body system, it doesn't include a definition for every possible health condition.

To allow for situations where a serious health condition occurs but where the life insured does not meet the requirements of any of the health events under a specific body system, there is a safety net.

In such a situation, we will assess the life insured against the *safety net categories*. The two *safety net categories* are:

- inability to perform activities of daily living (ADL) and
- occupational impairment.

A benefit cannot be paid under either of the *safety net categories* if the life insured meets any of the other *health event* categories.

Example: fifth claim – safety net

Ten years later, Michael begins to experience deteriorating health, and he is eventually diagnosed with a serious degenerative disease.

The disease and symptoms do not fall within the criteria for a specific health event under a defined body system. However, the condition is very disabling, and it soon prevents Michael from working. The effects of his condition are permanent.

When Michael applied for cover, he was allocated an 'any occupation' definition for occupational impairment. He can now be assessed against the 'any occupation' part of the *occupational impairment* definition, and may be paid a benefit.

Upon assessment, it is found that Michael's condition meets the defined criteria for the *occupational impairment* definition. This qualifies him for a benefit category A.

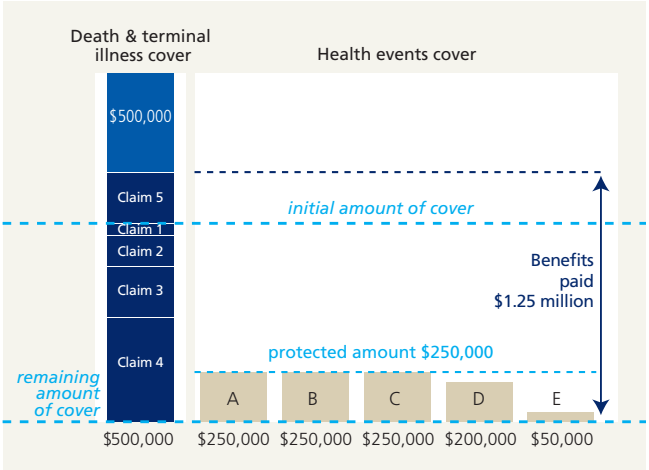
The condition is not a *progressive condition*, nor has it fallen within a *limited claim period*. Due to the previous claims paid under the policy, the maximum amount payable for benefit category A is now $250,000 and this amount is paid to Michael.

As with the previous claim, this claim has again 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 follows:

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*.



Michael no longer has automatic cover for *terminal illness* and death, but he still retains his Additional death cover ($500,000 for death or *terminal illness*).

Other policy features, exclusions and conditions

Advancement for funeral expenses

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:

- 10% of the *maximum amount payable* for benefit category AA, and
- $15,000.

The maximum amount we will pay under this benefit (or similar benefit) is $15,000 across all cover held with us for the life insured.

This benefit is not payable if:

- the life insured's death is the result of suicide within 13 months of policy commencement
- it is the result of anything that is excluded under the policy or
- there is reasonable doubt about whether the death benefit will become payable.

Before this benefit becomes payable, we must receive medical evidence as to the cause and the date of death. If we agree this benefit is payable, it will be paid to the nominated beneficiary, the policy owner if different to the life insured or the legal personal representative of the policy owner, within two business days of receipt of all of the required documents.

The death benefit that is paid will be reduced by the amount of the Advancement for funeral expenses.

This benefit is not available under a policy that is owned by the trustee of a superannuation fund.

Inflation protection

The value of the insurance cover is protected against the impact of inflation by automatically increasing the benefit amounts each year.

We will increase the *initial amount of cover*, *remaining amount of cover*, Additional death cover and protected amount for benefit categories AA to E on each policy anniversary before the life insured's 65th birthday.

The benefit amount is increased on each policy anniversary by the greater of:

- 5% and
- the percentage increase in the *consumer price index* published for the quarter ending immediately prior to three months before the policy anniversary over that published for the quarter ending immediately prior to 15 months before that policy anniversary.

The increase can be rejected if it is not required. To reject the increase, contact us within 30 days of receiving the offer.

Future insurability

Under this feature, after certain events for the life insured, you can apply to increase the *initial amount of cover* until the life insured's 55th birthday, 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.*

The minimum increase to the *initial amount of cover* under this feature is $10,000. An increase under this feature cannot be made until 12 months after the benefit start date for the applicable insurance cover.

The increase in cover must be requested in the six month period following 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 $1,000,000.

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 life insured.

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.

Events	Maximum increase
The life insured: • marries or registers a *partnership* • divorces or de-registers a *partnership* • becomes a parent (through the birth or adoption of a child) • becomes a full time *carer* • becomes a widower (though the death of a *partner*) • has a child who turns 18	The lesser of: • 25% of the *initial amount of cover* when your policy started, and • $200,000.
The life insured takes out a new mortgage or increases an 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.
The life insured's *income* increases 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*.

Financial planning advice

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 life insured across all cover with us. The financial adviser whose services are being reimbursed must be qualified and operating under an Australian Financial Services Licence.

This benefit is not available under a policy that is owned by the trustee of a superannuation fund.

When cover is reduced

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

If you request a change to the *initial amount of cover* for Health events, terminal illness & 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 'How we calculate the amount we will pay' on page 9.

When a benefit will not be paid

We will not pay a benefit under your policy if any of the following apply in respect of the life insured:

- for Death & terminal illness cover (benefit category AA):
  - if the *terminal illness* or death occurs directly or indirectly as a result of an intentional self-inflicted act within 13 months of policy commencement.

    We will waive the intentional self-inflicted act exclusion if, immediately prior to the commencement of this benefit, the life insured was covered for death under a policy which was in force for at least 13 consecutive months (without lapsing and/or reinstatement) with us or another insurer, and we agreed to replace this cover. The waiver will only apply up to the amount that we agreed to replace.
- for Health events cover (benefit categories A–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 and the claim is for that excluded condition (see 'Health events' on page 57) or

- if the *health event* occurs within 90 days of the date an application for Health events cover (including a fully completed Life Insured's Statement) is lodged with us or the date any cover is reinstated and the *health event* has a 90 day exclusion specified (see 'Health events' on page 57).

  We will waive this 90 day elimination period if the Health events cover under this policy replaces cover for the same insured event with us or another insurer, but only to the extent of the benefit amount replaced, and only if the life insured is not within our or the other insurer's 90 day elimination period. This waiver can also apply to any increase in the Health events cover which meets the same criteria.

- the *health event* first occurs or symptoms leading to the condition occurring or being diagnosed first became apparent before the date an application for Health events cover (including a fully completed Life Insured's Statement) is lodged with us or the date any cover is reinstated.

- for all cover:
  - if death, *terminal illness* or the *health event* is caused or contributed to by anything excluded under the policy as indicated on the policy schedule.

Optional benefits

The policy schedule shows the optional benefits applying under the policy and, if applicable, the benefit amount(s). Each optional benefit only applies if specified on the policy schedule.

Additional death cover option

Your policy will state whether Additional death cover applies and, if so, the amount provided and the benefit expiry date.

You can purchase an amount of additional Death & terminal illness cover that will be paid if the life insured is diagnosed with a *terminal illness* or dies. The additional Death & terminal illness 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 & terminal illness cover, separate from your Health events, terminal illness & death cover, that is not affected by other claims under the policy.

Extended care option

Your policy schedule will state if the Extended care option applies to your policy.

The Extended care option is only available where the combined total of the *initial amount of cover* plus the amount of cover provided under the Extended care option (being an additional 50% of the *initial amount of cover*) does not exceed $4,000,000 at application.

Under this option, up until the policy anniversary following the life insured's 65th birthday, an additional amount of 50% of the *initial amount of cover* will be paid if a claim has been paid for a *health event* under benefit category A, and the life insured either:

- has the presence of a medically recognised disease or disorder resulting in a *permanent* and irreversible inability to perform four out of six *activities of daily living* or
- suffers permanent and irreversible *whole person impairment* of at least 60%.

A benefit is only payable once under the Extended care option.

The premium for this option will end on the earlier of the payment of a benefit under the Extended care option or the cessation of cover for the Extended care option on the policy anniversary following the life insured's 65th birthday.

Zurich Child Cover

The Zurich Child Cover policy pays a range of benefits on the serious illness of an insured child. Multiple children can be covered under the one policy. Zurich Child Cover can be selected in combination with any of the other policies described in this PDS.

Child cover

Child cover provides a lump sum payment if an insured child suffers one of the insured trauma conditions covered by your policy. The payment could be used to cover additional unexpected expenses as a result of the sickness or injury, or provide funds to allow you or your *partner* to take time off work to care for your child while they are unwell.

In-built benefits

Benefit name	Description
Trauma benefit	Pays the Child cover benefit amount if an insured child suffers one of the 18 insured trauma conditions.
Injury advancement benefit	An advance payment of $10,000 is payable if an insured child suffers *single loss of limb or eye* or *severe accident* or *illness requiring intensive care*.
Carer benefit	A monthly carer benefit of $5,000 is payable if the Child cover benefit amount is $200,000 or more and the policy owner or the policy owner's *partner* has to stop *full-time paid employment* to care for an insured child at home (unless a Trauma benefit is payable).
Death & terminal illness benefit	Pay up to $200,000 on the death or *terminal illness* of an insured child.

In-built policy provisions

Benefit name	Description
Inflation protection	Cover will increase every year, unless declined by you, without health assessment.
Cover increase provision	The sum insured can be increased by $10,000 on each insured child's 6th, 10th and 14th birthdays, without our reassessment of his/her health within 30 days of any of the specified birthdays.
Continuation of cover	Allows the insured child to convert the Child cover policy to an adult policy without the need for medical underwriting once they reach the age of 15.
Interim cover	Puts some accident cover in place as soon as cover is applied for, as set out in the Interim cover terms on page 37.
Premium holiday	Allows a break in cover (max 12 months over the life of the policy) to ease financial pressure.

Trauma conditions

The trauma conditions that are covered under Zurich Child Cover are set out in the table below. Our insurance definition for each covered condition can be found in the Child cover definitions section of this PDS, starting on page 74.

Insured trauma conditions
bacterial meningitis
benign tumour of the brain or spinal cord
blindness
cardiomyopathy
chronic kidney failure
deafness
diplegia
encephalitis
hemiplegia
loss of limbs or sight

Insured trauma conditions
loss of speech
major head trauma
major organ transplant
*malignant cancer**
paraplegia
quadriplegia
severe burns
*stroke**

Benefits are not payable for covered conditions marked with an asterisk (*) if they arise in the first 90 days after cover is applied for or is reinstated.

Zurich Child Cover terms and conditions

The information provided below forms part of the Zurich Child Cover terms and conditions. Words or expressions shown in *italics* have their meaning explained in the Definitions section at the end of this PDS.

Upon acceptance of your application, we will issue you a policy schedule. The policy schedule shows each insured child covered under this policy and shows the Child cover benefit amount that applies to each insured child.

Each insured child is only covered for the amounts as shown on the policy schedule until the applicable benefit expiry dates. The benefit is only 'in force' from the start date until the benefit is terminated.

Increases to the benefit amounts may be applied for after policy commencement, but only if we accept the application after considering the insured child's health.

Cover is automatically increased in line with inflation each year under the Inflation protection benefit unless we receive a request not to make these increases.

Trauma benefit

The Child cover benefit amount is payable if the insured child is diagnosed with a trauma condition while this benefit and policy is in force. The policy schedule shows the benefit expiry date applying to the Child cover benefit for each insured child under the policy.

The insured trauma conditions are set out on the previous page. Each condition has an insurance definition which is set out in the section 'Child cover definitions' on page 74. No benefit is payable if the insured child's condition does not meet the specific definition set out in these policy conditions.

Some trauma conditions in the list are marked with an asterisk (*) to indicate that an exclusion period applies (see 'Exclusions' on the next page).

If the Child cover benefit exceeds $200,000, the portion of cover which exceeds $200,000 is only payable if the insured child survives for at least 14 days after the date of occurrence of the insured trauma condition.

Limitation

If an insured child suffers more than one insured trauma condition, the Child cover benefit is only payable in respect of one insured trauma condition.

Injury advancement benefit

An advance payment of $10,000 is payable if an insured child suffers one of the following additional insured events:

- *single loss of limb or eye*
- *severe accident or illness requiring intensive care.*

The definitions which apply to this benefit are set out in the section 'Child cover definitions' on page 74.

We will only pay this $10,000 benefit once in respect of each insured event for each insured child. The Child cover benefit amount applying to an insured child is reduced by the amount advanced following one of the two additional insured events.

Carer benefit

A monthly Carer benefit of $5,000 is payable if the Child cover benefit amount is $200,000 or more and the policy owner or the policy owner's *partner* has to stop *full-time paid employment* to care for an insured child at home, while this policy is in force.

The insured child must be confined to bed for a minimum of five consecutive days and must be under the regular care of, and following the advice of, a *medical practitioner.*

This benefit is not payable if the Trauma benefit has been paid or is payable, but may be paid in addition to an Injury advancement benefit payment for the same insured child.

The Carer benefit is paid for each complete month or 1/30th of the carer benefit is paid for each day this benefit is payable. The Carer benefit is not payable twice if both policy owner and his/her *partner* have to stop *full-time paid employment*.

A *medical practitioner* must confirm the insured child is confined to bed and requires full-time care. We will require this certification every month that the claim continues. The carer benefit is paid for a maximum of three months over the life of the policy.

Death & terminal illness benefit

We will pay the lesser of:

- the Child cover benefit amount and
- $200,000

if an insured child is diagnosed as *terminally ill*, or upon the death of the insured child while this policy is in force. The policy schedule shows the benefit expiry date applying to the Child cover benefit for each insured child covered under the policy.

Inflation protection

The value of the insurance cover is protected against the impact of inflation by automatically increasing the benefit amount each year.

The benefit amount is increased on each policy anniversary by the greater of:

- 5% and
- the percentage increase in the *consumer price index* published for the quarter ending immediately prior to three months before the policy anniversary over that published for the quarter ending immediately prior to 15 months before that policy anniversary.

The increase can be rejected if it is not required. To reject the increase, contact us within 30 days of receiving the offer.

The Child cover benefit amount will only be increased up to a maximum amount of $500,000.

Cover increase provision

The Insured child benefit amount applying to an insured child can be increased by $10,000 on his/her 6th, 10th and 14th birthdays, without our reassessment of his/her health, as long as:

- cover for the insured child will not exceed the maximum of $500,000
- we have not paid a benefit and there is no entitlement to a benefit under this policy in relation to the insured child.

The option can only be exercised within 30 days of any of the specified birthdays.

Continuation of cover

Within 30 days of any policy anniversary following the insured child's 15th birthday, he/she may apply to us in writing for a new death and trauma cover policy for the same benefit amount. We will issue the new policy subject to standard policy issue requirements including an assessment of smoker status but we will not reassess any other aspects of his/her health.

The policy provided will be that which provides the most comparable cover, in Zurich's opinion, available at the time of the conversion. The premiums for the new policy will be based on the rates applying to that policy at that time (which may depend on factors including smoker status). Any exclusions or loadings that applied to the original policy may also apply to the new policy.

Conversion is only available if we have not paid a benefit under this policy for the insured child.

Exclusions

No claim is paid if the insured event is caused directly or indirectly by:

- an intentional self-inflicted act or attempted suicide (in the first 13 months) or
- the intentional act of the policy owner or person who will otherwise be entitled to the benefit payable.

In the case of insured events marked with an asterisk (*), no claim will ever be paid if the condition occurred, is first diagnosed or the circumstances leading to diagnosis became apparent or a recommendation of the need to have surgery occurs, within 90 days of:

- the date a fully completed application for Zurich Child Cover is lodged with us, in respect of the applicable insured child
- the benefit start date of any increase in the Child cover benefit applied for in respect of the applicable insured child (but only in respect of the increase).

We will waive this 90 day elimination period if the child cover under this policy replaces cover for the same insured event for an insured child with us or another insurer, but only to the extent of the benefit amount replaced, and only if the insured child is not within our or the other insurer's 90 day elimination period.

In the case of insured events marked with an asterisk (*), no claim will ever be paid if the condition occurred, is first diagnosed or the circumstances leading to diagnosis became apparent or a recommendation of the need to have surgery occurs, within 90 days of:

- the latest reinstatement of the policy or
- the latest premium holiday end date.

Termination of the Child cover benefits

Zurich Child Cover terminates in relation to an insured child on the first to occur of:

- the payment of the Child cover benefit amount
- the death of the insured child
- the insured child being diagnosed as *terminally ill*
- our receipt of written notification to terminate this option
- the Child cover benefit expiry date shown on the policy schedule
- the policy anniversary following the insured child's 18th birthday or
- termination of the policy (see 'Termination of the policy' on page 46).

Zurich Income Protector

The Zurich Income Protector policy pays a monthly benefit if the life insured is unable to work due to sickness or injury. Two levels of cover are available, Zurich Income Protector Plus and Zurich Income Protector.

Income protection cover

Income protection insurance provides a *monthly benefit* if the life insured is unable to work due to a *sickness* or *injury* and is *totally disabled* or *partially disabled* for longer than the waiting period. It contributes towards a replacement income so that the life insured can concentrate on his or her recovery without having to worry about how to pay ongoing expenses.

Choice of cover

Level of cover	Description
Zurich Income Protector Plus	A fully featured level of cover, including: • three tier definition of *totally disabled* (ie. three ways to qualify for a benefit) • day one partial, meaning it is possible to claim a Partial disability benefit without ever being *totally disabled* (when held outside of super, refer to page 22) • full suite of in-built benefits, including Confined to bed benefit • selection of optional benefits to add.
Zurich Income Protector	A cost-effective level of cover which provides all the essentials of income protection. The cost of cover is reduced because: • the life insured must be *totally disabled* for at least five consecutive days during the waiting period to qualify for a Total or Partial disability benefit • the definition of totally disabled is 'unable to perform one or more *important income producing duties*' • after the Total disability benefit and/or Partial disability benefit has been paid for a period of 24 months, the ability to work is no longer based on a specific occupation • the Confined to bed benefit does not form part of the policy.

Choice of benefit type

The *insured monthly benefit* is the maximum amount payable per month. The amount payable may also depend on the benefit type.

Benefit type	Description
Indemnity	Indemnity means that the benefits we pay at claim time are capped at the life insured's income immediately prior to claim. Total disability benefits payable under the policy will be capped at 75% of *claimable income* (indemnity),* which is generally the income the life insured is earning at the time of the claim (the best consecutive 12 months in the previous two years can be used).
Agreed value	Agreed value means that the benefits we pay at claim time are not restricted by the life insured's income immediately prior to claim. Total disability benefits payable under the policy will be capped at 75% of *claimable income* (agreed value),* which allows benefits to be calculated with reference to the life insured's income at application. We don't ask for full financial information as part of the application (we rely on the information you provide in the Life Insured's Statement in relation to the life insured's income at that time). We may need to verify this at claim time and if you cannot substantiate the insured amount, we may adjust the benefit we pay accordingly. This benefit type is not available in superannuation, but can be accessed via superannuation optimiser.
Endorsed agreed value	Agreed value cover can be endorsed by us if full financial information is provided when you apply, which means we won't need any financial information to reassess or adjust the Total disability benefit we pay in the event of a claim. This benefit type is not available in superannuation, but can be accessed via superannuation optimiser.

*75% of annualised *claimable income* can be insured up to $320,000. After that a sliding scale applies, ie. 50% of the next $240,000 of annualised *claimable income* and 25% of any balance.

In-built benefits

Benefit name	Description
Total disability benefit	Pays a benefit if the life insured is *totally disabled* after the waiting period.
Partial disability benefit	Pays a proportion of the Total disability benefit if the life insured is *partially disabled* after the waiting period, based on the life insured's *pre-disability income* and *post-disability income.*
Specified injury benefit	Fixed period of benefits in lieu of the Total or Partial disability benefit if the life insured suffers a specified injury from a range of covered events including *quadriplegia*, loss of limbs or sight and certain *fractures*. This benefit does not apply if a 1 or 2 year waiting period is selected. This benefit is not available in superannuation, but can be accessed via superannuation optimiser.
Rehabilitation benefit	Extra benefits to help the life insured get back to work sooner including: reimbursement for approved workplace modifications, *rehabilitation programs* and other approved expenses. It does not cover health costs typically covered by Medicare or private health insurance. This benefit is not available in superannuation, but can be accessed via superannuation optimiser.
Funeral benefit	A lump sum of four times the *insured monthly benefit* to help with immediate expenses is payable on death during claim.
Confined to bed benefit (Plus only)	Benefits are payable right away during the waiting period (max 180 days) if the life insured is disabled and confined to bed for more than 2 days and unable to earn any income.

In-built policy provisions

Benefit name	Description
Inflation protection	Cover will increase every year, unless declined by you, without health assessment.
Waiver of premium	Premiums are waived while we are paying a claim.
Recurrent disability	No waiting period applies if disability recurs from a related cause within 12 months (six months for SR occupations).
Concurrent disability	If the life insured has more than one *sickness* or *injury*, the one which pays the most benefit will apply (we won't pay the benefit twice).
Medical professionals feature	Provides special terms for medical professionals who contract HIV, hepatitis B, or C and as a result have their occupational duties restricted.
Waiting period reduction feature	Allows for a one year or two year waiting period to be reduced to a one year or 90 day waiting period if the life insured leaves an employer and their salary continuance cover ends as a result.
Involuntary unemployment*	Premiums are waived for up to three months if the life insured is involuntarily unemployed.
Interim cover	Puts some accident cover in place as soon as cover is applied for, as set out in the Interim cover terms on page 37.
Premium holiday (not available under platform)	Allows a break in cover (max 12 months over the life of the policy) to ease financial pressure.

* not available for occupations categorised as Special Risk (SR)

Optional benefits

Optional benefits can be added after policy commencement but they then cannot be exercised if an insured event occurs or is apparent within 90 days after the option is added.

Option name	Description
Increasing claims option	Benefits can increase annually with CPI while on claim.
Super contributions option*	Cover is available for regular superannuation contributions in addition to the Total or Partial disability benefit, so that superannuation savings can continue during a claim. See page 30 for details of how this benefit works.
Day 4 accident option*	Benefits during the waiting period if the life insured is disabled due to accident. This option is only available with waiting periods of 30 days or less.
Family care option	Benefits can continue being paid to a surviving *partner* for up to five years if the life insured dies while on claim. This option is not available in superannuation, but can be accessed via superannuation optimiser.
Home support option	Cover for the life insured's *partner* carrying out *home duties* full-time up to age 55, see page 31. This option is not available in superannuation, but can be accessed via superannuation optimiser.
Future insurability option*	Allows an increase in cover without underwriting every year subject to conditions set out on page 32.
Lump sum accident option*	Lump sum payable once if the life insured suffers an *injury* which causes (within 180 days) *accidental death* or a specified loss, eg. loss of limbs or sight. This option is not available in superannuation, but can be accessed via superannuation optimiser.
Trauma advancement option*	An advance benefit payment if the life insured suffers a specified Trauma. No cover is provided for any condition which occurs or is apparent in the first 90 days after cover is applied for or reinstated and only one claim can be made on each event. This option is not available in superannuation, but can be accessed via superannuation optimiser.
Needlestick cover option	A lump sum payable on *occupationally acquired HIV* or *occupationally acquired hepatitis B or C* as a result of an occupational accident (for people who work in exposure-prone occupations). This option is not available in superannuation, but can be accessed via superannuation optimiser.

* not available for occupations categorised as Special Risk (SR)

The terms and conditions which apply to Zurich Income Protector are set out on page 24.

Income protection cover in superannuation

If you choose to hold your income protection cover within superannuation, benefits are only payable where the life insured satisfies a condition of release under superannuation law. The total benefit may also be capped if benefits and any ongoing income exceed what the life insured was earning before the disability.

Superannuation optimiser

If superannuation optimiser applies to your income protection, the cover is held across two policies which are connected via related policies:

- one held within superannuation (providing the part of the cover that also meets the definition of *temporary incapacity*), and
- one outside of superannuation (providing the part of the cover that does not meet the definition of *temporary incapacity*).

Although both policies will have the same *insured monthly benefit*, the insured amount set out on each policy schedule represents the total insured amount across both related policies. See the section 'Superannuation optimiser – income protection' on page 42 for full details

Benefit examples

The following examples are provided to show how the monthly Total disability benefit and Partial disability benefit is calculated, and to illustrate how the amount payable will differ under endorsed agreed value, agreed value and indemnity benefit types.

Claimable income is a defined term we use to set the maximum amount of monthly benefit, and it is determined differently for agreed value and indemnity benefit types. Refer to the definition of *claimable income* which is set out on page 52.

Assumptions:

- the *insured monthly benefit* at the time of claim is $6,000
- as the life insured is earning less than $320,000 per year, the examples reflect 75% of annualised *claimable income*
- the life insured is not eligible for any other benefits for the disability, so no offsets apply.

When the life insured is *totally disabled*	**Regular *income*** (*income* in the 2 years prior to claim is $8,000 per month)	**Fluctuating *income*** (*income* in the 2 years prior to claim is $6,000 per month)
Endorsed agreed value the *insured monthly benefit*, less any applicable offsets	Total disability benefit = $6,000	Total disability benefit = $6,000
Agreed value the lower of: • the *insured monthly benefit* and • 75% of *claimable income* less any applicable offsets	*Claimable income* is $8,000 Total disability benefit is the lower of: • $6,000 and • 75% of $8,000 = $6,000	*Claimable income* is $7,500 (based on *pre-application income*) Total disability benefit is the lower of: • $6,000 and • 75% of $7,500 = $5,625
Indemnity the lower of: • the *insured monthly benefit* and • 75% of *claimable income* less any applicable offsets	*Claimable income* is $8,000 Total disability benefit is the lower of: • $6,000 and • 75% of $8,000 = $6,000	*Claimable income* is $6,000 Total disability benefit is the lower of: • $6,000 and • 75% of $6,000 = $4,500

When the life insured is *partially disabled* life insured is working three days per week (down from five)	**Regular *income*** *post-disability income* is $4,800 per month *pre-disability income* is $8,000	**Fluctuating *income*** *post-disability income* is $3,600 per month *pre-disability income* is $6,000
Endorsed agreed value	$\frac{\$8,000 - \$4,800}{\$8,000} \times \$6,000$ Partial disability benefit is $2,400	$\frac{\$6,000 - \$3,600}{\$6,000} \times \$6,000$ Partial disability benefit is $2,400
Agreed value		$\frac{\$6,000 - \$3,600}{\$6,000} \times \$5,625$ Partial disability benefit is $2,250
Indemnity		$\frac{\$6,000 - \$3,600}{\$6,000} \times \$4,500$ Partial disability benefit is $1,800

Zurich Income Protector terms and conditions

The information provided below forms part of the Zurich Income Protector or Zurich Income Protector Plus terms and conditions. Words or expressions shown in *italics* have their meaning explained in the Definitions section at the end of this PDS.

Upon acceptance of your application, we will issue you a policy schedule. The policy schedule shows whether the cover is Zurich Income Protector or Zurich Income Protector Plus, the life insured covered under the policy, the *insured monthly benefit*, whether the policy is 'endorsed agreed value', 'agreed value' or 'indemnity', the benefit period, the waiting period, the premium structure and any optional benefits provided.

If the policy is one of two related policies issued under superannuation optimiser, it will show whether the policy is the superannuation policy or the non-superannuation policy. If the superannuation optimiser applies, please also refer to the section 'Superannuation optimiser – income protection' on page 42 for important information regarding how payments are made from the two related policies under which benefits are provided.

The policy schedule also shows the benefit expiry date applying to each insured benefit. Benefits are only payable if a covered event occurs while the policy is in force. Benefits are only 'in force' from the applicable start date until the applicable benefit is terminated.

You have the option to make changes to your policy. Additional optional benefits or increases to the benefit amounts may be applied for after policy commencement, but will be effective only if we accept the application after considering the life insured's personal circumstances including health, occupation and pastimes.

The benefits provided by the Zurich Income Protector and Zurich Income Protector Plus policy are set out below. Optional benefits are described in the Optional benefits section starting on page 30.

Some benefits do not form part of the policy if the policy is issued to the trustee of a superannuation fund – these are clearly indicated.

The waiting period and benefit period

Two important aspects of this policy are the selected waiting period and benefit period. Both are shown on the policy schedule.

The waiting period is the period of time the life insured must be disabled before being eligible for the relevant benefit. The waiting period for a claim begins on the date of disability, which is the day the life insured is *totally disabled* or *partially disabled* due to *sickness* or *injury* and has consulted a *medical practitioner* in relation to their disability. Under Zurich Income Protector, the life insured must additionally be *totally disabled* for at least five consecutive days during that period.

The benefit period is the maximum length of time that we will pay the Total or Partial disability benefit when the life insured suffers from the same or related *sickness* or *injury* during the life of the policy. All benefits cease, if not earlier, at the policy anniversary following the life insured's 65th birthday unless the 'to age 70' benefit period is selected, in which case all benefits cease on the policy anniversary following the life insured's 70th birthday.

Return to work during the waiting period

The waiting period will restart if the life insured returns to work and is no longer *totally disabled* or *partially disabled*. However we will allow the life insured to return to work during the waiting period, without the waiting period restarting for up to:

- five consecutive days if the waiting period is 30 days
- 10 consecutive days if the waiting period is 60 days, 90 days, 180 days, 1 year or 2 years
- six consecutive months if the waiting period is 2 years and the life insured is also covered by a type of income protection insurance with a benefit period of two years provided through membership of a regulated superannuation scheme in Australia or provided through their employer, or
- six consecutive months if the waiting period is 1 year and the life insured is also covered by business expenses insurance with a benefit type of key person replacement.

The waiting period will be extended by the number of days worked while the life insured is not *totally disabled* or *partially disabled*.

Total disability benefit

Qualifying criteria

- **Zurich Income Protector**
  We will pay the Total disability benefit if the life insured is:
  - *totally disabled* or *partially disabled* for the duration of the waiting period
  - *totally disabled* for at least five consecutive days during the waiting period and
  - remains *totally disabled* after the waiting period ends.
- **Zurich Income Protector Plus**
  We will pay the Total disability benefit if the life insured is *totally disabled* or *partially disabled* for the duration of the waiting period and remains *totally disabled* after the waiting period ends.

Benefit payment

Under endorsed agreed value cover, the Total disability benefit amount will be the *insured monthly benefit*, less any applicable offsets.

Under agreed value or indemnity cover, the Total disability benefit amount will be the lower of the *insured monthly benefit*, and the monthly equivalent of:

- 75% of the first $320,000 of annualised *claimable income*
- 50% of the next $240,000 of annualised *claimable income*
- 25% of the balance of annualised *claimable income*

less any applicable offsets.

The Total disability benefit is payable 15 days after the waiting period ends, provided claim requirements are met, and monthly thereafter. Benefits are generally paid two weeks in arrears and two weeks in advance. If eligibility to receive the benefit ends before the next monthly payment due date, we will pay 1/30th of the Total disability benefit for each day (less than 15 days) that the life insured is eligible for the benefit.

The Total disability benefit is payable until any one of the following events occurs:

- the life insured is no longer *totally disabled*
- the benefit period ends
- the *insured monthly benefit* expiry date shown on the policy schedule
- the policy is terminated
- the death of the life insured.

If a claim is made while the life insured is outside Australia, we will only continue to pay the Total disability benefit if, in addition to meeting all of the benefit requirements, the life insured has a medical examination every 12 months. The *medical practitioner* performing the examination must be approved by us. We will pay for this medical examination, but not for transport to attend it.

Additional conditions under superannuation ownership

If the policy is issued to the trustee of a superannuation fund, the Total disability benefit is subject to the superannuation restrictions and limitations described on page 29.

Partial disability benefit

Qualifying criteria

- **Zurich Income Protector**
  We will pay the Partial disability benefit if the life insured is:
  - *totally disabled* or *partially disabled* for the duration of the waiting period
  - *totally disabled* for at least five consecutive days during waiting period and
  - remains *partially disabled* after the waiting period ends.
- **Zurich Income Protector Plus**
  We will pay the Partial disability benefit if the life insured is *totally disabled* or *partially disabled* for the duration of the waiting period and remains *partially disabled* after the waiting period ends.

Benefit payment

The Partial disability benefit amount will be proportionate to the income loss and calculated on a monthly basis using the following formula:

$$\frac{\textit{pre-disability income} - \textit{post-disability income}}{\textit{pre-disability income}} \times \text{the monthly amount we would pay if the life insured was claiming for a Total disability benefit}$$

The Partial disability benefit is payable 15 days after the waiting period ends, provided claim requirements are met, and monthly thereafter, in arrears. If eligibility to receive the benefit ends before the next monthly payment due date, we will pay 1/30th of the Partial disability benefit for each day (less than 15 days) that the life insured is eligible for the benefit.

The Partial disability benefit is payable until any one of the following events occurs:

- the life insured is no longer *partially disabled*
- the benefit period ends
- the *insured monthly benefit* expiry date shown on the policy schedule
- the policy is terminated
- the death of the life insured.

You will need to provide evidence of any *post-disability income* before the Partial disability benefit can be paid.

If a claim is made while the life insured is outside Australia, we will only continue to pay the Partial disability benefit if, in addition to meeting all of the benefit requirements, the life insured has a medical examination every 12 months. The *medical practitioner* performing the examination must be approved by us. We will pay for this medical examination, but not for transport to attend it.

Additional conditions under superannuation ownership

If the policy is issued to the trustee of a superannuation fund, the Partial disability benefit is subject to the superannuation restrictions and limitations described on page 29.

Offsets

The Total disability benefit, Specified injury benefit and Confined to bed benefit amounts will be reduced by other benefits received during the relevant month from the following sources as a result of the life insured's *sickness* or *injury*:

- sick leave entitlements paid
- other disability income policies
- workers' compensation or other legislated benefits.

However, if the policy is held outside of superannuation (not issued to the trustee of a superannuation fund):

- sick leave entitlements will not be offset
- other disability income policies disclosed to us in your application will not be offset
- workers' compensation or other legislated benefits will not be offset if the life insured's occupation category is A1, A1M, A1L or A2, as shown on the policy schedule.

If the benefit received is:

- a lump sum or part of a lump sum paid as compensation for pain and suffering or as compensation for loss of use of a limb or
- a lump sum total and permanent disablement or trauma benefit

the payment received will not be offset or included as *post-disability income*.

For the purposes of these offsets:

- a disability income policy is any individual or group disability insurance policy, including cover under a mortgage repayment policy or credit insurance policy, which pays a regular benefit due to the life insured's *sickness* or *injury* and
- where these amounts are paid or payable in a lump sum and cannot be allocated to specific months, then 1/60th of the lump sum shall be taken into account each month for a maximum period of five years.

Specified injury benefit

This benefit does not form part of the policy if the policy is issued to the trustee of a superannuation fund or if the policy is issued with a 1 year or 2 year waiting period.

The Specified injury benefit is payable as a monthly benefit for the duration of the specified injury benefit period if any one of the specified injuries happen to the life insured:

- while the policy is in force and
- before termination of the policy.

Specified injury	Specified injury benefit period (months)
quadriplegia	60
paraplegia	60
hemiplegia	60
diplegia	60
Loss of both feet, both hands or sight in both eyes	24
Loss of a foot and a hand	24
Loss of a foot and sight in one eye	24
Loss of a hand and sight in one eye	24
Loss of a leg or arm	18
Loss of a foot or hand or sight in one eye	12
Loss of the thumb and index finger of the same hand	6
fracture of a thigh or pelvis	3
fracture of a leg (between the knee and foot), kneecap, skull (excluding bones of the face or nose), upper arm between elbow and shoulder (shaft) or shoulder blade	2
fracture of a forearm (including wrist but excluding elbow or hand), jaw or collar bone	1.5

Under this benefit, 'loss' means that the life insured cannot use and will never be able to use that body part again. In the case of the eye, it means that the life insured will never be able to see again from that eye.

The waiting period is waived and the Specified injury benefit is paid (even if the life insured is still earning an income) until:

- the end of the Specified injury benefit period shown in the table
- the end of the benefit period shown on the policy schedule
- the death of the life insured

whichever happens first.

We will not pay for more than one specified injury per claim.

Under endorsed agreed value cover, the Specified injury benefit will be the *insured monthly benefit*, less any applicable offsets.

Under agreed value or indemnity cover, the Specified injury benefit will be the amount we would pay under the Total disability benefit.

We will not pay any other benefit under this policy while the Specified injury benefit is being paid. If at the end of the Specified injury benefit period the life insured is *totally disabled* or *partially disabled* because of the same specified injury, we will pay the Total or Partial disability benefit (as applicable) from the later of:

- the end of the Specified injury benefit period for the specified injury and
- the end of the waiting period.

Rehabilitation benefit

This benefit does not form part of the policy if the policy is issued to the trustee of a superannuation fund.

The Rehabilitation benefit is payable when the life insured has qualified for the Total disability benefit, Partial disability benefit or Specified injury benefit after expiry of the waiting period or within the waiting period if the life insured would otherwise qualify for the Total disability benefit or Partial disability benefit.

The Rehabilitation benefit is payable as follows:

Workplace modification

This benefit provides assistance if the life insured's workplace needs modification to allow the life insured to return to *gainful employment*. We will pay up to three times the monthly Total disability benefit or Partial disability benefit (as applicable) for expenses incurred in modifying the life insured's workplace.

Rehabilitation program

While the life insured takes part in a *rehabilitation program*, we will pay an additional 20% of the monthly Total disability benefit or Partial disability benefit (as applicable) each month for a maximum period of 12 months.

Rehabilitation costs

We will pay up to 12 times the monthly Total disability benefit or Partial disability benefit (as applicable) for the expenses of rehabilitating the life insured. These expenses include the costs of special equipment designed to assist the life insured to re-enter the workforce. We will not cover health costs which are typically covered by Medicare or private health insurance.

To receive the Rehabilitation benefit, our written approval must be obtained before expenses are incurred.

Funeral benefit

The Funeral benefit is payable if the life insured dies while the Total disability benefit, Partial disability benefit, Specified injury benefit, Day 4 accident benefit or Confined to bed benefit is payable.

We will pay a lump sum of four times the *insured monthly benefit*.

If the life insured is also covered under another Zurich income policy, we will only pay this benefit once.

Confined to bed benefit

This benefit only applies to Zurich Income Protector Plus.

The Confined to bed benefit is payable if, while the policy is in force and before termination of the policy, the life insured is confined to bed because of *sickness* or *injury* for more than two days in a row and during that period, is totally dependent on the full-time care of a nurse or a personal care attendant and unable to earn any income from personal exertion.

Under this benefit, 'Confined to bed' means that a *medical practitioner* states (in writing) that the life insured is confined to bed and he/ she needs the full-time care of a nurse or personal care attendant for more than two days in a row.

'Nurse' means a nurse legally registered to practice in Australia or, if we approve, a nurse legally registered to practice in another country. Nurse does not include:

- the policy owner, his/her relative or his/her business partner or employee
- the life insured, his/her relative or his/her business partner or employee.

'Personal care attendant' means a person upon whose care the life insured is totally dependent and cannot be:

- the life insured's *immediate family member*
- an employee of the life insured or an employee of the life insured's *immediate family member*
- the life insured's employer

unless they have ceased full-time work or taken leave specifically to care for the life insured.

We will pay the Confined to bed benefit for each complete month or 1/30th of the Confined to bed benefit for each day that this benefit is payable. This benefit is only payable during the waiting period to a maximum of 180 days.

Under endorsed agreed value cover, the Confined to bed benefit will be the *insured monthly benefit*, less any applicable offsets.

Under agreed value or indemnity cover, the Confined to bed benefit will be the amount we would pay under the Total disability benefit.

Other policy features, exclusions and conditions

Inflation protection

The Inflation protection benefit protects the value of the insurance cover against the impact of inflation by offering the opportunity to adjust for this with indexation increases.

Each policy anniversary prior to the life insured's 65th birthday, the *insured monthly benefit* can be increased by the percentage increase in the *consumer price index* published for the quarter falling immediately prior to three months before the policy anniversary over that published for the quarter falling immediately prior to 15 months before that policy anniversary.

The increase may be rejected if not required. To reject the increase, simply contact us within 30 days of receiving the offer.

Indexation increases will apply automatically while there is an entitlement to make a claim if a policy anniversary falls during a period of claim. This ensures that after the claim, the *insured monthly benefit* will be the same amount as it would have been if the claim had not occurred. The increase will be applied to the *insured monthly benefit* after the claim is finalised, but will not apply to the calculation of benefits during a claim.

Under indemnity cover, if the indexation increase would mean that the *insured monthly benefit* is greater than 75% of the life insured's average monthly *income* or if the life insured is not in *full-time paid employment*, the increase may be rejected to avoid paying unnecessary premium.

Indexation increases will cease on the policy anniversary following the life insured's 65th birthday.

Waiver of premium

We will waive the premium for any period during which a *monthly benefit* is payable. If we receive the completed claim form within 30 days from the start of the life insured's *sickness* or *injury*, we will also refund the portion of the premium paid for the waiting period if we subsequently pay a *monthly benefit*.

Recurrent disability

If the life insured's disability recurs from the same or related cause within 12 months of his/her returning to work, the claim will be considered to be a continuation of the same claim and a further waiting period will not apply.

If the life insured's disability recurs from the same or related cause later than 12 months after he/she returns to work, the claim will be considered to be a continuation of the same claim, but further Total disability benefits or Partial disability benefits will only be payable after expiry of a further waiting period.

Where a 'continuation of the same claim' applies, the policy terms and conditions which apply to the claim will be those that applied at the original claim commencement date.

Employment related salary continuance

If the policy is taken out with a two year waiting period, and the life insured is also covered by employment related salary continuance which has a two year benefit period, we will use the original start date of the claim when we assess the waiting period, excluding any periods where he/she has returned to work under recurrent disability provisions in that policy.

For Special Risk (SR) occupations

If the life insured's disability recurs from the same or related cause within six months of his/her returning to work, the claim will be considered to be a continuation of the same claim and a further waiting period will not apply.

If the life insured's disability recurs from the same or related cause later than six months after he/she returns to work, the claim will be considered to be a continuation of the same claim, but further Total disability benefits or Partial disability benefits will only be payable after expiry of a further waiting period.

Where a 'continuation of the same claim' applies, the policy terms and conditions which apply to the claim will be those that applied at the original claim commencement date.

Concurrent disability

If more than one separate and distinct *sickness* or *injury* resulted in the disability, payments will be based on the *sickness* or *injury* that provides the highest benefit.

More than one benefit at a time

We will only pay one benefit, being the highest, for the same period where it would otherwise be possible to qualify for the following combinations of benefits:

- Total disability benefit and Partial disability benefit
- Total or Partial disability benefit and Specified injury benefit
- Total or Partial disability benefit and Trauma advancement benefit
- Confined to bed benefit and Specified injury benefit
- Confined to bed benefit and Trauma advancement benefit
- Confined to bed benefit and Day 4 accident benefit
- Trauma advancement benefit and Specified injury benefit
- Day 4 accident benefit and Specified injury benefit
- Day 4 accident benefit and Trauma advancement benefit.

Medical professionals feature

If a medical professional contracts HIV, hepatitis B or hepatitis C, professional guidelines may restrict his/her ability to perform certain procedures and result in a reduction of income, well before the *sickness* results in a physical inability to perform the duties of his/her occupation.

If you have Zurich Income Protector Plus as shown on your policy schedule, and the life insured is a medical professional, we will consider that the life insured is unable to perform his/her *important income producing duties* when assessing whether the life insured meets the definition of *totally disabled* or *partially disabled*, if the following apply:

- the occupation class shown on the policy schedule is A1M
- the life insured 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 life insured's usual occupation necessary to produce income, and
- due to the life insured's HIV, hepatitis B or hepatitis C status, he/she is required to cease performing exposure prone procedures as a result of the guidelines of the professional governing body in the applicable state.

The other components of the Total disability benefit and Partial disability benefit, 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 hepatitis C virus (as applicable) inactive and non-infectious, or
- the life insured has elected not to take an approved vaccine that is recommended by the relevant professional governing body for use in the life insured's occupation and which is available prior to the event which causes infection.

Waiting period reduction feature

If you have a Zurich Income Protector or Zurich Income Protector Plus policy and the waiting period is '1 year' or '2 years' as shown on your policy schedule, the waiting period can be reduced without medical underwriting to '1 year' or '90 days' if the life insured also has salary continuance cover provided through their employer and that cover terminates because they leave their employer. This is not available if the life insured:

- elects to take up any continuation of cover option on the salary continuance cover
- is on claim or eligible to claim (on either policy) at the time of applying to reduce the waiting period, or
- is not engaged in *full-time paid employment* with a new employer.

You must apply to change the waiting period within 30 days of the life insured ceasing employment with the employer through which the salary continuance cover was provided. Evidence of the cover, cessation of employment and other information necessary to assess 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.

Exclusions

No amount will be payable for *sickness* or *injury* occurring as a direct or indirect result of any one or more of the following:

- an intentional self-inflicted act
- attempted suicide
- *uncomplicated pregnancy or childbirth*
- an act of war (whether declared or not)
- any event or medical condition specified as an exclusion on the policy schedule.

We will not pay a benefit for a disability due to elective or donor transplant surgery unless the elective or transplant surgery occurred at least six months after:

- the start of the policy
- if the policy is ever reinstated, the date of reinstatement
- in respect of an increase in the *insured monthly benefit*, the date of the increase.

We will not pay for any period while the life insured is in jail.

Superannuation restrictions and limitations

If the policy is issued to a superannuation trustee, the payment of benefits is conditional upon the trustee's ability to pay the benefit in accordance with relevant superannuation legislation, as amended from time to time.

Benefits are only payable if the life insured:

- meets the definition of *temporary incapacity* and the amount is capped at the *superannuation payment limit* or
- meets the definition of *permanent incapacity* where superannuation optimiser does not apply.

To age 70 benefit period

The following conditions and limitations apply if the age 70 benefit period is selected.

After the policy anniversary following the life insured's 65th birthday:

- we will not pay a benefit under any optional benefit selected (as shown on the policy schedule) and
- the total amount we pay will be the applicable percentage (shown in the table below) of total benefits otherwise payable under the policy. The applicable percentage at the commencement of a claim will apply for the duration of the claim.

Age at policy anniversary prior to claim commencing	Percentage of total benefit payable
65	100%
66	80%
67	60%
68	40%
69	20%

Involuntary unemployment

For all occupation categories, except Special Risk (SR), we will waive the premium for up to three months if the life insured is involuntarily unemployed, other than as a direct result of *sickness* or *injury* and if:

- the life insured is registered with an employment agency approved by us
- unemployment started at least 12 months after the start of the policy or, if the policy is ever reinstated, the date of reinstatement and
- each request to waive premium occurs at least 12 months after the end of any previous period of waived premium.

Under this provision, 'involuntary unemployment' means that the life insured becomes unemployed due to retrenchment, redundancy or employer insolvency. It does not mean retirement, unpaid leave, the end of a fixed term contract or dismissal from employment.

A total of twelve months premium may be waived during the life of the policy.

Optional benefits

The policy schedule shows the optional benefits applying under the policy and, if applicable, the benefit amount(s).

Each optional benefit terminates on the first to occur of:

- our receipt of written notification to terminate the benefit
- the optional benefit expiry date
- termination of the policy (see 'Termination of the policy' on page 46).

Where any optional benefit does not have an expiry date specified on the policy schedule, the optional benefit expiry date is equal to that of the main policy.

Each optional benefit only applies if specified on the policy schedule.

Increasing claims option

After each twelve continuous months of Total or Partial disability benefit payments, the benefit will be increased by the percentage increase in the *consumer price index* for the previous year.

If the benefit is added to the policy after the policy commencement date, as shown on the policy schedule, benefits will not be increased for a *sickness* or *injury* which occurs or is apparent within 90 days after the date the Increasing claims option is added to the policy.

Super contributions option

The super contributions monthly benefit (or a proportion thereof) is payable at any time a Total disability benefit, Partial disability benefit, Specified injury benefit, Confined to bed benefit or Day 4 accident benefit is being paid.

The amount payable will be the super contributions monthly benefit multiplied by the proportion of the *insured monthly benefit* we are paying as a Total disability benefit, Partial disability benefit, Specified injury benefit, Confined to bed benefit or Day 4 accident benefit.

Under indemnity cover, this is subject to a maximum of the actual average monthly superannuation contributions the life insured or the life insured's employer made in the 12 months preceding the claim.

Inflation protection, the Increasing claims benefit and the Future insurability option apply to the Super contributions option.

In selecting this benefit we are deemed to be directed to pay any super contributions monthly benefit payable to a nominated complying superannuation fund.

If this benefit is added to the policy after the policy commencement date, as shown on the policy schedule, no super contributions monthly benefit is payable for any *sickness* or *injury* that occurs or is apparent within 90 days after the date the Super contributions option is added to the policy.

Day 4 accident option

The Day 4 accident benefit is payable if the life insured is *totally disabled* due to an *injury* for more than three consecutive days during the waiting period. We will pay 1/30th of the Total disability benefit for each day of the waiting period for as long as the life insured continues to be *totally disabled* solely due to his/her *injury*.

No claim is payable for any *injury* occurring before or within 90 days after the date the benefit is added to the policy, as shown on the policy schedule (if the Day 4 accident option is added to the policy after the policy commencement date).

Family care option

This benefit only applies where the policy owner is also the life insured.

The Family care benefit is payable if the life insures dies while a *monthly benefit* is being paid, and leaves a surviving *partner*. We will continue to pay the *partner* a *monthly benefit* for up to five years after death while the *partner* remains alive, but not beyond the balance of the benefit period or the expiry date shown on the policy schedule, if earlier.

The amount payable will be adjusted in the same manner that would have occurred had the life insured continued living.

This benefit is not payable if death occurs within 90 days after the date the benefit is added to the policy, as shown on the policy schedule (if the Family care option is added to the policy after the policy commencement date).

Home support option

This benefit only applies for the covered *partner* named on the policy schedule. Only one person can be covered under this benefit and each person can only be covered under one Zurich income policy.

The Home support benefit is payable if:

- the covered *partner* is unable, because of *sickness* or *injury*, to perform each and every daily *domestic duty* and
- a *medical practitioner* confirms the need for home help for the covered *partner*

during the 60 day waiting period, but only while this continues after the end of the waiting period.

We will pay the Home support benefit to the policy owner (or directly to the *partner*, with written instructions to do so) from the end of the waiting period, but not beyond the earlier of the expiry date shown on the policy schedule or the policy anniversary following the *partner's* 55th birthday.

The Home support benefit payable is:

- a monthly amount to reimburse fees paid for home duties such as cooking and cleaning, up to $1,000
- a monthly amount to reimburse child care costs for children under 12 years, up to $1,500
- a monthly amount of $2,000 to help with additional living expenses.

Restrictions and limitations

No cover is provided under the policy for any insured event which is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) before the Home support benefit start date.

We will not pay a benefit if the covered *partner* is disabled due to any one or more of the following:

- intentional self-inflicted act
- attempted suicide
- *uncomplicated pregnancy or childbirth*
- an act of war (whether declared or not)
- a *mental health condition*
- any event specified as an exclusion on the policy schedule.

We will not pay for any period while the covered *partner* is in jail.

A Rehabilitation benefit is also payable if the Home support benefit is payable, as follows:

Home modification

This benefit provides assistance if the covered *partner's* home needs modification to allow the covered *partner* to return to carrying out the home duties. We will pay up to $6,000 for expenses incurred in carrying out the modification.

Rehabilitation program

If the covered *partner* takes part in a *rehabilitation program*, we will pay up to an additional $1,000 each month after the waiting period for up to 12 months.

Rehabilitation costs

We will pay up to $12,000 for the expenses of rehabilitating the covered *partner*. We will not cover health costs which are typically covered by Medicare or private health insurance.

The expenses must be incurred while the Home support benefit is payable and, to receive the benefit, our written approval must be obtained before expenses are incurred.

The Rehabilitation benefit is payable only once in relation to the same or related cause.

All Home support benefits, including the Rehabilitation benefit, are payable for a maximum period of two years over the life of the benefit.

Future insurability option

The Future insurability benefit allows increases to the *insured monthly benefit* (and any super contributions monthly benefit) by up to 15% on every policy anniversary after this benefit begins, to reflect an increase in income without reassessment of the life insured's health. We must receive notification in writing within 30 days of the relevant policy anniversary for the increase to apply and evidence of an increase in income may be required, as determined by us.

The increase cannot be made:

- if the policy anniversary following the life insured's 54th birthday has already passed
- if we are currently paying benefits or have ever paid benefits under the policy
- to the extent that after the increase, the *insured monthly benefit* will be more than:
  - 75% of the first $320,000 of annualised *claimable income*
  - 50% of the next $240,000 if annualised *claimable income*
  - 25% of the balance of annualised *claimable income*

  at that date
- to the extent that after the increase, the super contributions monthly benefit will be more than the actual average monthly superannuation contributions the life insured or the life insured's employer made in the preceding 12 months (indemnity only).

If any special conditions or exclusions apply to the existing cover, as shown on the policy schedule, then those special conditions or exclusions will automatically apply to the increased cover.

Restrictions and limitations

This benefit is not available to the life insured if the *insured monthly benefit* has been issued with a medical loading (shown on the policy schedule).

The sum of all increases under this benefit cannot exceed the *insured monthly benefit* amount applying to the life insured on the benefit start date.

Any increase under this benefit cannot cause the *insured monthly benefit* amount applying to the life insured to exceed $30,000.

If this benefit is added to the policy after the policy commencement date, as shown on the policy schedule, the *insured monthly benefit* cannot be increased for any income changes occurring within 90 days after the date the Future insurability option is added to the policy.

Lump sum accident option

The Lump sum accident benefit is payable if the life insured suffers an *injury*, while the policy is in force and before the expiry date shown on the policy schedule, which causes, within 180 days of the accident, one of the events set out below. The lump sum payable will be the percentage set out below of the Lump sum accident benefit amount shown on the policy schedule.

Under this benefit, 'loss' means that the life insured cannot use and will never be able to use that body part again. In the case of the eye, it means that the life insured will never be able to see again from that eye.

Restrictions and limitations

We will only pay an amount under this benefit once during the life of the policy.

Event	Percentage of Lump sum accident benefit amount
accidental death	100%
Total and permanent loss of:	
both hands or both feet or sight in both eyes	100%
one hand and sight in one eye	100%
one foot and sight in one eye	100%
one hand and one foot	100%
one arm or one leg	75%
one hand or one foot or sight in one eye	50%
thumb and index finger from same hand	25%
thumb or index finger	15%
two or more fingers	15%
one finger	5%

No claim is payable for any *injury* occurring before or within 90 days after the date the benefit is added to the policy, as shown on the policy schedule (if the Lump sum accident option is added to the policy after the policy commencement date).

Trauma advancement option

If the life insured suffers one of the trauma conditions listed below while the policy is in force and before the expiry date shown on the policy schedule, we will pay a benefit for six months, regardless of whether the life insured is disabled. The Trauma advancement benefit will be paid in advance as a lump sum during the waiting period.

Under endorsed agreed value cover, the Trauma advancement benefit will be the *insured monthly benefit* for a period of six months.

Under agreed value or indemnity cover, the Trauma advancement benefit will be the lesser of:

- the *insured monthly benefit* and
- the amount we would pay under the Total disability benefit

for a period of six months.

The benefit is payable if the life insured survives for at least 14 days after suffering any of the following four trauma conditions:

- *coronary artery bypass surgery*
- *heart attack*
- *malignant cancer*
- *stroke*.

The definitions which apply to this option are set out in the section 'Trauma advancement option definitions' on page 76.

We will not pay a benefit for any trauma condition which occurs or becomes apparent within 90 days of the date an application for Zurich Income Protector or Zurich Income Protector Plus (including a fully completed Life Insured's Statement) is lodged with us.

We will waive this 90 day elimination period if the Trauma benefit under this policy replaces cover for the same insured event with us or another insurer, but only to the extent of the benefit amount replaced, and only if the life insured is not within our or the other insurer's 90 day elimination period. This waiver can also apply to any increase in the Trauma advancement benefit which meets the same criteria.

We will not pay a benefit for any trauma condition which occurs or becomes apparent within 90 days of:

- the latest reinstatement of the policy
- the latest premium holiday end date.

No other *monthly benefit* is payable in respect of the same six month period that the Trauma advancement benefit is being paid. Eligibility to receive a Total or Partial disability benefit for the remaining balance of the benefit period will be determined in the normal way after the end of the six month period.

A Trauma advancement benefit will only be paid once for each insured event and no benefit will be payable after the benefit expiry date shown on the policy schedule.

The occurrence of the trauma must be confirmed by our medical advisers and, for this purpose, we reserve the right to require the insured to undergo an examination or other reasonable tests, at our expense.

Needlestick cover option

We will pay a lump sum equal to the amount insured under this benefit if the life insured becomes infected with HIV (Human Immunodeficiency Virus), hepatitis B or hepatitis C as a result of an accident occurring during the course of the life insured's normal occupation.

Any accident giving rise to a potential claim must be reported to us within seven days of the accident.

In the event of a claim we must be provided with all of the following:

- proof of the occupational accident that gave rise to the infection including the incident report and the names of any witnesses to the accident
- proof that the accident involved a definite source of the relevant infection
- proof that a new infection with either HIV, hepatitis B or hepatitis C has occurred within six months of the documented accident, demonstrating sero-conversion from:
  - HIV antibody negative to HIV antibody positive
  - hepatitis C antibody negative to hepatitis C antibody positive
  - hepatitis B surface antigen negative to hepatitis B surface antigen positive
- access to test independently all the blood samples used.

Restrictions and limitations

The maximum combined amount we will pay for either:

- *occupationally acquired HIV* and
- *occupationally acquired hepatitis B or C*

under all policies issued by us is $2,000,000. This does not include any TPD benefits or *monthly benefit* in respect of the life insured.

Exclusions

A benefit will not be payable if:

- HIV, hepatitis B and hepatitis C is contracted by any other means
- a medical cure is found for Acquired Immune Deficiency Syndrome (AIDS) or the effects of the HIV virus, hepatitis B or hepatitis C (as applicable) or in the event of a treatment being developed and approved which makes these viruses inactive and non-infectious
- the life insured elects not to take an available medical treatment which results in the prevention of hepatitis B or hepatitis C prior to making a claim.

Applying for cover

Step by step

Here is an easy step-by-step diagram which shows how you can get Zurich cover in place, with the help of your financial adviser.

1. Work out what you need

The first step involves a discussion with your financial adviser. He or she will help determine what types of cover you need, how much cover, ownership structure and any tailoring to your circumstances.

Once the policy parameters are agreed with you, a personalised premium quote will be provided.

2. Make sure you understand what is recommended to you

This PDS contains all the information you need to know about the Zurich Active policies – including the policy conditions. Read this PDS carefully to make sure you understand the policy or policies you plan to apply for. If you are applying for Zurich cover through a superannuation fund, read the PDS issued by the trustee as well to understand the effects of taking insurance through super.

3. Making an application for cover

Complete our Application form, as well as our Life Insured's Statement, which asks about health, financial situation, lifestyle and pastimes.

Your financial adviser will help you to complete and submit both parts electronically or on paper.

4. Up to 90 days of interim cover

From the time an application is submitted and premium payment is arranged, we provide up to 90 days of interim cover against accidental death and/or accidental injury, depending on the covers applied for.

Interim cover generally ends when we finish our assessment, ie. we issue a policy or we decline the application. Interim cover is temporary and has special terms and conditions set out in the Interim cover terms on page 37.

5. Our assessment of your application

We will assess the information provided to us in the Life Insured's Statement. Any disclosed health condition will be covered under the policy, unless we are unable to offer cover, or specifically exclude the condition.

Depending on factors including age, health, cover applied for and sum insured we may need additional information directly from the life insured, from the life insured's doctor or we may request a medical examination or test. The majority of applications are assessed without any medical testing.

6. Alternate terms may apply

If our assessment of the application results in any premium loading or special exclusion, then your financial adviser will be in touch with you to agree the revised terms, which will form part of your application. We will only issue a policy once we have your agreement to the revised terms in writing.

If you decide not to go ahead with the application at this point, the process will end.

7. Policy is issued

Once our assessment is complete and we accept your application, a policy schedule will be created and issued. The policy schedule shows the details of the individual policy, including sums insured and cover commencement and end dates. It will also show any special conditions and exclusions that have been agreed.

8. Store your documents

Keep the policy schedule and this PDS (which contains the policy conditions) as evidence of your insurance.

Each year, depending on your policy, we will be in contact to tell you the premium for the next 12 months, offer to increase cover in line with inflation and update you about any policy enhancements we've made.

Store all your Zurich documents together, so you can find them if you need to make a claim.

9. Keep in touch

You and your financial adviser will agree a timeframe for regular contact. You should also contact him or her if your situation changes or if you need financial advice.

You can contact us any time on 131 551 for help with maintaining your policy, arranging premium payments or if you need to make a claim.

Premium and other costs

Premium

The cost of insurance is referred to as the premium. It includes the cost of the selected policy for the life insured, any optional benefits selected, stamp duty and any other government charges that may be levied from time to time.

Choice of premium structures

You can choose between 'stepped' and 'level' premiums.

Stepped premiums will generally increase each year based on the rates applicable for the life insured's age at that time.

Level premiums for the sum insured at policy outset are based on the age of the life insured when cover begins. Premiums for any increase in cover are based on the age of the life insured at the date of the increase.

Level premiums do not stay level for the life of the policy. Level premiums convert to stepped premiums on the policy anniversary following the life insured's 65th birthday.

Both stepped and level premiums increase:

- if the sum insured increases
- if the policy is impacted by any change in stamp duty
- if we change the premium rates for all policies in the same category.

More information about when we can change premium rates is in the next column and information about stamp duty can be found on the next page.

Choice of payment options

You can choose to pay premiums as set out in the table below:

	first premium	monthly	quarterly	half-yearly	yearly
direct debit	✓	✓	✓	✓	✓
credit card	✓	✓ (direct debit)	✓ (direct debit)	✓	✓
BPAY	✓	✗	✗	✓	✓
platform deduction	n/a	✓	✓	✓	✓

Paying premiums from a superannuation fund

Payments can be made from your *eligible superannuation fund*. Please refer to the PDS for your fund for further details including how you can make rollovers to meet the required premium.

Unpaid premiums will cause cover to lapse

If premiums are not paid when due, your policy will lapse after 30 days and you will not be covered. You may be able to reinstate your policy after it lapses. Reinstatement of cover is explained on page 46.

Premium rates are not guaranteed

Premium rates for Zurich Active policies are not guaranteed and can change from time to time. Any change, however, will affect all policies in the same category, not just an individual policy. We will notify the policy owner of any changes to premium rates at least 30 days prior to the change taking effect. The premium payable from the start of your policy is shown on your policy schedule, and will not change before the first policy anniversary.

Premium calculation factors

Your premium will depend on:

- the amount of cover you require (the higher the sum insured, the higher the premium)
- any optional benefits you choose (the more optional benefits you select the higher the premium)
- whether you select stepped or level premiums (stepped premiums are generally lower than level premiums at the start of the policy, but stepped premiums generally increase each year as the life insured gets older whereas level premiums do not)
- the frequency of your premium payments (paying half-yearly, quarterly or monthly will attract an increased premium)
- the life insured's current age (generally premiums increase with age)
- the life insured's gender (for example, Death cover premiums are generally higher for males than for females, while income protection premiums are generally higher for females than for males)
- whether or not the life insured is a smoker (premiums are higher for smokers than for non-smokers; a non-smoker is defined as a person who has not smoked tobacco or any other substance and has not used nicotine replacements in the past 12 months)
- the life insured's occupation (generally occupations with hazardous duties or higher occupational risk have higher premiums)
- the life insured's health and
- any pastimes the life insured participates in (generally premiums are higher for those who engage in hazardous activities).

Additional factors influence the cost of income policies:

- the benefit period selected (the longer the benefit period, the higher the premium)
- the waiting period selected (the shorter the waiting period, the higher the premium)
- the level of cover selected (the premium is higher for Plus cover).

For Health events, terminal illness & death cover, the premium is based on the *initial amount of cover* throughout the life of the policy. However, if the Extended care option applies, the cost of this option included in the premium for the *initial amount of cover* will end on the earlier of the payment of a benefit under the Extended care option or the Extended care option expiry date, on the policy anniversary following the life insured's 65th birthday.

Other charges

State governments impose stamp duty on life insurance policies. Duties vary from State to State. Applicable stamp duty will be included in your premium and will be based on where the life insured resides. There are no other taxes currently levied by State or Federal governments. Should changes in the law or residency result in additional taxes or imposts in relation to your policy, these amounts may be added to your premium or deducted from insurance benefits.

Direct debits from your financial institution may incur an additional fee, charged by your financial institution.

Goods and Services Tax (GST) is not currently payable on insurance premiums for the policies described in this PDS.

If we introduce any new charges, the policy owner will be notified at least 30 days prior to such charge taking effect.

Your financial adviser will provide you with a premium illustration

The illustration will show the cost of each cover and any optional benefits you select as well as the details of any fees and/or stamp duties that may apply. If you request, your financial adviser can also provide you with a table of premium rates giving all rates and factors for all of the policies described in this PDS. Further information on how premiums are calculated can be obtained by contacting us (see the inside back cover of this PDS for details).

Commission

We may pay commission and other benefits to financial advisers and other representatives. Your financial adviser will provide details of the benefits he or she will receive if we issue you a policy in the Financial Services Guide and, if applicable, the Statement of Advice that he or she will give to you. We pay these amounts out of your premium payments – they are not additional amounts you have to pay.

Premium holiday

These policies include a Premium holiday provision which can be exercised after the first year. During the holiday, no premiums are payable and no cover is provided.

The provision does not apply to policies which are set up under a platform arrangement.

Duty of disclosure

When completing your application form, it is important that you (both the proposed owner and life insured) answer the questions correctly and note the following important information.

Your duty of disclosure

Before entering into a life insurance contract, we must be told anything that each of you as the proposed policy owner and the life to be insured (if a different person to the proposed policy owner) knows, or could reasonably be expected to know, may affect our decision to provide the insurance and on what terms.

The duty applies until we agree to provide the insurance. It also applies before the insurance contract is extended, varied or reinstated.

We do not need to be told anything that:

- reduces the risk we insure; or
- is common knowledge; or
- we know or should know as an insurer; or
- we waive the duty to tell us about.

If you are the life to be insured (but not also the proposed policy owner), you not telling us something that you know, or could reasonably be expected to know, that may affect our decision to provide the insurance and on what terms, may be treated as a failure by the proposed policy owner to tell us something that they must tell us with the following consequences for the proposed policy owner.

If we are not told something

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

If we are not told something that we are required to be told, and we would not have provided the insurance if we had been told, we may avoid the contract within 3 years of entering into it.

If we choose not to avoid the contract, we may, at any time, reduce the amount of insurance provided. This would be worked out using a formula that takes into account the premium that would have been payable if we had been told everything we should have been told. However, if the insurance contract has a surrender value, or provides cover on death, we may only exercise this right within 3 years of entering into the contract.

If we choose not to avoid the insurance contract or reduce the amount of insurance provided, we may, at any time vary the contract in a way that places us in the same position we would have been in if we had been told everything we should have been told. However, this right does not apply if the contract has a surrender value or provides cover on death.

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

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any personal or sensitive information ('information'), you (including any person information is being provided about as part of the application) should know the following.

We collect, use, process and store personal information and, in some cases, sensitive information about you in order to comply with our legal obligations, to assess your application for insurance cover, to administer the insurance cover provided, to enhance customer service or products and to manage claims ('purposes'). If you do not agree to provide us with the information, we may not be able to process your application, administer your cover or assess your claims.

By providing us or your intermediary with your information, you consent to our use of this information which includes us disclosing your information where relevant for the purposes, to the policy owner, your intermediary, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our business partners or as required by law within Australia or overseas.

The Australian laws include:

- Australian Securities and Investment Commissions Act 2001
- Corporations Act 2001
- Insurance Contracts Act 1984
- Life Insurance Act 1995
- Superannuation Industry (Supervision) Act 1993
- Anti Money Laundering and Counter Terrorism Financing Act 2006
- Anti Money Laundering and Counter Terrorism Financing Rules Instrument 2007 (No. 1)
- Income Tax Assessment Act 1997
- Taxation Administration Act 1953
- Superannuation Guarantee (Administration) Act 1992
- Small Superannuation Accounts Act 1995
- Superannuation (Unclaimed Money and Lost Members) Act 1999
- Superannuation Resolution of Complaints) Act 1993
- Superannuation (Government Co-contribution for low income earners) Act 2003 and
- Family Law Act 1975 (Part VIIIB)

as those acts are amended and any associated regulations. From time to time other acts may require, or authorise us to collect your personal information.

Zurich may also obtain information from government offices and third parties to assess an application or a claim. We may use personal information (but not sensitive information) collected about you to notify you of other products and services we offer.

If you do not want your personal information to be used in this way, please contact us.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your information to, a list of countries in which recipients of your information are likely to be located, details of how you can access or correct the information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687 or email us at privacy.officer@zurich.com.au.

Interim cover

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

Interim cover does not necessarily provide the same coverage as the policy or policies being applied for. The terms of interim cover are limited to those set out in this section. These terms cannot be varied or extended by any representation made by us or your financial adviser.

Defined terms and interpretation

All terms appearing in *italics* are defined terms with special meanings. Detailed definitions are set out in the relevant definitions section at the end of this PDS.

Your financial adviser acts as your agent, not ours, in relation to this interim cover.

Interim cover

Provided you meet the Interim cover eligibility criteria, we will provide you with interim cover from the Interim cover effective date until the Interim cover termination date, subject to the specific terms of interim cover set out in this section.

Interim cover effective date

Interim cover is effective from the Interim cover effective date ('effective date'), which is the date that you have properly completed a paper or electronic Application form for Zurich Active (the application) for the policy/policies you are applying for and either:

(a) you have completed a Payment authority or

(b) you have completed a Rollover authority to transfer an amount into an *eligible superannuation fund*, from which the premium will be paid, equal to the premium for the insurance you have applied for or

(c) you have set up your platform account from which the premium will be paid.

If you have selected the Tele-underwriting option, the Life Insured's Statement is not required to be completed for interim cover to commence.

Interim cover termination date

The interim cover, once effective, terminates at the earliest of the time and date you, your financial adviser or the policy owner withdraws your application by contacting us or:

(a) 4.00pm on the 90th day after the effective date or such earlier time and date as we advise you or your financial adviser in writing (for example, if we decline the application)

(b) the time and date when insurance cover commences under another contract of insurance (whether interim or not) which covers the life insured and is intended to replace the cover provided under this interim cover

(c) the end of the 14th day after the effective date if you have not submitted your application to your financial adviser

(d) the end of the 21st day after the date we notify you or your financial adviser that the insurance cover applied for would be subject to non standard terms (such as a premium loading or an exclusion) if you do not respond to our assessment (ie. alter the application)

(e) the end of the 28th day after the effective date if your financial adviser has not submitted your application to us.

Interim cover eligibility criteria

You are not eligible for this interim cover and no interim contract is entered into if you have on the effective date:

(a) current insurance with us or another insurer of a similar type which provides the same or similar cover (whether individually or as part of a package) which you have indicated in your application will be replaced by the cover being applied for in this application or

(b) a current application with us or another insurer for insurance of a similar type which provides the same or similar cover (whether individually or as part of a package) or

(c) interim cover with us or another insurer for insurance of a similar type which provides the same or similar cover (whether individually or as part of a package) or

(d) had interim cover or other insurance cover with us in the previous 24 months of a similar type that had terminated (except to the extent you are increasing cover on an existing policy) or

(e) previously applied for insurance of a similar type providing similar cover with us or another insurer (whether individually or as part of a package) and the application was declined, deferred or postponed.

Terms and conditions

The interim cover is:

(a) only provided for the type(s) of insurance you have applied for in the application (interim cover is specifically not provided for a *partner* included in your application under the Home support option)

(b) subject to the terms, conditions and exclusions applicable to the interim cover and

(c) subject to the other relevant terms, conditions and exclusions of the relevant policy conditions for the insurance you have applied for, except to the extent the policy conditions provide greater cover than provided in this Interim cover.

If you are applying to increase insurance with us then interim cover applies only to the amount of the increase, not exceeding the relevant limits set out in this interim cover.

Exclusions

To the extent permitted by law, no interim cover is provided:

(a) if you would not have been entitled to the interim cover or for any amount in excess of what we would have covered you for, based on our underwriting criteria applicable for the relevant insurance immediately before interim cover is effective or

(b) if the event leading to the claim occurs while the life insured is outside Australia or

(c) where the event leading to the claim is caused directly or indirectly by:

  (i) suicide or attempted suicide

  (ii) intentional self-inflicted *injury* or act

  (iii) the taking of drugs other than as prescribed by a doctor

  (iv) engaging in any criminal activities

  (v) engaging in any pursuit or occupation which would cause us to reject or apply special conditions to acceptance of the application for insurance or

  (vi) an act of war (whether declared or not) or

  (vii) military service, other than death while on war service.

Terms of interim cover provided for Zurich Active Cover

If you have applied for **Health events, terminal illness & death cover**, the life 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.

The amount we will pay in respect of any life (regardless of the number of applications being assessed) will be the lesser of:

- the *initial amount of cover* applied for to a maximum of:
  - benefit category AA: $1,000,000
  - benefit category A: $500,000
  - benefit category B: $325,000
- the normal *initial amount of cover* the life insured would have been accepted for under our normal underwriting criteria.

Terms of interim cover provided for Zurich Child Cover

We will pay the interim Child cover benefit if the insured child dies as the result of an *accident* or suffers one of the child trauma conditions listed below as the result of an *accident*, where the *accident* occurs during the period of interim cover and death or the condition occurs within 90 days of the *accident*.

Child trauma conditions covered for interim cover are:

- *paraplegia*
- *quadriplegia*
- *loss of limbs or sight*
- *loss of speech*
- *major head trauma*
- *severe burns*.

Definitions for these conditions can be found in the section 'Child cover definitions' on page 74.

The amount we will pay in respect of any insured child (regardless of the number of applications being assessed) will be the lesser of:

- $200,000 or
- the amount of cover you are applying for.

Terms of interim cover provided for Zurich Income Protector/Plus

We will pay a Total disability benefit if, solely as a result of an *accidental injury* during the period of this interim cover:

- the life insured totally ceases work and
- the life insured is unable to earn from personal exertion any income for a period of at least the nominated waiting period and
- the life insured is under the regular care of a *medical practitioner*.

The benefit will be paid in the event the life insured sustains an *accidental injury*, which occurs after this cover commences.

The amount we will pay you each month, provided the life insured continues to meet the above criteria, will be the lesser of:

- $5,000 or
- the *insured monthly benefit* you are applying for or
- the amount of cover the life insured would have been accepted for under our normal underwriting criteria.

The maximum period we will pay a benefit for is 12 months.

If you make a claim

If you make a claim under the interim cover you must pay us the premium for this cover that we require, which will be what we would have charged you for the policy/ies you have applied for, to cover the period up until the date that we admit your claim.

Duty of disclosure

In completing the Application form for Zurich Active you declare that you have read and understood your duty of disclosure set out on page 36.

If you have failed to disclose any such matters to us or made a misrepresentation when you completed your application and you have interim cover, we may exercise our rights specified in the duty of disclosure notice, including voiding the interim cover.

For the policy/ies applied for, the duty also applies up until the time we decide to enter into a contract of insurance with the policy owner. Please ensure you contact us if any information in your application changes or you need to disclose further matters after it is completed, as it can affect any final cover.

Confirming this cover

You may contact us in writing or by phone to confirm the currency of your interim cover if you or your financial adviser do not already have the required confirmation details.

If you need to make a claim under your interim cover, you must provide us with sufficient proof that an insured event occurred between the interim cover effective date and the interim cover termination date, including proof that you completed our application.

Additional information

Policy ownership

You can structure your insurance with:

- **non-superannuation ownership**: where one or more individuals, a company, or a trust (ie an entity that is not a trustee of a superannuation fund) owns the insurance
- **superannuation ownership**: where a trustee of a superannuation fund (of which you are a member) owns the insurance. This can include:
  - the trustee of an *eligible superannuation fund*
  - a trustee of a self-managed superannuation fund (SMSF).

In some cases we allow insurance to be split across two policies, with different policy owners.

Non-superannuation ownership

When you apply for cover outside of superannuation, the policy is issued directly to you as the policy owner. You can apply for cover on your own life or the life of another person unless applying for income protection cover, which is generally only available on your own life. If you apply for cover on the life of another person, you must have an insurable interest in the life insured that is satisfactory to us.

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 we agree to a different arrangement which we will note on your policy schedule.

If a benefit becomes payable, the benefit is generally paid to the policy owner. If the life insured and policy owner are the same, the amount payable on the death of the life insured will generally be paid to the life insured's legal personal representative, or nominated beneficiaries.

Nomination of beneficiaries for Death benefits

If there is only one policy owner who is also the life insured, that policy owner may nominate one or more beneficiaries to receive the Death benefit in the event of death. If the policy owner makes a nomination we will pay the Death benefit directly to the nominated beneficiaries in the proportions specified in the nomination.

Nominations only apply to Zurich Active Cover policies.

The nomination is subject to the following rules:

- the policy owner must be both the sole policy owner and the life insured to make a valid nomination
- a nominated beneficiary must be an individual, corporation or trust
- contingent nominations (eg. nominations which provide for multiple scenarios) cannot be made
- the policy owner may change a nomination at any time or revoke a previous nomination but the change does not take effect until we receive and accept the new nomination
- the nomination must be properly executed in the form we specify before we can accept it
- the policy owner may have only one nomination in force at any time, and cannot supplement a nomination (to add beneficiaries, the policy owner must replace the nomination by making a new one)
- an attempt at making a new nomination received by us revokes past nominations even if the attempt at making the nomination is defective
- if ownership of the policy is assigned to another person or entity, then any previous nomination is automatically revoked
- payment of the Death benefit will be made using the latest unrevoked valid nomination
- if a nominated beneficiary dies before the policy owner, the portion of the Death benefit nominated in respect of that beneficiary will be paid to the policy owner's legal personal representative
- if a nominated beneficiary is alive at the time of the policy owner's death but we are notified of their subsequent death before we can pay him/her, then the entitlement will be paid to the deceased beneficiary's legal personal representative
- a nominated beneficiary has no rights under the policy, other than to receive the nominated policy proceeds after a claim has been admitted by us (he or she cannot authorise or initiate any policy transaction)
- we may delay payment if the nomination or nominations become the subject of legal proceedings or external dispute resolution processes
- a court order or decision of an external dispute resolution process in relation to a nomination overrides the nomination.

Ownership within superannuation

When you apply for a cover within superannuation, the policy is issued to the trustee of the relevant superannuation fund as policy owner.

If you are the trustee of a self-managed superannuation fund, it is your responsibility as trustee to consider:

- the appropriateness of providing each type of insurance cover within superannuation and its potential implications for the complying status of your fund
- the taxation consequences of holding the cover, and
- superannuation law that operates to limit when benefits received by you as trustee can be paid out of the fund.

If a benefit becomes payable under a Zurich Active policy 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 law current at the time of payment.

Restrictions on insurance held within superannuation

Superannuation law requires superannuation fund trustees to ensure insurance benefits they acquire from 1 July 2014 are aligned with the superannuation payment rules. We have applied restrictions to the insurance benefits we offer to superannuation fund trustees in accordance with these requirements.

See below for details of the terms that apply to Zurich Active Cover held within superannuation. The terms that apply to income protection held within superannuation are explained on the next page.

Death & terminal illness cover within superannuation

The following condition applies to Death & terminal illness cover within superannuation:

- *Terminal illness* – claims for *terminal illness* must also satisfy the additional certification provisions set out in the definition of *terminal illness*.

Health events, terminal illness and death cover within superannuation

The Advancement for funeral expenses is not available if your insurance is held within superannuation.

All Health events cover provided within superannuation is subject to the condition that, at the time of claim, the life insured also satisfies the definition of *permanent incapacity*.

Zurich Active Cover within superannuation is subject to the superannuation optimiser structure, in which case benefits that do not meet *permanent incapacity* are excluded from the superannuation policy, but will be held on a non-superannuation policy.

Under this structure, the Financial planning advice feature is held on the non-superannuation policy.

Superannuation optimiser – health events, terminal illness & death cover

If you choose to hold part of your Zurich 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.

The policy issued to the trustee of a superannuation fund will hold the cover for Death & terminal illness cover 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 definition of *permanent incapacity*. We refer to this policy as the 'superannuation policy'. The cover provided under this policy has been designed to align with the superannuation law payment rules.

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 the definition of *permanent incapacity)* • Extended care option (meeting the definition of *permanent incapacity)*	• *Health events* covered under benefit category A (not meeting the definition of *permanent incapacity*) • *Health events* covered under benefit category B, C, D and E • Extended care option (not meeting the definition of *permanent incapacity)*

Claims under the superannuation policy

Claims for Death & 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 definition of *permanent incapacity*.

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 law).

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 'Premium and other costs' on page 35.

Income protection cover within superannuation

Zurich Income Protector can be structured within superannuation in one of two ways:

- wholly within superannuation, in which case restrictions apply that are designed to meet the requirements of superannuation law, or
- via the superannuation optimiser structure, in which case benefits that do not meet the definition of *temporary incapacity* are excluded from the superannuation policy, but will be held on a non-superannuation policy.

Superannuation optimiser – income protection

When you apply for Zurich Income Protector that is to be owned by a trustee of a superannuation fund, the cover can be issued as two separate related policies linked to each other under the superannuation optimiser structure.

One policy will be owned by a trustee of a superannuation fund (referred to as the superannuation policy) and the cover it provides is known as the 'superannuation component'. The income protection benefits held under this policy are restricted by us. Our restrictions include rules to ensure any payments made under the superannuation policy as a result of a disability will be consistent with superannuation law.

The remainder of the income protection benefits which would otherwise be available will be provided under a policy issued outside superannuation (referred to as the non-superannuation policy). The cover provided under this policy is called the 'non-superannuation component'.

The following conditions apply to Zurich Income Protector subject to superannuation optimiser:

- the Specified injury benefit and Rehabilitation benefit are not available under the superannuation policy (but will be available under the non-superannuation policy)
- the Family care option, Home support option, Lump sum accident option, Trauma advancement option and Needlestick cover option can only be included in the non-superannuation policy
- any *sickness* or *injury* resulting in a payment under the Specified injury benefit, Rehabilitation benefit or Trauma advancement benefit, (under the non-superannuation policy), will not result in a benefit payment under the superannuation policy for the same period.

The cover provided under each policy is summarised in the table below.

Superannuation component	Non-superannuation component
• Benefits that meet *temporary incapacity*, up to the *superannuation payment limit* for the: – Total disability benefit, or – Partial disability benefit. • Funeral benefit. Benefits excluded: • Total disability and Partial disability for any *sickness* or *injury* qualifying for payment under the Specified injury benefit, Rehabilitation benefit or Trauma advancement benefit under the non-superannuation component. (But only for the period that such benefit is payable under the non-superannuation component.)	• Benefits that do not meet *temporary incapacity* or, where the benefit meets *temporary incapacity*, any amount of the benefit that exceeds the *superannuation payment limit* for the: – Total disability benefit, and – Partial disability benefit. • Specified injury benefit • Any benefits payable under the Family care option, Home support option, Lump sum accident option, Trauma advancement option and Needlestick cover option (if selected).

The total benefits that are payable under the policies together will not exceed the amount that would otherwise be payable if the Zurich Income Protector policy had been issued to a single policyholder.

The 'non-superannuation component' only provides cover for a benefit also listed under the 'superannuation component' in any particular month where, because of the superannuation optimiser restrictions, the 'superannuation component' cannot pay the benefits.

In any particular month, the benefit entitlements may be split across the two policies. For example, there may be instances when, in a particular month, the total benefit is payable under the 'superannuation component' or under the 'non-superannuation component'. There may also be instances where we pay a portion of the benefit payable under each of the related Zurich Income Protector policies.

In the event of a claim we first consider the type of benefit to be assessed and the policy under which it is to be assessed. Claims will be assessed to determine whether they meet the requirements for a Specified injury benefit. Similarly, if the Trauma advancement option applies, claims will be assessed to determine whether they meet the requirements of the option.

We will pay the benefit under the appropriate policy based on the information available to us at the time the decision is made by us.

Income claims under the superannuation policy

Claims for the following benefits are considered under the superannuation policy:

- Total disability benefit (including payments under the Day 4 accident option, where selected)
- Partial disability benefit
- Confined to bed benefit (Zurich Income Protector Plus only)
- Funeral benefit.

In the event of a claim for either the Total disability benefit, Partial disability benefit or Confined to bed benefit, assessment will first be made under the superannuation policy to determine:

- if a benefit can be paid under the policy (because the life insured satisfies the requirements of *temporary incapacity*), and if so
- how much of the benefit that can be paid under the terms of the insurance can be paid under the superannuation policy (because the amount of payments must not exceed the *superannuation payment limit*).

No benefit will be paid from the superannuation policy for the same period for which a benefit has been paid or is payable from the non-superannuation policy under the Specified injury benefit or Trauma advancement benefit.

The amount of the benefit that can be paid is determined as the lesser of:

- the amount otherwise calculated under the terms of the insurance, and
- the *superannuation payment limit*.

If a benefit is payable under the superannuation policy, the benefit will be paid to the trustee of the superannuation fund. The release of the benefit from the superannuation fund to the member will be determined by the trustee, subject to the governing rules of the superannuation fund and superannuation law current at the time of payment.

Income claims under the non-superannuation policy

In the event of a claim, the amount payable will be:

- any amount payable under the Specified injury benefit, Rehabilitation benefit or benefit payable under the Family care option, Home support option, Lump sum accident option, Trauma advancement option and Needlestick cover option
- any amount payable for the Total disability benefit, Partial disability benefit or Confined to bed benefit that cannot be paid under the superannuation policy because the life insured does not satisfy the requirements of *temporary incapacity*, and
- any amount payable under the Zurich Income Protector terms which exceeds the *superannuation payment limit* and could not be paid under the superannuation policy.

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

Restrictions to the insured monthly benefit

The policy schedule will indicate if a policy is related to another under superannuation optimiser and the policy number to which it is related. If related to another policy under this arrangement, the *insured monthly benefit* under both policies must always be the same. If the *insured monthly benefit* under either policy is altered, then the other will similarly be altered and the premium adjusted accordingly. If either policy is cancelled, then the other will also be cancelled.

Other conditions that apply to income protection under superannuation optimiser

The *insured monthly benefit*, benefit type, benefit period and waiting period under each policy must be the same. If you request to change any of these under one policy, reduce the amount of cover or cancel one of the policies, the same changes will be made to the other policy to ensure that these policies continue to correspond with each other.

For the duration of a claim, each month we will determine, by applying the policy terms, whether a benefit is payable under the superannuation policy or the non-superannuation policy, or in some cases, by apportioning the total amount payable between the two policies so that benefits are payable under both policies. The payment of a benefit under one policy will also count towards the benefit period of the other policy.

If the requirements of the Waiver of premium feature are satisfied because a claim is payable under either or both of the policies under a superannuation optimiser structure, we will waive the premiums payable under both policies.

If the requirements of the Involuntary unemployment premium waiver feature are satisfied, we will waive the premiums payable under both policies under a superannuation optimiser structure.

If a Premium holiday is taken, it must be taken on both policies at the same time.

Ownership by the trustee of an *eligible superannuation fund*

Where the trustee of an *eligible superannuation fund* is the policy owner, all written notices regarding the policy, including, but not limited to, the policy schedule, anniversary, dishonour and cancellation notices will be issued to the trustee of the *eligible superannuation fund* as policy owner. The trustee is solely responsible for communicating with the member in regard to the policy and is responsible for payment of the premium in respect of the member by the due date.

In some circumstances, we may, by agreement with the trustee, send notices to the member directly.

Important information about applying for Zurich Active policies within superannuation through membership of an *eligible superannuation fund* can be found in the PDS and/or other documents issued by the fund trustee.

Transferring ownership

If you wish to change the ownership of your policy from one owner to another, you may use a Memoranda of transfer which is available from us. The Memoranda of transfer cannot be used to change ownership in some instances eg. from a non-superannuation owner to a superannuation fund, instead you have the option to cancel and replace your policy in order to make this change. Please contact us if you require further information about assignment of ownership.

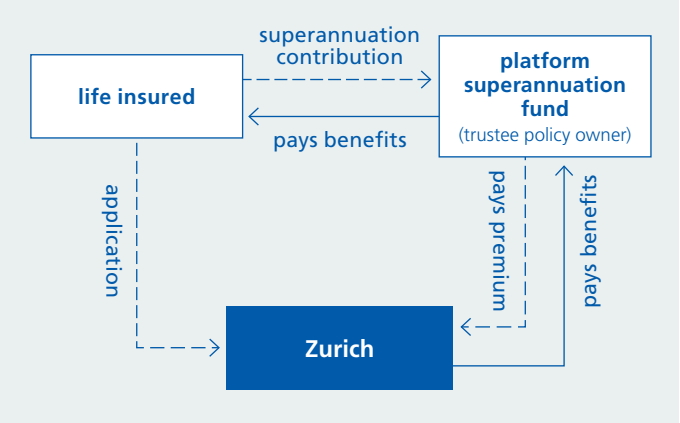
Holding insurance through a platform

You can take out Zurich Active Cover or Zurich Income Protector/Plus through selected platforms. Platforms offer the convenience of consolidated finances and reporting. If you include Zurich insurance in your platform account, your premiums will be paid by automatic deduction from the platform account on the same day each month, quarter, half year or year (depending on your chosen payment frequency).

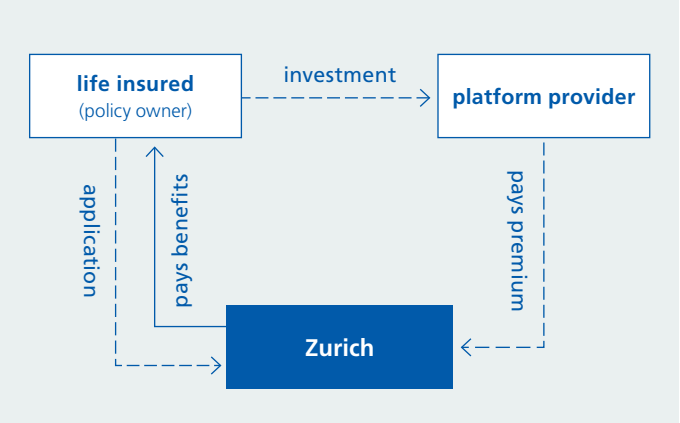
The platform may be a superannuation platform allowing insurance to be funded by a superannuation account or it may be a non-superannuation platform funded by an investment account.

The diagrams below show how this works.

Superannuation platform



Non-super platform



If premiums are not paid in any month due to insufficient funds, then the outstanding premium will be deducted from the account in the following month, to bring premiums up to date.

Information about how the platform operates can be found in the PDS prepared by the platform provider or the trustee of the platform superannuation fund.

If cover is set up though a non-superannuation platform, then the full range of Zurich Active Cover and Zurich Income Protector/Plus benefits are available. If cover is held through a superannuation platform, then normal restrictions apply to the benefits which can be held in superannuation. In summary, the cover available via a superannuation platform is as follows:

- Death & terminal illness cover
- Health events cover which will meet the definition of *permanent incapacity*
- Income protection cover which will meet the definition of *temporary incapacity*.

Benefits which are not available with superannuation ownership are identified on pages 3 and 4.

If additional types of cover are required, then a cost efficient solution is to use Zurich's superannuation optimiser, which will allow access to cover which cannot be held in superannuation due to superannuation law, via a second policy held outside super.

More information about superannuation optimiser can be found on pages 41 to 43.

General policy conditions

The information provided below forms part of your Zurich policy terms and conditions after your policy is issued.

These general policy conditions apply to:

- Zurich Active Cover
- Zurich Child Cover
- Zurich Income Protector and Zurich Income Protector Plus

in addition to the product specific terms and conditions set out in the previous sections of this PDS.

The policy includes these policy conditions and the latest policy schedule, which will be sent when the policy is issued or when we issue you an updated policy schedule following a change. The policy schedule shows details of the policy including the policy type, ownership details, the lives insured, the amount of cover, any optional benefits chosen, any terms and conditions particular to the policy and the benefit expiry date/s.

Please check both these policy conditions and the policy schedule carefully to ensure that the policy provides the correct cover and has been established in accordance with the application.

Any reference to 'policy anniversary' is a reference to the anniversary of the policy commencement date shown on the policy schedule.

If we have accepted an application to vary an existing policy with a benefit or option which is no longer available (as the policy is described in the latest PDS), the terms and conditions for such benefit or option are set out in the latest version of the policy conditions that describes it.

This policy only provides the insurance benefits outlined, it does not have a cash value and is referable to our No. 2 Statutory Fund. The contract is between us and the owner of the policy. If the policy is held in superannuation, this will be the trustee of the fund.

All communications (including instructions, requests and notifications) must be made between the policy owner and us except where there is an agreement for communications to be made between another person and us. For example, this would apply to the life insured in the case of life insurance policies issued to an *eligible superannuation fund*.

Guarantee to renew

As long as each premium due is paid within the grace period allowed (see 'Unpaid premium' on the next page), the policy can be continued up to the latest benefit expiry date on the policy schedule regardless of changes in the life insured's personal circumstances.

Guaranteed upgrade of benefits

We may improve the terms of the benefits. If we do so without any change in the standard premium rates applying to that benefit under this class of policy, we will incorporate the improvement in the policy. Any medical condition existing at the time the improvement is offered or any injuries sustained prior will be excluded from being eligible for payment under the improved terms.

Changes to the policy

You have the option to make changes to your policy. A written request must be submitted if a change to the policy is required. In order to consider the request, we may ask for further information or require a specific application form. If we agree, we will confirm any changes in writing. Only an authorised member of our staff can agree to change or waive any condition of the policy. A financial adviser does not have authority to change or waive any policy conditions.

Worldwide cover

This policy provides cover 24 hours a day, seven days a week, worldwide.

Termination of the policy

The policy terminates on the first to occur of:

- the death of the life insured covered under the policy
- the latest benefit expiry date on the policy schedule
- the non-payment of any premium within 30 days of its due date
- termination of the related policy (if superannuation optimiser applies)
- our receipt of written notification to terminate this policy.

Some additional terminations apply depending on the cover selected:

Zurich Active Cover:

- the policy anniversary after the life insured's 99th birthday
- the *maximum amount payable* under benefit category AA reduces to nil (only in respect of Death & terminal illness cover)
- before the life insured's 65th birthday, the maximum combined total payable for all Health event claims has been reached, as explained under the Claim protector feature, see page 12 (only in respect of cover for *health events*)
- after the life insured's 65th birthday, the *maximum amount payable* under benefit categories A to E reduces to nil (only in respect of cover for *health events*).
- the payment of 100% of the Death benefit.

Zurich Child Cover:

- the policy anniversary after the last insured child's 18th birthday
- the payment of 100% of the Child cover benefit in relation to the last insured child under the policy.

Zurich Income Protector and Zurich Income Protector Plus:

- the *insured monthly benefit* expiry date
- the death of the life insured covered under the policy, unless a benefit continues to be payable under the Family care option or Home support option
- if the life insured's occupation is Special Risk (SR), the policy will terminate at the end of any 12 month period during which the life insured has not been engaged in *full-time paid employment* other than where this is a direct result of a claimable event under the policy or where we have given written permission for cover to continue.

Premium and reinstatements

Premium means the amount payable for the primary benefit and each optional benefit included in the policy, including any increase in benefit, stamp duty and any other government charges that may be levied from time to time.

Payment of premium

The premium is payable on the due dates shown on the policy schedule and subsequent notices. Premiums must be paid to keep the policy in force. All premiums must be paid in Australian dollars.

Unpaid premium

If any premium is not paid within 30 days of its due date, regardless of the method of payment chosen, the policy will lapse and no benefits are payable.

Reinstatement

In the first 30 days after lapse, we will reinstate the cover immediately if we receive a request and all outstanding premiums are paid. If the policy is reinstated in this period, no benefits will be paid for an event which occurred or was apparent while the policy was lapsed.

After 30 days, the policy can be considered for reinstatement if we receive a signed reinstatement application. We will consider an application for reinstatement within 12 months of the due date of the first unpaid premium but we may decline to reinstate or impose conditions. If the policy is reinstated in this 12 month period, the cover recommences from the date that we accept the application for reinstatement and no cover is provided during the period of lapse. This means that no payments will be made for an insured event which occurred or became apparent while the policy was lapsed.

Amount of premium

The premium payable from the start of the policy to the first policy anniversary is shown on the policy schedule. The policy anniversary is the anniversary of the commencement date shown on the policy schedule. Where relevant, the policy schedule will also show whether stepped premium or level premium applies.

Stepped premium

Where the stepped premium structure applies, the premium payable changes on each policy anniversary.

At that time, the premium is calculated for the life insured based on our current standard premium rates on the basis of:

- the gender, age next birthday and smoking status of the life insured
- the waiting period and benefit period (where relevant)
- the life insured's occupation (where relevant)
- the type of cover selected (where relevant)
- if applicable, any optional benefits applying
- the amount of cover (for Health events, terminal illness & death cover, the *initial amount of cover*)
- the frequency of payment
- any extra premium or loading applying.

Level premium

Where the level premium structure applies, the premium payable does not change on each policy anniversary until the policy anniversary following the life insured's 65th birthday, when premiums will be calculated each year as per the stepped premium structure.

If the amount of cover increases at the policy anniversary under the Inflation protection benefit, the premium for the increase in cover is calculated at that time from our current standard premium rates on the basis of:

- the gender, age next birthday and smoking status of the life insured
- the waiting period and benefit period (where relevant)
- the life insured's occupation (where relevant)
- the type of cover selected (where relevant)
- if applicable, any optional benefits applying
- the amount of the increase in cover for each benefit provided
- the frequency of payment
- any extra premium or loading applying.

Even when the level premium structure applies, the premium may change if we change the standard premium rates applying to a benefit provided by the policy.

Premium review

We cannot change the premium rates applying to a benefit provided by this policy unless we change the premium rates applicable to that benefit under this class of policy generally. We will provide at least 30 days notice of any changes in premium rates applying to this policy.

Taxes

The premium will include any taxes imposed on insurance premiums under applicable laws. Should any changes in the law or to any relevant person (eg. change in residency) result in additional or increased taxes or impost in relation to the policy, we may accordingly add these amounts to the premium or deduct them from any insurance benefits.

Overpayment of premium

If there is any overpayment of the premium, we may retain the overpayment, unless it exceeds $5.00.

Premium holiday

This provision does not form part of the policy if the policy is administered via platform.

A Premium holiday can be activated by request, on any policy which has been continuously in force for a period of at least 12 months. A Premium holiday can be activated for any number of months up to 12 months, starting from the latest unpaid premium due date.

When a Premium holiday is activated we will confirm in writing:

- the premium holiday start date
- the premium holiday end date and
- the next premium due date.

From the premium holiday start date until the premium holiday end date ('premium holiday period'):

- the policy is not in force for any life insured
- no premiums are required in respect of that period and
- Inflation protection increases will continue to be offered if a policy anniversary passes.

No cover is provided under the policy for any insured event which:

- is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) before the premium holiday start date, unless all elements of the insured event are already fully satisfied before the premium holiday start date or
- occurs or is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) at any time during the premium holiday period.

If we receive the requested premium within 30 days of the next premium due date, the policy will be back in force automatically on the premium holiday end date, subject to the above exclusion. The premium will recommence and become payable from the premium holiday end date. If the requested premium is not paid within 30 days of the next premium due date, the policy will terminate.

Varying a Premium holiday

Subject to our approval and on any additional terms we determine, a Premium holiday which has already started can be extended or reduced. We must receive the request 14 days before the earlier of the original or proposed premium holiday end date and the variation is not effective until we confirm our acceptance in writing.

If the premium holiday period is reduced, in addition to the conditions above, no cover is provided under the policy for any insured event which occurs or is apparent (through diagnosis, circumstances or symptoms which could lead to a claim) in the first 90 days after the revised premium holiday end date.

Restrictions and limitations

A Premium holiday cannot be used to access premiums that have already been paid. We will not refund any paid premiums under this provision.

Any subsequent Premium holiday must be separated by 12 months during which all requested premiums are paid on the policy.

A Premium holiday may only be used once in any 12 month period and a maximum total period of 12 months of Premium holiday is available over the life of the policy.

For the purposes of these policy conditions, when the policy is back in force following a period of Premium holiday, it is considered a reinstatement of the policy and certain benefits are not payable for a period of time after the premium holiday end date.

Residency and applicable laws

These policies are designed for customers who are resident in Australia. If you or the life insured becomes a resident of another country, you need to let us know as your policy may no longer be suitable for your individual needs, and you may no longer be eligible to pay premiums. The local laws and regulations of the jurisdiction to which you or the life insured moves may affect our ability to continue to service your policy in accordance with its terms and conditions.

We do not offer tax advice, so if you or the life insured decide to live outside Australia, we recommend obtaining advice on the tax consequences of changing your/the life insured's country of residence in relation to your policy. We will not be held liable for any adverse tax consequences that arise in respect of you or your policy as a result of such a change in residence.

We and other companies within the worldwide Zurich group of companies have obligations under Australian and foreign laws. Regardless of any other policy terms and conditions, we reserve the right to take any action (or not take any action) which could place us or another company within the group at risk of breaching Australian laws or laws in any other country. This may include suspending or terminating your policy.

All financial transactions, including acceptance of premium payments, claim payments and other reimbursements, are subject to compliance with applicable trade or economic sanctions laws and regulations.

We may terminate the policy if we consider you, the life insured, your directors and officers (if applicable), or beneficial owners as a sanctioned person, or you conduct an activity which is sanctioned, according to trade or economic sanctions laws and regulations. Further, we will not provide any cover, service or benefit to any party if we determine this places us at risk of breaching applicable trade or economic sanctions laws or regulations.

This policy is based on the legal and regulatory requirements applicable at the time the policy is issued. Should the legal and regulatory requirements change in a material way, Zurich is entitled to adapt the terms and conditions to the changed legal and regulatory requirements, provided the change is lawful.

Taxation

The following information is a guide only for individual policy owners.

It is based on current taxation laws, their continuation and their interpretation. Different tax implications may arise depending upon the entity owning the insurance policy. The taxation of superannuation is complex and will depend on your age, the type of contribution, and the status of the beneficiary. For information about your individual circumstances, contact your tax adviser.

Zurich Active Cover

In most cases, you cannot claim a tax deduction for the premiums you pay for your policy. One exception to this is if you take out a Zurich Active Cover policy as 'key person' insurance in a business. In this case, part or all of the premiums may be tax deductible, however, there may be other tax implications (such as fringe benefits tax). We recommend you consult your tax adviser on this issue.

If a tax deduction is not claimable for the premiums, the benefit paid is normally not assessable for taxation purposes*. If a tax deduction is claimable, the benefit paid may be assessable for taxation purposes.

* This assumes (1) related Death cover proceeds are either received by the original beneficial owner or by an owner who acquired the policy for no consideration, or (2) other cover proceeds are received by the life insured or a relative of the life insured (eg. *partner*, brother, sister, etc but not for example, a cousin). If your situation varies from either of these assumptions, there may be different taxation results.

Zurich Child Cover

You cannot claim a tax deduction for the premiums you pay for this policy. As a tax deduction is not claimable for the premiums, the benefit paid is normally not assessable for taxation purposes. However, any carer benefits you receive from your policy must be included in your tax return and will be taxed at your marginal income tax rate.

Zurich Income Protector/Plus

The premiums you pay for your policy, except for the premiums for the Lump sum accident option, Home support option, Family care option and Needlestick cover option, if applicable, can generally be claimed as a tax deduction by both employees and self-employed people. Every year we will tell you the amount of premium you have paid during that financial year and we will exclude the cost of any non-deductible benefits.

The Total disability benefits, Partial disability benefits, Funeral benefit and, if applicable, Super contributions option benefits you receive from your policy must be included in your tax return and will be taxed at your marginal income tax rate. However, lump sum amounts under the Lump sum accident option and Needlestick cover option are not generally taxable.*

If you have opted to insure your monthly superannuation contribution by selecting the Super contributions option then these benefits will be applied directly to your fund as superannuation contributions. Benefits are applied on your behalf pursuant to a 'direction to pay' which you give us by making an application for this benefit. This benefit counts as part of your income for tax purposes and we do not deduct or withhold tax from it. If you are self-employed you may be entitled to a deduction on some or all of the superannuation contributions made on your behalf.

* This assumes (1) proceeds are either received by the original beneficial owner or by an owner who acquired the policy for no consideration, or (2) cover proceeds are received by the life insured. If your situation varies from either of these assumptions, there may be different taxation results.

Policies held by superannuation trustees

Zurich Active Cover and Zurich Income Protector/Plus may be set up with external superannuation ownership.

Premiums paid by a superannuation fund for benefits that align with a condition of release are generally tax deductible to the fund. Benefits paid under the policy from the insurer to the trustee are generally not assessable as income or capital gains to the fund.

For self-managed superannuation funds, you should consult your tax adviser on the taxation implications of contributions made by your members to your fund and payments of insurance proceeds from your fund to members. For members of an external superannuation platform provider, please consult the taxation section of the PDS prepared by your platform provider.

Making a claim

The information provided below forms part of your Zurich policy terms and conditions after your policy is issued. Words or expressions shown in *italics* have their meaning explained in the relevant definitions section at the end of this PDS.

How to claim

The claimant should notify us as soon as is reasonably possible after the occurrence of the event giving rise to the claim. A claimant can do this by contacting Zurich Customer Care and a claim form will be forwarded to the claimant to complete, sign and return to us. Alternatively the claimant can access claim forms on our website www.zurich.com.au.

Claim requirements

A person claiming a benefit (claimant) is responsible for providing all evidence to support their claim to us at their expense.

We need the following items in a form satisfactory to us before we can assess any claim:

- the policy schedule
- proof of a claimable event or condition and when it occurred
- supporting evidence from appropriate specialist *medical practitioners* registered in Australia or New Zealand (or other country approved by us)
- proof of the life insured's age
- in the case of a claim under the Home support option, proof of the covered *partner's* age
- proof of incurred costs where the benefit payment is based on reimbursement
- if requested, a signed discharge from the person entitled to receive payment.

For any Advancement for funeral expenses, applications must be made by the person to whom the Death benefit is payable or by another person acceptable to us and must include the funeral invoice and either a copy of the death certificate or cause of death certificate.

For Zurich Income Protector/Plus, we will require some or all of the following, in a form that is satisfactory to us:

- financial evidence including evidence of other insurance cover on the life insured
- evidence of *claimable income*, *pre-application income*, *pre-disability income* and *post-disability income* and any payments received while on claim and
- for agreed value claims, evidence of income at the time of application (and, if we have accepted an application for an increase in cover, the life insured's income at the time you applied for the increase in cover).

Where any reference is made to the life insured's 'average monthly *income* in the 12 or 24 months immediately prior to a point in time', it can be measured as the previous financial year/s prior to that time rather than strictly the 12 or 24 months prior, if you have evidence which is aligned to financial years.

Assessing the claim

In assessing the claim we will also rely on any information the policy owner or the life insured disclosed to us as part of the application. Where information was not verified at the time of application we reserve the right to verify it at the time of claim.

For Zurich Active Cover and Zurich Child Cover, proof of the occurrence of any insured event must be supported by:

- one or more appropriate specialist *medical practitioners* registered in Australia or New Zealand (or in another country approved by us)
- confirmatory investigations including, but not limited to, clinical, radiological, histological and laboratory evidence
- if a *health events* claim is a result of a surgical procedure, we will require evidence that the procedure was medically necessary.

Our medical advisers must support the occurrence of the insured events. We reserve the right to require the life insured to undergo an examination or other reasonable tests to confirm the occurrence of the insured event.

For any *health event* claims, an appropriate medical specialist or suitably qualified neuropsychologist or clinical psychologist will be required to confirm the diagnosis of the condition.

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.

Where the diagnostic techniques used in our Health event condition definitions are impractical to apply or have been superseded due to medical improvements, we will consider other appropriate and medically recognised tests.

For Zurich Income Protector and Zurich Income Protector Plus:

- a claimable condition must also be supported by confirmatory investigations including, as appropriate (but not limited to) any clinical, radiological, histological and laboratory evidence that we reasonably require to substantiate the claim
- the life insured may be asked to provide copies of personal and business tax returns, assessment notices and/or other financial evidence to substantiate the life insured's income
- when it is necessary to enable us to calculate the amount of the benefit payable, the life insured must allow us to examine the life insured's business and personal financial circumstances.

We should be notified in writing within 30 days of the *sickness* or *injury*. If we are notified after 30 days, the waiting period will commence from the date that we are notified.

Medical examination

We may require the life insured to undergo an examination and reasonable tests, necessary to enable the diagnosis to be confirmed by a specialist *medical practitioner* appointed by us. If we request a medical examination by a *medical practitioner* we select, we will pay for it.

If a claim is made while the life insured is outside Australia, we will only continue to pay the Total disability benefit or the Partial disability benefit if the life insured has a medical examination every 12 months. The *medical practitioner* performing the examination must be approved by us. We will pay for this medical examination, but not for transport to attend it.

Payment of the Death benefit under Zurich Active Cover

If the policy owner had made a nomination of beneficiary or beneficiaries that was valid at the time of the life insured's death, we will pay the Death benefit under this policy in accordance with the directions and in the proportions specified by the policy owner if it is lawful for us to do so. If the nomination or nominations are subject to external dispute resolution processes, we will pay these benefits as directed by a court or by the relevant dispute resolution authority.

If the policy owner had not made a nomination of beneficiary or beneficiaries that was valid at the time of the life insured's death, we will pay any Death benefit to:

- the policy owner if the policy owner was not also the life insured
- the policy owner's estate if the policy owner was also the life insured.

All claims are paid in Australian dollars.

Payment of all other benefits

All benefits under this policy will be paid to the policy owner unless otherwise specified in these policy conditions.

All claims are paid in Australian dollars.

Definitions

Note that Definitions for *health events* are grouped together for convenience and begin on page 57.

accident/accidental means a fortuitous and unforeseen event, resulting in an injury, which is not caused, or contributed to, by an intentional act of the life insured.

accidental death means the life insured dies as a result of sustaining bodily injury caused by accidental, violent, external and visible means where death occurs within three calendar months of the *injury* being sustained.

accidental injury means bodily injury caused by accidental, violent, external and visible means while this policy is current.

any occupation means any occupation, business or employment for which the life insured is suited by education, training or experience that would generate earnings greater than 25% of the life insured's earnings in the most recent period of 12 months in which he or she was *gainfully employed*.

carer means the life insured begins to provide unpaid care for the first time and that care:

- is medically necessary due to disability, chronic illness or frail age
- was not previously required
- is likely to be required for a continuous period of at least six months

The commencement of care for the first time must be evidenced by either a letter from a *medical practitioner* or evidence that the life insured is receiving a Centrelink carer benefit for providing that care.

claimable income means:

- **if the benefit type is indemnity:** the life insured's highest average monthly *income* over any consecutive 12 months in the 24 month period preceding the waiting period applying to the claim.
- **if the benefit type is agreed value:** the higher of the life insured's:
  - highest average monthly *income* over any 12 consecutive months in the 24 month period preceding the waiting period applying to the claim, and
  - *pre-application income*.

Periods of unpaid leave, long service leave, maternity leave, paternity leave or sabbatical leave, up to a maximum of 12 months, will be added to the 24 month period referred to above. For example, if the life insured has been on maternity leave for six months during the 24 month period prior to *sickness* or *injury*, then the 24 month period will become the 30 month period immediately prior to *sickness* or *injury*.

consumer price index means the 'Weighted Average of Eight Capital Cities Index' as published by the Australian Bureau of Statistics or, if that index ceases to be published or is substantially amended, such other index we will select.

domestic duty/domestic duties means the tasks performed by a life insured whose sole occupation is to maintain the family home. These tasks include, unassisted by another person, cleaning of the home, cooking of meals for their family, doing the family laundry, shopping for the family's groceries and taking care of dependent children (where applicable).

Domestic duties do not include duties performed outside the life insured's home for remuneration or reward.

eligible superannuation fund means a superannuation fund through which an arrangement exists between the trustee and Zurich for members of the fund to be able to obtain Zurich Active insurance.

fracture means any fracture resulting from an accident requiring fixation, immobilisation or plaster cast as treatment.

full-time paid employment means being employed or self-employed, working 24 hours or more per week and receiving appropriate remuneration.

gainful employment / gainfully employed means the life insured is engaged in an occupation, business or employment for remuneration or reward.

health event means a *sickness* or *injury* or treatment for a *sickness* or *injury*, or in the case of the safety net categories, the functional capacity limitation arising from a *sickness* or *injury*, meeting the criteria as defined in the section 'Health events' starting on page 57.

The date of occurrence of the health event for the *safety net categories* is:

- for 'Inability to perform Activities of Daily Living (ADL)', the date the life insured is unable to perform the requisite number of *activities of daily living*
- for 'Occupational impairment' where the applicable criteria is based on irreversible *whole person impairment*, the date the life insured suffers *whole person impairment* of at least 25% due to *sickness* or *injury* or
- for 'Occupational impairment' where the applicable criteria is not based on irreversible *whole person impairment*, the date after the life insured has been absent from work, or absent from their *own occupation*, or not performing *domestic duties* (as applicable) for a continuous period of at least three months due to *sickness* or *injury*.

The date of occurrence of the health event for the other health event categories is:

- for a *sickness*, the date a *medical practitioner* confirms diagnosis, or
- for an *injury*, the date the *injury* occurs
- for treatment, the date the life insured undergoes the treatment.

In order to be eligible to claim, the occurrence of the health event as described above must occur after the benefit start date and before the benefit expiry date.

immediate family member means a *partner*, child, brother, sister or parent.

important income producing duties means duties which are essential to the life insured's ability to produce his/her *pre-disability income*.

income means income calculated:

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

It is based on total remuneration from personal exertion and includes salary, wages, director's fees, allowances, packaged fringe benefits, regular commissions, regular bonuses, regular overtime payments and pre-tax superannuation contributions.#

If the life insured is a business owner or self-employed, income also includes the life insured's share of net income of the business, based on his/her ownership of and/or role in the business (calculated after the deduction of expenses incurred in producing that income but before the deduction of tax).

Income does not include investment income, such as rental income from third parties and interest.

Please note that the result of this calculation for a business owner is likely to be different to what the life insured received from the business in the form of dividends, distributions and/or drawings.

Income does not include superannuation contributions if the Super contributions option has been selected, except where assessing whether the life insured is *totally disabled* or *partially disabled*.

initial amount of cover means the amount of cover originally issued by us, adjusted for indexation increases over time, plus any subsequent increases or decreases to the cover that you apply for and which are accepted by us.

injury means accidental bodily injury inflicted after the policy commencement date and while the policy is in force.

insured monthly benefit means the amount of monthly benefit applied for and accepted by us, plus indexation in accordance with the policy conditions. The insured monthly benefit will be set out in the original policy schedule and any subsequent updated policy schedule that we issue.

Benefit calculations for a claim will be based on the insured monthly benefit effective as at the end of the relevant waiting period.

limited claim period means a period of 12 months following the occurrence of a *health event*, during which time subsequent *health event* claims will be impacted by any amounts already paid.

loss of independent existence means the total and irreversible inability to perform at least two of the tasks under the self-care category of *activities of daily living*, as set out in the section 'Health event definitions'. 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.

loss of limbs means the total and irreversible loss of the use of two limbs, where 'limb' means whole hand or whole foot.

loss of sight means 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.

maximum amount payable means the maximum amount payable for each of the Health event benefit categories A to E.

medical practitioner means a medical practitioner legally registered to practise in Australia or New Zealand or a medical practitioner legally registered to practise in another country.

Medical practitioner does not include:

- the policy owner, his/her relative or his/her business partner or employee
- the life insured, his/her relative or his/her business partner or employee
- other para-medical professionals such as chiropractors, physiotherapists or naturopaths.

mental health condition means any disorder classified in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current at the start of the period of disability (or such replacement or successor publication or if none then such comparable publication as selected by us).

Such mental disorders include, but are not limited to, stress (including post traumatic stress), physical symptoms of a psychiatric illness, anxiety, depression, psychoneurotic, psychotic, personality, emotional or behavioural disorders or disorders related to substance abuse and dependency which includes alcohol, drug and chemical abuse dependency.

For the purposes of this policy, mental disorder does not include dementia (except where the dementia is related to any substance abuse or dependency), Alzheimer's Disease or mental disorder caused by head injuries.

monthly benefit means a periodic benefit payable under the policy conditions, including the Total or Partial disability benefit and any other in-built benefits paid in lieu of the Total or Partial disability benefit, ie. Specified injury benefit, Confined to bed benefit, Day 4 accident option and Trauma advancement option.

own occupation means the occupation, business or employment in which the life insured was *gainfully employed* at the time of the injury or *illness* for which the claim for *occupational impairment* is made (or, if not *gainfully employed* at that time, the occupation, business or employment in which the life insured was most recently *gainfully employed*).

partially disabled (for Zurich Income Protector) means the life insured is working or is capable of working but solely due to *sickness* or *injury* he/she:

- has a reduction of 20% or more in the ability to perform *important income producing duties* in the *primary occupation* he/she performed in the 12 consecutive months immediately before the *sickness* or *injury* causing disability and
- is under the regular care of, and following the advice of a *medical practitioner*.

After the Total disability benefit and/or Partial disability benefit has been paid for a period of 24 months, the ability to work is no longer based on a specific occupation. The life insured will only be partially disabled if he/she:

- has a reduction of 20% or more in the ability to perform the *important income producing duties* of each occupation to which he/she is reasonably qualified by education, training or experience and
- is under the regular care of, and following the advice of a *medical practitioner*.

If the life insured becomes partially disabled at a time when he/she hasn't been working for more than 12 consecutive months due to:

- unemployment
- long service leave
- maternity or paternity leave

we will determine eligibility for the Partial disability benefit based on any occupation to which he/she is reasonably qualified by education, training or experience.

partially disabled (for Zurich Income Protector Plus) means the life insured is working or is capable of working but solely due to *sickness* or *injury* he/she:

- has a reduction of 20% or more in the ability to:
  - perform *important income producing duties* or
  - generate *income* or
  - maintain the number of hours worked in the *primary occupation* he/she performed in the 12 consecutive months immediately before the *sickness* or *injury* causing disability and
- is under the regular care of, and following the advice of a *medical practitioner*.

If the life insured becomes partially disabled at a time when he/she hasn't been working for more than 12 consecutive months due to:

- unemployment
- long service leave
- maternity or paternity leave

we will determine eligibility for the Partial disability benefit based on any occupation to which he/she is reasonably qualified by education, training or experience.

partner means a person with whom the life insured is legally married or in a *partnership*.

partnership means a prescribed relationship which is registered under State or Territory law for the purposes of the Acts Interpretation Act 1901.

permanent incapacity means permanent incapacity as defined by superannuation law, as amended from time to time and applied as if Zurich was the trustee of the relevant superannuation fund and the life insured was a member of the fund.

'Superannuation law' includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations.

post-disability income means the life insured's *income* in the months following *sickness* or *injury* while *partially disabled*.

During the first three months that a *monthly benefit* is being paid, the life insured's post-disability income will not be considered post-disability income if it is 10% or less of his/her *pre-disability income*.

We will only pay benefits where the loss of income is a result of *sickness* or *injury*. Where *income* has been reduced as a result of causes other than *sickness* or *injury*, we will adjust the life insured's post-disability income so that it only reflects the proportion of the *income* lost as a result of *sickness* or *injury*. In doing so, we will take into account available medical evidence (including the opinion of the life insured's registered doctor) and any other relevant considerations directly related to the life insured's medical condition (including information provided by the policy owner or life insured).

pre-application income means:

- **if the life insured is a business owner or self employed, and his/her average monthly income in the 12 months immediately prior to application is greater than his/her average monthly income in the preceding 12 month period by 20% or more:** the average monthly *income* over the 24 months immediately prior to the application for cover or the most recent of any approved increases (other than indexation increases)
- **in all other cases:** the average monthly *income* over the 12 months immediately prior to application for cover or the most recent of any approved increases (other than indexation increases).

Pre-application income is increased by the percentage increase in the *consumer price index* published for the quarter falling immediately prior to the three months before each policy anniversary over that published for the quarter falling immediately prior to 15 months before that policy anniversary, up until the start of the waiting period applying to the claim.

pre-disability income (for endorsed agreed value and agreed value policies) means the life insured's highest average monthly *income* during any consecutive 12 months in the period starting 12 months immediately prior to commencement of this policy and ending when the waiting period applying to the claim begins.

We will index this amount each year on the anniversary of the date we accepted the claim, by the percentage increase in the *consumer price index* published for the quarter falling immediately prior to claim anniversary over that published for the same quarter in the previous year.

pre-disability income (for indemnity policies) means the life insured's highest average monthly *income* over any consecutive 12 months in the 24 month period preceding the waiting period applying to the claim.

Periods of unpaid leave, long service leave, maternity leave, paternity leave or sabbatical leave, up to a maximum of 12 months, will be added to the 24 month period. For example, if the life insured has been on maternity leave for six months during the 24 month period prior to *sickness* or *injury*, then the 24 month period will become the 30 month period immediately prior to *sickness* or *injury*.

We will index this amount each year on the anniversary of the date we accepted the claim, by the percentage increase in the *consumer price index* published for the quarter falling immediately prior to claim anniversary over that published for the same quarter in the previous year.

primary occupation means any type of business, service, trade or employment which encompasses the duties predominantly carried out by the life insured. It is not specific to any place of employment, particular employer or position.

progressive condition means any condition or procedure that is directly or indirectly related to the same underlying condition, medical cause or pathology as a prior claim.

rehabilitation program means a program or plan that:

- is designed to assist the life insured in returning to work either in his/her usual occupation or in any other occupation for which he/she is suited by training, education or experience and
- has been approved by an appropriately tertiary qualified vocational or rehabilitation specialist.

remaining amount of cover means the amount of cover under the policy following a Health event claim.

safety net categories means the 'Inability to perform Activities of Daily Living (ADL)' and 'Occupational impairment' Health event categories.

sickness means sickness or disease which first manifests itself after the policy begins, or a pre-existing sickness or disease disclosed to us in the application that we have not expressly excluded. Any sickness or disease that is the direct or indirect result of elective or donor transplant surgery within six months of the start or reinstatement of the policy is excluded.

superannuation payment limit means the amount we determine in our absolute discretion as satisfying the requirements of superannuation law in regard to the permissible insurance benefits payable in respect of a member of a superannuation fund and applied as if Zurich was the trustee of the relevant superannuation fund and the life insured was a member of the fund.

In making the determination, it is recognised that Zurich may interpret superannuation law in a particular manner which may change over time. We will make a determination in accordance with procedures maintained by us.

This limit may mean that the total benefit paid under the policy for any month will be capped so that the life insured is not receiving more in total (including all insurance benefits and income) then he/she was receiving before the *sickness* or *injury*.

'Superannuation law' includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations.

temporary incapacity means 'temporary incapacity' as defined by superannuation law as amended from time to time and applied as if Zurich was the trustee of the relevant superannuation fund and the life insured was a member of the fund.

For the life insured to meet this definition, this may include the life insured having to cease gainful employment (as defined under superannuation law) solely due to the *sickness* or *injury* for a period of at least one full day during the waiting period.

'Superannuation law' includes the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations.

terminally ill means the life insured is diagnosed with a *terminal illness*.

terminal illness means:

If the policy is not issued to the trustee of a superannuation fund: any condition caused by *sickness* or *injury*, where despite all reasonable medical treatment, the life insured is expected to live for no more than 24 months as confirmed and certified by:

- a specialist registered *medical practitioner* treating the condition with supporting evidence of the condition, possible medical treatment and the prognosis, and
- if required by us, a specialist registered *medical practitioner* approved by us who is an expert in the condition.

If the policy is issued to a trustee of a superannuation fund: any condition caused by *sickness* or *injury*, where despite all reasonable medical treatment, the life insured is expected to live for no more than 24 months as confirmed and certified* by:

- a specialist registered *medical practitioner* treating the condition with supporting evidence of the condition, possible medical treatment and the prognosis, and
- a registered *medical practitioner* approved by us.

* Each period of life expectancy, certified by the two *medical practitioners*, must not have ended.

totally disabled (for Zurich Income Protector) means solely as a result of a *sickness* or *injury*, the life insured:

- is not working in *gainful employment* and
- is unable to perform one or more of the *important income producing duties* of the *primary occupation* he/she performed in the 12 consecutive months immediately before the *sickness* or *injury* causing disability.

The life insured must also be under the regular care of, and following the advice of a *medical practitioner*.

After the Total disability benefit and/or Partial disability benefit has been paid for a period of 24 months, the ability to work is no longer based on a specific occupation. The life insured will only be totally disabled if he/she:

- is not working in *gainful employment* and
- is unable to perform one or more of the *important income producing duties* of each occupation to which he/she is reasonably qualified by education, training or experience.

The life insured must also be under the regular care of, and following the advice of a *medical practitioner*.

If the life insured becomes totally disabled at a time when he/she hasn't been working for more than 12 consecutive months due to:

- unemployment
- long service leave
- maternity or paternity leave

we will determine eligibility for the Total disability benefit based on any occupation to which he/she is reasonably qualified by education, training or experience.

totally disabled (for Zurich Income Protector Plus) means solely as a result of a *sickness* or *injury*, the life insured:

- is not working in *gainful employment* and
- is unable to perform one or more of the *important income producing duties* of the *primary occupation* he/she performed in the 12 consecutive months immediately before the *sickness* or *injury* causing disability

or

- is not working in *gainful employment* and
- has a reduction of 80% or more in the ability to generate *income* in the *primary occupation* he/she performed in the 12 consecutive months immediately before the *sickness* or *injury* causing disability

or

- is not working in *gainful employment* for more than 10 hours per week and
- is unable to perform his/her *important income producing duties* for more than 10 hours per week.

The life insured must also be under the regular care of, and following the advice of a *medical practitioner*.

If the life insured becomes totally disabled at a time when he/she hasn't been working for more than 12 consecutive months due to:

- unemployment
- long service leave
- maternity or paternity leave

we will determine eligibility for the Total disability benefit based on any occupation to which he/she is reasonably qualified by education, training or experience.

If the life insured is working less than 24 hours per week when he/she becomes totally disabled, we will replace '10 hours' with 'five hours' for the purpose of determining eligibility for the Total disability benefit.

uncomplicated pregnancy or childbirth means pregnancy, childbirth or termination which does not result in any serious medical complication. It includes participation in an IVF or similar program, normal discomforts such as morning sickness, backache, varicose veins, ankle swelling or bladder problems, giving birth, miscarrying or having a termination.

whole person impairment means whole person impairment based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment approved by us – the examining doctor will be provided with specific evaluating protocols.

Health events

The benefit payable for any covered *health event* is determined with reference to benefit categories A to E (from most serious to least serious).

In this section, the following body systems are used to group the covered *health events*.

- cancer
- heart and artery
- brain and nerves
- digestive system
- kidneys and urogenital tract
- lungs
- musculoskeletal system
- ear
- eye
- HIV/AIDS
- general

Within each body system, definitions are provided for the relevant benefit categories, as set out below.

For conditions which do not meet any of the definitions under the above body systems, there are two additional Health event categories which are designed to provide a safety net. These *safety net categories* are set out on page 65.

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 by a *medical practitioner*
	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 by a *medical practitioner*
	prostate cancer where the tumour is described histologically as TNM Classification T1 and has a Gleason score greater than 6
E	*carcinoma in situ*
	The presence of one or more melanomas which are classified as melanoma in situ or stage T1aN0M0.
	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 or intra-epidermal 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

Cancer (continued)

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	
A	Multiple myeloma 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	*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 90 days of the date an application for Heath events cover (including a fully completed Life Insured's Statement) is lodged with us 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 we waive the 90 day elimination period, as explained on page 15.

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 six 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 six 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 six 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 six 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 six 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 three readings, three 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 90 days of the date an application for Heath events cover (including a fully completed Life Insured's Statement) is lodged with us 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 we waive the 90 day elimination period, as explained on page 15.

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 90 days of the date an application for Heath events cover (including a fully completed Life Insured's Statement) is lodged with us 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 we waive the 90 day elimination period, as explained on page 15.

Health event category: Cognitive conditions	
A	*severe cognitive impairment*
B	*moderate cognitive impairment*
D	*mild cognitive impairment*
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
	Open surgery to remove a *benign central nervous system tumour*
E	Keyhole surgery to remove a *benign central nervous system tumour*
	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, abscesses, haematomas, trans-sphenoidal hypophysectomy and biopsy procedures.

Brain and nerves (continued)

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*
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.

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

Digestive system (continued)

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
	permanent ongoing faecal incontinence unresponsive to either medical or surgical therapy, including colostomy
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 two 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 three 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.

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 life insured's medical condition, the life insured 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.

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 three months and under the continuous care of a respiratory physician
	Multiple episodes of recurrent pulmonary emboli separated by a period of six months requiring insertion of a veno-caval filter

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 two or more *occupational core duties*, where these duties require the use of the specific musculoskeletal function to complete at least 80% of the life insured's average weekly work hours, and • earn an *income* in any occupation which provides at least 75% of the life insured's *income* in the most recent 12 month period in which they were *gainfully employed*
	permanent and irreversible *whole person impairment* of at least 60%
B	*permanent* and irreversible *loss of the use of two limbs*
C	*permanent* and irreversible *whole person impairment* of at least 40%
D	*permanent* and irreversible *loss of use of one upper limb*
	permanent and irreversible *whole person impairment* of at least 25%
E	*permanent* and irreversible *loss of use of one lower limb*
	Le Fort III facial reconstruction surgery
	Amputation of two 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

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

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

HIV/AIDS

A	*advanced AIDS*
B	*accidental HIV infection*

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

- if a treatment is developed and approved which renders the HIV virus inactive and non-infectious, or
- if the life insured has elected not to take an approved vaccine that is recommended by the relevant government body for use in the life insured's occupation and is available prior to the event which causes infection.

General

Health event category: Hospital admission	
D	*intensive care unit (ICU)* admission for at least five weeks where ongoing assisted mechanical ventilation is required for at least three weeks
E	Hospital admission for at least four weeks after spending at least one 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 five week period)

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

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

Safety net

Health event claims will always be assessed first against the relevant definitions for the affected body system, as set out on the previous pages of this section.

If in our opinion you do not meet a definition under any specific body system, we will assess you against the *safety net categories* set out below. You cannot elect to access these *safety net categories* if you meet the definition of a covered *health event* in any other Health event category in order to access a higher benefit payment for your condition.

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 of 6 *activities of daily living*
B	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 3 out of 6 *activities of daily living*
C	Presence of a medically recognised disease or disorder resulting in *permanent* and irreversible inability to perform 2 out of 6 *activities of daily living*
Health event category: Occupational impairment	
A	*occupational impairment*

Health event 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 Zurich 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 event benefit categories' and 'Health event definitions' sections of this PDS.

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. In the case of angioplasty, an angioplasty procedure will not be considered a *progressive condition* to a prior angioplasty procedure and a subsequent claim for angioplasty will be paid if it occurs outside of the *limited claim period*.
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 basis of an inability to perform *activities of daily living*.

Health event definitions

accidental HIV infection means *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 life insured'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 life insured starting antiviral therapy**.

The *accident* causing infection with HIV must have occurred after the date of policy commencement, or reinstatement, whichever is latest.

HIV infection caused by any means other than those described above, including recreational intravenous drug use and sexual activity, other than assault as described is excluded.

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.

activities of daily living (ADL) means the six 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 performed, the whole category is scored as an inability to perform that ADL category.

The ability to perform the tasks of each ADL category 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.

When a life insured is being measured on their ability to perform any tasks of an ADL category:

- all tasks for which an impairment is present must be scored, irrespective of the medical condition(s) causing the impairment, and
- assistive devices must be used, where applicable.

Supporting objective medical evidence or investigations must be provided for each task of an ADL category scored. 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 1: Self-care

Specific tasks:

- bathing
- grooming
- dressing
- eating and feeding
- bowel and bladder function
- mobility

Score required in order to be considered unable to perform this ADL category:

- 'cannot' in at least one specific task, or
- 'with help' in at least two specific tasks.

ADL category 2: Communication

Specific tasks:

- speaking
- reading
- writing
- keyboard use

Score required in order to be considered unable to perform this ADL category:

- 'cannot' in at least one specific task, or
- 'minimal' in at least two specific tasks.

ADL category 3: Physical activity

Specific tasks:

Intrinsic

- standing
- sitting
- reclining
- walking
- stooping
- squatting
- kneeling
- reaching
- bending
- twisting

Functional

- carrying
- lifting
- pushing
- pulling
- climbing
- exercising

Score required in order to be considered unable to perform this ADL category:

- cannot' in at least three specific tasks, or
- 'with help' in at least six specific tasks.

ADL category 4: Sensory function

Specific tasks:

- hearing
- seeing
- tactile sensation
- tasting
- smelling

Score required in order to be considered unable to perform this ADL category:

- 'cannot' in at least one specific task, or
- 'minimal' in at least two specific tasks.

ADL category 5: Hand functions	
Specific tasks:	
• grasping	• percussive movements
• holding	• sensory discrimination
• pinching	
Score required in order to be considered unable to perform this ADL category: • 'cannot' in at least one specific task, or • 'minimal' in at least two specific tasks.	

ADL category 6: Advanced functions	
Specific tasks:	
• travel (riding, driving)	• problem solving
• sexual function	• stress adaptation
• social interaction	• sleep pattern
• understand concepts	• recreational/social activities
• memory	
Score required in order to be considered unable to perform this ADL category: • '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).

acute renal failure means 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 Intensive Care Unit accredited by the Australian Council on Healthcare Standards (ACHS)

advanced AIDS means 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.

aplastic anaemia means 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.

benign central nervous system tumour means a non-malignant tumour of the central nervous system, including tumours of the brain and spinal cord, 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.

bone marrow or stem cell transplant means the life insured is the recipient of a bone marrow or stem cell transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner.*

cancer means 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 means a focal autonomous new growth of carcinomatous cells 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 fallopian tube is limited to the tubal mucosa.

Carcinoma in situ of the vulva also requires high grade dysplasia of the cervix at CIN III or above, confirmed histologically by biopsy.

Note: FIGO refers to the staging method of The Federation Internationale de Gynecologie et d'Obstetrique.

cardiomyopathy means disease of the heart muscle causing it to enlarge and become weaker.

chronic lung disease means 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.

chronic renal failure means chronic irreversible failure of the function of both kidneys requiring *permanent* and ongoing haemodialysis or peritoneal dialysis. The life insured must be under the continuous care of a renal physician.

colectomy means total colectomy requiring *permanent* colostomy or resulting in ileorectal anastomosis.

colostomy/ileostomy means the creation of a *permanent* non-reversible opening, linking the colon and/or ileum to the external surface of the body.

coma means 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.

complete loss of hearing means 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: 5th edition, with and without the use of an appropriate aid.

complete loss of hearing in one ear means the total and irreversible loss of hearing in one ear, with and without the use of an appropriate aid.

corneal transplant means the life insured is the recipient of a cornea, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.

coronary artery bypass graft means the undergoing of coronary artery bypass grafting for the treatment of coronary artery disease that is considered the appropriate and necessary treatment by a *medical practitioner*. Angioplasty, intra-arterial procedures or other non-surgical techniques are excluded.

crohn's disease means diagnosis of Crohn's disease that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.

diagnosis of bilateral hemianopia means unequivocal diagnosis of complete and *permanent* bilateral hemianopia as diagnosed by an appropriate medical specialist.

diagnosis of cavernous sinus thrombosis means unequivocal diagnosis of cavernous sinus thrombosis by a medical specialist via an MRI scan.

diagnosis of motor neurone disease means unequivocal diagnosis of motor neurone disease.

diagnosis of multiple sclerosis means unequivocal diagnosis of multiple sclerosis, evidenced by appropriate neuro-imaging and spinal fluid abnormalities.

diagnosis of muscular dystrophy means unequivocal diagnosis of muscular dystrophy, which causes progressive and selective degeneration and weakness of voluntary muscles.

diagnosis of myasthenia gravis means unequivocal diagnosis of myasthenia gravis.

diagnosis of parkinson's disease means unequivocal diagnosis of Parkinson's disease. Parkinson's disease as a result of medication or drugs is excluded.

endovascular heart valve repair or replacement means heart valve repair or replacement via percutaneous intravascular techniques not involving open thoracotomy.

endovascular iliac or femoral artery aneurysm repair means iliac or femoral artery aneurysm repair or replacement via percutaneous techniques.

endovascular or open carotid artery stenosis repair means the undergoing of percutaneous or open carotid artery stenosis repair.

endovascular repair of an aortic aneurysm means abdominal or thoracic aneurysm repair or replacement via percutaneous techniques.

endovascular repair to correct structural lesions of the heart means repair to correct structural lesions of the heart via percutaneous techniques.

end stage liver disease means 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.

gastrointestinal disease means disease of the gastrointestinal system evidenced by organic pathology obtained by biopsy and present continuously for at least 12 months.

heart attack means myocardial infarction, characterised by the death of a portion of heart muscle due to inadequate blood supply.

A rise and/or fall of cardiac enzymes, Troponin or other biochemical markers must be present and caused by myocardial infarction, with at least one value above generally accepted laboratory levels of normal. Furthermore, the clinical evidence and disease management pathway must be consistent with the diagnosis of acute myocardial infarction and confirmed as the hospital discharge diagnosis.

If the above is inconclusive then we will consider a claim based on conclusive evidence that myocardial infarction has occurred.

heart or heart and lung transplant means the life insured is the recipient of a heart or heart and lung transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner.*

heart valve replacement or repair means 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.

impairment of the lower limb means *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.

impairment of the upper limb means *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.

inner ear or middle ear surgery means surgery to the cochlear or middle ear bones, where the surgery is considered the appropriate and necessary treatment by a medical specialist.

intensive care unit (ICU) means an Intensive Care Unit accredited by the Australian Council on Healthcare Standards (ACHS)

liver transplant means the life insured is the recipient of a liver, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner.*

loss of musculoskeletal function means 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*, or

c) at least 50% *impairment of the lower limb.*

The condition must be *permanent* and supported by appropriate radiological evidence.

loss of the use of two limbs means 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 lower limb means the *permanent* and irreversible total loss of the use of one whole foot.

loss of use of one upper limb means the *permanent* and irreversible total loss of the use of one whole hand.

lung or heart and lung transplant means the life insured is the recipient of a lung or heart and lung transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.

mild cognitive impairment means total and *permanent* deterioration or loss of cognitive capacity supported by neuropsychometric testing, as set out in the Zurich Neuropsychometric Test* (as current at the time of testing) with test scores of 'below average', as defined in the test score criteria, in at least two of the following domains:

- intelligence
- memory
- visuo-spatial
- attention
- language
- executive functioning.

* The Zurich Neuropsychometric Test, including scoring criteria, will be sent to the testing practitioner and is available on our website, zurich.com.au.

moderate cognitive impairment means total and *permanent* deterioration or loss of cognitive capacity supported by neuropsychometric testing, as set out in the Zurich Neuropsychometric Test* (as current at the time of testing) with test scores of 'below average', as defined in the test score criteria, in at least four of the following domains:

- intelligence
- memory
- visuo-spatial
- attention
- language
- executive functioning.

*The Zurich Neuropsychometric Test, including scoring criteria, will be sent to the testing practitioner and is available on our website, zurich.com.au.

occupational core duties means the primary *income* generating tasks being performed by the life insured in the occupation, business or employment in which they were *gainfully employed* at the time of the *sickness* or *injury* (or if not *gainfully employed* at that time, the occupation, business or employment in which the life insured was most recently *gainfully employed*).

occupational impairment means the relevant definition of occupational impairment that applies to the life insured, as shown on your policy schedule.

Before the policy anniversary following the life insured's 65th birthday:

a) if the own occupation definition applies, due to *sickness* or *injury*:

- the life insured has been absent from their *own occupation* for a continuous period of at least three months, and in our opinion, is incapacitated to the extent that they are unlikely ever again to be able to engage in his/her *own occupation*

  or

- the life insured has suffered irreversible *whole person impairment* of at least 25% which shows no further chance of improvement, and in our opinion, is incapacitated to the extent that he/she is unlikely ever again to be able to engage in his/her *own occupation*

b) if the any occupation definition applies, due to *sickness* or *injury*:

- the life insured has been absent from work for a continuous period of at least three months, and in our opinion, is incapacitated to the extent that he/she is unlikely ever again to be able to engage in *any occupation*

  or

- the life insured has suffered irreversible *whole person impairment* of at least 25% which shows no further chance of improvement, and in our opinion, is incapacitated to the extent that he/she is unlikely ever again to be able to engage in *any occupation*

c) if the domestic duties definition applies, due to *sickness* or *injury*:

- the life insured has not performed *domestic duties* for a continuous period of at least three months and, in our opinion, is incapacitated to the extent that it is unlikely he/she will be able to perform *domestic duties* and it is unlikely that he/she will engage in *any occupation* ever again

  or

- the life insured has suffered irreversible *whole person impairment* of at least 25% which shows no further chance of improvement and, in our opinion, is incapacitated to the extent that it is unlikely he/she will be able to perform *domestic duties* and it is unlikely that he/she will engage in *any occupation* ever again

d) if the occupational impairment definition shown on your policy schedule is 'not applicable', then no occupational impairment cover applies.

e) if the occupational impairment definition shown on your policy schedule is 'definition assessment at claim', whether cover for occupational impairment is included and, if so,

which definition of occupational impairment applies, will be determined by Zurich at the time of claim, based on the information provided to us during the application process and in accordance with the standard Active underwriting rules applying as at May 2012.

f) if the occupational impairment definition shown on your policy schedule is 'occupational underwriting at claim' and if the life insured provides satisfactory information to us at the time of claim regarding the duties performed and hours worked as at the date of application, whether cover for occupational impairment is included and, if so, which definition of occupational impairment applies, will be determined by Zurich at the time of claim in accordance with Zurich's standard Active underwriting rules applying as at May 2012.

open aortic graft surgery – abdominal or thoracic means open surgery with aortic grafting that is considered the appropriate and necessary treatment by a *medical practitioner* 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 means 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.

paraplegia means total, *permanent* and irreversible loss of the use of two limbs as a consequence of *sickness* or *injury*, where a limb is defined as the shoulder down to the hand or the hip down to the foot.

percutaneous coronary angioplasty means the undergoing of percutaneous balloon dilatation, atherectomy or stent placement to correct a narrowing or blockage that is considered the appropriate and necessary treatment by a *medical practitioner* on the basis of angiographic evidence.

permanent means irreversible, present for a minimum of six months and expected to show no improvement or reversibility, while on optimal therapy, if appropriate (unless the *health event* specifically references an alternate timeframe over which the permanency will be measured).

permanent cardiac defibrillator insertion means the life insured has a *permanent* cardiac defibrillator inserted. Cardiac pacemakers are specifically excluded.

permanent total aphasia means 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.

permanent vegetative state means 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 three months with no hope of recovery as confirmed by a medical specialist.

pneumonectomy means removal of an entire lung.

portal vein thrombosis means isolated thrombosis of the portal vein.

prostate cancer means localised prostate cancer characterised by focal autonomous new growth of cancer cells.

psychiatric condition means 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.

quadriplegia means total, *permanent* and irreversible loss of the use of all four limbs as a consequence of *sickness* or *injury*, where a limb is defined as the shoulder down to the hand or the hip down to the foot.

radical or modified radical mastoidectomy means removal of the mastoid bone and bones of the middle ear due to chronic disease.

renal transplant means the life insured is the recipient of a kidney transplant, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.

severe burns means tissue injury caused by thermal, electrical or chemical agents causing third degree burns.

severe cognitive impairment means total and *permanent* deterioration or loss of cognitive capacity supported by neuropsychometric testing, as set out in the Zurich Neuropsychometric Test* (as current at the time of testing) with test scores of 'below average', as defined in the test score criteria, in all of the following domains:

- intelligence
- memory
- visuo-spatial
- attention
- language
- executive functioning.

* The Zurich Neuropsychometric Test, including scoring criteria, will be sent to the testing practitioner and is available on our website, zurich.com.au.

severe congestive cardiac failure means failure of the functioning of the ventricles of the heart with poor cardiac output and congestion of the lungs or systemic veins.

severe crohn's disease means 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.

severe epilepsy means averaging more than two 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

severe loss of binaural hearing means 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: 5th edition, with and without the use of an appropriate aid.

severe osteoporosis means before the age of 50, the life insured:

- 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).

severe peripheral vascular disease means severe arterial insufficiency in vessels resulting in ischaemia of the limbs as a consequence of atherosclerosis.

severe ulcerative colitis means diagnosis of ulcerative colitis that has failed to be controlled by standard therapy including cortisone treatment, and requires *permanent* immunosuppressive medication.

small bowel transplant means the life insured is the recipient of a small bowel, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.

stroke means a neurological event caused by a cerebrovascular incident. The stroke must:

- be confirmed by an appropriate medical specialist
- be evidenced by the acute onset of objective neurological signs and clinical symptoms, and
- be evidenced by neuro-imaging.

Transient ischaemic attacks, cerebral events due to reversible neurological deficits and migraine are excluded.

surgical repair to correct structural lesions of the heart means 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.

total lack of social interaction means 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.

total pancreas transplant means the life insured is the recipient of a total pancreas, where the transplant is considered the appropriate and necessary treatment by a *medical practitioner*.

total pericardiectomy for constrictive pericarditis means the undergoing of a thoracotomy with a total pericardiectomy for constrictive pericarditis.

transplant waiting list means inclusion on an official Australian transplant waiting list, approved by us. The inclusion must be upon the advice of an appropriate medical specialist.

whole person impairment means whole person impairment based on the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition, or an equivalent guide to impairment approved by us – the examining doctor will be provided with specific evaluating protocols.

Child cover definitions

activities of daily living are:

(1) bathing and showering

(2) dressing and undressing

(3) eating and drinking

(4) using a toilet

(5) moving from place to place by walking, wheelchair or with the assistance of a walking aid.

bacterial meningitis means all potential manifestations of bacterial meningitis causing:

- *significant permanent impairment* or
- a permanent and total inability to perform without physical help from someone else, at least one of the *activities of daily living*.

benign tumour of the brain or spinal cord means a non-cancerous tumour in the brain or spinal cord which is histologically described and which produces neurological deficit causing *significant permanent impairment* or the undergoing of radical surgery for its removal.

We do not cover any of the following:

- cysts, granulomas and cerebral abscesses
- malformations in, or of, the arteries or veins of the brain
- haematomas or
- tumours in the pituitary gland.

blindness means the irrecoverable loss of sight in both eyes as a result of *sickness* or *injury*. The extent of the visual loss must be such that the eyesight is reduced to or less than 6/60 central acuity or degree of vision of less than or equal to 20 degrees.

cardiomyopathy means impaired ventricular function resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

chronic kidney failure means end stage renal failure presenting as chronic irreversible failure of both kidneys to function as a result of which permanent regular renal dialysis is instituted or renal transplant undertaken.

deafness means severe hearing impairment in both ears, whether aided or unaided, resulting in an average hearing threshold in both ears of 91db or greater as measured at 500, 1000 and 1500 Hz.

diplegia means the permanent and total loss of function of both sides of the body due to disease, illness or injury of the brain or spinal cord.

encephalitis means an inflammatory disease of the brain resulting in neurological deficit causing:

- at least 25% impairment of whole person function that is permanent or
- total and permanent inability to perform at least one of the *activities of daily living*.

hemiplegia means the permanent and total loss of function of one side of the body due to disease, illness or injury of the brain or spinal cord.

loss of limbs or sight means the entire and irrevocable loss of use of two or more of the sight in one eye, and a hand or a foot.

loss of speech means the total loss of speech both natural and assisted as a result of *sickness* or *injury* which is permanent. Loss of speech related to any psychological cause is excluded.

major head trauma means accidental cerebral injury resulting in permanent neurological deficit:

- causing *significant permanent impairment* or
- which results in a permanent and irreversible inability of the life insured, to perform, without the physical assistance of an adult, any one of the *activities of daily living*.

major organ transplant means the life insured:

- undergoes the organ transplant or
- upon specialist medical advice is placed on an official Australian acute care hospital waiting list to undergo organ transplant or
- undergoes permanent mechanical replacement

for one or more of the following: kidney, heart, liver, lung, pancreas, small bowel and bone marrow.

The transplantation of all other organs or parts of any organ or of any other tissue is excluded.

malignant cancer means the presence of a malignant tumour, including leukaemia, malignant lymphoma and other haemopoietic malignancies.

The tumour must be confirmed by histological examination, or appropriate pathological testing in the case of non solid tumours, and:

- the life insured must require major interventionist therapy including surgery, radiotherapy, chemotherapy, biological response modifiers or any other major treatment, or
- the tumour must be sufficiently advanced such that major interventionist therapy is no longer recommended.

The following cancers are specifically excluded:

- chronic lymphocytic leukaemia less than RAI Stage 1
- all cancers described as carcinoma in situ. Carcinoma in situ of the breast is covered only if it requires:
  - the removal of the entire breast, including nipple sparing mastectomy or
  - breast conserving surgery and radiotherapy or
  - breast conserving surgery and chemotherapy (chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells)

  Carcinoma in situ of the breast treated by breast conserving surgery and other forms of adjuvant systemic therapy, including endocrine manipulation therapy, hormonal manipulation therapy or non-endocrine adjuvant therapy, is not covered.
- all skin cancers unless:
  - they have metastasised to other organs or
  - the tumour is a malignant melanoma of stage T1bN0M0 or higher
- prostate cancers diagnosed as T1 with a Gleason score of 5 or less, unless major interventionist therapy is performed.

paraplegia means the permanent and total loss of use of both legs resulting from disease, illness or injury of the brain or spinal cord.

quadriplegia means the permanent and total loss of use of both arms and both legs resulting from disease, illness or injury of the brain or spinal cord.

severe accident or illness requiring intensive care means an accident or illness that has resulted in:

- the life insured requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours a day) in an authorised intensive care unit of an acute care hospital and
- *significant permanent impairment*.

severe burns means tissue injury caused by thermal, electrical or chemical agents causing third degree (full thickness) burns to at least:

- 20% of the body surface area as measured by The Rule of 9 or the Lund & Browder Body Surface chart or
- 50% of each hand and/or 50% of the face.

significant permanent impairment means a permanent impairment of at least 25% of whole person function as defined in the current edition of the American Medical Association publication 'Guide to the Evaluation of Permanent Impairment', or an equivalent guide to impairment approved by us.

single loss of limb or eye means the total and permanent loss of use of:

- one foot or
- one hand or
- sight in one eye (to the extent of 6/60 or less).

stroke means a cerebrovascular event producing neurological sequela lasting at least 24 hours. This requires clear evidence on a Computerised Tomography (CT), Magnetic Resonance Imaging (MRI) or similar scan that a stroke has occurred and of:

- infarction of brain tissue or
- intracranial or subarachnoid haemorrhage.

Cerebral symptoms due to transient ischaemic attacks, reversible neurological deficit, migraine, cerebral injury resulting from trauma or hypoxia, disturbances of vision or balance due to disease of the eye, optic nerve or the vestibular apparatus of the ear are excluded.

terminally ill means the life insured is diagnosed with a *terminal illness*.

terminal illness means any condition caused by *sickness* or *injury*, where despite all reasonable medical treatment, the life insured is expected to live for no more than 24 months as confirmed and certified by:

- a specialist registered *medical practitioner* treating the condition with supporting evidence of the condition, possible medical treatment and the prognosis, and
- if required by us, a specialist registered *medical practitioner* approved by us who is an expert in the condition.

Trauma advancement option definitions

coronary artery bypass surgery means the actual undergoing of coronary artery bypass surgery which is considered medically necessary to correct or treat coronary artery disease but not including angioplasty, other intra-arterial or laser procedures.

heart attack means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the 99th percentile of the upper reference limit and at least one of the following:

- signs and symptoms of ischaemia consistent with myocardial infarction or
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block [LBBB]) or
- development of pathological Q waves in the ECG or
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

If the above tests are inconclusive or our noted diagnostic techniques are impractical to apply or have been superseded, we will consider other appropriate and medically recognised tests.

A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease which is not performed as necessary treatment for a heart attack is excluded. Also excluded are other acute coronary syndromes including but not limited to angina pectoris, and other causes of cardiac biological marker rise included but not limited to pulmonary embolism.

malignant cancer means the presence of a malignant tumour, including leukaemia, malignant lymphoma and other haemopoietic malignancies.

The tumour must be confirmed by histological examination, or appropriate pathological testing in the case of non solid tumours, and:

- the life insured must require major interventionist therapy including surgery, radiotherapy, chemotherapy, biological response modifiers or any other major treatment, or
- the tumour must be sufficiently advanced such that major interventionist therapy is no longer recommended.

The following cancers are specifically excluded:

- chronic lymphocytic leukaemia less than RAI Stage 1
- all cancers described as carcinoma in situ. Carcinoma in situ of the breast is covered only if it requires:
  - the removal of the entire breast, including nipple sparing mastectomy or
  - breast conserving surgery and radiotherapy or
  - breast conserving surgery and chemotherapy (chemotherapy means the use of drugs specifically designed to kill or destroy cancer cells)

  Carcinoma in situ of the breast treated by breast conserving surgery and other forms of adjuvant systemic therapy, including endocrine manipulation therapy, hormonal manipulation therapy or non-endocrine adjuvant therapy, is not covered.
- all skin cancers unless:
  - they have metastasised to other organs or
  - the tumour is a malignant melanoma of stage T1bN0M0 or higher
- prostate cancers diagnosed as T1 with a Gleason score of 5 or less, unless major interventionist therapy is performed.

stroke means a cerebrovascular event producing neurological sequela lasting at least 24 hours. This requires clear evidence on a Computerised Tomography (CT), Magnetic Resonance Imaging (MRI) or similar scan that a stroke has occurred and of:

- infarction of brain tissue or
- intracranial or subarachnoid haemorrhage.

Cerebral symptoms due to transient ischaemic attacks, reversible neurological deficit, migraine, cerebral injury resulting from trauma or hypoxia, disturbances of vision or balance due to disease of the eye, optic nerve or the vestibular apparatus of the ear are excluded.

How to contact us

Enquiries and policy admin

We can answer enquiries relating to any of the products in this PDS, and if you take out a policy with us, we can help you to keep your policy details up to date.

We can also help you with basic alterations to your policy, to help keep cover in line with your needs – for example if you wish to exercise an option on your policy.

Please contact Zurich Customer Care in the most convenient way for you:

131 551

client.service@zurich.com.au

Locked Bag 994
North Sydney NSW 2059

www.zurich.com.au

Financial advice

Your financial adviser should be your first point of contact for financial advice. Zurich can only provide you with factual information about these products and how they operate.

Zurich head office
Zurich Australia Limited
5 Blue Street
North Sydney NSW 2060

Additional support

We recognise that some customers require additional support, for example customers who are from a non-English speaking background. Your financial adviser will help you through the process at the time when you apply for a policy, if you make a change to your policy, if you make a claim or if you wish to make a complaint. If you contact us and we identify that you need additional support or that you are experiencing financial hardship, we will provide you with reasonable additional support including providing you with options available under your policy.

Complaints resolution

If you have a complaint about any product described in this PDS, you should contact Zurich Customer Care on 131 551. We will aim to acknowledge any complaint within 5 days and to resolve your complaint within 45 days. If you are not satisfied with the response you receive from us, or we fail to resolve the complaint within 45 days, you can raise the matter with the Financial Ombudsman Service (FOS). FOS is an independent body designed to help you resolve complaints relating to your Zurich product, as well as complaints relating to financial or investment advice and sales of financial or investment products. You can contact FOS at GPO Box 3, Melbourne VIC 3001. The telephone number is: 1300 780 808 and the email address is: info@fos.org.au.

If you wish to complain about a policy which is held in super, you will need to contact the superannuation fund trustee.

Issue Date: 18 December 2017

ZURICH®

Zurich Insurance-only Superannuation Plan

Product Disclosure Statement

This Product Disclosure Statement ('PDS') is issued by Equity Trustees Superannuation Limited ABN 50 055 641 757 AFSL 229757 RSEL L0001458 (the 'Trustee') as trustee of the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust ABN 68 964 712 340 (the 'Zurich Plan') and Zurich Australia Limited ABN 92 000 010 195 AFSL 232510 ('Zurich') who is the issuer of the insurance policies to the Trustee for the benefits provided from the Zurich Plan. This PDS dated 18 December 2017 (Zurich Plan PDS) covers financial products issued by the Trustee and insurance products issued by Zurich under Zurich Wealth Protection, Zurich Active and Zurich FutureWise policies. The Trustee and Zurich each take full responsibility for the whole of the Zurich Plan PDS.

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This PDS contains important information about the Zurich Insurance-only Superannuation Plan, a division of the Aon Master Trust ABN 68 964 712 340 (the 'Zurich Plan'). The trustee is Equity Trustees Superannuation Limited (the 'Trustee') ABN 50 055 641 757 AFSL 229757 RSEL L0001458. The Plan provides members with access to death and disablement cover through superannuation, and accepts contributions and rollovers only for the purposes of paying premiums for that cover. Members do not have an account balance in the Zurich Plan.

This PDS incorporates by reference the Zurich Wealth Protection and Zurich Active PDSs issued by Zurich Australia Limited with an issue date of 15 May 2017 and the Zurich FutureWise PDS issued by Zurich Australia Limited with an issue date of 1 October 2016, as supplemented or replaced from time to time, for which Zurich is responsible. The Zurich Wealth Protection, Zurich Active and Zurich FutureWise PDSs may be obtained from the Trustee or Zurich on request, at no charge or are available from your financial adviser. Unless otherwise indicated, a reference to this 'PDS' or 'product disclosure statement' includes both this PDS for the Zurich Plan and the applicable PDS for the insurance product issued by Zurich. The Trustee is not the issuer of the insurance policies or the Zurich Wealth Protection, Zurich Active and Zurich FutureWise PDSs.

The Trustee is the provider of death and disablement superannuation benefits in the Zurich Plan which are wholly insured benefits. Zurich Australia Limited ABN 92 000 010 195 AFSL 232510 ('Zurich') is the provider of insurance cover to members of the Zurich Plan. Further information about the insurance cover you can apply for under this PDS is in the separate PDSs issued by Zurich ('Zurich PDSs'). Applications to the Trustee for membership of the Zurich Plan must be made along with an application for insurance. The application for membership of the Zurich Plan and application for insurance can be submitted electronically by your adviser acting on your behalf or on a current paper application form. You should consider both this PDS issued jointly by the Trustee and Zurich and the relevant PDS issued by Zurich (which also forms part of this jointly issued PDS) before completing the application for membership of the Zurich Plan and any application for insurance.

The Trustee has delegated administration of the Zurich Plan to Aon Hewitt Limited ABN 48 002 288 646. Aon Hewitt Limited may (with the Trustee's consent) engage other service providers (for example, Zurich Australia Limited and Insurance & Superannuation Administration Services Pty Ltd (IASAS) to assist with aspects of the Plan's administration.

The information contained in this Zurich Plan PDS is general information only. Your objectives, financial situation or needs have not been taken into account. You should consider the appropriateness of the information in this Zurich Plan PDS, taking into account your objectives, financial situation and needs, before acting on any information in the PDS. Information about tax provided in this Zurich Plan PDS is a guide only and is based on our understanding of the tax laws current at the date of the Zurich Plan PDS. These laws can change, so you should speak to your tax adviser regarding the tax consequences of holding insurance cover through superannuation. References to *superannuation law* in this Zurich Plan PDS include the Superannuation Industry (Supervision) Act 1993 (Cth) and associated regulations as amended from time to time.

All of the information contained in this Zurich Plan PDS is current at the time of preparation of this PDS. Information contained in this Zurich Plan PDS can change from time to time. If the change is to information that is not materially adverse information, the updated information will be available at zurich.com.au and aonmastertrust.com.au. A paper copy of any updated information will be given, or an electronic copy will be made available, to you on request without charge by contacting Zurich (see the contact details on page 11).

Preparation Date: 3 November 2017

Introducing the Zurich Insurance-only Superannuation Plan

The Zurich Insurance-only Superannuation Plan of the Aon Master Trust (the Zurich Plan) provides members with access to death and disablement insurance cover within superannuation. It does not provide superannuation account balances or investment returns to members. Some of the key features of the Zurich Plan are:

- The Trustee accepts contributions and rollovers to pay the premiums for insurance policies held through the Zurich Plan, subject to the terms and conditions summarised in this Zurich Plan PDS. The Zurich Plan does not offer a superannuation savings or investments facility.
- The Trustee can generally claim a tax deduction for the premium it pays and it may offset this against the tax payable on any contributions made by your employer or contributions made by you that are tax deductible.
- An amount will only be payable from the Zurich Plan if Zurich pays a benefit because an insured event happens under the policy. The Trustee will only pay the amount it is entitled to receive from Zurich less any tax that must be withheld. All amounts are paid as superannuation benefits, in accordance with *superannuation law*, and applicable tax treatment.
- The Trustee will only accept your application for membership of the Zurich Plan on or after the date of this Zurich Plan PDS if your application for insurance is accepted by Zurich and you have provided the Trustee with your Tax File Number. Other than interim cover that may be provided by Zurich while your insurance application is being assessed, your insurance cover in the Zurich Plan only commences once applicable premiums are paid from contributions and/or rollovers received. Membership of the Zurich Plan is subject to terms and conditions determined by the Trustee from time to time. You are not required by law to provide us with your Tax File Number and we cannot compel you to do so. However, if you would like to participate in this product, your Tax File Number is necessary.

The PDS provides important information that will help you understand the types of insurance benefits available through the Zurich Plan and the tax treatment that may apply, your options for meeting the costs of the insurance, and the potential risks of holding insurance through the Zurich Plan.

In this Zurich Plan PDS, 'you' means the person who will become the life insured (since the owner of the policy will be the Trustee) as a member of the Zurich Plan.

The insurance benefits available

The benefits available from the Zurich Plan are insured superannuation benefits pursuant to available insurance cover.

Zurich is the provider of insurance cover to members of the Zurich Plan. If your application for cover is accepted, Zurich will issue an insurance policy to the Trustee and you will be the life insured under the policy. The Zurich Plan provides you with access to various types of insurance cover from which you may select provided you meet relevant eligibility criteria and other terms and conditions relating to the acceptance of cover (for example, entry ages and minimum and maximum sums insured).

The insurance products available through the Zurich Plan under this PDS are:

- **Zurich Wealth Protection and Zurich FutureWise** which provide the following types of insurance:
  - Life insurance – providing cover for death and terminal illness
  - TPD insurance – providing cover for total and permanent disablement or 'permanent incapacity'
  - Income protection insurance – providing cover for 'temporary incapacity' where you are unable to work to earn income due to sickness or injury.

Note: A FutureWise insurance product is only available through the Zurich Plan under this PDS to individuals that have an existing FutureWise policy at the date of application for membership of the Zurich Plan who wish to replace all or part of the policy with insurance cover through the Zurich Plan.

- **Zurich Active** which provides the following types of insurance:
  - Cover for Death, terminal illness and a range of specified health events that also result in 'permanent incapacity'
  - Income protection insurance – providing cover for 'temporary incapacity' where you are unable to work to earn income due to sickness or injury.

As a member of the Zurich Plan, you may be provided with insurance cover through one insurance product or multiple insurance products. Also, your insurance cover may give rise to multiple superannuation interests ('interests') in the Zurich Plan, in relation to a single insurance product or multiple insurance products.

The terms and conditions of the available insurance cover under this PDS, including limitations and exclusions, are described in Zurich Wealth Protection PDS, Zurich Active PDS and Zurich FutureWise PDS current at the date when cover is applied for, as supplemented or replaced from time to time. The amount of cover you select and

any special conditions Zurich applies to your cover will be set out in a policy schedule. A copy of the policy schedule will be sent to you by Zurich if your application for insurance is accepted.

Transferring cover to the Zurich Plan

The Trustee may also accept the transfer of an existing insurance policy in respect of a member of the Zurich Plan provided:

- the policy was issued to the trustee of the Zurich Master Superannuation Fund or to the trustee of the Macquarie Superannuation Plan (the 'transferring trustee');
- the life insured under the policy requests the transfer of the policy in the form required by the Trustee and Zurich from time to time (for a copy of the current form contact Zurich using the General Enquiries details shown on page 11). By completing this form the life insured will also be applying for membership of the Zurich Plan;
- the transferring trustee agrees to assign the policy to Equity Trustees Superannuation Limited in its capacity as trustee of the Aon Master Trust;
- Equity Trustees Superannuation Limited agrees to accept the transfer of the policy having regard to any internal policies or procedures it determines from time to time for the 'acceptance' of such transfers.

If the transferring trustee or Equity Trustees Superannuation Limited does not agree, you cannot be a member of the Zurich Plan. If they agree, Equity Trustees Superannuation Limited will become the owner of the policy.

In these circumstances, the insured superannuation benefits applicable to a Zurich Plan member with a transferred policy (Transferred insurance-only member) will be in accordance with the transferred policy and any terms and conditions including limitations and exclusions, as described in disclosure documents previously provided to the Transferred-insurance only member while a member of the Zurich Master Superannuation Fund or the Macquarie Superannuation Plan. These disclosure documents can be obtained on request by contacting Zurich using the General Enquiries details shown on page 11. Note this means:

- this Zurich Plan PDS applies to the Transferred-insurance only member, subject to any modifications applicable only to Transferred-insurance only members shown in the PDS; and
- the Zurich Wealth Protection PDS, Zurich Active PDS and Zurich FutureWise PDS (and insurance cover described therein) do not apply.

It is important to note that there are differences between holding insurance cover directly from Zurich and holding insurance cover through the Zurich Plan. These differences include:

- When you have insurance cover through the Zurich Plan, the Trustee is the owner of the insurance policy and holds it on your behalf as the life insured. You cannot apply for cover on the life of another person (e.g. spouse or child) via the Zurich Plan.
- Insurance cover held in the Zurich Plan is subject to *superannuation law* which governs the type of insurance benefits that can be provided via a superannuation fund. These rules do not apply to insurance cover obtained directly by you outside of superannuation. This means that not all types of insurance cover described in the Zurich Wealth Protection PDS, Zurich Active PDS and Zurich FutureWise PDS can be held in the Zurich Plan. For example, trauma cover is not available through the Zurich Plan.
- Not all the insurance features (including definitions), benefits or options available in respect of insurance cover described in the Zurich Wealth Protection PDS, Zurich Active PDS and Zurich FutureWise PDS apply to insurance cover held in the Zurich Plan. For example, TPD cover through the Zurich Plan cannot be based on your permanent incapacity to perform your own occupation only. Also insurance cover described in the FutureWise PDS is only available through the Zurich Plan if you hold an existing FutureWise policy and wish to replace all or part of the policy with insurance cover through the Zurich Plan.
- The Zurich Wealth Protection PDS, Zurich Active PDS and Zurich FutureWise PDS explain which insurance benefits are not included, or are subject to additional terms, when held through super. Benefits not included through super may be accessed via a second policy owned directly by you through the Zurich Superannuation Optimiser structure - for more details, refer to the relevant Zurich PDS.
- The terms and conditions applicable to insurance cover differ depending on whether you have insurance cover directly under the Zurich Wealth Protection PDS, Zurich Active PDS or Zurich FutureWise PDS or you have insurance cover through the Zurich Plan.
- To the extent premiums are paid to superannuation as a contribution (ie not rollovers), the contribution may be deductible against your income if you lodge a valid Notice of Intent to Deduct Contribution and the Trustee issues an acknowledgement of that notice. The Trustee is not required to issue an acknowledgement in certain circumstances including if the Trustee is unable to pay the contributions tax applicable to contributions that are treated as deductible against your income. The Trustee can generally claim a tax deduction for premiums paid to Zurich in respect of insurance including premiums paid by a partial rollover. For partial rollovers, you are not able to claim the premiums as a deduction against your income. Instead, the tax deduction received by the Trustee on premiums paid by partial rollovers will usually be passed on to you in the form of a reduced premium. Situations where this premium reduction may cease in the future are explained in the section "Paying premiums by rollover from another superannuation fund" on page 5.
- If you have a complaint relating to insurance cover held via the Zurich Plan, it must be dealt with through the Trustee's complaint handling process, not Zurich's complaints handling process. However, Zurich will assist with the processing of such complaints.

For further information about the differences, refer to the Zurich PDSs available from your adviser, or consult your adviser.

While the Trustee has determined that insurance cover described in the Zurich PDSs can be held through superannuation, this does not mean that the Trustee considers that an individual insurance policy available via the Zurich Plan is suitable for your personal situation, objectives or needs or that the performance of Zurich or any individual policy is guaranteed. The suitability of insurance cover available to you via the Zurich Plan depends on your individual circumstances. The Trustee is unable to provide personal financial advice to you in relation to insurance cover via the Zurich Plan. Before applying for insurance cover under an existing Zurich Wealth Protection or Active policy or before replacing an existing Zurich FutureWise policy, you should carefully read the relevant Zurich PDS which sets out important information including:

- Eligibility for insurance cover. If you are not eligible for insurance cover you will not be able to become a member of the Zurich Plan.
- Your duty of disclosure when completing an application for insurance. If you do not adhere to your duty of disclosure, adjustments to your insured benefits (including in some cases complete loss of your insurance cover) may occur.
- Insurance benefits provided including when cover starts and ends, minimum and maximum insured amounts and any applicable payment limits. Interim cover may apply while your application is being processed. (Refer to the relevant Zurich PDS for more information.) If you have multiple types of cover under related policies via the Zurich Plan, benefit payments under either of the related policies may reduce the benefits under the other policy.
- The cost of cover.
- The terms and conditions of those benefits, including important definitions.
- Exclusions and restrictions on the payment of those benefits.

As with any insurance provided to individuals, Zurich may impose additional conditions, exclusions, restrictions or premium loadings (depending on your personal circumstances) as a condition of the acceptance of cover. If you agree to these additional terms, they will be set out in a policy schedule, a copy of which will be provided to you.

You should also consider whether you need to consult an adviser before applying for insurance cover and becoming a member of the Zurich Plan. Your adviser can provide you with a Statement of Advice and other disclosure documents relevant to your insurance, taking into account your individual situation.

You will only be entitled to a benefit from the Zurich Plan if a benefit is paid by Zurich because an insured event occurs while you are covered under a policy, and you have satisfied a condition of release under *superannuation law*. In some cases where a benefit is payable, the Trustee may direct Zurich to pay it as a superannuation benefit instead of making the payment itself.

Fees and costs

The cost of insurance

The cost of insurance under a Zurich Wealth Protection, Active or FutureWise policy is referred to as the premium and is determined by Zurich. Zurich charges a management fee on Zurich Wealth Protection and Zurich FutureWise as part of the premium, depending on the frequency of your premium payments. Premiums can be paid monthly, quarterly, half-yearly or yearly in advance, with the management fee for a year being higher the more frequent your premium payments are.

The premium will also include any commission or other amounts or benefits paid (or payable) to your adviser by Zurich and stamp duty, where applicable. The Trustee pays the premium (including any management fee charged by Zurich, stamp duty or amounts payable to your adviser) with amounts you contribute or rollover to the Zurich Plan.

The actual cost for you will depend on the insurance cover you select and a range of factors as explained in the relevant Zurich PDS. Your financial adviser can provide you with a quotation that will set out the indicative cost of your insurance for the first year of the policy. Zurich may impose additional insurance costs (loadings) depending on your personal circumstances as a condition of the acceptance of cover. You will be advised of any loadings at the time of application.

The cost of insurance may be adjusted for any changes to your cover during a financial year.

Further information about insurance costs including management fees charged by Zurich, amounts payable to your adviser and stamp duty is shown in the relevant Zurich PDS. Transferred insurance-only members should refer to the disclosure documents previously provided to them while a member of the Zurich Master Superannuation Fund, or the Macquarie Superannuation Plan, which can be obtained on request by contacting Zurich using the General Enquiries details shown on page 11.

Other fees and costs

The Trustee does not charge any additional fees or costs to members of the Zurich Plan. The Trustee may bill you directly for any liability arising under any government charges or imposts relating to your Zurich Plan membership or deduct any such liability from an insured benefit that is or becomes payable to you.

Paying for insurance through superannuation

Premiums can be paid either by you or your employer making superannuation contributions to the Zurich Plan or by rolling over benefits from another superannuation fund. Some conditions apply to the types of contributions and rollovers that can be accepted by the Trustee as explained below. Under the administrative arrangements for the Zurich Plan, Zurich will accept contributions and initiate rollovers (where a member consents) to the Zurich Plan on behalf of the Trustee and then immediately apply the amounts collected to pay premiums.

Making contributions to superannuation

Contributions can be paid yearly, half-yearly, quarterly or monthly, and must be in Australian dollars.

As noted above, the frequency of your contributions will determine the amount of the management fee (and premiums) charged by Zurich.

The following table summarises what payment methods are available based on the contribution type:

Contribution type	Payment method				
	Direct Debit	BPAY®	Credit Card	Super-Stream compliant method*	Rollover
Personal	✔	✔	✔	✔	✘
Self-Employed	✔	✔	✔	✔	✘
Spouse	✔	✔	✔	✔	✘
Employer (Compulsory)	✘	✘	✘	✔	✘
Employer – Salary Sacrifice	✘	✘	✘	✔	✘
Employer – Voluntary	✘	✘	✘	✔	✘
Rollover	✘	✘	✘	✘	✔

To pay by credit card or direct debit from an Australian bank account, you must provide a valid authority to enable the contribution to be deducted when due. Any direct debit instruction you provide is subject to the terms of the Direct Debit Request Service Agreement as set out in the application form. Cheques are not accepted.

If you choose to pay the premium yearly, contributions can also be made by BPAY®. If you choose to make contributions by BPAY®, Zurich will provide you with payment instructions once a policy has been issued and when the policy becomes due for renewal each year.

As the Zurich Plan does not offer a superannuation savings or investments facility, the Trustee cannot accept contributions in excess of the premiums due for insurance held in the Zurich Plan. The Trustee is also unable to accept Government contributions into the Zurich Plan.

® Registered to BPAY Pty Ltd ABN 69 079 137 518. Only available in premiums are paid yearly.

* SuperStream is a government reform aimed at improving the efficiency of the superannuation system. As part of the SuperStream reforms, employers must make super contributions on behalf of their employees by submitting data and payments electronically in a consistent and simplified manner prescribed by the Australian Tax Office (ATO).

Eligibility to contribute to superannuation

To make contributions to the Zurich Plan, certain conditions must be met under *superannuation law*, depending on your age and who is making the contribution. Generally, you are eligible to contribute to superannuation (or have voluntary employer contributions made on your behalf) if you are 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. Spouse contributions cannot be made for you unless you are aged under 70. Compulsory employer contributions can be made for you regardless of your age.

Under *superannuation law*, we cannot accept personal contributions from you or your spouse, including personal tax-deductible contributions, if we do not hold your Tax File Number (TFN).

To make contributions to the Zurich Plan, certain conditions must be met as determined by the Trustee as set out in this Zurich Plan PDS. This includes the condition that you provide us with your TFN when you apply for membership of the Zurich Plan.

Limits on superannuation contributions made each financial year

Government contribution caps limit the amount of contributions that can be paid into the superannuation system for you each financial year, whether they are made to one or more superannuation funds. It is your responsibility to ensure you do not exceed these caps. Taxation penalties may apply where these caps are exceeded, usually levied on you directly. For information about the contribution caps, refer to www.ato.gov.au.

Tax on contributions

Generally the Trustee is required to pay tax of 15% on concessional contributions (employer contributions and, if you are eligible, personal contributions that you advise the Trustee you intend to claim as a tax deduction against your personal income where the Trustee acknowledges your intended claim). However, premiums paid are generally tax deductible to the Trustee, so that any tax payable on contributions will be offset by the amount of the tax deduction available. If the amount of tax payable on contributions (including personal contributions for which you intend to claim a tax deduction against your income) cannot be met by the Trustee, the Trustee may not acknowledge your intended claim.

An additional tax of 15% applies to certain concessional contributions that do not exceed the concessional contributions cap, that, when added to an individual's taxable income and certain other amounts, exceed $250,000. This additional tax is levied on the individual, not the superannuation fund, and cannot be offset by the tax deduction available to the Trustee.

If you pay premiums by making non-concessional contributions (for example, where you are not eligible to claim a tax deduction for personal contributions, or your spouse makes non-deductible contributions for you) the Trustee will not pass on to you the benefit of any tax deduction on premiums.

Paying premiums by rollover from another superannuation fund

If your premiums are paid yearly, you may pay by rollover from another superannuation fund. If you choose this option, you must provide a valid authority that instructs the Trustee to request from your nominated fund the amount required. You may do this by providing an Enduring Rollover Authority, which allows the Trustee to request your nominated fund to roll over benefits each year until you revoke the instruction. Your nominated fund may apply limits or other conditions on rollovers, including partial rollovers, such as minimum withdrawals, and may charge fees for processing your request. You should check the terms and conditions with your nominated fund, and ensure there is a sufficient balance in your account to cover the rollover each year.

If you roll over from another complying taxed superannuation fund, the Trustee's current practice for members with cover through a Zurich Wealth Protection, Zurich Active or Zurich FutureWise policy is to pass on the benefit of the tax deduction available for premiums, by reducing the rollover amount required to cover the premium due by 15%. For example, if the premium due (including management fee and stamp duty) is $1000 and the value of the tax deduction is $150, the portion of the premium to be paid by the partial rollover is reduced to $850, resulting in a 15% reduction for you. You will be notified of the reduced amount required before the partial rollover request is sent to your nominated fund. Any changes to this practice will be communicated to you with advance notice. As the provision of this reduction relies on the Trustee exercising its discretion, the Trustee may reduce or cease applying this reduction at any time in the future where the Trustee considers it appropriate to do so.

The Trustee is unable to accept rollovers that have an untaxed element.

The Trustee is unable to accept rollovers that contain United Kingdom (UK) transfer or New Zealand KiwiSaver transfer amounts. The Trustee is also unable to accept rollovers that are not equal to the specific amount due. Rollovers that cannot be accepted will be returned to the transferring superannuation fund. If a rollover is returned, you will be requested to provide alternate instructions so that the premium can be paid.

Non-payment of premium

Contributions or rollovers must be received when the premium is due for payment. Under the administrative arrangement for the Zurich Plan, Zurich will notify you directly of the premium obligations. If contributions or rollovers are not received by Zurich when the premium is due, Zurich will be entitled to cancel the insurance after giving notice to you.

If a payment sufficient to meet the amount due is not made by the date notified, Zurich will then cancel the insurance and you will cease to be a member of the Zurich Plan.

The Trustee is not responsible for ensuring your insurance cover does not lapse due to insufficient or late premium payments. You may have to re-apply for insurance cover if it lapses.

Insurance cover may cease in other circumstances.

Cooling-off period

Zurich provides a 14 day cooling-off period during which time you can cancel your insurance if you decide that it does not meet your needs. If you cancel insurance during the cooling off period, your membership of the Zurich Plan will also cease. You will be entitled to a refund of the premium (including any management fee) paid to Zurich but subject to tax and superannuation preservation rules imposed by the law on the Trustee. See the section below titled 'Refunds' for more information.

If you wish to use the cooling-off period, you must not have made a claim and must notify Zurich (in writing or by phone – see Zurich's contact details on page 11) within 14 days of the earlier of:

- the date you receive your copy of the policy schedule from Zurich, or
- the end of the 5th day after the policy was issued, and your membership commenced.

Varying your insurance cover

After you become a member of the Zurich Plan, you can make changes to your insurance (such as vary the type or amount of insurance cover) at any time. For example, you may increase the amount of your death, TPD or income protection cover, subject to Zurich's assessment of your application and approval, and payment of applicable premiums. If you want to increase your cover, you will need to complete the Zurich Insurance Application Form. Other alterations to your cover can be made with a letter or a short application form, depending on the change. For information about the documentation needed to vary your cover, contact Zurich's Customer Care team on 131 551. Eligibility criteria and minimum and maximum insurance amounts apply. Refer to the relevant Zurich PDS for information or, in the case of Transferred insurance-only members, refer to the disclosure documents previously provided to you while a member of either the Zurich Master Superannuation Fund or the Macquarie Superannuation Plan. Any changes will be effective only if Zurich accepts your application and will be shown in a revised policy schedule, a copy of which will be provided to you.

Cessation of cover (and membership)

Insurance cover ceases in certain circumstances as described in the applicable Zurich PDS including termination of the applicable insurance policy by you (in writing, by a notice provided to Zurich Australia Limited), on your death or when the benefit expiry date is reached. Your insurance cover in the Zurich Plan may also cease if you have related cover under a non-superannuation Zurich insurance policy. For further information, refer to the relevant Zurich PDS and your policy schedule. Transferred insurance-only members should refer to the disclosure documents previously provided to them while a member of the Zurich Master Superannuation Fund, or the Macquarie Superannuation Plan, which can be obtained on request by contacting Zurich using the General Enquiries details shown on page 11.

Refunds

Superannuation contributions and rollovers received into the Zurich Plan (which the Zurich Plan cannot accept or retain because it does not offer a superannuation savings or investments facility) are subject to superannuation preservation rules. In cases where a premium is refunded by Zurich to the Trustee (for example, a part refund of yearly premium where cover is cancelled before the next cover anniversary, or a full refund of the initial premium paid where cover is cancelled in the cooling off period), whether or not preservation rules apply, the refund must be rolled over to another complying superannuation fund. The amount refunded for a premium you paid by rollover will be calculated on the rollover amount received, not the higher gross premium before any reduction in the premium amount by 15% (due to tax deductions received, and passed on, by the Trustee).

The Trustee may transfer any refund of premiums to an Eligible Rollover Fund (ERF) if you do not nominate a superannuation fund for the transfer, or if for whatever reason your nominated fund cannot accept the payment. The ERF presently nominated by the Trustee for this purpose is the Aon Eligible Rollover Fund (Aon ERF).

The Australian Prudential Regulation Authority (APRA) has approved the Aon Eligible Rollover Fund to operate as an ERF. The Trustee reserves the right to change the chosen ERF without prior notice to you.

Should an amount be transferred to the Aon ERF:

- you will become a member of the Aon ERF and will be subject to its governing rules
- your account will be invested according to the investment strategy of the Aon ERF
- the Aon ERF may charge fees to your account and other costs that may apply
- you may not be offered insurance cover, and
- all subsequent enquiries relating to your benefit should be directed to:

  Aon Eligible Rollover Fund
  PO Box 1949
  WOLLONGONG NSW 2500
  Email: contactaon@pillar.com.au
  Phone: 1300 880 588
  Fax: 1300 267 582

You should refer to the PDS for the Aon ERF for more information.

Benefit payments and tax

Death, terminal illness and permanent incapacity benefits can only be paid to eligible members of the Zurich Plan in the form of a lump sum. Income protection benefits are paid to eligible members of the Zurich Plan in the form of a regular income.

To claim a benefit, you must satisfy Zurich's claim requirements. For information about this, refer to the relevant Zurich PDS.

Zurich will pay the insurance benefit as soon as the requirements in your policy have been satisfied. Payments are made to the Trustee (other than income protection benefits which Zurich pays direct to you, on behalf of the Trustee). It is then up to the Trustee to be satisfied the benefit can be paid from the Zurich Plan and to determine to whom the benefit will be paid. This might be you, your legal personal representative or one or more of your dependants. In the case of death benefits, you may nominate your beneficiaries (see page 7).

Benefits paid from the Zurich Plan are treated as superannuation benefits for tax purposes. Where required, tax payable on a benefit will be withheld before an amount is paid from the Zurich Plan by or on behalf of the Trustee.

Lump sum benefits

Lump sum benefits will not be paid until the Trustee has determined to whom the benefit will be paid. If a lump sum benefit becomes payable, tax may be deducted before a benefit is paid. As the Zurich Plan does not offer a superannuation savings or investments facility, any insurance benefit received by the Trustee from Zurich will not attract investment earnings for the period that it is held in the Plan.

The taxation of lump sum death benefits will depend on the relationship between the deceased member of the Zurich Plan and the beneficiary. If the beneficiary is a dependant (as defined under taxation law) of the deceased member the benefit may be paid free of tax. Otherwise, the taxable component of the death benefit will generally be taxed at up to 15% plus the Medicare levy. If the benefit contains an untaxed element then a tax of 30% plus the Medicare levy can apply. Refer to page 8 for information about who qualifies as a 'dependant'. You should note that an adult child (aged 18 or more) is not a dependant for taxation purposes, unless they otherwise are financially dependent on the deceased member or in an interdependency relationship with the deceased as defined in *superannuation law*.

The taxation of lump sum benefits that qualify as a permanent incapacity benefit (requiring the Trustee to be reasonably satisfied that your ill-health, whether physical or mental, makes it unlikely that you will engage in gainful employment for which you are reasonably qualified by education, training or experience) depends on your age and other circumstances. If you are 60 or more, the benefit is tax free unless the benefit includes an untaxed element. If you are under age 60, any tax-free component can be received free of tax and the balance of the benefit may be taxable, depending on whether or not you have reached your preservation age.

Your preservation age depends on your date of birth as follows:

Before 1/7/60	age 55
1/7/60 - 30/6/61	age 56
1/7/61 - 30/6/62	age 57
1/7/62 - 30/6/63	age 58
1/7/63 - 30/6/64	age 59
From 1/7/64	age 60

If you are at or above your preservation age but under age 60, the taxable component up to the low rate cap amount ($200,000 for the 2017/18 financial year, which may be indexed in future years) is received tax free. The taxable component above the low rate cap

amount will be taxed at a maximum rate of 15% plus the Medicare levy. If you are under your preservation age, the taxable component of the benefit will be taxed at a maximum of 20% plus the Medicare levy.

Terminal illness benefits that qualify as the payment of a benefit to a person with a terminal medical condition (requiring the Trustee to be satisfied that you are suffering a terminal medical condition as defined in *superannuation law*) are tax-free. This tax treatment applies if, in summary, the following circumstances exist:

- two registered medical practitioners have, jointly or separately, certified that the person suffers from an illness, or has incurred an injury, that is likely to result in the death of the person within a 24 month period after the date of the certification (the certification period);
- at least one of the medical practitioners is a specialist practicing in an area relating to the illness or injury suffered by the person; and
- for each of the certificates, the certification period has not ended.

Income benefits

The benefits paid under your income protection insurance (in the form of regular income payments that qualify as temporary incapacity benefits under *superannuation law*) must be included in your tax return and will be taxed at your marginal income tax rate. This tax treatment applies if, in summary, you ceased to be gainfully employed (including if you have ceased temporarily to receive any gain or reward under a continuing arrangement for you to be gainfully employed) due to ill-health (whether physical or mental) but the ill-health does not constitute permanent incapacity.

Death benefit nominations

This section of this Zurich Plan PDS sets out rules relating to death benefit nominations for your benefits in the Zurich Plan. These rules apply to all members of the Zurich Plan; however special arrangements may apply to members transferred to the Zurich Plan under a successor fund arrangement. If you become a member of the Zurich Plan as a result of a successor fund transfer, you should refer to the significant event notice provided to you by the trustee of the transferring fund.

You have the option of nominating to whom a death benefit from the Zurich Plan will be paid. Where the Trustee has consented to your nomination, your benefit will be paid as a lump sum to the person(s) that you have nominated as long as your nomination remains valid and effective, and has been made in the prescribed manner.

The nomination will be a non-lapsing nomination unless certain prescribed life events ('prescribed circumstances') occur after you give us the nomination, which cause the nomination to lapse.

The prescribed circumstances are:

- you marry or enter a de facto relationship; or
- you divorce or end a de facto relationship.

The Trustee will not accept such a nomination if it is made by an attorney or any other agent. 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;
- it clearly identifies the proportions in which the death benefit is to be allocated between nominated beneficiaries, if more than one;
- it complies with any other form and content requirements of the Trustee from time to time.

To make a nomination simply complete the death benefit nomination section of the application for membership, or complete and return the Binding Death Benefit Nomination (non-lapsing) form available on the Zurich website zurich.com.au or by calling Zurich's Customer Care team on 131 551.

The Trustee can only consent to a nomination in respect of one or more of your dependants (as defined in *superannuation law*) or a legal personal representative. To remain a valid and effective nomination, a nominated beneficiary must still be a dependant or a legal personal representative at the time of death. If the Trustee has consented to your nomination and that nomination, or a part of it, is no longer valid and effective at the time of payment, the Trustee will not pay the death benefit in accordance with the nomination, or that part of it that is not valid and effective and will, instead, apply the process set out below.

The nomination will cease to be valid and effective if you revoke it, it lapses in prescribed circumstances or you make a new valid and effective nomination.

A nomination only applies to the death benefit payable under each particular insurance product you hold in the Zurich Plan, for which a nomination has been made. There can only be one nomination in place for each insurance product at any given time. Therefore if you hold multiple products in the Zurich Plan any subsequent nomination in respect of a product revokes a prior nomination in respect of that product only - which may mean you need to make multiple nominations. You may revoke or change your nomination in respect of a product at any time by completing a new non-lapsing death benefit nomination form. It will come into effect once the Trustee has consented to it.

You should periodically review each of your nominations to ensure you still wish for the Trustee to pay the person(s) you have nominated, because it will not automatically become invalid after a fixed period of time. To amend or revoke a nomination, you must complete and return another Binding Death Benefit Nomination (non-lapsing) form.

Details of any nomination that the Trustee has consented to will be included in your annual statement, however the validity and effectiveness of any nomination is finally determined by the Trustee at the date of death.

Definition of dependant

Under *superannuation law*, a dependant includes:

- your current spouse (including de facto spouse) of either gender,
- your children of any age (including adopted children, stepchildren and your spouse's children),
- someone who is financially dependent on you, or
- someone with whom you have an 'interdependency relationship'.

Two people have an 'interdependency relationship' if criteria in *superannuation law* is satisfied. This includes:

- they have a close personal relationship; and
- they live together; and
- one or each of them provides the other with financial support; and
- one or each of them provides the other with:
  - domestic support and personal care, but not if one of them provides domestic support and personal care to the other under an employment contract or a contract for services or on behalf of another person or organisation such as a government agency, a body corporate or a benevolent or charitable organisation; or
  - support or care of a type and quality normally provided in a close personal relationship, rather than by a mere friend or flatmate.

Two people also have an interdependency relationship if they have a close personal relationship but they do not meet the other requirements of interdependency because:

- either or both of them suffer from a disability including a physical, intellectual or psychiatric disability, or
- they are temporarily living apart.

Please note, children aged 18 or more are not considered to be dependants for taxation purposes unless they satisfy the definition of dependant in the *superannuation law* in some other way. Depending on who you nominate there may be different taxation consequences. You should obtain taxation advice about this, having regard to your personal circumstances.

Definition of legal personal representative

Your legal personal representative, for the purpose of any distribution of death benefits, usually means the executor of the will or administrator of the estate of a deceased person.

What prescribed circumstances will cause the binding nomination to lapse?

The nomination will lapse if, after the nomination is made, you marry, or enter a de facto relationship or you divorce or end a de facto relationship.

What if the binding nomination lapses in prescribed circumstances?

In such cases, your nomination will become wholly ineffective.

What if a nominated beneficiary is not your dependant or your legal personal representative?

In such cases, the nomination relating to the portion of the benefit attributable to that nominated beneficiary will be ineffective.

No nomination

Where there is no binding death benefit nomination or a binding death nomination has been made but it is ineffective in whole or in part, the Trustee must pay the death benefit (or applicable proportion) in accordance with the trust deed. This generally means that the benefit will be paid to your legal personal representative (which may include an executor named in your Will without a grant of probate where the death benefit is less than $100,000 or such other probate limit determined by the Trustee from time to time), unless the Trustee:

- has not identified your legal personal representative or a person who has filed an application for grant of probate or letters of administration within 6 months of the Trustee being notified of your death; or
- is notified, by a person that the Trustee considers reasonably qualified to form the view, that your estate (excluding, for this purpose, the death benefit) is insolvent because the estate's assets (excluding, for this purpose, the death benefit payable from the Fund) will be exhausted in meeting the estate's liabilities.

If either of the above apply, the benefit is instead paid to your spouse or, if none, your children (including an unborn child) in equal shares (where there are more than one). If you have more than one spouse at the date of death, the benefit is paid to them in equal shares.

Note that a person is only a 'spouse' or a 'child' if the Trustee is aware of the person's existence and is satisfied of their status as such.

If you have no spouse or children, the benefit is paid to your legal personal representative (even if your estate is insolvent) or, if the benefit is not paid to your legal personal representative, it must be dealt with as unclaimed money under government legislation.

Risks of holding insurance through superannuation

There are risks you should consider before deciding to hold insurance through superannuation, including:

- In addition to the terms and conditions of the applicable insurance policy which govern the grant of insurance cover, and payment of benefits, by Zurich to the Trustee, insurance benefits through superannuation are also subject to *superannuation law* and the Trust Deed and Rules of the Aon Master Trust. In relation to the insurance benefits provided by the Trustee from the Zurich Plan, if there is any inconsistency between the applicable insurance policy and the Trust Deed, the Trust Deed prevails.
- If you change your mind about holding insurance through the Zurich Plan (during the cooling off period – see page 5) you will not usually be able to obtain a refund of premiums in cash (preservation rules mean that the refund will usually have to be paid to another superannuation product).
- A benefit paid from the Zurich Plan is a superannuation benefit for tax purposes. Depending on your tax circumstances, it may be subject to more tax than would otherwise apply if the benefit was paid from the same insurance held outside of superannuation.
- Limits apply to the amount you can contribute to superannuation each year. Any contributions you make to the Zurich Plan in order to pay premiums will reduce the amount you may be able to contribute to other superannuation accounts you hold for retirement savings purposes.
- Where you choose to pay premiums by rollover from another superannuation fund, your retirement savings will be reduced so that you may have less available to you on retirement than otherwise may have been the case.
- Taxation or *superannuation law* may change in the future, altering the suitability of holding insurance in superannuation.

Your adviser and how to apply

This superannuation product (including the insurance available through this product) is available through financial advisers, referred to in this Zurich Plan PDS as 'your adviser'. Your adviser may act as your agent and lodge on your behalf an application for membership of the Zurich Plan. If your application is accepted, Zurich may pay your adviser a commission for selling the insurance. You can obtain details from your adviser of any commission paid. The commission is paid by Zurich out of insurance premiums it receives from the Zurich Plan. Commissions are not paid by the Trustee.

Your adviser can assist you to make an application for membership of the Zurich Plan, along with an application for insurance. If your adviser lodges an online application on your behalf, the adviser is required to confirm that they have authorisation to act as your agent. It is your responsibility to ensure that the information provided to Zurich and the Trustee by your adviser is accurate and complete. The Trustee and Zurich will rely on the accuracy of the information provided via the online application as if a paper application was signed and submitted by you.

Applications for membership of the Zurich Plan can only be accepted after the insurance application has been accepted by Zurich. In accepting your application, the Trustee and Zurich will rely on declarations and authorisations made by you, either directly or via your agent, relating to the following matters:

- You have appointed your adviser to act on your behalf in relation to the application and, if you choose to submit an online application, you have appointed your adviser to complete and lodge an application as your agent.
- You have received this Zurich Plan PDS and the relevant Zurich PDS for the insurance product(s) you have chosen to apply for.
- You confirm the information supplied in connection with the application is true and correct and no information material to the application has been withheld.
- You authorise the collection of premiums from the account designated in the application, and where you have designated a bank account, you confirm you have received a copy of the Direct Debit Request Service Agreement.
- You have read the Privacy Statement (see page 10) and the Anti-money laundering and counter terrorism-financing requirements (see page 10) contained in this Zurich Plan PDS.
- Where you have chosen to have premiums paid by making new contributions to superannuation, you are eligible to do so under *superannuation law*.

Tax file number collection

Collection, use and disclosure of tax file numbers (TFNs) by superannuation funds is authorised under *superannuation law*. The Trustee will only use your TFN for purposes authorised by law. The purposes may change in the future as a result of legislative change. The purposes currently authorised include:

- taxing benefit payments at lower rates than may otherwise apply
- passing your TFN to the Australian Taxation Office
- allowing the Trustee to provide your TFN to another superannuation provider if your benefit is transferred to that provider. However, the Trustee will not do so if you advise in writing that you do not want it to be passed on, and
- locating accounts in the Aon Master Trust or, with your consent, consolidating certain accounts within the superannuation environment.

Declining to quote your TFN is not an offence, however, if you do not provide your TFN:

- 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 no-TFN tax
- you may pay more tax on your superannuation benefits than you have to, and
- it may be more difficult to find your superannuation benefits if you lose contact with your superannuation fund.

As a consequence, the Trustee has determined that it will not accept your application for membership of the Zurich Plan until you provide your TFN.

Trustee Privacy Statement

Important: You should also read Zurich's privacy statement in the Zurich PDSs. A more detailed Zurich Privacy policy is also available on the Zurich website, www.zurich.com.au.

When you provide instructions to Equity Trustees Superannuation Limited and/or any related bodies corporate under EQT Holdings Limited ("the EQT Group"), the EQT Group will be collecting personal information about you. This information is needed to admit you as a Member of the Fund, administer your benefits and identify when you may become entitled to your benefits and to comply with Australian taxation laws and other applicable laws and regulations. If the information requested is not provided, the EQT Group may be unable to process your application or administer your benefits, or your benefits may be restricted.

Use and Disclosure

The information that you provide may be disclosed to certain organisations to which the EQT Group has outsourced functions, or which provide advice to the EQT Group and/or to Government bodies, including but not limited to:

- Organisations involved in providing, administration and custody services for the Fund, the Fund's insurers, accountants, auditors, legal advisers, and/or those that provide mailing and/or printing services
- In the event that you make a claim for a disablement benefit, the insurer may be required to disclose information about you to doctors and other experts for the purposes of assessing your claim
- The ATO, APRA, ASIC, AUSTRAC, Centrelink and/or other government or regulatory bodies
- Those where you have consented to the disclosure and/or as required by law.

In some cases, these organisations may be situated in Australia or offshore though it is not practicable to list all of the countries in which such recipients are likely to be located.

A copy of the Fund Administrator's Privacy Statement is available online at www.aonmastertrust.com.au/privacy.htm A copy of the Insurer's Privacy Statement is available in the Zurich PDSs and online at www.zurich.com.au.

Collection of Tax File Number ("TFN")

We are authorised by law to collect your TFN under the Superannuation (Industry) Supervision Act 1993 (Cth). We will only use your TFN for legal purposes including calculating the tax on payments, providing information to the ATO, transferring or rolling over your benefits to another superannuation fund and for identifying or finding your superannuation benefits where other information is insufficient.

Under the law, you do not have to supply your TFN but if you do not, your benefits may be subject to tax at the highest marginal rate on withdrawal plus the Medicare Levy. (Note, however, that you cannot participate in the Zurich Plan if you do not provide your TFN).

Direct Marketing

The EQT Group may from time to time provide you with direct marketing and/or educational material about products and services the EQT Group believes may be of interest to you. Should you not wish to receive this information from the EQT Group (including by email or electronic communication), you have the right to "opt out" by advising the EQT Group by telephoning (03) 8623 5000, or alternatively via email at privacy@eqt.com.au.

Access and Correction

Subject to some exceptions allowed by law, you can ask for access to your personal information. We will give you reasons if we deny you access to this information. The EQT Group Privacy Statement outlines how you can request to access and seek the correction of your personal information.

Privacy complaints

The EQT Group Privacy Statement contains information about how you can make a complaint if you think the EQT Group has breached your privacy and about how EQT will deal with your complaint.

Privacy Policy

The EQT Privacy policy is available at www.eqt.com.au/global/privacystatement and can be obtained by contacting the EQT Group's Privacy Officer on (03) 8623 5000, or alternatively by contacting us via email at privacy@eqt.com.au. You should refer to the EQT Group Privacy policy for more detail about the personal information the EQT Group collects and how the EQT Group collects, uses and discloses your personal information.

Anti-money laundering and counter terrorism financing requirements

As a result of anti-money laundering and counter terrorism financing requirements in Government legislation, you may be required to provide proof of identity prior to being able to access your benefits in cash (called "customer identification and verification" requirements).

These requirements may also be applied by the Trustee from time to time in relation to the administration of your superannuation benefits as required or considered appropriate under the Government's legislation. You will be notified of any requirements when applicable. If you do not comply with these requirements there may be consequences for you, for example, a delay in the payment of your benefits.

As a result of the requirements, the Trustee is subject to the supervision of another regulatory body (called AUSTRAC) that has responsibility for the Government's legislation. The Trustee is required to provide yearly compliance reports to AUSTRAC and notify AUSTRAC of suspicious transactions. This may involve the provision of personal information about you to AUSTRAC.

You must not knowingly do anything to put the Trustee or Zurich in breach of the Anti-Money Laundering and Counter-Terrorism Financing Act 2006 (Cth) (AML/CTF Laws) and/or its internal policies and procedures, rules and other subordinate instruments. You undertake to notify the Trustee and Zurich if you are aware of anything that would put them in breach of AML/CTF Laws.

If requested, you agree to provide additional information and assistance and comply with all reasonable requests to facilitate the Trustee's and Zurich's compliance with AML/CTF Laws in Australia or an equivalent law in an overseas jurisdiction and/or its internal policies and procedures.

You undertake that you are not aware and have no reason to suspect that:

- the money used to fund the insurance is derived from or related to money laundering, terrorism financing or similar activities (illegal activities), and
- proceeds of insurance made in connection with this product will fund illegal activities.

In making an application pursuant to this Zurich Plan PDS, you consent to the Trustee disclosing, in connection with AML/CTF Laws and/or its internal policies and procedures, any of your personal information as defined in the Privacy Act 1988 (Cth) we have.

In certain circumstances, we may be obliged to freeze or block a payment receipt or benefit payment where it is used in connection with illegal activities or suspected illegal activities. Freezing or blocking can arise as a result of the monitoring that is required by AML/CTF Laws and/or its internal policies and procedures. If this occurs, we are not liable to you for any consequences or losses whatsoever and you agree to indemnify the Trustee and Zurich if they are found liable to a third party in connection with the freezing or blocking of a payment or benefit payment.

The Trustee and Zurich retains the right not to provide services to any applicant that either Trustee or Zurich decides, in its sole discretion, that it does not wish to supply.

The Aon Master Trust

The Aon Master Trust is a resident, complying and regulated superannuation fund within the meaning of *superannuation law*. The Aon Master Trust is not subject to a direction from APRA under Section 63 of the Superannuation Industry (Supervision) Act 1993 (Cth). A direction under Section 63 would prohibit acceptance of any contributions made by an employer sponsor.

The Trust Deed and Rules of the Aon Master Trust set out the powers and duties of the Trustee and the rights and obligations of the members of the Fund. A copy of the Trust Deed and Rules is available at aonmastertrust.com.au or a copy can be sent to you on request.

An annual report about the management and financial condition of the Aon Master Trust for the period to 30 June is prepared each year. If you do not elect to receive a hard copy annual report you can view the annual report online at aonmastertrust.com.au You may elect to have a hard copy of the annual report sent to you free of charge.

Who to contact

In the first instance, enquiries should be directed to Zurich:

General enquiries

Telephone: 131 551
Email: client.service@zurich.com.au
Post: Zurich Insurance-only Superannuation Plan
C/- Zurich Australia Limited
Locked Bag 994
North Sydney NSW 2059

Claims

Telephone: 131 551
Email: life.claims@zurich.com.au
Post: Zurich Insurance-only Superannuation Plan
C/- Zurich Life Claims
Locked Bag 994
North Sydney NSW 2059

You should be aware that all telephone conversations with you or your adviser are recorded.

Privacy Officer

Aon Master Trust
Telephone: (03) 8623 5000
Email: privacy@eqt.com.au

Zurich Australia Limited
Telephone: 132 687
Email: privacy.officer@zurich.com.au

What to do if you have a complaint

Superannuation law requires the Trustee to take all reasonable steps to ensure that complaints are properly considered and dealt with within 90 days. If you have a complaint:

- contact the Zurich Plan administrator on 1800 333 613, or
- write to us.

Complaints Officer
Equity Trustees Superannuation Limited
PO Box 810
South Melbourne VIC 3205

We will ordinarily respond to your complaint as soon as possible but within 45 days of receipt. If you are still not satisfied with our response, or we do not respond within 90 days, you may wish to refer the matter to the Superannuation Complaints Tribunal (SCT), an independent body set up by the Federal Government to review trustee decisions relating to individual members.

You can contact the SCT on 1300 884 114 or info@sct.gov.au

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